New Physicians and Residents: Direct Primary Care (DPC)

Anastasia Benson, DO

ACOFP FULL DISCLOSURE FOR CME ACTIVITIES

Please check where applicable and sign below. Provide additional pages as necessary.

Name of CME Activity: ACOFP 55th Annual Convention and Scientific Seminars

Dates and Location of CME Activity: March 22-25, 2018 – JW Marriott

Name of Faculty/Moderator: Anastasia Benson, DO

DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

SBV A. Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services.

B. I have, or an immediate family member has, a financial relationship or interest with a proprietary entity producing health care goods or services. Please check the relationship(s) that applies.

	Research Grants	_____	Stock/Bond Holdings (excluding mutual funds)
_____	Speakers' Bureaus*	_____	Employment
_____	Ownership	_____	Partnership
_____	Consultant for Fee	_____	Others, please list:

Please indicate the name(s) of the organization(s) with which you have a financial relationship or interest, and the specific clinical area(s) that correspond to the relationship(s). If more than four relationships, please list on separate piece of paper:

Organization With Which Relationship Exists	Clinical Area Involved
1.	1.
2.	2.
3.	3.
4.	4.

*If you checked "Speakers' Bureaus" in item B, please continue:

- Did you participate in company-provided speaker training related to your proposed Topic? **Yes:** **No:**
- Did you travel to participate in this training? **Yes:** **No:**
- Did the company provide you with slides of the presentation in which you were trained as a speaker? **Yes:** **No:**
- Did the company pay the travel/lodging/other expenses? **Yes:** **No:**
- Did you receive an honorarium or consulting fee for participating in this training? **Yes:** **No:**
- Have you received any other type of compensation from the company? Please specify: **Yes:** **No:**
- When serving as faculty for ACOFP, will you use slides provided by a proprietary entity for your presentation and/or lecture handout materials? **Yes:** **No:**
- Will your Topic1 involve information or data obtained from commercial speaker training? **Yes:** **No:**

DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS

SBV A. The content of my material(s)/presentation(s) in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

_____B. The content of my material(s)/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated below:

I have read the ACOFP policy on full disclosure. If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether a conflict of interest may exist, and I may be asked to provide additional information. I understand that failure or refusal to disclose, false disclosure, or inability to resolve conflicts will require the ACOFP to identify a replacement.

Signature: _____ **Date:** 1/25/18

Anastasia Benson, DO

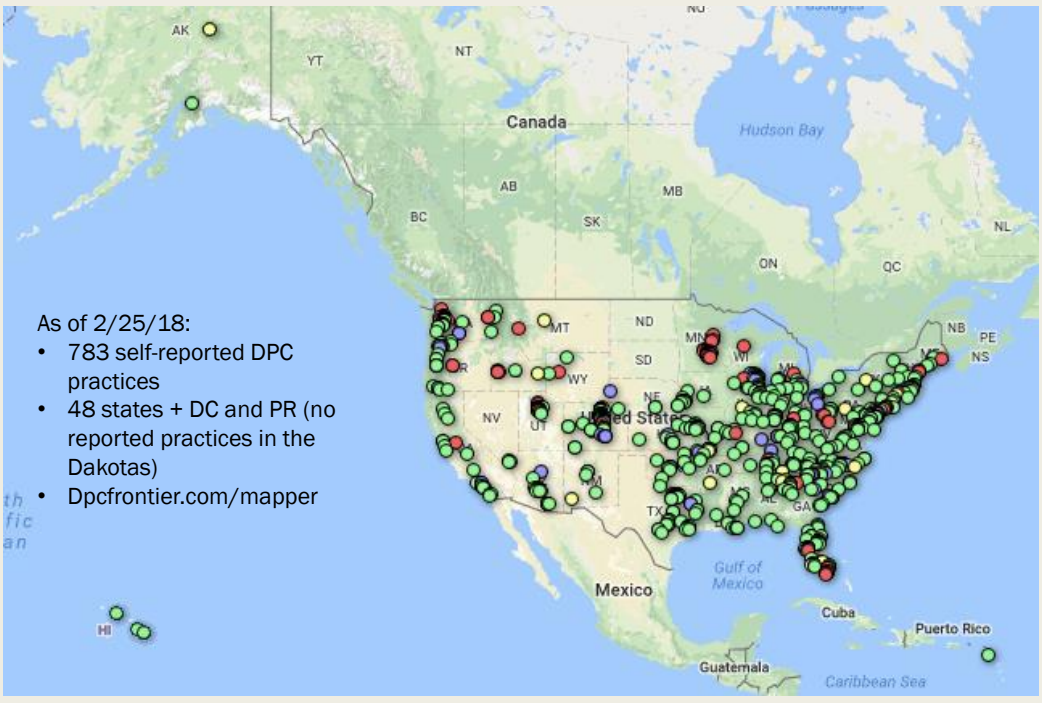
Please email this form to joank@acofp.org or fax to 847-952-5116

NO LATER THAN JANUARY 19, 2018

DIRECT PRIMARY CARE

An Introduction to the Future of Primary Care

Anastasia (Staci) Benson, DO, MA
ACOFP Annual Conference 2018



As of 2/25/18:

- 783 self-reported DPC practices
- 48 states + DC and PR (no reported practices in the Dakotas)
- Dpcfrontier.com/mapper

Linnea Meyer, a physician in Boston, says the direct-pay model frees her to focus on...

THE WALL STREET JOURNAL.

Home World U.S. Politics Economy Business Tech Markets Opinion Arts

OFF DUTY TRAVEL
My Summer Vacation Is Better Than Yours: ...

THAT'S DEBATABLE
Is It Gross for Men to Wear Sandals In the City?

THE A-HED
Thanks for Your Job Application—Shall We Begin at ...

LIFE | HEALTH | JOURNAL REPORTS: HEALTH CARE

With Direct Primary Care, It's Just Doctor and Patient

Patients pay a monthly fee for a range of basic services, eliminating the insurance middleman

Practice Management > Practice Management

CMS Wants in on Direct Primary Care

— The last thing most DPC physicians want

by MedPage Today Staff
February 19, 2018

THE WALL STREET JOURNAL.

Home World U.S. Politics Economy Business Tech Markets Opinion Arts Life Re

JASON GAY
If Offices Go Old School, I Need Booze

MY RIDE
Can't Afford a Shelby? Just Build Your Own

WHAT'S NEWS
Alexa Chung Launches Her Own Fashion Line

LIFE | HEALTH | JOURNAL REPORTS: HEALTH CARE

How to Cut Your Health-Care Bill: Pay Cash

Hospitals and other providers increasingly are offering cash prices far below what they charge

THE WALL STREET JOURNAL.

Home World U.S. Politics Economy Business Tech Markets Opinion Arts Life Real Estate

AT A GLANCE

How Empowered Patients and Doctors Can Improve Health Care

Wisconsin legislation looks to regulate, acknowledge direct primary care clinics

Primary care clinics allow doctors to spend more time with patients, charge them flat monthly fee

THE WALL STREET JOURNAL.

Subscribe Now | Sign In

Home World U.S. Politics Economy Business Tech Markets Opinion Arts Life Real Estate

OPINION | COMMENTARY

The Four Legs of a New Health-Care System

The Great Recession enabled ObamaCare. Now the law's failure makes reform possible.

Rep. Tom Price in January at a ceremony for a bill to repeal ObamaCare. *PHOTO: BLOOMBERG*

By JAMES C. CAPRETTA and SCOTT GOTTLIEB
Nov. 30, 2016 7:08 p.m. ET

So what is DPC?

Defining Direct Primary Care

- 3 general components to qualify as a DPC practice
  - Charge a periodic fee
  - Not bill any third parties on a fee for service basis, and
  - Any per visit charge must be less than the monthly equivalent of the periodic fee

- Does NOT:
  - *Exclude hybrid practices*
  - *Prohibit ancillary fees*
  - *Mean that any non-DPC relationships (by this definition) are illegal. It's just not in this protected class from the insurance commissioner.*

(www.dpcfrontier.com)

The Knope Clinic | The Clinic | Dr. Knope | For Patients | Media | Blog

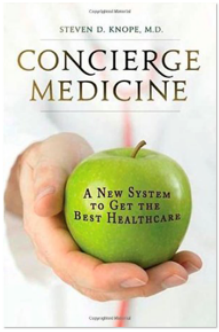
What is Concierge Medicine?

Concierge medicine, boutique medicine and *direct practices* are all terms used to describe a new form of medicine in which patients pay a doctor directly for enhanced medical care. In return for payment, the patient receive services such as guaranteed same-day appointments, 24/7 access to the physician by cell phone or beeper, and house calls. In addition, wellness care and preventative care are often provided. A comprehensive approach to healthcare allows time to address the unique needs of the individual.

What is central to all forms of concierge medicine is that third-party reimbursement to the doctor is either eliminated or relegated to partial payment for the doctor's services. Patients take responsibility for payment. They decide to make a personal investment in their own healthcare. In practice, concierge medicine is not a single entity. It is a term used to describe many different private financial arrangements between doctors and patients. What all forms of concierge practice have in common is that they represent a return to the privatization of medicine.

Though the retainer aspect of concierge medicine is new, paying a doctor directly for his services is nothing new at all. Before the advent of Medicare in the mid 1960s and before HMOs, PPOs and every other kind of "O", patients paid doctors directly for their care. By creating this massive bureaucracy, patients have lost the ability to simply call their doctor and get immediate medical care. Doctors have been forced to run from room-to-room, often seeing 30 patients per day, spending precious little time with each. Most physicians have no time to advocate for their patients. They have become the unwitting financial advocates for insurance companies, their CEOs and their stockholders. Concierge medicine restores order to the doctor-patient relationship by removing the financial interests of the middleman.

The cost of concierge medicine varies widely depending on the services offered and the local market. At the present time, concierge care ranges from $1,500 per year at the low- end (often payable in monthly installments of $125) to $15,000 per year at the higher-end.



Praeger Publishers
200 pages
$34.95
ISBN-13: 978-0313354779

Buy the Book

Amazon

Powells

Barnes & Noble

IndieBound

Generalities of a DPC Practice

- Monthly fee ranges $50-$100
  - *Pricing based on age vs set fee*
- Includes all visits, virtual visits, basic medications, in-house labs/testing
  - *Some do home/work site visits*
- Have negotiated labs/imaging discounts, often wholesale pricing
- Any procedure done in-office is often included or done at substantial discounts to traditional FFS clinics
- Care for 400-800 patients
- Goal to build value in the membership

****DPC is NOT health insurance****

By The Numbers

	DPC (Individuals)	DPC (Employers)	Fee-For-Service
Panel/FT provider	600-800	1,300-1,500	2,000-3,000
Clinic Visits/Day	6-10	8-12	20-30
Tech. Visits/day	8-12	8-12	0-5
Visit Length (New)	60-90 min	30-90 min	15-30 min
Visit Length (Estab)	30-60 min	15-30 min	10-15 min

*This does not reflect every clinic.

So why is DPC needed?

- Physicians
  - *Burnout*
  - *Shortage/Talent Retention*
  - *Improving Quality of Life*
  - *Focusing on relationship with patient, not payers*
- Patients
  - *Improved access to care and potentially quality*
  - *Cost savings*
  - *Improved satisfaction with their health experiences*
  - *Promoting wellness – early intervention*
- Healthcare System
  - *Saving costs through transparency and free market competition*
  - *Decrease administration costs*
  - *Decreased potential downstream costs*

CBS NEWS NEWS SHOWS VIDEO MO

CBS NEWS / May 15, 2017, 12:50 PM

Physician burnout is o rise

13 Comments / Shar

If you've ever worried that your doctor seems burned out on the j right. Physicians are busier than ever, and hospitals are worried t gets overwhelmed, the quality of care goes down and medical err

Amanda North is a busy doctor at Montefiore Hospital in New Y also the mother of three. Shortly after the birth of her youngest c herself exhausted and overwhelmed.

"I was stres CBS News. ' I wasn't gett do rather th achieving."

Just a year i many as 50

DALLAS SEMINAR: TECHNIQUES TO RECONNECT WITH YOUR PATIENTS

CME Physician Depression and Suicide Prevention

Dear Dr. Benson:

Between electronic health records, MACRA rules, and diminishing revenue, many physicians are feeling disillusioned and buried in stress. But there's still one thing that matters enough to put up with all of it — your patients.

TMA's Love Being a Doctor Again seminar will show you how connecting with your patients on a deep level will help rekindle your passion for medicine and lead

FROM SEA TO SHINING SEA

Stressed out? Medscape says you should move to one of these states

When Medscape ranked the 2017 best and worst s focused on factors likely to alleviate—and cause—

By THE DO STAFF

THURSDAY, MAY 11, 2017

SECTIONS SEARCH Chicago T

ESDAY JUN. 7, 2017 SPORTS BREAKING EAT.DRINK.DO. TRENDING OPIN

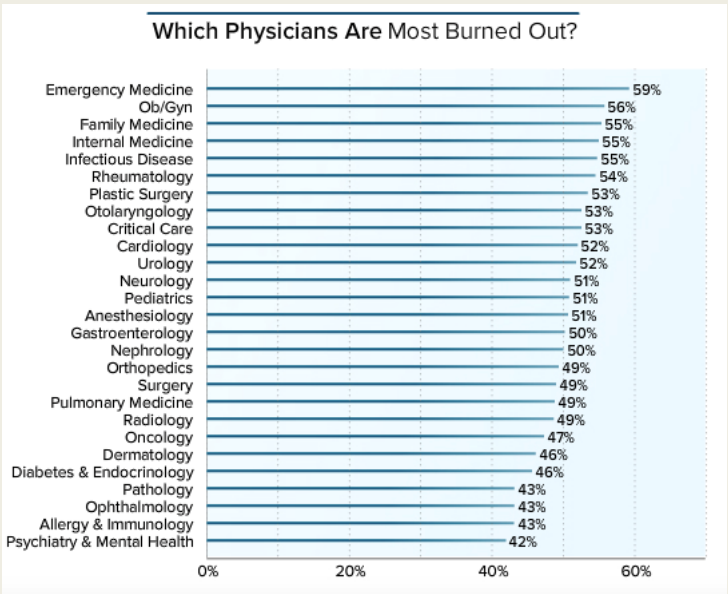
Doctor depression, suicide slowly coming out of shadows

AMA | STEPSforward PRAC HOM

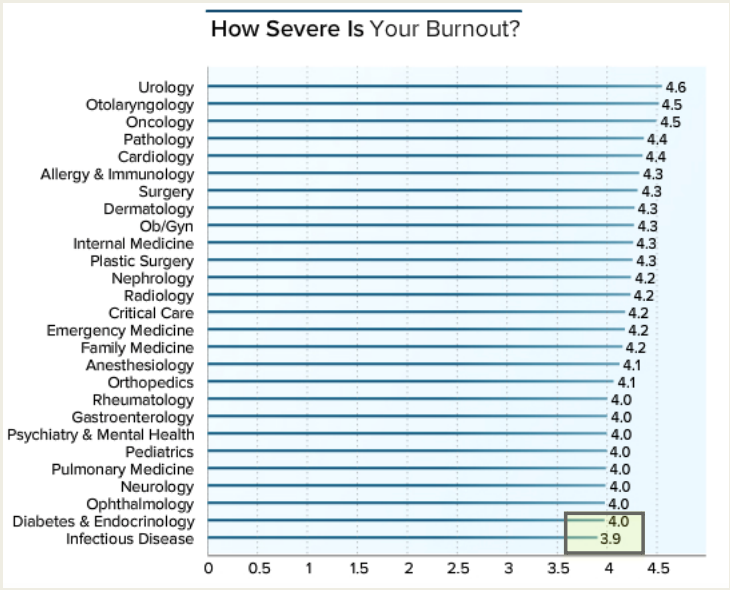
Create a holistic, supportive culture of wellness

Physician wellness: preventing resident and fellow burnout

Toyin Okanlawon, MD, MPH
Harvard Business School

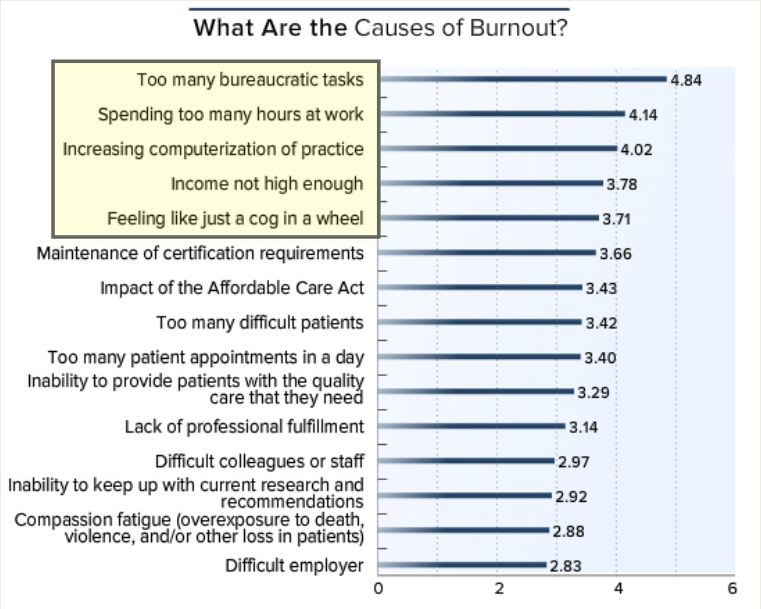


(Medscape Lifestyle Report: Bias and Burnout, 2017)



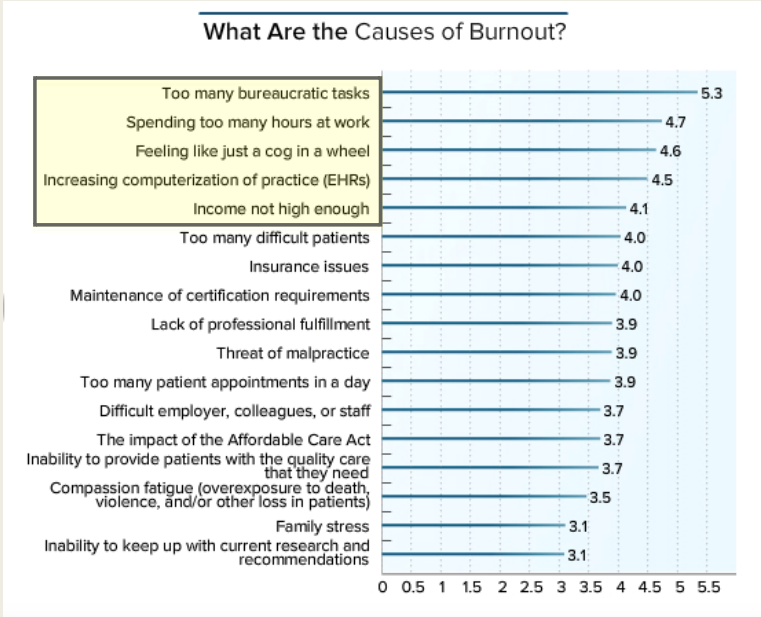
(Medscape Lifestyle Report: Bias and Burnout, 2017)

2016



(Medscape Lifestyle Report: Bias and Burnout, 2016)

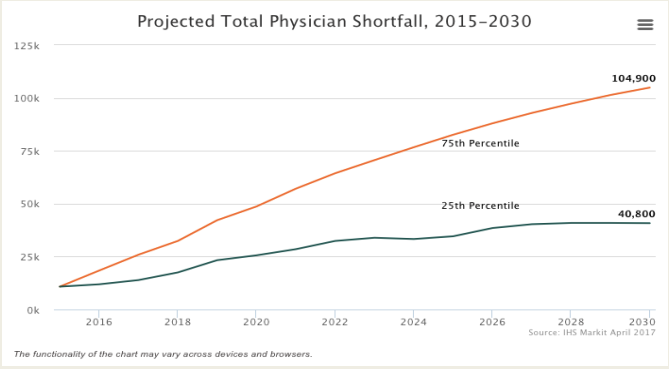
2017



(Medscape Lifestyle Report: Bias and Burnout, 2017)

FYI: There's a projected shortage

- Physician retirement decisions have greatest impact on supply and over 1/3 of all currently active physicians will be 65+y/o within the next decade
  - *39% of physicians indicate they will accelerate retirement due to changes in the healthcare system*



(IHS for AAMC, April 2015)

SEP 7, 2016 @ 08:00 AM 125,251 VIEWS The Little Black Book of Billionaire Secrets

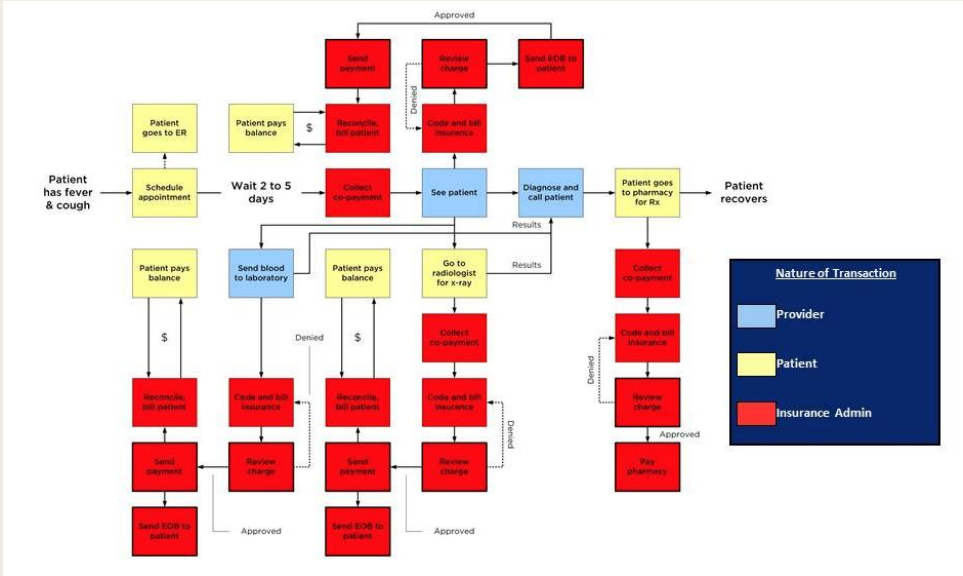
Doctors Wasting Over Two-Thirds Of Their Time Doing Paperwork

Bruce Y. Lee, CONTRIBUTOR
I cover the intersection of business, health and public health. FULL BIO
Opinions expressed by Forbes Contributors are their own.

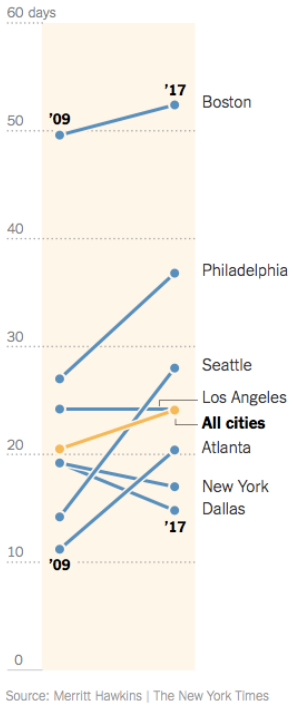
Paperwork for many doctors has become overwhelming. While initiatives have tried to convert paperwork into electronic paperwork, are the new systems actually designed to make doctors' lives easier? (Photo by Joe Raedle/Getty Images)

If medical school curricula were based on what a recent study says many doctors actually do with their time, more than half of medical school would be on how to do paperwork. Medical school admissions essays would be on "why I really want to do paperwork when I grow up." Required classes would be "Introduction to Filling Out Forms" and "Advanced Form-filling." Indeed, a recently published study in the *Annals of Internal Medicine* found that for

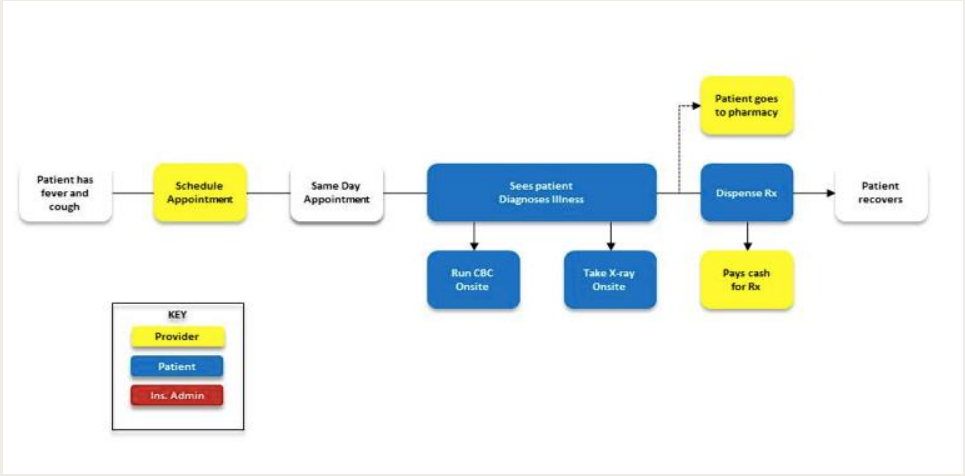
(Forbes.com, Sept. 7, 2016)

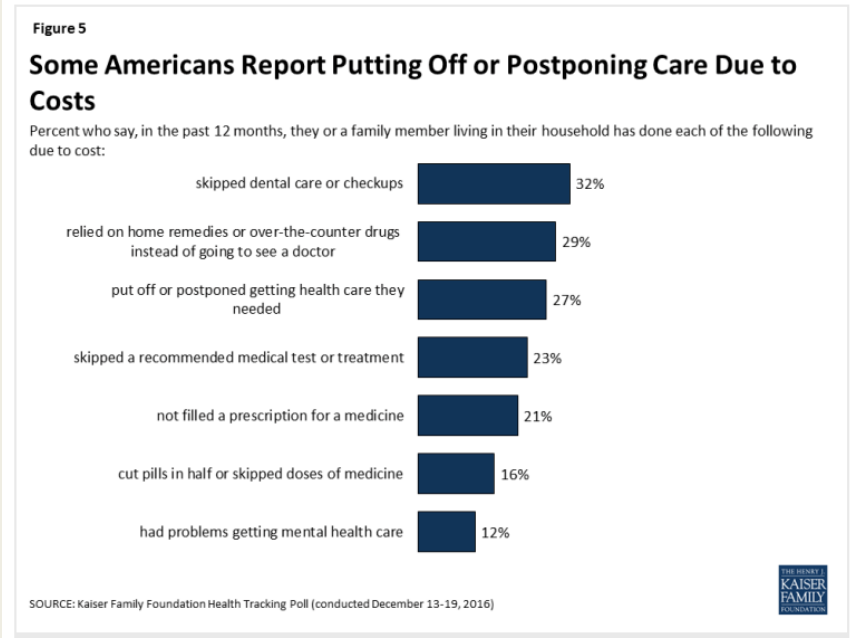


The average number of days to see a doctor from 2009 to 2017 has overall steadily increased.

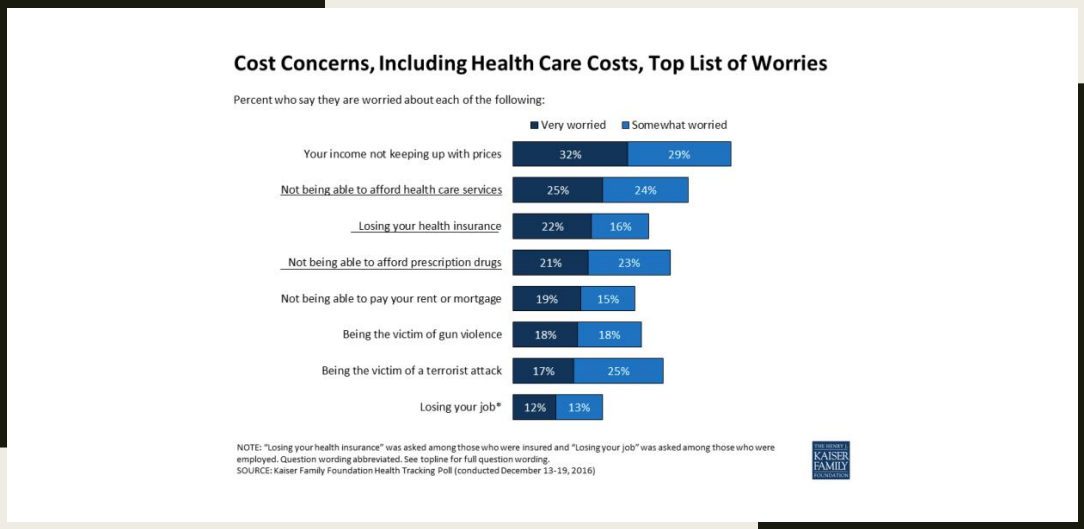


(MerrittHawkins, 2017)





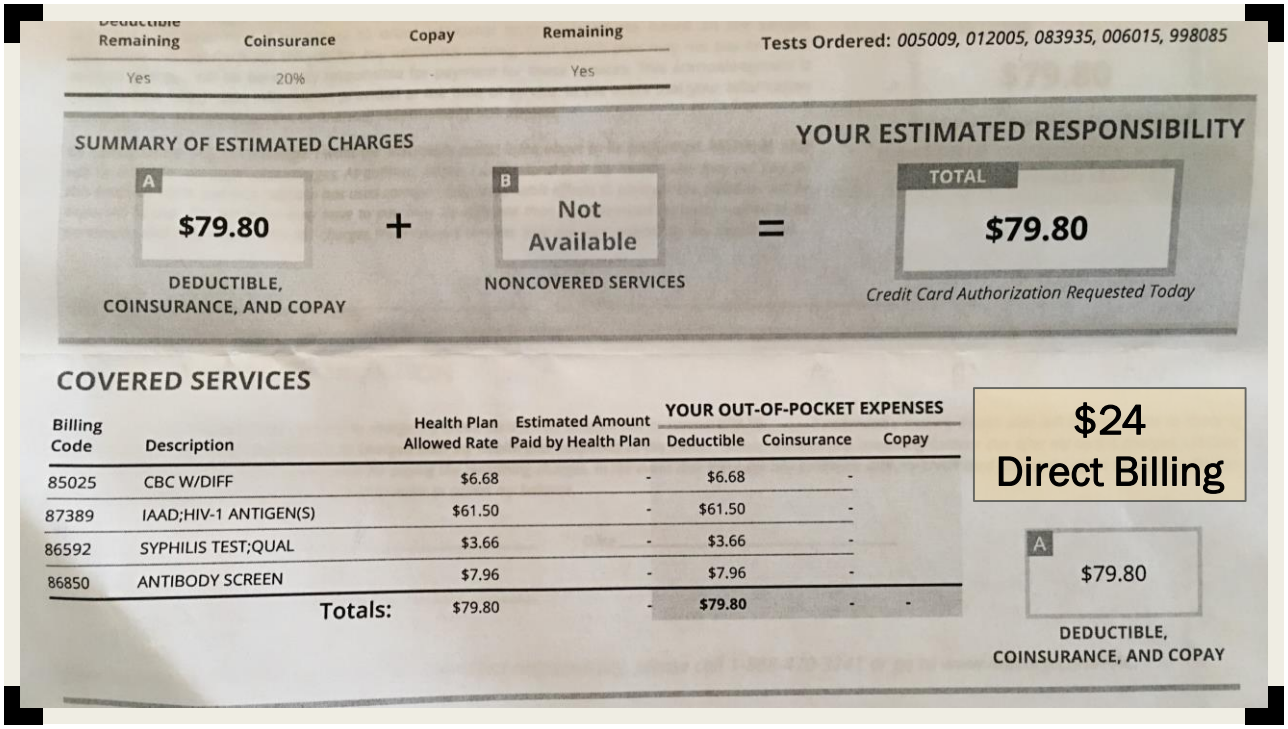
https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/



https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/

DPC Helps Save Patients Money

Procedure	Charge at local hospital	Reimbursement by local insurance co.	Self Pay	DPC cost to patient
Draw fee	$40.00	$11.01	$15.60	$5.00
FLP	$141.68	$11.69	$61.26	$2.95
Complete Blood Count	$220.00	$56.67	$23.15	$1.50
Vitamin D	$550.00	$158.63	$66.10	$10.50
Comprehensive Metabolic Panel	$345.00	$90.03	$38.62	$1.95
TSH	$135.00	$34.68	$61.10	$2.45
EKG	$256.00	$134.08	?	FREE!



Deductible Remaining	Coinsurance	Copay	Remaining
Yes	20%	-	Yes

Tests Ordered: *005009, 012005, 083935, 006015, 998085*

SUMMARY OF ESTIMATED CHARGES

YOUR ESTIMATED RESPONSIBILITY

A $79.80 — DEDUCTIBLE, COINSURANCE, AND COPAY

\+

B Not Available — NONCOVERED SERVICES

=

TOTAL $79.80

Credit Card Authorization Requested Today

COVERED SERVICES

Billing Code	Description	Health Plan Allowed Rate	Estimated Amount Paid by Health Plan	YOUR OUT-OF-POCKET EXPENSES Deductible	Coinsurance	Copay
85025	CBC W/DIFF	$6.68	-	$6.68	-	
87389	IAAD;HIV-1 ANTIGEN(S)	$61.50	-	$61.50	-	
86592	SYPHILIS TEST;QUAL	$3.66	-	$3.66	-	
86850	ANTIBODY SCREEN	$7.96	-	$7.96	-	
	Totals:	$79.80	-	**$79.80**	-	-

$24 Direct Billing

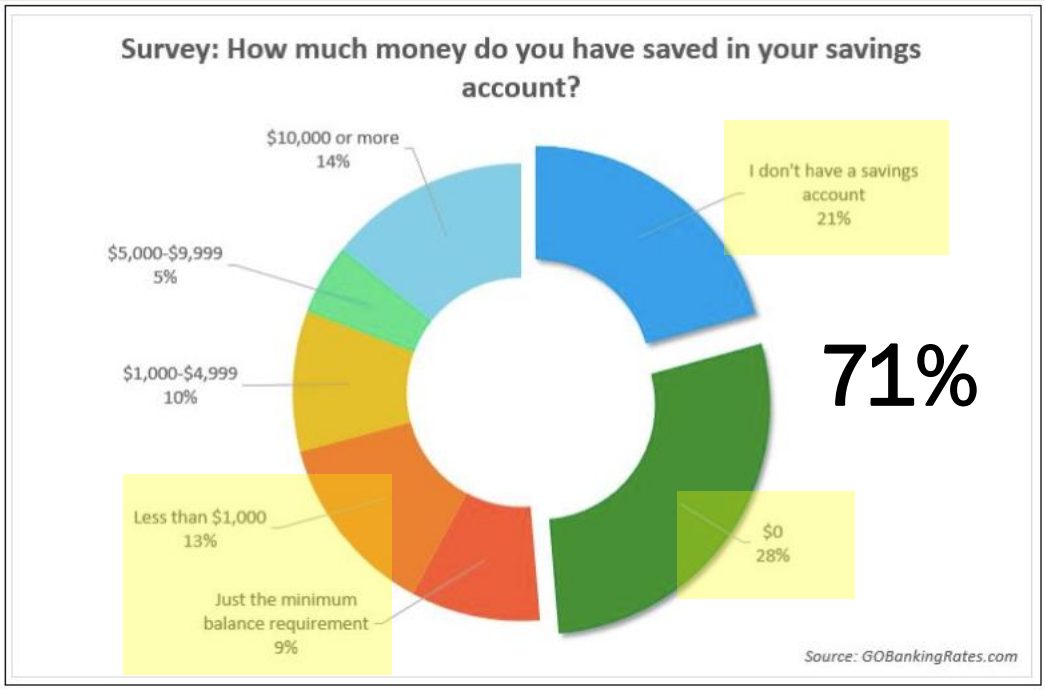
A $79.80 — DEDUCTIBLE, COINSURANCE, AND COPAY

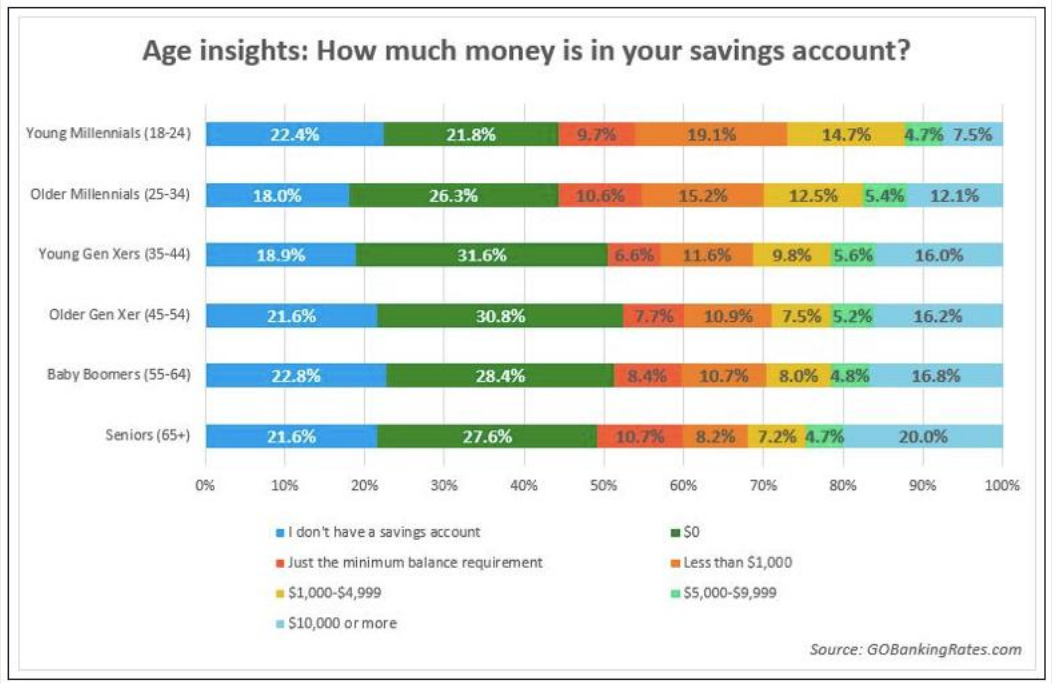
25y/o CF w/ Abdominal Pain

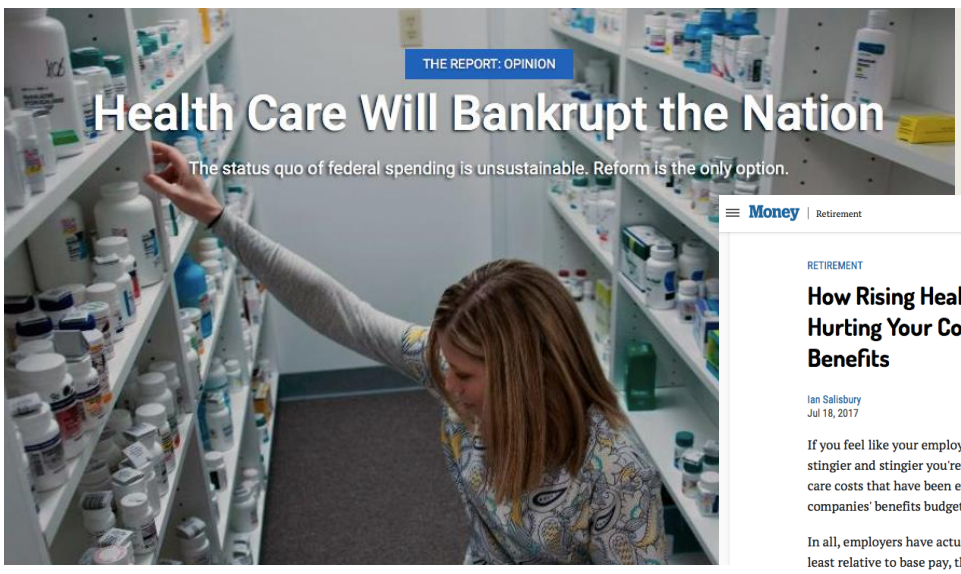
	Insurance Rate (Patient Paid)	DPC Rate
Urgent Care Visit	$179	unneeded
PCP Visit	$369 (2 visits)	Included ($45/mo)
OB/Gyn Visit	$423 (First visit)	$125 (unneeded but included)
TSH	$112	$4.75
GC/CH	$323	$38 (unneeded but included)
Pelvis Ultrasound	$596	$220
CT Abd/Pelvis	$1300	$525
Pap w/ HPV	$92.25	$58
TOTAL	$3394.55	$1015.75
SAVINGS	**Total of $2378.80 for just ONE ACUTE problem!**	

36y/o CM w/ Pneumonia

	Local Urgent Care	DPC Clinic
Office Visit	$170	Included ($65/mo)
CBC	$51	$3.57
Breathing Treatment	$162	Included
Dexamethasone IM	$75	Included
Rocephin IM	$90	Included
CXR	$110	$55
Follow-up Appt	$168	Included
TOTAL	$785	$58.57
SAVINGS	**$726 savings! Almost 1yr of membership for this patient!**	







The Senate's plan to repeal and replace Obamacare has hit a setback

Money | Retirement

RETIREMENT

How Rising Health Care Costs Are Hurting Your Company's Retirement Benefits

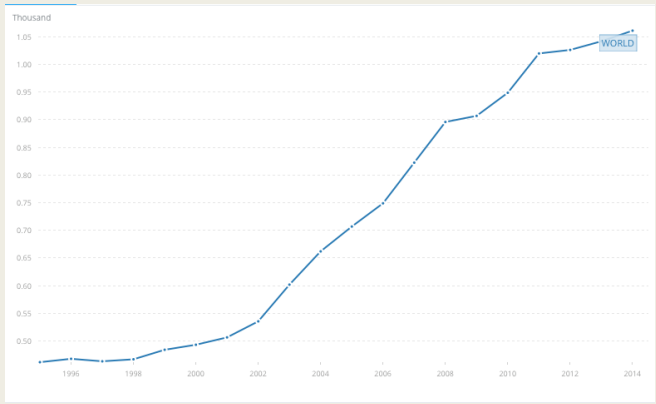
Ian Salisbury
Jul 18, 2017

If you feel like your employer's retirement plan has been getting stingier and stingier you're right. One big culprit: Soaring health care costs that have been eating up a bigger and bigger share of companies' benefits budgets, leaving little left over for retirement.

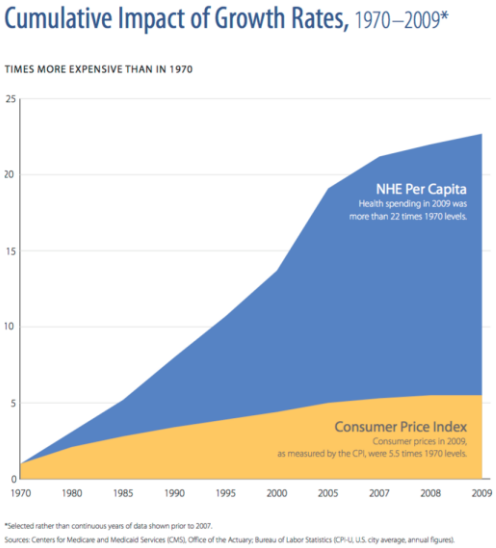
In all, employers have actually been spending more on benefits, at least relative to base pay, than they did half a generation ago, according to Willis Towers Watson, a consulting company that helps large corporations design benefits packages. As of 2015, total benefits comprised about 18.3% of workers compensation, on average, up from 14.8% in 2001.

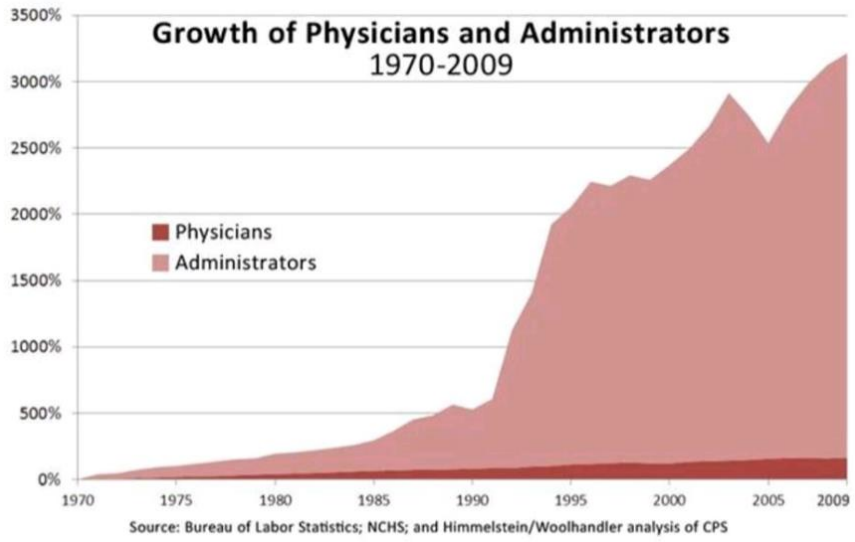
America's Largest Industry

- Healthcare is America's largest industry
  - 17.8% of the GDP ($3.2 trillion/year) in 2015



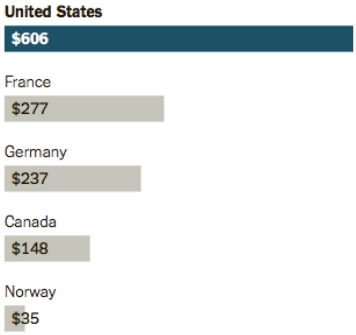
(TheWorldBank.org; CMS.gov)





RANKING COSTS

Per capita spending on health insurance administration in the United States far outpaced that in other industrialized nations in 2011.



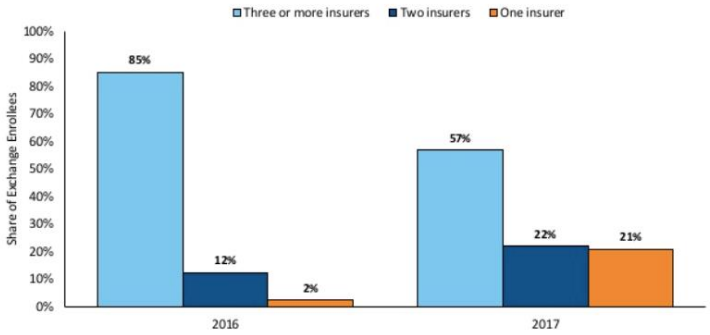
Sources: Compdata Surveys (salaries); the Commonwealth Fund and the Organization for Economic Cooperation and Development (administrative costs)


WASSERMAN
©12 @THE BOSTON GLOBE
DIST BY TRIBUNE MEDIA SERVICES
WWW.BOSTON.COM/WASSERMAN
DOC- CAN YOU SEE THE PROBLEM?
I'M AFRAID SO.
INSURANCE COMPANIES


AFFORDABLE CARE ACT
APPROVED
MAR 2 3 2010
UPHELD
JUNE 2012

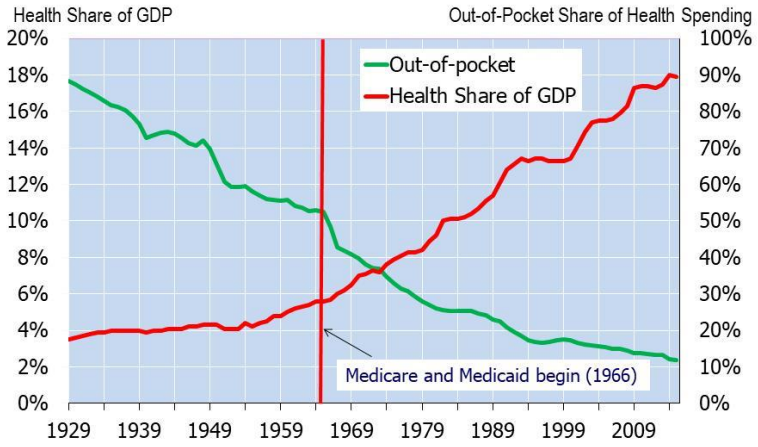
Figure 1

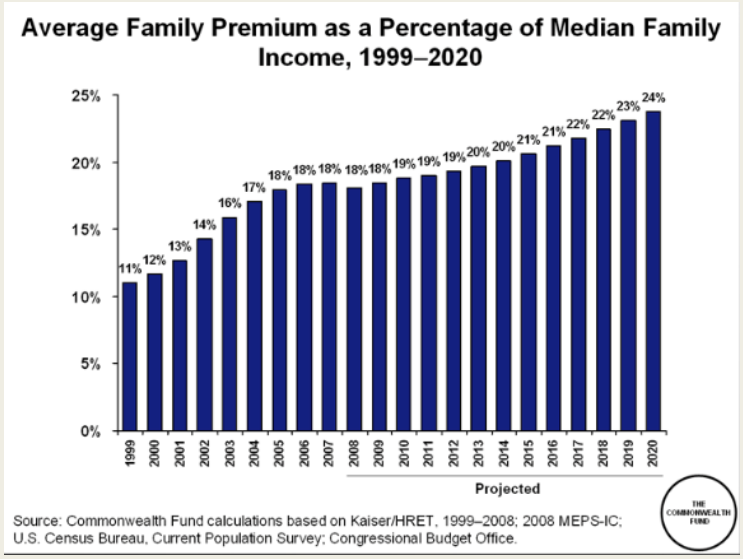
57% of exchange enrollees will have a choice of three or more insurers in 2017, down from 85% of exchange enrollees in 2016

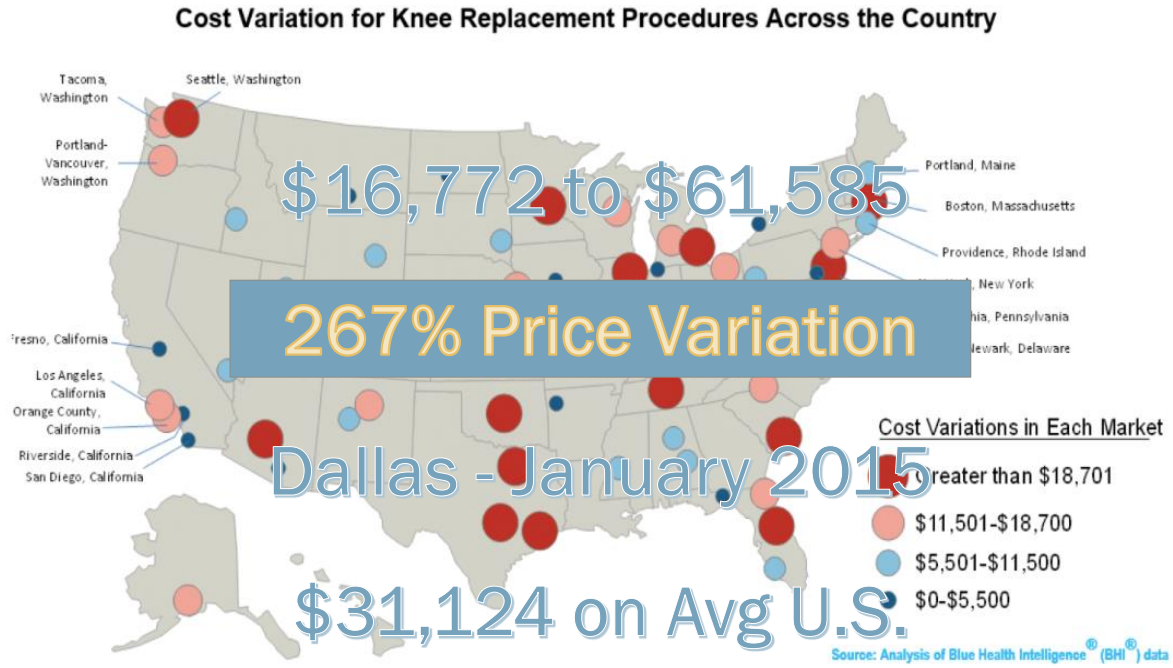


Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups.

The steady decline in the out-of-pocket share of health spending has helped fuel the explosion in health spending



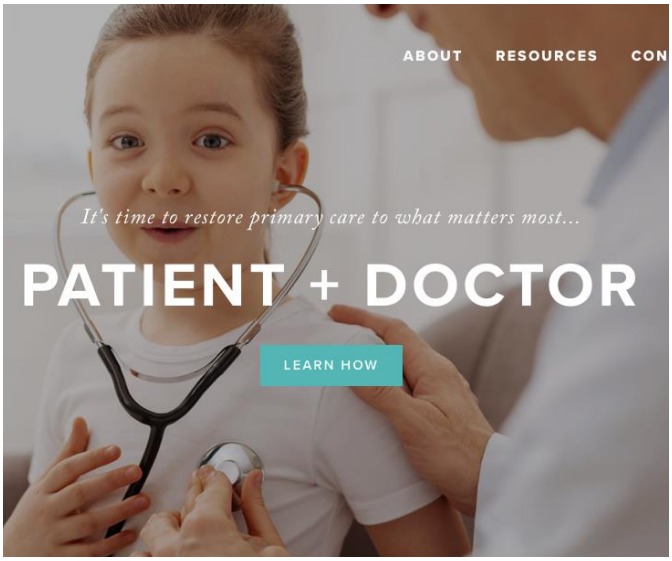

Average Family Premium as a Percentage of Median Family Income, 1999–2020
25%
20%
15%
10%
5%
0%
11%
12%
13%
14%
16%
17%
18%
18%
18%
18%
18%
19%
19%
19%
20%
20%
21%
21%
22%
22%
23%
24%
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Projected
Source: Commonwealth Fund calculations based on Kaiser/HRET, 1999–2008; 2008 MEPS-IC; U.S. Census Bureau, Current Population Survey; Congressional Budget Office.
THE COMMONWEALTH FUND


Cost Variation for Knee Replacement Procedures Across the Country
Tacoma, Washington
Seattle, Washington
Portland-Vancouver, Washington
Portland, Maine
Boston, Massachusetts
Providence, Rhode Island
New York
Pennsylvania
Newark, Delaware
Fresno, California
Los Angeles, California
Orange County, California
Riverside, California
San Diego, California
$16,772 to $61,585
267% Price Variation
Dallas - January 2015
$31,124 on Avg U.S.
Cost Variations in Each Market
Greater than $18,701
$11,501-$18,700
$5,501-$11,500
$0-$5,500
Source: Analysis of Blue Health Intelligence® (BHI®) data

2011 CMS Medicare Claims

- Ventilator: $115,000 (GWU) vs $53,000 (PH)
- Lower joint replacement: $69,000 (GWU) vs $30,000 (SMH)
  - *$117,000 (CJW-Richmond) vs $25,600 (WMC)*
  - *$163,832 (LCMC) vs $42,632 (BMC-Irving)*
    - Reimbursed: $12,643 (LCMC) vs $14,202 (BMC-Irving)
- Bronchitis: $34,310 vs $8,159 (NYC, 63 blocks apart)
- Uncomplicated Pneumonia: $124,051 (Philadelphia) vs $5,093 (Water Valley, MS)
- CHF exacerbation: $173,250 (Newark) vs $7,304 (Western TN)
- Joint replacement: $223,373 (Monterey Park, CA) vs $5,304 (Ada, OK)

(The Washington Post, 5/8/2013; CMS.gov)



Qliance Savings Data – 2013-14

	Incidents Per 1,000 Qliance patients	Incidents Per 1,000 Non-Qliance patients	Difference (Qliance vs. Other)	Savings per patient per year
ER Visits	81	94	-14%	($5)
Inpatient (days)	100	250	-60%	$417
Specialist Visits	7,497	8,674	-14%	$436
Advanced Radiology	310	434	-29%	$82
Primary Care Visits	3,109	1,965	+58%	($251)
Savings Per Patient	---	---	---	$679
Total Savings per 1000 (after Qliance fees)				$679,000
% Saved Per Patient				19.6%

Data Sources: *All claims data (except prescription claims) from carriers for selected large employers; Qliance EMR data; Employer eligibility data.*

Claims Attribution: *All claims incurred by Qliance patients prior to first Qliance visit were excluded; All employees with any interaction with Qliance included as our patients, even if the employee used another primary care provider (which is possible in some of the plan designs among clients); All claims incurred after any interaction with Qliance included, regardless of employee's intent to use Qliance as their primary care provider; All non-primary care provider visits included under "specialist" category (such as physical therapy, acupuncture, etc.)*

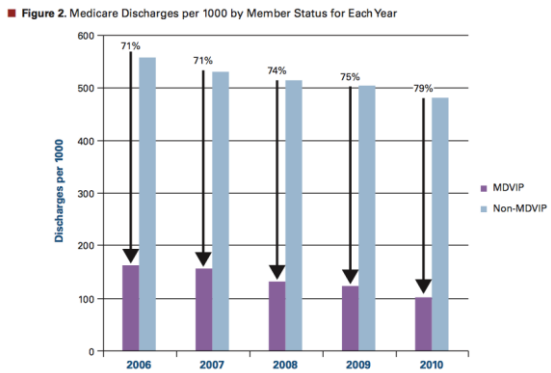
Population: *Eligible members in employer-sponsored health plan; Employees only, to remove confounding factors from differences in dependent benefits structures and participation variances among clients.*

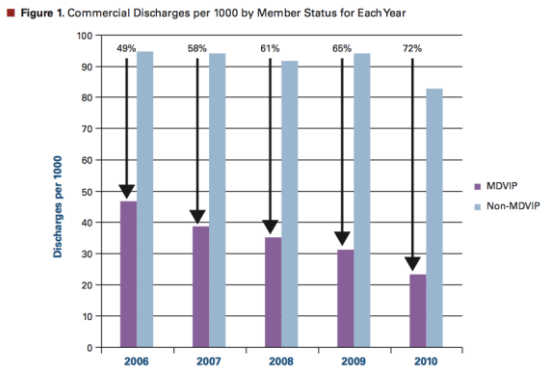
Saving Money with DPC

- Of Union County's 2,000 covered lives, 40% are DPC participants, while the remaining 60% are signed up with the CDHP.
- DPC participants incur 38% less in medical expenses than CDHP participants, yielding annual savings of $1,408,089.
- DPC participants incur 37% less in prescription expenses compared to CDHP participants, yielding annual savings of $269,680.
- DPC participants spend 46% less out of pocket for prescription and medical expenses than CDHP patients, a $333,639 annual savings.
- 73 percent of DPC participants report significant improvement in their overall health since electing the DPC option.

"The DPC model goes beyond *reforming* our nation's health care system. It's blazing a trail to effectively *transform* it."

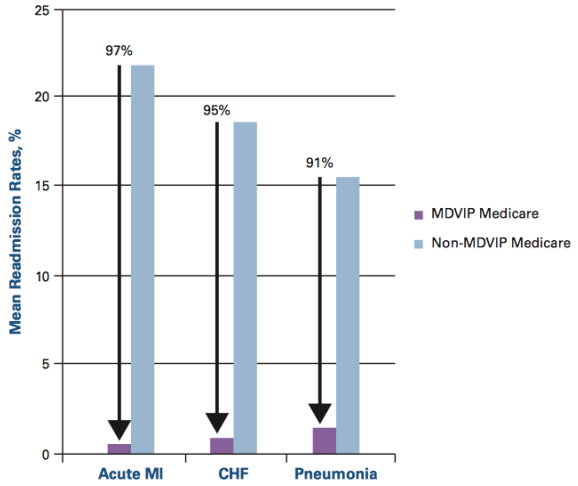
(Forbes.com, July 19, 2016)



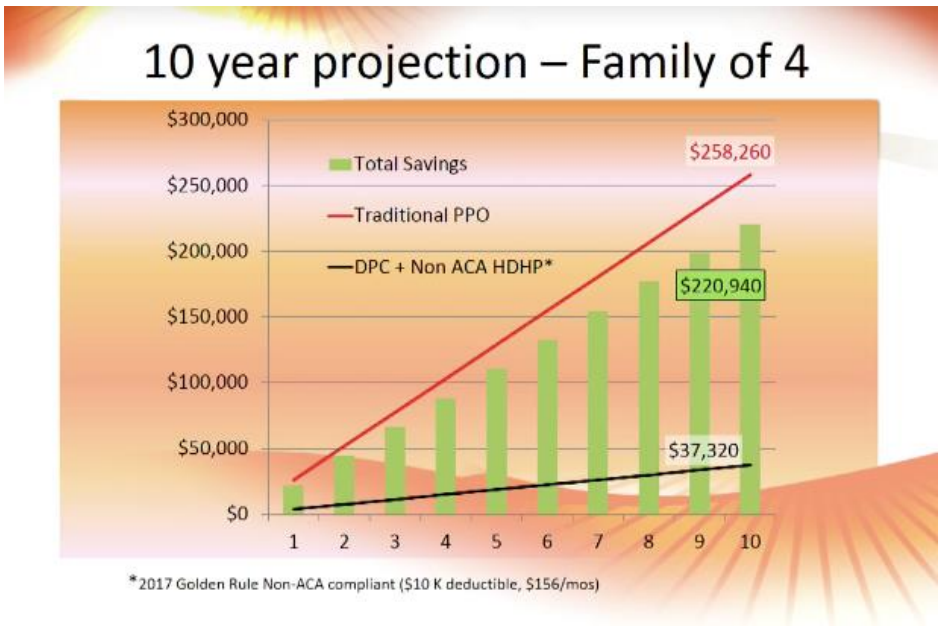


(Klemes et al. Personalized Preventative Care Leads to Significant Reductions in Hospital Utilization. *Am J Manag Care. 2012;18(12):e453-e460.)*

Figure 3. Mean Readmission Rates for MDVIP Medicare Members (2008-2010) Versus Non-MDVIP Medicare Members (2009) in the 5 Reporting States



(Klemes et al. Personalized Preventative Care Leads to Significant Reductions in Hospital Utilization. *Am J Manag Care. 2012;18(12):e453-e460.)*



Opening a DPC Practice

Total # Patients	Monthly Fee Per Patient						
	$40	$50	$60	$70	$80	$90	$100
300	$144,000	$180,000	$216,000	$252,000	$288,000	$324,000	$360,000
400	$192,000	$240,000	$288,000	$336,000	$384,000	$432,000	$480,000
500	$240,000	$300,000	$360,000	$420,000	$480,000	$540,000	$600,000
600	$288,000	$360,000	$432,000	$504,000	$576,000	$648,000	$720,000
700	$336,000	$420,000	$504,000	$588,000	$672,000	$756,000	$840,000
800	$384,000	$480,000	$576,000	$672,000	$768,000	$864,000	$960,000
900	$432,000	$540,000	$648,000	$756,000	$864,000	$972,000	$1,080,000
1000	$480,000	$600,000	$720,000	$840,000	$960,000	$1,080,000	$1,200,000
1100	$528,000	$660,000	$792,000	$924,000	$1,056,000	$1,188,000	$1,320,000
1200	$576,000	$720,000	$864,000	$1,008,000	$1,152,000	$1,296,000	$1,440,000
1300	$624,000	$780,000	$936,000	$1,092,000	$1,248,000	$1,404,000	$1,560,000

Mean DPC clinic monthly fee in 2015 was $77

Days worked/wk	Hours worked/day	Average Visit Time	Visits Per Day	Total Available Visits (46wk)	Patient Volume (4 visit/yr)
5	7	30 min	14	3220	805
5	7	45 min	12	2760	690
5	7	60 min	7	1610	402.5
5	7	90 min	6	1380	345
5	8	30 min	16	3680	920
5	8	60 min	8	1840	460
5	8	90 min	6	1380	345
5	7	15 min	28	6440	1610

My Start-Up Expenses

approx. $19,000

Form the PA/PLLC	Patient/Employer Contracts
Exam table (stirrups)	Office/Medical Supplies
Office furniture	Logo Design
Scale	Marketing Materials
EKG	Disposable Procedure Kits
Laptop	Clinic Medications
Printer/Fax/Scanner All-In-One	Prescription Pads
TV	Fridge
Kid Playroom Toys/Furniture	Build-out (sink/cabinets)

Monthly Overhead

$3,800

	Monthly Expense		Monthly Expense
EMR	$257	Malpractice	$112
Internet/Phone	$125	Business Insurance	$67
Spruce (texting app)	$24	TxWorkForceComm	$65
Accounting	$200	General Supplies	$100
RubiconMD	$150	Processing Fees	$130 (varies)
Rent	$2019	Advertising	$120
Misc.	$250	Website/Tech	$23
Electricity	$200	Salaries (Doc/Staff)	$0
Cell	$75		

Don't forget to do your home budget too!

I am not a lawyer and nothing I say should be construed as legal advice.

DPC and the Affordable Care Act

Sec. 10104. Amendments to Subtitle D

(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 quality health plan.

(PPACA, Pub. L. No. 11-148, 124 Stat. 199, § 10104.)

Federal HHS Definition of DPC

76 Fed. Reg 41900 (July 15, 2011) (amending section 1301 (a)(3) of the Affordable Care Act

A "Direct Primary Care Medical Home" plan is defined as "an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services"

(www.dpcfrontier.com, Jan 8, 2017)

Enhancing Direct-to-Patient Relationships
HHS is committed to reducing regulatory burdens facing medical professionals, especially those serving in rural areas. To achieve this goal, HHS continues to look for ways to improve or eliminate regulations that impede the ability of medical professionals to provide the best possible care to their patients. HHS also believes that health care providers are a valuable resource whose input and ideas are essential to a positive health care reform effort. HHS also is committed to an open and transparent process for developing new voluntary payment models that providers can participate in. Finally, HHS has established various avenues of technical assistance to help clinicians be successful in providing efficient, high-quality care to their patients.

Achieving the President's goals to reform Medicaid will require providing States with more flexibility to improve healthcare delivery to meet the needs of their unique populations. Direct Primary Care practices, in which physicians offer primary care services to patients at a set price, generally without payer or insurer involvement, are a mechanism to improve physician-patient relationships. Some State Medicaid programs are already testing this innovative care delivery model. HHS will explore opportunities for States and providers to further expand Direct Primary Care, which will support improved health outcomes for Medicaid populations.

(HHS 2017 Budget)

IRS Tax Treatment of DPC

- While ACA and many states contain language expressly stating that DPC is NOT insurance, the IRS continues to maintain the argument that DPC is a type of "gap" insurance
- HSA is considered a "gap" product, and you cannot have another similar product (DPC per IRS but not the ACA)
  - *Legislators have asked the IRS to update section 223(c) of the Internal Revenue Code based on ACA specifically stating DPC was not an insurance plan and it should be recognized as a "qualified medical expense"*
  - *http://media.wix.com/ugd/677d54_d6cf9ad6556a4e99b73123d735f7aa25.pdf*
- Bipartisan bills SB 1358 and HR 365 to resolve IRS issue

(www.dpcfrontier.com, Jan 8, 2017)

Opting out of Medicare

- When NOT opted out
  - All membership charges are for “non-covered services”
  - Constantly evolving, monitor Medicare’s schedule of services closely
  - Talk to your legal counsel
- When opted out
  - Patient signs opted out waiver, can then bill them your free directly
  - How to do this is a lecture in itself
    - http://aapsonline.org/opting-out-of-medicare-a-guide-for-physicians/
  - With MACRA, as of 6/17/15 – the opt out is permanent until the physician revokes the opt out
    - Can revoke at any time, but is on 2yr intervals (previously you had to re-opt out every 2yrs)
    - Your opt out automatically renews every 2 years until you revoke it

Patient’s Right of Refusal

- Medicare Beneficiary Right of Refusal
  - A beneficiary refuses, of his/her own free will, to authorize submission of a bill to Medicare. In such a case, the Medicare provider is not required to submit a claim for the covered services and may accept an out of pocket payment for the service. Limits apply.
  - Federal Register/ Vol. 78, No. 17, 5626-5630/Fri, Jan 25, 2013
  - Medicare patient must agree:
    - No compulsion to enter into cash transaction
    - Provider would otherwise bill Medicare
    - Agreement is not a “Private Contract” and provider may continue to bill Medicare for services
    - Medicare allows cash discounts proportional to savings in

Patient's Right of Refusal

- Private Insurance Patient
  - HITECH-HIPAA Omnibus Rule, Sept 23, 2013
    - Allows Right to restrict disclosure
    - Patient has firm right to demand that a healthcare provider not disclose the patient's protected health information to patient's health plan
    - Patient must make a **Request to Restrict** disclosure
      - Disclosure is to a health plan for payment or healthcare operations
      - Disclosure is not required by law, and
      - Patient (or someone on their behalf) has paid in full out of pocket
    - Individual can use FSA or HSA to pay for the healthcare items or services they wish to restrict from another plan

Q1. What type of practice does not bill insurance as method of payment?

A. Concierge Medicine
B. Direct Primary Care
C. Urgent Care
D. Fee for Service Clinic
E. Shared Savings Clinics

Q2. What law allows a patient to refuse to use their private insurance?

A. HITECH-HIPAA Omnibus Rule
B. The Century Cures Act
C. Bill H.R. 365
D. The Affordable Care Act
E. None of the above, you have to use your insurance

Q3. Can a participating Medicare provider accept cash payments from a Medicare beneficiary?

A. Yes, always
B. Never
C. Only if patient signs a right of refusal
D. One-time
E. Unsure

Q4. In what setting can you moonlight and see Medicare patients and bill Medicare if you've opted out?

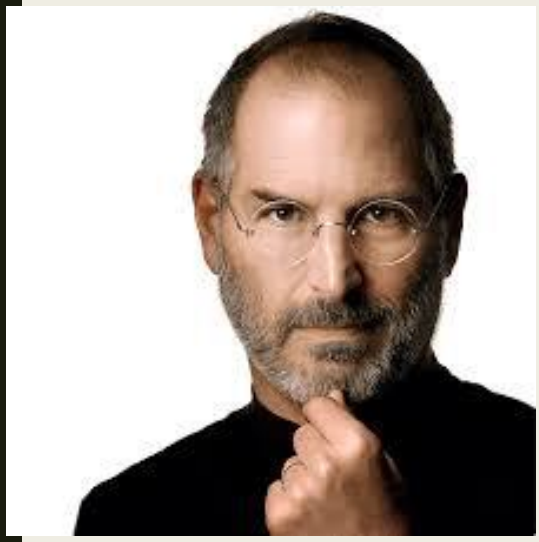
A. Urgent Care/Emergency Room
B. Private Clinic
C. Direct Primary Care Clinic
D. Hospital Setting
E. Pain Management Clinic

Q5. What percentage of Americans report less than $1,000 in their savings?

A. 20%
B. 40%
C. 55%
D. 70%
E. 90%

“It’s more fun to be a pirate than to join the Navy.”

-Steve Jobs



Further Resources

- www.dpcfrontier.com
- www.iamdirectcare.com
- https://d4pcfoundation.org
- www.dpcare.org
- “Catastrophic Care” by David Goldhill
- ReasonTV DPC Interview
  - *https://www.youtube.com/watch?v=6-Vqjo2S1us&t=22s*