Direct primary care references in new CMS program plan leave cash-only docs skeptical

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Alternative payment models

A CMS program currently in planning stages appears to seek input from the direct primary care (DPC) community — but DPC providers *Part B News* talked to aren't sure they see how their model would fit.

On April 23, CMS announced that, based on feedback it received on its "New Directions" request for information (RFI) issued in September 2017, it was putting out a new RFI for suggestions for a Center for Medicare and Medicaid Innovation (CMMI) pilot program called Direct Provider Contracting that would attempt to improve care and save money by "allowing Medicare beneficiaries to contract directly with healthcare providers" (*PBN blog 4/24/18*).

Details so far are vague, but from the RFI CMS seems to envision a capitated payment system with which providers would cover at least basic primary care health services for patients on a per beneficiary per month (PBPM) payment.

Also interesting to observers were references to direct primary care, a practice model heretofore considered to be close to the philosophical opposite of Medicare. The agency asks providers in that model several questions, including "whether your practice ever participated in Medicare… how you made the transition to solely direct contracting arrangements (if applicable); and key lessons learned in moving away from fee-for-service entirely (if applicable)."

DPC is similar to concierge medicine and "hybrid" concierge medicine in that patients pay for their own services, usually via a monthly payment, rather than via normal insurance models (*PBN 3/6/17*). The major difference is that concierge is generally a premium service — fees can be high, and subscribers get perks like longer visits and "executive" physicals. Also, hybrid programs continue to take insurance, including Medicare, to cover services not in the concierge contract, says Wayne Lipton, managing partner of Concierge Choice Physicians in Rockville Center, N.Y.

DPC: All cash and cheap

In DPC, on the other hand, insurance is not involved, as providers serve their patients more or less the way they did before health insurance existed, treating them with primary care services they need to the extent of their abilities and sending them on for emergency or specialist service when necessary. As the name implies, the emphasis is on routine medical needs, and fees tend to be lower than those demanded by concierge practices.

"DPC is usually $100 or less per month, affordable to most Americans, like a cell phone bill," says Niran Al-Agba, M.D., operator of her own pediatric "micro-practice" in Silverdale, Wash., and a frequent writer on DPC topics at the Health Care Blog and elsewhere. For that price, the DPC provider is expected to cover most of the patient's primary care needs, she adds.

Jay Keese, a principal with Capitol Advocates in Washington, D.C., and executive director of the Direct Primary Care Coalition (DPCC), a group of physicians who practice in the DPC model and advocate for its legal status, takes an accommodationist view of CMS' plan: he says DPCC has been "engaged" with the agency on the proposed model and they intend to respond to the RFI.

"CMS wants to test a range of models," he says. "The one that seem easiest for CMS would be, go to the existing doctor and pay their Medicare beneficiaries so they can pay their doctor."

'Cowboy' medicine

But Al-Agba is skeptical that DPC providers will want to work with CMS — and vice versa. For one thing, she sees DPC providers as "cowboys" who like doing medicine the old-fashioned way. "Traditionally, physicians a half-century or more ago did everything in their offices and had one nurse on staff to assist," she says. "My father was in practice for 47 years; we did blood draws, we stitched — we could do everything." But as medicine has become more impersonal, "many physicians are burning out or unhappy with losing touch with their patients," which Al-Agba says is much of the appeal of DPC.

Al-Agba says DPC practices can get savings for their patients that Medicare is unlikely to replicate. For example, in states that allow them to dispense, they can buy meds at a discount and pass them along to patients near cost. "A DPC physician can get a course of amoxycillin for $1.50," she says. "And DPC practices don't mark up — maybe a little, like 10% to cover costs. So now the patient is skipping the pharmacy and saving maybe hundreds of dollars. The government doesn't like that. The pharmaceutical companies don't like when [doctors] take control."

"CMS needs to understand why physicians flee Medicare and embrace DPC," says Adam Habig, co-founder and president of Freedom Healthworks, a DPC company in Indianapolis. "Reimbursement levels are not the only culprit — it's also the onerous administrative oversight, coding audits and reporting burdens that are just as likely to drive talented doctors away."

Al-Agba thinks EHR requirements are not only a sticking point but also unnecessary.

"I'm still on paper [records]," she says. "I still have a transcriptionist. Once you get involved with Medicare they require that you use an EHR. But they could take data from claims." She mentions the Medicaid demo she's involved with as a pediatrician: "They compile from claims data. If they can do that, why not [do it] for everyone else?"

"The reason we do this is to spend more time with patients, not to input data in the computer," says Paul Thomas, M.D., of Plum Health DPC in Detroit. "I think the program will come with some sort of reporting requirement that I probably won't want to deal with."

Monthly fee scalable?

CMS' proposed PBPM fee for "primary care services… which may include office visits, certain office-based procedures, and other non-visit-based services covered under the physician fee schedule, and flexibility in how otherwise billable services are delivered" sounds close to the DPC monthly-payment model. But Lipton warns that transplanting that model to more complex Medicare practices might not make a good fit.

"Insurers have moved away from capitated payments to primary care doctors for a reason: Capitated plans incentivize doctors to triage patients," says Lipton. This was part of the reason why HMOs failed in the 1990s. "To guard against that, CMS would have to pay adequate capitation rates and build in incentives," says Lipton — but that might cut against the cost-savings CMS seems to have in mind.

Though the model suits doctors whose relationship with patients is close, the monthly fee might provide perverse incentives for other doctors, says Al-Agba."I just had a little girl who fell and cut her mouth," she says. "I stitched her up. If I'm only getting 10 bucks every month no matter what I do for her, I'm incentivized to send that patient to the ER. And I'm cheaper than the hospital!"

"I'd like to believe that Medicare is serious about innovation," says Habig, "especially with leadership's previous success at the state level" in programs like Healthy Indiana — the Medicaid waiver innovation that brought future CMS Administrator Seema Verma to prominence. "When DPC has the potential to generate enormous cost savings by offering enhanced care instead of rationing, CMS should take a hard look," Habig says.

"However, [CMS] leadership must recognize what makes DPC so powerful and attractive to patients and doctors [is] its liberation of the patient-physician relationship from the inefficiencies of the larger health care system," Habig says. "Is CMS capable of granting seniors the freedom to spend even a small portion of their own benefit dollars on DPC without strings attached?" — *Roy Edroso (redroso@decisionhealth.com)*

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