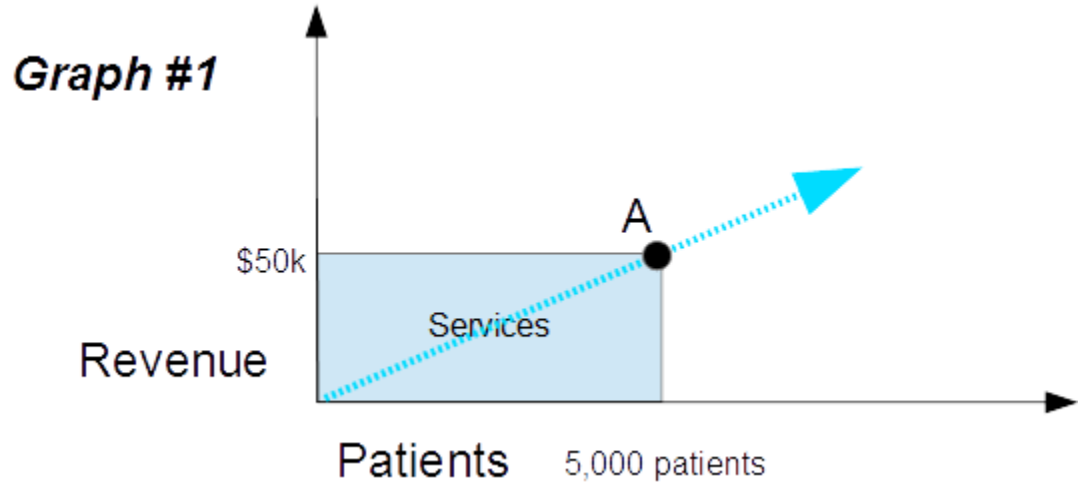
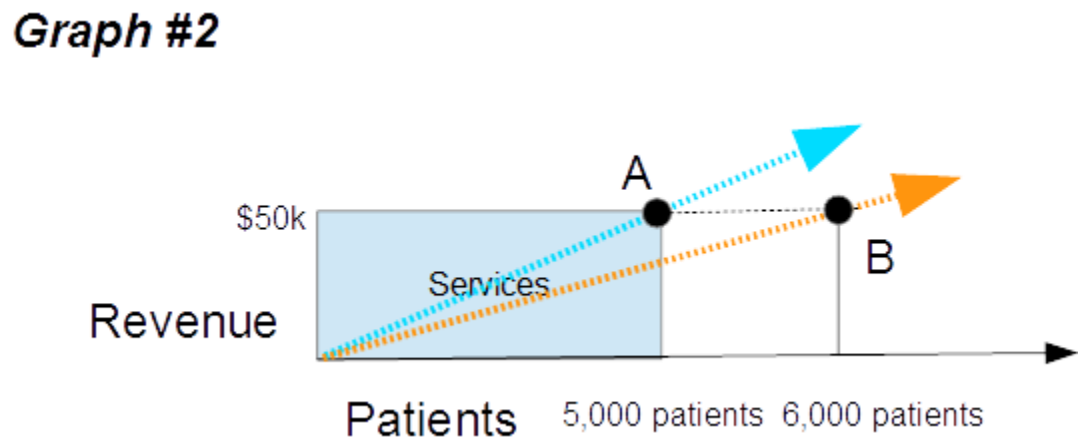
Medical Practice Model Economics Overview

A revenue graph illustrates the relationship between revenue and patient volume.



Graph #1 shows a mature traditional medical practice. A mature practice has a full schedule and has maximized goods and services. A mature practice has made all of the marginal improvements to increase revenue from goods and services.

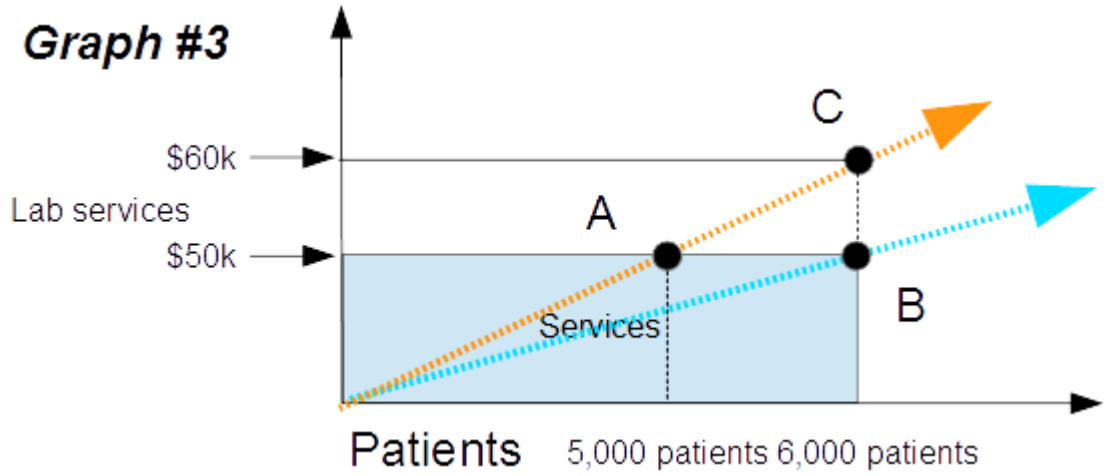
Point A shows that the mature practice has 5,000 active patients and generates $50k a month in revenue.



Graph #2 shows that increasing the number of patients from 5,000 to 6,000 does not increase revenue from $50k. Instead, the practice moves from point A to point B without an increase in revenue. This is because the practice has already made all of the marginal improvements, such as seeing more patients each day. Adding more active patients to a mature practice typically only adds to the waiting period to see a provider. Assuming that patients scheduled in the future would come in sooner if given the chance, the waiting period to see a provider represents excess demand. Excess demand is the first important concept in practice economics.

Adding patients to a mature practice does have two significant benefits. First, having excess demand protects against practice atrophy. If a practice had just become mature, for example, losing one active patient might mean that one appointment goes unfilled—and the practice loses revenue. If a practice has excess demand, however, losing one patient theoretically just shortens the waiting period by one appointment—and the practice maintains its revenue.

A second benefit to adding patients to a mature practice is that it improves the practice's ability to support goods and services. The additional 1,000 patients added to the practice in Graph #2, for instance, may allow the practice to add laboratory services that the practice could not financially support with 5,000 patients.



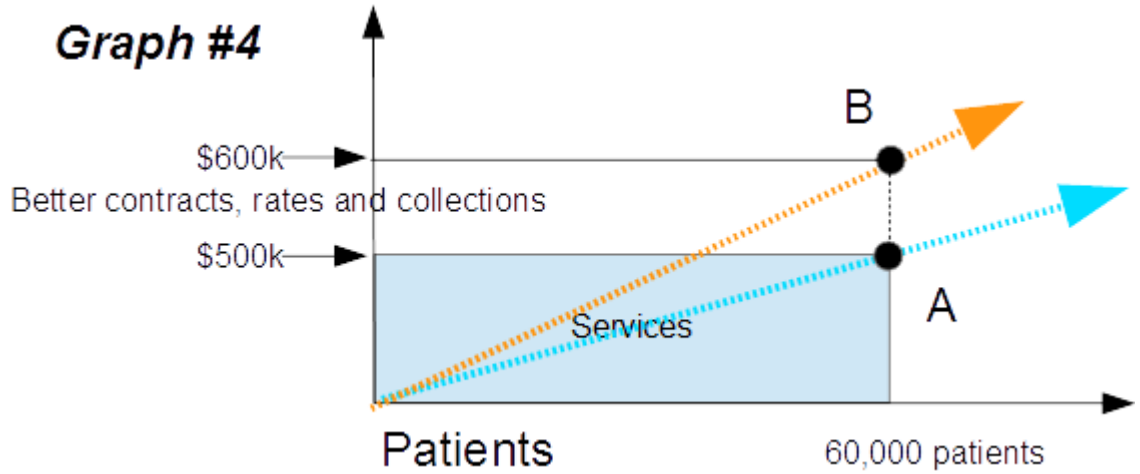
In Graph #3, revenue increases from point B to point C because the laboratory services generate an additional $10k in revenue.

For a mature practice, adding patients does not add revenue. In this case, revenue is increased by adding profitable goods and services. Patient volume is an underlying factor in growing revenue because increasing patient volume increases the potential market for every added good and service. Increased patient volume gives the practice greater patient steerage. Patient steerage is the second key concept in practice economics.

The practice model used so far has been a traditional practice. Almost all of the revenue in a traditional practice is reimbursed through insurance agreements. The historical growth cycle for traditional practices is for one physician to start a practice, reach maturity and then add another provider to address the excess demand.

Adding a second provider requires that the practice add more patients to again achieve maturity, (unless the excess demand exceeds the capacity created by adding the additional provider). As the practice adds more patients, it considers adding other services reimbursed by the insurance agreements, (laboratory, imaging, etc.), to increase revenue. This cycle evolves solo practices into group practices, group practices into multi-specialty practices and multi-specialty practices into medical centers.

As traditional practices become larger, their ability to influence factors related to their revenue increases. Larger practices can gain access to contracts that might be unavailable to small practices. Larger practices can also negotiate higher rates than smaller practices. Larger practices are also better able to manage the complex task of billing and collections. When large practices use their size in these ways, they are utilizing market leverage. Market leverage is the final key concept in practice economics.



Graph #4 shows a practice that leverages its size to gain access to better contracts, rates and collections. The increase in revenue from $500k to $600k, (remember—it is a group practice now), doesn't occur because the practice has added goods or services. Instead, this increase in revenue occurs because the practice has used its market leverage to influence insurance agreements and affect billing and collections efficiency.

The increased market leverage of large practices often comes at the expense of smaller practices. Insurance plans tend to offset the larger amounts paid to large practices by reducing the reimbursement paid to smaller practices, (or maintaining stagnant rates with smaller practices).

The competition from larger practices and the lack of market leverage are not the only difficulties facing small practices. Solo and small practices often face additional difficulties from limited resources such as:

Limited access to new patients.
Limited access to new providers.
Limited access to new services.
Limited capital to expand services, add providers and develop staff.
Limited administration to deal with government regulations, (HIPAA, Meaningful Use, OSHA, etc.).

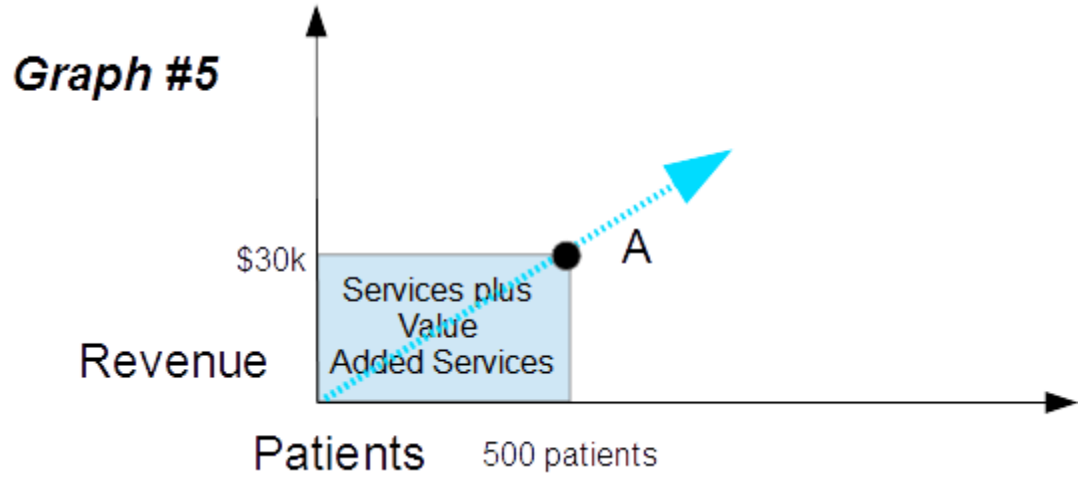
Alternatives to the Traditional Practice Model
In response to the difficulties of growing a traditional practice, other practice models have been developed. Most alternative practice models seek to establish agreements with patients. Two such alternative practice models are the direct payment model and the concierge model.

The direct payment model requires that patients pay the practice directly for services received. The direct payment may be per-visit or per-month. Direct payment models seldom participate with insurance. Instead, direct payment models often require patients pay a flat fee for services or membership.

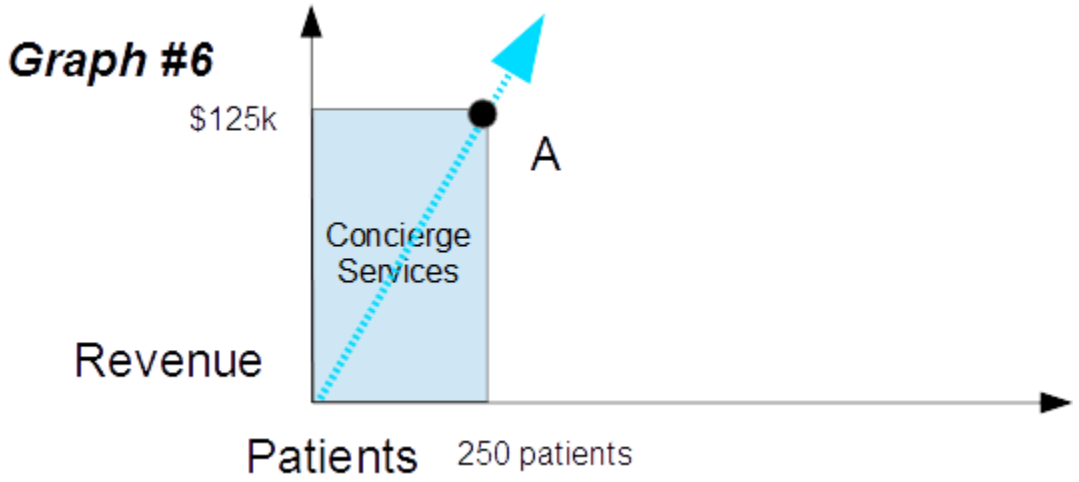
The concierge model utilizes a retainer-type fee that the patient is required to pay to be a patient. The concierge fee is in addition to fees for services provided. Concierge practices usually do not participate with insurance companies as in-network providers because insurance agreements typically do not allow physicians to charge additional fees. Concierge practices may facilitate patients using insurance by filing claims on their behalf.

The revenue graph for a direct payment model varies by how the direct payments are structured. For a direct payment practice that charges the patient directly for each visit and simply "cuts out" the insurance company, the revenue graph is the same for a traditional practice. This direct payment model is more focused on reducing costs related to participating with insurance and managing a smaller patient population than increasing revenue.

Direct payment models that build services into membership fees are essentially adding value-added services to the traditional services offered by a medical practice. Other than the addition of value-added services to traditional services, this direct payment model revenue graph is the same as a traditional practice, although the membership fee for the value added services may allow the practice to make more money on fewer patients, as shown in Graph #5.



Concierge practices are often developed by converting mature traditional practices to the concierge model. In a typical concierge practice conversion, only 20% of the patients from the traditional practice remain with the concierge practice. Patients of a concierge practice pay a concierge fee that can ranges anywhere from $1,500 to $15,000 annually.



Graph #6 shows a revenue chart for a concierge practice. A small number of patients, (250), pay a large concierge fee, (shown at $500 a month), to generate substantially more revenue than a traditional solo practice or direct payment practice could generate. A concierge practice would actually generate revenue in addition to the concierge fee, but the picture is clear that a concierge practice can generate substantially more revenue than a practice using the other two models.

Direct Payment and Concierge Models Summary
Both direct payment and concierge models offer immediate financial benefits compared to the traditional model. Direct payment and concierge models open revenue streams not present in the traditional model through the implementation of membership and concierge fees. As such, the revenue received from each visit in both of the alternative models tends to be much higher than the traditional model. Direct payment and concierge practices also have smaller patient populations, so overhead is less than a traditional practice.

Increased revenue and decreased cost result in the direct payment and concierge models being more viable than traditional models in the short term. Providers who practice in these models tend to be happier practicing medicine as a result of the immediate financial returns, a smaller, more easily managed patient base and an improvement in overall autonomy. Provider satisfaction is important, of course, because it is necessary for any practice model to be sustainable.

The long-term prognosis for direct payment and concierge models compared to the traditional model is not as favorable. First, the insurance companies have placed a premium on cost control. These cost controls have resulted in insurance companies removing the out-of-network cap previously offered by many non-HMO plans. Direct payment and concierge practices that do not participate with insurance plans expose patients to increased, uncapped out-of-network expenses.

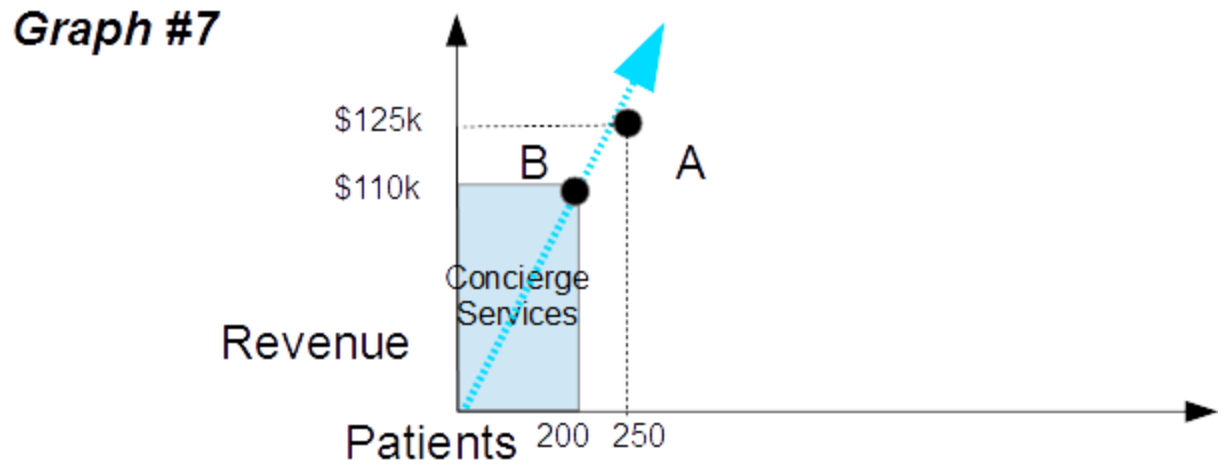
The potential types of expenses to insured patients utilizing out-of-network providers may also increase, as it is foreseeable that ANY services ordered or referred to by an out-of-network provider may not be covered. Insurance companies have focused on “skinny networks” that utilize a limited number of hospitals and providers. In further controlling costs, it is foreseeable that these skinny networks will become the gatekeepers of all services, including specialists, imaging, lab, home health, durable medical equipment, etc.

While some direct payment and concierge providers have been able to straddle the fence by not being in-network but still referring to services covered by insurance, the insurance companies may sever out-of-network providers from referring to any service covered by insurance. Patients who utilize providers who do not participate with their insurance plan would essentially be unable to realize any insurance benefit.

Another problem facing both direct payment and concierge models is that neither model supports excess demand very well. While patients are generally accepting of having to wait for an appointment in a traditional practice as a trade-off for using their insurance, patients are much less tolerant of waiting for appointments in direct payment and concierge clinics. Patients who have paid a membership or concierge fee want the access to providers that they believe their payment entitles them to receive.

Without excess demand, practice atrophy becomes a significant issue for direct payment and concierge practices. In a mature traditional practice, losing a couple of patients seldom affects revenue because of the excess demand. In direct payment and concierge practices, losing several patients frequently decreases revenue because there is often no excess demand.

Once direct payment and concierge practices lose patients, they must aggressively "backfill" the open patient slots with new patients to avoid a continued drop in revenue. Finding new patients can be a delicate tasks, however, as pursuing a marketing campaign entails getting a "just right" response. Otherwise, interested patients have to be turned away or put on a waiting list, which can create ill-will in the community and depress future patient enrollment.



Graph #7 shows that a concierge practice raising its $500 per-month concierge fee to $550 results in the loss of 50 patients. Even with the increased concierge fee, losing 50 patients and their fee causes a decrease in revenue of $15k a month as the practice moves from point A to point B.

Once direct payment and concierge practices are unable to successfully address practice atrophy or find it necessary to increase their revenue to match inflation, offer new services or better

compensate the provider, they risk entering a “death spiral” where the actions taken to add revenue actually hasten the demise of the practice.

Patients are attracted to practices, including these models, based on a variety of needs, including the onset of health issues, loss of insurance, financial hardship (direct payment model), financial windfall (concierge model), proximity to practice location and the availability of other providers. As each patient's various needs change over time and these alternative practice models face practice atrophy and changes in an ever-changing health care market, the benefits of the direct payment and concierge models may be negated.

While direct payment and concierge models provide the initial benefits of 1) improved viability due to increased revenue and/or lower costs and 2) increased sustainability due to provider satisfaction, the issue of excess demand and the cap on revenue inherent in both of these models can threaten long-term viability. In addition, as direct payment and concierge practices inherently limit the number of active patients, they lack the scalability of traditional practices.

Practice Models Comparison
The three practice models presented include:

1. The Traditional Practice Model
2. The Direct Payment Practice Model
3. The Concierge Practice Model

Each practice model can be implemented with its own variations. The distinction between the practice models isn't the products and services provided. The distinction between the practice models is the agreements that determine the payment for goods and services.

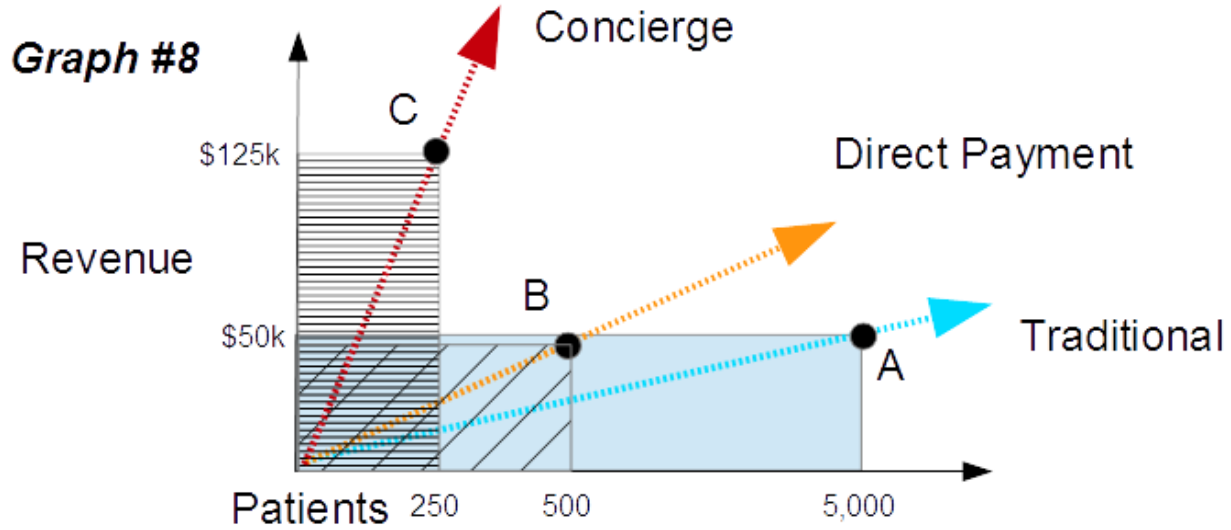
- Traditional practices contract with insurance companies to provide services to the insurance companies' plan members and are compensated per the terms of the insurance companies' provider agreements.
- Direct payment practices contract with patients to provide goods and services and are paid directly by patients for goods and services provided, (and/or the membership fee to access services).
- Concierge practices derive the majority of their revenue from concierge fees from patients for good and services. Concierge practices may or may not contract with insurance companies for good and services.

The strengths and weaknesses of each model have also been identified:

Model	Strengths	Weakness
Traditional	Participates with insurance	Low compensation
	Large patient base	Large group competition
	“Scalable” with excess demand	Suspect viability
Direct Payment	Achieves revenue w/ min costs	Excludes insurance
	Excludes insurance admin	Limited growth

	Smaller patient base	Sustainability is suspect
Concierge	Maximizes profits	Limits insurance
	Greatest physician autonomy	Limited growth
	Smaller patient base	Sustainability is suspect

The chart identifies three important criteria used for evaluating practices that have already been previously used but not stressed: viability, sustainability and scalability. These criteria are related to the key practice economic concepts of excess demand, patient steerage and market leverage. Comparing the practice models helps to identify the relationship between the key practice criteria and key economic concepts.



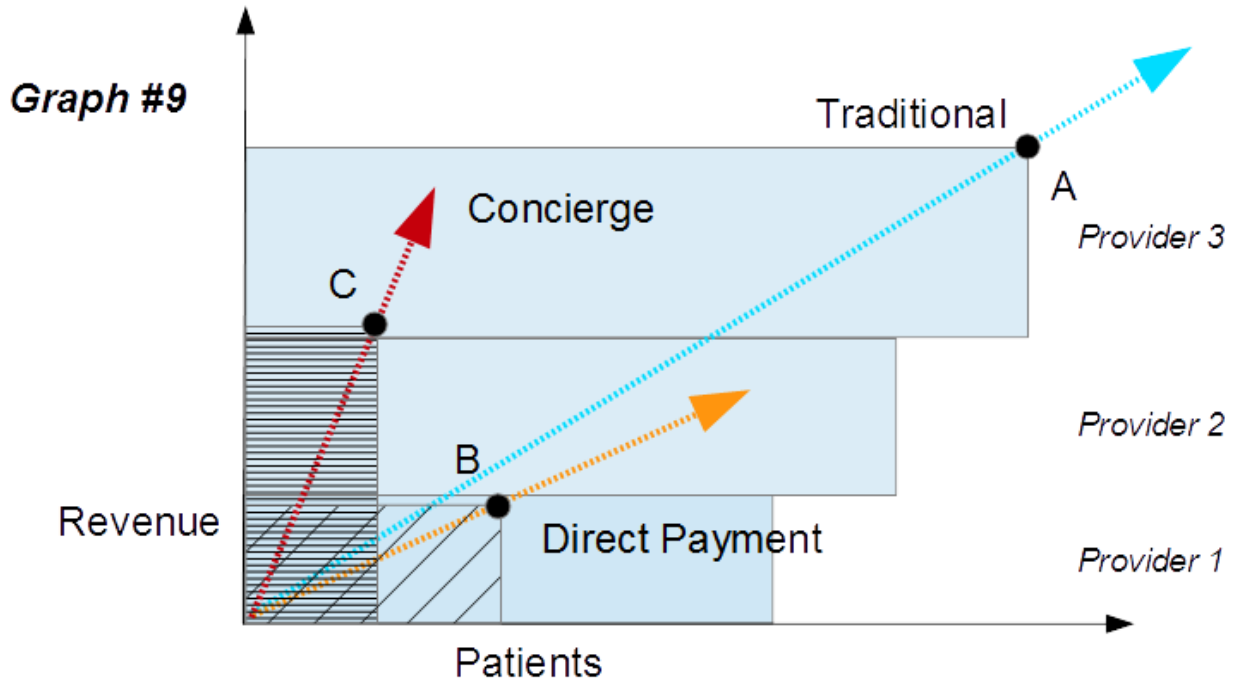
Graph #8 compares a normal solo practice of each practice model. The concierge practice has the fewest patients generating the most revenue. This reflects that concierge practices tend to be the most profitable due to concierge payments.

The direct payment practice has more patients that the concierge practice but less patient than the traditional practice. Direct payment practices tend to generate revenue consistent with traditional practices, but are often more viable due to cost savings from fewer staff, less space, and the absence of billing and collection costs.

The revenue graph for the traditional practice shows why traditional solo practices are so prone to failure. Traditional practices have the highest patient base and yet the lowest revenue. The large patient base, however, generates significant costs for traditional practices, including larger staff, more office space, added administration of dealing with insurance companies, and billing and collection costs.

The obvious issue is why any provider would want to invest their time, energy and efforts in building a traditional practice with its more patients, less revenue and bigger headaches.

The value of traditional practices is found in the weaknesses of direct payment and concierge models. Because neither practice model supports excess demand and faces limits on revenue, direct payment and concierge practices lack the scalability of traditional practices. The factors resulting in the increased short-term viability of direct payment and concierge practices also essentially ensure that revenues in these models will be stagnant once the practice matures.



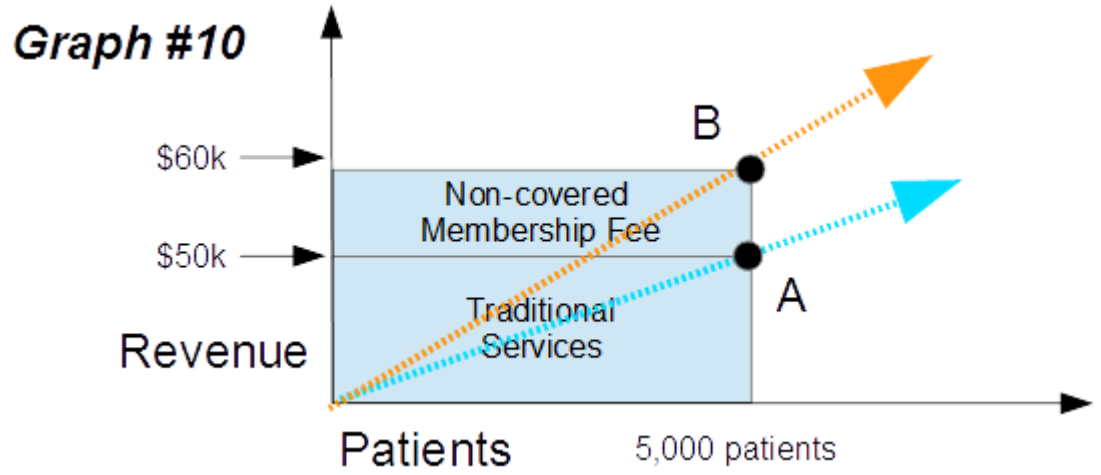
Traditional practices, however, are very scalable due to their excess demand, patient steerage and market leverage. Graph #9 shows a traditional practice adding providers, (as a result of excess demand). Each additional provider is represented by another blue rectangle. In this scenario, each additional provider allows the practice to add proportionally more revenue than the previous provider(s) as a result of steering patients to additional goods and services as well as leveraging the practice's increased size in the marketplace.

The ability of traditional practices to expand revenue exponentially means that traditional practices are scalable. While management companies have branded direct payment and concierge models, neither of these models have developed groups and multi-specialty practices because they lack the excess demand, patient steerage and market leverage necessary to grow. The scalability of traditional practices makes traditional practices more valuable long-term than direct payment and concierge practices and helps to off-set the viability issues of traditional solo and small group practices.

Hybrid Practice Models

With traditional practices difficult to build and direct payment and concierge practices hard to maintain, hybrid models have emerged that attempt to blend elements of the traditional, direct payment and concierge practices. One popular hybrid model is for a traditional practice to charge a fee for “non-covered services.” Because the patient is being charged for services not covered

by their insurance contract, providers implementing this fee have remained in-network with insurance plans.



Graph #10 shows a mature traditional practice that increases revenue by adding a non-covered membership fee. The membership fee is an element of the direct payment model, because patients pay the fee directly to the provider outside of an insurance agreement. The excess demand provides a buffer to the practice atrophy and price-increase dangers that challenge direct payment and concierge practices.

There is currently debate about what services are covered in insurance agreements and, therefore, what constitutes a non-covered benefit. For example, insurance agreements almost always require the contracting provider to provide after-hours coverage. A practice may interpret that clause to mean they could provide an answering service to refer patients to the emergency room. The practice could then assert that they could charge a membership fee for the non-covered benefit of having after-hours calls go instead to an on-call physician from the practice.

So long as the practice maintains a membership fee that is marginal to patients, patients will likely consider the practice a traditional practice and the practice will avoid the expectations that patients have for direct payment or concierge practices. The value of hybrid practice models is that they allow practices to improve traditional practice viability without sacrificing the scalability of traditional practices.

Summary

Medical practice economics show the importance of excess demand, patient steerage and market leverage. These factors make a hybrid model the model most likely to achieve viability, sustainability and scalability.