Direct Primary Care:
An Alternative Practice Model to the Fee-For-Service Framework

What is direct primary care?

Direct primary care (DPC) is a subset model of the retainer-based practice framework for primary care practices. There is not a single DPC practice model; rather the model represents a broad array of practice arrangements that share a common set of characteristics. Perhaps the defining characteristic of DPC practices is that they offer patients the full range of comprehensive primary services, including routine care, regular checkups, preventive care, and care coordination in exchange for a flat, recurring retainer fee that is typically billed to patients on a monthly basis. DPC practices are distinguished from other retainer-based care models, such as concierge care, by lower retainer fees (typically ranging from $50 to $150 per month), which cover at least a portion of primary care services provided in the DPC practice.

What is the retainer fee?

The practice retainer fee is a set recurring charge billed directly to patients to cover the comprehensive and coordinated primary care services provided by the DPC physicians and practice staff under the terms of a practice retainer or membership contract. To date, DPC practice retainer fees range from between $50 and $150 per month. The value of the practice retainer fees is most commonly based on the breadth of primary care services covered under the retainer contract.

The intent of the retainer fee structure in the DPC model is to ensure that family physicians are appropriately paid for the entire range of value-added services they provide for their patients. In the current fee-for-service (FFS) payment system, nearly 50% of a family physician's workday is spent outside of face-to-face visits, often in conducting vital follow-up or helping to coordinate care for patients as they communicate with other clinical providers.[i] Under FFS, these critical non-face-to-face services often go uncompensated. Under a DPC retainer fee, the practice can ensure that family physicians are appropriately compensated for providing comprehensive care, and not just the care provided during an office visit.

How does direct primary care differ from traditional primary care?

The opportunity to spend more time interacting with patients and providing ongoing follow-up services is at the heart of the patient-centered care provided in DPC practice settings. The regular and recurring revenue generated by the practice retainer fees allows physicians participating in DPC practices to overcome some of the pressures associated with the traditional FFS payment system. Because DPC physicians are no longer generating revenue *solely* on the basis of how many patients they see per day, many report that they have significantly more time to spend with patients in face-to-face visits. Additionally, many DPC physicians provide a larger array of non-face-to-face services, such as tele-visits or e-visits, for their patients, to ensure primary care services can be accessed in a manner most convenient for patients and their families.

What is the difference between DPC practice models?

The variance between DPC practices is often found in the breadth of primary care services covered by their retainer contract fee structure. Some DPC practices have retainer fees that cover the entirety of primary care services, including care management and care coordination, as well as services involving external organizations such as off-site diagnostic facilities. This means that patients do not have to pay out of pocket for any services delivered to them through their DPC practice beyond the monthly retainer fee. Other DPC practices cover a far more limited scope of services and collect service fees from patients at the time of care to cover costs occurred in the visits. This is because these DPC practices continue to participate in traditional FFS contracts with third-party insurance carriers but utilize the retainer fees to supplement their contracts. Typically, these retainer fee structures only cover services that would otherwise go unreimbursed under those insurance network contracts.

Why would I want to consider practicing in a DPC practice?

One of the most appealing aspects of the DPC model for family physicians is that the retainer fee payment structure can greatly simplify the business of operating a family practice. DPC practices report significantly reduced operating rates when compared with traditional primary care practices. This is primarily because DPC practices do not need to maintain staff dedicated to organizing, reviewing, filing, and managing payment claims to third-party payers. Further, because many DPC practices do not participate in contracts with private insurance carriers, they avoid the economic pressures of diminishing contract service rates. DPC practices that choose to continue participating in insurance carrier contracts can act in a far more proactive manner and participate in insurance contracts that are economically beneficial for the practice and its patients.

Additionally, many family physicians practicing in DPC settings report that the opportunity to spend more time with patients has resulted in improved professional satisfaction. This anecdotal evidence is bolstered by the evaluations and assessments that draw a connection between physicians' satisfaction and the duration of patient visits.[ii] Further, the simplification of practice administration and billing processes has resulted in an improved work-life balance for DPC physicians.

How will transforming into a DPC practice affect my patients?

The core result of the DPC practice model is that physicians and patients have the opportunity to spend more time interacting. The consequence of spending more time with each patient, however, is that family physicians practicing in a DPC setting typically have much smaller patient panels than they would in the traditional FFS system. Generally, DPC physicians have a panel of between 600 and 800 patients. In typical FFS settings, the patient panels tend to range from between 2,000 and 2,500 per family physician[iii, iv]. This often results in patients losing access to their personal physicians if they elect to not participate in the DPC contract or if their physicians cannot take on new DPC contract patients.

Patients who do receive personal care in the DPC practice will find their primary care services significantly altered when compared with care received in traditional practice settings (e.g, increased time spent with their family physicians). There are a number of reported outcomes of increasing visit time, including improved patient experience of care[v,vi] and improved clinical outcomes as patients become more engaged in managing their own health care.

DPC patients will also find it much easier to access their physicians and the DPC practice offices. This facilitates care that is timely and convenient. A number of DPC practices offer non-face-to-face visit options, such as e-visits, to empower patients to access care in a manner that best fits their needs. Additionally, many DPC practices also have expanded their operating hours while opening scheduling for same-day visits. Finally, some DPC practices provide patients a means to contact their physicians, or an on-call physician from the practice, 24 hours a day.

How will transforming into a DPC practice affect my current insurance contracts?

Physician owners and practice administrators of a DPC practice can choose whether to continue to participate in insurance carrier contracts. Many DPC practices elect to forgo insurance payment contracts and operate solely off of their patients' retainer fees and/or patient fees collected at the time of service. An immediate consequence of terminating an insurance carrier contract is that the practice will automatically be deemed as out-of-network. This may not have a significant impact on the practice, but it does affect patients who continue to receive health insurance coverage, either through an employer-sponsored plan or an individual market plan. The primary result is that insured patients who choose to receive care through a DPC practice may pay more out of pocket for primary care services.

Some DPC practices, however, do choose to continue participating in a smaller number of insurance plan contracts. The process for determining which insurance plans to continue accepting varies among DPC practices. Factors to consider in the determination process include:

- concentration of patients across contracted insurance carriers (i.e., payer mix);
- favorable contract payment rates for primary care services;
- timeliness of the plan's ability to process and pay out on a standing claim; and
- value-added practice support services that are deemed advantageous to the DPC practice.

If a DPC practice chooses to continue participating in a set of insurance plan contracts, the DPC practice providers must make clear to patients what medical services and procedures are covered by the insurance carrier contract. Many insurance carriers will not pay for services determined to be covered by the DPC retainer fee contract.

Can a DPC practice treat patients with insurance coverage?

Patients who receive health care insurance coverage, either through employers or individual insurance plans, can receive primary care in a DPC practice. This is true even if the DPC practice does not participate in any insurance contract. The reality is, however, that receiving care in a DPC setting can increase the responsibility of patients to manage their health care-related finances. Insured patients can typically receive reimbursement from insurance carriers for care received in a DPC practice via the claims process. The process typically requires the patient to submit an itemized bill for review and approval by the insurance carrier.

It is up to DPC practice owners and administrators to determine how much support, if any, the practice will provide to patients in managing claims. Some DPC practices provide fully itemized bills at each visit that can be submitted to insurance carriers. Others will submit itemized bills to insurance carriers as a non-participating practice on behalf of patients but elect to forgo managing the patient's ongoing claims-review process. In the current market environment, however, a significant number of DPC practices elect to not see patients that carry traditional insurance coverage.

What about Medicare?

Direct primary care practices can continue to see Medicare beneficiaries, as long as the practice's retainer fee does not cover services already covered under Medicare. DPC practices seeking to include Medicare beneficiaries in their patient populations should contact a health care attorney familiar with retainer-based practice models to review the DPC retainer contract to ensure there is no conflict with Medicare's regulation of concierge care delivery.

How do I begin exploring the DPC model for my practice?

There are a few simple steps that any primary care practice can take to investigate the DPC model.

1. The first practical step is to conduct a practice evaluation to determine whether the practice would benefit from transforming into a DPC practice. As part of the evaluation process, practice administrators and physicians should, at the very least, address:
   - whether the practice physicians would be interested in spending more time with patients and would be willing to see fewer patients as a consequence;
   - current and ongoing practice management and operational cost trends;
   - current insurance carrier contracts in order to determine which, if any, could be carried over if the practice decides to undertake the DPC transformation. **Here** is a guide for how to begin evaluating your insurance carrier contracts from the *Journal of Family Practice Management;* and
   - receptivity of the practice's patient base to determine whether there is enough consumer interest to ensure a stable patient panel for the participating physicians.
2. The next step is to confer with health care consultants or health care attorneys familiar with the DPC or other retainer-based models of care. These resources can provide insight about local and state regulations governing the practice of retainer-based medicine and whether current insurance carrier contracts may be amendable to complementary services covered under a retainer fee. If an appropriate consultant or attorney is not available, contact your state AFP chapter for references, or check the **AAFP's Buyer's Guide** resource listing.
3. Contact national DPC/concierge franchise operators to explore opportunities to establish a DPC practice under a franchise contract. The leading national franchise chains provide new DPC practices with proven business models and a corresponding body of practice resources (manuals, practice tools, and well-established operating guidelines), marketing material, and legal support staff. Typically, these franchise operators charge a percentage of a practice's retainer fee, as they are collected across a multiyear contract. In considering the resources provided by any franchise operator, practice leaders must weigh whether the diminished practice revenue is worth reduced administrative burden and support in undertaking the actual practice transformation process.

Informing patients about the DPC model

Perhaps the most important step for practices seeking to become DPC practices is that they keep the existing patient population well informed of the ongoing transformation. Practice leaders and staff must be as transparent as possible throughout the process, particularly because it is very likely that the practice will be unable to transition its entire patient base into the new DPC retainer contract framework.

Patients who choose to participate in the new practice delivery model must be made aware of what is entailed in the DPC practice arrangement: what services are covered under the retainer fee; how much patients are expected to pay, on an ongoing basis and at the time of visits; and what level of support the practice will provide for patients in managing their own claims.

Physicians and practice administrators in a new DPC practice should work even more diligently on behalf of patients who choose not to participate in the retainer contract and/or those who could not participate in the retainer contract due to patient panel constraints. The DPC practice should work to ensure that these patients find new primary care physicians. This is particularly true for high-risk patients. These efforts are critically important, because physicians bear an ethical mandate to not abandon patients (**AMA Code of Medical Ethics – Retainer Practices**) and could be subject to legal challenges if it is determined that they have violated this ethical guideline. **Here** is a recent article from the *Journal of Family Practice* outlining practical guidelines for ethically ending a patient relationship.

Direct Primary Care Resources:

The Direct Primary Care Coalition

The American Academy of Private Physicians

The American Medical Association's resources for "Cash-based Practices"

[i] Gottschalk A, Flocke SA. Time spent in face-to-face patient care and work outside the examination room. *Ann Fam Med.* 2005;3(6):488-493.

[ii] Solomon J. How strategies for managing patient visit time affect physician job satisfaction: a qualitative analysis. *J Gen Intern Med.* 2008;23(6):775-780.

[iii] American Academy of Family Physicians. Teamwork within a practice can relieve patient overload. *AAFP News Now.* October 9, 2012. www.aafp.org/online/en/home/publications/news/news-now/practice-professional-issues/20121009teambasedcare.html.

[iv] Murray M, Davies M, Boushon B. Panel size: how many patients can one doctor manage? *FPM.* 2007:14(4):44-51.

[v] Kong MC, Camacho FT, Feldman SR, Anderson RT, Balkrishnan R. Correlates of patient satisfaction with physician visit: differences between elderly and non-elderly survey respondents. *Health and Quality of Life Outcomes.* 2007;5(62). www.hqlo.com/content/5/1/62.

[vi] Dugdale DC, Epstein R, Pantilat SZ. Time and the patient–physician relationship. J Gen Intern Med. 1999:14(S)S34-S40.

[vii] Wasson JH, Anders SG, Moore LG, Ho L, Nelson EC, Godfrey MM, et al. Clinical microsystems, art 2. Learning from micro practices about providing patients the care they want and need. The Joint Commission Journal on Quality and Patient Safety. 2008:34(8):445-452.