Direct Primary Care: 2013 Industry Landscape

About the Author

Dave Chase is the CEO of patient relationship management company Avado, the first cloud-based EHR-agnostic patient portal. He was named one of the 10 most influential people in healthIT and a "healthcare transformer" by the StartUp Health Academy. Chase has been invited to the White House and presented before the head of Medicare and the Pioneer ACOs. He is also a co-editor and writer of a book commissioned by HIMSS on patient engagement. Previously, he was a senior consultant in Accenture's healthcare practice and a founder of Microsoft's $2 billion health platform business. He left Microsoft in 2003 to work in startups as an executive to multiple high growth companies.

Avado services patient-centric providers moving to accountable models who value coordinating care amongst the various members of the care team – the patient/consumer, healthcare professionals, family members and caregivers. Avado also partners with software vendors to provide a competitive advantage over silo'ed tools and was selected by 22 pioneering healthcare providers in New York state for a statewide program pioneering accountable models. Avado has been featured in the New York Times, Wall Street Journal, TechCrunch, Washington Post, Bloomberg and numerous healthcare industry publications.

Why the interest in Direct Primary Care? With any startup, founders make a bet about how the future will develop with the goal of getting there before the competition. Avado believed that healthcare was destined to become much more patient-centric, accountable and coordinated which has proven to be true. The founders then sought out which organizations were ahead of the curve and had the potential to scale up to address a broad populous. It was in that quest that Chase discovered a nascent Direct Primary Care (DPC) movement. Though DPC wasn't broadly known at the time, Chase believed it represented a microcosm of how healthcare delivery would be delivered in the future whether it was part of a DPC model or not. Patient relationship management tools such as Avado are particularly applicable to DPC organizations.

Through the discovery process of visiting DPC clinics and speaking with leaders of these organizations, Chase learned a great deal more and began to write about this nascent movement. Chase dubbed DPC providers the "Triple Aim champs" delivering "concierge medicine for the masses." Just as airbags and anti-lock breaks first were delivered to affluent and then went mass market, DPC has made that same transition with DPC practices serving undocumented workers and other low income segments as well as middle income families. At roughly the same time, a DPC clause was added to the Affordable Care Act that few know about even to this day.

Introduction

This paper provides the landscape of an emerging practice model called Direct Primary Care (DPC) sometimes referred to as "concierge medicine for the masses". There are over a half million people in DPC practices. With DPC legislation passed in some states and inclusion in the Affordable Care Act (ACA), the implications, successes and obstacles to DPC growth are explored. The field is too young for detailed national studies so some of the early notable players were studied. Over a dozen DPC organizations were studied as well

as interviewed payers, purchasers and consumers to gain their perspective on the DPC model. In state regulatory and legislative language these practices are sometimes referred to as “retainer practices, “ and are defined as those that charge a recurring monthly fee in exchange for a set of services.

Direct Primary Care is defined as retainer practices that charge less than $100 per month per patient. Most charge in the $50-80 per month range. Of note, we are not including in this definition practices that continue to bill insurance companies for their services but charge in addition a monthly fee to patients. While these practices are able to provide additional time and resources to their patients, they are still largely driven by the current fee-for-service business model, and subject to its limitations.

History

Just a few decades ago, it was the norm to have a direct paying relationship with one’s physician, whether it was cash or bartering some product or service. As health insurance expanded from primarily catastrophic coverage to payment for all facets of healthcare, the direct relationship between patient and provider deteriorated. One of the founders of the Direct Primary Care movement, Dr. Garrison Bliss, articulated the changes in healthcare payment and their effect as follows:

> *“To a very real extent, when patients do not pay or control the payment to their physicians, their power and influence in health care declines. In the current fee-for-service health care insurance environment funded by employers and governments, physicians are paid for diagnosis and treatment codes.*

Bliss goes on to say that the result of these changes has led to a decline in the perceived value of primary care, a massive dependence on medical technology and a focus on higher cost procedures over effective, results-oriented health care.

Brian Klepper, PhD, and David C. Kibbe, MD, MBA outline the roots of valuing specialist care at the expense of primary care in a piece about the playing field being extremely tilted towards specialists in this Kaiser Health News piece. Part of the transition back to patient-driven care began with the first concierge practice, opened in Seattle in 1996 by Howard Maron and Scott Hall. It was called MD2 ("MD squared") and charged $1,000 per member per month. Shortly thereafter in 1997, also in Seattle, Garrison Bliss and Mitch Karton converted Seattle Medical Associates from a fee-for-service insurance Internal Medicine practice to a maximum $65 per monthly fee Direct Primary Care practice. This is currently a three- physician practice that remains highly successful and popular. Dr. Bliss later went on to establish Qliance Medical Group of Washington PC, the first scalable Direct Primary Care practice designed for the mass market.

Bliss and Karton determined that a panel size of 800 for their combined practice would be the break-even point. 1600 would be a full practice. (i.e., 2 MDs with 800 patients each). Bliss and Karton designed their DPC practice with the following design principles that persist to this day:

- Work for our patients directly – know who's the boss (the patient).
- Give the providers and the patients time to do the job right. Keep the panel sizes low and expectations high.
- Be open when patients need you to be open (12-hr days, weekends) and/or accessible electronically.
- Don't charge insurance co-pays or deductibles.
- Don't pay providers to do anything but the right thing for our patients – no incentives to "do stuff" as the fee-for-service model has encouraged.
- Build an electronic medical record that does medicine, not insurance billing.
- Monthly fees go to care, not an "insurance bureaucracy tax".
- Frequently ancillaries are either free or at cost such as lab tests and prescriptions.

Within a year of Seattle Medical Associates converting its practice to Direct Primary Care, yet another innovative practice in Seattle – SimpleCare - was created by Vern Cherewatenko, M.D. and David MacDonald, D.O. Dr. Cherewatenko describes what led them to switch their model:

> We both had excellent business staff and business-wise ran a very tight ship. Our combined practice billings totaled over $10 million, not a tiny operation by any means. With a combined annual practice billing of $10 million we calculated that we were losing approximately $7 per patient or $80,000 per month.

They realized they couldn't make it up in volume. With 2 clinics, 55 providers and 75,000 patients, they needed 6 clerks just to deal with copying of records from patients transferring in and out of various managed care plans. They analyzed their average patient charges and they described it as follows:

- Their charge for a 10-minute patient visit was $79.
- The insurance companies typically reimbursed $43
- Costs of collection were anywhere from $5-20 depending on the staff time, billing system, etc. (All doctors know they are discounted, but most doctors overlook what it costs to *collect* the $43).
- Therefore, the actual fee reimbursement for a $79 charge was $23.
- With a single, all-inclusive exam room overhead at $30 (the national average), they discovered they were losing about $7 on each of the 75,000 patients they were seeing annually.

This analysis caused them to rethink what they had taken for granted.

> "We knew we could not cut our overhead any further-- we had been doing that for the past 2 years (cheaper copy paper, less fancy patient info, less nurses, less receptionists, no more "pantry stocking," and so on). We were running as lean as we could, practically on bare bones."

Extent of Direct Primary Care

Although DPC practices are currently evolving primarily as a grassroots movement and most of these practices make little effort to obtain national recognition, they have been identified in at least 24 states and are burgeoning in several regions including California,

Florida, Washington State and Texas. With the advent of scalable versions of DPC practices with national aspirations like Iora Health, MedLion, Paladina Health, Qliance, and White Glove Health, it is this author's opinion that the DPC movement will grow rapidly in the coming decade, particularly if the US health care system fails to find other solutions to the problems of declining primary care, high cost, accessibility and poor performance.

Note that some of the DPC providers profiled in this paper also offer additional primary care options such as near-site and on-site clinics. The care delivery model is essentially the same, however they offer their services only to a limited number of employers.

Cottage DPC Industry Emerges

After the first DPC practices formed in Seattle, an array of entrepreneurs followed the model pioneered by Dr. Garrison Bliss or simply came up with a model on their own, unaware that others had begun to develop similar practices. Some of the notable pioneers include Drs. Vic Wood of Primary Care One in West Virginia, Brian Forrest of Access Healthcare in North Carolina, and Samir Qamar of MedLion in California. In addition, venture-backed White Glove Health in Texas developed a model with Nurse Practitioners making house calls.

By sheer numbers, White Glove Health is the most successful DPC organization, with over 500,000 members. The others all have fewer than 5,000 patients thus far. Not all DPC practices have had quick success. For instance, Symbeo based out of New Jersey raised and then burned through capital before it became economically sustainable.

The entrance of the highly successful dialysis company, DaVita, is one of the biggest recent developments in DPC. They bought a DPC/onsite clinic company ModernMed, a healthcare service firm providing direct primary care in 12 states through employer-based, on-site clinics and private physician practices. Later, they bought Healthcare Partners, the country's largest operator of medical groups and physician networks, for over $4B. The DPC/onsite company is the foundation of DaVita's new division, Paladina Health. Some of the Healthcare Partners practices could transition to a DPC model. DaVita has jumpstarted Paladina by enrolling DaVita's largest concentration of employees in Tacoma, Washington with over 1,000 employees and their dependents.

Even more recently, Qliance has received a major infusion of capital from Cambia Health (parent company of a regional Blue Shield). This is one of the best signs that health plans are beginning to wake up to the DPC opportunity. Qliance's previous investors have been founders of some of the most successful technology companies of the last 20 years – Amazon, aQuantive, Dell and Expedia.

Five Largest DPC Providers:

	Key Accounts	**# of Patients**	**Fee structure**	**Unique attributes**
Iora Health	Dartmouth, Culinary Health Fund, Freelancers Insurance Company	2,400+	Per member, per month (PMPM) based on risk adjusted acuity, currently averaging approx $80 PMPM	Primarily near site clinics for union-based organizations, insurers, and self insured employers

MedLion	Primarily individuals	2,000+	$59/mth + $10 copay	Transitioning fee-for-service practices to DPC – supports hybrid insurance/direct practices; operates in CA, NV, WA
Paladina Health	DaVita employees + 15 undisclosed employers	8,000+	$85-$125 PMPM	Acquired ModernMed; Concierge-level physician access; Transparency solution; Puts fees at risk based on achieving cost savings, patient satisfaction, and clinical outcome targets
Qliance	United Food & Commercial Workers, Expedia	5,000+	Average $65 PMPM	Most comprehensive list of services covered in monthly fee
White Glove Health	Highgate Hotels, Beryl Companies, Ivie & Assoc	40,000 via self-insured employers; 450,000 via health plans	Up to $35 PMPM + $35 per visit fee	House/office calls & remote delivered by nurse practitioners overseen by doctors

Value Proposition, Scope of Practice and Pricing

The core value proposition DPC leaders describe is the gains from reducing administrative burdens while simultaneously delivering a more proactive model of care that leads to reductions in unnecessary downstream spending. Overall, primary care practices receive less than 5% of total healthcare spending. Buying into DPC results in a doubling of primary care spending. The argument is that by increasing primary care spending to about 10% of total health care costs, they can reduce downstream spending by more than this increment. That is, by helping their patients spend the rest of their healthcare dollar better, and by keeping them out of the expensive parts of the health care system -- namely ERs, specialist offices, and hospitals. This isn't done by the old gatekeeper model. Rather, patients generally have less need for the more expensive facets of healthcare or they choose not to pursue them when fully informed.

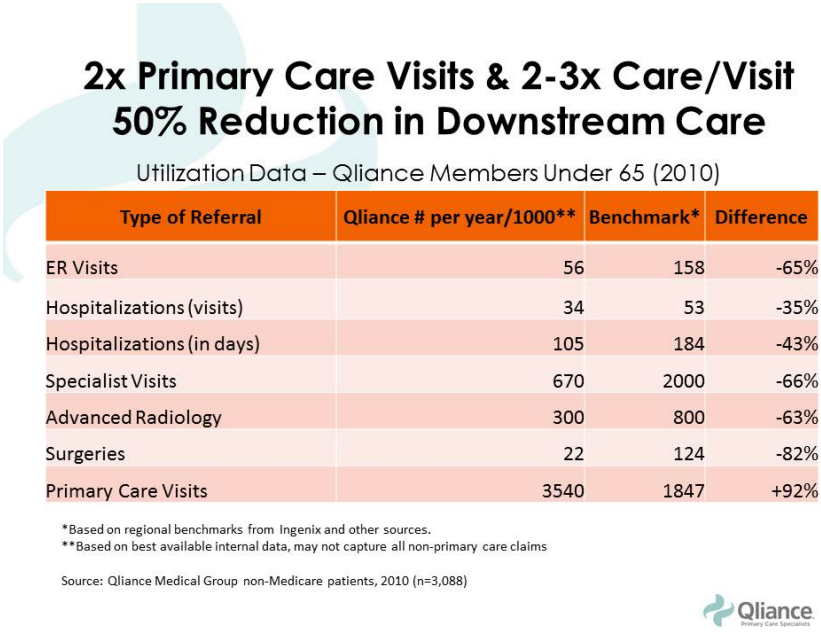
One example of how DPC can be more proactive is typically DPC practitioners develop schedules of preventive screening and regular check-ins that they manage. This is in contrast to a typical primary care practice that responds when patients present themselves. In the section entitled "DPC and the Healthcare Delivery System" the details on cost savings and health improvements are provided.

Qliance projected the cost savings to the entire healthcare system if their model was replicated would be $268 billion[i] ($864/person-yr x 310 million people). The breakdown of the monthly costs change was as follows:

- Non-primary care (specialty care, procedures, hospitalizations, etc.) reduced from $290 to $194
- Payer primary care transaction cost of $9 is eliminated
- Primary care costs increase from $31 to $64

Value Proposition

The value proposition for the emerging DPC industry as a whole is that if it was scaled nationally, overall healthcare costs could be reduced 20-30%. That is, not just slowing healthcare inflation but reversing it. Qliance has shown they can reduce utilization 40-80% on the most expensive facets of healthcare as demonstrated in the graphic below.



Iora Health has been able to show dramatic decreases in downstream costs for patients in their practices, mainly due to reduced hospitalization, ER rates, and specialty related outpatient costs. An independent academic reviewer looked at claims data and found that patients in a direct primary care practice working with a large union trust in Atlantic City NJ had 25% lower outpatient utilization, 48% less ER visits, and 41% fewer hospital admissions than patients in a matched control group. This translated into a 12.3% net lower total cost of care, even after taking into account the higher primary care costs than in usual practices.

In addition Iora has shown that this sort of practice model can increase productivity -- using a subset of the WPSI (Work productivity Short Inventory) survey, patients reported much less absenteeism (losing time from work) as well as presenteeism (being at work but not being as productive as possible) while in the DPC practice.

Saving Patients Money in Their Use of the Healthcare System

Typically, a high percentage of DPC consumers are either uninsured or have high-deductible plans. As a byproduct, they often seek guidance from DPC practitioners to keep their costs low. Often, the DPC provider knows which specialty practices have equal or better quality while offering dramatic savings off of the “retail” price. There are many

examples of DPC practices that know high quality specialists such as radiologists who will gladly discount 80% or more for immediate payment and avoidance of the costs of billing and collections. For instance, Qliance immediately pays a top healthcare provider in Seattle $17 for X-ray reviews which is a huge discount over their retail price.

DPC practitioners have the benefit of more time with patients, due to smaller panel sizes, to hear their story and fully discuss the trade-offs of particular screenings, treatments, and procedures. With the smaller panel size, DPC practitioners universally advertise their "unrushed 30-minute appointments" allowing for deeper dialogue with a patient that can be pivotal. For example, many people aren't aware of the overuse of CT scans that can lead to unnecessary exposure to radiation. One example illustrates this. A DPC physician described how in their previous practice pattern, when seeing a patient with constant migraines one would quickly order a CT scan at considerable cost. However, during the longer conversation enabled by the DPC model, the individual shared how her mother-in-law had recently moved in with her family. Long story short, the physician "prescribed" creating some boundaries, spending time meditating and going for walks as a means of taking a break. The patient followed the advice and the migraines went away. The result: a couple thousand dollars were saved and unnecessary radiation avoided.

Scope of Practice

The table below includes a list of services included in the scope of DPC practices. As there isn't a financial incentive to rapidly refer care to specialists, the scope of care can be broader than a typical primary care practice (e.g., some DPC practices provide x-rays and EKGs that would generally be referred outside of an insurance-based primary care practice). Similar to Patient-centered Medical Homes, coordination of care distinguishes DPC from most primary care practices. Some of those items may be outside of the scope of the membership fee, however they are generally offered at a modest cost. Following each item listed is whether the service is typically offered in some, most, or all of the dozen plus DPC interviewed for this paper.

Annual exams	All
Phone appointments	All
Email contact	All
Basic x-rays	Some
EKGs	Some
Pregnancy tests	Most
Spirometry	Some
Blood draws	All
Flu shots	All
Consultations and personalized coaching for weight loss, smoking cessation, and stress	Most

management.	
Chronic Disease Management for hypertension, diabetes, hyperlipidemia, heart disease, asthma, arthritis, osteoporosis and many other chronic conditions with referrals out to specialists when necessary	All
Specialist Care Coordination	All
Urgent Care: Same or next-day care for urgent medical issues including x-rays, sprains, strains, fractures, cuts requiring stitches, acute illnesses and more.	Most
Hospital Care Coordination	Most
Laboratory Tests including Blood glucose (Fingerstick), Hemoglobin/Hemotocrit, HIV Screening test, INR (blood coagulation measurement), Mononucleosis Test, Pregnancy Test, Stool Blood Test (FOBT), Strep Throat Test, Urinalysis	Most
Casts	Some
Skin biopsy	Some
Wound care	Most
IUD insertion	Some
Joint injections	Some
Ankle Braces, Forearm Splint, Finger Splint, Thumb Spica Splint, Cast Boot/Surgical Shoe, Walker Boot (short and long), Wrist Brace	Most
Skin tag & wart removal	Most
Peak Flow Meter	Some
Vaccines	All
Primary care level of treatment and counseling for the following: Infertility, Marital and family counseling, Mental health care, Sexual dysfunction	Some
Maternity/prenatal care	Some
Ultrasound (more complex referred elsewhere)	Some

Near-site clinics

Note: Onsite and near-site clinics could be a topic for an entire paper, however near site clinics are addressed because some DPC practices such as Paladina Health also provide near-site clinics.

Onsite workplace clinics have proven to be attractive for some larger employers. The benefits of greater access to primary care and the time savings and convenience for employees have been irresistible. However, one must have a critical mass of employees in one location for it to make economic sense. Consequently, a related phenomenon has been a hybrid of DPC and onsite clinics. Clinics are located *near* a set of organizations, but not at a worksite -- thus, the term "near site clinic." Iora Health, based in Boston, is one of the

pioneers of this model. They have had particular success with unions, such as UNITEHere, which represents casino workers in Atlantic City and Las Vegas, and the Freelancer's Union that represents freelancers in Brooklyn. Like DPC, near-site clinics avoid the complexity and overhead of insurance.

Near-site clinics also require a critical mass of employees or union members to pencil out. Relative to insurance-based primary care, the economics can be extremely attractive (see Iora Health profile for further detail). Nonetheless, if the employer/union isn't funding the build out, startup costs easily can run well into six figures. In these cases, DPC can be a more attractive option as the union, for instance, is only paying for those employees who are signed up; they pay on a per member, per month basis rather than being responsible for the full cost of the near -site clinic.

Pricing for Direct Primary Care

Based on our study of DPC practices, typical pricing ranges from $20 with higher per-visit fees to the upper threshold of $100, which typically includes a broader array of services. An employer, union or individual paying the monthly membership fee views the investment in primary care coverage rather than a "fee for service" transaction between patient and provider as prudent.

There is a wide array of pricing and a great deal of experimentation taking place in DPC, as one would expect in an evolving market. The variety of pricing models also reflects the regulatory environment under which DPC practices operate. For example, where there is DPC legislation (Oregon, Utah, Washington), the DPC organization doesn't have to do gyrations to avoid looking like insurance. [See more in the Regulation section of this paper on how national legislation has recently entered the mix.] For example, some practices charge a nominal per visit fee and bill after the end of the month as a means of avoiding the appearance of being classified as insurance and the accompanying reserve requirements and insurance regulations.

The following are the pricing themes common to all DPC practices studied:

- No insurance thus no deductibles.
- Discounts for an entire family. Commonly, the total family rate is equivalent to twice the rate for an individual.
- Transparent and low prices for any services not covered in the monthly membership.

DPC practices typically recommend that members also obtain a high deductible wraparound policy to cover emergencies and catastrophic events. To date, patients have simply acquired regular high deductible policies not specifically designed to be paired with DPC. In addition, many have arrangements for services the DPC plan doesn't cover at a substantial discount (e.g., $400 for an MRI where the advertised rate or "rack rate" for that same facility is $4000).

Regulatory Trends

Prior to the inclusion of DPC into the Affordable Care Act, these practices were on their own

to ensure they were within the bounds of existing provider regulations. The inclusion of DPC is very brief and leaves much to the states as to how to interpret and administer the law's DPC clause.

DPC Clause Included in Affordable Care Act

A little noticed clause[ii] was included in the Patient Protection and Affordable Care Act (PPACA) to require that Direct Primary Care be included in the proposed insurance exchanges, with the caveat that these practices be paired with a wraparound insurance policy covering everything outside of primary care. It is the only non-insurance offering to be authorized in the insurance exchanges slated to begin in 2014.

State Regulatory Activity

States have struggled to determine how to regulate DPC practices. So far, ironically, most have placed DPC practices under insurance regulators even though they are explicitly non-insurance offerings.

The following table is a sampling of states with DPC practices and the corresponding regulatory authority under which they fall:

State	Department overseeing DPC
California	Same as any medical provider
North Carolina	Same as any medical provider
Oregon	Department of Consumer and Business Services
Texas	Same as any medical provider
Washington	Same as any medical provider

Most state legislatures have been silent on DPC to date. Only Oregon, Utah and Washington have passed DPC legislation explicitly stating DPC practices isn't subject to insurance regulations even though they have a flat monthly payment. Maryland has looked at DPC and provided tips from regulators to medical practices on how to ensure that the practice operates properly with current regulations.

Some of the following measures were enacted in response to rulings by insurance commissioners that retainer care had to be regulated as insurance as opposed to provider practice regulations:

Oregon, 2011[iii]: Exempted retainer practices from meeting insurance code regulations if the practices are certified by the state. Certification in part requires that the practice cannot have been licensed as an insurer, must provide only primary care, and must disclose to patients that the practice is not insurance.

Utah, 2012[iv]: By far the simplest legislation, Utah provides an exclusion from insurance regulation for retainer medical practices.

Washington, 2007[v]: Permits retainer practices, but specifies that these practices cannot submit claims or discontinue care to patients based solely on health status. Practices can

turn away patients if they reach capacity and can accept payment from some third parties, such as employers. Practices can charge an additional fee to patients for supplies, medications, and vaccines that are specifically excluded under the written agreement. Patients may submit these charges to their insurer.

Washington was the first state to explicitly allow DPC. The term "Direct Primary Care" was created by the founders of Qliance as part of legislation that made monthly fee primary care legal in the state of Washington in 2007. This was necessitated by state law that could not differentiate a single primary care physician charging a monthly fee for care from a "health care service contractor" such as Group Health Cooperative or Kaiser Permanente. Attempts to update that law were aggressively opposed by the health insurance industry, although the final legislation passed with overwhelming bipartisan support and collaboration of the Insurance Commissioner of the State of Washington. It is codified in section 48.150 of Washington's code is outlined[vi] in the section entitled "Direct patient-provider primary health care".

West Virginia, 2006: Allowed physicians to provide primary and preventive health care for a prepaid fee through a three-year pilot project that began in 2007. The pilot was extended for one year and expired on June 30, but the three existing retainer practices were allowed to continue. The pilots have since ended with Dr. Vic Wood's Primary Care One being the only direct practice in the state allowed to continue. Dr. Woods is planning on going back into the legislature and opening the pilots back up. Officially, the way the legislation was written was that everyone left up and running after the pilot ended was allowed to continue. Every direct practice had to be approved by the state in the pilots. The qualifications were so cumbersome no one else applied.

The **Maryland** Insurance Administration[vii] provided guidance to retainer-based practices in 2009, stating they object to the following:

- Annual retainer fee covers unlimited office visits or a limited number of services that the physician cannot reasonably provide to each patient in his or her panel;
- No limitations on the number of patients accepted into the practice;
- Annual retainer fee does not represent the fair market value of the promised services;
- Physician has substantial financial risk for the cost of services rendered by other providers; or
- The retainer agreement is non-terminable during the contract year and/or does not provide for pro-rated refunds.

For the Bundled FFS Model retainer practice (Maryland's term for DPC), the Maryland Insurance Administration recommends the following to avoid running afoul of the law:

- Limiting the services provided in the year for an annual fee to an annual physical exam, a follow-up office visit and a limited number of other office visits;
- Establishing the annual fee by reviewing the market value of the annual physical exam and a follow-up office visit as well as each office visit, with the annual fee equal to sum of the market value for each specified service;

- Defining the services to be provided in a written agreement;
- Allowing a consumer or the physician to terminate the retainer agreement for any reason and provide for the pro rata reimbursement of the retainer fee if the written agreement is terminated; and
- Placing a cap on the number of patients based on the physician's ability to provide all the services specified in the written agreement to each patient on the panel.

In the relatively early days of DPC, a handful of unions such as the casinos workers union in Atlantic City, the freelancers unions in Brooklyn, United Food and Commercial Workers in Seattle and culinary workers union in Las Vegas have been the early adopters. Teacher's unions are one of the areas that are particularly ripe according to Chris Shoffner of Physician Care Direct who has worked with unions on benefits design. Healthcare costs have devastated education budgets so they are desperately looking for solutions that can save money. As outlined in the DPC and the Healthcare Delivery System section, the casino workers union cared for by Iora Health lowered overall spending 12.3% while costs continued to escalate elsewhere.

California situation

Michael McClelland, of McClelland Advocacy, Ltd. a health care law and lobbying firm, was previously the Chief of Enforcement for the Department of Managed Care for California's Department of Managed Care. He is an expert in California Managed Care law and Direct Primary Care. The following is his assessment of the California situation:

> In California, existing law gives the California Medical Board exclusive jurisdiction over the practice of medicine including licensure, care, billing and financial arrangements. They should be re-affirming their jurisdiction but have yet to. Thus the question of should the DMHC (the Department of Managed Health Care) regulate DPC is not the question; DMHC should regulate DPC only if DPC is a health plan or HMO. DPC in most of its forms is explicitly not insurance. Further, federal law likely prevents the State from impeding the practice of DPC. The Medical Board and not DMHC handle concerns about the practice of medicine.
>
> Consider that Washington state created a consumer line to receive complaints regarding DPC and have yet to receive one complaint. Furthermore, DPC is precisely a self-regulating consumer protection model. Because patients actually pay for their care, they can and will vote with their feet should a DPC physician not deliver as promised.

The Senate Health Committee chaired by Senator Ed Hernandez, O.D., had policy questions and concerns as recorded in the California Senate Committee on Health analysis[viii]. They primarily focused on whether there was, in fact, a need for the bill and if there was, whether there would be adequate consumer protection. DPC practices have been lawfully operating in California, however there is ambiguity regarding whether legislation is required for DPC practices to operate in the insurance exchanges. The ACA didn't explicitly address this point.

At the close of the hearing, the committee chair stated a desire to work with Senator Harmon who introduced SB 1320 to address DPC. No specific next steps were defined.

Governor Brown and legislative leaders have stated an intent to call a special session to address ACA compliance. Whether SB 1320 will be a part of this session is unknown.

California Insurance Exchange

At the time of this writing, it's unclear to what extent ACA Section 1301(a)(3) Qualified Health Plans (QHPs) will be "listed" on the Exchange. The Exchange has recently issued a draft solicitation that will be used to invite health plans to bid for listing on the Exchange. There is no reference to Section 1301(a)(3) QHPs in the solicitation. There has been some effort to make the California Exchange aware of 1301(a)(3) QHPs by a NGO called the Healthcare Exchange Advocacy and Responsibility Team (HEART). On July 17, 2012 HEART submitted a document[ix] to Exchange staff referencing DPC.

DPC, Purchaser and Payer Perspective

DPC perspective

For this report, the authors interviewed CEOs or executives of a dozen DPC companies. The comments below reflect the comments made by these CEOs when asked the questions listed in the profiles. In addition, there was an open-ended discussion to learn more about their organizations.

DPC practitioners believe that they achieve the Triple Aim[x] (improve patient experience, improve health and lower per capital costs) perhaps better than any other delivery model in place in the U.S., and they are mystified that DPC hasn't grown faster than it has. They recognize the inertia that exists even if there isn't high satisfaction with current models. Their perspective is straightforward and explained by an analogy. DPC practitioners outline that people wouldn't put up with co-pays, EOBs, deductibles, pre-approvals and other things taken for granted in healthcare today if that was applied to the equivalent items in car maintenance. No one pulls out his or her State Farm card for a trip to the mechanic, yet that's what is done with day-to-day healthcare. They view the administrative burden as an "insurance bureaucracy tax" that can add 40% to the cost of healthcare yet is something that both providers and consumers are unhappy with (see the Net Promoter Score graphic in the Consumer Attitudes section that shows how low health insurance ranks versus other industries).

DPC in Public Sector Funded Healthcare

Another way to look at it is DPC providers' response to the question of using DPC as a way to deliver public sector-funded primary care. This concept elicited a strong response from DPC leaders that summarizes their perspective on DPC and the rest of the healthcare system. Here is how Dr. Garrison Bliss described it:

> "The issue of using DPC for the poor is from our point of view a no brainer. Why use the most expensive inflationary system available (by which I mean the insurance system, whether public or private) to take care of those with the least money and most in need of basic services? The structure that makes sense to me is to create a thriving marketplace in direct primary care, competing on price, access and quality – and working exclusively for our patients. Then add a fixed monthly stipend for primary care for every Medicaid patient in the United States – a stipend that covers the lowest priced/highest functioning primary care available."

The following is a composite of the arguments DPC providers make for why DPC would be a good way to provide primary care to Medicare and Medicaid beneficiaries where there was universal agreement across the DPC providers:

1. No government management system to control or manage care – it manages itself with the patient at the helm.
2. Converting dependent impoverished citizens into patients with economic clout and respectful treatment.
3. Eliminating the cost overhead of insurance billing on both the MD and the government side.
4. No more barriers to basic care for Medicare and Medicaid patients – they can use all they need.
5. Eliminating the fee-for-service incentive disaster that produces massive overutilization and huge downstream expenses.
6. Financially stabilizing the primary care world with consistent monthly fee payments to cover fixed costs while allowing those doctors with better ideas or higher prices to go for the upscale patients or those wanting better art work and longer visits.
7. Free up primary care doctors to further improve their quality, access and patient centered services – not their billing savvy.
8. If the government wanted to regulate, they could demand an annual report on each patient they support, giving the actual utilization, health care outcomes and proof of appropriate management of common illnesses, immunizations and cancer screening. The government could actually pay for results, not process. Primary care practices would have to be certified as producing an acceptable level of results and patients would have access to success profiles both in terms of cost and quality when selecting their doctor for next year.
9. The government could track the overall costs created by each practice and make those numbers public as well. The high cost practices would eventually lose certification, particularly if the money ended up in the hands of their employer (hospitals, big multispecialty clinics).
10. If the government wants to tackle the HotSpotters patients[xi], they just need to up the monthly ante for the sickest patients – they will get their money back with huge interest from the reduced downstream costs and reduced transaction costs that these patients generate. With the big fees they will also be able to require more complete reporting of how their chronic illnesses are being managed.

Purchaser perspective

Self-Insured Employers

It is generally assumed that self-insured employers are gigantic corporations; however, many are organizations with as few as 50 employees who are turning to self-insurance with stop-loss policies that protect them from rare, but potentially financially devastating, claims. These self-insured employers are driving much of the move to a re-emphasis of the importance of primary care. The bottom line is the bottom line. Studies such as IBM's find increased access to primary care provides the highest ROI for allocation of their healthcare spending.

Highgate Hotels[xii], Ivie & Associates[xiii] (a marketing & adverting agency), The Beryl Companies[xiv] (operates a healthcare customer contact center for some of the nation's leading hospitals) are three examples of self-insured employers working with DPC providers. These organizations work with White Glove Health that works with over 400 employers (a mix of self-insured and fully insured employers). The following items are some of the ways they measure the success of the DPC model:

- Lower absenteeism.
- Reduced ER visits (they've seen a 10-40% reduction) and other medical costs (they've seen reductions of $25,000-130,000 in the first year and more in subsequent years).
- Decreased employee stress & Improved morale.
- Saving time going to/from a doctor's office and waiting room time which can add 2-4 hours away from work.

Jennifer Limon, Manager of Compensation and Benefits at Beryl says the whole tone of the annual open enrollment season has changed measurably:

> "Instead of delivering the bad news during open enrollment: costs are going up, benefits are being reduced—it is a positive time where we are able to report that costs are not going up and we receive feedback from our co-workers about how pleased they are with the healthcare coverage that the company is providing
>
> Ms. Limon goes on to say that employees now have an incentive to seek care early that can head off more serious issues. Indeed, because the WhiteGlove visits are seen as inexpensive, the firm expects to see costs continue to decline as workers seek early treatment.
>
> "We were looking for ways to help reduce healthcare costs and absenteeism," explains Andrew Pryor, VP, and Human Resources for Beryl. "Our absenteeism rate affects our revenue. When we reviewed our company's current health plan, we

discovered that three out of four co-worker's visits were for routine and preventative-care issues, for conditions such as sinus or ear infections. We also found that a typical visit took two to four hours out of the day, when we accounted for travel time and waiting at the physician's office."

It was IBM's study of their $2B spend on healthcare globally that moved the company to action. The findings from their global study led to a surprisingly simple formula described by Dr. Paul Grundy (Head of IBM's healthcare transformation) as follows: "More primary care access led to a healthier population which, in turn, led to less money spent. This is why IBM has become proponents of the Patient-centered Medical Home as the foundation of the transformation of healthcare delivery." Separately, in Denmark[xv], the government broadly implemented the PCMH model re-emphasizing the importance of primary care. As a byproduct, the number of hospitals (and hospital days) has dropped by more than half proving the old adage "an ounce of prevention is worth a pound of cure."

Unions

DPC has gained an early foothold with aforementioned unions. About 20% (or 1000) of Qliance's patients are members of United Food and Commercial Workers union. Iora Health has had a strong focus on unions, and is working with UnitedHERE Union in Atlantic City, the Freelancer's Union in Brooklyn and the Culinary Workers Union in Las Vegas. Their model is different than other DPC practitioners in that the unions make a substantial commitment by identifying their highest-cost members and targeting them for the Iora program. The critical mass of patients from the unions allows an Iora Health location to be established with much of the financial risk mitigated since there is a full patient panel.

Payer perspective

Payers of healthcare will be able to realize the benefits of DPC in controlling costs and increasing patient wellness only if the solution is more widely available and easily adopted by providers. "Access to a physician, screening tests and baseline generic drugs are not expensive when paid directly to the provider, much like an onsite clinic", states Chris Shoffner, VP of Physician Care Direct. "Through technology, any provider can immediately become a DPC provider. That is how we scale the DPC solution and meet the needs of the payer, provider and patient in the future."

Although DPC is included in the federal health reform and it has demonstrated some strong results, the authors of this report found many payers and purchasers were not aware of the existence of these companies and this model of care. This section looks at the broad definition of payers and purchasers from self-insured employers to unions to insurance companies.

Insurance Carriers

Proponents of DPC assert that the most cost effective way to pay for healthcare is to pair DPC with a high-deductible wraparound policy. The idea is that insurance is used for what it's best for — rare items (house fires, cancer, major car accident). For day-to-day healthcare, DPC is paid for in a model that is akin to a gym membership — a flat monthly fee regardless of how much one uses it (though some have co-pays mainly due to state insurance regulations). Contracting with DPC is a relatively new phenomenon. This is a description of the activity that's been announced to date by the major DPC companies. (Note: we've been told there are additional discussions underway, however to date, Cigna and MEBS are the only carriers to announce anything.)

Cigna

Cigna is the first major carrier to embrace DPC. They are pairing DPC with their plan for self-insured companies with more than 50 employees. As an early adopter of pairing DPC with a complementary insurance program, hypothetically they gain at least two key advantages over their competition:

1. New business generation. It is a key tactic for capturing new business by having a unique offering to prospective clients.
2. They will have a full year of experience working with DPC practices before the Insurance Exchanges that are part of the federal health reform kick in.

Cigna's marketing statement of what they are doing states:

> "Cigna has adapted their Level Funding Plan for employers to accommodate Qliance as a primary care network option for companies who want to enhance primary care access for their employees, improve the quality of care, and drive overall healthcare savings. Cigna, the first insurance carrier to actively include Qliance in their plan, has been on the forefront of finding innovative solutions for the employer market, and Qliance is proud to be an active partner in their efforts."

Chris Blanton, President and General Manager of Cigna PNW, asserts that his organization and Qliance both want to improve access to quality, affordable care:

> "Employers who use Cigna's self-funded plan options and Qliance's enhanced primary care solution are able to offer their employees access to high-quality, patient-centered comprehensive care with savings opportunities for employers and their employees. With the ever growing shortage of primary care services in today's marketplace, we see this as a unique opportunity to address the issues of access, quality and affordability."

Associated Mutual

Associated Mutual is a health plan with strength in serving unions such as the AFL-CIO and Ohio Health Care Trust. They are based in Grand Rapids, Michigan. Associated Mutual ' President, Tim Spink described how he was initially skeptical of offering DPC as it sounded

more expensive than the per member per month costs for primary care that they assume in their baseline model. He thought if he was paying $x per year to a physician and many of those covered lives won't go to the physician in a given year, it sounds like it would be more expensive than a traditional fee-for-service model. Or he compared it to HMOs. It can look like it's significantly higher cost than HMO. The big difference that overcame his skepticism is the nature of the ongoing patient-provider relationship. Further, there is much more covered in the fixed cost going to the physician than what he initially thought. The way Spink looked at it is that it's more about elimination of CPT codes. That is, there are two key byproducts of a DPC practice:

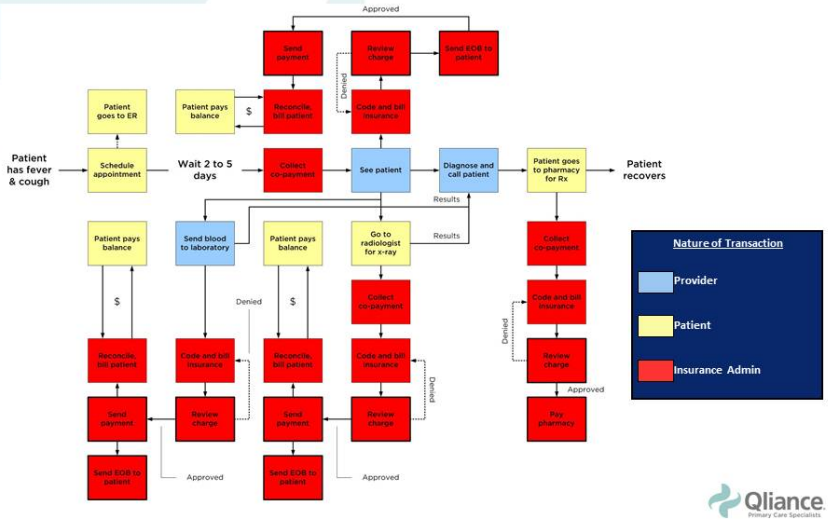
1. A very large percentage of common medical issues can be handled in a DPC practice especially when they have no financial incentive to refer patients out since they aren't subject to productivity objectives driven by the fee-for-service model.
2. As outlined in the DPC and the Healthcare Delivery System section, they dramatically drive down utilization of the most expensive facets of healthcare (hospitalizations, ER visits, surgeries and specialist visits).

Consumer Perspective

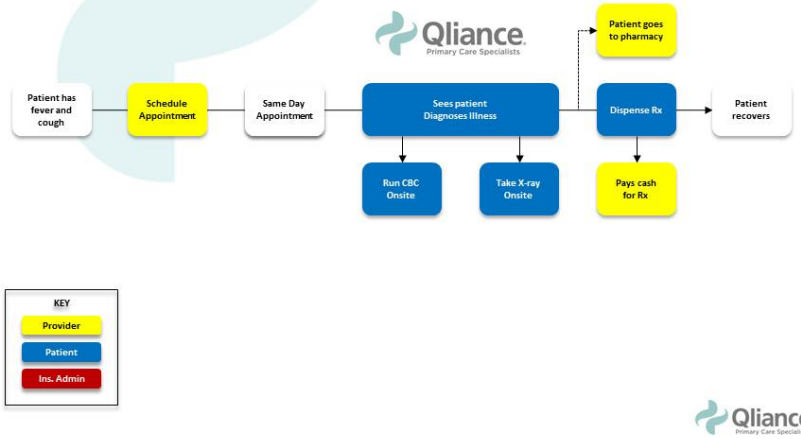
Broad studies haven't been done to measure consumer attitudes regarding DPC. As mentioned previously, there is generally very low awareness that such a model exists. Consequently, the paper is limited to a sampling of consumer interviews, 3rd party review sites such as Yelp and studies done by the DPC practices themselves.

The following two graphics depict the process for a typical primary care visit operating in an insurance model and a DPC model. Not only does the DPC model drive significant savings, the consumer experience is greatly improved.

High FFS Primary Care Admin Cost Promotes Visit Volume vs. Time with Patient



Efficient Direct Primary Care Medical Homes Promote Time with Patients vs. Visit Volume



Low Income Consumer Perspective (sub $25,000 per year income)
Since 1/3 or more of most DPC practices are uninsured and many are low income, patients identified by DPC practices as lower income were interviewed.

Amy J., a patient of NeuCare/Dr. Ryan Neuhofel ("Dr. Neu) is uninsured and pays the monthly membership and per visit fees of NeuCare. She described her experience with conventional primary care practices as "expensive, very impersonal, and the visits always seemed quick and rushed."

In contrast, she's very happy with this DPC practice. "Dr. Neu takes a lot of time to go over all my problems during each visit. This is important because I've been dealing with a lot of health issues lately. I was amazed at the cost considering the level of care. It was much better than the $80 I was paying for the rushed urgent care visits. Dr. Neu is not prone to give unnecessary antibiotics and tests. He's very thorough and spends a lot of time with me. He's like what a family should be. He's available, responsive, and present. You don't see this in other clinics."

On the negative side, here's what she had to say: "Dr. Neu doesn't accept insurance. My son has insurance through the government and isn't covered in this clinic. However, I should add that the extra out-of-pocket cost is worth it."

A patient of Palmetto Proactive Healthcare, Linda H., is 62 years old and described her situation as follows: "I saw another family doctor for about 35 years. BCBS would cover the visit but when I lost my insurance I had to start paying $200 to $250 for each visit--even if it was only for 5 minutes. I couldn't afford that. I then started using the ER but they wouldn't accept me for charity care. I also didn't qualify for Medicare because I wasn't disabled or over 65. Then one day, I was at my local Bi-Lo Pharmacy and I bumped into Dr. Aya handing out pamphlets about his clinic. I read it and decided to try it out. Since then, I've seen Dr. Aya twice over the last four months."

Grameen America Partners with DPC Provider to Low Income Patients

Nobel Peace Prize Winner, Muhammad Yunus, is famous for creating the concept of microfinance which has brought thousands out of poverty via the Grameen Bank. Grameen America is their U.S. affiliate which has already lent $77 million to over 15,000 women impacting 60,000 people (each borrower averages a family of four). Their microfinance repayment rate is 99.4% in the U.S. Grameen has partnered with Iora Health to offer primary care services in New York. They believe addressing healthcare is a key facet of bringing people out of poverty.

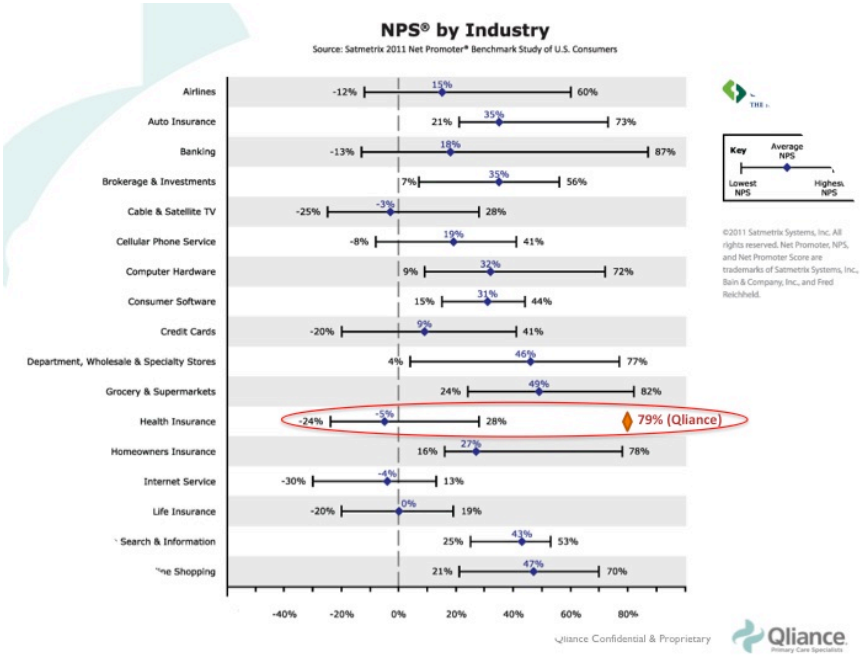
Grameen's plan is to initially offer Iora's services to their borrowers. After that, they will extend that to their family members (including children) and eventually more broadly. Like their microfinance program, it isn't designed as charity. Rather, Grameen borrowers will pay $10 per week ($43/month) which they expect will be economically sustainable. The borrowers fall outside of what Medicaid and Obamacare address so the rest of the healthcare system is quite happy to keep these individuals out of the ER or even Federally Qualified Health Centers. Grameen's "competition" will be the ER and FQHC so they must demonstrate that higher level service and dealing with the same healthcare team provides distinct advantages over disjointed care in the ER/FQHC.

This development will further debunk the myth that DPC isn't applicable to the broad system. If anything, given the extremely high Net Promoter Scores Iora achieves, if there is a "two tier healthcare system" it is higher income people receiving an inferior care model.

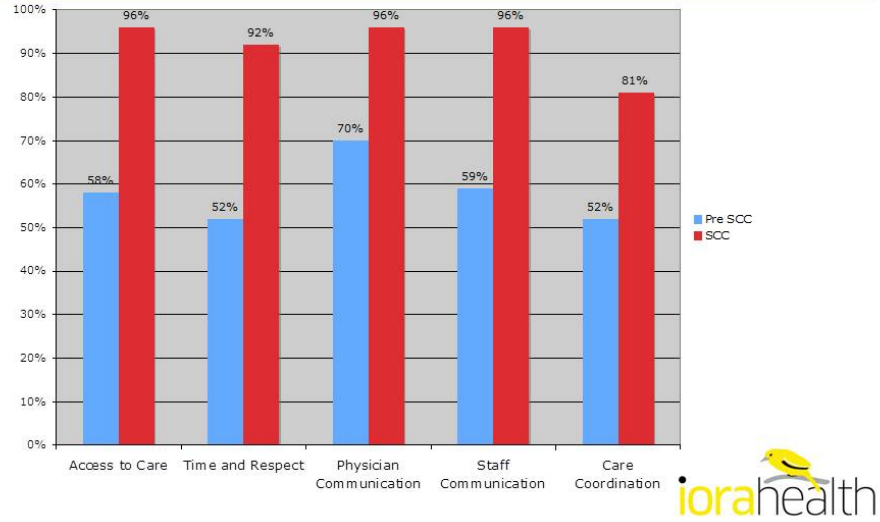
Qliance Net Promoter Score Study and Iora Patient Experience Measures

Net Promoter Score (NPS) is a generally accepted way of measuring consumer attitudes of a brand or industry. The graphic below compared the high, low and average by industry with

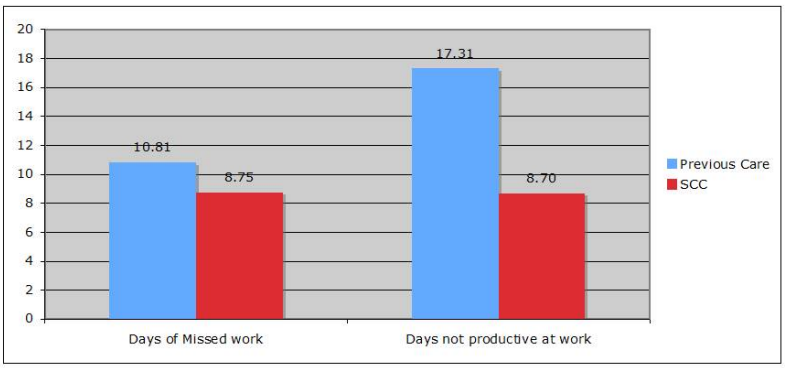
Health Insurance having the lowest average NPS. Lower even than cable companies and airlines. Though DPC models aren't insurance, they are a useful item to compare since DPCs are an alternative for day-to-day healthcare. Qliance's NPS is higher than vaunted brands such as Google and Apple demonstrating the strong value proposition to consumers.



Patient Experience was improved over prior care in all domains of CG-CAHPS Survey (nationally validated survey created by AHRQ, administered at intake and then after 1 year in SCC)



Patients self reported productivity also rose after joining the SCC (comparing 6 month period before and after joining the practice)



Technology Trends Supporting DPC and Requirements

Without exception, every DPC practice points out that there are stark differences between DPCs and traditional insurance-based primary care. The DPC model demands software that is very different from traditional EHRs. As they say, it's "square peg, round hole." The well-resourced pioneers conducted thorough reviews of the software landscape before developing their own custom systems. Qliance, for instance, reviewed over 240 different U.S.-based EHRs before looking elsewhere and choosing to adapt a European-based system. White Glove Health made a large investment in their own technology and they believe it's a key part of their differentiation.

As the DPC market has matured, off-the-shelf software, engineered for the unique requirements of DPC, has emerged. Not only is this lowering the cost to obtain functional software, but it is opening up new means of delivering care. As traditional practices evolve to accountable models, these requirements will be the same. DPC practices simply are the early adopters. The following are facets of the technology changes and their implications on DPC:

- Cloud-based Software-as-a-Service: As low overhead operations, DPC practices not only demand the price advantages that come with cloud-based services, they want the simplicity of not having to set up and maintain server software as well as having to update individual PCs that most healthIT still requires.
- Nimble software: The practice patterns are continuing to evolve particularly as new technologies open up care models that weren't possible before. Consequently, the ability to easily modify workflow, templates, etc is vital.
- Mobile devices: Both patients and doctors have mobile devices wherever they are. DPC practices, as inherently customer focused organizations, naturally want to deliver convenience to their patients. One DPC practice shared how they haven't seen a patient with shingles in person in years. Instead of the hassle of scheduling an appointment (often taking days to get in), they can take a picture of the symptoms

with their mobile device and send it to their doctor right away. Assuming it is shingles, the doctor can call in a prescription and save everyone time and money.
- Biometric devices: There is an explosion of personal biometric devices. Increasingly, patients are buying them or providers are buying them on behalf of patients with chronic conditions.

There are three broad themes to the unique requirements for DPC practices:

- Longitudinal relationship (vs. transactional) care orientation: See the sidebar on how a long-term service orientation is central to DPC models and imperative to tackling chronic disease.
- Membership management: Rather than a fee-for-service model, most DPC providers have a membership-based model. The financial health of the practice is greatly enhanced if patients stay with the practice a long time and are as healthy as possible. For a DPC practice to realize its full potential, it is critical to have tools that allow for membership communication, management and retention.
- Consumer convenience: One of the biggest differences cited by providers who transitioned from an insurance-based practice to a DPC practice is face-to-face patient-provider interaction. MedLion has been transitioning practices from insurance-based to DPC and Dr. Samir Qamar states that the doctors are frank that they "forced" patients to come into their office, as that was the only way they could get paid. As has been seen in Denmark where 80% of patient-provider interaction is asynchronous, most care doesn't require a live, in-person encounter. There is a considerable price tag, both in time and money, associated with a typical encounter at an insurance-based practice. Doctors tend to factor in waiting room time as a potential burden; however, there are other nuisances (driving, getting child care, parking, tolls, waiting, etc.) associated with the standard appointment that can substantially complicate the patient experience. During the study, we visited Qliance and MedLion clinics. It's striking how patients aren't waiting in the waiting room. If there is anyone there, it's a family member waiting. When we asked why, both state that it's a combination of longer appointments that don't overlap each other and their accessibility via email and phone that obviate the need for face-to-face encounters.

Even the fundamental model of how traditional healthIT has been deployed is very different. Traditional technology implementations are very involved with many months of planning before go-live. During that time, there is a great deal of process planning and re-engineering before configuring the system to reflect what has been decided. Roughly speaking, process is weighted 80-90% toward pre go-live with 10-20% focused on post go-live to deal with go-live issues and some further training. In highly dynamic environments such as DPC, the pre and post live weighting needs to be flipped on its head (i.e., 20% planning, 80% analyzing, refining, testing, etc.). While some areas of healthcare will be stable, the most critical area to manage is where the greatest costs reside — chronic disease. Some best practices have begun to emerge, however one can expect a high degree of iteration to address the various areas of chronic disease management. Some of the traditional software has strengths in its ability to address different *internal* workflows after significant customization. However, healthcare providers report that if they need to reorder workflow, the system has to be reconfigured with considerable time and expense involved.

The capabilities necessary in a DPC practice are quite different than what is needed in an insurance-based primary care practice. Those practices have largely focused on what's required with Stage 1 Meaningful Use requirements outlined in the table below. However, the requirements that come with DPC provide a preview of what other patient-centric, accountable and coordinated reimbursement models such as ACOs will need.

As Dr. Rushika Fernandopulle of Iora Health states, "despite all the hype, most of today's EHRs are really mainly billing systems that allow docs to justify higher level codes for billing and tracking collections. DPC practices don't care about these games; and the things we do care about -- engaging with patients, population management, and managing teams aren't served well by current EHRs. Thus, many of us especially who are at some scale are either making large modifications to existing systems or building new tools from scratch."

The table below outlines the requirements of a DPC-based practice in terms of patient-facing tools versus an insurance-based practice. As mentioned above, the requirements for a DPC-based patient portal are simply what any accountable model will eventually require. The table is an aggregation of the Meaningful Use requirements and the features in the homegrown and off-the-shelf patient portals in use by DPC practices.

	Insurance- based Patient Portal	DPC-based Patient Portal
Stage 1 Meaningful Use		
Electronic copy of health information	✔	✔
Clinical summaries	✔	✔
Stage 2 Meaningful Use (proposed)		✔
Summary care record for each transition of care or referral	✔	✔
Secure messaging	✔	✔
Reminders sent per patient preference		✔
Patient specific patient education		✔
Incremental Capabilities Needed for DPC and Fee-for-Value Models		
Membership management (monthly fees, etc.)		✔
Retention marketing tools		✔
2-way Patient-provider mobile health tracking		✔
Multi-provider patient portal to have one place where all provider information flows		✔
Remote biometric device connection		✔

Patient-enabled scheduling		✔
Practice/doctor website		✔
1:many publishing on patient education materials and office announcements		✔
Electronic forms to remove administrative burdens		✔

DPC and the Healthcare Delivery System

Though DPC practitioners are quick to point out they don't want any "gatekeeper" role or financial incentives that drive referrals to outside health professionals, they do help their patients make informed decisions regarding other healthcare services. While they reduce the need to refer out, there are still many instances where a referral is necessary. DPC practitioners assert that because they have smaller panel sizes, they are able to spend time to coordinate care with other providers and describe this as a core part of their value proposition. This was confirmed in interviews with patients of DPC practices. This contrasts sharply with the volume-oriented metrics the insurance-based primary care physician is often subject to where they don't have the "luxury" to follow-up with referral recipients. In a typical multi-specialty practice, primary care is a loss leader like milk is for a grocery store. In insurance-based medicine, a primary care provider typically refers out millions of value every year to specialists, imaging centers and laboratories.

Dr. Garrison Bliss believes this is a root cause of healthcare inflation. “This makes primary care physicians valuable to hospital and multispecialty care groups, not because they can reduce costs, but because they can increase them.” DPC practitioners interviewed for this report indicate that one of the reasons for the persistence of the sub 10-minute office visit and the 3,000 patient primary care panel is that overwhelmed primary care physicians can be counted upon to refer more and do less themselves.

Commonly asked questions about how DPC practices work with the rest of the healthcare delivery system

How does referral to specialists work, especially in terms of chronic care? Here’s how Iora Health’s Dr. Rushika Fernandopulle described it: “We tend to make many fewer referrals than typical practices and handle the vast majority of chronic care management ourselves. We have a small group of specialists who have agreed to work with us in a more collaborative way including MD-MD phone, video and email consults, and real time specialist-PCP discussions while patients are being seen.”

What happens when a patient is hospitalized? Fernandopulle stated, “Similarly we co-manage our patients in the hospital with a small group of hospitalists. We try to see all our patients in the hospital at least once, and discuss the cases with the hospitalist daily. We also expect email or phone communication the same day as discharge.”

To what extent do DPCs serve the same role as medical homes; in what ways do they differ? Fernandopulle: “We, like most other DPCs, follow many of the principles of the medical home, and indeed would score highly if we chose to get certified. We have not

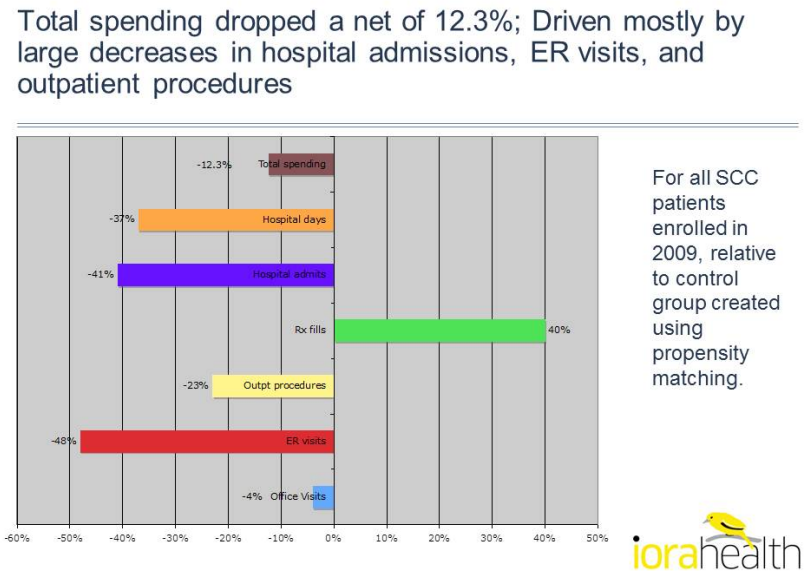
chosen to go that route now because we think it is a distraction. We are designing our practices to best serve our patients, period. The medical home criteria like all others like it are designed by committees with the usual baggage that comes from such a process. If we happen to meet the criteria, then they have gotten them right. The criteria are very structural -- do you have a policy to do this or that. With the right sort of policy tweaks one can become a level 3 medical home without really changing much about how care is delivered (and of course many are playing this game). When you walk into a good practice that is trying to really take care of patients, you can feel it -- the whole is much more than the sum of its parts."

Generally speaking, the way DPC practices interact with the rest of the healthcare delivery system is no different than other primary care practices. The following are the unique facets of how some DPC practices work with the rest of the delivery system:

- A large chunk of DPC practices serve patients who are uninsured and/or have very high deductibles and pay cash for all but the most catastrophic items. Consequently, formally or informally, most DPC practices offer a wide array of cash pricing for imaging, colonoscopy, sleep apnea evaluation, labs, meds at discounted prices negotiated by the DPC organization with outside providers. Several of the DPC companies note that they are able to get 85-90% discounts off of what one would pay if you weren't in a pre-negotiated arrangement for items such as MRIs for making immediate cash payment. For those other organizations, they calculate what they actually make after insurance discounts, billing and collection costs. As an alternative to that hassle, they give a massive discount for immediate cash payment. While some items are exactly the same service, DPC providers also provide alternative recommendations. For example, Qliance shared how a typical sleep apnea evaluation study in a hospital can run $3,000. However, there are home studies that they argue are more effective. The price the provider offered for the home test is $70, a 98% savings over the alternative. The founder of WhiteGlove Health, shared one of his experiences. "I had an ear infection that was causing me to be very dizzy and nauseous while traveling in Massachusetts. So, I went to the Mass General ER and the bill was many $1,000s and they never looked into my ear, but instead, they performed lots of other expensive procedures. The next day when I got home, I called WhiteGlove and medical care was brought to me at my home within 2 hours and $35 later (and no other expenses to my health plan), where they diagnosed me with an ear infection and handed me the generic Rx meds I needed."
- Palmetto Proactive Healthcare in Spartanburg, SC has had the local hospital refer discharged patients to them. Often these are patients who cannot get into their primary care physician (PCP) in a timely manner or those without a PCP. In order to avoid hospital readmission penalties, paying the modest visit or monthly fee is great "insurance" to ensure the patients aren't readmitted. After the patients get the experience of the DPC model, many take over the monthly fee.
- One of the most unique DPC practice models is WhiteGlove Health. Thus far, they operate in Arizona, Kansas, Massachusetts, Missouri, Tennessee, and Texas. They serve the employees and dependents of fully insured companies as well self-insured employers such as Highgate Hotels, Ivie & Associates, The Beryl Companies and

provide in-person care via nurse practitioners who go to the home or workplace. They have a single, flat visit fee of $35 (all inclusive) and a number of different membership classes and associated fixed fees. The employer, consumer, and in some limited cases, the insurance company pays the membership fees. The patient or member pays the $35. And when care is needed, their mobile and telephonic provider network provides medical care, including diagnostics and generic Rx meds (at time of visit, as allowed by law) and does not use the rest of the delivery system unless the medical needs are outside their scope and then they refer out like any other primary care provider.

DPC Dramatically Reduces Downstream Utilization



Key Issues and the Future

The growth and evolution of DPC will be dynamic. In this section, detailed are some of the open issues and questions that might impact the evolution of the DPC market. Finally, how things to evolve in the future are outlined.

Does DPC exacerbate the primary care physician shortage?

The most common critique of DPC is that if you substantially reduce panel sizes, this markedly exacerbates the primary care shortage in this country unless there is at least a 2-4x increase in the number of PCPs being trained. It is estimated that there will be a shortage of 35,000-44,000 primary care physicians by 2025[xvi]. This is a particularly significant issue with the aging population since DPC providers are restricted in how they can serve the Medicare population. There is legislation[xvii] proposed by Rep. Bill Cassidy, MD (R-LA) and Jay Inslee (D-WA) to expand DPC to cover Medicare patients. One must

look at the causes of the shortage of PCPs and analyze whether DPC addresses or worsens the issue.

Dr. Josh Umbehr is a DPC practitioner takes this issue head-on:

> *The increased accessibility and quality of DPC can't help but mitigate the shortage. I am the urgent care. I am the ER. I do the home care needed to decrease hospitalizations. I'm their pharmacy and the lab. I'm their diagnostic center. I'm the missing link to ensure continuity of care and eliminate costs. How many fewer doctors are needed now because one doctor is correctly incentivized to improve all of these factors? How many physicians will avoid retirement, change their practice, and return to and embrace Family Medicine again? How many students will gravitate towards primary care now because it's better care, better lifestyle and better money?*

The following are the primary factors for the PCP shortage:

1. The top issue according to a Physicians' Foundation study that stated half of PCPs would leave medicine if they could was the red tape associated with insurance. Respondents stated they are spending more time on paperwork than patient care.
2. Primary care is one of the lowest compensated specialties in medicine. Roughly 40% of medical school students enter in a primary care related field such as Internal Medicine. However, by the time they graduate from medical school, only about 10% *haven't* sub-specialized due in large part to school loans they'll have to repay. The American Medical Association's Relative Value Scale Update Committee ("RUC" for short) largely determines how medicine is compensated. It has long been dominated by specialists. Thus, it's not surprising that specialists related activities receive the highest value.
3. The practice model of a typical PCP is described by many as a "hamster wheel" as productivity goals result in patient encounters averaging less than 10 minutes. This is unsatisfying to most PCPs who recognize that a longer encounter is necessary to deliver optimal care.

MedLion's Dr. Samir Qamar describes what led him to start MedLion in response to the issues he saw with traditional insurance-based primary care.

> *"While I was in my residency, I was struck by how dissatisfied the PCPs I was training with were. They were running so fast they weren't able to deliver the kind of care the family doctors I grew up with provided. It was clear that they were simply a loss-leader for high margin referrals for other medical services. What else can happen if you have 7 minutes per patient? There isn't enough time to look beyond a presenting symptom and order a test, prescribe a drug or refer out as quickly as possible.*
>
> *I also observed all of the time doctors spent dealing with billing issues and the accompanying administrative staff. In a practice such as MedLion's, we run on a very, very low overhead model. This allows us to charge a very reasonable amount that is*

affordable to farm workers and many uninsured patients we care for. We feel DPC is making primary care attractive again. Not only will more med students choose this path but we are finding doctors who left primary care are coming back when they learn about the DPC model."

As DPC proponents would say, the way to solve the primary care shortage is to make it appealing once again. DPC directly addresses the issues that have led to the shortage in the first place. Dr. Umbehr drew an interesting analogy.

> *I'm sure you know how the argument goes, if you don't want an animal to go extinct, eat it. To monetize buffalo meat is to ensure that, like chickens and cows, the buffalo will never go extinct. Well, I'm here to tell you that PCPs are Noooooo different. Reward their work and make their work rewarding and you'll have a shortage of specialist before you know it!*

The following items remain open questions or issues that need to be tracked in the months and years ahead:

- Is Direct Primary Care a limited phenomenon, or are there signs that it will grow to (pick some relevant metric)?
- Will DPC providers demonstrate sufficiently compelling cost reduction and outcomes improvement metrics to gain traction in the market?
- Will DPC become a part of state health insurance exchanges, and will employers and consumers choose to go the DPC/catastrophic coverage route?
- Regional employee benefit consulting firms and brokers such as Lockton and The Holmes Organisation have embraced DPC. Will national players such as Towers, Aon and others embrace DPC with their clientele?
- Will practices that have adopted the Patient-centered Medical Home take the next move to DPC and remove insurance from a portion of their practice?

Future

In the foreseeable future, healthcare will remain dynamic and somewhat unpredictable, particularly the political dimensions. However, one can reasonably expect the following to be drivers of the evolution of DPC and primary care, in general.

- Massive competition and innovation: It's hard to imagine a more competitive time period than we are entering today. The winners in the fee-for-service game have been those who have been most adept at maximizing billing codes as that is what the incentive system has rewarded. As the reward system in healthcare shifts to value and outcomes, primary care is the clear winner. Unlike the past, a premium will be placed on those organizations most able to deliver high quality primary care. One can expect a tremendous amount of innovation as a result.
- Care will be provided closer and closer to home. As has been seen in places such as Denmark where primary care has been prioritized due to its efficacy, more than 80% of patient-physician interaction is no longer face-to-face. When it is necessary,

DPC models either bring the provider to the patient's home/workplace or one can get in almost immediately to the doctor's office rather than waiting days or weeks. The payment mechanisms of DPC allow remote care to be offered without as much concern about financial incentives/disincentives.

- The income disparity between specialists and primary care physicians will narrow. The combination of the increased value being placed on proactive primary care coupled with a limited supply of primary care physicians suggests that they will earn more money in the near to medium term feature.
- Fee-for-service will wane. If an organization can't demonstrate positive outcomes and measure them, they will be pushed out.
- Broadly speaking, healthcare is going to be subject to deflationary pressures as private and public sector budgets are unable to support the current level of spending, let alone further healthcare inflation. Lower overhead models demonstrate that lower cost doesn’t have to mean lower profits or lower positive health outcomes.

[i] FFS cost data from seven large self-funded groups. Includes both employer and employee payments. Payer transaction cost estimated based on TPA discussions. Qliance DPMH monthly fee based on average age for self-funded groups. Qliance DPMH non-primary care cost based on self-funded pilot impact 2010 that is consistent with Qliance 2009 Impact Study. Excludes cost of prescriptions.

[ii] **Senate Language - H.R. 3590EAS - SEC. 10104 (3). On P. 2068**

TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

[iii] Sections 1 through 6, chapter 499, Oregon Laws 2011 (Enrolled Senate Bill 86)

[iv] http://le.utah.gov/~2012/bills/hbillenr/hb0240.pdf

[v] http://apps.leg.wa.gov/rcw/default.aspx?cite=48.150&full=true

[vi] It is the public policy of Washington to promote access to medical care for all citizens and to encourage innovative arrangements between patients and providers that will help provide all citizens with a medical home. Washington needs a multipronged approach to provide adequate health care to many citizens who lack adequate access to it. Direct patient-provider practices, in which patients enter into a direct relationship with medical practitioners and pay a fixed amount directly to the health care provider for primary care services, represent an innovative, affordable option which could improve access to medical care, reduce the number of people who now lack such access, and cut down on emergency room use for primary care purposes, thereby freeing up emergency room facilities to treat true emergencies.

[vii] http://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/2009retainermedicinereport-final.pdf

[viii] California Senate Committee on Health analysis

[ix] http://heartca.org/images/heart_responses-final-draft-cafpeditstredits.pdf

[x] http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

[xi] The Hot Spotters, The New Yorker January 24, 2011

[xii] http://www.whiteglove.com/images/stories/documents/highgate-hotels-whiteglove.pdf

[xiii] http://www.whiteglove.com/images/stories/documents/ivie-whiteglove.pdf

[xiv] http://www.whiteglove.com/images/stories/documents/beryl-whiteglove.pdf

[xv] General Practice and Primary Care in Denmark, The Journal of the American Board of Family Medicine, March 2012

[xvi] Colwill JM, Cultice JM, Kruse RL. Will generalist physician supply meet demands of an Increasing and aging population? Health Aff (Millwood). 2008 May-Jun;27(3):w232-41. Epub 2008 Apr 29

[xvii] http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.3315.IH: