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AMERICA'S LEADING PRACTICE MANAGEMENT JOURNAL

Building a Cash Only Practice

David Albenberg, MD
Access Healthcare

Today's Objectives

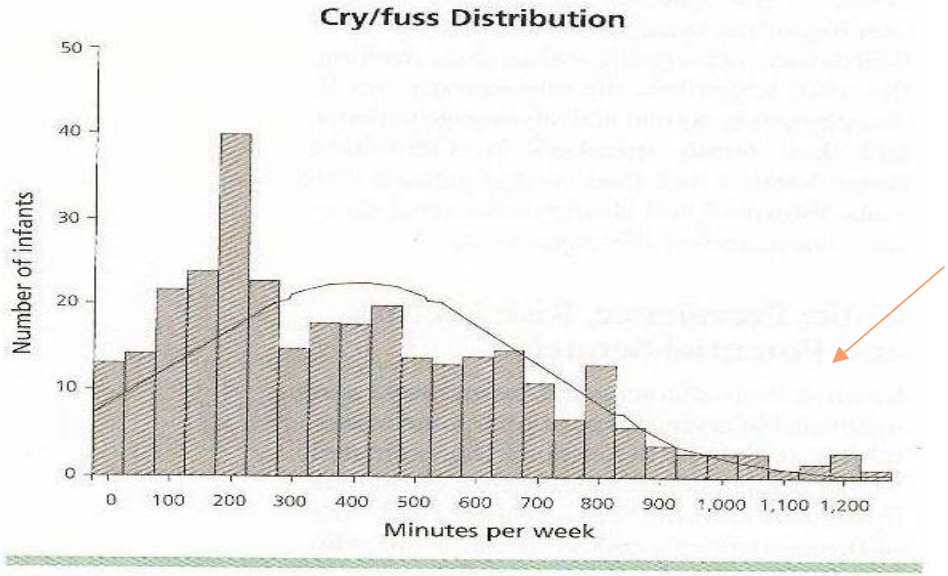
- Convey our experiences and the experiences of others transitioning to a cash-based practice
- Highlight the steps in transitioning to a cash-only practice
- Itemize successes and pitfalls along the way
- Outcomes – compare practice management metrics
- Demystify some current beliefs regarding the workings of a retainer-based practice
- Identify resources for transitioning your practice
- Allow ample time for discussion

Not Covered

- **Current state of traditional Primary Care**
- **Ethics of cash-based practices**
- **Step-by-step approach to setting up a practice**

Ground Rules

No Whining



You are here

FIGURE. Distribution of crying or fussing at three months of age in 320 infants. "Minutes per week" represents the total minutes of crying and fussing during the 12th week of life (mean = 400.5 minutes; standard deviation = 280.6 minutes).

Adapted with permission from Clifford TJ, Campbell MK, Speechley KN, Gorodzinsky F. Sequelae of infant colic. Evidence of transient infant distress and absence of lasting effects on maternal mental health. Arch Pediatr Adolesc Med 2002;156:1185.

2006 AMERICAN FAMILY PHYSICIAN www.aafp.org/afp

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Natural History of Your Future

- **Resentment**
- **Burnout**
- **Early Retirement**

Dear Dave,

Glad to see you're succeeding in the boutique practice business. I'm in solo practice, Carson City, NV. I see pts 5 days/week, 1/2 Sat each month, having about 15 patients I still do house calls on (mainly bed-ridden). However, the financial rewards have really not been there. My practice is about 50-60% Medicare. The overhead, even employing 2 people, is killing me. We grossed $250k last year, I took home $44k after taxes. So, I'm really considering calling it quits.

Dear Dave,

One of my colleagues who had 4000 active charts, went out of business last year, saw at least 25 pts/day, couldn't make ends meet. Another one had to sell his practice to an urgent care set-up to avoid going under. Another closed and went to work in Reno. No one is buying primary care practices anymore. When practices go under around here, the patients vanish, since all docs are busy. No new PCP's are moving into the area. Most internists don't earn $120k around here either. Not worth continuing as far as I'm concerned.

- **Ethics Question – How ethical is it for an overworked, burnt-out provider to spend 7 minutes with a patient in their time of need?**

Your Options

- **See more patients?**
- **Tweak the system?**
- **Go to work for the insurance companies?**
- **Retire?**
- **Academic medicine?**
- **Laser hair removal?**
- **Cash-only practice?**

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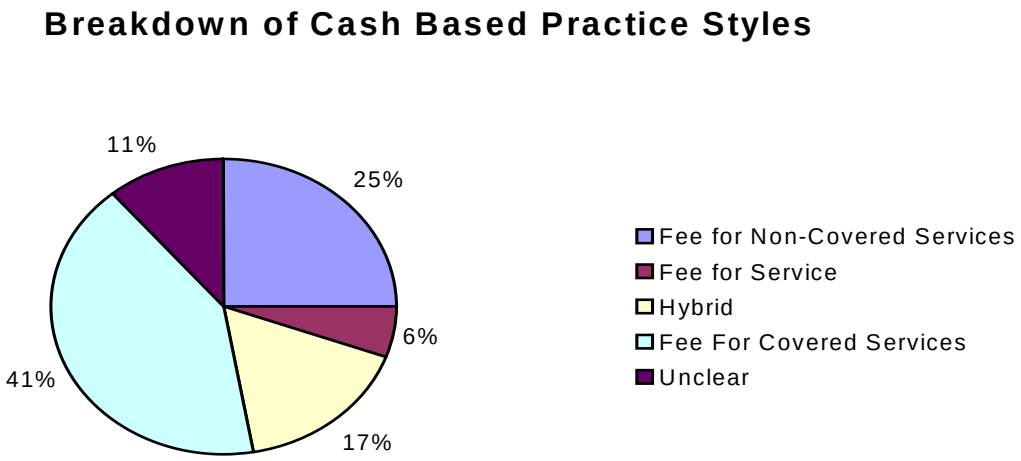
Cash-Only Practices
a misnomer?

Three models:

- Fee-for-Service
- Retainer-Based Practice
  - **Fee for Non-Covered Services** – AKA “Double Dippers”
  - **Fee for Covered Services** – Pure Retainer
- Hybrids



Survey of SIMPD Member Websites 08/06 www.SIMPD.org

The Cash Practice: AMA Survey

- Motivation **- ethics**
  - possible decreased in physician charity care
  - risk of patient abandonment
  - exacerbation of existing health care inequities based on rationing by ability to pay
- Methods **- survey of 144 retainer physicians standardized to randomized control physicans**
- Findings
  - much smaller panels 900 v 2300 pts
  - retainer physicians treat fewer minority and Medicaid patients
  - Retainer physicians are more likely to:
    - accompany patients to specialists
    - do house calls
    - have 24 / 7 access
    - do more charity work (non-statistical)
- Additional stats:
  - 85% converted from non-retainer practices
  - 94% perform charity care
  - 12% retention of patients through transition
- Conclusions **- Despite differences between retainer and nonretainer practices, there is also substantial overlap in services provided. These findings, in conjunction with the scope of patient discontinuity when physicians transition to retainer practice, suggest that ethical and legal debates about the standing of these practices will endure.**
- Outcome **– AMA Ethics Position Statement`**

J Gen Intern Med. 2005;20(12):1079-1083.

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The Cash Practice: GAO Report

- Motivation **- The recent emergence of concierge care has prompted federal concern about how the approach might affect beneficiaries of Medicare, the federal health insurance program for the aged and some disabled individuals. Concerns include the potential that membership fees may constitute additional charges for services that Medicare already pays physicians for and that concierge care may affect Medicare beneficiaries' access to physician services.**
- Identification **- 147 Concierge Physicians – 112 responded to survey, almost all practicing primary care**
- Fees **- ranged from $60-$15,000 / year averages $1,500 - $1,999**
- **Most often reported features - same- or next-day appointments for non-urgent care, 24-hour telephone access, and periodic preventive care examinations**
- Insurance **- About three-fourths of respondents reported billing patient health insurance for covered services and, among those, almost all reported billing Medicare for covered services**
- Resolutions **–**
  - HHS has determined that concierge care arrangements are allowed as long as they do not violate any Medicare requirements.
  - The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems
  - GAO's review of available information on beneficiaries' overall access to physician services suggests that concierge care does not present a systemic access problem among Medicare beneficiaries at this time

8/05 - http://www.gao.gov/new.items/d05929.pdf

Milestones in Retainer Medicine: The Pendulum Swings

- Pre 1939 – **Age of fee-for service medicine**
- 1939 **– Blue Cross founded as a not-for profit by AHA**
- Post WW II **– Wage & Price Freeze – regulations limiting wages encourages employers to compete for employees by offering healthcare benefits to employees – triangulation begins**
- 1965 **– More government intervention – tax codes favoring employer-sponsored insurance**
- 1965 **- Medicare / Medicaid enacted**
- 1996 **– MD Squared founded by Howard Marion, NYT coins movement – "boutique"**
- 3/2002 **– "Waxman Letter" – Questioning "double-dipping" / MDVIP**
- 10/2003 **– AMA forms "Ethical Guidelines" re transition**
- 12/2003 **– George Bush furthers 'ownership society' – Establishment of HSAs promotes Consumer Directed Medicine**
- 3/2004 **– OIG Alert – "double-dippers" beware**
- 8/2005 **– GAO report on Concierge Medicine**
- 2/2006 **– Washington is the first state ruling on retainer practices**
- 3/2006 **– West Virginia insurance commissioner ruling**

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The Cash Practice: Retainer Amenities

- Access **– same day visits, 24/7 access, minimal wait times, cell phone access, e-mail, telephone consults, house / office calls**
- Amenities **– more "pleasant" surroundings, coordination of care**
- Attention **– longer visits, accompaniment to specialists**
- Focus on Prevention **– Annual Executive PEs**

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Our Story…
Year Zero: 2002 – March 2003

- **May to December 2002 – "**12 Steps to Freedom"
- **December 2002 –** The Letter
- **December 6, 2002 –** No Looking Back
- **December 2002 to March 2003 –** The Rebirth
- **March 2003 –** Shouting from the Rooftops

The Transition Letter

November 15, 2002

Dear _____,

After five years at James Island Medical Care, I am excited **to inform you of plans to establish my new practice at a downtown location. In my time here, I have been grateful for the** relationships **that I have established with my partners, Drs. Costa and Scott, my loyal and hard-working staff, and most of all,** my valued patients**. While I am fortunate to have been given the opportunity to nurture honesty, trust and respect within those relationships, my one regret is that our current high-paced and volume-driven practice environment has not allowed me the time during daily encounters to further those relationships.**

Not only will my new model reflect a move towards a retrospective era of traditional family medicine with the patient at its heart, but it will help me launch Charleston's first example of a national model of "Retail Medicine" characterized by reduced time in the waiting room, increased amount of physician attention**,** more 'access' **to the physician in the way of evening and weekend hours, e-mail contacts, cell-phone after hours access and even house calls for emergencies. I intend to provide the same base of continuity care, mixed with same-day availability for walk-in urgent care, but at a reduced cost to you. In exchange, I will ask that patients make payment at the time of service. For those that have insurance plans,** we will provide you **with the documentation necessary for you to directly receive out-of-network reimbursement from your insurance carrier. A lower daily patient volume will allow me the ability to spend** more time with each patient **to provide the type of** individualized attention **that I believe you are looking for and deserve. Your help in this respect will allow me to turn my focus away from the daily frustrations of practice management, in which I have no formal training, back to the patient where my attention belongs.**

After completion of my duties at JIMC over the next few weeks, I will be pursuing the full-time task of setting up the practice in anticipation of a March 1st opening. In the meantime, please read the enclosed article entitled, "Pay as you go", which highlights the nationwide growing trend towards this type of 'patient-focused' practice. If you are interested in making the transition to the new practice, please sign the below transfer of records request and fax it or mail it to us at the above address so that copies of your record will be available to us on your first visit. Those of you who fax records requests will be kept up to date on our progress with future mailings. For those of you who wish to remain with James Island Medical permanently or in transition towards our opening, you will be seen by Dr. Robinson who will be taking my place in the practice. I welcome any questions that you may have in the interim.

Looking forward to simplifying,
David L. Albenberg, MD

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Our Story…
Year One: March 2003 – March 2004

- March 17, Opening **– saw 20 patients that week, 11 the following week; 04/03 Income: $7,085 – Expenses $42,751**
- Branding **– "The doctors that don't accept insurance"**
- Hybrid Model **– "contra-insurance" model tested**
- Personal Financial Status **– savings dwindling**
- July **– First Paycheck!**
- Identity Crisis - Struggling to find our Niche / Branding
  - **Confusion**
    - Healthcare "Spa"
    - Concierge / Boutique
    - Consumer-directed "friendly"
    - Doctor in the House

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OPTIMUM, QUALITY CARE
IN A COMFORTABLE,
RELAXED ATMOSPHERE
IN TWO LOCATIONS
THAT ARE
MANAGED-CARE FREE.

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don't fit your schedule,
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Our Story…
Year Two: March 2004 – March 2005

- Numbers increasing - **Projections show us growing beyond our physical plant within two years**
- Begin to define branding and niche – "**Modern medicine at an old-fashioned pace"**
- Focus on office efficiencies
- Late 2004 - **Begin searching for property for second office / partner**

Our Story…
Year Three: March 2005 – March 2006

- March 2005 **– Secured contract on second location**
- May 2005 **– Signed first licensing agreement with like-minded physician**
- Summer 2005 **– The "talk"**
- August 2005 **– The letter (the sequel)**
- October 2005 to present **– The transition**
- February 2006 **– Second office opens 3 months behind schedule, drop-dead date for transition to retainer model**

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Transition Letter – The Sequel

August 1st 2005

Dear Patients & Friends,

Almost three years ago, I left my traditional practice in search of a better way of practicing medicine. The inadequacies that I felt as a physician were not just imagined as I approached a patient base of 4000, seeing close to 30 patients a day. Many of you who have followed me out of that chaos continue to remind me of that history. Out of pure desperation and a promise never to return to a high volume practice, I dreamt up Access Healthcare in its current form. Although the idea of not filing insurance to slow down the pace was radical here in South Carolina in late 2002, many other desperate physicians were designing similarly innovative practices around the nation with the sole goal of increasing physician accessibility and reducing patient volumes.

In March of 2003, we opened the practice with fewer than 100 patients with the mission of improving patients accessibility to their physician in the way of less waiting time, longer face-to-face time, same-day visits, 24/7 availability, email / phone consults and the return of the house call. And the practice was a huge success. We appeared on the front page of the Post & Courier the day we opened and have subsequently been the focus of dozens of newspaper articles and television news pieces largely focusing on that improvement on access. A survey that we sent out after our first year in practice revealed a 97% patient satisfaction rate with the practice.

Now a little over 2 ½ years later and with 15 times the patients with which we started, I am approaching a similar dilemma to that which I faced in my former life namely, what to do with the demands from the exponential growth of the practice.

Earlier this summer, I made the difficult decision to limit my practice to 300 patients beginning November 1st, all of whom will be under an annual retainer plan. Only by doing this will I be able to continue to give the focused, dedicated, personalized service to those folks who remain with me. For those folks who can't or do not want to make the transition, Dr. David Robinson will be available to see you on the same pay-as-you-go basis to which many of you have already been accustomed. David and I have a long history together dating all the way back to college and he is one of the few physicians in Charleston to whom I would entrust your care.

Additionally, so that I can be everything for those limited patients without charging anything above the plan price, we are extending my availability to 24/7 and including all of the in-house labs and procedures that we perform in the office for all three plans. You will also notice our efforts to simplify our plans substantially and have designed family plans to give families incentive to join the practice together.

I appreciate that some of you will not be pleased with these changes. To you, I can only promise that my motivation for making these changes is to indefinitely provide the highest level of personalized care that you are already receiving and never to head back in the direction of feeling inadequate about addressing my patients' needs.

There will be a few other changes around the office as well as Nicole heads up our new Mount Pleasant office, Liz heads back to nursing school and Stacey goes back to work for Blackbaud. Many of you have already met Jason Perey, who has been working for us since February and Mary Ruth Hunter who joined the practice as a registered nurse just last week.

Please see the attached sheet which describes our new plans in detail. I encourage you to contact Nicole by email @ nicole@letssimplify.com, by telephone, or in person at the practice if you wish to discuss these plans in any more detail. As always, I will also remain available for and will welcome feedback from you during this understandably confusing transition.

Thank you once again for your continued support of the practice,

Dr. Dave

The Product…

www.LetsSimplify.com

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Outcome Measures:
Comparison – Practice Management

	Former Practice	Retainer Practice
• **Patients / Day**	**27-30**	**12-15**
• **FTEs / Physician**	**17 / 3**	**3.5 / 2**
• **Staff Name Recall**	**90%**	**100%**
• **IT Investment**	**Minimal**	**$60,000**
• **Dictation Costs**	**$25,000 / yr**	**0**
• **Startup Investment**	**$30,000**	**$125,000**

Outcome Measures:
Comparison - Patient Care / Workflow

	Traditional Practice	Retainer Practice
• Dr / Physician Relationship	**Poor**	**“Re-establishing” Relationships**
• Special Skills	**Master of Apology** **Art of Interruption**	**Focused on Patient Care**
• Documentation	**2 hours dictation daily**	**“Point of Care” Technology**
• Workflow Environment	**Chaos and Entropy**	**Order & Accountability**

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Outcome Measures:

Comparison – Intangibles

	Former Practice	Retainer Practice
Physician Disposition	**Increasing irritability** **Desk kicking** **Rising BP**	**Less weekday irritability**
Job Security	**None**	**"Ownership"**
Office Hours	**M to F: 8-6 Sat 9-1**	**M to F: 8-6 Sat 9-1**
Call	**Telephone Triage 24/7**	**See patients 24/7**
Malpractice Threat	**Tenuous**	**Contained**
Recurrent Dreams	**Men in suits**	**Promoting retainer medicine nationally**

Outcome Measures:
Practice Finances (4/15/06)

Traditional Family Practice

- **3000-4000 active charts**
- **$116 / patient encounter**
- Total Gross Revenue **$508,226 / year / provider**
- **Net Collections: 76.25%**
  - $**387,522**
- **Overhead percentage: 65%**
- **Take home $**135,622

* MGMA Cost Survey 2004

Access Healthcare

- **250 Active Retainer Patients**
  - $363,900 Annual Retainer Revenue
    - $1213 / year / patient
    - $100 / month / patient
- **Non-Retainer Revenue $100,000 / year**
  - $105 / patient encounter
- Total Gross Revenue **$463,900K / year / provider** (at capacity)
- **Net Collections: 99.8%**
  - $**462,972 (at capacity)**
- **Overhead percentage: 74%**
- **Take home $**120,372

*Capacity set at 300 retainer patients

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Surrogate Markers for Success

- **Casualty of the traditional system**
- **Strong patient following**
- **Gratification Delay / Investment Minded**
- **Business Minded – systems and work-flow orientation**
- **Value-Chain – Adds value**
- **Eager to regain boundaries**
- **High Risk Tolerance**
- **Committed – financially, professionally, emotionally, philosophically**
- **Grounded – financially, professionally, emotionally, philosophically**
- **“Second Order Change” – Abandon old beliefs and embark in new territory**
- **Clinically Sound – relationship-oriented doctor**

The Process

- **Step 1:** Soul Searching
- **Step 2:** Due Diligence
- **Step 3:** Jump
- **Step 4:** Unravel
- **Step 5:** Commit to a Business Model
- **Step 6:** Choose a Physical Plant
- **Step 7:** Gather Resources
- **Step 8:** Find a Mentor
- **Step 9:** Shout from the Rooftops
- **Step 10:** Implement
- **Step 11:** Open
- **Step 12:** Continuous Quality Improvement

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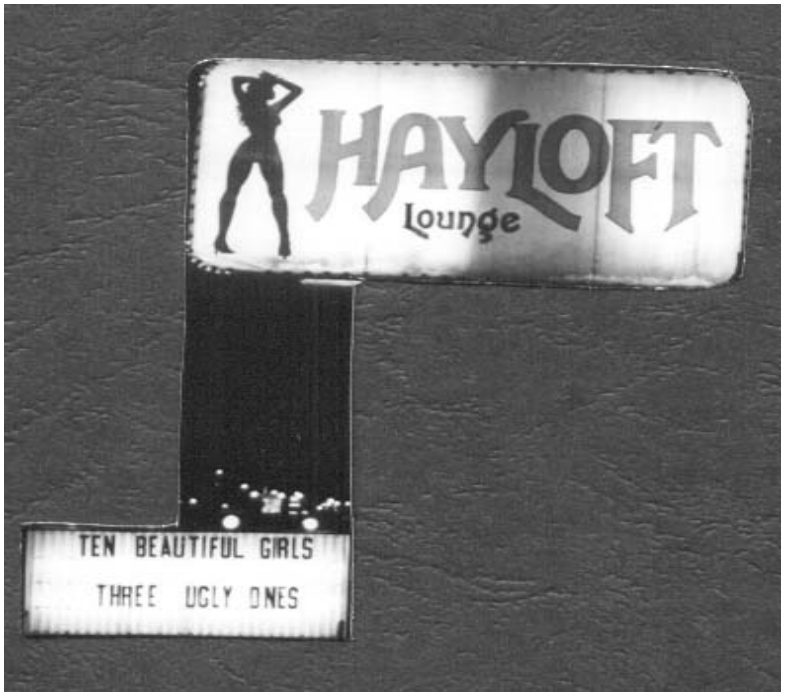
The Pitfalls

Pitfall #1 - Dishonesty



"Honesty is the first chapter in the book of wisdom."

- Thomas Jefferson

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Pitfall #2 - Narcissism

"Reimbursements **from medical carriers continue to decline. The demand is placed on the** Physician **to increase the** volume **of patients he or she needs to see. In the meantime,** overhead **expenses related to running medical practices such as staffing and malpractice continue to increase. This has necessitated sacrificing the time Physicians are able to spend on an individual's visit, a compromise** I **am unwilling to make.** My **patience has worn thin. Patient care in the future will necessitate an unacceptable compromise a Physician like myself will be unable to provide."**

- transition letter, anonymous

Pitfall #3 – Tweaking the System

“I’m not sure what to do about staying on Medicare, I have so many Medicare patients with whom I have excellent relationships.”

- anonymous prospective retainer physician

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Pitfall #4 – Failure to Relocate

"In retrospect, our biggest mistake was staying in the same office with the same staff. Americans respond to packaging. Sure, we improved the product, but without a change in packaging, many of our patients were confused about why they were paying us more money."

- Fred Michaels, MD after closing his fee-for-service practice

Pitfall #5 – Immediate Gratification

“This is so much fun! When do I get paid?”

- Jennifer Pullano, DO upon week 4 of transition

“Instant Gratification takes too long.”
- Carrie Fisher

Pitfall #6 – It’s for the “Lifestyle”

"I wanted to spend more time with patients, which I achieved," he said. "At the same time I wanted to have better quality of life outside the office; that's the part I didn't achieve."

– Rick Versace to the Boston Globe after closing his Cape Cod Concierge practice

Pitfall #7 – Ignore Legal Council

“The department of Health and Human Services will advise physicians contemplating use of such [retainer contracts with (specifically Medicare) patients] to seek legal counsel to ensure that such contracts adhere with the law.”

- HHS Director Tommy Thompson reply to Waxman Letter 05/01/2002

Pitfall #8 – Ignore Political Environment

"If I'd have known that the political landscape [in Massachusetts] was this hostile to the retainer model, I'd have opened the practice in North Dakota."

-Rushika Fernandapulle after closing *Renaissance Health*, a retainer practice in Arlington, MA

Pitfall #9 – Ignore your Business Consultants

“We are fully convinced that this type of practice is not something that someone can do by just putting up a shingle.”

- **Wayne Lipton Senior VP of physician development, MDVIP**

Pitfall #10 – Failure to Innovate

Resources - Consultants

- **Consultants –**
  - Roberta Greenspan, Specialdocs
    - www.specialdocs.com
  - Nicole Stroud, Palmetto Practice Consultants
    - www.palmettoconsultants.com
  - Allison McCarthy, Corporate Health Group
    - www.corporatehealthgroup.com
  - Helen Hadley, Vantage Point Consultants
    - www.vantagepointconsult.com/
  - Marc Grossman, Grossman Systems
    - www.grossmansystems.com
  - Concierge Choice Physicians
    - www.choicemd.com

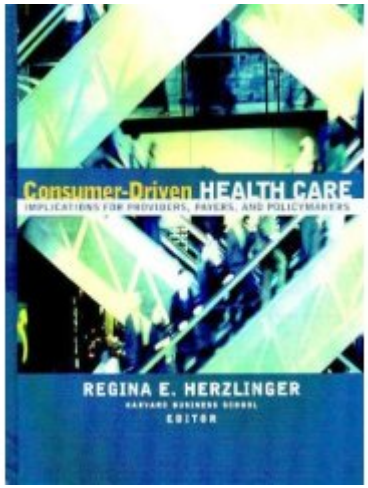
Resources - Legal

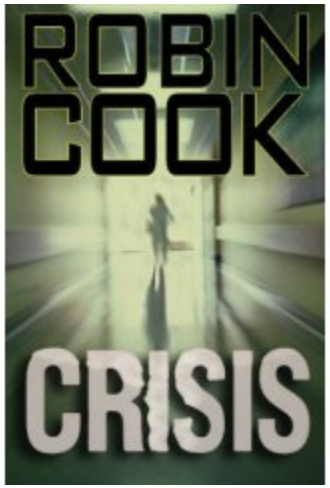
- Vasilios J. Kalogredis, Kalogredis, Sansweet, Dearden and Burke, Wayne, Pa
  - www.ksdbhealthlaw.com
- Thomas Shapira, Much Shelist, Chicago, IL
  - www.muchshelist.com
- Jack Marquis – Warner, Norcross & Judd, Holland, MI
  - www.wnj.com/RetainerMed/
- David Hilgers – Brown, McCarrol, Austin, TX
  - www.brownmccarroll.com
- Michael Blau, McDermott, Will & Emery, Boston, MA
  - www.mwe.com

Resources - Franchises

- **Franchises**
  - MDVIP
    - www.MDVIP.com
  - Total Access Medical
    - www.totalaccessmedical.com
  - MD2
    - www.md2.com

Resources – Readings





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Resources – Professional Societies

Association of American Physicians and Surgeons, Inc.
A Voice for Private Physicians Since 1943

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society for innovative medical practice design
Physicians supporting innovative medical practice design.

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Quotables

- **“I don’t have insurance, but I heard that you don’t *believe* in insurance. Is that true?”**
  - patient when asked for her insurance card
- **“Albenberg, that’s that doctor that only accepts cash, right? Sounds pretty shady to me.”**
  - Fomer patient, not electing to transfer to the new practice style
- **“What kind of whacko doctor do you have? We're not familiar with these shenanigans.”**
  - Companion rep in response to "doctor who does not file insurance“
- **“Hey, How’s that *experiment* down there on Calhoun Street going?”**
  - fellow physician inquiring about the practice after year one

Questions?

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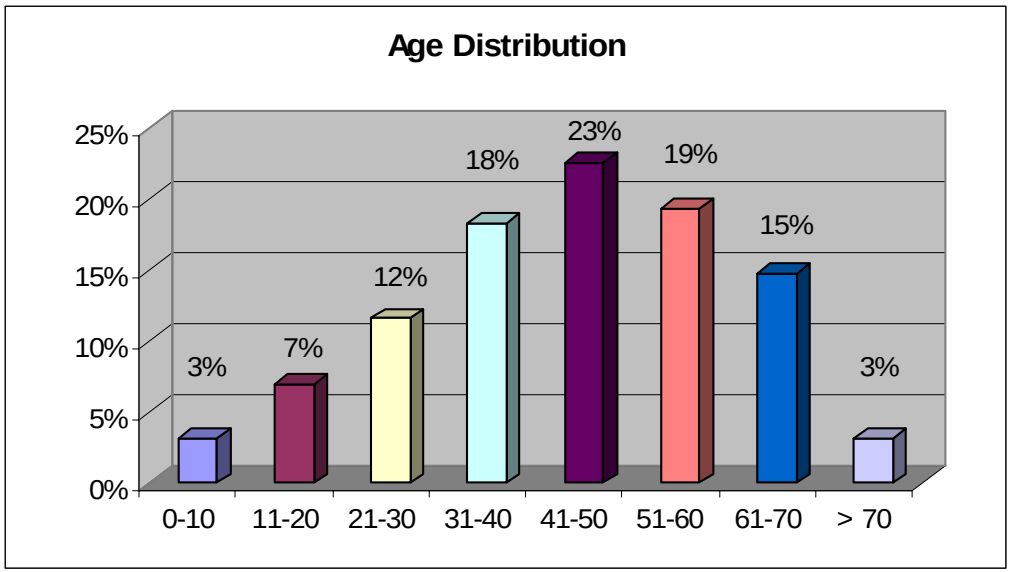
Appendix:
Additional Outcomes Data

Outcome Measures:
Patient Demographics



Future of Family Medicine Project:
Patient Profile of Family Medicine Practices

Mean age of patient: 47
Mean household income of $42.3K / Yr

2005 - Charleston, SC Mean Household Income: $37,810
Access Healthcare Patient Household Income:

22%: < $49K
27%: $50K to $99K
23%: $100K to $199K
29%: > $200K

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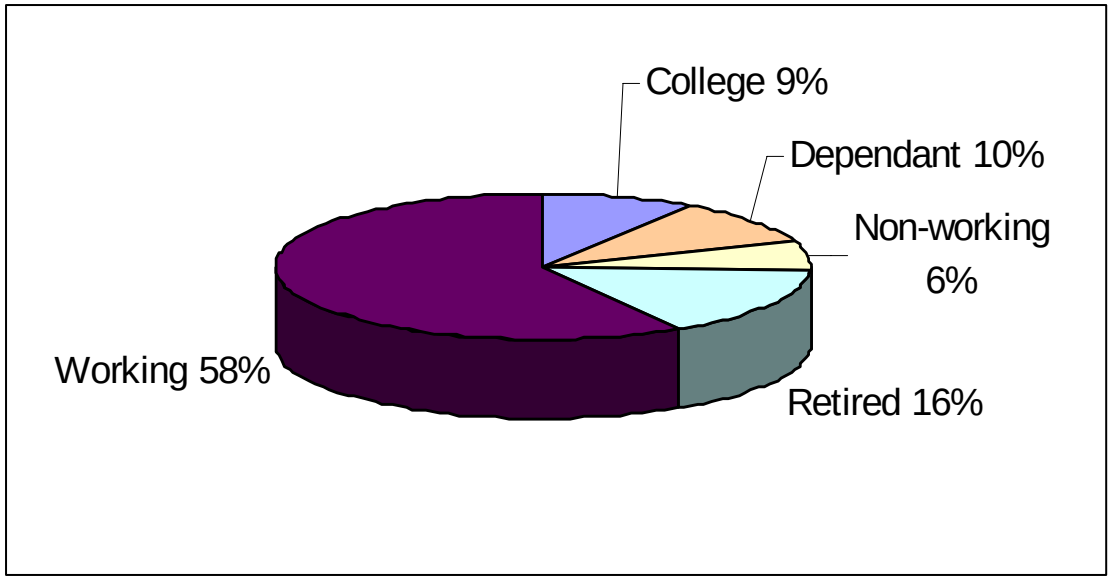
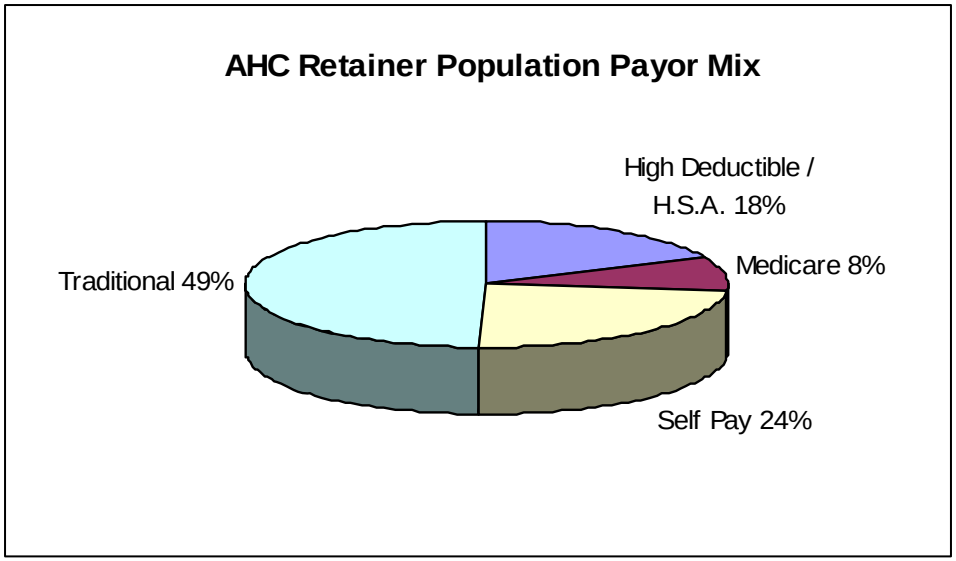
Outcome Measures:
Patient Demographics

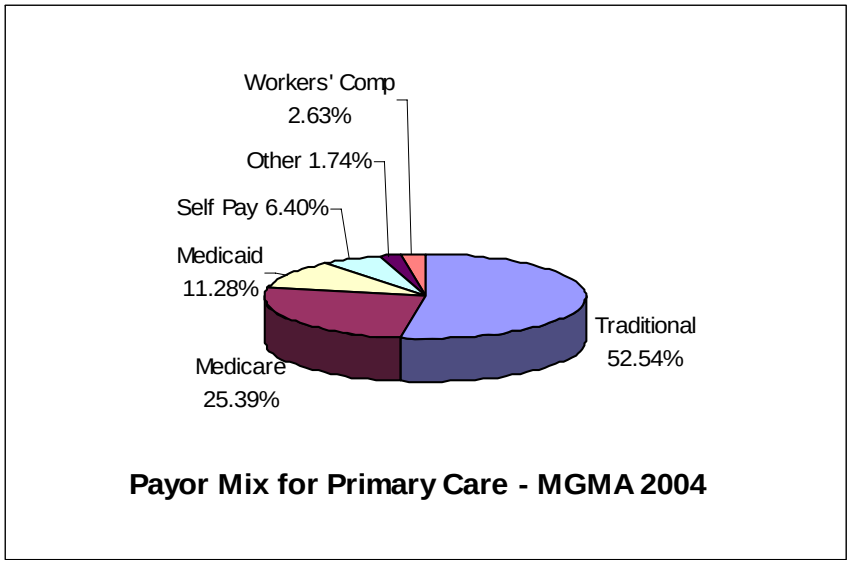
Retainer Patient Demographic: Employment Status



Outcome Measures:
Patient Demographics

Insurance Payor Mix





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Outcome Measures:
Patient Demographic - Motivation

Survey: Primary & Initial Motivation to the Practice - The Defining Questions

- Value-Seekers
  - I'm uninsured or have a high deductible, so my medical practice has to be a cost-effective solution.
  - I really found value in the mission of the practice - to spend quality time focused on personalized care.
- Inertia-Enablers
  - The medical model is not important, it's my longstanding relationship with my doctor that matters.
  - I didn't really want to start over with a new doctor.
- Financially Unconcerned
  - Money's no issue, so I want to have to have all the amenities of this kind of model.
- Hypervigilant – The Worried Well
  - Accessibility is important. I want my doctor to be available to me when I get sick.
- Hypervigilant – Medical Misfits
  - I have a complex medical history and wanted a physician who would spend more time with me.
  - I never really felt like I had a medical home in the traditional practices - often I just wouldn't even go to the doctor.

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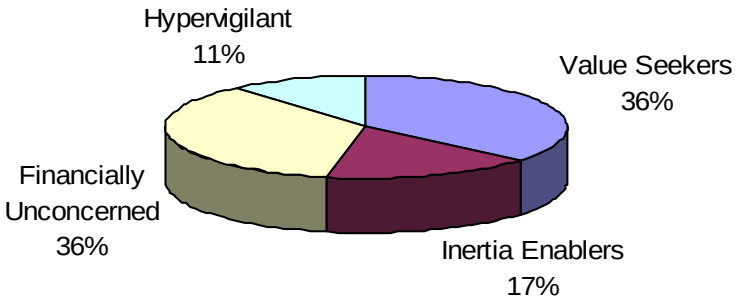
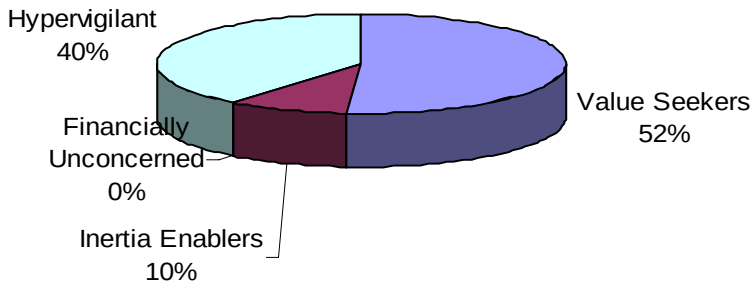
Outcome Measures:
Patient Demographics

Primary & Initial Motivation to the Practice

Practice assessment



Patient Reporting



Five Patient Types:
- Financially Unconcerned
- Inertia Enablers
- Value Seekers
- Hypervigilant:
  - Worried Well
  - Medical Misfit

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Outcome Measures:
Utilization - Annual

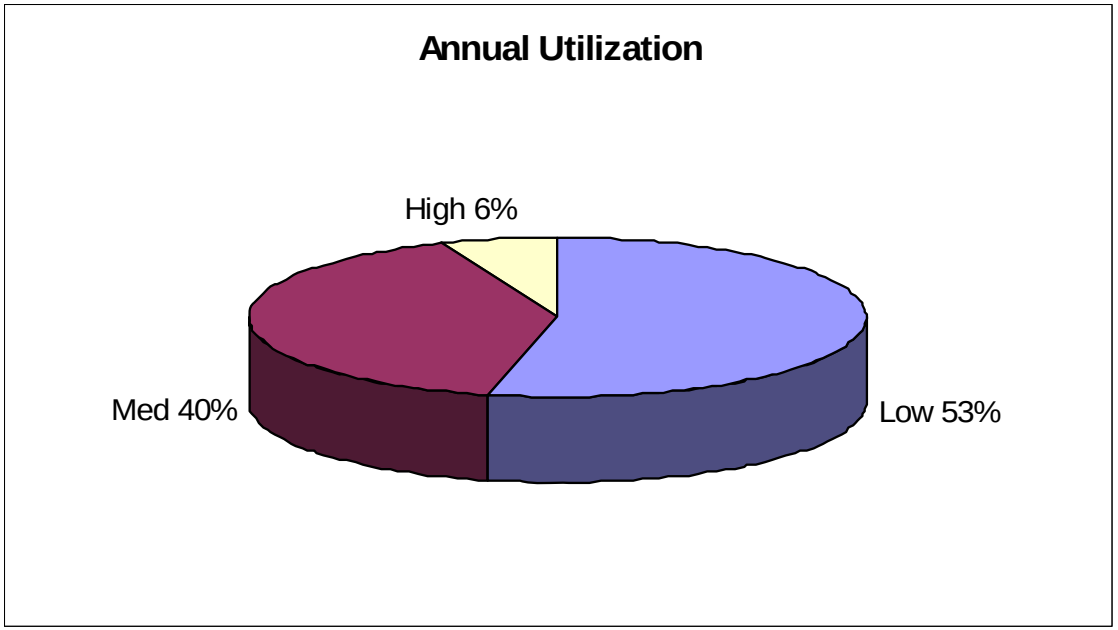
Low Utilization:
< 4 visits / yr

Med Utilization:
4 to 7 visits / yr

High Utilization:
> 7 visits / yr

Primary care providers report an average of 2.5 to 3.0 visits / pt / year

AAFP & MGMA



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Outcome Measures:
Patient Satisfaction – Survey 2006

10. Please rate us in the following areas?

The top percentage indicates total respondent ratio; the bottom number represents actual number of respondents selecting the option	1 Extremely Unsatisfied	2 Unsatisfied	3 Neutral	4 Satisfied	5 Extremely Satisfied	N/A
1. Practice facility	0% 0	0% 0	1% 1	24% 20	74% 61	0% 0
2. Practice staff	0% 0	0% 0	0% 0	21% 17	79% 65	0% 0
3. Availabiliy for same day appointments	0% 0	0% 0	4% 3	20% 16	74% 60	2% 2
4. Time with the physician	0% 0	0% 0	0% 0	18% 15	82% 67	0% 0
5. Encounter with the physician	0% 0	1% 1	2% 2	11% 9	85% 70	0% 0
6. Follow up / Follow through after appointment	0% 0	1% 1	6% 5	20% 16	73% 60	0% 0
7. Accessibility of physician	0% 0	0% 0	0% 0	15% 12	84% 68	1% 1

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Outcome Measures:
Patient Satisfaction – Survey 2006

11. Please rate your overall level of satisfaction with the practce		Number of Responses	Response Ratio
Extremely Unsatisfied		0	0%
Unsatisfied		0	0%
Neutral		1	1%
Satisfied		20	24%
Extremely Satisfied		61	74%
	Total	82	100%

Outcome Measures:
Practice Finances (04/15/06)

Retainer medicine economics

	Traditional primary care	Retainer medicine
Number of patients	2,000	1,000
Office visits per year	4,000	2,000
Revenue per visit	$100	$100
Office visit revenue	$400,000	$200,000
Membership fees	N/A	$360,000
Total revenue	$400,000	$560,000
Operating expense/overhead	$225,000	$260,000
Management/Consultant fees	N/A	$50,000
Physician benefits	$20,000	$30,000
Physician compensation	$155,000	$220,000

Source: John A. Deane, "Retainer Medicine: A New Approach to Primary Care," presented during the Medical Group Management Association's annual conference, October 2004. Reprinted with permission.

Access Healthcare
300
2500
$105
0
$363,000
$463,000
$343,00
0
0
$120,000

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