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Direct pay: A promising care model with challenges

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Fed up with the "hamster wheel" of traditional fee-for-service medicine, many primary care physicians are exploring direct pay models as a way to provide better care for patients and derive more satisfaction from practicing medicine.

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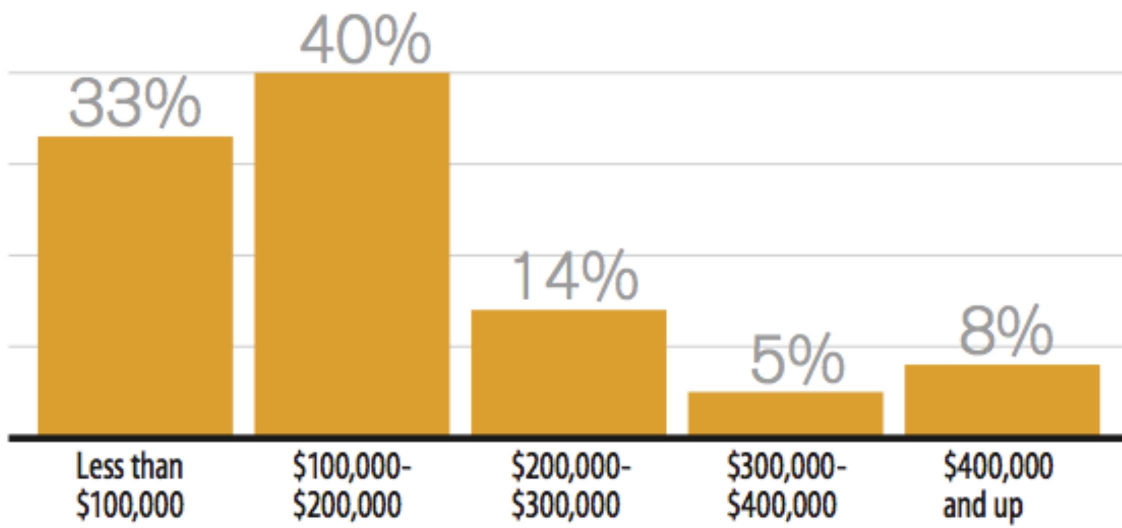
While there is no standard definition for what constitutes a direct pay practice, for the most part they fall into one of three categories. The first is a straight cash model, in which patients simply pay out-of-pocket for a procedure or consultation. Sometimes the practice will give the patient a superbill that the patient can submit to his or her insurance company for reimbursement.

Under the second, more common form of direct pay, patients pay a monthly fee to be included in a physician's panel. The fee covers unlimited office visits and 24/7 access to the physician, including via text or e-mail. In most cases it also includes whatever in-office procedures and tests the physician offers, although some practices charge extra for these.

The third form, often referred to as concierge or personalized medicine, also includes a monthly fee, but one that is generally higher than in direct pay practices. In return, the patient receives services such as a comprehensive annual physical exam, and guaranteed no-waiting appointments. Unlike the other two forms of direct pay, many practices that call themselves concierge maintain contracts with insurance companies.

Direct pay practices: Data from the field

INCOME OF DIRECT PAY PATIENTS



Next: Managing the transition

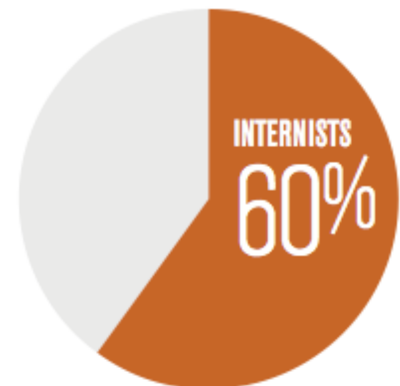
Managing the transition

While the vast majority of physicians using direct pay say they are satisfied with it, ensuring a smooth transition to direct pay (or start-up if it's a new practice) can be challenging.

READ: Why cost gives independent physicians an edge

To start with, not every practice is well-situated for making a successful conversion. It requires a loyal patient base and solid reputation in the community, says Rob Lewis, vice president of physician marketing and operations for SpecialDocs, a consulting firm that helps practices transition to concierge-style medicine. How long a practice has been operating, and how long it's patients have been with it, are among the first features SpecialDocs looks at when deciding whether to take on a conversion client, he adds.

For a typical primary care practice with a patient panel of about 2,000, Lewis says, between 300 and 600 will elect to stay with the practice after it converts to a concierge model.



As with virtually any issue involving the practice of medicine, finances are a significant consideration in the direct pay equation. Cash flow generally is not a problem at first, either because the practice still has contracts with third-party payers or patients have paid fees in advance of the conversion, or both. But getting the fee structure right is another matter.

"You have to do your due diligence and look at how appealing your practice is likely to be in your particular community," says Harry Izbicki, DO, co-owner of Izbicki Family Medicine, a direct-pay practice in Erie, Pennsylvania. "If you charge too much, you won't get enough patients to support your business. But if you charge too little, you're leaving money on the table and maybe working harder than you have to."

After deciding to transition to some form of direct pay, informing patients—and persuading them to sign up—becomes the next key challenge. The reason is simple: if patients don't understand direct pay/concierge medicine, or why your practice is going to use it, or the benefits they will derive from it, they won't stay with you.

The time required to switch to a direct-pay model varies depending on the size of the practice and patient demographics, but generally requires three to six months. Izbicki says it took his practice about four months to complete the transition, "and was really mostly dependent on contractual obligations of notifying each insurer that we were opting out of our contracts," he says.

Next: Success stories

Success stories

The number of practices using direct pay is difficult to pin down, in part because some physicians are reluctant to say they do so, says Michael Tetrault, editor-in-chief of the online publications "Concierge Medicine Today" and "The Primary Care Journal." "There are slightly less than 4,000 physicians who are verifiably, actively practicing concierge medicine or direct primary care across the United States, with probably another 8,000 practicing under the radar," Tetrault says. That compares to an estimated 500 who were doing so in 2000, he adds. The Direct Primary Care Journal believes that the growth in direct-pay, non-retainer style primary care practices will grow at a rate of roughly 10-15% in the next few years.

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—HARRY IZBICKI, DO, CO-OWNER OF IZBICKI FAMILY MEDICINE, A DIRECT-PAY PRACTICE IN ERIE, PENNSYLVANIA

Whatever form they take, such practices almost always have smaller patient panels than under the traditional fee-for-service model, allowing physicians to spend more time with each patient and get to know them better. Equally important, it frees practices from the expense and frustrations of dealing with third-party payers.

The experience of Izbicki Family Medicine is typical. After nearly three years of practicing independently, co-owners Jon and Harry Izbicki realized that the traditional fee-for-service reimbursement model wasn't working for them, either financially or personally.

"We were in the cattle drive of medicine that the insurance companies have most doctors running nowadays," recalls Jon who, like his brother, is a D.O. "We realized how it was affecting us adversely from a business standpoint and knowing that to keep our doors open we had to see more and more patients, which started cutting into the amount of time we could spend with them."

In response, the brothers decided to convert to a direct-pay model. They set monthly fees ranging from $135 for a family to $65 for an individual, which covers all office visits and includes same-day appointments and 24/7 access to the providers. The practice negotiated a direct-purchase agreement with a local provider of lab services, enabling them to provide services such as lipid panels and blood workups for a fraction of the usual cost, often $10 or less.

In addition, because Pennsylvania allows physicians to dispense medications, the practice operates a pharmacy at which patients can get prescription medications for up to 90% less than at commercial pharmacies.

So far, says Harry, direct pay is succeeding. "We have the time to more effectively manage the medical concerns of our patients, without worrying about the number of patients we need to see each day to break even, or whether they have insurance," he says.

He adds that the practice retained about 15% of its patient panel following the conversion, but "we still have upwards of a thousand patients who have yet to either sign up or tell us they've transitioned to a new physician."

Like most practices converting to direct pay, Izbicki continued to treat all its patients up to the day of conversion, regardless of whether they planned to continue with the practice. Patients who wanted to transfer to another practice were directed to a local hospital and the county medical society for help in finding a new provider.

Next: Access to primary care

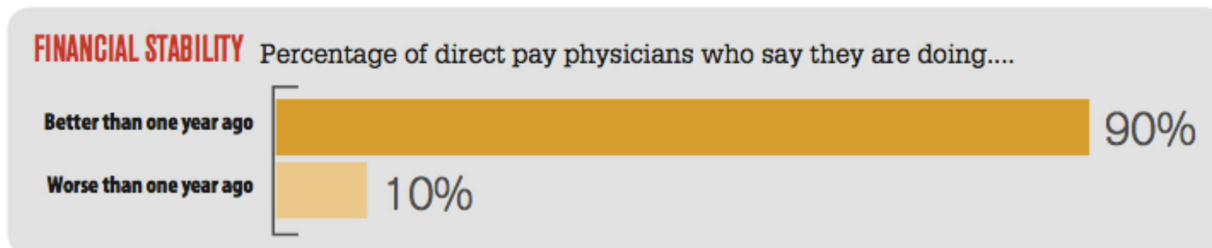
The ability to spend more time with each patient is often the deciding factor for practices that choose a direct pay model, says Matt Jacobson, founder and chief executive officer of SignatureMD, which helps practices transition from fee-for-service to a concierge-style practice. "The only correlation we can see between any sort of medical practice and better patient outcomes is time. Simply spending more time with patients inherently leads to better results," he says.

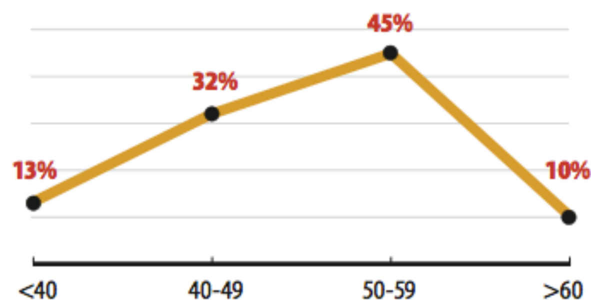
Most of the physicians SignatureMD works with end up with between 350 and 400 patients in their panels, each of whom pays an "amenity fee" averaging $1,720 annually, Jacobson says. For that they receive guaranteed same- or next business-day appointments and appointments for non-emergency medical issues are guaranteed to start on time.

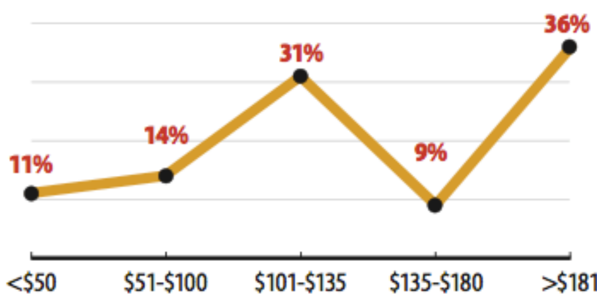
Jacobson says nearly all his client practices use what he terms a "market segmented" model, under which patients who choose not to use the concierge service remain with the practice and continue to use third-party payers, but are treated by a midlevel rather than the physician. "Those patients often matriculate up to the concierge practice over time as they tend to have a change in health or economic circumstance," he says.

For Brian Forrest, MD, a major benefit of direct pay has been the ability to provide more access to primary care. Forrest heads Access Healthcare, a family practice in Apex, North Carolina, about 10 miles from the state capital of Raleigh. When he opened his doors in 2002, he says, the county had about 85,000 people without health insurance, and probably ha more today.

To help address that need, he decided he would keep Access's overhead expenses as low as possible, which also meant not going through insurance companies for payment. As a result, he was able to set a monthly fee of $25 per patient, plus $5 per office visit. For patients who preferred not to join the practice, there was an a la carte pricing schedule with no service costing more than $40.







Source: Concierge Medicine Research Collective, 2009-2012

Today the practice has three providers, with a patient panel of 6,300, of whom 3,300 are active, says Forrest. Membership fees have risen to $40 month. The practice also charges $20 for each office visit. "That covers the variable cost of seeing patients in the office [rather than through telemedicine or e-mail,] says Forrest. It's the right amount to keep patients from coming more than they should, while not causing them to delay any necessary care."

Forrest schedules one patient visit per hour, but spends an average of 45 minutes per patient. The remaining quarter-hour is for dealing with walk-ins. "It's a luxurious pace, and I love it," he says. His patient panel includes everyone from homeless people to millionaires.

"The homeless people say there's nothing else they can afford. And we have millionaires who drive two hours away who tell me 'I can't pay anyone to get the kind of care I get here.'"

Because Access has used direct pay from the outset, it didn't have to go through the process of explaining the model to existing patients. Even so, Forrest says that when patients calling for appointments learned how the practice operated, "initially 80% of the people would just hang up the phone. But now that people have gotten to know us, I'd say 90% of the people who walk in the door understand that we don't do insurance."

Among his fastest-growing subset of patients, he adds, are patients covered by Medicare who want to be "off the grid." "They don't want to go to a doctor participating in meaningful use who will make their data available to Medicare," he says.

Next: Prior authorizations

Prior authorizations

Since most patients at direct-pay practices still have some form of health insurance, physicians are not free of the burden of obtaining prior authorizations for some procedures and medications.

READ: The prior authorization predicament

At the same time, having fewer patients reduces the number and the time spent on them. Apex in North Carolina "has to deal with the same [prior authorization] bureaucracy as everyone else," says Forrest. When faced with a rejection from an insurance company he will sometimes threaten to tell his local newspaper that the insurer is denying needed coverage to a patient. "Most doctors can't do that because their contracts with insurance companies prevent them from talking about it [authorization denials]," he says. "I can, and I get everything approved."

Doug Nunamaker, MD, a physician with Atlas Family Practice in Wichita, Kansas, says many of his patients have high-deductible insurance plans that don't cover many of the procedures typically requiring prior authorizations, so he does them no more than two or three times a year.

Atlas has about 1600 patients in its panel, which allows its providers to spend at least 30 minutes—and sometimes up to 90 minutes—on each appointment. Nunamaker averages about six patient visits per day. "There's either quality or quantity, and traditional medicine now is all about the quantity," he says. "If I can only spend six or seven minutes with a patient, they're not getting good care."

Staffing changes

Practices switching to a direct-pay model often find they undergo staffing changes. That's due in part to the need for higher standards of patient service, particularly among practices using concierge medicine, says Signature MD's Jacobson "You can't charge a premium fee without having premium service across the board," he says.

Jacobson advises clients to identify the staff member who best relates to patients and making him or her the primary point of contact with patients who have signed up for concierge services. "You want the person who treats patients like they're at the Ritz Carlton focusing on the membership patients," he says.

Lewis says physicians sometimes will use the conversion process as an opportunity to dismiss staffers who haven't been performing well, although those people often wind up leaving of their own accord. On the other hand, "some physicians, if they have a particularly tight-knit staff, will decide to keep everyone initially, and wait for attrition to pare down the staff."

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