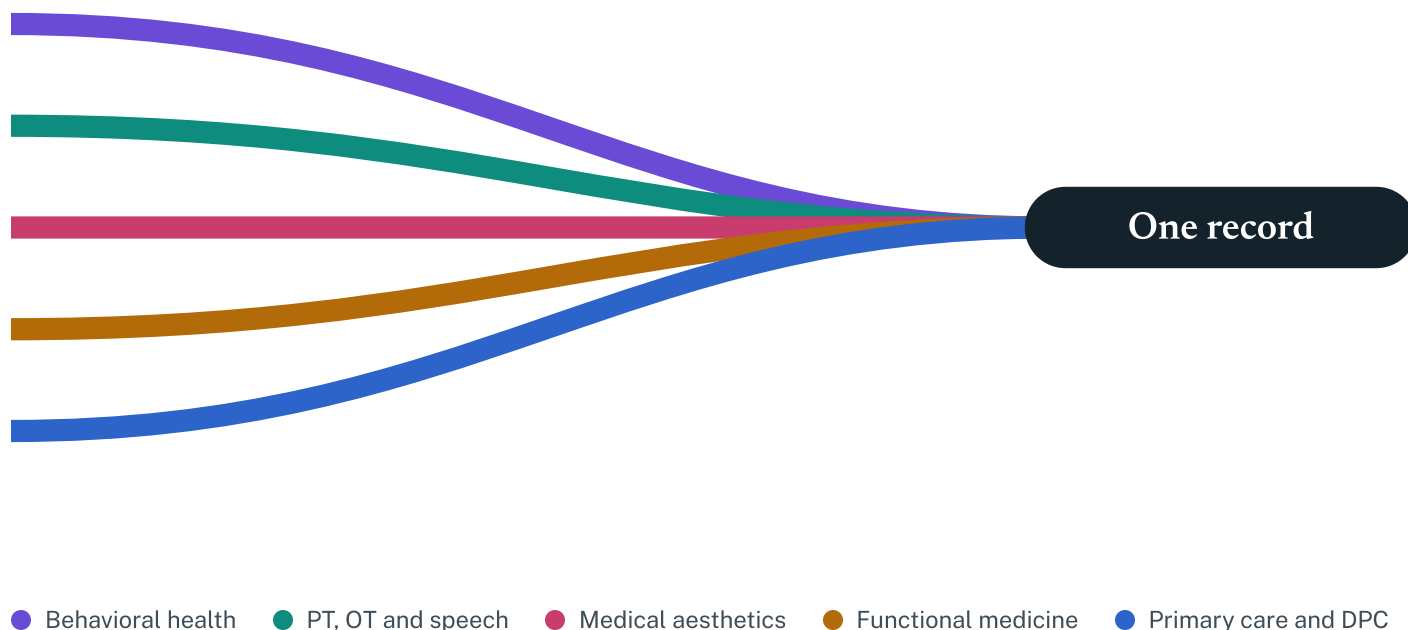


The Converging Practice

Why outpatient care is merging across behavioral health, therapy, aesthetics, functional medicine and primary care; how fast each line is growing in the United States and worldwide; and why a single record that enforces each line's rules is the infrastructure this shift requires



Six findings

~\$121B

Annual US care revenue across the five lines today, growing to about **\$165B by 2030** in the central case (range \$149B to \$183B) **ESTIMATE** ^{1,2,3}

6.4%

Central annual growth of the five lines combined (range 4.3% to 8.6%), against **5.4%** for all US health spending to 2034⁴

10–16%

Annual growth of the three cash and membership lines (aesthetics, functional medicine, direct primary care), two to three times the health-spending rate^{5,6,3}

≈10,000

Practice-level merging events a year: about 6,950 practices changing ownership and about 3,200 sites adding a line **ESTIMATE** ^{7,8}

95%

Of medical groups say regulatory burden rose over the last three years; the Federal Register set a page record in 2024^{9,10}

45% vs 19%

Patients improved under integrated behavioral and primary care versus usual care in the landmark IMPACT trial¹¹

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Executive summary

Outpatient care in the United States is reorganising. Practices are being bought, practices are adding lines of care they did not offer five years ago, and more clinicians work in organisations that span several specialties. The five lines this paper examines sit at the centre of that movement: behavioral health; physical, occupational and speech therapy; medical aesthetics; functional medicine, including hormone care; and primary care, including direct primary care (DPC).

Together these lines earn about \$121 billion a year in US care revenue **ESTIMATE**. Combined, they grow at about 6.4% a year in the central case, faster than the 5.4% CMS projects for national health spending through 2034⁴. The growth is uneven, and the unevenness matters. Behavioral health and therapy are large and grow steadily. Aesthetics, functional medicine and direct primary care are smaller, grow two to three times faster, and are paid in cash, packages and memberships rather than insurance claims. By 2030 those three lines rise from about a quarter of the five-line total to about a third **ESTIMATE**.

The lines are also converging inside the same practices. 38.8% of family physicians already work with behavioral-health clinicians¹². Between 54% and 60% of med spas run a medical weight-loss line¹³. More than 5,300 clinics run a hormone line, about 70% of them conventional primary-care, OB/GYN, internal-medicine and urology practices¹⁴. 27.8% of US physicians now work in multispecialty practices, up about six points since 2012¹⁵.

Each line is regulated at a different object: behavioral health at the note and every disclosure of it; therapy at the minute, the assistant and the calendar; aesthetics at the vial, the supervisor and the photo; functional medicine at the lab order, the claim and the supplement; direct primary care at the membership contract¹⁶. Those rules are multiplying and changing on different clocks. Most practice software is built for one line and encodes that line's answers as constants, which are wrong in the next line. When a practice combines lines, its staff catch the collisions by hand.

MedOp's approach is one patient record for all five lines, in which every visit carries its line and that line's rules are enforced at signing and before a claim or charge leaves the practice. This paper sets out the market evidence for that approach, quantifies the growth of each line in the United States and worldwide, defines the criteria a line must meet to join the combined record, documents the rising regulatory load that makes software enforcement necessary, and reviews the clinical evidence that integrated care improves outcomes. It also states where the evidence is thin. No study has tested all five lines on one record; the strongest outcome evidence covers behavioral health integrated with primary care, and the rest is a reasoned extension of it.

SECTION 2

The approach under examination

A practice that runs more than one line of care has three choices today. It can run a separate system for each line, with two charts, two portals and two bills for a patient seen in both. It can stretch a general electronic health record over every line, with staff applying each line's rules by hand. Or it can run one record that knows which line each visit belongs to. MedOp is built on the third choice.

LINE	REGULATED AT	WHAT THE RECORD MUST ENFORCE
● Behavioral health	The note and every disclosure of it	Psychotherapy-time codes from the session clock; 42 CFR Part 2 consent and redisclosure; psychotherapy notes kept apart; scheduled outcome measures
● PT, OT and speech	The minute, the assistant and the calendar	Timed units from treatment minutes; KX threshold running totals; assistant modifiers from who delivered each minute; plan-of-care certification windows
● Medical aesthetics	The vial, the supervisor and the photo	A current good-faith exam before any injectable; supervision attestation; lot and expiry tracking; photo consent by purpose
● Functional medicine	The lab order, the claim and the supplement	Versioned protocols; clinician verification of every imported lab result before anyone sees it; superbills and HSA receipts for cash-pay care
● Primary care and DPC	The membership contract	Plan versions that never change once members join; no insurance claim for a covered service; HSA-compatible plan design

Table 1. Five lines, five regulated objects. Source: MedOp regulatory analysis¹⁶.

How the record works

- **Every visit is stamped with its line**, and the line is locked once documentation begins. A change after that is a recorded, audited action.
- **Each clinician is credentialed per line**. A provider can only document in the lines they are assigned to.
- **The clinical core is shared**: allergies, medications, problems and consents follow the patient across lines.
- **Sensitive records stay walled**. Psychotherapy notes and Part 2 records are withheld from other lines; a clinician sees a collapsed stub and may open it only through an audited override. AI agents are denied those records outright.

- **Payment is decided per visit.** A therapy visit produces a claim; a service covered by a membership never does; a cash service produces a receipt the patient can use with a health savings account.
- **AI agents work inside the same record** under the same line rules, as drafts that a person approves.

All five lines are live in MedOp's production platform. MedOp's pilot is an integrated behavioral-health and aesthetics practice in Florida, whose behavioral-health side runs on MedOp with 2,868 patient records and 18,037 appointments migrated. The platform has shipped more than 900 tagged releases and is guarded by more than 21,600 automated tests and more than 290 database-enforced row-level security policies. MedOp is priced at \$169 per provider per month, with every line and an AI receptionist included, and \$149 for each practice's first twelve months. No compliance or certification is claimed for MedOp in this paper.

SECTION 3

The market is merging

Three forces are reshaping US outpatient care at once: practices are changing hands, practices are adding lines, and more care is delivered by organisations that span specialties. The five lines sit in the middle of all three.

82.0%

Of US physicians employed by hospitals or corporate entities on 1 January 2026, up from 52% in 2018⁷

27.8%

Of physicians in multispecialty practices in 2024; single-specialty practice fell from 45.4% to 37.2% since 2012¹⁵

104

Behavioral-health deals announced in 2025, up 42% on 2024¹⁷

4 → 175

Private-equity physical-therapy deals, 2010 to 2023¹⁸

Lines are being added, not only bought

Ownership change is the most visible part of consolidation, but the more important part for a records platform is service-line addition: an existing practice starts delivering a second line to the patients it already has. MedOp's companion study counted roughly 6,950 practices a year moving into hospital or corporate ownership (net, 2024–25) and at least 3,200 sites a year adding one of the five lines, for about 10,000 practice-level merging events a year **ESTIMATE**^{7,8}. Overlaps are not removed, so this is an order of magnitude rather than a count.

- Primary care is absorbing behavioral health.** 38.8% of family physicians work with behavioral-health clinicians¹², and the number of clinicians billing Collaborative Care to Original Medicare grew about sixfold from 881 in 2018 to 5,131 in 2022¹⁹.
- Aesthetics is merging with medicine.** 60% of med spas offered GLP-1 weight-loss treatment on 2024 data, easing to 54% by August 2025; practices offering it grew revenue about 9% while others fell 2%¹³. Weight management moves aesthetics practices into functional-medicine and primary-care territory.
- Functional medicine spreads by addition.** No functional-medicine clinic roll-up exists. Instead, Fullscript's practitioner base grew from 70,000 in 2022 to more than 135,000 in 2026⁶, and more than 5,300 clinics run a hormone line, most of them conventional practices¹⁴.
- Membership primary care is growing while retail clinics retreat.** Concierge and DPC sites rose 83%, from 1,658 to 3,036, between 2018 and 2023, and clinicians in them rose 78%³.

PRACTICE TYPE ↓ ADDS →	BEHAVIORAL HEALTH	PT, OT AND SPEECH	MEDICAL AESTHETICS	FUNCTIONAL MEDICINE	PRIMARY CARE AND DPC
Behavioral health	—	Pediatric therapy platforms add speech and OT	Not yet measured	Ketamine and interventional psychiatry	Rarely adds primary care
PT, OT and speech	Little evidence	—	Cash-pay wellness add-ons planned by 45.5%	Nutrition and wellness services	Orthopaedic and system joint ventures
Medical aesthetics	No data	No data	—	Weight loss, hormones, IV: 54–60% offer GLP-1 care	Weight management overlaps primary care
Functional medicine	Integrative centres include behavioral health	Chiropractic and PT overlap	Wellness franchises combine IV and aesthetics	—	Hormone lines sit inside primary care
Primary care and DPC	20–43% integrated; Collaborative Care billers ×6	Employer on-site clinics with PT	DPC practices adding aesthetics	~70% of hormone-line clinics are conventional practices	—

Figure 1. Where the lines are combining. Measured nationally Named deals or regional data Not yet measured . Source: Five Lines in Motion⁸, citing AMA, Meadows/Milliman, Guidepoint Qsight, biote and others. No national dataset counts practices that run two or more of these lines; the multi-line operator is an emerging category that no vendor has defined.

The consolidators are reaching the same conclusion from the other side. Bain's 2026 private-equity report says physician platforms must move from loose confederations to integrated platforms with shared infrastructure, AI-enabled operations and revenue-cycle

improvement²⁰. A group that combines practices of different specialties needs one operating record as much as an independent practice adding its second line does.

SECTION 4

Five lines, five growth curves

Every one of the five lines grows faster than the US economy, and three of them grow two to three times faster than health spending. The data quality varies by line, and this section says so.

LINE	US CARE REVENUE	ANNUAL GROWTH	BASIS FOR GROWTH	CONFIDENCE
● Behavioral health	\$35.7B	4.0–5.3%	US behavioral-health market, 5.3% a year 2025–32 ²² ; outpatient clinics about 4.0% a year ¹	High
● PT, OT and speech	\$53.2B	2.4–6.2%	US physical-therapist industry 2.4–3.2% ¹ ; outpatient rehabilitation centers 4.9–6.2% ²³	Medium
● Medical aesthetics	\$15.4B ESTIMATE	6.0–15.6%	Med spa count 5,431 to 10,488 in 2018–23, 14.1% a year ² ; US med spa market 13.7–15.6% ⁵ ; AmSpa's whole-industry figure implies about 6%	Medium
● Functional medicine	~\$9B ESTIMATE	8.5–16%	Fullscript practitioners +93% in about 4.5 years (15.7% a year); IFM certifications +65% in four years (13.3%) ⁶ ; global integrative-medicine estimates from 8.5% ²⁴	Low
● Primary care and DPC	\$7.5B ESTIMATE	9.3–12.8%	Concierge and DPC sites +83% in 2018–23 (12.9% a year) ³ ; US concierge-medicine market 9.3–10.4% ²⁵	Medium

Table 2. US size and growth by line. Care revenue bases as used in MedOp's market analysis (IBISWorld for behavioral health and therapy; AmSpa locations × average revenue for aesthetics; MedOp estimates for functional medicine and DPC). Research firms define these markets differently, so ranges are shown rather than single points.

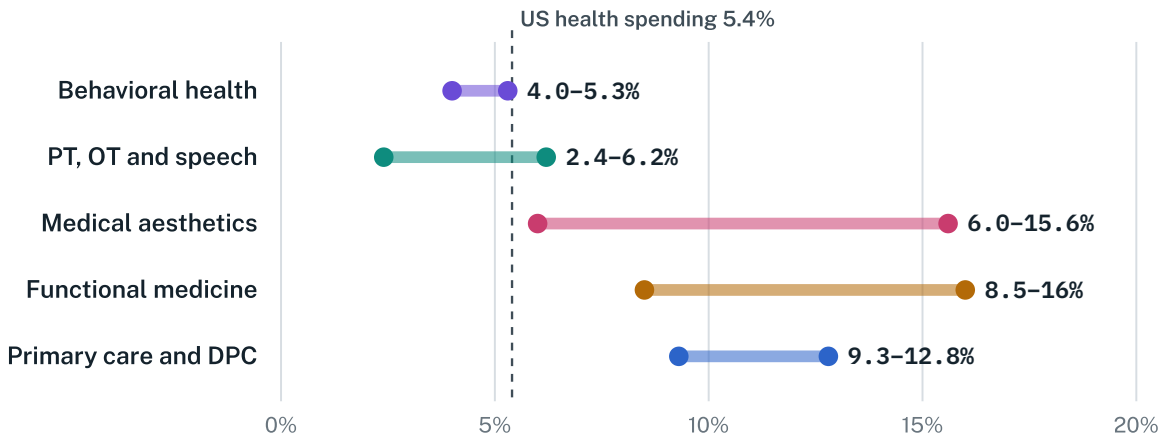


Figure 2. Annual growth by line, United States. Low and high ends of the cited estimates. Reference: national health spending, 5.4% a year 2025–34 (CMS)⁴. Sources in Table 2.

● Behavioral health

The second-largest line and the one most often added to other practices. Census counts 46,513 offices of mental-health practitioners and 13,449 psychiatrist offices²⁶. Demand is structural: mental-health counselors are projected to grow 18% over the decade²¹. Growth in revenue is steady rather than fast, but the line's importance to a combined record is outsized, because it carries the strictest disclosure rules of any line.

● PT, OT and speech

The largest line by establishments (52,058) and revenue²⁶. Dollar growth is modest at 2.4% to 6.2%, but the workforce grows 12% to 17% over the decade²¹, and the line's billing rules are the most arithmetic of the five. That makes software enforcement easy to prove: units, modifiers and thresholds are either right on the claim or they are not.

● Medical aesthetics

The fastest-growing line by location count, from 5,431 med spas in 2018 to 10,488 in 2023 and more than 11,000 in 2024². 81% are single-location. The line is cash-paid and commerce-heavy, and it is adding medical services (weight loss, hormones, IV

● Functional medicine

The line with the weakest data and some of the strongest adoption signals. There is no establishment count. Adoption proxies grow 13% to 16% a year⁶. Functional medicine depends on specialty labs, supplements and longitudinal tracking, so it benefits most from sharing a chart with the primary-care or aesthetics record the patient already has.

● Primary care and DPC

Primary care is the least independent specialty, but its membership models are growing: concierge and DPC sites grew about 13% a year from 2018 to 2023³, and more than 2,700 DPC practices operate in all fifty states²⁷. From 1 January 2026, DPC fees up to \$150 a month for an individual can be paid from a health savings account²⁸. The membership engine DPC needs is the same one aesthetics and functional medicine use for packages and programs.

therapy) that need prescribing, labs and clinical notes.

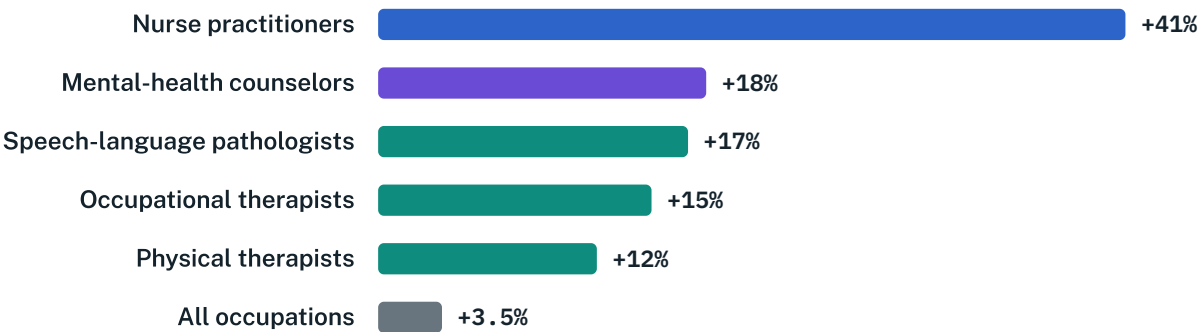


Figure 3. Projected employment growth, 2025–2035. US Bureau of Labor Statistics, 2025–35 projections, released 27 August 2026²¹. Nurse practitioners are the fastest-growing occupation in the economy.

SECTION 5

The US market in aggregate

The United States spent \$5.3 trillion on health in 2024, 18.0% of GDP. CMS projects 5.4% annual growth through 2034, against 4.1% for the economy, taking health to 20.6% of GDP and \$9.0 trillion. Physician and clinical services, the category the five lines sit in, grow 5.5% a year⁴.

Applying each line's growth range to its revenue base for five years gives the picture in Table 3. In the central case the five lines grow from about \$121 billion to about \$165 billion, a compound 6.4% a year. At the national health-spending rate they would reach only \$157 billion, so the five lines outgrow health care itself by about \$8 billion over five years.

LINE	TODAY	2030 LOW	2030 CENTRAL	2030 HIGH	SHARE TODAY	SHARE 2030
Behavioral health	\$35.7B	\$43.4B	\$44.8B	\$46.2B	29.6%	27.2%
PT, OT and speech	\$53.2B	\$59.9B	\$65.7B	\$71.9B	44.0%	39.8%
Medical aesthetics	\$15.4B	\$20.6B	\$25.7B	\$31.8B	12.7%	15.6%
Functional medicine	\$9.0B	\$13.5B	\$16.0B	\$18.9B	7.5%	9.7%
Primary care and DPC	\$7.5B	\$11.7B	\$12.7B	\$13.7B	6.2%	7.7%
Five lines	\$120.8B	\$149.2B	\$164.9B	\$182.5B	100%	100%

LINE	TODAY	2030 LOW	2030 CENTRAL	2030 HIGH	SHARE TODAY	SHARE 2030
Compound annual growth		4.3%	6.4%	8.6%	US health spending: 5.4%	

Table 3. Five-line US care revenue, 2030. **ESTIMATE** MedOp arithmetic from the growth ranges in Table 2; not a forecast.

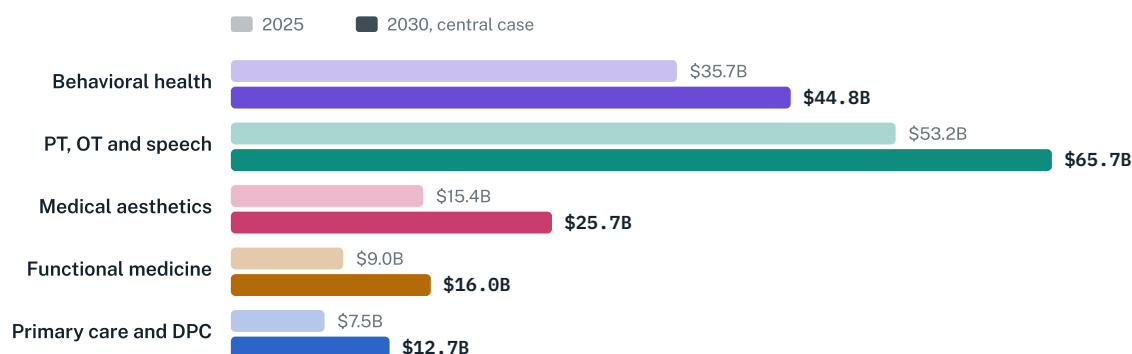


Figure 4. Five-line US care revenue, today and in 2030. Central case: each line grows at the midpoint of its range in Table 2 for five years. MedOp arithmetic; not a forecast.

Three things the aggregate shows

- **The mix is shifting toward cash and membership care.** Aesthetics, functional medicine and DPC rise from 26% of the five-line total to about 33% in the central case. These are the lines where insurance-centred software is weakest and where a practice most needs packages, memberships, receipts and commerce on the clinical record.
- **The workforce grows faster than the revenue.** Every clinical occupation in these lines grows at four to twelve times the all-occupation rate of 3.5%²¹. More clinicians per practice means more seats on a per-provider platform, independent of new practice formation.
- **Software spending is a small, growing slice.** The global electronic health record market was \$35.9 billion in 2025, growing 5.1% a year, with outpatient systems the fastest-growing type²⁹; practice-management software adds \$8 billion to \$18 billion growing 7% to 10% a year³⁰.

SECTION 6

What the growth means for MedOp

The market evidence supports a specific strategy: sell one record to practices that already combine lines, then grow inside each account as it adds lines and clinicians.

81,264

Independent practices of one to twenty providers in the states MedOp's rule packs cover first: the serviceable market in MedOp's model

\$8,110

Platform spend a year for a four-provider practice at the \$169 list price (\$7,150 in its first year at \$149)

OWNER ASSUMPTION

≈\$659M

Annual platform spend across the serviceable market at list; about \$975M with paid AI tasks

OWNER ASSUMPTION

\$0

Added platform price for a practice's second or third line, or another location

Why the growth pattern favours a combined record

- 1. The fastest-growing lines are the ones practices add.** Aesthetics, functional medicine and DPC are rarely acquired as stand-alone clinics; they arrive as a new service inside an existing practice. On a single-line system each addition means a second system. On MedOp it is a setting on the record the practice already uses.
- 2. Seat-based pricing tracks the workforce.** MedOp charges per provider. Clinical employment in these lines grows 12% to 41% over the decade²¹, so revenue per account rises as practices hire, without a new sale.
- 3. The merging events are the sales moments.** About 10,000 times a year a practice changes hands or adds a line **ESTIMATE**⁸. Each event forces a software decision, and each is a point at which a combined record is the simpler answer.
- 4. Consolidators need the same thing.** Groups and management services organisations that combine practices of different specialties are a channel as well as a customer: one relationship brings many practices onto one record.

The sequencing rule

MedOp sells first to practices that already run two lines, then sells the second line to practices that run one. The first proves the record; the second proves the expansion. The opening customer is the integrated behavioral-health and aesthetics practice, the shape of MedOp's pilot, starting in Florida, where the first rule packs are written. PT, OT and speech follow as the second wedge, sold with the billing companies that already run claims for many rehabilitation clinics. Functional medicine and primary care are sold first into existing accounts.

About the figures in this section. The serviceable-market count and the per-practice spend come from MedOp's internal planning model and rest on owner assumptions, chiefly an average of four providers per practice; they are not yet measured and will be tested with MedOp's founding practices. This paper does not present revenue projections for MedOp.

Criteria for a MedOp combined practice line

A combined record is only as sound as the rules for what goes into it. MedOp applies two sets of criteria: eight tests a line of care must pass to join the record, and seven requirements that define a combined practice.

A. The eight tests for a line of care

#	TEST	WHAT IT REQUIRES
1	Outpatient, practice-scale care	Delivered mostly in independent practices of one to twenty providers, where one platform runs the whole operation
2	A shared patient	Documented patient flow with at least one other line: patients seen in both, or one line routinely referring to or adding the other
3	A distinct regulated object	The line is regulated at something software can check at the moment of care: a note, a minute, a vial, a lab order, a contract
4	A shared clinical core	Allergies, medications, problems and consents must follow the patient across this line for safety
5	A payment model one engine can hold	Its claims, cash or membership rules can be decided per visit beside the other lines, including where they conflict
6	Growth or scale	Grows faster than national health spending (5.4% a year), or is large enough that enforced billing rules pay for themselves
7	Evidence that combining improves care	Clinical, safety or access evidence that the line does better when it shares a record with the others
8	Rules that can bind AI agents	Its sensitive records can be scoped so that agents see only what the line permits

Table 4. Admission tests for a line of care.

How the five lines score

LINE	1	2	3	4	5	6	7	8
● Behavioral health	Meets	Meets	Meets	Meets	Meets	Meets	Meets	Meets
● PT, OT and speech	Meets	Partly	Meets	Meets	Meets	Meets	Meets	Meets
● Medical aesthetics	Meets	Meets	Meets	Meets	Meets	Meets	Meets	Meets

LINE	1	2	3	4	5	6	7	8
● Functional medicine	Meets	Meets	Meets	Meets	Meets	Meets	Partly	Meets
● Primary care and DPC	Meets	Meets	Meets	Meets	Meets	Meets	Meets	Meets

Table 5. All five lines pass. Two partial scores are recorded honestly: PT, OT and speech shares patients with the other lines less than they share with each other (test 2), and functional medicine's outcome evidence is still emerging (test 7). A sixth candidate line would have to pass the same eight tests.

B. The seven requirements of a combined practice

#	REQUIREMENT	DEFINITION	HOW MEDOP MEETS IT
1	Two or more lines, one patient population	The organisation (a practice, group or management services organisation) delivers at least two of the five lines to patients it shares	Lines are switched on per practice; a patient is one record across all of them
2	One identity and a shared core	One patient identity, with allergies, medications, problems and consents visible to every line that treats the patient	Shared core on one record
3	Every encounter carries its line	The line of each visit is known at booking and fixed once documentation starts	Line stamped on the visit and locked; later changes are audited
4	Clinicians work only in their lines	Each clinician is credentialed for the lines they practise	A provider assigned to no line cannot document in it
5	Sensitive records stay walled	Psychotherapy notes and Part 2 records are withheld from other lines unless an authorised clinician opens them for a recorded reason	Collapsed stub with an audited override for clinicians; denied to AI agents
6	Payment decided per visit	Each visit is claimed, charged or covered by membership according to its line, and a covered service is never also claimed	Claim guard and membership coverage resolver at every claim site
7	One portal, one bill, one audit trail	The patient sees one portal and one statement; every access is recorded in one tamper-evident log	One portal, one ledger, one audit log

Table 6. A practice that meets requirement 1 is a combined practice; requirements 2 to 7 are what its record must do. MedOp's regulatory analysis found that only an integrated, line-aware record meets all six of a multi-line practice's software requirements; a single-line platform meets none, and two platforms or a general EHR meet one each¹⁶.

SECTION 8

The global market

World health spending was about \$9.8 trillion in 2022, 9.9% of global GDP³¹. Research firms put the global markets for the same five lines at roughly \$300 billion to \$385 billion, growing at rates similar to or above the US rates. These figures are directional: each firm defines its market differently, and most were seen only in report summaries.

LINE	GLOBAL MARKET	FORECAST ANNUAL GROWTH	SIGNAL
● Behavioral health	\$151–211B	2.8–6.7%	Outpatient counselling about half of the market ³²
● PT, OT and speech	\$95–104B	6.1–7.8%	Occupational therapy the fastest-growing segment within outpatient rehabilitation ³³
● Medical aesthetics	\$24.2B (med spas)	10.7–15.9%	About 38 million aesthetic procedures in 2024, up 42.5% in four years; North America 41% of med-spa revenue ^{34,5}
● Functional medicine	\$15–25B	8.5–20%	Integrative-medicine estimates vary widely; lowest confidence of the five ²⁴
● Primary care and DPC	\$18–20B (concierge)	9.7–11.7%	Membership medicine is largely a US model; DPC-specific global figures are not credible ³⁵
Five lines	≈\$300–385B		Directional only

Table 7. Global size and growth by line. Research-firm estimates; not comparable with the US care-revenue bases in Table 2.

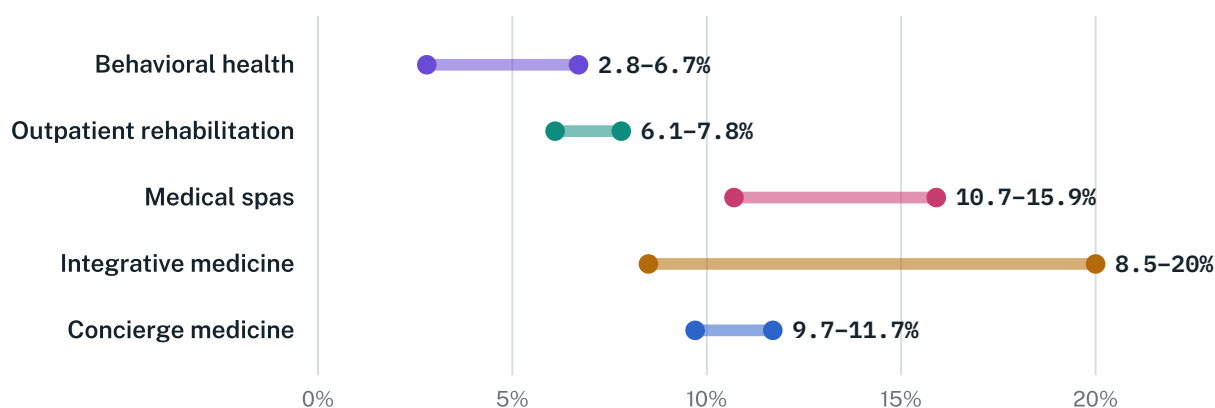


Figure 5. Annual growth by line, worldwide. Low and high ends of published research-firm forecasts, mostly 2025–2033. Sources in Table 7.

What the global picture means

- **The convergence is not only American.** Aesthetic procedures grew 42.5% worldwide in four years³⁴, and integrative care is growing on every continent. Practices outside the US are adding lines for the same reasons.
- **The rulebooks are local.** Every country regulates sensitive records, prescribing, supervision and payment in its own way. A combined record transfers only if its rules are kept apart from its code.
- **MedOp's design keeps them apart.** Line rules and state rules are held in rule packs that are reviewed before they apply, so a new jurisdiction is new packs, new privacy terms and new clinical review rather than a new product. MedOp serves the United States today; no other jurisdiction's packs are built, and the US remains the largest single market and the focus of this paper.

SECTION 9

Regulation is rising, and compliance is moving into software

The rules on these practices are growing in number, changing more often and arriving on different clocks for different lines. More of them can only be met by a system that applies them at the moment of care.

106,109

Federal Register pages in 2024, a record, including a record 45,028 pages of final rules¹⁰

95%

Of medical groups say regulatory burden rose over three years; 90% say prior-authorization burden rose in the last year⁹

39

Prior authorizations per physician per week, taking about 13 hours of physician and staff time⁵⁰

3

Changes to Medicare telehealth eligibility between October 2025 and February 2026⁴⁹

2018

Therapy cap replaced by the KX threshold, reset every January³⁶

● PT, OT and speech

Collaborative Care and behavioral-health integration codes¹⁹

● Behavioral health

● Primary care and DPC

2021–22

Information blocking in force; full electronic health information from October 2022³⁷

● All five lines

Good-faith estimates required for self-pay patients³⁸

● Medical aesthetics

● Functional medicine

● Primary care and DPC

Assistant payment differential for therapy minutes³⁶

● PT, OT and speech



Figure 6. Selected federal and state rules affecting the five lines, 2018–2028. Coloured tags show the lines each rule touches.

Three patterns

1. **Deadlines accumulate even in a deregulatory period.** Several rules were vacated, paused or delayed in 2025–26: the reproductive-health privacy rule⁴⁴, the 2024 parity provisions⁴⁵, the HIPAA Security Rule⁴⁸. Yet Part 2, the payer prior-authorization rule, USCDI v3 and the DPC tax change all took effect on schedule, and the proposed HTI-5 rule, while removing 34

of 60 certification criteria, would widen information blocking to cover AI and automated access⁴¹.

2. **Rules change on dates, and each change belongs to a line.** The therapy KX threshold rose every year from \$2,150 in 2022 to \$2,480 in 2026³⁶. Telemedicine prescribing flexibilities expire each December⁴⁷. Telehealth eligibility flipped three times in five months. A practice needs software that applies the rule in force on the date of service, for the line of the visit.
3. **Rules from different lines collide in one chart.** One patient can carry a Part 2 consent from behavioral health, a Schedule III testosterone prescription from hormone care, a good-faith estimate for a cash aesthetics service and a membership that must never be claimed. Single-line software holds one of these well; staff carry the rest.

Why this creates dependence on software control

The newer rules are written as system behaviours: release health information without delay and log any exception; tag substance-use records and carry the redisclosure notice; consume payer APIs for prior authorization; keep a running total per beneficiary; refuse a claim for a covered service. A policy manual cannot do these things. As the rules multiply, practices depend more on the system of record to enforce them, and the cost of a record that does not know a visit's line rises with every rule. That is the strongest structural argument for the combined record, and it strengthens each year the rulebooks grow.

This section summarises rules for context and is not legal advice. Status as of 24 October 2026.

SECTION 10

How care improves under this model

The case that integration improves care is strongest where it has been studied most: behavioral health delivered alongside primary care. The other gains follow from removing the gaps between lines that a fragmented record creates.

Patients with both behavioral and physical conditions are where cost and harm concentrate. In one study of 21 million commercially insured people, the 5.7% who were high-cost and had both kinds of condition accounted for 44% of total spending, while half of all patients with a behavioral condition had less than \$68 a year of behavioral treatment⁶⁵. Those are the patients a combined practice sees, and the patients a split record serves worst.

MECHANISM	WHAT THE EVIDENCE SHOWS	STRENGTH	HOW THE COMBINED RECORD APPLIES IT
Integrated behavioral and primary care	IMPACT trial: 45% of patients improved versus 19% with usual care ¹¹ . Cochrane review of 79 trials: consistent small-to-moderate benefit for depression and anxiety up to two years ⁵¹ . Intermountain: 18.1 versus 23.5 emergency visits per 100 person-years, with slightly lower payments ⁵² .	Strong	Shared record with psychotherapy notes and Part 2 walled; Collaborative Care registry, time ledger and month close
Less fragmented care	Patients of the most fragmented primary-care physicians: 9.1% versus 7.1% preventable hospitalisations and \$10,396 versus \$5,854 annual spending ⁵³ . Fewer than half of US primary-care physicians hear back from specialists about medication changes ⁵⁴ . Medication-history errors reach up to 67% of patients at hospital admission ⁵⁵ .	Moderate (observational)	One medication and allergy list across every line; interaction checks wherever a line prescribes or dispenses
Measurement-based care	Frequent symptom feedback to clinicians improves outcomes in nearly all trials reviewed ⁵⁶ , yet only 13.9% of clinicians use standard progress measures monthly and 61.5% never do ⁵⁷ .	Strong	PHQ-9, GAD-7 and PCL-5 sent on a schedule in English and Spanish, trended on the chart
Early physical therapy	Early, guideline-adherent PT for low back pain: imaging 12.8% versus 22.2%, opioid use 60.4% versus 71.1%, costs \$1,914 versus \$3,068 ⁵⁸ .	Moderate (observational)	Therapy on the same record as primary care, so referral and plan of care are one step
Safer aesthetics	A 2024 multistate cluster of botulism-like illness followed injections by unlicensed or untrained people or with counterfeit product; CDC advises licensed, trained injectors using authorised product ⁵⁹ .	Safety evidence	No injectable without a current good-faith exam, supervision record and a tracked, unexpired lot
Membership primary care	A Society of Actuaries study found 12.6% lower overall service use and 40.5% fewer emergency visits for DPC members, but total employer plan cost 1.3% higher once fees were counted ⁶⁰ .	Mixed	Membership engine with plan rules checked before publishing; claims refused for covered services

MECHANISM	WHAT THE EVIDENCE SHOWS	STRENGTH	HOW THE COMBINED RECORD APPLIES IT
Less administrative burden	Primary-care physicians spend 5.9 hours of an 11.4-hour day in the EHR ⁶¹ ; 43.2% reported burnout in 2024 ⁶² . The one multi-arm randomized trial of AI scribes found up to 9.5% less note time, with inaccuracies to review ⁶³ .	Moderate	Rules enforced at signing instead of after; AI drafts that a person approves
Functional medicine	Cleveland Clinic cohort: better patient-reported physical health at six months (+1.59 versus +0.33), not significant at twelve ⁶⁴ .	Emerging	Versioned protocols and clinician-verified labs on the shared record

Table 8. Evidence that combined, rule-enforcing care improves outcomes, safety or efficiency.

How healthcare improves

- **Fewer missed problems.** Depression and anxiety are found and treated in the practice the patient already visits, and tracked with measures rather than impressions.
- **Safer prescribing.** One medication list across therapy, hormone care, weight loss and primary care means interactions are checked against everything the patient takes.
- **Privacy that holds when lines combine.** The most sensitive records stay walled even as the rest of the chart is shared, so patients do not have to choose between integrated care and confidentiality.
- **Safer cash-pay care.** Aesthetic and IV services are delivered under recorded exams, supervision and lot tracking on a medical record, not in a booking system.
- **More clinical time.** Rules checked at signing and drafts prepared by AI agents return time that now goes to rework, denials and duplicate entry.

The limits of the evidence. No study has evaluated all five lines on one record. Collaborative Care effects are modest, and evidence beyond two years is lacking. Savings estimates for administrative simplification are models; one major review found no studies showing administrative waste can be cut⁶⁶. Integration costs money before it saves it. DPC, functional-medicine and early-PT studies involve self-selected patients. Shared records alone show weak effects⁶⁷; outcomes change when the workflow around the record changes. The model described here is built on that last point: the record enforces the workflow, not just stores the data.

SECTION 11

What would prove this thesis wrong

A thesis worth publishing should state what would refute it. These are the six developments that would weaken the case for a combined record, and how MedOp's approach responds to each.

IF THIS HAPPENED	WHAT IT WOULD MEAN, AND THE RESPONSE
Multi-line practices are fewer than the convergence data suggest	No national dataset counts them. MedOp also sells to single-line practices, especially in therapy, where enforced billing arithmetic stands on its own.
Integration costs more than practices will pay for	MedOp charges no extra platform price for added lines, and enforced billing rules aim to recover more than the platform costs. This is to be measured with the founding practices.
Incumbents add multi-line features	Several platforms already serve two or three disciplines. The durable advantage is maintained depth in five lines' rules and expansion inside accounts, not a feature list.
Regulation is rolled back	Some rules have been. The obligations that took effect in 2026 did so on schedule, and the obligations that bind practices most directly (records, consent, billing) continue to grow.
The evidence for some lines stays thin	Functional medicine and DPC outcome evidence is emerging or mixed. The combined record is justified first by safety and administration in those lines, and by outcomes where trials exist.
A clinical, privacy or security failure	Rules are enforced at signing, a person approves every clinical action an AI agent proposes, and tenant isolation is enforced in the database. Outside attestation is still to come.

Table 9. Risks to the thesis.

SECTION 12

Conclusion

The evidence supports four conclusions. First, US outpatient care is merging: practices are changing hands, adding lines and working across specialties, at a rate of roughly 10,000 practice-level events a year. Second, the five lines examined here grow faster than health care as a whole, about 6.4% a year combined, and the fastest of them are the cash and membership lines that practices add rather than buy. Third, the rules on these practices are multiplying and changing on separate clocks, and more of them can only be met by a system

that applies them at the moment of care. Fourth, the best clinical evidence shows that care improves when behavioral health and primary care are delivered together, and the remaining gains come from closing the gaps a split record creates.

Together these point to one piece of infrastructure: a single patient record that knows the line of every visit, enforces that line's rules, shares what should be shared and walls off what must not be. That is the approach MedOp has built. The market is moving toward it whether or not any one company serves it; the question for practices is whether their record moves with them.

Paul Pereira

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Method, disclosures and sources

Method

- **US care revenue** bases are those in MedOp's market analysis of 23 October 2026: IBISWorld for behavioral health and therapy; AmSpa's location count times average revenue per location for aesthetics; MedOp estimates for functional medicine and for concierge and direct primary care. They are annual revenues, not practice counts.
- **Growth ranges** take the lowest and highest credible published rate for each line. Where only counts exist (med spas, DPC sites, functional-medicine practitioners), the compound annual growth of the count is used as a proxy.
- **2030 projections** apply each line's low, midpoint and high rates to its base for five years. They are arithmetic, not forecasts.
- **Global figures** are research-firm estimates, most seen only in report summaries, and are not comparable with the US bases.
- **Merging events** combine net practice acquisitions (Physicians Advocacy Institute) with MedOp estimates of sites adding a line; overlaps are not removed.
- Figures marked **ESTIMATE** are MedOp arithmetic; figures marked **OWNER ASSUMPTION** rest on assumptions in MedOp's planning model that are not yet measured.

Disclosures

The author has a financial interest in MedOp. This paper describes MedOp's approach and is not independent research. It contains estimates and forward-looking statements, is not legal, clinical or investment advice, and is not an offer of securities. No compliance or certification is claimed for MedOp. Platform facts were measured on 19 October 2026; regulatory status is as of 24 October 2026.

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