



A PUBLICATION FOR THE
DPC COMMUNITY

THE TOOLKIT

2026

FALL ISSUE: MEDICARE



TRICARE, IHS AND
MEDICAID

WHO OWNS YOUR
CHARTS

WHAT YOU MISSED AT
THE ILLINOIS DPC
SUMMIT

THE MEDICARE EDITION

THE HSA RULE, THE OPT-OUT CALENDAR, AND THE FIRST ENROLLMENT
SEASON WITH THE ANSWERS IN HAND.

THE \$150 RULE

What the HSA change means for your membership, and the four words to put on your website

THE DECEMBER 1 DEADLINE

The Medicare opt-out calendar most physicians learn about too late

THIRTY-SIX DAYS

Dr. Nyasha Spears sued for the right to practice in her own city. Duluth filled her waiting room.

HOW TO READ

THIS ISSUE

Some pages need five minutes, some deserve your whole coffee. Every one was built to be used, not just read. Find the time you have. Click on the links below in our digital version at toolkit.mydpcstory.com

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the one-page HSA self-audit, tear out or download
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SETTLE IN

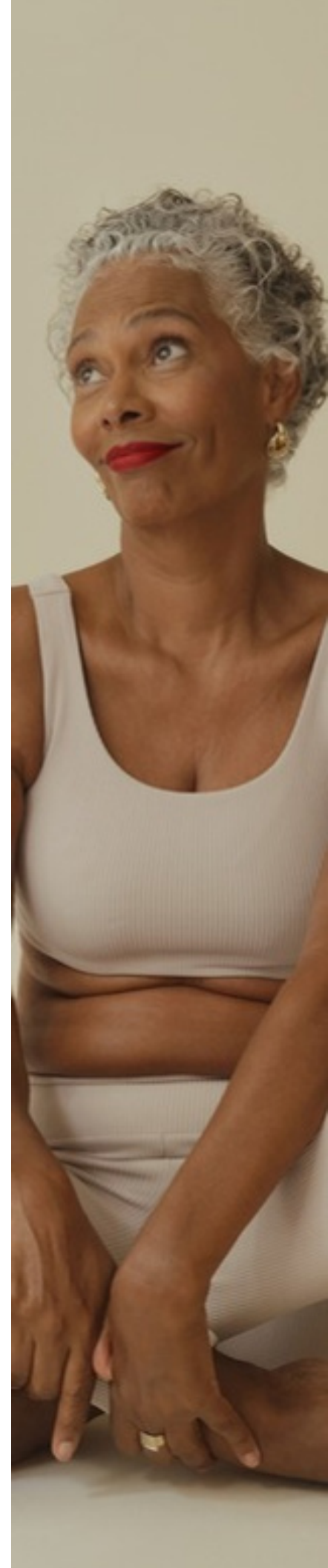
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A LETTER TO THE PHYSICIAN ON THEIR DPC JOURNEY

Maryal Concepcion, MD FAAFP

Last fall, this magazine went to print in the middle of a gray area. HR 1 had passed in July, the IRS hadn't said what it meant, and I wrote a policy piece that ended on three open questions. The guidance landed December 9, in the middle of open enrollment, when some of us may not have had time to read it.

This fall is different. It's the first enrollment season with the HSA rules in hand from day one. We know the number, what the fee has to cover, and what to put on a website. That's why this issue exists. It isn't locked in a Facebook algorithm, so please share it with someone who may need it as well.

Open enrollment is when patients rethink everything. Coverage resets, employers rebid, Medicare mails plan letters, and every year physicians tell me this is when memberships lapse. Not because patients are unhappy; patients leave a DPC membership behind because they have "a new, cheaper plan," and "no one explained how the membership fits." This issue gives you that explanation before anyone asks.

In August I sat down with Dr. Phil Eskew for a [My DPC Story State-by-State episode](#), and the front of this issue came out of it. **The \$150 Rule** is the HSA change in the order you need it: what changed, what the number means, and what to do if you're above it. **The December 1 Deadline** is the Medicare opt-out calendar I wish someone had handed me before I filed my own affidavit and waited two months to see my name on the list. Both are educational, not legal advice.

Later pages cover the season itself. The Door That Only Opens When a Plan Leaves is for the patient whose Medicare Advantage plan is ending. Designing an Open Enrollment Season is how we run it at Big Trees MD, mistakes included. Who Owns Your Charts reads an EHR agreement like a non-compete.



Then there are the doctors. Dr. Nyasha Spears sued her former employer for the right to practice in her own city, and Duluth filled her waiting room. Dr. Christa Springston, Dr. Katie Burden-Greer, and Dr. Drew Hertz each answered the question that walks in with a new patient's insurance card: Can I still see you?

One more thing. My DPC Story is an official media partner at HLTH, November 15 through 18 in Las Vegas, and I'm moderating a [panel on the rural health workforce on the 15th](#). We'll be recording on the floor all four days. [Get \\$250 off registration at HLTH with code H26MYDPCSTORY](#). The Winter issue of the Toolkit will carry what we bring back.

In this edition:

- The \$150 Rule, with a one-page website checklist
- The December 1 Deadline and the opt-out calendar
- Can I Still See You? TRICARE, IHS, and Medicaid
- Thirty-Six Days: Dr. Nyasha Spears and Amity Creek
- The Door That Only Opens When a Plan Leaves
- Designing an Open Enrollment Season
- Who Owns Your Charts
- The Illinois DPC Summit

If you finish this issue with a question, and I expect you will, go to mydpcstory.com/contact and leave me a voicemail. Your name, your state, your question. We play them on air and answer them. Here's to a January with no surprises!

~Maryal, Host and Founder of My DPC Story

- Maryal



MEET THE TEAM



Kiera Hanselman
CHIEF GROWTH OFFICER



Nathalia Hyland
HEAD OF MARKETING & STRATEGY



Noreen Gutierrez
CHIEF OPERATING OFFICER



Michael Hanselman
HEAD OF VIDEO PRODUCTION



Filipe Martins
HEAD OF PODCAST PRODUCTION

“

We're proud to help
the DPC movement
grow together!

@mydpcstory



A STANDING FEATURE · NOW IN EVERY ISSUE

YOUR NEXT STEP IN DPC

*My DPC Story exists because we believe every physician deserves to know there is a different and better way to practice medicine. Wherever you are on that path, this page is for **you**.*

READY TO PLAN

You have decided. Now you need the roadmap. The 90-Day DPC Startup Checklist walks you from decision to open doors, one week at a time, with the podcast episodes to match every milestone.



**BUILD YOUR
LAUNCH PLAN**

*finish the
checklist
and the
Dashboard
is waiting
for you*

NEWLY OPEN

The doors are open and the real learning begins. The First Year Dashboard gives you the tracking pages, monthly rhythms, and decision checkpoints that carry you from opening day through month twelve.



**GROW
WITH US**

JUST EXPLORING

Curious whether DPC could work for you? Start with the DPC Starter Guide.



START HERE

OPEN FOR YEARS

Refine it, scale it, or reimagine it. Take the Growth Audit.



GO DEEPER

**EVERY RESOURCE ON THIS PAGE IS FREE.
IT IS OUR WAY OF KEEPING THE PROMISE THIS PODCAST WAS BUILT ON.**



THE \$150 RULE

What the HSA change means for your membership, and what it doesn't.

For about ten years, the IRS looked at a Direct Primary Care membership and saw two problems. Neither was ever tested in court. **Both went away on January 1, 2026.**

The first was whether a monthly fee counted as a medical expense at all. The second was bigger. The IRS treated a membership as a kind of health plan, which could wreck a patient's HSA entirely.

BUILT FROM THE AUGUST
STATE-BY-STATE EPISODE
OF MY DPC STORY WITH
DR. PHIL ESKEW, DO, JD, MBA
EDUCATIONAL, NOT LEGAL
ADVICE

TWO SECTIONS, TWO QUESTIONS

Dr. Eskew has answered these questions for the DPC community for more than a decade, first at **DPC Frontier**, which he created, and then in Washington, D.C. and beyond. In his opinion, both arguments were wrong from the start, and the agency never sued anyone over them. The gray area did its work anyway: it scared employers and large businesses away from the model.



Can my patient spend it?
Opened years ago

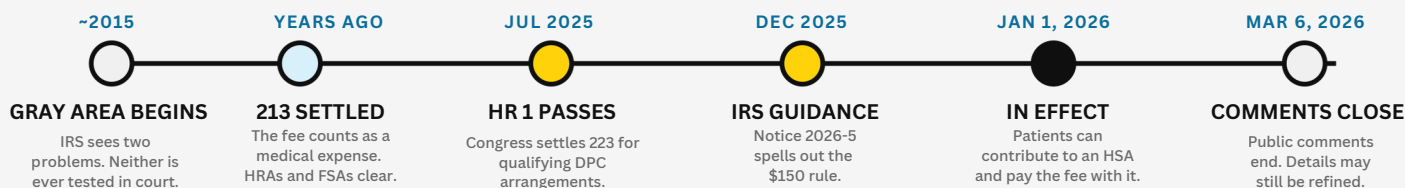


Can my patient keep the HSA?
Opened Jan 1, 2026

As the episode framed it: 213 is whether your patient can spend the money, and 223 is whether your patient can keep the account. That's the whole thing.

HOW WE GOT HERE

Dates to Know



WHAT IS SETTLED NOW

A patient in a qualifying DPC arrangement can contribute to an HSA and pay the fee with it. Three conditions decide what qualifies.

THE NUMBER IS NOT A WALL

Above \$150 you're back in the old gray area. The tax position belongs to the patient, unless you promised it in your copy.

UNBUNDLE BEFORE YOU CUT

Enrollment fee, blood draws, dispensed meds, injections and EKGs can be priced on their own. Regulators wanted that anyway.

THE SCOPE QUESTION

Prescription drugs other than vaccines and atypical labs sit outside the fee. Don't overthink it.

EMPLOYERS AND THEIR ACCOUNTS

HRA, FSA and HSA answer to different sections of the code. Ask which one they already use.

CHECK YOUR WEBSITE THIS WEEK

A one-page self-audit for the first open enrollment under the new rule. **Keep reading!**



**LISTEN TO THE
EPISODE HERE**



WHAT IS SETTLED NOW

THREE CONDITIONS



A patient enrolled in a qualifying DPC arrangement can contribute to an HSA, and can use HSA funds to pay the periodic fee. Three conditions decide whether an arrangement qualifies.

The 213 side was fixed years ago, which cleared the way for HRAs and FSAs. The 223 side, the one that mattered for HSAs, waited until HR 1 passed in July 2025 and the IRS issued guidance that December.

The IRS took public comments on the guidance through March 6, 2026, so details may still be refined.

01

The fee is under the cap

\$150 a month or less for one person, or \$300 a month or less for an arrangement covering more than one. The limits are aggregate across all such arrangements a person has, and they adjust for inflation after 2026.

02

Longer billing is fine if it stays fixed

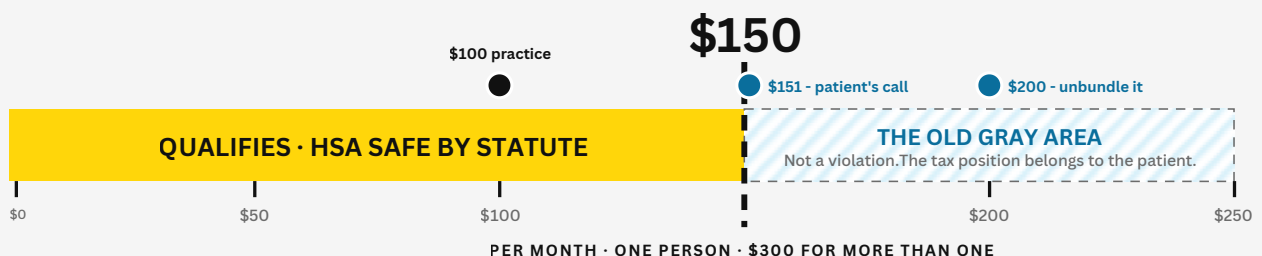
Fees can be billed for up to a year if they stay fixed and periodic and don't exceed the monthly limit on an annualized basis. For 2026, that means up to \$1,800 a year for single coverage.

03

Primary care only, and the fee is the sole compensation

The statute leaves out procedures requiring general anesthesia, prescription drugs other than vaccines, and laboratory services not typically administered in an ambulatory primary care setting.

THE CAP IS A DOTTED LINE, NOT A WALL



A dotted line, not a wall. Above it, the practice is back where the whole community lived for a decade.

THE NUMBER IS NOT A WALL

ABOVE \$150, THE TAX POSITION BELONGS TO YOUR PATIENT

The \$150 figure has caused more anxiety than anything else in the rule. Cost of living in California is not cost of living in Kansas, and plenty of practices charge more.

Dr. Eskew's answer is that a practice above the cap is not in violation of anything. It is back in the old gray area, the one the whole community lived in for a decade.

In that gray area, the tax position belongs to the patient. If a patient at a \$151 practice takes the question to their own accountant, and the accountant applies common sense and says yes, that is the patient's own tax position.

The physician carries no liability for it, with one exception: **a practice that promises HSA eligibility on its website, in its marketing, or in its agreement has taken a position on someone else's tax return.**

That's why the episode landed on four words for your website: **"We accept HSA cards."** Dr. Eskew used to advise saying nothing at all. Now, for a practice that has done its homework on the cap and on scope, he suggests that sentence, with any fine print reserved for the agreement itself. A practice with a higher-priced tier, or an intensive addiction medicine or cosmetic component, can still say it.

WHOSE TAX POSITION IS IT?

IS THE FEE \$150 OR LESS?

(\$300 for more than one person)

YES

QUALIFIES

Patient can contribute and pay with HSA funds

NO

DID YOU PROMISE "HSA ELIGIBLE" IN YOUR COPY?

NO

PATIENT'S POSITION

Their accountant decides. No liability.

YES

YOUR POSITION

You took a stand on their return.

SAY INSTEAD "WE ACCEPT HSA CARDS."

"IF YOU SWIPE IT AND IT GOES THROUGH, IT GOES THROUGH."

DR. PHIL ESKEW

FOUR WORDS FOR YOUR WEBSITE

"WE ACCEPT HSA CARDS."

Listing HRA and FSA cards alongside is fine too. And you don't have to police the card reader.

IF YOU NEED TO GET
UNDER \$150

UNBUNDLE BEFORE YOU CUT

A practice charging \$200 a month that wants to fit under the cap has more options than a straight price cut. The rule's own language creates them: the fixed fee has to be the sole compensation for the care itself. Things that are not the care itself can be priced on their own.

The enrollment fee is the clearest example. It pays for the work that happens before care starts: reading 300 pages of records on a new patient with chronic migraines, possible MS, and possible rheumatoid arthritis, so that the first visit is worth everyone's time. It also protects a practice from the patient who joins for a month, uses everything, and leaves.

The other levers have always sat outside the membership at many practices: a charge for the blood draw, a markup on

dispensed medications, a fee for injections or an EKG, itemized OMT for a DO who loves doing it. None of it is new. What's new is the reason to look at it again.

There's a second reason, and it predates the HSA change. State insurance commissioners have never liked practices bundling more and more into the monthly fee.

A membership that promises to cover a \$2-a-month generic has taken on price risk. If a tariff pushes that drug to \$200 a month, the practice is still on the hook. Some commissioners have said so directly.

Pricing labs, medications, and procedures separately is what the regulators wanted all along.

The condition on all of it is transparency. Whatever the structure, it has to be visible in the agreement and the marketing.

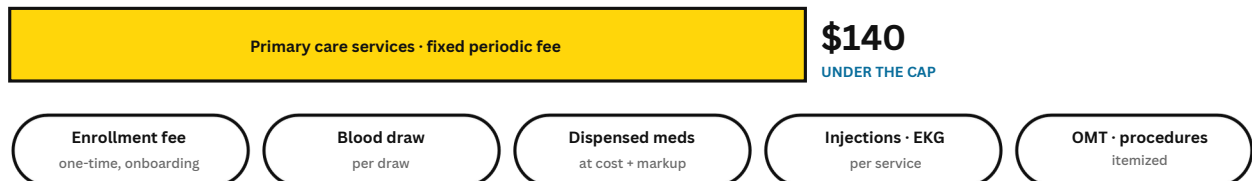
Check your state's DPC law before changing anything. **DPC Frontier** is Dr. Concepcion's and Dr. Eskew's favorite reference for where to start a state DPC law search.

BEFORE · ONE \$200 FEE, EVERYTHING BUNDLED



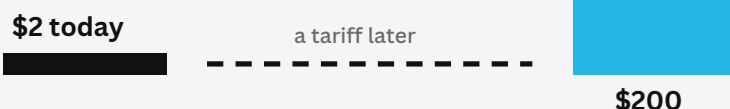
The fee is the sole compensation for all of it, including things that are not the care itself. Over the cap, and it carries price risk on every dispensed drug.

AFTER · THE CARE IN THE FEE, THE REST PRICED ON ITS OWN



Visible in the agreement and the marketing. Check your state's DPC law first. Your insurance commissioner wanted it this way all along.

THE \$2 GENERIC PROBLEM



Bundled into the fee, the practice eats the difference. Priced separately, the risk goes away.

REMEMBER
**PRICE
THE CARE.
ITEMIZE THE
REST.**

THE SCOPE QUESTION

TYPICAL ACCORDING TO WHOM?

The rule excludes prescription drugs other than vaccines, which matters for the many practices that dispense in-house. It also excludes lab services "not typically administered in an ambulatory primary care setting," which raised an obvious question on the episode: typical according to whom? A rural physician who learned phlebotomy so her town could get blood drawn locally isn't sure whether that counts.

Dr. Eskew's reading is that the drafters were probably thinking of urgent care chains running point-of-care panels, not the handful of practices still doing urine microscopy in the office. He argued in Washington that this level of detail belonged at the state level, since states have defined what insurance is since 1945, and that the federal rule didn't need to go there. It went there anyway.

His advice, which he acknowledged might surprise people coming from an attorney: ***don't overthink it.*** If he audited the websites of most practices, he'd find that nearly all of them are already operating in a way that's fine.

INSIDE THE FEE

Primary care services

Vaccines

Labs typical in an ambulatory primary care setting

The fee is the sole compensation for this care

LEFT OUT

Price these on their own

Cosmetic, addiction or specialty tiers

Prescription drugs (other than vaccines)

Labs not typically done in primary care
"Typical according to whom?"

Procedures needing general anesthesia

THREE THINGS TO WRITE DOWN

01

The \$150 number is not a wall.

Above it, the tax position belongs to your patient and their accountant. It becomes yours only if you promise it in your own copy.

02

Unbundle before you cut.

Enrollment fee, blood draws, injections, EKGs and dispensed medications can be priced on their own. Your insurance commissioner would rather you did it that way.

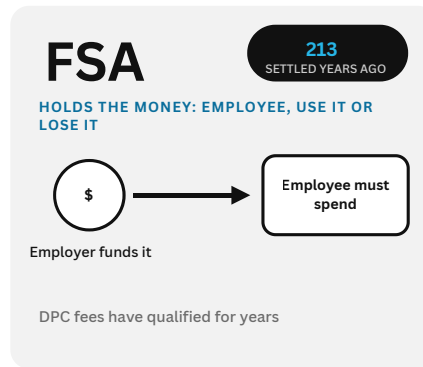
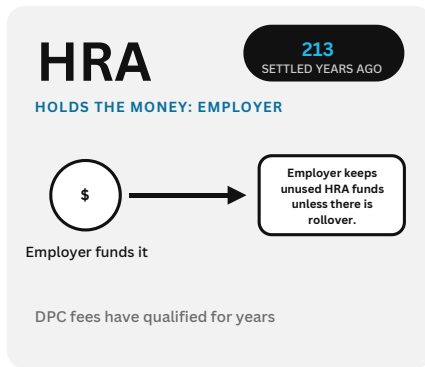
03

Go look at your website this week.

If it says "HSA eligible," change it. The checklist on page 13 is built for that step.

EMPLOYERS AND THEIR ACCOUNTS

When a practice sits down with an employer at renewal time, the employer has usually already picked its account type. Dr. Eskew's advice is to meet them where they are.



In his experience, it's rare for a DPC physician to independently talk an employer into using a vehicle it wasn't already using, and the IRS assumption that DPC will push the whole country into HSAs is unlikely to play out. Three accounts come up, and they answer to different sections of the tax code.

An HRA looks to section 213 to define a medical expense, and that question was settled years ago. The FSA does too, so DPC fees have qualified for some time. The HSA is the account that needed the

2026 fix, because its eligibility runs through section 223. That's the section that now says a qualifying DPC arrangement doesn't disqualify anyone.

At the table you'll usually find a CEO or owner, someone in HR who wants this simple, and a broker whose commission tends to rise with the cost of the policy. The practice's job is to speak enough of the language not to scare anyone off with something inaccurate, and to fit the membership into the account the employer already has.

WHO'S AT THE TABLE



ASK FIRST: WHICH ACCOUNT?

HRA · employer keeps the rest

FSA · use it or lose it

HSA · employee keeps it

THE PLAN NOBODY BUILT

When the Affordable Care Act was written, any plan that counted as real coverage had to include ten categories of care. Primary care was one of them. But the law left a door open. An insurer could sell a plan that carved primary care out entirely, as long as it confirmed the buyer had a Direct Primary Care membership somewhere. In this situation, because the insurer wasn't paying for what the patient was already getting, the plan could be cheaper. No one built it. Not one of the large carriers ever put that product on a shelf, and, as far as Dr. Eskew knows, the door is still open.

What did change this year is adjacent. As of January 1, 2026, bronze and catastrophic plans bought on an ACA exchange are treated as HSA-compatible, whether or not they meet the usual high-deductible definition. So the pairing physicians have described for years, a low-cost catastrophic plan plus a DPC membership plus an HSA, is now possible on paper in a way it wasn't before.

It is still not a product. Nobody on the episode had seen a bronze plan designed around a DPC membership, and the carve-out plan the ACA allowed remains theoretical. What exists today is a patient assembling the pieces themselves.

Dr. Eskew's view is that patients willing to ask what something costs will value a DPC practice no matter what structure sits behind it. He's also surprised no one has pushed to raise the deductible threshold that defines a high-deductible plan, since many plans now carry deductibles far above what HSA eligibility requires.

WHAT A PATIENT CAN ASSEMBLE TODAY

BRONZE OR CATASTROPHIC EXCHANGE PLAN

For the big risk. HSA-compatible as of Jan 1, 2026, whatever its deductible.

+

A DPC MEMBERSHIP

For everything else. At \$150 a month or less per individual member, it's a qualifying arrangement.

=

AN HSA THAT RECOGNIZES BOTH

Possible on paper for the first time.
Still not a product any carrier sells.

ONE CORRECTION FROM THE EPISODE

McCarran-Ferguson, mentioned in passing as a Supreme Court case, is a 1945 federal law. It leaves the regulation of insurance to the states, which is why a state insurance commissioner and not the federal government decides what counts as insurance where you practice, and why some states have laws protecting DPC and others don't.



**LISTEN TO THE
EPISODE HERE**



HEAR THE FULL CONVERSATION

The August state-by-state episode of My DPC Story with Dr. Phil Eskew, DO, JD, MBA covers HSAs, Medicare opt-out, TRICARE, Medicaid and more. mydpcstory.com

CHECK YOUR WEBSITE THIS WEEK



*A one-page self-audit for the first open enrollment season under the new HSA rules.
Educational, not legal advice.*

YOUR COPY

- ☐ Search your website, social profiles, and patient agreement for the phrase "HSA eligible" or any promise that memberships qualify. Replace it with: **We accept HSA cards.**
- ☐ If you take HRA and FSA cards too, say so in the same sentence. Keep any conditions in the agreement, not the headline.
- ☐ Remove any language that tells patients what they can deduct or claim. That's a conversation for the patient and their accountant.

YOUR FEE

- ☐ Write down your monthly fee for one adult and for a family. Compare to **\$150** and **\$300**.
- ☐ If you bill quarterly, semi-annually, or annually, confirm the annualized amount is at or under the monthly cap times twelve (\$1,800 for single coverage in 2026).
- ☐ If you're above the cap and want to stay there, decide whether to say so plainly on the pricing page, so no one assumes otherwise.
- ☐ If you want to get under the cap, list what's currently bundled: blood draws, dispensed medications, injections, EKGs, procedures. Decide which could be priced separately, and check your state's DPC law before you change anything.

YOUR SCOPE

- ☐ Confirm the membership covers primary care services only. A separate cosmetic, addiction medicine, or specialty component belongs in its own tier or agreement.
- ☐ Note where you dispense medications. The rule excludes prescription drugs other than vaccines, so dispensing belongs outside the fixed fee.
- ☐ Confirm your enrollment fee is described as covering onboarding work, not care.

YOUR PATIENTS AND EMPLOYERS

- ☐ Prepare a one-line answer for the question you'll get in October: **Can I use my HSA? Yes, we accept HSA cards; check with your plan or accountant about contributions.**
- ☐ For employer contracts, ask which account they use - HRA, FSA, or HSA - before you propose anything.

Download this page at toolkit.mydpcstory.com.

Source: [IRS Notice 2026-5](#) and the [August 2026 My DPC Story State-by-State episode with Dr. Phil Eskew](#). Fee limits adjust for inflation after 2026.

REMOVE THIS

"HSA-ELIGIBLE."

USE THIS INSTEAD

"WE ACCEPT HSA CARDS."

ASK YOUR DPC LEGAL QUESTION!



MYDPCSTORY.COM/CONTACT

WHO IS **AT THE TABLE** WHEN THESE DECISIONS GET MADE?

NOVEMBER 15 to 18. The Venetian Expo, Las Vegas, NV

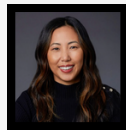
My DPC Story is proud to be an official media partner of HLTH 2026

Sunday

Nov 15

2:00 PM

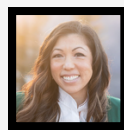
NURSE & CLINICIAN INSIGHTS: CLOSING THE RURAL HEALTH WORKFORCE TECHNOLOGY GAP



Speaker

Alice Lin Fabiano

Global Head, Social Impact, Johnson & Johnson
President, J&J Foundation



Speaker

Dr. Maryal Concepcion, MD FAAFP

Family Physician & Podcast Host
My DPC Story



Speaker

Joseph Agoada

CEO and Founder
Sostento



Speaker

Erica DeBoer, RN, MA, CCRN, CNL

SVP, Chief Nursing Officer
Sanford Health

The team will be recording podcast interviews on the floor all four days. If you have a DPC story or a rural care problem worth putting on the record, find us in Las Vegas.

REGISTER WITH CODE

H26MYDPCSTORY

**\$250 OFF REGISTRATION FOR
TOOLKIT READERS**



Not going? The Winter Issue of the Toolkit carries what the team brings back!

The DECEMBER 1 Deadline

The Medicare opt-out calendar, the window most physicians learn about too late, and what you can still do afterward.



FILE BY
DEC 1
FOR JAN 1

If you want to be opted out of Medicare on January 1, 2027, your affidavit needs to be in by about December 1. That's three weeks before Christmas, in the middle of open enrollment, at the exact moment no physician is thinking about paperwork.

The calendar is old, built for paper, and nobody on the episode could say why it works the way it does. But it's the law on the books, and Dr. Eskew has walked hundreds of physicians through it. Here is how it runs.

Which is why this is running in October.

BUILT FROM THE AUGUST STATE-BY-STATE EPISODE OF MY DPC STORY WITH DR. PHIL ESKEW, DO, JD, MBA

READING TIME · 9 MIN
EDUCATIONAL, NOT LEGAL ADVICE

IN THIS STORY

1

Four dates
a year

2

Who
processes it

3

Don't opt
out yet

4

Opted out is
not excluded

5

Income while
opted out

01 FOUR DATES A YEAR

Opt-outs take effect on four days: January 1, April 1, July 1, and October 1. To land on one of them, your paperwork has to arrive at least 30 days before.

The common mistake is filing on the first day you're free. Take a resident finishing June 30 who plans to opt out immediately. They can't file before June 30, because they still work for the hospital.

If they file July 1, the opt-out doesn't take effect until October 1. For those three months they can't privately contract, and they can't bill Medicare in the traditional way either, because filing the affidavit is a promise to stop.

They also can't abandon patients. Unless a group practice is absorbing their panel, they end up seeing Medicare patients for free until the effective date.

FILING THE AFFIDAVIT IS A PROMISE TO STOP.

The fix is to do the math backward. The resident should file in late August, so the 30-day clock lands them on October 1 with the shortest possible gap. Aim for a one-month window, not a four-month one.

A RELATED SURPRISE.

Nearly every physician is enrolled in Medicare already, from residency, without remembering a form. Dr. Concepcion didn't.

Dr. Eskew says the default enrollment cuts both ways. You have no say in it, but it hands you a PECOS number and other credentials that are hard to obtain later.

02 WHO ACTUALLY PROCESSES IT

The affidavit doesn't go to the government. It goes to a Medicare Administrative Contractor, a private company assigned by region, and only the Part B contractor matters for outpatient DPC. Ignore the separate cohorts for durable medical equipment.

That creates a puzzle for anyone moving. A resident finishing in Massachusetts and opening in California is known to one contractor and a stranger to the other.

Dr. Eskew, moving from Pennsylvania to Wyoming a decade ago, filed with every contractor he thought could claim jurisdiction and let whichever processed it first win.

THE SHORT VERSION

THE WINDOW

Opt-outs take effect only on Jan 1, Apr 1, Jul 1, and Oct 1. Paperwork must arrive 30 days before.

THE TRAP

Filing on your first free day can leave you seeing Medicare patients for free for months.

THE FIX

Choose the effective date first. File just over 30 days ahead of it.

THE ADVICE

Most physicians new to Direct Primary Care shouldn't opt out yet. Think about building a waitlist first.

FOUR DATES A YEAR. COUNT BACK 30 DAYS.

FILE BY

DEC 1

TAKES EFFECT

JAN 1

FILE BY

MAR 1

TAKES EFFECT

APR 1

FILE BY

JUN 1

TAKES EFFECT

JUL 1

FILE BY

SEP 1

TAKES EFFECT

OCT 1

DO THE MATH **BACKWARD**

A RESIDENT FINISHING JUNE 30

| JUL 1 | AUG 1 | SEP 1 | OCT 1 →

FILES JULY 1
3-month gap



FILES LATE AUGUST
About 1-month gap



Two things are better now than they were. The opt-out no longer needs renewing every two years; once filed, it stays in force, though it still rotates on a two-year cycle if you ever want back in.

And the opt-out list is public. You can look up any physician by name and confirm the status, including your own. That's the confirmation to trust, along with the letter.

The contractors don't always know the rules either, and some have processed a late-August filing a week later instead of on October 1.

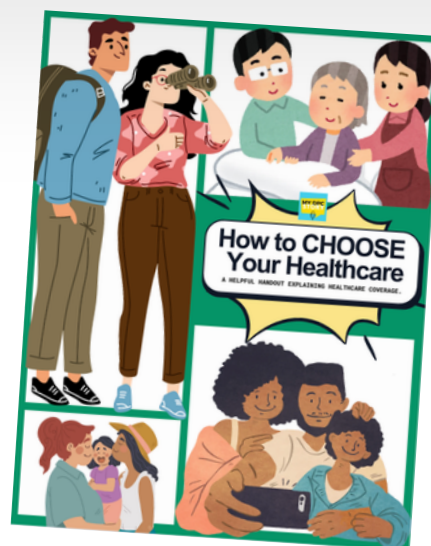
DR. CONCEPCION'S CALIFORNIA AFFIDAVIT WAS PROCESSED BY A CONTRACTOR IN MICHIGAN.

CHECK YOUR STATUS

1. Search your name on the CMS [public opt-out list](#).
2. Keep the contractor's letter on file.
3. Trust those two, not the phone line.

FOR PATIENTS

THE HOW TO CHOOSE YOUR HEALTHCARE HANDOUT



PHYSICIANS: HAND THIS GUIDE TO YOUR PATIENTS.

Get the free printable version of the following pages for your clinic website, your exam room and (not-for-waiting) waiting area, plus a shareable link for your patient newsletter. Your patients get clarity. You get one less conversation to repeat.

03

DON'T OPT OUT YET

For most physicians new to DPC, Dr. Eskew's advice is not to opt out right away. His shortest answer: **build a waitlist.**

If you don't have Medicare patients waiting to join, you don't have a reason to opt out yet, especially if you're still moonlighting somewhere that requires participation.

Joining an established practice where two of three physicians have opted out doesn't obligate the third.

Medicare patients adopt the model more slowly than price-sensitive

younger patients, so the waitlist takes time. Opt out when you'll enroll 20 patients on day one and the practice no longer needs the outside income.

If you do it and regret it, there is one exit. Within 90 days of the effective date, you can terminate the opt-out and rejoin. The catch is that everything you did in the meantime is invalidated.

Five patients under private contract at \$100 a month for three months means \$1,500 refunded, because changing your mind unwinds the contracts too.

READY WHEN YOU CAN CHECK ALL FOUR

- ☐ Medicare patients are on your waitlist.
- ☐ About 20 will enroll on day one.
- ☐ The practice no longer needs outside income.
- ☐ No moonlighting job requires participation.

THE ONE EXIT: 90 DAYS

5 patients @ \$100/mo @ 3 months

\$1,500

refunded if you change your mind. The contracts unwind too.

“IF YOU DON'T HAVE MEDICARE PATIENTS WAITING TO JOIN, YOU DON'T HAVE A REASON TO OPT OUT YET.”

DR. PHIL ESKEW

04

OPTED OUT IS NOT EXCLUDED

The name is misleading, and it causes real problems. “Opting out” means opting out of Medicare's payment process so that you can contract privately. You are not disenrolled. Medicare still knows who you are, and you remain credentialed.

You can still order labs and imaging, refer to specialists, and write prescriptions, and Medicare pays for all of it the same way it would for a participating physician.

OPTED OUT	EXCLUDED
Your choice, by affidavit	After fraud or a qualifying felony
Still credentialed	Removed from the program
Labs, imaging, referrals and prescriptions paid	Not covered
“Ever barred?” No.	“Ever barred?” Yes.

Exclusion is different. That's what happens after fraud or a qualifying felony, and it removes a physician from the program entirely.

Employment contracts and license renewals often ask whether you've ever been barred from Medicare. For an opted-out physician, the honest answer is no.

But you may spend years explaining the distinction to employers, licensing boards, and the occasional specialist's front desk, because when a third party sees "opted out" it often hears "kicked out."

WHEN A THIRD PARTY SEES "OPTED OUT," IT OFTEN HEARS "KICKED OUT."

05

WHAT YOU CAN STILL DO FOR INCOME

This is the question behind most of the hesitation, and Dr. Eskew has seen enough cases to sort them.

✓ WORKS

Correctional medicine

Medicare doesn't apply while someone is incarcerated.

WORKS, WITH A CONDITION

VA, part-time

If the VA never bills Medicare secondarily.

Hospice administrative work

If you aren't rounding and coding visits.

Indian Health Service

Same condition as the VA. Watch the word "participating."

× DOESN'T WORK

Precepting

Everyone in the chain has to be participating.

TRICARE

Requires participation. You're out of network.

Most Medicare Advantage plans

Generally require full participation to contract.

WORKS WHILE OPTED OUT.

Part-time work at the VA, as long as the VA never bills Medicare secondarily; one physician he knew worked 10 to 15 hours a week there for the benefits while her practice grew.

Hospice administrative work, provided you aren't rounding and coding visits. Correctional medicine in jails and prisons, where Medicare doesn't apply while someone is incarcerated.

Indian Health Service arrangements can work on the same condition as the VA, though some default agreements say "participating"

when they mean credentialed, and that wording becomes a problem.

DOESN'T WORK. Precepting, because everyone in the chain has to be participating. TRICARE, which requires Medicare participation and hasn't changed its contracts, so you're simply out of network.

Most Medicare Advantage plans, which function like any private insurer and generally require full participation to contract, though a few have paid DPC practices a monthly fee in the past.

ASK BEFORE YOU SIGN

Does this facility ever bill Medicare as a secondary payer?

VA and IHS work only if the answer is no.

Does the contract say "participating" or "credentialed"?

Default IHS language often says the first and means the second.

Will I round or code visits?

For hospice administrative work, the answer has to be no.

OPTING OUT? DATES TO PUT ON THE WALL **NOW**, WHILE IT'S FRESH ON YOUR MIND.

FILE BY

DEC 1

for January 1

FILE BY

MAR 1

for April 1

FILE BY

JUN 1

for July 1

FILE BY

SEP 1

for October 1

KY

KENTUCKY

CO

COLORADO

AND MEDICAID IS ITS OWN SYSTEM

There is no opt-out. The equivalent status, where you stay credentialed but can bill privately, is called ordering, referring, and prescribing, or ORP, and every state was required to build it under the ACA. Not all did it well. In Kentucky and Colorado, you can't see Medicaid patients privately even with that status.

The [Medicare & Medicare Advantage Survival Guide](#) includes this calendar in its 2027 update.

Built in part from the August state-by-state episode of My DPC Story with Dr. Phil Eskew, DO, JD, MBA. Educational, not legal advice. Confirm your status on the public opt-out list.



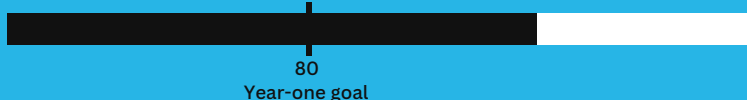
PHOTO: DR. KATIE BURDEN-GREER AT OUTLAW MEDICAL, WEELETKA, OKLAHOMA

WHY SHE HASN'T OPTED OUT YET

Dr. Katie Burden-Greer opened her DPC on Muscogee (Creek) Nation land. Members of her practice have IHS and still choose her DPC membership. She is still opted into Medicare, and the reason is exactly the one Dr. Eskew describes.

142

MEMBERS AT 14 MONTHS



MEMBERSHIP

Kids*	\$25
Ages 20-35	\$50
Ages 36-64	\$85

Per month. *With an adult member. Patients 65+ can't join while she's opted in.

Dr. Burden-Greer opened Outlaw Medical in Weleetka, Oklahoma, a town of about 800, after nearly eight years as a hospitalist. She had no panel to bring with her. Her goal was 80 members in the first year. At 14 months she

had 142. One day a week she works at an IHS facility, and that shift is the income that lets her sleep. Her plan was to opt out at around 200 patients, once the practice could carry itself.

"I LIKE HAVING THAT SAFETY NET."

DR. KATIE BURDEN-GREER

Until then, patients over 64 can't join the membership. She was clear about that on her website from the start, which is the transparency Dr. Eskew says matters more than the timing.

The pricing was built for the people who couldn't get to a doctor. Ages 20 to 35 are set low on purpose for the pipeliners and welders in her

family and her town who don't see doctors regularly because they can't take time off work.

Hours run 9 to 6 so teachers and nine-to-fivers can come after work, plus a half day the first Saturday of the month for the handful of patients who have no other option.

She grew up a patient in the Creek Nation health system, going to the ER for asthma because there was no way to just reach a doctor. Her area is about 21 percent Native, and she worried before opening that people with no-cost tribal care wouldn't pay a membership.

What she found was a system where establishing primary care takes four to six months and same-day needs get sent to the emergency room. The morning of her My DPC Story podcast recording, a patient with a kidney infection called in pain. She was at the clinic in 15 minutes.

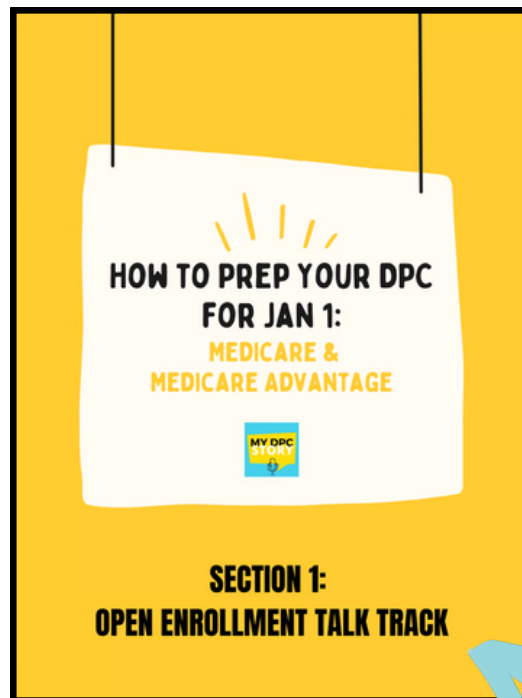


HEAR HER STORY
Dr. Burden-Greer on My DPC Story, April 2025, recorded **onsite** at Outlaw Medical. mydpcstory.com

FROM THE MY DPC STORY SHOP

THE OPT-OUT IS YOUR PAPERWORK. HERE ARE COPY AND PASTE SCRIPTS TO USE IN YOUR CLINIC TO DELIVER THE CARE.

MEDICARE & MEDICARE
ADVANTAGE SURVIVAL
GUIDE (updated for 2027)
Built from what Big Trees
MD (Dr. Concepcion's
practice) uses to explain
how membership fits before
it lapses.



Inside

- Front desk scripts for the calls that start in late September
- Ready-to-send patient emails and texts
- A one-page handout on how DPC works alongside Medicare
- An open enrollment tracker so every Medicare patient gets a touchpoint
- Social media templates

New for 2027

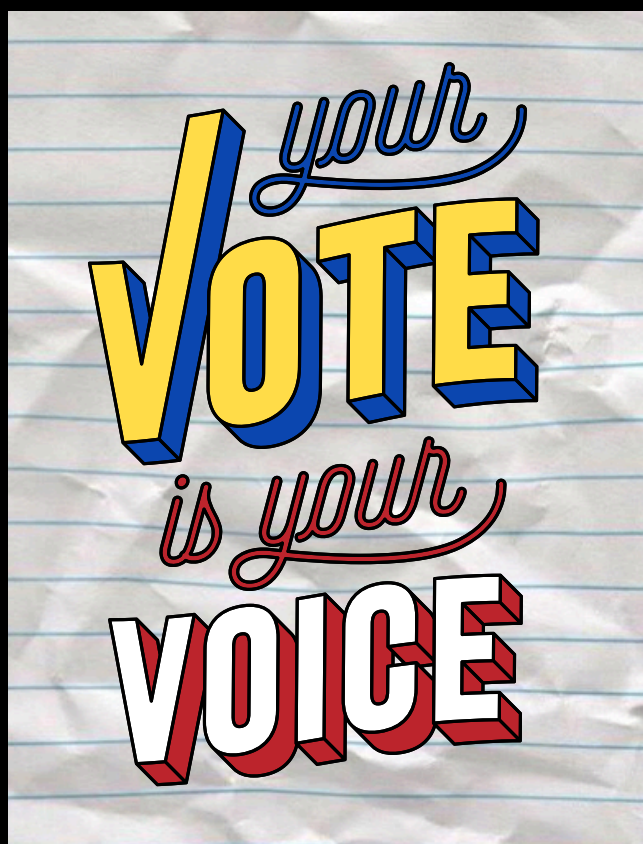
A physician section with the opt-out calendar from this issue, the filing deadline for each effective date, and the steps that confirm your affidavit went through.

*Hand these scripts to
your front desk!*



**Battle of the EHRs
2027**

Jan 4, 2027
ballot opens



The Battle of the EHRs is back. Rate the EHR you actually use, one ballot per physician. Watch the My DPC Story newsletter for the ballot link.

CAN I STILL SEE YOU?

TRICARE: THE LETTER THAT CAME AFTER THE OPT-OUT

Dr. Christa Springston opened her practice in January and opted out of Medicare soon after. The letter arrived not long after that. It thanked her for her service and informed her she was no longer a TRICARE physician.

She had expected to keep some ability to refer. For five years she had been an associate at a fee-for-service practice in the same community, enrolled with TRICARE, and for a few weeks after leaving she could still send referrals through. Then the government shared the opt-out data, TRICARE removed her, and the referral path closed.

The timing was the problem. Tyrone, GA (where her original office was) sits south of Atlanta's perimeter, close enough to the airport that the town of about 8,000 is full of airline workers, and many of them are retired military. Twenty years of service earned them TRICARE, and a large share were enrolled in TRICARE Prime, the managed plan that requires a referral from your in-network PCM, or Primary Care Manager, for imaging, medication or a specialist to be submitted and approved before the patient can count on it being covered. Prime patients can't switch plans until open enrollment. So for most of her first year, patients who had followed her to the new practice were driving back to her former employer for the sole purpose of getting a referral.

She posted about it in a DPC physicians' group, and that post is how she ended up on the podcast. Her frustration was double. She has TRICARE herself, through her husband's Air Force career, and calls it a great benefit right up until the moment a family wants choices outside of their network or without seeing their PCM. As a physician, she called it one of the most restrictive managed plans in the country, and said it bothered her that people who served 20 years were handed a benefit that didn't let them pick their own doctor.



DR. CHRISTA SPRINGSTON OF HEALTHSPRINGS DIRECT, PEACHTREE CITY, GA FROM [EPISODE 59 OF MY DPC STORY](#), RECORDED IN HER FIRST YEAR OF PRACTICE

THE CONVERSATION SHE HAD TO HAVE

At first she didn't ask new members which TRICARE plan they had. She described it as a bad "don't ask, don't tell" situation, and learned the hard way that she needed to.

The conversation that followed, with many patients, went like this: TRICARE Select lets you self-refer, so you can stay here and I can send you where you need to go. The trade-off is higher bills



if you're hospitalized and a copay for each specialty visit, about \$30-50, which adds up fast across a course of physical therapy. Thirty dollars is nothing next to cash prices, but it landed as a cost that shouldn't be there, given what they'd been promised.

Many had already switched to Select by the time she opened. For the rest, she worked around the gap until enrollment opened, and every one of them, she said, was planning to switch so they could stay.

THE MEMBERSHIP THAT PAYS FOR ITSELF

Her membership includes something most practices don't offer: FAA physicals. She holds certification for Class 1, 2, and 3 exams. Airline captains need two a year, and she said at least one airline reimbursed pilots up to \$500 annually for them, which covered about two-thirds of a membership on its own. The pilots come in for the exam, ask what else the membership covers, and get a physician who can also tell them which allergy medication won't jeopardize their aviation medical certificate.

The FAA work also fell outside her non-compete, which barred family or internal medicine within ten miles of her former practice for two years. She measured the distance to her executive suite eight times online: 10.02 miles. Her former employer had reminded her that even home visits and telemedicine from her house fell inside the

radius. She rented a single 12-by-17-foot room with a shared receptionist, conference rooms she could book for family meetings and nutrition classes, and no build-out cost. She left her old job without soliciting a single patient. The practice told them she had gone home to spend time with her family. They found her anyway, through Google, Facebook, at the grocery store, and through parents on her kids' Little League team.

She had planned on a small telemedicine practice and instead grew fast enough that she was in the office five days a week within nine months, with pitches out to three local employers who were all, she said, waiting on open enrollment.

Her advice to a physician considering the same move was short: do it now, and expect to be bigger than you planned.



LEARN MORE ABOUT DR. SPRINGSTON AND HEALTHSPRINGS DIRECT [HERE](#) OR EMAIL DR. SPRINGSTON AT INFO@HEALTHSPRINGSDIRECT.COM

TRICARE **PRIME** VS. **SELECT**, AS EXPLAINED TO PATIENTS

TRICARE's open season is separate from Medicare's and the Marketplace's. This is how Dr. Christa Springston describes the difference to her patients.

01

TRICARE PRIME.

A managed plan. Every referral for imaging or a specialist has to be submitted to TRICARE and approved first. Requires a physician who is enrolled with TRICARE, which in turn requires Medicare participation. An opted-out DPC physician cannot be that physician, and Prime members can only change plans at open season or a qualifying life event.

02

TRICARE SELECT.

Lets the patient self-refer. The costs of that freedom are higher bills for inpatient care and a copay per specialty visit, which she quoted between \$30-50. Members can pair Select with a DPC membership and keep their doctor.

WHAT IT MEANS FOR HER PRACTICE.

Ask which plan a member has at enrollment. Don't assume a retired service member is on Select. And plan for a gap: a Prime patient who joins in January may not be able to switch until fall.

WHY EVERY STATE DESERVES ITS OWN DPC SUMMIT

JUNE 2027 - NEWPORT BEACH, CALIFORNIA - calidpc.com/summit

This June, 80 physicians gathered in Newport Beach for three days of the second annual California DPC Summit. On Friday, people walked in carrying weight. You could see it in their faces. By Sunday, that weight had lifted. That shift is the whole point, and it is by design.



CAN I STILL SEE YOU?

MEDICAID: THE EIGHTEEN-MONTH CONTRACT

When Dr. Drew Hertz started recruiting pediatricians to a direct care network, the first objection he heard wasn't about money or call. It was: I love my Medicaid patients, and I'm not willing to stop seeing them.

He heard it over and over, ahead of the three other reasons pediatricians gave for hesitating (being on call, the income dip during transition, and doubt that the model works). And he heard a version of it from professional organizations, who argued that direct care would *widen* the gaps in children's health. He and his co-founders, Dr. Keili Mistovich and Dr. Justin Mistovich, wanted to answer both with data rather than argument.

Dr. Hertz came to direct care after a career inside health systems in Northeast Ohio, most recently as a vice president overseeing about 200 general pediatricians and OB-GYNs at a children's hospital. Earlier, he'd won a federal innovation grant that helped establish one of the first pediatric Medicaid accountable care organizations in the country. He left, he says, when he could no longer innovate or advocate for physicians and patients the way he wanted to, and spent the pandemic consulting. Zest, founded in 2022, is structured as a management services organization: each physician owns their own LLC and hires the network to run the practice. He describes himself as having been "the man" for years, and the structure as a conscious effort not to become that again.

DEFINING PRIMARY CARE FROM SCRATCH

The Medicaid arrangement began over lunch. Dr. Hertz knew the Ohio chief medical officer of a managed care plan from his population health work, and the two met every few months. Once Zest had launched, the executive suggested they try it together.



DR. DREW HERTZ, ZEST PEDIATRIC NETWORK, OHIO. FROM HIS [EPISODE OF MY DPC STORY](#) AND THE NETWORK'S PUBLIC ANNOUNCEMENTS.

EIGHTEEN MONTHS TO ONE NUMBER

It took 18 months. The hardest part was a question neither side could answer at the start: what does the plan spend on primary care? Managed care plans know what they pay for professional services, facilities, pharmacy, and equipment. They don't track primary care as a category. Agreeing on a per-child figure for a month of primary care, a number both sides could defend, was most of the work.

The result, announced in July 2024 with AmeriHealth Caritas Ohio, is a value-based contract. The plan pays Zest a base amount per member per month, which Dr. Hertz describes as essentially a membership fee, plus a bonus at year end tied to quality measures. Families in the program pay nothing. Members get the same access as Zest's other patients: same-day and virtual visits, and the ability to text or call the physician directly. The plan's stated reason for trying it is that, by the Ohio Department of Medicaid's count, more than 40 percent of infants



and 30 percent of children ages 3 to 6 covered by the program were missing annual well visits, often because of transportation, work schedules, and child care. In April 2025, the two organizations added a second project aimed at shortening waits for autism evaluations, which Ohio families on Medicaid had faced for months.

WHY HE WANTED THE PLAN'S DATA

Dr. Hertz is candid that there is no published data on pediatric direct care. Actuarial studies exist for adults on Medicare and commercial plans showing lower costs and high satisfaction. For children, nothing. A managed care plan sees every claim, so a contract with one is the fastest route to an honest answer about whether the model saves money and improves outcomes for kids on Medicaid. Zest's own survey of its members found that 70 percent said they'd avoided an emergency department visit because of the model, but that is self-report, and he knows it.

The data available to date demonstrated high patient satisfaction and low ED utilization among enrolled members. The program does not yet have other results.

WHAT THE NETWORK DOES WITH A PANEL OF 300

Pediatric panels run smaller than adult ones. Zest

targets about 300 per physician, because young children need more frequent visits and their parents worry more. Pricing runs the opposite direction from adult practices: highest for infants, dropping through college age, with discounts for a second and third child and a conversation with the physician for four or more.

A panel that small can't support a dietitian or a psychologist on site. A network can. Zest shares lactation consultants, sleep specialists, dietitians, parent coaches, and a psychologist across its offices, mostly by video, in what Dr. Hertz calls a hub-and-spoke model. He found, after leaving the health system, that the community was full of people who wanted to work with pediatricians outside a system and had never been asked.

His other argument, which he admits he's still refining, is against the annual well visit itself. He calls it a floor invented by the interaction of insurers and guidelines. A child who is fine on June 30 can be bullied, start an eating disorder, or start having accidents at school by September 15, and a model built on one visit a year won't know. Direct care, he says, exists to check in when something changes, not on the birthday.

Zest now has 16 pediatricians and will be entering its fifth state near the end of the year. Offices are in California, Florida, Ohio, Pennsylvania, and South Carolina (coming soon).



ZEST PEDIATRICS OF SOLON WITH DR. MICHAEL PERISA,
ZEST PEDIATRIC NETWORK

IS A PLAN-PAID FEE STILL DPC?

Some readers will look at a Medicaid plan paying a monthly amount with a quality bonus and see capitation under a friendlier name. The concern has history. On the August episode, Dr. Phil Eskew noted that Medicaid pilots have been tried before, in Michigan, Nebraska, and elsewhere, with mixed results, and warned that arrangements like these carry a standing risk: that the selected relationship of DPC gives way to the arranged marriage of capitation once a payer is in the room.

Dr. Hertz's response: We need to consider this as a primary care cap, not full capitation. A primary care capitation payment that goes to the physician, not to a corporate entity that employs physicians, is rather rare, and likely has never been done in pediatric Medicaid. However, there are challenges. Many Medicaid managed care companies are held to HEDIS quality measures which can only be met through the submission of CPT codes. Checking boxes and submitting/working claims is the antithesis of the principles of DPC. So there will need to be a compromise on both parties if we are to truly study this.

Connect with Dr. Hertz: Drew.Hertz@ZestPeds.com

MY DPC STORY · STATE BY STATE

Your questions, BY VOICEMAIL



DR. NYASHA SPEARS · DULUTH 90 SECONDS

The question sitting in the back of your head is one someone else is sitting on too. **Ask it.**

LEAVE A VOICEMAIL
[**mydpcstory.com/contact**](https://mydpcstory.com/contact)

The August episode with Dr. Phil Eskew opened with a voicemail. Dr. Nyasha Spears, calling from Duluth, explained in ninety seconds why her non-compete case matters to every physician who wants to leave a system and open a practice. **That's what the voicemail line is for.**

The rules that shape a DPC practice differ by state. No single episode can cover them all. So the series moves state by state, and the questions come from you.

HOW IT WORKS

- 01 Go to mydpcstory.com/contact and leave a voicemail.
- 02 Say **your name, your state, and your question.** That's all.
- 03 Selected voicemails play on air and get answered on the episode covering that state, or on a multi-state episode like the one with Dr. Eskew.

THIRTY-SIX DAYS

Her clinic closed with 36 days' notice. Her contract said she couldn't practice within 25 miles for two years. Dr. Nyasha Spears sued for her freedom, opened her DPC under a judge's order, and is now waiting on the Minnesota Court of Appeals.



*Dr. Nyasha Spears & Dr. Kristin Lusian visit with MN Senator Jen McEwen at their new medical practice, Amity Creek Primary Care.
Photo Credit: Sean Lim, legislative aide to Sen. Jen McEwen*

The email arrived at 12:30 on a Thursday, announcing a mandatory meeting at 4:00. Dr. Nyasha Spears didn't see it. "I don't read email when I'm at work, because I'm busy doing work," she says. A partner called to ask if she had. She had a 3:40 physical on the schedule, and no one had moved it.

She went to the manager's office and said so. "That 3:40 appointment is a person who is employed somewhere," she remembers saying. "She took that appointment because it was at the end of the day." Then she called the patient and rescheduled the visit herself.

Duluth was in a COVID surge, so she wore a mask into the conference room. "I was very glad about that, because I was fuming mad." Around the table sat the clinic's physicians, a PA, the hospital CEO, and the head of clinics. The message, as she recalls it, was that to better serve patients, the P.S. Rudie Medical Clinic would close. She describes it as the only clinic in downtown Duluth. Its last day was 36 days out.

Nobody was moving the practice somewhere else. Seven physicians were assigned, in that meeting, to five different locations. The clinic she was sent to sat past the end of the bus line.

She said in the room that she believed this violated their contracts and released them from their non-competes. She recalls being told that was not the case. She let it go. “I’m not a lawyer, and I’m not looking at the contract.”

The contract required 180 days’ notice.

WHY SHE WOULDN'T LEAVE

Dr. Spears did not grow up in Duluth. She was a third-year medical student in a rural program when she came to a conference on rural health care, sat in a revolving restaurant on top of a hotel, and watched a February sunrise over Lake Superior with a cup of bad hotel coffee. “It was almost like a religious experience,” she says. “I was like, this is the place I’m supposed to be.”

She did her residency in Duluth and met her husband there. They spent ten years 70 miles down the south shore in Ashland, Wisconsin, a town of 8,000, practicing full-spectrum family medicine. She did operative obstetrics. When they came back, it was to raise their kids somewhere they’d call home. “It breaks my heart when I hear that people have to leave their communities to practice medicine,” she says. “Every community needs physicians.”

The Rudie clinic suited her. It was nearly a hundred years old and sat downtown, a block from single-occupancy housing for low-income seniors and close to a homeless shelter. It also drew corporate staff from a company headquartered nearby. She saw patients who told her they’d been born under the founder, patients who lived in bus shelters, and everyone between. Her medical assistant had worked with her for ten years. When someone at the front desk thought a caller sounded short of breath, they got up, walked down the hall, and pulled her out of a room.

Then the community hospital that owned the clinic merged into a larger system. What she describes next is what every physician who has been through a merger will recognize. In her telling: the lab closing earlier, the front desk closing earlier, messages routing to another city, her schedule booking out further than any patient wanted to wait. “The corporate model just makes us all widgets, and it

doesn’t really matter which widget is providing the care,” she says. “I felt mad all the time, and that is not who I am. I’m not an angry person.”

Her patients felt it too. Many had chosen St. Luke’s because it was the community hospital, the one without fireplaces in the waiting rooms. “That feeling just disappeared rather quickly,” she says. “People are grieving. They’re still grieving.” Around then a friend called.

Dr. Kristin Lusian had been a new physician in Ashland when Dr. Spears backed her up on one of her first C-sections, and she had since landed at the other hospital system in Duluth. She was thinking of leaving to start a Direct Primary Care practice. Dr. Spears remembers it as the first time she understood what DPC was, and she remembers her answer: “Oh yeah, girl, you run.”

Dr. Lusian was under her own two-year non-compete. She looked at driving an hour and a half each way to get outside it and decided it wouldn’t work with young kids. The idea waited.



THE WORKAROUNDS SHE PRICED OUT

Before the clinic closed, Dr. Spears spent months looking for a way around her own restriction. She thought about buying a mobile home and parking it 35 miles up the road. She drove the North Shore looking at sheds that might convert. There was an

orthopedic office on the Iron Range with space to rent, an hour and a half away, and a shabby Airbnb at about 45 miles.

“They were very smart about the radius of the non-compete,” she says, “because you get out of Duluth and there’s nothing there.”

None of it felt honest. “I don’t want to go to a small town, set up my practice and then leave, feeling like I’ve used that community just as a stepping stone.” At the DPC Summit, an attorney giving advice from the stage said: whatever you do, don’t lawyer up. Be reasonable, go explain what you want, and it will be fine. “I literally burst into tears,” Dr. Spears says, because by then she already had a lawyer.

She had tried the reasonable conversation first, and she had pitched it as a win for the system. “You do not have to pay my salary, you don’t have to pay my overhead, you don’t have to pay for my staff. You don’t pay my malpractice.” Every referral for hips, knees, oncology, and cardiac care would still go to the hospital she knew. “And they were having none of it.” She still thinks the direct conversation is worth trying. “If it works, that’s clearly the best. But don’t be surprised if it doesn’t.”

to open a Direct Primary Care practice, that she would take no insurance, and that she did not consider it competition.

“I love family medicine. I love being a doctor. I’m willing to work hard,” she says. “I just couldn’t do it under this banner anymore.”

The plan at home was for her husband, also a family physician, to stay in his job for the income and the health insurance. It didn’t hold. He now works three days a week in Ashland, 70 miles away and outside the restricted area. “We decided both of us couldn’t be legally in jeopardy.”

THE SUIT

Through the summer of 2025, her attorney, Jeff Oberman of Minneapolis, sent letters making the same case she had made in person. Nothing moved. She filed suit on October 26, 2025, in Minnesota’s Sixth Judicial District.

She asked for no money, on purpose. “My goal at that time was my freedom. I just wanted to be set free. I did not want to punish the institution.”

The first draft of the complaint listed everything she says the system had failed to provide at the clinic she’d been reassigned to. She and Oberman cut that whole section. “That’s where all the opinions were,” she says, and opinions meant discovery and argument. They kept two claims. The clinic had closed on 36 days’ notice when the contract required 180. And enforcing a non-compete against a primary care physician in a city short of them was against the public interest.

She calls the first claim the black-and-white one. Oberman had made the second argument before, but every prior case had settled. This one didn’t. On February 17, 2026, Judge Shawn Reed granted a temporary injunction. The court found that enforcement would keep her from practicing in her established community, disrupt care for her patients, and reduce access to primary care in an area with a documented shortage. “Non-competes should not be enforced in a manner that harms the community,” the order said.

In statements to news outlets covering the case, Aspirus St. Luke’s has said that her agreement contains a reasonable restriction of a common kind, that she is free to practice outside its service area, and that in protecting its legal rights it is acting in the



GIVING NOTICE

The seven physicians talked about hiring an attorney together. Some had very young children, and a legal fight was more than they could take on. “It’s very scary,” Dr. Spears says.

She decided to go. Her notice letter said she planned



interest of its patients and community.

BUILDING IT WITHOUT BEING ALLOWED TO

While the case moved, Amity Creek Primary Care got built without her. Dr. Lusian formed the LLC alone, borrowed the money alone, signed the lease alone, and hired the builders alone. After more than 15 years in family medicine she knew she could open a practice by herself. She wanted to open it with a partner she trusted.

The two kept Dr. Spears's finances entirely out of the business, so no one could later claim she had put a dollar in.

What Dr. Spears could do was help decide. Where the walls went. Which way the doors swung. Whether to drive to Milwaukee for a used autoclave she dates to the Carter administration. (They have it.) "It was like the family remodel," she says, and it is why she recommends a partner: the decision fatigue is easier to carry with two.

Between them they kept physical notebooks full of lists, worked each one until it was half done, and copied the rest forward to a new list. The procedure room got a 1987 Ritter power chair with foot controls, because, as she puts it, a little general surgeon lives deep inside her head.

The name came from the creek next door and from the word itself. Amity is friendship, she says: with each other, with patients, and with the town. Then, in February, her lawyer called to say the injunction was granted, and "everything went a million miles an hour."

They opened in April in Duluth's Lakeside neighborhood. A bike rack had been on the first version of the business plan. It still wasn't installed when a patient asked, in the first week, whether she could bike to her next appointment.

Before the clinic closed, Dr. Spears spent months looking for a way around her own restriction. She thought about buying a mobile home and parking it 35 miles up the road.

WHO WALKED IN

Six patients in the first days. One was a woman in her sixties with catastrophic insurance who hadn't seen a doctor in years. They talked for an hour, and then she mentioned her gut symptoms.

In the old system, Dr. Spears says, that is the moment you start talking fast. This time she told the patient it deserved its own conversation and asked when she could come back. Then she walked into the break room and said to Dr. Lusian: "You're not gonna believe this, but I'm having her come back to finish our conversation."

At six weeks, the practice had 130 patients between the two physicians, with no advertising beyond a website, word of mouth, and a lawsuit in the paper. By June they were covering rent, overhead, and debt payments, though not yet paying themselves. By October, six months after opening, the count was 240.

What matters to Dr. Spears is who the patients are. "I was worried about getting kind of a bougie practice," she says. Instead: two sandwich-shop workers making \$16 an hour who can't afford insurance. A small business owner with four kids and decent income, but not \$2,700 a month for coverage. A woman whose husband carried the family's coverage until his own illness cost him the job it came with, leaving her uninsured for the first time in her life and still years from Medicare.

"They're weepy," she says. "They're so thrilled with what we're able to do."

These are the people who miss the safety nets.

Dr. Spears supports the safety nets and says so; she would expand Medicare and Medicaid. But in Minnesota, she says, people inside those programs can still find a physician. The ones falling through are choosing between rent and a doctor.

Her complaint said the practice would focus on uninsured and underinsured patients. Her waiting room says it is. “Every interaction feels like a movement of the justice needle,” she says.

She misses obstetrics and hospital medicine. She also sleeps at night, and she reads the journal article now instead of the summary at the bottom of UpToDate. She sewed up a mountain biker’s leg, her partner’s patient, while Dr. Lusian was at a kindergarten graduation. Her kids clean the building and mow the lawn, and her son wants to learn the autoclave.

Her complaint said the practice would focus on uninsured and underinsured patients. Her waiting room says it is.

NINETY DAYS

Dr. Spears expected the injunction to end it. Her lawyer told her the losing side usually comes to the table at that point. “I really wanted to settle, because I wanted this to be done,” she says. “The judge found in my favor. That’s good enough for me. Just let me go.”

No settlement came. After the practice opened, Aspirus St. Luke’s appealed the injunction and, separately, asked the district court to stay it while the appeal ran. That put her in two courts at once: defending the order at the Court of Appeals, and defending her ability to stay open in the meantime.

In June, the district judge heard the motion to stay and left the injunction in place. She could keep seeing patients while the appeal proceeds. The judge also set aside her request for summary judgment rather than denying it, reserving the question until the appeal is decided. Dr. Spears reads that as a good sign. It would have been easy to say no.

On October 8, 2026, she sat in the Minnesota Court of Appeals as the system argued that the injunction should never have been granted. The court has 90 days to decide.

She describes the cost as extraordinary. “For people who are thinking about going on the legal battle front, the money is no joke,” she says. In a note to My DPC Story and The Toolkit after the hearing, she wrote that the filings and responses “have generated

IF YOU'RE UNDER A NON-COMPETE

What Dr. Spears would tell a colleague. One physician's experience, not legal advice.

READ THE CONTRACT LIKE A PRENUP.

“It’s an employment disagreement contract,” she says. When she signed, the salary was more money than anyone in her family had ever seen, and the first years were good. “The problem is that things change.” Read it for how it ends.

TRY THE CONVERSATION FIRST, AND DON'T BE SURPRISED IF IT FAILS.

Explain that you’re not a threat, that the system saves your salary and overhead, and that your referrals will still come to them. If it works, it’s the best outcome. In her case, months of letters produced no movement.

KNOW YOUR DATES TO THE DAY.

Her husband’s contract required notice 180 days before an auto-renew date, not 180 days before leaving. Miss the window and you owe another year. Physicians in her group had learned that the hard way.

KEEP A RUNNING DIARY.

Dates, what happened, which resources were missing that day. “It’s difficult to put all that stuff back together, even just a few weeks later.” She wishes she had kept copies of key emails, because access ends the day you leave. Ask your own attorney what you may keep, and never keep patient information.

PLEAD WHAT'S BLACK AND WHITE.

The claim that held was simple: 36 days’ notice against a 180-day requirement. The list of everything else was cut from the complaint because it invited discovery and argument.

KEEP YOUR MONEY OUT OF A PARTNER'S BUSINESS.

If someone opens before you’re legally free, don’t put a dollar in. Advise, design, make lists. Let them borrow alone.

DON'T PUT TWO PEOPLE IN LEGAL JEOPARDY.

Her husband took work 70 miles away, outside the restricted area, so only one of them was fighting.

BUDGET FOR THE FIGHT, THEN BUDGET AGAIN.

A temporary injunction is not the end. The appeal, the motion to stay, and the appellate hearing each cost money, and the other side may prefer an expensive fight to a settlement.

astonishingly high legal bills.” She is not backing off. “This is a fight for all physicians and all patients,” she wrote.

While she waits, she goes to work. “I love my job, I love my job, *I love my job*,” she says. One of her teenagers, both of whom are thinking about medicine, asked her: “Do you think this means that I could really enjoy being a doctor?”

The court has until early January to answer its question. She has already answered that one.

HOW TO STAND WITH DR. SPEARS

Give to the legal fund. Katherine Blauvelt, a friend of Dr. Spears, administers a fundraiser for her legal costs as the appeal runs. It is hosted at fundrazr.com/SupportDoctorSpears. In her own words: the outcome “will potentially help every physician who wants to legally leave a big system and open DPC.”

Send her your patients, and your questions. Amity Creek Primary Care is at 5931 E. Superior St. in Duluth’s Lakeside neighborhood. Dr. Spears credits the DPC community with answering exactly these calls: “What do you think about this? How do you solve this problem? Where do you get your sleep studies?”

Hear the whole conversation. Dr. Spears appears on two episodes of the My DPC Story podcast, recorded the week she opened and again at two months in. See the links to the right.

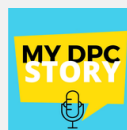
Take a seat at the table. Dr. Spears argues the movement’s next job is policy: reaching every patient who needs a DPC physician. **The DPC Coalition** is the organization doing that work, at dpcare.org.

WHERE THE CASE STANDS

As of October 12, 2026. The temporary injunction is in force, Amity Creek is open with 240 patients, and the Minnesota Court of Appeals has the case under advisement.

WHEN	WHAT HAPPENED
By early January 2027	<i>Court of Appeals decision due, 90 days after the October 8 argument</i>
October 8, 2026	Oral argument at the Minnesota Court of Appeals on Aspirus St. Luke’s appeal of the temporary injunction
June 2026	District court hears Aspirus’s motion to stay the injunction and leaves it in place; her request for summary judgment is reserved until the appeal is decided
April 2026	Amity Creek Primary Care opens in Duluth’s Lakeside neighborhood
February 17, 2026	Judge Shawn Reed grants a temporary injunction barring enforcement of the non-compete while the case proceeds
October 26, 2025	Dr. Spears files suit in Minnesota’s Sixth Judicial District, seeking release from a two-year, 25-mile non-compete
October 2025	Minnesota Attorney General’s Office opens an investigation into the use of non-competes at Aspirus St. Luke’s, a matter separate from her case
May 2025	Dr. Spears gives notice and states her plan to open a DPC practice
March 2025	P.S. Rudie Medical Clinic closes on 36 days’ notice; her contract called for 180

The case remains open. Italics mark the step still ahead.



EPISODE 1

PLAY



EPISODE 2

PLAY



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Small-batch coffee, loose leaf tea and merch from a physician-owned business. No board, no investors. If you have worked a twelve, this one is for you.

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target market.
You are the
reason.

Chief Complaint is owned by a working family physician, not a brand agency. Beans come from smallholder farms and farmer owned cooperatives, roasted in small batches only after you order.

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BUY AT CHIEF COMPLAINT COFFEE.COM

Despite it all,
we're still here.



THE DOOR THAT ONLY OPENS WHEN A PLAN LEAVES

About a million Medicare Advantage members are losing their plan on January 1. For some of them, that letter is the only chance they will ever get to buy a Medigap policy without medical underwriting. And their deadline is not December 7.

THE LETTER NOBODY RECOGNIZES

In early October, roughly 600,000 Humana Medicare Advantage members opened an envelope telling them their plan will not exist in 2027. Humana is not alone. Confirmed withdrawals from Centene, Molina and UnitedHealthcare push the number of members losing a plan past one million. Plan options fall in most of the 51 jurisdictions where individual Medicare Advantage is sold, by the trade press count of the CMS landscape



files, and the counties that lose plans skew rural. Thinner networks, fewer enrollees to spread fixed costs across, less room to make the math work. That last part is us. It is also most of you. The call does not arrive sounding like a non-renewal. The patient says she got a letter and does not know what it means. Or she says her plan is going away. Or she says nothing at all, because the letter went in the pile with the Medicare & You handbook and four pieces of plan marketing, and she is not going to bother her doctor about mail.

Your front desk does not need to know which carrier left which county. It needs one question, asked out loud, in October:

Did your letter say the plan ends, or changes?

Those are two different letters, and only one of them has a door in it.

FOR TWO YEARS WE HAVE TOLD THEM THE OPPOSITE

The talk track in our own Medicare & Medicare Advantage Survival Guide carries the same caution four separate times. The front desk fast script: if you use that window to go back to Original Medicare, a Medigap policy can require medical underwriting and you can be turned down. The end-of-call wrap script says it again. So does the December 7 email. So does the patient FAQ.

That is true. It is the right warning. It is why we repeat it. A patient who walks out of an Advantage plan on her own at 79, with heart failure and two years of prior authorizations behind her, may find that nobody will sell her a supplement at any price. A plan exit is the exception.

When a Medicare Advantage plan leaves a member's county or ends its contract, federal law hands that member a guaranteed-issue right to buy a Medigap policy without medical underwriting. Her health does not matter. The answer is yes. The window runs 63 days, and she can start before the old coverage even ends.

For someone who has been in Advantage for nine years, this may be her only route back to Original Medicare with a supplement, and it exists only because the carrier left. She could not have gotten it by leaving on her own.

The problem is that our own scripts, as written, would talk her out of using it. The staff member reads Medigap can require medical underwriting and you can be turned down off the card, the patient

hears don't, and by March the window has closed. Nobody did anything wrong. The script was written for the common case, and this is the uncommon case that is happening to a million people at once.

There are two limits on this, and they are where people overcorrect. The guaranteed-issue right covers a defined set of Medigap plan letters from the companies selling them in her state, not everything on the shelf. And the clock is real: miss the 63 days and she is back to underwriting. Neither is a front desk judgment call, which is what SHIP is for.

The 2027 edition branches the script, with one question before any of the rest of it: did your letter say the plan ends, or changes?

DECEMBER 7 IS NOT THEIR DEADLINE

Our last-chance email, the one that goes out December 5 through 7, says today is the final day to change a Medicare Advantage or Part D plan. For most of the panel, true. For the patient whose plan was non-renewed, false.

When a plan ends its contract, the member gets a special enrollment period that runs from December 8 through the end of February. It exists for exactly this reason: a person who lost her plan through no decision of her own should not be made to choose in the last 48 hours of open enrollment. Confirm the dates for a given patient with SHIP, because a mid-year termination and a year-end non-renewal do not run on the same clock.

Two things follow.

She will not go uninsured if she does nothing. She lands in Original Medicare on January 1, with no drug coverage unless she picks a Part D plan. Whether that is a good landing or a bad one depends entirely on whether anyone told her about the Medigap window first, which is the whole argument of the section above.

And a blast email that tells her the door closes December 7 is wrong on the most consequential week of her year. That is the kind of mistake a practice makes once and never learns about, because nobody writes back to say the email was wrong. She just ends up somewhere.

The repair is small. A conditional line in the December send, and a way to mark who was non-renewed, so the list splits in two before it goes out.



WE ARE NOT AGENTS, AND THAT IS THE POINT

All of the above could be read as an argument for a DPC practice getting into plan selection. It is the argument for the opposite.

We do not sell insurance. We do not recommend a plan. We take no commission, we accept none, and we say so out loud, early, so that nobody wonders. What we do is narrower and worth more: ask one question in October, get the letter and the medication list uploaded, hand the decision to someone whose actual job it is, and write down that we did.

The order of the hand-off matters. SHIP first. Your State Health Insurance Assistance Program counsels for free, in person, with no financial stake in the answer. A broker second, and only the one or two you have met and would send your own mother to.

There is a reason to hold that order this year that most practices have not heard. Aetna told marketing organizations in August that it would stop paying commissions on a long list of its Medicare Advantage plans for 2027, and other carriers are trimming broker compensation as well. So a broker who does not bring up a particular plan may be telling you something about the commission

rather than something about the plan. That is not an accusation. It is an incentive, and incentives are easy to see once you know to look. SHIP does not have one.

Ask. Upload. Hand off. Document. Never promise coverage. A practice's value in October is not expertise in plan design. It is that somebody noticed the letter.

THE JANUARY NOBODY SCHEDULES FOR

This part has nothing to do with enrollment and everything to do with us.

Prior authorizations do not travel with the patient. When she changes plans on January 1 - by choice, or because the old plan left - every approval the old plan granted evaporates. The biologic. The continuous glucose monitor. The pump supplies. The inhaler that took four months and two appeals to get approved the first time.

All of it starts over, with a new reviewer who has never seen her chart.

She does not know this. She finds out at the pharmacy counter on January 6, or at the supply company on January 9, and then she calls you, because you are the doctor who answers the phone. In a fee-for-service practice that January gets absorbed by whoever is working the fax line. In DPC it is worse, because the call comes to you. It is also better, because you can see it coming in November.

The workflow is three lines:

1. In November, run the panel for every Medicare patient on a therapy that needed prior authorization. Most EHRs will not filter on that directly; pulling by medication class is usually faster than fighting the report builder.
2. Mark which of them is changing plans.
3. In the first week of January, resubmit. Before she calls.

Networks reset on the same morning. A new plan means a new hospital list, a new specialist list, a new imaging center, and sometimes a different preferred pharmacy. Those are worth checking in November, while you can still tell her. In February you find out from a referral that did not go through.

No general Medicare guide covers any of this, because general Medicare guides are written for beneficiaries. This one is written for the practice

that will take the call. What the rest of it looks like month by month - who does what in September, where the season breaks, and what it actually costs a small practice in hours - is the companion piece that follows: Designing an Open Enrollment Season.

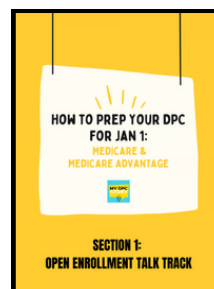
WHAT IS FREE, AND WHAT IS NOT

The piece that follows is the whole season, September through March, and it is free. It is the Medicare & Medicare Advantage Survival Guide, lite. A season nobody prepared for is bad for every practice in this movement, not only the ones who buy things from us.

What the full guide adds is all of it already written. The front desk scripts word for word, including the ones for the calls you do not expect. The four patient emails, each with a short and an ultra short text version, ready to send. The reply for the patient who wants you to tell them which plan to pick. The one page handout on how DPC works alongside Medicare. The social captions. The tracker already built, with the dropdowns in it. And new for 2027, a physician section carrying the opt-out calendar from this issue, the filing deadline for each effective date, and the steps that confirm your affidavit actually went through. It is at payhip.com/mydpcstory.

The 2027 update carries everything in this article: the non-renewal branch, the guaranteed-issue window, the December 8 calendar, the November prior-authorization list, and the numbers in the box. Already own it? If you bought the guide prior to October 2026 and the 2027 version has not landed in your inbox, email hello@mydpcstory.com and we will send it to you. Just send us your proof of purchase, no form. Updates are free for as long as we keep making them.

And if you take one thing off this page, take the question. Before Thanksgiving, ask every Medicare patient on your panel: did your letter say the plan ends, or changes? Nine words. It is the highest-yield question your front desk will ask all year.



GRAB OUR COMPLETE
MEDICARE & MEDICARE
ADVANTAGE SURVIVAL
GUIDE

[PAYHIP.COM/MYDPCSTORY](https://payhip.com/mydpcstory)



KEEP THESE AT THE FRONT DESK

Everything in this article comes down to two things a staff member has to recognize: which envelope is in front of the patient, and what the 2027 numbers actually are when someone calls to ask why the price moved.

The first table is the one to print. Five things arrive between late September and December. Only two of them start a clock, and on a kitchen counter they look exactly like the three that do not. The second is the reference for October and January.

FIVE THINGS LAND IN THE MAILBOX. TWO START A CLOCK.

THE ENVELOPE	WHO SENT IT	WHAT IT ACTUALLY MEANS	WHAT YOUR FRONT DESK ASKS FOR
Annual Notice of Change (ANOC)	The plan	The plan continues next year, with these changes to drugs, costs and pharmacies	Upload it with the current medication list. Book 15 minutes if anything moved.
Non-renewal or termination notice	The plan	The plan will not exist on January 1	Upload it. Consider calling SHIP this week — there is a Medigap window and it closes.
Evidence of Coverage (EOC)	The plan	The full contract. Long, posted online, rarely read	Only when a specific drug or service is in question
Medicare & You handbook	CMS	The annual handbook. Not personal, not a deadline	Nothing. Keep it in the drawer.
Glossy plan marketing	Marketing organizations	Not from Medicare, not from us, and not a deadline	Set it aside. Bring the two letters above instead.

STARTS A CLOCK

The two that start a clock look, in an envelope on a kitchen counter, exactly like the three that do not. That is the whole reason to ask.

2027 NUMBERS TO KNOW

	2026	2027
Part D out-of-pocket cap	\$2,100	\$2,400
Part D standard deductible	\$615	\$700
Part D base premium	\$38.99	\$41.33
Insulin, per covered product per month	\$35	\$35
Medicare Advantage plans nationwide	5,553	5,532
Cheapest standalone Part D premium	—	\$5.30 in 44 states + D.C.

- The Premium Stabilization Demonstration ends after 2026. Standalone Part D premiums for 2027 were set without it, so expect premium-increase calls in October, not only counter-price calls in January.
- Negotiated prices on 15 more drugs take effect January 1, 2027. Some patients will see a January bill go down. Say so; it is the rare good news in this envelope.

IF THE PLAN ENDED: WHEN THE NEW ONE STARTS

ENROLLMENT REQUEST RECEIVED	COVERAGE BEGINS
December 8 – 31	January 1
Any day in January	February 1
Any day in February	March 1

THE LITE VERSION AND THE FULL GUIDE

YOU ALREADY HAVE, FREE

The whole season, start to finish

The ending-or-changing question

The 63 day Medigap window and the December 8 calendar

The November prior authorization list

What to write down in December

THE GUIDE ADDS

Front desk scripts, word for word

Four patient emails with text versions

The one page handout, brandable

The social captions and the tracker

New for 2027: the physician section and opt-out calendar

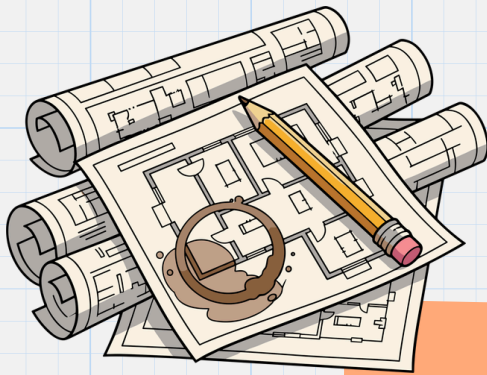
ALREADY OWN IT?

The 2027 update is free. Bought before October 2026 and it has not reached your inbox? Email hello@mydpcstory.com. Just send us your proof of purchase, no form.

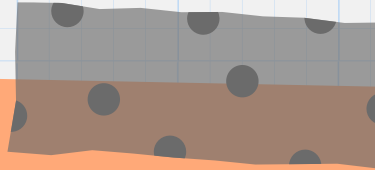
THE FULL GUIDE [PAYHIP.COM/MYDPCSTORY](https://payhip.com/mydpcstory)

SOURCES: AS OF OCTOBER 12, 2026. PART D DEDUCTIBLE AND OUT-OF-POCKET CAP: CMS, CY 2027 RATE ANNOUNCEMENT, APRIL 6, 2026. ATTACHMENT V, TABLES V-2 AND V-6. PART D BASE PREMIUM AND THE END OF THE PREMIUM STABILIZATION DEMONSTRATION: CMS, ANNUAL RELEASE OF PART D NATIONAL AVERAGE MONTHLY BID AMOUNT, JULY 28, 2026. PLAN COUNTS: CMS PRESS RELEASE, SEPTEMBER 28, 2026. LOWEST STANDALONE PART D PREMIUM: CMS 2027 MEDICARE ADVANTAGE AND PART D LANDSCAPE, STATE-BY-STATE FACT SHEETS. INSULIN CAP AND THE 15 NEGOTIATED DRUGS: CMS.GOV, MEDICARE DRUG PRICE NEGOTIATION PROGRAM, DECEMBER 8 SPECIAL ENROLLMENT PERIOD AND EFFECTIVE DATES: CMS MEDICARE ADVANTAGE AND PART D ENROLLMENT AND DISENROLLMENT GUIDANCE, §30.6.10(A). MEDIGAP GUARANTEED-ISSUE RIGHTS: MEDICARE.GOV AND CMS, CHOOSING A MEDIGAP POLICY (PUB. 0270).

DESIGNING AN OPEN ENROLLMENT SEASON



SIX TOUCHPOINTS ACROSS FIVE MONTHS. THE TRACKER THAT HOLDS THEM TOGETHER. AND WHAT THE WHOLE THING COSTS A TWO-PHYSICIAN RURAL PRACTICE. THIS IS THE ONE WE ARE RUNNING RIGHT NOW AT BIG TREES MD. INCLUDING THE PARTS WE GOT WRONG LAST YEAR. IT IS THE MEDICARE & MEDICARE ADVANTAGE SURVIVAL GUIDE. LITE. THE FULL ONE IS AT [PAYHIP.COM/MYDPCSTORY](https://payhip.com/mydpcstory).



THE SIX TOUCHPOINTS. (NOT A CAMPAIGN)

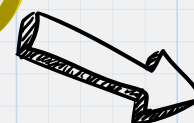
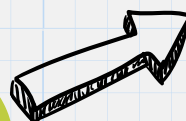
Every fall I hear from physicians that open enrollment is the season memberships lapse. Not because patients are unhappy. Because patients hear a new plan is cheaper, nobody explained how the membership fits, and cancellations land in January without having a conversation attached to it.

The instinct is to fix that with a campaign. Don't. A campaign is something you have to find time for, and in a practice our size that means it happens in a good year and does not happen in a hard one.

What works is smaller and a lot more boring. Six touchpoints across five months. Each one short. Each one stuck onto something the practice already does. Two emails and a text in the fall, one question asked at the front desk, one list built in November, one week of cleanup in January.

We are two physicians in Arnold, in a county that has two independent practices left in it. There is no marketing department here. There is a tracker, a folder of saved messages, and the discipline to ask one question in October. That is the whole system. I am going to walk you through it in the order it happens, including the part last year where we told a group of patients something that was just wrong.

One thing before the calendar, because without it none of the rest holds: decide who owns the season. Not the physician. Ours is front desk owned with a physician backstop, because every step below is a question, an upload, or a list. None of it is a clinical decision. If nobody owns it, it belongs to whoever is least busy that Tuesday, which is another way of saying nobody owns it.



SEP

BUILD THE LIST

One afternoon, once a year. Everything after this is maintenance.

- **Pull the panel. Everyone 64 and over, plus anyone younger on Medicare through disability or end stage renal disease.** Do not trust the insurance field in the chart to tell you who is on Medicare. In most EHRs that field is whatever somebody typed at intake in 2023. Age plus a manual sweep is slower and it is right.
- **Confirm Part B, specifically.** "I'm on Medicare" is the beginning of the question, not the answer. Part A is the hospital. Part B is outpatient, and Part B is the only part that changes what we do. A patient with Part A alone who is still on an employer plan is a different conversation. Sometimes it is a penalty conversation.
- **Flag the ones who get hurt if this goes wrong.** Five or more medications. Insulin, biologics, specialty drugs. Anyone who started a new Advantage plan last year. Anyone with a heavy prior authorization history. And the one nobody thinks to flag, anyone on COBRA or still contributing to an HSA between 64 and 68.
- **Start the tracker and save the messages.** The tracker is one spreadsheet with a row for every Medicare patient. Any spreadsheet will do, and the one we use comes built with the guide. The messages are the emails and texts you will send in October and December, written once now so nobody is drafting them in the middle of a busy week.
- **Put State Health Insurance Assistance Program (SHIP) at the desk.** The phone number and the Plan Finder link, printed, taped where the person answering the phone can see them. Not in a shared drive. *Taped.* Then wait. Plans have to mail the Annual Notice of Change (ANOC) by the end of September. *Those envelopes are the starting gun.*

OCT

ASK THE QUESTION

This is the month the season really is on fire. You'll likely be asking this one a bunch.

At the front desk, on every Medicare call and every check-in: Did your letter say the plan ends, or changes?

That question is new this year, and it is the most valuable nine words your staff will say. A plan that is changing sends an Annual Notice of Change, and the ordinary October 15 to December 7 window applies. A plan that is ending hands the patient a guaranteed-issue right to Medigap with no medical underwriting, and a window that runs past December 7. Different letter. Different clock. Different referral, the same day. The piece before this one is the long version of why.

Here is an example of the ask that follows: upload the letter and the current medication list to the portal. Photos are fine. Phone photos of a crumpled letter are fine. We are not grading penmanship.

Around October 15: the "Open Enrollment is here" email to the whole Medicare list, and the short text to anyone who does not open email. Both already written. Both already saved.

The slot: a 15-minute coverage check on the schedule, telehealth allowed. It is not a clinical visit. It is somebody sitting with the patient, looking at what came in the mail, and deciding whether this is a SHIP call or a nothing to see here.

One boundary, and say it out loud every time. We do not pick the plan. We notice the letter, we get it uploaded, we hand it to SHIP. That is the job.

THESE 15
MINUTES
ARE THE
THINGS
PATIENTS
TELL THEIR
FRIENDS
ABOUT!





CHECK THE THINGS THAT BREAK IN JANUARY

NOVEMBER DECIDES WHAT YOUR JANUARY LOOKS LIKE.

The prior authorization list. Approvals do not travel to a new plan. Every biologic, CGM, pump supply, specialty drug and high tier inhaler that took four months and two appeals to approve goes back to zero on January 1 for anyone who changes plans. Pull that list now. Most EHRs do not store prior auth as a field you can search on, because that fact lives in a fax or a payer portal or somebody's note. So pull by medication class and accept that the list comes back a little long.

New this year, we charge for it. We raised prices practice wide for the first time in five years, and prior authorization came out of the membership in the same move. Here is how it reads in our agreement now. *We no longer handle prior authorizations as part of the membership.* Patients get a guide for calling their insurance company and doing it themselves. If a patient wants us to file it, that is a minimum of about two hours of staff time and a \$150 processing fee.

It is the argument the \$150 Rule makes in the front of this issue. The fixed fee pays for the care. The things that are not the care get priced on their own. Prior auth is not primary care, we did not invent the work, and insurers are the reason it exists. If you are thinking about the same change, the enrollment season is the reason to decide before January rather than during it.

Where that landed us: over the cap, on purpose. Adults 42 to 64 are \$135 a month. Adults 65 and over are \$185. That second number is above the \$150 line in the new HSA rule, and we went there knowing it.

NONE OF THAT IS A PLAN RECOMMENDATION. WE FLAG IT AND WE HAND IT OFF.

Read the \$150 Rule piece in the front of this issue and you will see why it bothered me less than you would expect. Above the cap a practice is not in violation of anything. It is back in the gray area the whole community lived in for a decade, and the tax position belongs to the patient and her accountant, not to us, unless we promise something in our own copy.

For the 65 and over tier it is close to moot. Take Social Security at 65 and Part A enrolls you automatically, and any part of Medicare ends new HSA contributions, though she can still spend what is already in there on the membership. The cap is a live question for the people not on Medicare yet, which is the tier sitting under it.

What being over the cap changes is the words on your website. Not "HSA eligible." "We accept HSA cards." The one-page checklist in the front of this issue is the one we ran on ourselves before we raised the price.



THE NETWORK CHECK.

A new plan means a new hospital list, new specialists, a new imaging center, sometimes a different preferred pharmacy. For anyone who is switching, confirm the two or three places their care actually goes.



THE NON-RENEWAL REFERRALS

Anyone whose plan is ending has a 63-day guaranteed-issue window that is already running, so those patients go to SHIP in November. This is the one step in the season with a door that closes.

NOV

THE SEPTEMBER FLAGS YOU CHECK NOW.

Give the COBRA and HSA patients between 64 and 68 a benefits check now. COBRA does not count as active employer coverage, and missing the Part B window costs them ten percent of the premium for every year they could have had it, permanently.

If a patient is still putting money into an HSA, Part A can be backdated six months, so contributions have to stop six months before the effective date.

DEC

SEND TWO MESSAGES, NOT ONE

December 1 is your deadline, not your patients'. To be opted out of Medicare on January 1, 2027, your affidavit has to reach the Medicare contractor by about December 1, three weeks before Christmas, when no physician is thinking about paperwork. If you are opting out, the calendar is elsewhere in this issue. If you are not, skip to the next part.

December 5 to 7 is the last reminder, and it goes out in two versions.

To most of the list: today is the final day to change an Advantage or Part D plan for 2027. Upload the letter and the medication list if you have not, and call us if you are unsure.

To the non-renewal patients: your plan is ending, so December 7 is not your deadline. Your special enrollment period runs to the end of February, and if you have not talked to SHIP about a Medigap policy, consider doing it this week.

Send one email instead of two and the non-renewal patients get the wrong date. We almost did that last year, which is why the tracker has a column for it.

Then write down what happened, while it is fresh. Encounter tag, ANOC on file or not, meds reviewed, pharmacy confirmed, prior auth list built, private contract on file if you are opted out. Do it in December, because January is pharmacy calls and denied referrals, and you will not have time then to work out who you already talked to.



THE LANDING

First week of January, work the list. Everyone who changed plans and takes something that needed approval is starting over, with a new reviewer who has never seen the chart. What happens next depends on how your practice is built. If you file prior authorizations, file them from the November list before the phone rings. From a list it takes a morning. From inbound calls it takes six weeks, and it costs you the patient's confidence that the membership is worth what she pays for it. We do not file them as part of the membership, so for us the list turns into December phone calls instead. Either way she should hear it from you before she hears it from the pharmacy.

January 5 to 15, the pharmacy email. Prices look higher, and most of the time it is one of five fixable things. Not a preferred pharmacy. A 30 day fill that should be 90. A deductible that reset. A tier change or a new prior auth. Or a patient who should be on the Medicare Prescription Payment Plan and spreading the cost across the year. Tell them to send a photo of the receipt and the plan card and message you the drug name.

Ask one thing before any of that troubleshooting. Has she applied for Extra Help? For a patient at the edge, the low income subsidy moves more money than every pharmacy trick combined, and nobody asks.

January 1 to March 31, the Advantage window. A patient already in an Advantage plan gets one change in here. Switching to a different Advantage plan is straightforward. Going back to Original Medicare is not, unless she has a guaranteed-issue right, and the patient whose old plan was non-renewed does, through that same window. Everyone else is looking at underwriting. We ask patients to call us before they move, and then we point them to SHIP.

Late March, close the loop. Twenty minutes. What came in, what we missed, what we will ask differently in September. Write it down while it still stings.



WHAT WE GOT WRONG AT BIG TREES MD

I would rather hand you our mistakes than a clean version of a system nobody runs cleanly.

We waited for patients to bring us the letter. They do not. It goes in the pile with the handbook and the glossy marketing, and a patient who has had the same plan for nine years has no reason to think it is a medical matter. The season got better the year we started asking instead of waiting.

We treated "on Medicare" as one category. It is at least three: Part A only and still working. Original Medicare with a supplement, and an Advantage plan with a network and prior authorizations. We had people in the Medicare column who were not on Part B at all, and we gave them advice built for somebody else.

We built the whole thing around pharmacy sticker shock, because that is what generates a phone call in January. The other risk, a plan disappearing and a Medigap door closing with nobody noticing, generates no call at all. That is exactly why it has to be on a checklist.

We handed out a broker's name before we handed out SHIP. The broker was good. The order was wrong, and the order is what patients remember.

I did not know I had been enrolled in Medicare since residency. I found out while filing my own opt-out affidavit. If that is true of the person writing the guide, assume it is true of some of your panel.



IF YOU ARE READING THIS IN MID-OCTOBER WITH NOTHING BUILT...YET

You have not missed it! You have missed September, which was the easy month. Here is the version that fits in one week.

- ✓ 1. **Today.** Tape the SHIP number and the Plan Finder link at the front desk. Thirty seconds, and it is the piece everything else hands off to.
- ✓ 2. **Today.** Give your front desk the nine words: Did your letter say the plan ends, or changes? They do not need to know what the answer means. They need to write it down and tell you.
- ✓ 3. **This week.** Pull a list of everyone 64 and over. Not a perfect list. A list.
- ✓ 4. **This week.** Send one email: open enrollment is here, upload your plan letter and medication list, call us if anything looks off. That is the whole email. Add your clinic name and send it.
- ✓ 5. **By the end of the month.** Work only the flagged patients: insulin, biologics, specialty drugs, a new Advantage plan last year, or a letter that says the plan is ending. That is a small number of people and most of the risk.
- ✓ 6. **November.** Build the prior-authorization list. If you do nothing else from this article, do step 2 and this one.

That is a season. It is not the polished version and it will still catch most of what would otherwise land on you in January. The polished version is next year's problem. Next year it starts in September, because in March you will have written down what went wrong.

THE
MEDICARE &
MEDICARE
ADVANTAGE
SURVIVAL
GUIDE IS
ALREADY
WRITTEN



Every touchpoint on this map is a specific set of words going to a specific patient. Nine words at the front desk. One email the week the letters land, with a text version for the patients who do not read email. An answer ready for whoever picks up when a patient calls to ask whether they should drop Part B.

A tracker row for each Medicare patient tells you who still needs which one. This map is the season itself, and it is free, because a season nobody prepared for is bad for every practice in this movement and not just the ones who buy things from us.

What the **Medicare & Medicare Advantage Survival Guide** adds is all of it already written: the front desk scripts word for word including the calls you do not expect, the four patient emails each with a short and an ultra short text version ready to send, the reply for the patient who wants you to tell them which plan to pick, the one-page handout on how DPC works alongside Medicare, the social captions, the tracker already built with its dropdowns, and new for 2027 a physician section carrying the opt-out calendar. You can run the season off this page. The guide is so that nobody at your practice spends October writing it.

Find the full guide:
payhip.com/mydpcstory



Already own it? If you bought the guide prior to October 2026 and the 2027 version has not reached your inbox, email hello@mydpcstory.com and we will send it. Just send us your proof of purchase, no form. Updates are free for as long as we keep making them.

And if your season this year is only the nine words at the front desk, *that* is still a season. Start there!

WHO



OWNS

YOUR CHARTS

READ IT LIKE A NON- COMPETE

Maryal Concepcion, MD FAAFP

READING TIME - 7 MIN
EDUCATIONAL, NOT LEGAL ADVICE
WRITTEN WHILE SWITCHING EHRs

Somebody taught all of us to find the non-compete in an employment contract. Nobody told us to do the same to the software agreement that decides where our patients' records live. I am leaving the EHR I opened with, and it was not the workflow. It was the terms.

The Battle of the EHRs returns. Voting opens January 4, 2027 and runs through April 30. Ten rating labels, unchanged from 2025, so the results compare across both years. One ballot per physician, by newsletter only. Results in the Summer 2027 issue.

1 HOW YOU AGREE

Using the software can count as signing for it.

Some agreements treat continued use as acceptance, not just a signature. That can arrive as a screen you have to clear before you reach the chart. If the only options are agree or stop working, nothing was negotiated and if it lands on a clinic day, nothing was read either. **Ask: how will I be told about new terms, how long do I get, and what happens if I decline?**

2 WHAT CAN CHANGE

Not everything in the contract needs your signature to move.

Look for the company's right to amend the agreement, the policies, or the prices, and for when a change takes effect. Watch for documents brought in by reference rather than printed in front of you; one that lives at a web address can be revised on its own. **Ask: which documents can change without my signature, and when do changes take hold?**

3 THE DATA LICENSE

The non-compete of software contracts. Almost nobody reads it.

You will usually grant a license to what you put in, and the definition can be broad: notes, messages, attachments, templates, anything the system records or generates. The question is not whether they may use it to run the service for you. It is whether they may also use it to build their products. **Ask: what may my data be used for beyond operating the software, and does that end when I leave?**

4 WHAT YOU PROMISE

About your patients, usually without knowing it.

The companion to the data license. Agreements often have you warrant that you already obtained every permission the license needs. The duty lands on the physician, who did not write the clause and may never have been told it is there. **Ask: what am I promising about my patients, and what should I have told them?**

5 WHO OWNS THE REST

Pooled data, usage data, and the ideas you hand over.

Anonymized or pooled data, technical and usage data, and suggestions you make are commonly owned by the company and may be used commercially. Check which of those outlive your contract, because some are written to. A workflow fix you propose at 10 PM can become their property, for good. **Ask: who owns the data derived from my practice, and what survives my leaving?**



6 SOMEBODY ELSE'S RULES

Duties that arrive from the networks you connect to.

Your agreement can carry requirements set by the networks the software plugs into: prescribing, labs, payments. The most common is screening: a clause making you pay to run criminal background checks on anyone handling patient information, repeat it when standards change, and certify in writing that you did.

Ask: which outside parties impose duties on me here, what do they cost, and what am I certifying?

7 AUDITS

And who pays for them.

Look for the company's right to audit how you use the system, on what notice, and who bears the cost. A clause that makes you reimburse an audit that finds a problem creates an incentive you are funding. **Ask: what can they audit, how often, and who pays?**

8 WHAT YOU INDEMNIFY

Their limit is written down. Yours may not be.

The cap on the company's liability is usually spelled out plainly. Your obligation to defend them often is not limited at all, and can be written broadly enough to reach claims arising from what they did with your data.

Ask: is my indemnity capped, and what does it cover?

9 CHANGE OF CONTROL

Yours, not just theirs.

Nearly every agreement lets the company hand the contract to a buyer freely. Check whether it runs both ways. Some treat a change in who controls your practice, like adding an owner, selling, restructuring, as something needing the company's permission, and give them the right to end the contract when it happens. If you intend to bring on a partner one day, find that paragraph now. **Ask: what happens to this contract if I take on a partner or sell?**

10 SAYING WHAT YOU THINK

Some agreements restrict it.

Some agreements restrict using the product to compare it against others, or publishing any evaluation of it without permission. If that becomes normal, physicians comparing notes about their own software in public becomes a contract question. **Ask: am I restricted from describing my experience with this product?**

11 HOW DO I LEAVE

Format, fee, notice period.

The question is not "can I export my data." The answer is always yes. What format, what fee, how long the export stays available after you go, and whether the notice period is time you keep paying for a system you have already left. My husband is the one who pushed me on this, and I am grateful. **Ask: what is the window, what is the format, and what does it cost?**

THE BIGGEST ONE IS NOT A CLAUSE

Who owns the company, who advises it, and where they have been before. None of it is written in the agreement, and all of it decides how the agreement gets used.

Every clause on the two pages before this one is a permission. Whether a company ever uses a permission depends on who is running it and who they answer to. The same amendment clause can sit unused in a founder-run company for a decade and be used the month after a sale. The export fee that was waived for years can be charged in

full once the people who waived it are gone. So before you read the agreement, read the company. It takes about an hour, almost all of it is public, and it is the part of this exercise a lawyer cannot do for you, because the question is not what the words allow. It is what these particular people are likely to do with them.

12 WHO OWNS IT

Private equity, venture capital, or the people whose names are on the door.

Find the funding. A company backed by private equity or venture capital has investors who need a return on a schedule, and the ways to get one out of a software company are to raise prices, use the data, or sell the company. None of those is wrong. All of them are permissions you have already granted somewhere in the pages before this one. **Ask: who funds this company, what do they need from it, and by when?**

13 WHO ADVISES IT

The board and the advisory roster are usually published.

Look for physicians on the board or the advisory list who run practices like yours, as opposed to operators and investors only. A company whose advisors have never taken a call from a patient will make decisions about your charts the way a software company does, because that is what it is. **Ask: who on the board or advisory list has run a practice, and are they still there?**

14 WHERE THEY HAVE BEEN

Founders have histories. Read them before you sign.

A founder who has started and sold several companies is good at starting and selling companies. That is a skill, and it tells you what the plan is. Look up the previous ones: what they were, how long they lasted, how they ended, and what happened to the customers at the end. A professional profile and a few press releases are enough. **Ask: what did the founders build before this, and what became of the customers?**

15 WHAT HAPPENED LAST TIME

Track records are public, and the DPC forums are blunt.

Price changes, outages, breaches, acquisitions, pivots and lawsuits are all searchable. So is how the company behaved when a customer left: how long the export took, what it cost, and whether anyone was still answering the phone. Consider asking two practices that left in the last year, not two that stayed. **Ask: how did this company treat the last people who left it?**

Also worth considering: updates you cannot decline, usage ceilings that trigger extra charges, who eats a billing error and on what deadline, and what the word “support” is actually defined to mean.

I am not a lawyer, and none of this has to land on you alone. There are attorneys who review software agreements for small practices, and having one read yours before you sign is something worth considering. The hour on the company is yours to do first.

WHAT YOU MISSED AT THE ILLINOIS DPC SUMMIT



At nine o'clock on the first morning, nobody was standing at a podium. Physicians sat at six tables arguing over what is actually true about practicing Direct Primary Care in Illinois, with a speaker at every table arguing back. By quarter to ten, everyone in the room had talked, laughed, been wrong about something, and found out where the answers live. Nobody had seen a slide, and nobody would all weekend. That is the Illinois DPC Summit, held October 2 and 3 at the NIU Naperville Conference Center, hosted by Dr. Clodagh Ryan and Paula Tomczyk of Cara Direct Care and produced by My DPC Story. The room is capped at forty seats on purpose. Here is what you missed.



THE ROOM

TEN SPEAKERS, AND NOT ONE OF THEM ON A STAGE.

The speakers did not present. They sat down at the tables and asked about your practice instead of describing their own. Over two days they moved from table to table while attendees stayed put, so nobody spent the weekend waiting for a turn at a microphone. There were no slides in any room, which sounds like a small thing until you have spent a conference in the dark taking notes you will never read again. What replaced them is what physicians say they want from every meeting and rarely get: colleagues who have already done it, sitting close enough to answer the actual question.

"This was so great! Loved the interaction and networking format. Will definitely come again." — attendee reflection page

NO LAW

ILLINOIS HAS NO DIRECT PRIMARY CARE STATUTE. THE LEGAL QUESTIONS CAME UP BOTH DAYS.

Illinois has no law that defines Direct Primary Care. That stays abstract until you are the one wording your website, or answering a patient who wants to know if this is insurance. Legal guardrails came up both days, in sessions and over lunch. In a state with a statute there is something to point at. Here there isn't, so physicians draw their own lines and hope they drew them right. Sitting with other Illinois physicians, hearing where they drew theirs and what worried them while they did it, is not something a lecture gives you.

"Phil's (Dr. Eskew) session going over precedent clarified many concerns from the day prior."
— asked which single session was worth the trip



ONE ON ONE SPACE

A CLOSED DOOR, TEN MINUTES, AND THE QUESTION YOU WOULD NEVER ASK IN FRONT OF A ROOM.

Some questions do not get asked in a crowd. What should I pay myself? Does this model hold for someone like me? Is my pitch any good, or are people being kind? So three small rooms ran the way a DPC visit runs: private, unhurried, one person's real question. Attendees met with a speaker over breakfast and lunch. Some brought a pitch and heard which line to keep and which to cut. Others brought their numbers and had them looked at honestly by a physician who has run the books. Nothing said in those rooms left them.

"The small group sessions. One on one." — asked which single session was worth the trip

THE NUMBERS

REAL BOOKS, OPENED IN FRONT OF EVERYBODY.

Physicians in practice said out loud what they pay themselves, what staff actually costs, and what blindsided them in year two. Then the whole room built an Illinois cash-rate sheet together: what people really pay for a metabolic panel, an MRI, their top ten medications. Speakers shared pricing and by the end of Saturday, everyone had numbers that are close to impossible to find anywhere else, alongside a coverage directory of colleagues they met on Friday and can call on Monday. Neither page exists outside the people who were in that room.

*"An actual practical list on what I need to do and how to do it."
— a physician starting from zero patients, on what she was leaving with*



THE EMPLOYER

SPEAKERS PLAYED THE EMPLOYERS. THEN THE ROOM
PITCHED ONE TOGETHER.

Most of the physicians there wanted to work with local employers and had never asked one. So speakers took the employer's chair and stayed in character. First they showed what a pitch actually sounds like, which beats being told what to say. Then the room pitched an employer as a group, with the employer pushing back the way a real one does. You find out quickly which parts of your pitch land and which ones make a business owner go quiet. Nobody had to do it alone the first time.

THE PRACTICE NOBODY BUILT

THE ROOM TOOK A PRACTICE NONE OF THEM OWNED AND TRIED TO KEEP IT
ALIVE FOR THREE YEARS.

Everybody started with the same practice. Not anyone's real one, so nobody had to defend their own choices. Then the room ran it forward three years and made the calls together as the scenarios landed, including the ones nobody plans for. People say what they actually think about pricing when the pricing isn't theirs. Physicians already in practice said what the same decision had cost them in real life. By the end the room had kept a practice alive for three years, which is three years of mistakes nobody has to make in their own clinic.

"The Business You Have Never Run." — asked which single session was worth the trip



WHO WAS THERE

Most of the room was planning to open in the next six to eighteen months. Some were a few months in and hungry for members. A handful had been running practices for years and were deciding whether to grow or cap.

They were together on purpose, because the physician two years ahead of you remembers exactly what you are about to face. Several came from outside Illinois, from Iowa and Virginia and Florida, and found that almost none of the weekend was Illinois-only. The agreement, the numbers, the first hundred members and the first

employer look much the same wherever you practice.

On Friday morning everyone wrote down how confident they felt, on a scale of one to five. On Saturday afternoon they answered the same question on the same page, next to what they had written a day earlier. Of the eleven who turned in a page so far, ten had moved up, and the average went from about 2.5 to about 3.9. The one person who moved down explained why in the margin: she had found things she needed to change.

"I met many, and we all agree that going into DPC is a decision often not regretted." — physician attendee



**"YES!
DEFINITELY,
SIGN ME UP!
I'M BRINGING
MY
HUSBAND!"**

— asked whether she would come back next year

JOIN US NEXT OCTOBER

The Illinois DPC Summit comes back the first weekend of October 2027, in Chicagoland, as three days instead of two. Seats are limited again and nearly a quarter of the tickets have already sold. The format only works when every person has a seat at a table, a turn to talk, and a speaker within reach.

If you have sat through good lectures and left still with the unfinished agreement, the unfinished workflow and the unanswered money question, bring them with you. You will leave with them done. And if you do not practice in Illinois, come anyway. Physician attendees flew in from Iowa, Virginia and Florida this year!

Your numbers, your first members, and the business nobody trained you to run are the same problems in every state.

Save your seat for the 2027 Illinois DPC Summit:
caradirectcare.com/summit

If next October is too long to wait, it does not have to be. We run other events through the year, in person and virtual, and they are all listed at mydpcstory.com/upcoming-events.

IL DPC SUMMIT Hosted by Dr. Clodagh Ryan and Paula Tomczyk, Cara Direct Care · Produced by My DPC Story



Lean Startup Business Plan (Example)

PROBLEM01	SOLUTION05
- List a frustration your target market has. - ACME Clinic is too hard to access because they have 3000 patients per doctor. - ACME Clinic has a non-physician model for care. Existing Alternatives - List a potential competitor or similar business and their offering. Wildfire Aesthetics has a trendier marketing approach that appeals to all demographics Front Porch Family Medicine has a "for students" community college agreement	- List how your business can solve a customer’s problem. - Offer innovative healthcare at a friendlier price. - Appeal to a larger and growing demographic who want a relationship with their doctor.
UNIQUE VALUE PROPOSITION02	KEY METRICS06
- Write about what makes your product (you ARE the product!) special so you can convince a stranger to become your customer. High-Level Concept - Provide a short, catchy, easy-to-remember description of your product	- List a metric by which you measure the success of your business. 10% profit increase by our third year - Increased customer retention rate at the end of each year
CUSTOMER SEGMENTS03	UNFAIR ADVANTAGE07
- List personas of the people that you expect to use your product. - Students - Professionals EARLY ADOPTERS - List specific characteristics of your early adopters. - Students who see having access by text as a break from the stress of having to make an appointment in person to review labs. - Professionals who appreciate cost-savings through transparent lab and imaging pricing.	- List what sets you apart from competitors. - All-In-One services. - New features that patients are looking for.
	CHANNELS - List the ways you plan to reach your audience. - Physical space - Social media
COST STRUCTURE04	REVENUE STREAMS08
What are the fixed and variable costs to launch your product or service? Consider the cost at each stage from setting up a website, hiring employees, production, marketing, and bringing them to patients.	How will you generate income? Show a pricing model of your product or service and include other revenue sources, such as sales and subscription fees.





Lean Startup Business Plan (Your Turn!)

PROBLEM01	SOLUTION05
UNIQUE VALUE PROPOSITION02	KEY METRICS06
CUSTOMER SEGMENTS03	UNFAIR ADVANTAGE07
	CHANNELS
COST STRUCTURE04	REVENUE STREAMS08

Find More Resources at mydpcstory.com



THE DPC DIRECTORY



GET LISTED TODAY

FIND WHAT YOU NEED FOR YOUR DPC JOURNEY

CONNECT
TODAY

**GET
LISTED!**

Who will you meet next?

Created by Maryal Concepcion, The DPC Directory is a place to connect with others in the DPC ecosystem. From finding help with marketing, business management consulting and more, the DPC Directory is a place to find help, offer your own services and build a better future together!



GET YOUR FREE LISTING TODAY!

[THEDPCDIRECTORY.COM](https://thepcdirectory.com)

BEFORE YOU PUT THIS DOWN



THE STORY CONTINUES WHERE YOU ARE



SCAN ME

Get your digital copy of this issue and all the previous issues of our magazine! Click on all the links, share articles with colleagues, and send the How to **Choose Your Healthcare** guide straight to your patients.
toolkit.mydpcstory.com

EXPLORING/
PLANNING

DPC Starter Guide
90-Day DPC Startup Checklist



NEWLY OPEN

First Year Dashboard



OPEN FOR YEARS

The Growth Audit



SEE YOU ON YOUR JOURNEY! - *Maryal*

MYDPCSTORY.COM