VIEWPOINT

Direct Primary Care
One Step Forward, Two Steps Back

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Primary care is the bedrock of reform of the US health system. New payment and care delivery models emphasize the importance of primary care medical homes with reimbursement prioritizing value over volume. It remains unclear how best to restructure US health care spending to attain the Triple Aim (ie, improving the experience of care, improving the health of populations, and reducing per capita costs of health care) as well as the 4 C's of primary care (contact, continuity, comprehensiveness, and coordination). Of the myriad models emerging over the last decade, direct primary care (DPC) is unique in its renunciation of insurance companies and other third-party payers. Instead, patients contract directly with a primary care physician to pay a recurring out-of-pocket fee in exchange for a defined set of primary care benefits.[1]

DPC models vary in their structure, yet they generally provide coverage for acute care and long-term care, basic disease treatment, discounted prescriptions, vaccinations, screening tests, and basic care coordination. Physicians can choose to include services that might not traditionally be reimbursed in fee-for-service models, including electronic correspondence with patients, home visits, and 24/7 service lines. Although DPC is similar in structure to "retainer" or "concierge" medicine, the major differences are that the DPC model traditionally does not "double dip" by billing insurers and historically has been less costly,[2] with typical monthly fees between $70 and $100 per patient.[3] Patients with direct-pay primary care contracts must also purchase wraparound insurance (ie, typically high-deductible plans) for services not covered by the retainer, such as hospitalization and subspecialist care. To date, uptake has been limited, with only an estimated 13% of primary care physicians adopting some form of direct payment models.[4]

> Changes to the current fee-for-service reimbursement model are needed, but direct primary care is not the promised panacea of payment reform.

At its core, DPC emphasizes to patients that their health care dollars are best spent on cultivating a longitudinal, therapeutic relationship with an accessible primary care physician. Proponents of DPC argue that the model generates system-level cost savings, improved patient outcomes, broader access to care, and clinician and patient satisfaction. Because DPC models do not rely on fee-for-service reimbursement, physicians are able to devote resources to previously nonbillable care coordination efforts. With a smaller patient panel and because DPC physicians do not bill third-party payers, physicians can focus on building therapeutic, longitudinal relationships with patients.[5] DPC advocates suggest that these changes yield significant improvements in both patient and population-level health outcomes, reducing the rates of hospital readmissions, specialist visits, radiologic and laboratory testing, and emergency care. Individual DPC practices have indicated that practice-level data on outcomes support these claims; however, no study, to our knowledge, has produced data to support anecdotal claims by individual practices.

Despite its theoretical promise, DPC models, thus far, lack long-term quality outcomes and are limited by a variety of structural flaws.[3] Foremost, DPC practices lack specific mechanisms to counteract adverse selection that threatens equity in access to care. DPC presents physicians with an incentive structure built on accepting healthier patients with limited health care needs and a willingness to pay a retainer fee. Practices directly benefit when targeting healthier patients and declining coverage to the ill. Some DPC practices have experimented with risk-adjustment models to account for differences in health care needs, although in the absence of cross-subsidization mechanisms like those established in the Affordable Care Act, it is unlikely that patients most in need of care would be willing or able to afford an appropriately risk-adjusted retainer in a DPC setting. Indeed, limited existing data suggest that concierge practices, which admittedly are similar to but not the same as DPC models, are less likely than nonretainer practices to serve Medicaid, Hispanic, and African American populations, as well as people with diabetes.[6] It is likely for this reason that the American College of Physicians issued caution in its position statement on concierge practices and DPC, emphasizing that "such models potentially exacerbate racial, ethnic and socioeconomic disparities in health care and impose too high a cost burden on some lower-income patients."[6]

DPC fails to address fundamental market inefficiencies and facilitates a substantial gap in catastrophic coverage. By relying on high-deductible wraparound coverage to supplement primary care services, patients bear a steep cost-sharing burden. Even though a large majority of health care needs can be met in a primary care setting, even limited episodes of care outside of a DPC practice could be financially devastating for DPC patients. The success of DPC hinges on the presumption that primary care can yield a net financial advantage for patients by replacing or preventing the utilization of subspecialty, ancillary, and hospital care. Furthermore, DPC circumvents the

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quality metrics and incentive structures designed to improve population health and reduce national health care expenditures. DPC practices once held accountable through value-based payment systems have no obligation to report or measure quality metrics. Although the underlying assumption is that patients would terminate their contacts if they perceive insufficient value in their retainer, this presumes that patients are educated consumers of health care. DPC allows practices to avoid the undertaking of adopting alternative payment models designed specifically to promote high-quality, cost-efficient care.

By reducing patient panels by nearly two-thirds, without a commensurate decrease in revenue, DPC makes an implicit assertion that the health care system is better served by more primary care.[7] Although current research does not validate the claim that primary care is a panacea for the problems with the US health care system, there is evidence that health outcomes improve when patients have access to a usual source of care and in areas with a higher number of primary care physicians per capita.[8] This suggests that capitated payment models in primary care have historically failed because there were no concurrent efforts to correct system-wide resource allocation differences between spending on primary care and spending on other medical care.

Changes to the current fee-for-service reimbursement model are needed, but DPC is not the promised panacea of payment reform. Though flawed in design and execution, the fundamental argument of DPC is tenable: comprehensive care must be compensated with comprehensive payment. DPC shifts payment from encounter-based reimbursement to comprehensive global payments, giving physicians flexibility in determining the most appropriate mix of patient services and care coordination. DPC therefore represents a simplified model of risk-adjusted, comprehensive payment that lacks the necessary oversight needed to hold physicians accountable for data reporting as well as individual and population health outcomes. DPC directs attention to the many shortcomings of the current fee-for-service reimbursement model. However, DPC is not a scalable model built on fundamental incentive drivers that shape physician and patient behavior to achieve systemic cost savings, promote equity in access, and yield improvement in population health outcomes. Lessons learned from DPC—mainly the potential utility of global capitated payments—should be applied when developing new payment reform models and envisioning a new future for primary care delivery. However, DPC is not the answer to the problem.

ARTICLE INFORMATION

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