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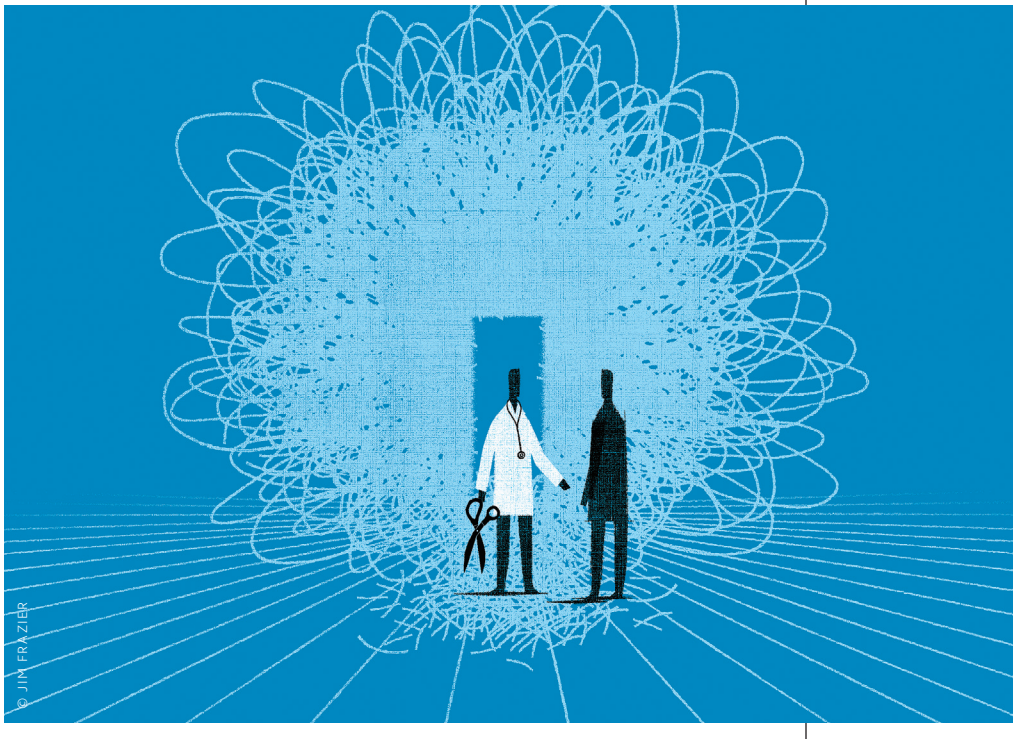
CME

Transitioning to Direct Primary Care

Imagine practicing medicine without all the administrative burdens related to billing insurance. Here's how one physician made the switch.



After nine years in private practice, I had reached a crossroads. I enjoyed my coworkers and loved caring for my patients, but I had come to hate my job. Administrative duties — meaningful use, patient-centered medical home certification, insurance hassles, etc. — kept me working after office hours and left little time for myself or my family. I was burned out.

At that point, when I was at rock bottom professionally, I attended the Direct Primary Care Summit. Within a few hours, I had decided that direct primary care (DPC) was my future.

A commonly accepted definition of a DPC practice is one that charges patients or their employers a periodic fee (usually monthly) for a contracted suite of services and does not bill any third parties (i.e., insurance companies or government programs) on a fee-for-service basis. If the practice levies a per-visit charge, that charge is less than the monthly equivalent of the periodic fee.[1] By cutting out

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third-party insurance and the associated hassles and overhead costs, physicians can focus on providing care for a smaller panel of patients and devote more time to each of them. The American Academy of Family Physicians' (AAFP) official position on DPC is that the organization "supports the physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system model, including the DPC practice setting."[2]

In 2016, I founded Hickory Medical Direct Primary Care, where more than 75% of our patients contract directly with us for their care. The rest have memberships purchased by their employers. The businesses pay the monthly membership fee, and the employees pay the visit fees. Like most DPC practices, we strongly encourage our patients to maintain insurance coverage for catastrophic health problems that require hospital care. But we do not bill insurance for any of our services, and visits do not generate charges that patients can submit to insurance. We are happy to write orders for medications, procedures, and referrals that patients can then bill through insurance, but we often find that patients' out-of-pocket costs are less when they pay cash for these services than when they use their insurance, especially for medications. Among the growing number of patients on high-deductible plans, few are able to meet their deductibles annually, so they often bear the full cost of their health care.

Still, patients are used to the insurance-based payment model. Leaving that model can be hard for both patients and physicians, even those who are extremely unhappy with it. The share of DPC practices remains small, but interest is growing. There were 1,265 DPC practices nationwide as of May 1, with DPC physicians in every state except North and South Dakota.[3] A 2018 AAFP survey showed that 3% of members were practicing in a DPC model and another 3% were actively transitioning to a DPC model. The survey also showed that 41% of those who were not already in a DPC model were interested in it.[4]

If you're among the physicians interested in DPC, this article outlines how I switched, and how you can too.

KEY POINTS

- Direct primary care (DPC) physicians are paid directly by patients or their employers, usually with a monthly membership fee, and don't bill third parties (like insurance companies) on a fee-for-service basis.
- DPC physicians are a small percentage of the overall primary care picture nationally, but interest in the model is growing as frustrations increase with the administrative burdens of billing insurance.
- The transition to DPC is difficult financially, but once a practice has matured over several years, DPC physicians can make as much as they made before.

FIRST STEPS: MISSION AND FINANCES

The first challenge of DPC is identifying what you want your practice to look like. With no health system protocols or insurance regulations to restrict you, your options will be limited only by your imagination and what your patients will support. Given that flexibility, you will want to clearly define your practice's mission early in the process. It's important to know the patients you want to serve, the types of care you want to offer, and your professional expectations before you start.

At our practice we decided our mission is to provide excellent, affordable, convenient care for individuals of all ages, as well as businesses and families in our working-class, rural community. We provide sick care, health maintenance services, and chronic disease management through in-home visits and office visits, and also offer some office-based procedures. We work to make tests and medications cost-effective for patients regardless of their health insurance status, and we strive to improve the health of our community through advocacy as well as direct care.

Once you've identified your mission, the next step is determining how much startup money you will need.

The finances of transitioning to DPC scare away many physicians. Indeed, it is why many must hit rock bottom emotionally before being willing to take the leap. Based on my conversations with other DPC doctors, most of us with mature practices make as much or more than we did in insurance-based practice, but it is almost impossible to avoid a substantial decrease in income during the transition. It's natural for physicians to think their

patients will follow them as they switch to DPC, but in reality most physicians convert only about 10% of their patients initially. As a result, most physicians transitioning to DPC will go three to six months with little to no income, and it may take three years or more to reach their target income, depending on the population they serve and how high they set the target. To maintain personal finances, many doctors who are transitioning to DPC get additional work either before their practice opens or in the early months of their practice. There are many opportunities to moonlight, such as working in a locums position, an emergency department or urgent care setting, a Veterans Affairs facility, or the prison system. These side gigs can help you personally finance the start of your DPC practice. If you have a strong business plan, it is also possible to get a bank loan, which allows for a more stable salary earlier, at the expense of profits later.

The cost of starting a DPC practice can be as low as $5,000 for a model focused exclusively on home visits with no staff. It can be as high as several hundred thousand dollars for those buying or building an office and hiring staff.

In my situation, I knew for some time that I would not be able to continue at my insurance-based practice, so I was saving money to finance the start of Hickory Medical without moonlighting. I wanted to establish a permanent location that did not have a startup feel, and I wanted to start with a full-time nurse. We signed a two-year lease and paid the rent up front for a building that our landlord completely renovated to our design. Our practice required initial funding of $100,000. In less than three months our membership fees were covering nursing, malpractice insurance, and other costs. The first year in practice, my salary was roughly the same as my nurse's. By the end of the second year, my salary was the same as it was in my insurance-based practice. By the third year, we covered all our startup costs while paying full salaries. Even during the COVID-19 public health emergency, when so many traditional practices were experiencing financial difficulties due to the decreased volume of office visits, our practice income has remained stable.

BUSINESS DECISIONS: NAME, TYPE, AND LOCATION

The time from when you decide to start your practice until you are ready to start seeing patients will generally be at least three to six months, but some people take up to a year. If you're not well-versed in business, you will need to find an accountant, lawyer, or other professional to help with the many decisions you will face.

Even the seemingly simple step of choosing a practice name requires careful consideration. You want a name that is easy to pronounce, spell, and remember. It is worth taking a moment to Google the name you're considering to see what would appear when patients search for you online. You also have to consider whether your business name should include "direct primary care," a term that may not be well-known in your area.

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Once you have selected a name, you can register a domain name online to establish your practice website. The largest online registrar is GoDaddy.com, but there are also alternatives such as SquareSpace.com, Wix.com, and Bluehost.com that offer different pricing and privacy features. For more details, visit https://www.wpbeginner.com/beginners-guide/how-to-register-a-domain-name-simple-tip-to-get-it-for-free/.

Next, register your corporation with state and federal authorities. There are many different ways to organize a business: sole proprietorship, general partnership, limited liability company (LLC), limited liability partnership (LLP), C corporation, S corporation, or nonprofit. All have different tax and legal implications.[5] Nonprofits don't pay income taxes, but must devote some revenue to activities that benefit their community, such as health education or indigent care. C corporations pay a 35%

tax on all net income collectively, whereas the other for-profit models disperse profits to individual owners or shareholders, who then report it as taxable personal income. If you have a partner, an LLC or LLP will protect you from liability for your partner's malpractice, but a general partnership won't (this is obviously not a concern for a sole proprietor). An accountant or lawyer can help lay out all the pros and cons. At the federal level, register with the IRS for tax purposes and with the U.S. Patent and Trademark Office if you want to trademark your business name. At the state level, business registration is usually done through the secretary of state's office, but some states delegate this task to other agencies. You can find the proper agency in your state (and get more information on state and federal registration) on this Small Business Administration website: https://www.sba.gov/business-guide/launch-your-business/register-your-business.

Another decision you need to make is the location of your practice. Those starting with a small budget might need to consider using home visits, having an exam room at a local nursing home, or renting a room or two from a local practice. For those starting with more capital, renting or buying an office may be better options, as they allow you to set up a permanent location right away and begin to shape a more durable brand. Reflecting on the mission of your practice will help you select the location and office arrangement that is right for you. Try to go where your target patients are. But if you have a non-compete clause in your current contract, you need to consider that as you select a location.

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We chose the name Hickory Medical Direct Primary Care because it was memorable but neutral, and we won't need to change it as we grow and add physicians or locations. We chose to include both "Medical" and "Direct Primary Care" because few people in our area knew what direct primary care was when we started. We registered as an S corporation at the federal level and an LLC in the state of Ohio. Because it was important to our mission to be a part of our community, we rented a 100-year-old building downtown and partnered with a local developer who built a nice but modest interior.

PRACTICE MODEL DESIGN

In the DPC community we frequently say, "If you have seen one DPC practice, you have seen one DPC practice." There's a lot of variation, but a few things generally hold true.

All DPC practices charge a periodic membership fee, usually monthly. According to an AAFP data brief, most DPC practices charged $50 to $75 a month for individual adults and $75 to $175 for families, as of December 2017.[6] Many practices have some form of tiered pricing by age. According to the data brief, 13% of offices also bill a per-visit charge. When establishing pricing, consider the income you need to generate, the number of available appointments, and the number of patients within each pricing tier that you will be able to see. In our experience, patients average between three and four contacts per year. Higher prices reduce the number of visits and panel size needed to break even, but they also result in slower growth in new patients. Particularly in areas with lower population density, membership price is the single biggest determinant of growth.

You will need to determine which services you will include with the membership fee. Some practices include unlimited office visits rather than charging a per-visit fee. Some DPC physicians give patients their cell phone number and allow unlimited texts, phone calls, and video visits. Some include routine labs, immunizations, and nutrition services. The slate of included services is up to you. Generally, it is best to start with fewer services and gradually add more. This prevents patient dissatisfaction and allows room to shape the practice. You can also consider offering some procedures and services to members at an additional cost that is still lower than market rates.

You also need to decide how you will interact with government payers such as Medicare and Medicaid. The ability to see and treat Medicaid patients in a DPC format varies by state (for more information, see https://www.dpcfrontier.com/medicaid). Most DPC doctors have opted out of Medicare so they can instead see Medicare patients under direct contracts, which reduces the risk of running afoul of Medicare regulations. However, Medicare only allows doctors to opt out as individuals, not as a practice, and those who opt out will have some limitations in where they are able to work during the two-year opt-out period if they decide to return to insurance-based settings. Other DPC doctors may choose to not see any Medicare patients, or to stay in Medicare but charge only for non-covered services. In this last scenario, if a practice bills a Medicare patient for a covered service, the provider is at risk for civil and criminal penalties for Medicare fraud.[7]

Next, you need to develop a contract for patients to become members. Your contract should clearly describe what is covered and what is not covered by their membership, and clearly explain that their membership is not health insurance. Most DPC practices have their contracts on their websites. DPCFrontier.com is an excellent resource for state-specific legal concerns that your contract should address, but it is still important to have a lawyer review your contract before you use it.

At Hickory Medical, we started with a monthly membership fee of $39 for adults and $19 for children, and a $20 visit fee. After three years we increased the monthly fee to $41 for adults and $21 for children. The membership fee includes same-day appointments, basic labs, and communication by phone, text, or secure email (during or after office hours). The visit fee includes some in-office procedures, such as shave biopsies, cryotherapy, joint injections, and electrocardiograms. We also charge a $20 procedure fee for sutures and excisions since they require a surgical tray and additional supplies. The membership fees cover our fixed costs (salaries, rent, utilities, etc.), while the visit and procedure fees pay for variable overhead costs (disposable equipment, lab service, etc.). This allows us to offer more services while keeping the monthly fee as low as possible.

We have capped our patient panel at about 1,000 patients. This is larger than the average DPC panel cap of about 600 patients,[4] but we're able to manage the patient load with about 33 hours in the office each week and 30-minute appointments. I opted out of Medicare and am a non-billing, ordering, referring, or prescribing-only provider for Ohio Medicaid.

PRACTICAL CONSIDERATIONS

Once you have the broad strokes of your practice designed, you will be able to get into more granular decisions.

Staffing. Your budget, panel size, and suite of services should drive how much support staff you hire. I started my practice with one staff member: my nurse from my previous practice. Her duties included answering calls, rooming patients, drawing blood, dealing with incoming test results or other information, and scheduling patients. We've since added a second nurse. My practice has otherwise been a family affair. My brother, who has no formal business qualifications but is a college professor with people skills and a highly adaptable mind, started as an unpaid advisor but for the last couple of years has been on payroll as a practice manager. His duties include managing business relations, communicating with patients, strategic planning, and dealing with the details of day-to-day operations. My father, a retired family physician, provided backup coverage in the early years, gave advice, and has at times been our janitorial staff. Consider looking for untapped resources within your own personal network to find people who can support your transition and help you stay on mission.

Dispensing medications. According to the AAFP data brief, 61% of DPC practices dispense medications to patients.[6] These practices purchase generic medications, stock them either in bulk or pre-counted, and manage relevant regulatory obligations. Most states allow physicians to dispense medications on the basis of their medical license, but some do not (see https://www.dpcfrontier.com/dispensing-medications). When dispensing, practices need to educate patients about the medication and consider malpractice coverage implications. Our practice chose not to dispense

medications because of our larger panel size and because we found we could offer only limited savings compared to programs such as GoodRx. There are also many pharmacies within 10 miles of our practice, so convenience was not much of an issue for our patients. But, depending on the practice, offering discounted medications to members could be an attractive draw.

Panel characteristics. Suburban settings with large numbers of potential patients who have high disposable incomes are the easiest places to establish a DPC practice. But there are many practices thriving in rural areas, small towns, and urban settings as well.[3] My practice serves a medically underserved, blue-collar, and working class population, but we do not see many patients who are on Medicaid or who have extremely limited income. Instead, we work with our local community health center to make sure that those patients have care, because the health center is reimbursed extremely well for treating those groups. We have, however, found that we generally provide less expensive care than the community health center for underinsured working patients, even if they qualify for sliding scale charges.

> I am now able to give my patients the care they deserve and still have time for myself and my family.

PATIENTS BENEFIT TOO

While the transition to DPC has been good for me, I believe it has also been good for my patients, who appreciate the extra time and attention I can now give them. Independent studies that compare patient outcomes in DPC practices versus traditional practices are somewhat lacking.[8] Studies by DPC groups Qliance and Access Healthcare Direct both showed a 65% reduction in emergency department visits and 30% to 50% reduction in hospitalizations for patients in DPC practices.[9,10] They also found that DPC patients report higher satisfaction, maintain better blood pressure control, and have fewer specialist visits and surgical procedures. Our experience anecdotally affirms these positive outcomes.

Leaving my old practice was one of the hardest things I have ever done. It was particularly hard to leave patients I had cared for their entire lives and families I had treated through multiple generations. But I recognized that if I did not change, I would no longer be able to care for any patients, because of burnout. In my case, the move to DPC was one of desperation, but it has been the best thing that I have done professionally. I am now able to give my patients the care they deserve and still have time for myself and my family. While I faced significant anxiety and uncertainty in the transition period, I no longer need to worry about things like insurance regulations or audits. I have gone from extreme burnout to having a job that I love every day. FPM

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

1.Defining direct primary care. DPC Frontier. Accessed May 1, 2020. https://www.dpcfrontier.com/defined

2. About direct primary care. American Academy of Family Physicians. Accessed May 1, 2020. https://www.aafp.org/media-center/kits/about-primary-care.html

3. Mapper. DPC Frontier. Accessed May 1, 2020. https://mapper.dpcfrontier.com

4. Martin S. AAFP survey reveals DPC trends. American Academy of Family Physicians. June 19, 2018. Accessed May 1, 2020. https://www.aafp.org/news/blogs/inthetrenches/entry/20180619ITT_DPC.html

5. Sansweet JB. Choosing the right practice entity. *Fam Pract Manag*. 2005;12(10):42-44.

6. 2018 Direct Primary Care (DPC) Study. American Academy of Family Physicians. Accessed June 17, 2020. https://www.aafp.org/dam/AAFP/documents/about_us/membership/2018DataBriefDPC.pdf

7. Shay DF. Opting out of Medicare: how to get out and stay out. *Fam Pract Manag*. 2017;24(6):17-20.

8. Cole ES. Direct primary care: applying theory to potential changes in delivery and outcomes. *J Am Board Fam Med*. 2018;31(4):605-611.

9. Qliance. New primary care model delivers 20 percent lower overall healthcare costs, increases patient satisfaction, and delivers better care. Jan. 15, 2015. Accessed May 1, 2020. https://www.prnewswire.com/news-releases/new-primary-care-model-delivers-20-percent-lower-overall-healthcare-costs-increases-patient-satisfaction-and-delivers-better-care-300021116.html

10. Forrest BR. Direct primary care: implications for the health care workforce. Presented at the University of North Carolina Sheps Center Health Workforce Seminar. Feb. 1, 2018. Accessed May 1, 2020. https://www.shepscenter.unc.edu/wp-content/uploads/2018/04/BForrest_DirectPrimaryCare_ShepsWorkforceSeminar_1Feb2018.pdf