Disruptive Doctors Welcome Here

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Participate in polling questions and submit your questions to https://aafp4.cnf.io/

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Learning Objectives

At the end of this educational activity, participants should be better able to:

- Summarize the rise and growth of DPC
- Discuss emerging issues and future challenges for DPC practices
- Recognize the potential DPC has to transform healthcare

Exhibit A - DISRUPTIVE DOCTOR

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Disruptive Physician

- Term originated 1998 – 2001
- Used to describe doctors whose bad behavior negatively affects hospital staff, patients and workplace morale
- Label often used as a tool to punish independent, vocal physicians

Possible Consequences

- Summoned to meeting with administration (the Star Chamber)
- Enroll in a multi-day, “JACHO Consistent” Treatment Program (or re-education camp)
- Terminated/ forced to resign
- Reported to state medical board

AMA Definition

Personal conduct, whether verbal or physical, that negatively affects or that potentially may affect patient care.

State Boards of Medicine

- Hostile avoidance or the “cold shoulder” treatment
- Intentional miscommunication
- Unavailability . . . delaying or not answering pages
- Speaking in a low or muffled voice Impatience with questions
- Sarcasm

A combination of conditions led to loss of autonomy and increasing numbers of “disruptive physicians”

3rd Party Payor Pressures

- Reduced reimbursements
- PBMs
- Pre-authorizations
- Routine, unwarranted denials
- Contracts of adhesion

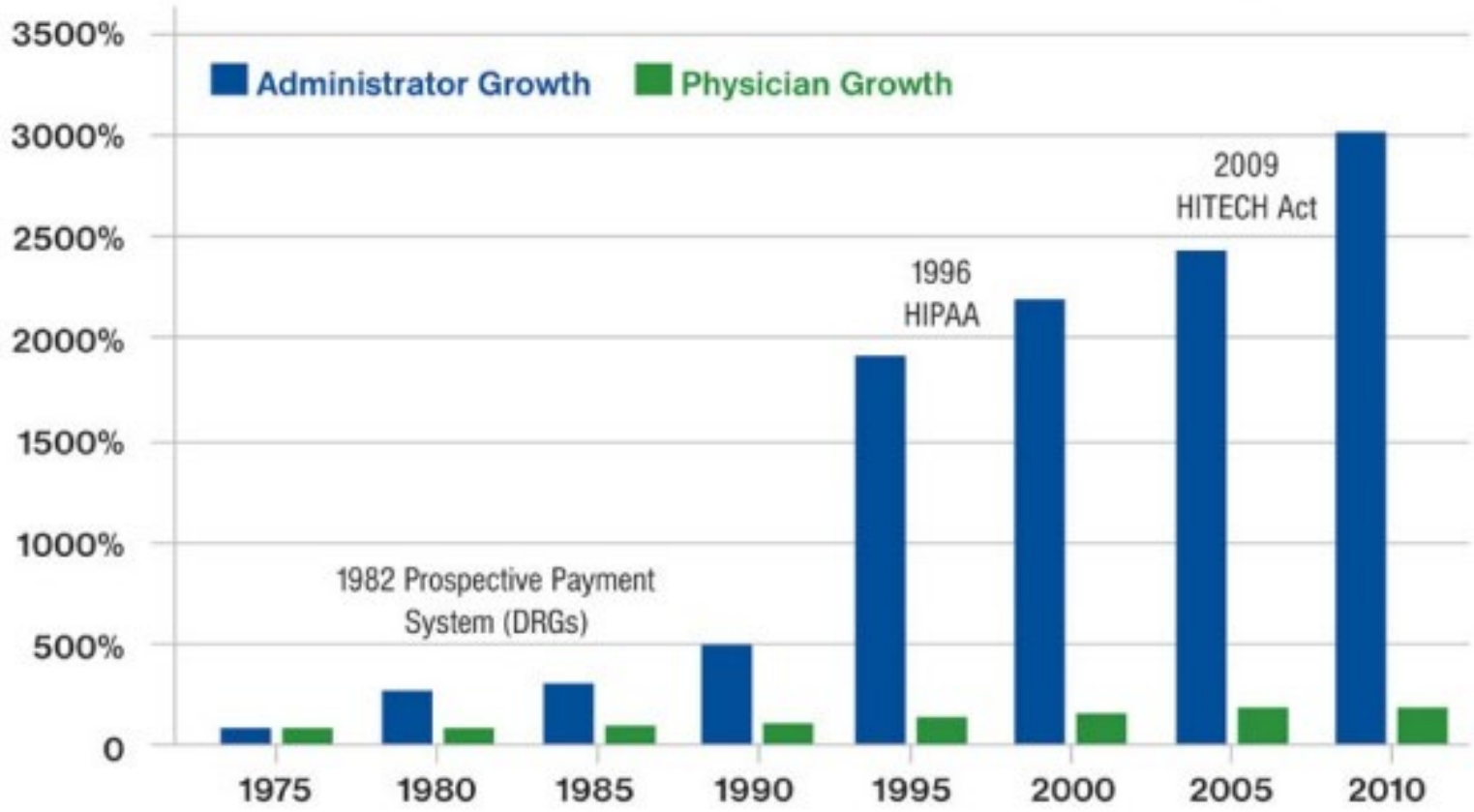
Hospital Pressures

- Patient satisfaction scores
- No control over schedule (17 minute visits)
- Insufficient nursing and medical assistant staff
- Increased, uncompensated, administrative duties
- Egregious employment agreements

Regulatory Pressures

- Meaningful Use
- ACA
- HIPAA
- MIPS
- MACRA
- PCMH
- RACs

Health Care Administrators Outpace Physicians



SOURCE: "The Rise (and Rise) of the Healthcare Administrator," AthenaInsight, Nov. 17, 2017.

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This Was an Intended Effect

"The economic forces put in motion by the [Accountable Care] Act are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups."

and

"reforms will unleash forces that favor integration … only hospitals or health plans can afford to make the necessary investments in information technology and management skills."

— Obama administration health care advisers, Nancy-Ann DeParle, Ezekiel Emanuel, and Robert Kocher ,Letter published in *Annals of Internal Medicine* in 2010.

Physicians in Private Practice

2012 - 48.5%

2018 - 31.0%

2018 Survey of America's Physicians: Practice Patterns and Perspectives

“The trouble is that we’re in the business of making hamburgers and you're not making enough hamburgers.”

- Hospital Administrator


"THE BREAKING POINT"
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Battle for Legitimacy

Game On . . .

Persistent, Disruptive Doc 1

Insurance Commissioner 0

West Virginia

- Dr. Vic Wood : “It’s all about removing the financial middlemen between doctor and patient”
- 2003 – advertises unlimited primary care for a monthly fee of $83 for an individual, $125 for a family
- State insurance commissioner warns that Wood is operating illegal insurance business —a felony punishable by up to five years in prison— tells him to stop

But He Didn’t Stop

- For three years, Dr. Wood worked for legislation to legalize direct pay practice.
- Enormous push-back from insurance lobby
- His Initial bill died in the house after passing the senate

Persistence

- Appointed by governor to a task force on the needs of the uninsured
- Task force recommends a three year, DPC pilot project – signed into law in 2006
- The legislation was flawed with severe restrictions
- In 2017, the legislature passed an exemplary DPC statute

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The Cost of Being Disruptive

- Lobbyist Expenses
- Lost income
- $300,000
- 180 mile drives (often weekly) to state capital
- "It almost pushed me to the point of bankruptcy."

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DPC gains momentum

- One Year Later Washington Passed DPC Legislation Other States Followed

Growth

- 26 states have DPC statutes
- 1086 known DPC practices across 48 states (https://mapper.dpcfrontier.com/)
- CMS interested in DPC as an option for Medicare and CHIP
- Pilot programs established or being established in several states for Medicaid and state employees

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DPC Conversion

- 4.5 % of physicians responding to a 2018 physician survey indicated that they intend to either partially or fully transition to concierge/DPC practice in the next 1 to 3 years.
- This is more doctors than plan to be hospital employees (4.3%), or merge with another group (2.8%).

2018 Survey of America's Physicians: Practice Patterns and Perspectives

Employer Contracting

- Small employers with self-insured plans increased from 14.2 percent in 2015 to 17.4 percent in 2016.
  - https://insurancenewsnet.com/oarticle/research-finds-growth-in-self-insured-health-plans-among-smaller-employers#.XQHJpRZKiUl

- Business Management Daily names direct employer/physician contracting as one of the top 4 employee benefits trends to watch in 2019.
  - https://www.businessmanagementdaily.com/52353/4-key-employee-benefit-trends-to-watch

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Emerging Issues And Challenges

Regulations
and
Opportunists

Regulations- HSA Problem

No fix yet for the long standing Health Savings Account (HSA) problems:

- The “gap plan” problem — the IRS has determined that DPC is a health plan under section 223(c)(1) of the code, making DPC members ineligible to establish or contribute to an HSA.
- The “qualifying expense” problem — assuming the Gap plan problem goes away, the question remains (and the IRS declined to decide) whether DPC periodic fees are reimbursable as qualified medical expense under 213(d).

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OTHER REGULATORY CONCERNS

What's to Worry About?

- New legislation
- Amended legislation
- Regulation Creep
- Special interests

Who are the Special Interests?

- Hospitals
- Insurance Companies
- Corporate medicine

Rule No.1: Be Involved

- Essential for physicians to be *personally* involved in,have a voice in, and monitor, any legislative or policy efforts affecting DPC
- You can’t depend on a surrogate
- No one knows or cares about your issue like you.
- You can speak more passionately, with more knowledge and with more credibility than the best lobbyist

Nobody Does It Better

Effective Involvement

- Keep informed about everything that touched DPC
- Communicate with your legislators
- Direct involvement – testify at hearings, etc.
- Talk to public
- Talk to your patients

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Read the proposed language

- Read the statutes and regulations and proposed amendments
- Plain language rule
- Less is more
- Words matter . . . a lot

Oregon DPC Statute

Must be certified by the Department of Consumer and Business Services

Must provide **only primary care** and must limit the services or the number of patients to an amount that the practice can provide in a timely manner

- Must be financially responsible and have the necessary business experience or expertise to operate the practice
- May not engage in dishonest, fraudulent or illegal conduct in any business or profession
- Disclosures- **Any other disclosures** required by the department by rule.
- Misdemeanor involving dishonesty

Invasive Certification Questions

II. Experience and expertise (OAR 836-200-0305(1)(C)):

1. Describe the background or training of the applicant that provides the necessary business experience or expertise to operate a retainer medical practice, including the number of years the applicant has been in practice. See OAR 836-200-0305(1)(C)(iv) for more information.

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DEPARTMENT OF CONSUMER & BUSINESS SERVICES

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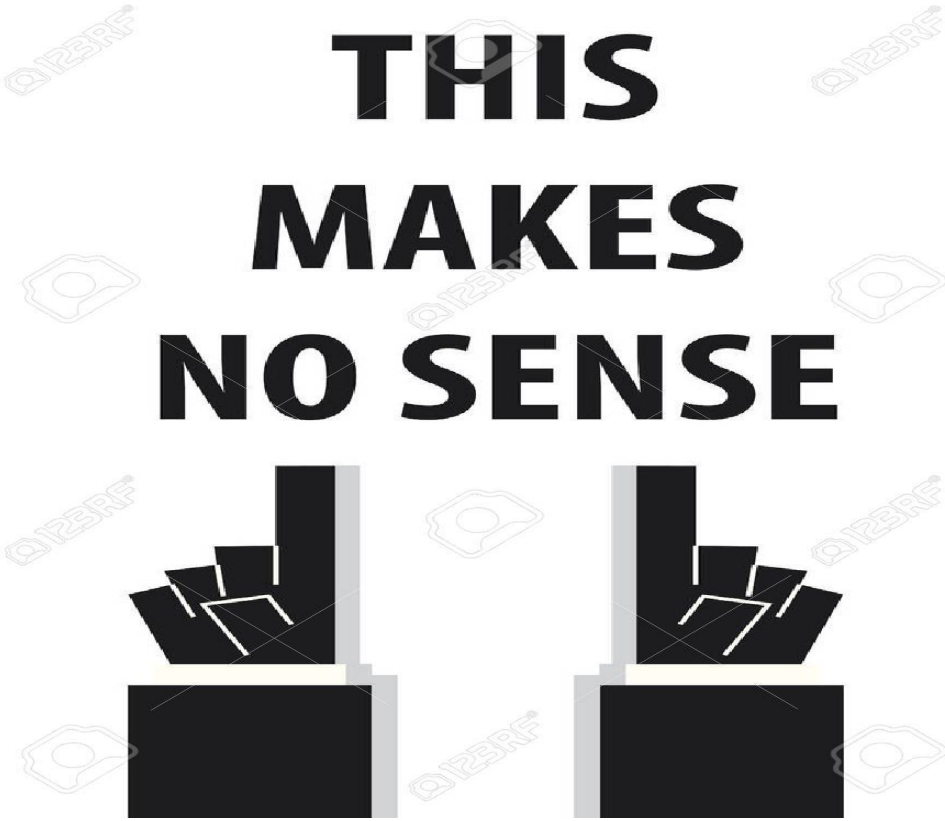
But Wait — There's More!



Recertification. Every. Single. Year.

OAR 836-200-0310- must provide the following:

1. The total number of patients under a retainer agreement

2. The total number who voluntarily terminated the agreement

3. The total number that the practice terminated- and the reason

4. The total number who applied and whom the practice declined – and the reason

Compare

The
Wyoming Statute:
A Thing of Beauty

A direct primary care agreement means a written agreement that:

- (A) Is between a patient or their legal representative and a health care provider;
- (B) Allows either party to terminate the agreement in writing, without penalty or payment of a termination fee, at any time or after notice as specified in the agreement which notice shall not exceed sixty (60) days;
- (C) Describes the health care services to be provided in exchange for payment of a periodic fee;
- (D) Specifies the periodic fee required and any additional fees that may be charged;
- (E) May allow the periodic fee and any additional fees to be paid by a third party;
- (F) Prohibits the provider from charging or receiving additional compensation for health care services included in the periodic fee; and
- (G) Conspicuously and prominently states that the agreement is not health insurance and does not meet any individual health insurance mandate that may be required by federal law.

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WORDS MATTER

Too Many Words

- Providing an exclusive list of reasons that a physician can terminate a patient
- Limiting the type of specialties allowable
- Limiting the scope of services

Stay Disruptive

- Be vigilant
- Use your power
- Define the issues
- Shape the rules

Opportunists

Who Are They?

- Middlemen
- Hospitals
- Corporate Medicine
- Health plans

…The Usual Suspects

Consultants

- Do they know DPC?
- Do they know more than you?
- Do they know as much as you?
- Do they know as much as your DPC FB group?
- Do you need a consultant?

Networks

Can be beneficial in limited circumstances but have the potential to morph into the provider networks of the bad old days

Potential Issues

- Dictating terms of Patient Agreement
- Requiring you to perform data collection
- Requiring changes in your office policies and procedures
- Filling your practice with too many members from the network or too many members from one employer

Hospitals

- Some hospitals are Posers
- Some attracted to the positive buzz and employer interest
- Some want to cash in
- Slap the DPC label on a clinic and call it good
- Or they acquire private practices and call it DPC

The Problem Is

- Hospitals that are unwilling to get out of the way of their docs
- The docs are still hospital employees working in the same system, same culture, same rules— same old game
- They just can’t do it
- The patients’ DPC experience is virtually unchanged
- Damages public perception of DPC

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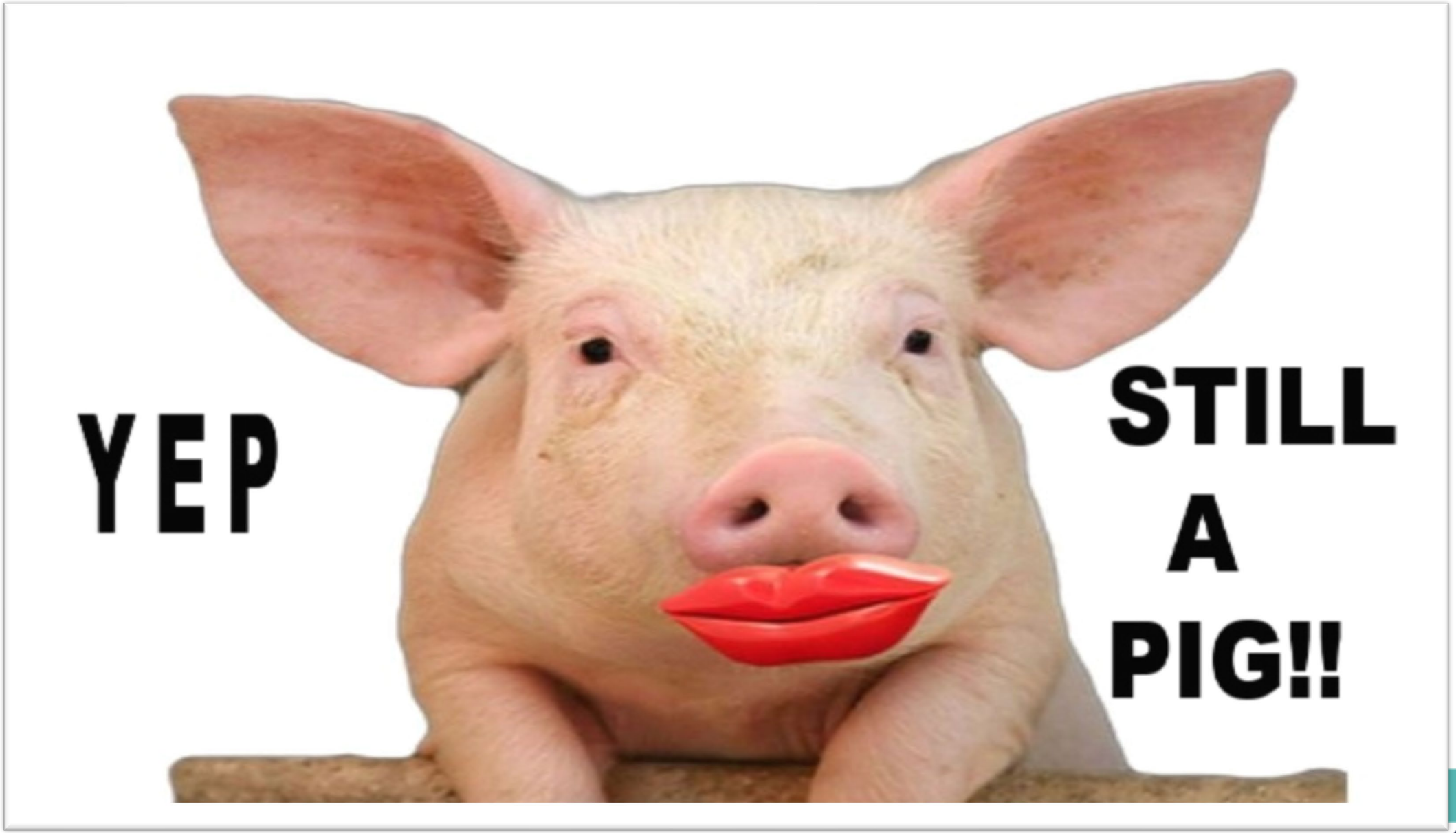

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Corporate Medicine

- Mostly mega corporations, insurance companies, and venture capital driven start ups.
- Most important goal is scaling DPC
- Sell, close, and purchase clinics on a rotating basis
- Most depend on large employers, health plans, Medicare Advantage - not usually individuals
- Prone to buzzwords and hyperbole— all going to “transform healthcare”

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Company 1

- Opened several DPC clinics in 2015, partnered with high profile doc
- CEO – “The ultimate goal is to be a kind of Starbucks for health care”
- Offer yoga, smoothies, cooking classes, and a “wellness ecosystem”
- Care delivered by teams – a doctor, nurse, and a health coach (no health care training necessary)

- Heavy reliance on health coaches, who are high in service but low in expertise and thus inexpensive to hire
- Daily mandatory staff meetings (huddles) to discuss patients and satisfaction scores
- The Huddle leader is rotated among the staff and that the Clinics have is no receptionists — doctors have phone duty with the rest of staff. The CEO explains that this is “to emphasize that the doctors don’t run the place”

- Policy experts describe the clinics as revolutionary, innovative, disruptive, game changing - the fix for healthcare
- NextWeb - one of "eight startups changing the healthcare industry.“
- CEO – “Building one good practice is mildly interesting, because a few people have done that.”
- Announces plans for hundreds of clinics nationwide

A Policy Wonk Explains Why Doctors Can't "Scale" DPC

"Most doctors have no business skills, and they don't understand what venture investors and private investors do,"

Dr. Arnold Milstein, professor of medicine and directs the Stanford Clinical Excellence Research Center.

Three Years Later

- After mounting losses, the company shuttered its main clinic along with several others
- Cited insurance company pressures
- Months later received $100 million in venture capital
- Partnered with Insurance Company
- Plans to double its Medicare population

Company 2

- Direct primary care “chain” ─ subsidiary of health care mega-corporation, direct primary care
- Primary goal —“disrupting the patient-doctor relationship”
- “ We make the primary care physician accountable for 85 to 90 percent of a person’s healthcare needs and makes sure they’re guiding any treatment that falls outside of that .” gatekeeper?

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- Six years after startup Subsidiary sells Company 2 to a venture capital firm for $100 million.
- Venture capital company raises $165 million to scale clinics
- Intends to expand into several states because, “this will make it more attractive to another buyer or the public markets.”

Company 3

- Another venture by Mr. “Doctors don’t run the place” (DDRP)
- Partnered with mega-giant health plan brings $65 million investment
- A “boutique-style health plan” with DPC clinics for its insureds
- DDRP - “We are building a brand new version of healthcare.”
- CEO – “A unique model of health care . . . we call it health care reimagined.” (HMO anyone?)

- Yoga, cooking classes, health care teams . . . again
- Within a year “Health Care Reimagined” is running $134 Million in losses
- Mega giant health plan shutters the clinics
- About six months later, DDRP raises $100 million in venture capital to pitch their DPC model to Medicare Advantage providers

If They Can't Build it, They'll Buy it

- The opportunists have a solid record of losses and failures
- This has not stopped the momentum
- Insurers and hospitals *need* to control physicians
- The newest target is DPC — the last bastion of physician independence and autonomy

Recent News Clippings

DIRECT PRIMARY CARE FUNDING TRENDS UPWARD

OCTOBER 17, 2018
By Ashley Bateman

Private-sector funding for primary care clinics is increasing, as companies seek new opportunities for investment in the $3.5 trillion U.S. health care market.

At hundreds of practices, on a consolidated basis it becomes very profitable.” - Michael Greeley, partner at health care venture capital firm Foundation Medical

www.nytimes.com/2015/03/29/upshot/small-company-has-plan-to-provide-primary-care-for-the-masses.html?_r=0&abt=0002&abg=1

One Medical, a primary care provider that offers concierge-style health care services giving patients off-insurance treatment for a flat membership fee, announced a $350 million investment from private equity firm the Carlyle Group in August. Having previously garnered funding from firms such as Benchmark Capital, Google Ventures, Maverick, and JP Morgan, One Medical says it plans to double the numbers of clinics and members under its umbrella.

May 17, 2019 02:34 PM

Blue Cross joins the doctors practice party

The insurer is embracing the idea of owning health centers a little later than its rivals—but it's getting on board in a big way in Texas and in Pullman.

"Everybody is basically playing catch-up to Optum," the consulting and services unit of UnitedHealth, Akers says. Optum's fast-growing medical care arm has been aggressively buying doctors groups. It's acquiring DaVita Medical Group, which has 300 clinics in six states, for $4.3 billion.

This is NOT DPC

- These are not Direct Primary Care practices, they are profit centers for corporate executives and the venture capital industry
- Patients are commodities
- Physicians are commodities too
- Opportunists need the halo effect of DPC
- They are trying to buy it
- If they succeed the term shall be as meaningless as Quality Care, Patient Centered, and every other corporate buzzword

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Real DPC Will Survive

- All of the opportunists' business plans depend of "scaling the model"
- Maybe scaling the model is what ruins it
- If you've seen one DPC practice, you've seen one DPC practice

- Dr. Milstein — “Doctors have no business skills”— Author of Stanford University Study: Uncovering America’s Most Valuable Care
- The very best primary care practices have either one location or a small handful of them
- Makes perfect sense

Why?

- Maybe doctors who do the real thing can't breath in the cookie cutter corporate structure
- Maybe patients want a relationship with their doctor without a third party "health coach" in the room
- Maybe a clinic run by autonomous doctors not obligated to investors just works better
- Maybe mandatory daily huddles and patient ratings reviews are useless

Mostly DPC Will Flourish Because

- You have the secret sauce
- You're in it for the right reasons
- You have the courage to take enormous *personal* risk
- You uplift and support one another
- And when you need to be you're as disruptive as well, you know

Here's to the crazy ones.
The misfits.
The rebels.
The troublemakers.
The round pegs in the square holes.
The ones who see things differently.
They're not fond of rules.
And they have no respect for the status quo.
You can quote them, disagree with them, glorify or vilify them.
About the only thing you can't do is ignore them.
Because they change things.

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Questions?

Submit your questions to:
aafp4.cnf.io

Don’t forget to evaluate this session!

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