Background Note on Direct Primary Care (DPC)

“People are comfortable with the status quo as long as they can afford the status quo. We need some turbulence in the market for people to see the value of innovation. If I tried to sell you car insurance that’s structured like health insurance now, you wouldn’t take it. It wouldn’t make any sense. But we stay in the status quo of health care because that’s the way we’ve always done it.” – Dr. Josh Umbehr

Health care systems globally are plagued by inefficiencies that impede access to and quality of primary care services. Primary care delivery, specifically, has been thwarted by complications related to issues such as payment schemes, as well as problems involving coordination and communication with other health and social services. In response to the challenges facing the current medical landscape, practices increasingly look for innovative health care solutions. Innovation can take several forms and can occur inside or outside a system. Practitioners often grapple with inside system strategies, including a shift in health care workforce composition, implementation of care teams, and different payment structures, such as capitation. However, sustained patient and provider frustration and disenchantment catalyzed the demand for – and development of – alternative, outside system innovations, such as Direct Primary Care (DPC).

Emergence of Direct Primary Care

In the 1990s, concierge medicine arose as an alternative model to traditional medical care under the fee-for-service structure. The model permits patients to circumvent traditional barriers to care (in particular access and gatekeeping practices) and aims to improve both physician and patient experience via a paid subscription to select primary care physicians. The subscription typically includes same-day appointments, around the clock phone coverage, email access, and telemedicine services. In order to accommodate these services, many concierge physicians still bill insurance or Medicare for medical visits, since the monthly subscription costs support only “non-covered” medical services. Consequently, patients end up paying two fees for care: the concierge subscription fee and the insurance premium. Overall, on average patients pay $200 per month, though prices vary immensely and patients may be charged as much as $30,000 a month.

While this model seeks to improve quality of care for patients and to improve the physician experience, some physicians yearned to not only serve populations that could afford both fees, but also low-income populations and the uninsured. In the mid-2000s, direct primary care (DPC) emerged as a distinct model that charges patients a periodic fee, typically around $50 per month with an upper limit of $100, but exists outside traditional billing structures to insurance or third-party payers. This model originally focused on...
revitalizing the doctor-patient relationship, relieving physicians of administrative burdens such as coding and third-party reimbursement, and providing access to care for the underserved.

The DPC Model: Elements of Practice
In addition to delivering affordable and accessible care, the DPC model aims to increase patient quality, increase patient satisfaction, and reduce overall cost. Although still relatively new, DPC practices appear in many variations and gradations around the country, and thus defining the model itself is difficult. However, the definition used within the DPC community that best captures this wide variation indicates that DPC practices are primary care practices that:

1. Charge a periodic fee
2. Do not bill any third parties on a fee-for-service basis
3. Ensure that any per-visit charge will be less than the monthly equivalent of the periodic fee

At DPC practices, patients can access their physician through same-day, open scheduling via email, cell phone, or Skype. While most DPCs do not accept insurance, it is still recommended that patients supplement their DPC membership with a form of catastrophic health insurance, such as a high-deductible health plan, or a wrap-around plan, in order to cover costly care beyond the scope of primary care. DPC physicians explain the need for catastrophic coverage by analogy: for cars, insurance does not cover every day needs such as gas and oil changes. Instead, insurance covers accidents and catastrophic events. Health insurance, they reason, should work the same way.

One of the most important elements of the DPC model is an enduring and unfettered patient-provider relationship. With third parties and outside payers removed, traditional time-intensive activities such as coding and billing procedures are not part of daily physician workflows or patient experience. According to DPC physicians, the “liberation” from fee-for-service structures allows them to prioritize relationship building with patients, which is one of the five key tenets of the DPC model (see Exhibit 1 for the five key tenets of direct primary care). Since its inception in the mid-2000s, the model has rapidly proliferated along the West Coast, the Midwest, and in pockets of the South. DPC advocates expect it to continue to spread across the nation (see Exhibit 2 for DPC practice distribution).

Variation within the Model
DPC practices vary in size and scope, as well as in many other structural and operational variables. As commonly stated within the DPC community, “If you have seen one DPC, then you have seen one DPC” (see Exhibit 3 for example DPC practices and their respective features).

Staffing
In both solo and network DPC practices, physicians are afforded a great deal of autonomy in developing a staffing structure that best supports their patient populations. Some DPC practices are minimally staffed with just a single physician, while others feature a large contingent of physicians. In early iterations, “pure” DPC practices were often operated by a single physician who built patient panels and managed his or her own income. More recently, iterations of the model have begun to include nurses, networks, or administrative assistance, but there remains a strong emphasis on a minimal workforce. For example, Dr. Ryan Neuhofel, CEO of NeuCare in Lawrence, Kansas, initially operated his practice alone, but recently began searching for a nurse in order to manage his increasing panel size. Qliance, a network
DPC in Seattle, employs a host of salaried physicians in order to deliver care across the Seattle metro area. Other practices include administrators or other health professionals such as medical assistants, nurses, nurse practitioners, patient navigators, or health coaches.

“Pure” vs. Hybrid
“Pure” DPC practices adhere to the membership model and do not bill insurance or third party payers for care costs. However, in other practices some patients pay the characteristic DPC fee, while others finance their care through the traditional fee-for-service system. This hybrid model tends to be desirable for physicians who prefer a gradual transition to DPC or are part of a larger practice where not all physicians are willing to make the switch. However, DPC proponents have some reservations about hybrid practices. “Pure” DPC practitioners assert that hybrids will not experience the same immediate overhead savings as “pure” DPC clinics, and that hybrid physicians may have difficulties explaining to patients why the practice accepts insurance for some and not for others. Furthermore, the hybrid model does not optimize the benefits that attract physicians to DPC: hybrid physicians still need to code, process claims, and file paperwork, all of which reduce the amount of time they can spend with patients. Ultimately, the DPC community questions whether the simultaneous operation of two care models will result in differential quality of care across a patient population.

Individual vs. Network
DPC practices either operate as separate, solo practices or they align with an existing DPC network. Solo practices are popular with physicians seeking an increased sense of clinical and operational autonomy. Potential drawbacks for solo practices include a lack of revenue at the start and more regulatory and legal preparation. While solo DPC practices are emerging across the nation at rapid rates, network practices are also growing. Predominant DPC networks include Access Healthcare Direct, Paladina Health, and Medlion. Medlion is the largest network and is comprised of more than 35 practices across more than 25 states. Medlion CEO, Dr. Samir Qamar, asserts that network DPCs provide many benefits. They minimize legal risk since networks have extensive experience across several jurisdictions, provide power in numbers, increase appeal for the creation of insurance wrap plans, enhance marketability, decrease business responsibility and management, and sustain autonomy while offering network support.

Cost
While typical primary care practices receive less than 5% of the total health care dollar, DPC practices generally charge 10%. The rationale behind the increase is that the DPC model and associated care will decrease subsequent health care costs incurred by patients, or downstream spending, and that the overall cost savings will be less than the percentage. Since DPC practices eliminate insurance administration and coding, they dramatically reduce overhead costs, thereby enabling physicians to charge up to 80% less for services than traditional offices (see Exhibit 4 for overhead reduction calculations). For this reason, DPC is often cited as the ultimate lean model to eliminate waste.

The Medical Group Management Association (MGMA) conducted a survey and found that, per physician, the average fee-for-service family practice’s revenue in 2008 was $621, 338. The average active panel size was 2,251 patients, yielding annual revenue per patient of $276. However, at $60 per month, the annual revenue per patient at a DPC practice is $720 or 2.6 times the average for all fee-for-service family practices. According to these numbers a DPC practice with just 863 patients per panel can realize the same annual revenue per provider as the average fee-for-service family physician with a panel of...
2,251. Based on this preliminary study, the MGMA concluded that the DPC model is economically sustainable.\textsuperscript{10} Recent data from one network DPC, Qliance, suggests that the model reduces systemic costs in addition to in-practice costs. Initial analyses indicate that Qliance patients demonstrated a 60% reduction in inpatient visits and a 14% reduction in ER visits (see Exhibit 5 for Qliance pricing data).

Pricing structures across the model are highly variable. Some practices charge patients in monthly, quarterly, or yearly increments, with age-stratified prices ranging from $30 to $125. Similarly, the prices may cover different services: at some practices the membership fee covers all clinical visits and diagnostic testing, while others may charge for additional visit fees for particular procedures. The network DPC Access Healthcare Direct, a network DPC based in Apex, NC, charges a monthly fee supplemented by an à la carte menu that features separate, individually priced services (see Exhibit 6 for example service pricing). On the other hand, at AtlasMD in Wichita, KS, the monthly fee covers access to in-office procedures and diagnostic testing, including EKGs, DEXA scans, Cryotherapy, lesion removal, and laceration repair. If a service is not included in the membership, AtlasMD patients still save as much as 95% on the cost of outside lab testing.

Additional Costs: Specialty Care and Pharmaceuticals
The costs for specialty services differ immensely from practice to practice and are also subject to regional and state level constraints. Many DPC physicians negotiate with specialists and ancillary service providers to give patients “cash up front” discounts. In exchange for immediate payment and the avoidance of the costs of billing and insurance, some specialists will offer significant savings off the typical fee-for-service billed price. Therefore the costs of specialty services in DPC practices are largely contingent upon physician-to-physician negotiations. When he first started, Dr. Jeff Gold, CEO of Gold Direct Care in Marblehead, MA, attempted to negotiate MRI pricing with radiologists in Massachusetts, but was unsuccessful because the hospitals owned the MRI equipment and MRIs were prescribed by hospital-affiliated radiologists. Though Dr. Gold was unsuccessful in his attempts in Massachusetts, he was able to negotiate with radiologists in New Hampshire. His practice is located in Marblehead, Massachusetts, which is close to the New Hampshire border, thereby permitting easy travel across state lines. Dr. Gold’s patients pay $700 cash up front for MRIs in New Hampshire, compared to the $3,900 they would have paid in Massachusetts.

Pharmaceutical cost is yet another variable that fluctuates across DPC practices. Most DPCs feature wholesale pricing, but costs can vary depending on when and how the pharmaceuticals are distributed. AtlasMD has an in-house pharmacy, and consequently medications can be dispensed at even lower prices at the time of service. For example, AtlasMD physicians can treat a patient’s depression by prescribing Zoloft and filling the prescription in-house for about $1.50/month. However, state law dictates whether a practice can include an in-house pharmacy, which contributes to the pricing differences across DPCs. As of December 2015, in-house pharmacies were permitted in 35 states.

Employer-Based Models
Some DPCs contract directly with employer groups, where the employer pays the monthly or periodic DPC fee for each of their employees. These contracts usually encapsulate businesses that offer their employees higher-deductible plans. By offering high-deductible plans, employers are better positioned to provide the employees with a DPC membership. These employer contracts appeal to DPCs of all network sizes. Colorado-based Nextera, a small networked DPC with seven locations, successfully negotiated a
contract with Left-hand Brewing Company. On the larger end of the scale, Qliance is transitioning toward contract-based care and has clients such as Expedia. Additionally, while not strictly employer-based, Iora Health is known for contracting with businesses and unions.

**Technology and Innovation**

Innovative technology is one of the key hallmarks of DPC, and several tools and platforms are already well integrated into DPC practices. However, consistent with the DPC model, the goal of these technologies is to facilitate health by enhancing and simplifying care delivery, not to replace the human aspect of health. When discussing the role of technology, DPC clinicians often cite Occam's razor – the simplest solution is often the best solution. To that end, DPCs frequently use basic platforms such as texting, phones, and Google Voice as methods to communicate with patients. Other commonly integrated technology platforms also include RubiconMD, Twine, and Hint (see Exhibit 7 for common technologies used with the DPC community).

**EMRs & EHRs**

Electronic record systems in the DPC community are structured in a completely different fashion from those found in traditional health care systems. Given that DPC physicians do not accept insurance, they do not need an EMR that supports fee-for-service billing and coding needs. Instead, EMRs in the DPC community are often designed by practitioners to accommodate specified workflows and patient needs.

Dr. Josh Umbehr and the AtlasMD team developed one of the first DPC-specific EMRs with guidance: “Simplicity boils down to two steps: Identify the essential. Eliminate the rest.”

As Dr. Umbehr developed his lean clinical practice, he also developed a simple, complementary EMR. Dr. Umbehr, like many DPC physicians, reasoned that the current traditional EMRs distract physicians from patient care and establish artificial barriers between doctors and their patients. Thus, in AtlasMD’s EMR, communication integration is one of the main features, and the EMR is built to accommodate multiple modes of communication. The software provides clinicians with a cell phone number connected to the EMR, enabling all texts to be stored in the system. Email exchanges, including pictures, are also integrated. The EMR is further supplemented with Human API integration, which provides physicians with patient-health data aggregated from several devices, including Fitbits and mobile applications.

Furthermore, other platforms such as RubiconMD and corresponding billing setups are built into the AtlasMD EMR system.

While many other DPC-specific medical record systems exist, InLight EHR, developed by Pri-Med, has gained national attention. The EHR features membership management, problem-oriented documentation, self-sourcing for medications, laboratories and diagnostics, an app for patient engagement called Twistle, an integrated fax system, and lab interfaces. The Mayo Medical Clinic considers this type of EHR to be particularly well-suited to DPC:

> The problem-oriented EHR is ideal for Direct Primary Care because most encounters are characterized by multiple problems, which is different from a specialist, who typically sees a patient for a single problem during any given visit. Additionally, DPC medicine has a more holistic approach to patient health that neatly aligns with the problem-oriented medical record, which provides a longitudinal view of the patient's health care over time.
DPC-specific EMRs and EHRs reflect some of the inherent flexibility and customization of the DPC model as a whole. Since DPC physicians practice outside traditional systems, like billing and insurance, they are able to design systems — from workflows to EHRs, EMRs, and other technologies — to address specific needs of clinicians and patients.

Legal and Regulatory Obstacles

Medicare and Medicaid
Medicare and Medicaid reimbursement structures are almost entirely dependent on the fee-for-service model, which makes it difficult to accommodate Medicare and Medicaid patients. Medicare, for example, already covers comprehensive primary care and does not generally provide capitated reimbursements for patient panels, as the DPC model monthly membership fee requires. DPC proponents reason that it is advantageous for practices, especially “pure” models, to “opt out” of Medicare. By “opting out” DPC providers are able to see Medicare patients under private contracts without any conflicts with Medicare regulation and law. When a practice does not “opt out”, providers must classify all charges as “non-covered services,” or any services already covered under Medicare (such as comprehensive primary care). Concierge practices often function in this fashion and hire attorneys in order to circumvent Medicare regulators’ attempts to expand the list of Medicare covered services. However, as the list of Medicare covered services grows, it is increasingly difficult for practices to classify membership plans as strictly non-covered services. Furthermore, Medicare auditors may suggest that the non-covered services are actually covered, and that the practice therefore violates False Claims Act laws.15

While many DPC practices do not regularly care for Medicare and Medicaid patients, two DPC practices have engaged these populations – Qliance and Iora Health. Qliance contracted with a Medicaid managed care organization whereby Medicaid covered the monthly fee for its beneficiaries. This was the first DPC to integrate Medicaid payers, and Medicaid insures half the patient population at Qliance. Similarly, Iora Health has developed partnerships with Humana and Tufts Health Plan in order to integrate Medicare Advantage beneficiaries into their practices.

Policy Complications
Prior to 2010 and the Affordable Care Act (ACA), Garrison Bliss, a founding member of Qliance, and Jay Keese, a lobbyist, discovered a large legal complication of the DPC movement: DPC contracts could be considered insurance and would therefore be illegal according to state law. To ensure that DPC physicians could legally practice, Keese and Bliss worked together to establish the Direct Primary Care Coalition. The Coalition initially served to demonstrate the reach, power, and viability of the model. With the support of Coalition and DPC leaders across the nation, a direct primary care clause was successfully integrated into the ACA Section 1301(a)(3):

Subtitle D Part 1, Number 3: 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.16
This clause permitted DPC practices to be included in the ACA’s insurance exchanges, with the caveat that these practices be paired with a wrap-around insurance policy covering services outside of primary care. However, despite the Coalition’s success in promoting DPC as care model and its sanctioning by the ACA, DPC continues to face further policy complications and legal hurdles on national and state levels.

**Federal Barriers: The IRS and the Enhancement Act**

Health Savings Accounts (HSAs) are tax advantaged accounts that one can contribute to or draw from to pay out-of-pocket for medical, dental, and vision services. While DPC is especially suited for HSA holders, according to the provision of the Internal Revenue Code (IRC 223 (c)), to be eligible for a HSA an individual cannot be covered under a high-deductible plan and another health plan “which provides coverage for any benefit which is covered under the high-deductible plan.” Although the ACA specifies that DPC is a medical expense and not a form of insurance, the IRS continues to categorize DPC practices using this provision. Consequently, the IRS maintains that DPC is a “health plan” and has not altered tax codes accordingly, thereby barring individuals from purchasing DPC plans using HSA funds.

On June 17, 2014, members of Congress wrote to the IRS Commissioner to ask for clarification on how the IRS treats direct primary care medical homes with regard to HSAs. The authors pointed out that ACA rules on exchanges and Qualified Health Plans clearly state that DPC is not health insurance, defining DPC as a health benefit outside of insurance. The IRS and Department of the Treasury responded to the letter from Congress by indicating that the rules regarding what constitutes medical care expenses under section 213(d) of the Internal Revenue Code is under review. While the IRS acknowledged Congress’ argument, they continue to maintain that the concept of a second plan is not restricted to insurance.

In response to the IRS’s position, the DPC Coalition and Senators Bill Cassidy, MD (R-LA) and Maria Cantwell (D-WA) developed the Primary Care Enhancement Act (PCEA). The PCEA was introduced on August 5, 2015 and has received backing from the American Association of Family Physicians (AAFP). The bipartisan bill defines DPC medical services as qualified health expenses under section 213 (d) of the tax code, permitting individuals with HSAs paired with high-deductible plans to pay for DPC services with their HSAs, which would effectively negate the stalled IRS review and could increase the appeal, spread, and viability of the DPC model (see Exhibit 8 for other features included in the PCEA).

The PCEA has the potential to remove some of the political and legal barriers that impede the practice of direct primary care. If passed, the bill would help secure the national position of DPC as an alternative, affordable source of primary care.

**State**

Regulatory and classification issues also persist at the state level. While DPC is federally recognized as a medical service, various state insurance commissioners have argued that DPC poses too much risk and that membership contracts amount to the “unlawful sale of insurance.” Given these regulatory barriers, the DPC Coalition is involved in developing state-level DPC laws (see Exhibit 9 for model state legislation). As of January 2016, DPC legislation has been passed in 14 states, with laws proposed in 7 others (see Exhibit 10 for a map of states with DPC legislation). Though the legislation is state specific, the Coalition helps state activists avoid common traps that can lead to downstream regulation and inadequate definitions of the DPC model.
DPC: Model & Movement

Despite the autonomous nature of DPCs and the variations among practices, the DPC movement remains unified and actively promotes solidarity at events like the Direct Primary Care Summit, where DPC clinicians from across the country gather to share experiences, challenges, and goals. Dr. Forrest notes that there is no “one right way” in the DPC model, and DPC advocates and providers are bound together by their passion to provide better health care services for patients. According to Dr. Forrest, the DPC movement is characterized by its collaborative spirit and supportive atmosphere.

Active mentoring helps maintain this spirit, and a few of the earliest DPCs leaders have strived to become invaluable resources within the DPC community. Dr. Umbehr regularly mentors aspiring and newly transitioned DPC clinicians by answering questions and providing guidance in setting-up DPC practices. AtlasMD has recently formalized this mentorship into a fully developed curriculum and starter kit, which is available on their website. The curriculum covers topics such as defining DPC, startup costs, in-house pharmacies, and marketing (see Exhibit 11 for the DPC curriculum topics). The kit provides an introduction to the bureaucratic side of DPC. The AtlasMD curriculum and materials are free of charge. Transitioning fee-for-service practices can also opt for paid consultations with Dr. Forrest.

Professional organizations are also engaged in the movement and facilitate large gatherings for the community. The annual Direct Primary Care Summit is jointly sponsored by the AAFP, the Family Medicine Education Consortium (FMEC), and the American College of Osteopathic Family Physicians (ACOFP), and it is the largest gathering of advocates of the DPC movement in the United States. The AAFP also hosts an annual Direct Primary Care Workshop, where new or aspiring DPC clinicians can learn how to transition to or convert a practice, connect with experienced DPC practitioners, and explore the care model.

The DPC movement also uses social media campaigns via platforms such as Twitter to unite physicians and spread the DPC model (see Exhibit 12 for the social activity of the #iamdirectcare campaign).

Conclusions: The Future of DPC

The AAFP has cited DPC as one of two viable models for the future, and as physician burnout rates continue to rise and clinicians spend more time coding, DPC proponents continue to position the model as such. In reducing third party involvement and operating outside the traditional health care system, DPC yields a lean model with the potential to reengage physicians and patients in health care. As one of Dr. Neuhofel’s DPC patients notes, “For years, my care was impersonal, inconvenient. And now I see my doctor when I want, for as long as I want, and we both can be as efficient as possible as we take care of my health.” However, despite the increasing popularity, support and satisfaction, DPC practices still struggle with viability on many levels. Financial sustainability, scalability, state and national legal disputes, and concerns about quality and oversight challenge the efficacy of the model. Without significant changes in legal status, Medicare and Medicaid negotiations, and training in business management and education for physicians, the model has a questionable future. Despite these challenges, the DPC model serves as a poignant example of outside system innovation in primary care, and it is therefore worthy of discussion among global audiences.
Exhibit 1: The Five Key Tenets of DPC

1. Service
2. Patient Choice
3. Elimination of fee-for-service
4. Advocacy
5. Stewardship

Exhibit 2: Direct Primary Care Practice Distribution (as of May 04, 2015)

### Exhibit 3: Examples of DPC practices

<table>
<thead>
<tr>
<th>Medicaid/Medicare Acceptance</th>
<th>Qliance</th>
<th>AtlasMD</th>
<th>Gold Direct Care</th>
<th>Medlion</th>
<th>Access Healthcare Direct</th>
<th>Nextera</th>
<th>Iora Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/ Medicare</td>
<td>Yes, Medicaid</td>
<td>Opted Out</td>
<td>Opted Out</td>
<td>Opted Out</td>
<td>Opted Out</td>
<td>Yes, hybrid model</td>
<td>Yes, Medicare</td>
</tr>
<tr>
<td>Medicare Acceptance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network or Individual</td>
<td>Network</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
<td>Network</td>
<td>Network</td>
<td>Network</td>
</tr>
<tr>
<td>Location</td>
<td>Seattle, WA</td>
<td>Wichita, KS</td>
<td>Marblehead, MA</td>
<td>Over 25 states</td>
<td>Over 16 states</td>
<td>Colorado</td>
<td>Over 5 states</td>
</tr>
<tr>
<td>Policy-Friendly State (Y/N)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Key attributes</td>
<td>Employer – Based</td>
<td>Developed first DPC-specific EMR</td>
<td>First DPC in MA</td>
<td>Working toward developing DPC law in MA</td>
<td>Largest network DPC</td>
<td>Second largest DPC network</td>
<td>Employer-Based model</td>
</tr>
<tr>
<td></td>
<td>Worked with a Medicaid Managed Care Company</td>
<td>In-house pharmacy and wholesale medication</td>
<td></td>
<td></td>
<td>Features some hybrid practices</td>
<td>Trains FFS practices on DPC transitions</td>
<td>Hybrid practices</td>
</tr>
</tbody>
</table>

Source: Compiled by the authors on 9/15/15 based on information available
Exhibit 4: DPC Overhead Reduction Calculations

Exhibit 5: Qliance and Traditional Fee-for-Service Cost Comparison

## Qliance vs. Non-Qliance Costs

<table>
<thead>
<tr>
<th></th>
<th>Per 1,000 Qliance pts</th>
<th>Per 1,000 Non-Q pts</th>
<th>Difference</th>
<th>Savings per pt per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits</td>
<td>81</td>
<td>94</td>
<td>-14%</td>
<td>($5)</td>
</tr>
<tr>
<td>Inpatient (days)</td>
<td>100</td>
<td>250</td>
<td>-60%</td>
<td>$417</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>7,497</td>
<td>8,674</td>
<td>-14%</td>
<td>$436</td>
</tr>
<tr>
<td>Advanced Radiology</td>
<td>310</td>
<td>434</td>
<td>-29%</td>
<td>$82</td>
</tr>
<tr>
<td>Primary Care Visits</td>
<td>3,109</td>
<td>1,965</td>
<td>+58%</td>
<td>($251)*</td>
</tr>
<tr>
<td>Savings Per Patient</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>$679</td>
</tr>
<tr>
<td>% Saved Per Patient</td>
<td></td>
<td></td>
<td></td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: Bliss, E. (2013). Direct Primary Care: Reinventing the Patient-Doctor Relationship [PowerPoint Slides].
Exhibit 6: Laboratory Pricing at Access Healthcare Direct

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Local alternatives</th>
<th>Dr. Forrest’s practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metabolic Panel</td>
<td>$169</td>
<td>$29</td>
</tr>
<tr>
<td>Cryosurgery to remove planters warts</td>
<td>$329</td>
<td>$49</td>
</tr>
<tr>
<td>EKGs, cholesterol panels, diabetes tests like HgBA1C, TSH (thyroid test) etc</td>
<td>EKG: $225</td>
<td>Included in annual physical or access card</td>
</tr>
<tr>
<td></td>
<td>TSH: $150</td>
<td></td>
</tr>
</tbody>
</table>

Exhibit 7: Common Technologies within the DPC Community

**RubiconMD**: A technology that connects primary care providers to networks of top specialists for quick e-consults. Through an online platform, physicians are able to send images to qualified specialists, who then interpret the images and determine whether or not specialty care is required. However, RubiconMD states that it is an information service and it does not provide medical diagnoses or treatment. Dr. Gold of Gold Direct Care subscribes to RubiconMD and notes that of his twenty RubiconMD consultations to date, only two have required follow-up care.

**Twine Health**: A cloud-based collaborative care platform that promotes physician, care team, and patient engagement. It is an app that syncs with other technologies, such as EMRs, and is largely geared towards millennials. Dr. Gold sees the value in Twine integration: “Give young people something like Twine, which doesn’t cost me that much money a month and they feel like they are constantly engaged with their physicians. That is what we are trying to do. We are trying to give even the healthy people who have signed up something to tangibly say this is different from what I had before.”

**Hint Health**: A software platform that aims to automate the direct billing cycle from beginning-to-end, eliminate manual tasks that undermine collections, and free up significant time and resources for patient care. Health Hint provides five interrelated elements that automate the revenue cycle for a specific array of practice models. In addition to providing services for DPC practices (both networked and individual), Hint Health supports concierge medicine practices, on-site clinics, and management companies from all around the nation.

Exhibit 8: Features included in the Primary Care Enhancement Act

1. Clarifies that Direct Primary Care (DPC) medical homes are medical services and not health plans or “gap coverage” under §223 (c) of the tax code relating to Health Savings Accounts (HSAs). Removes any real or perceived prohibition on individuals with HSAs having a relationship with a DPC practice.

2. Defines DPC services as a qualified health expense under the §213 (d) of the tax code, allowing individuals with HSAs paired with high deductible health plans to pay for DPC services with their HSAs.

3. Creates a new payment pathway for DPC as an alternative payment model (APM) in Medicare (and with Dual Eligibles) that would allow CMS to pay practices an affordable flat fee up to 20% of the average overall cost of care.
   a. Program starts as a demonstration under the CMS Center for Innovation and would become permanent for any practice showing improved outcomes over Fee-For-Service (FFS) in a three-year period.
   b. Does not allow for “balance billing” for covered primary care services already covered in the DPC arrangement.

4. Includes a waiver provision to allow qualified physicians who have opted out of Medicare to participate in the program at any time.

5. Allows for Medicare Advantage plans to pair with DPC practices as primary care partners in an ACO-like structure.

Exhibit 9: Model DPC Law Developed by the DPC Coalition

The people of the state of _______ enact.

(1) Definitions. As used in this section:

(a) "Primary care provider" means an individual or other legal entity that is licensed, registered, or otherwise authorized to provide primary care services in this state under _______. Primary care provider includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(b) "Direct primary care agreement" means a contract between a primary care provider and an individual patient or his or her legal representative in which the health care provider agrees to provide primary care services to the individual patient for an agreed-upon fee and period of time. A direct primary care practice: (1) charges a periodic fee for services, (2) does not bill any third parties on a fee for service basis, and (3) any per visit charge must be less than the monthly equivalent of the periodic fee.

(c) "Primary care service" includes, but is not limited to, the screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury within the competency and training of the primary care provider.

(2) Direct primary care agreement. A medical direct primary care agreement is not insurance and is not subject to [your state insurance code]. Entering into a direct primary care agreement is not the business of insurance and is not subject to [your state insurance code].

(3) A primary care provider or agent of a health care provider is not required to obtain a certificate of authority or license under this act to market, sell, or offer to sell a direct primary care agreement.

(4) To be considered a direct primary care agreement for the purposes of this section, the agreement must meet all of the following requirements:

(a) Be in writing.

(b) Be signed by the primary care provider or agent of the primary care provider and the individual patient or his or her legal representative.

(c) Allow either party to terminate the agreement on written notice to the other party.

(d) Describe the scope of primary care services that are covered by the periodic fee.

(e) Specify the periodic fee and any additional fees outside of the periodic fee for ongoing care under the agreement.

(f) Specify the duration of the agreement, any automatic renewal periods, and require that no more than twelve months of the periodic fee be paid in advance. Funds are not earned by the practice until the month of ongoing care is completed. Upon discontinuing the agreement all unearned funds are returned to the patient.

(g) Prominently state in writing that the agreement is not health insurance.

(5) Acceptance or discontinuance of patients. Direct primary care practices may not decline to accept new direct primary care patients or discontinue care to existing patients solely because of the patient’s health status. A direct practice may decline to accept a patient if the practice has reached its maximum capacity, or if the patient’s medical condition is such that the provider is unable to provide the appropriate level and type of primary care services the patient requires. So long as the direct primary care practice provides the patient notice and opportunity to obtain care from another physician, the direct primary care practice may discontinue care for direct primary care patients if (a) the patient fails to pay the periodic fee, (b) the patient has performed an act of fraud, (c) the patient repeatedly fails to adhere to the recommended treatment plan, (d) the patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice, or (e) the direct primary care practice discontinues operation as a direct primary care practice.

**Exhibit 10**: States with Direct Primary Care Laws (as of July 10, 2015)

Exhibit 11: AtlasMD’s DPC Curriculum Topics

<table>
<thead>
<tr>
<th>Atlas.MD DPC Curriculum Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. What is Direct Primary Care?</td>
</tr>
<tr>
<td>02. What Does it Mean to Cut out the Middleman?</td>
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<tr>
<td>03. Is Direct Care Right for You?</td>
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<td>04. How much will it Cost to Start a DPC Practice?</td>
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<td>05. What Technology Will I Need to Run a Smooth Practice?</td>
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<tr>
<td>06. Ins and Outs of Insurance in the Direct Care Model</td>
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<td>07. Charging and Billing for Direct Care Services</td>
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<tr>
<td>08. Running an In-House Pharmacy</td>
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<tr>
<td>09. Making the Transition: How to Approach Patients About Your Decision to Switch to DPC</td>
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<tr>
<td>10. Marketing Your Direct Primary Care Practice</td>
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<tr>
<td>11. Creating Value for Your Patients</td>
</tr>
<tr>
<td>12. Staffing Your Direct Care Clinic</td>
</tr>
<tr>
<td>13. Congratulations!</td>
</tr>
</tbody>
</table>

Exhibit 12: Social Activity of the #iamdirectcare Campaign

A) Background
The hashtag, #iamdirectcare, was spurred as a result of the October 1st, 2015 ICD-10 release. DPC physicians and advocates used the release as an opportunity to demonstrate collective pride and support for the model and to educate the public on how DPC is changing the face of health care. The hash tag permeated throughout Twitter and also appeared on t-shirts worn by DPC physicians. The DPC movement used the campaign to celebrate an alternative model of care that encompasses a patient-centric attitude, focus on transparency, and a divorce from the challenges of the traditional health care payment system.

B) Example Tweets from the Campaign

Dr. Josh, AtlasMD @AtlasMD · Sep 30
I love my job, I just dispensed 90 days of medicine for a patient for only $0.81 !! and thats why #iamdirectcare

Dr. Josh, AtlasMD @AtlasMD · Jul 23
15 minutes talking with a patient about their health...20 minutes laughing and learning about THEM! That's why #iamdirectcare

Mark B McColl, MD @mbmccoll · Oct 24
I want to be the very best I can be at what I do. I just don't want what I do to be EMR data entry. #freedomtopractice #iamdirectcare

Let's celebrate the first annual
#DirectCareHoliday
October 1st, 2015
Better Primary Care

Shane P @docshanep · Oct 1
Great ICD-10 free day!!! No hassle. No red tape. #iamdirectcare directaccess.md #atlasmd
Exhibit 12 Continued: Social Activity of the #iamdirectcare Campaign

C) Campaign T-Shirts

Endnotes


3 Ibid


10 Ibid


Affordable Care Act (ACA) Section 1301(a)(3): Subtitle D Part 1, Number 3


Ibid
