Healthcare Mosaic

Death of the Independent PCP; Hospitals, Advanced Practices, and Managed Care Orgs Increasing Control of the Provider Market

Summary: In our quarterly Healthcare Mosaic Report, we select a far-reaching topic of interest in the healthcare space and provide a variety of data points and analyses to offer a more complete picture of what it means for the broader healthcare marketplace (and investors in the space).

In our third quarter 2018 Healthcare Mosaic Report (our 14th in the quarterly series), we take a deeper dive into the acquisition of physician practices (or direct employment of practitioners) by hospitals, managed care organizations (MCOs), retailers, and alternative (or advanced) medical practices (which we define as concierge medicine practices or regional/national medical groups) and the impact of this consolidation on our healthcare services and healthcare technology coverage universes.

More specific, in this thematic report we analyze:

- recent physician practice acquisition activity among hospitals, retailers, and MCOs, as well as the increasing prevalence of alternative/advanced medical group models;
- why physicians are increasingly seeking employment at hospitals, MCOs, and large group practices, as opposed to owning their own independent practices;
- the forces driving hospitals, MCOs, retailers, and alternative provider groups to acquire and/or employ physicians at a greater rate than ever before;
- the myriad payment, physician reimbursement, and healthcare delivery model changes that are driving physicians into these models; and
- our thoughts on potential winners and losers (both in the public and private markets) as a result of these changes.

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**Introduction**

Over the past decade, the proportion of physicians employed by health systems, MCOs, and national/regional group practices has risen markedly, as hospitals and—more recently—managed care organizations have funneled vast sums of capital toward practice acquisitions and as venture dollars have flown into the nascent market of advanced medical group practices (concierge medicine, primary care membership models, urgent care chains, etc.).

**In fact, the largest employer of physicians in the United States is now a managed care organization, UnitedHealth (UNH $268.72; via its OptumCare subsidiary), which upon completion of several pending transactions, is anticipated to employ more than 55,000 physicians across the country.** To add perspective, this is more than two-and-a-half times the size of the employed physician group at the largest provider-owned medical organization in the United States (Kaiser’s Permanente Medical Groups, with roughly 19,200 total physicians) and roughly five times the No. 2 provider/employer (the Veterans Health Administration, with roughly 11,000 employed physicians).

**Similarly, the largest hospice operator in the United States also is an insurer, Humana (HUM $333.24), which recently acquired a number of assets from Kindred and Curo Health. And managed care operator Anthem (ANTM $266.66) is also following suit via its recent acquisition of Aspire Health, which was announced in late May 2018 and positions the company as the nation’s largest (non-hospice) community-based provider of palliative care.**

In tandem with this trend, the industry also has seen a marked uptick in the acquisition of group practices by leading health systems as well as the consolidation of myriad independent practices by national/regional medical groups.

In reviewing recent data, it is evident that there is some level of disagreement as to the precise proportion of physicians who remain in private practice; however, virtually all the sources acknowledge that the percentage practicing independently has decreased consistently over the past decade—and we believe this trend will accelerate in the near future.

For example, according to a survey conducted by Merritt Hawkins for The Physician Foundation, the proportion of physicians employed by hospitals and larger medical groups rose from 43.7% of respondents to 57.9% between 2012 and 2016, while the proportion identifying themselves as independent practice owners or partners fell from 48.5% to 32.7%.

**Furthermore, a March 2018 report from Physicians Advocacy Institute (PAI) indicated that between July 2015 and July 2016 alone, roughly 5,000 physician practices were acquired by hospitals, driving up the percentage of employed physicians by approximately 11% over this 12-month period.**

Similarly, the American Medical Association (AMA) recently released data showing the percentage of physician practices that reported being owned by a hospital or health system after being independent just a decade ago (exhibit below). Of note, more than 50% of oncology practices, roughly half of all multispecialty practices, and more than 40% of general surgery practices that were independent as recently as 2007 are now part of a health system, indicating that the practice acquisition/employment trend is now pervasive across almost all specialty types.
Concomitant with this trend, it also appears that a majority of physicians have acquiesced to employment versus the increasingly burdensome life of private practice, as surveys indicate physician employment is now much more common than private practice.

For example, data released by Merritt Hawkins show that, in 2004, the proportion of new hires that were employed by hospitals was only 11%, but by 2014 this had risen to 64% of new hires. And of note, this data does not account for the direct employment of physicians by MCOs, primary care membership models, or other advanced group practices, which we estimate are expanding at even faster rates than hospital/physician group alignments.

Accordingly, the proportion of new physicians entering private practice fell from 20% in 2004 to less than 1% in 2014 (exhibit below). And we believe the decline in private practice physicians is likely to continue, if not accelerate, going forward—especially as a larger portion of the remaining private practitioners begin to retire in waves over the next five years.
To be fair, many pundits argue that this trend also could unravel rather quickly, given recent data showing increasing hospital losses due to these practice acquisitions. More specific, The Medical Group Management Association (MGMA) recently estimated that hospitals’ multispecialty physician groups lose nearly $185,000 per physician annually, with other industry groups providing similar loss estimates.

However, the MGMA data appears to simply analyze the loss by estimating the cost of physician compensation and other expenses versus the amounts these physicians directly bill for, which we believe is misleading, at least when assessed in a vacuum. More specific, this analysis generally neglects the ancillary benefits that health systems receive from direct employment of practitioners, such as increased capture of referrals for surgical procedures and/or diagnostic tests, which can be highly profitable.

Moreover, as hospitals increasingly bear financial and quality risk for the care they provide (under accountable care organizations or other capitated-risk agreements), the ability to directly employ physicians and more actively manage their referral and spending patterns will become increasingly important—another benefit ignored by the abovementioned analysis.

As another counterpoint, we also reference a July 2018 study published by Modern Healthcare (its annual Hospital Systems Survey), which showed that of the hospitals that employed more physicians in 2017 76% indicated that the move did not materially change their financial performance, 23% said it improved finances, and less than 3% indicated a negative financial impact.

Accordingly, we believe that not only will these group acquisitions remain intact, but also that they likely will accelerate in the near future, as other pressures (such as lower Medicare reimbursement rates, negative payer mix shift, and increased consumer focus on healthcare prices) further pressure provider margins.

Of note, this analysis also ignores another incentive hospitals have had to acquire physician groups—higher billing rates following the acquisition. However, CMS and MedPAC are well aware of this misalignment of interests, at least based on recent studies and novel payment updates, which would align reimbursement rates across sites of care (versus the current model where the point of care is moved from the physician’s office to the hospital outpatient department [HOPD] to obtain higher reimbursements).

For example, a study completed by Avalere in collaboration with PAI estimated that items like cardiac imaging cost 80% more in a HOPD, a colonoscopy costs 35% more, and a basic E&M code (evaluation and management of patient) was 30% higher in the HOPD—even if the HOPD is an “off-campus” building not dissimilar to the physicians’ private practice.

While data on the impact for private insurers is less readily available, it appears that cost increases due to health systems’ employment of practitioners also can negatively affect their medical loss ratios (MLRs)—in our view, a large reason that many of these MCOs are becoming active acquirers of medical groups as well (as we discuss in more detail later in this report). Put
simply, managed care organizations are employing more physicians/buying more medical groups to better control medical costs related to their capitated payments (and perhaps to provide pricing leverage against the unowned portion of their network), not to profit off of the physician practices themselves.

In this regard, we see both providers and payers shifting toward the “new middle” in healthcare, where “payviders”—or entities that both receive capitated payments for patients and are directly responsible for providing their care—are more commonplace.

As we have discussed in numerous industry reports in the past, we believe this is the largest megatrend in the U.S. healthcare marketplace today, and one that holds tremendous promise by aligning incentives between the providers and payers of care (as they become one-and-the-same versus distinct entities with opposing incentives).

*Again, we view this as a major shift in the healthcare marketplace—one with broad implications for providers, the trillions in healthcare spending that physicians direct, and the broader ecosystem of healthcare services operators and technology vendors. Accordingly, we dedicate our third-quarter 2018 Healthcare Mosaic Report to the trend toward the employment (and acquisition) of physician groups, as well as the potential impact of this paradigm shift for public and private healthcare investors.*

**Review of Recent Consolidation Trends**

*Hospitals as acquirers.* As discussed above, the trend toward hospitals acquiring group practices has been a rather consistent phenomenon over the past decade. In fact, PAI data indicates that the number of hospital-employed physicians has increased from 95,000 in July 2012 to more than 155,000 in July 2016, up nearly 64% over the four-year period (most recent data).

Similarly, data indicate that the number of hospital-owned practices has increased from 36,000 to approximately 72,000 over the same time frame, indicating that hospitals are not only directly employing physicians, but also are more actively acquiring their medical practices. For example, based on the same data, PAI estimates that, as of July 2016, hospital ownership of medical practices was up 107% versus four years prior.

Of note, most of these transactions have occurred in local markets (see exhibit below), thus not generating the press received by other megadeals in the space (e.g., Optum’s nearly $5 billion pending acquisition of DaVita Medical Group [DVA $72.21; Outperform] or its recently closed $2.2 billion stake in Sound Inpatient Physicians); however, it is clear that hospitals have been extremely active acquirers of physician practices over the past several years.
We also have seen evidence of acute-care providers more actively acquiring downstream operations outside the core acute-care and ambulatory survey center (ASC) markets. For example, Toledo, Ohio-based ProMedica recently completed its acquisition of post-acute care provider HCR ManorCare for roughly $1.4 billion, creating the 15th-largest not-for-profit healthcare system (by revenue) in the United States.

In our view, this is another clear sign of a health system’s desire to control more assets outside the core hospital setting—not to generate incremental profits on these operations (which is a secondary objective), but rather to better coordinate the care and ensure lower costs, via a narrower care network (i.e., one that is more suitable to capitated risk [like launching a Medicare Advantage plan] or direct-to-employer/narrow-network sales).

To this end, we also highlight a July 2018 survey of health system leaders from Premier Inc., which showed that the strongest drivers of M&A activity were linked to the desire to better integrate care and manage patients across the care continuum. Of note, nearly 50% of surveyed health system leaders in the survey indicated they had completed a merger or acquisition in the past two years; more important, 77% reported they expected to do so in the next two years, indicating that this trend is likely to accelerate moving forward.

**Payers as acquirers.** In our view, one of the more interesting trends of late is the increased M&A activity between managed care organizations (MCOs) and providers. As discussed earlier, UnitedHealth Group’s OptumCare division has led the charge here—accumulating approximately 55,000 physicians (including pending transactions) via myriad group practice acquisitions across the United States, including more than $10 billion invested in provider group acquisitions since early 2017 alone.

However, the company actually has been an active acquirer of healthcare providers for most of the last decade, starting with its 2008 deal for Southwest Medical Associates (250 physicians in Nevada) and then its California acquisitions of AppleCare Medical Group (in 2010), Memorial Healthcare IPA (in early 2011), and Monarch HealthCare (2,300 California-based physicians in September 2011). Later in 2011, the company also entered the Texas and Florida markets via its purchase of WellMed (with 14,000 physician offices across those two states).

While these transactions were small enough to fly under most investors’ radar screen, the company’s acquisitions of MedExpress (the largest urgent care chain in the United States), Surgical Care Affiliates (one of the largest ambulatory surgical center operators in the country), Sound Inpatient Physicians (one of the nation’s largest hospitalist providers), and DaVita Medical Group (a pending deal worth nearly $5 billion, for one of the country’s largest medical groups) have certainly...
generated a significant amount of industry buzz and, in our view, clearly indicate the insurer's appetite to own key portions of the healthcare delivery chain.

_in fact, UnitedHealth management has been clear that it has analyzed roughly 300 total markets across the United States, and that it intends to invest in healthcare providers in 75 priority markets (versus around three dozen that the company has a presence in today), which can cover roughly 60% of the entire U.S. population._

**Humana** also has been aggressive on the M&A front of late and recently reorganized a number of its owned clinics and physician assets under a novel brand: Conviva Care Solutions. In 2018, the insurer purchased Family Physician Group in Orlando, Florida (22 clinics across four counties), and then made a splash in the post-acute care space by *creating the country’s largest home health and hospice operation* by combining Kindred at Home with Curo Health Services.

More specific, the insurer—along with partners TPG Capital and Welsh, Carson, Anderson & Stowe—recently announced that they would acquire Curo for roughly $1.4 billion; this follows the trio’s December 2017 announcement that it would purchase Kindred Healthcare for more than $4 billion, with TPG and Welsh taking over the long-term care hospitals and inpatient rehabilitation facilities at Kindred and working with Humana via a venture to operate the other Kindred Assets.

As discussed in the introduction to this report, **Anthem** also is following suit, via its recent acquisition of Aspire Health, which was announced in late May 2018. Of note, Aspire is the nation’s largest (non-hospice) community-based provider of palliative care, working with patients across 25 states. And managed Medicaid operator **Centene (CNC $146.36)** recently announced the acquisition of Community Medical Group—one of the largest medical groups in the state of Florida.

**So why are managed care organizations consolidating the market?** As we highlighted earlier, we believe that insurers are investing heavily in the healthcare delivery system in order to better control patient referrals and the pricing of medical care to improve margins on their insurance operations (again, profits directly from the provider groups themselves are a secondary goal, in our view). We also believe payers are more actively entering the provider space to help offset a potentially existential threat to their business models: the movement of risk to providers, more specific, those providers with the scale and reach to directly sell their services to large employers and thus eliminate the need for an insurance “middleman” (e.g., the recent contract between Henry Ford Health and General Motors [GM $37.31]).

Regarding the ability to control medical costs via owning providers, an interesting example can be seen in UnitedHealth’s operating model. Here, data shows that UnitedHealth is attempting to move its insurance customers toward its owned physician groups throughout the United States. For instance, New West Physicians—a group of roughly 120 physicians in the Denver area—is a favored plan in United’s NexusACO Colorado insurance offering for commercial customers; of note, visits to doctors in this group carry out-of-pocket costs that can be 20% to 30% lower than visits to non-owned practitioners. Further, owning enough providers in a plan’s own network should create a stronger negotiating angle against unowned providers, especially those with historically strong market share that view themselves as essential to the network.

Similarly, UnitedHealth offers Medicare Advantage (MA) plans with lower costs to see OptumCare doctors—which the company refers to as “tier-1 care providers.” For example, in 2016 the insurer began offering MA members a $0 co-pay for standard office visits when they “choose one of approximately 380 tier-1 primary care providers affiliated with WellMed,” which is the 2011 practice group acquisition referenced above. And we expect this strategy to expand markedly after the closing of the DaVita Medical Group transaction, as the company will have a much larger footprint to offer discounted services to MA beneficiaries across the country. **In our view, this could not only provide UnitedHealth with an advantage in its MA offerings/marketing but also could pull referrals from other primary care groups in overlapping markets (further pressuring these providers to consolidate into other entities).**

This also provides MCOs with a distinct advantage in the M&A space—especially relative to providers that have yet to move their business to fully capitated agreements (i.e., providers cannot fully benefit from lower medical cost trends and must instead focus on ensuring profitable operations when they acquire ancillary assets). Accordingly, we believe the trend toward private insurers acquiring healthcare services assets will continue to grow in the future—especially as the MA population remains the fastest growing insured segment in the United States during the next decade.

**Retailers as acquirers.** We also have seen increased interest among retailers and pharmacy chains as it relates to the healthcare space. The clearest example of this is the proposed **CVS (CVS $74.92)-Aetna (AET $198.92)** deal, where CVS would parlay its experience managing drug costs (via its retail operations and Caremark PBM business) into a broader
consumer healthcare offering—leveraging its stores to provide community healthcare clinics, telemedicine (via a partnership with Teladoc), and other consumer-centric care modules.

Again, we believe this is heavily focused on the MA population, as CVS locations will serve as ideal (i.e., low-cost and convenient) care delivery sites for MA beneficiaries from Aetna, thus lowering medical loss trends, improving patient satisfaction, and maximizing returns from the MA plan. Moreover, given the largely retail nature of selling MA plans (e.g., these are predominantly marketed directly to seniors, whereas other insurance products are generally sold to large employers), the CVS stores also could serve as promising marketing platforms/consumer engagement vehicles for Aetna to expand its MA market share.

We believe a similar strategy is also afoot at Walmart (WMT $96.12), which is often rumored to be looking into the healthcare space via a potential acquisition of Humana (of note, the two organizations already work together on a Medicare prescription drug plan that offers low-cost options to participating members).

We believe Walmart stores also would be a superior customer acquisition vehicle for Medicare Advantage operations (as nearly 90% of the U.S. population is within 15 miles of a Walmart store), and the combined entity could also leverage Walmart’s pharmacists, pharmacy operations, and on-site health clinics to provide a variety of lower-cost and highly convenient care options for plan members.

Even electronics retailer Best Buy (BBY $77.61) has entered the healthcare M&A fray of late, announcing (in mid-August 2018) the $800 million acquisition of GreatCall, a supplier of mobile healthcare devices and services for the elderly that is expected to close in 2019.

We also believe these combinations could help offset emerging competitive pressures from Amazon (AMZN $1,932.82; Outperform), both by getting patients into stores more frequently and helping retail sales, while also reducing some of the risk of lost sales to the home-delivery of pharmaceuticals from Amazon.

Moreover, the combination of healthcare and retail data could promote value-added analytics on patients (including analyses of social determinates of health). For example, retail data obtained via membership/loyalty programs could be used to track unhealthy food purchasing decisions (e.g., canned soup and potato chips—which are high in sodium and thus very risky—for a congestive heart failure patient). In turn, this data could lead to proactive care management to help change these risky behaviors before an acute event occurs.

We also believe this strategy will be even more successful given CMS’s recently expanded definition of supplemental health benefits for future MA enrollees. For example, insurers likely will soon be able to include benefits such as healthy meals within MA plans, or may be able to offer items such air conditioners to patients with respiratory diseases—all of which could leverage Walmart’s massive purchasing scale economies, existing inventory, and distribution assets over a national MA member base.

Again, we therefore believe the acquisition of more medical assets by retailers also is in its early stages.

The rise of alternative/advanced medical group practices (membership models, concierge medicine, urgent care, etc.). Another relatively recent phenomenon is the rise of alternative/advanced medical group practices—many of which serve smaller patient bases, but augment their sales via annual membership fees or upside from risk-sharing agreements (e.g., two-sided Medicare Accountable Care Organizations, or ACOs).

These practice range from concierge medicine groups (which charge the highest annual membership fees but offer the most customized service and maintain the lowest patient count—e.g., MDVIP, which is majority owned by Leonard Green & Partners) to primary care membership models (where consumers pay a small annual fee, typically around $150 to $250, to have easier access to a local primary care practice—e.g., One Medical—which is now in nine major metropolitan areas [Boston, Chicago, Los Angeles, New York, Phoenix, San Francisco, Seattle, San Diego, and Washington, D.C.] and works with more than 1,000 employers to offer One Medical as part of their benefits package). Of note, One Medical recently received a novel investment of up to $350 million in growth capital from Carlyle Group, which likely will accelerate expansion plans in the near future (with the company indicating it is set to double both its number of offices and member base over the next several years). This in addition to the roughly $180 million the company received, since launch, from investors such as JP Morgan (JPM $116.13), Alphabet’s GV (GOOGL $1,245.86), Benchmark, and Maverick.

There also is a large subset of national, physician-led delivery networks (many with both specialists and primary care doctors) that partner with population health management and technology companies to develop high-performance networks (e.g.,
those with the ability—and combined scale—to bear financial risk, join ACOs, sell direct to large employers). Many of these national operators either partner with physicians (who then pay management fees to the organization) or directly employ the doctors (and then share upside revenue generated from the value created in shared-savings models [which encourages these physicians to focus on lowering the cost-of-care and driving superior outcomes]).

**We also believe these practice models are focused on very specific patient populations**—for example, the infrastructure and support services of a national group focused on chronically ill Medicare Advantage (MA) patients or PACE participants (The Program for All-Inclusive Care of the Elderly, which are generally both dual-eligible and qualified for skilled nursing care) is vastly different than that of one focused on a relatively healthy commercial population (e.g., Oak Street Health and InnovAge vs. One Medical).

In the former, there is a greater need for larger health centers, senior services, transportation services, medication management, coding and risk adjustment, quality reporting, home care, etc., which creates a cost structure (and reimbursement needs) that cannot be supported by a healthy commercial population (which needs more urban locations, small offices and labs, technology-enabled solutions like telehealth consults, and basic primary care services).

Of note, **we believe these advanced practice models will become hugely disruptive to traditional primary care physician (PCP) practices**, which see all types of patients/take all payers. Put simply, today’s PCP model is antiquated and makes little sense, in our view, as the needs of each patient/payer are so different. Nonetheless, this remains the standard of care in most markets, yet we believe this is set to change rapidly over the coming years.

To assist investors in analyzing this trend, the exhibit below provides our view of the patient base, reimbursement environment, and key infrastructure needs for a variety of advanced practice models (note the PCP practices’ goal to be all things to all payers/patients).
A good example of the rapid growth in advanced practice models can be seen in **Privia Health**, which has established leading market positions in several geographies across the United States, with more than 500 locations and nearly 2,000 physicians that care for more than 6 million patients per year.

The company captured $400 million in capital in late 2014, via an investor group led by an affiliate of Goldman Sachs (GS $242.43), Pamplona Capital, Cardinal Partners, Brighton Health, and the company’s initial investors, and has since become what we believe to be the largest such model in the United States (both by investing capital in some “anchor” provider groups as well as partnering with other groups under revenue models that either capture a percentage of total collections or a share of the margin earned in risk-based contracts).

Of note, Privia Health leverages its own electronic health record as well as practice management vendors, including **athenahealth** (ATHN $154.57; Market Perform) and **Quality Systems** (QSII $22.66; Outperform), by layering additional technology tools onto these platforms in order to manage its practices, and its ACOs rank in the top 7% of the nation. The company also has achieved a 98% quality score in the MSSP (Medicare Shared Savings Program) along with hospital readmission rates that are 15% lower than industry averages and overall hospital admission rates roughly 20% below industry norms, according to the organization.
Another example is agilon health (backed by Clayton, Dubilier & Rice in 2016), which partners with primary care practices in order to provide the capital and proprietary technology needed to transition to value-based care delivery. Of note, agilon health works with more than 1,800 primary care physicians across several states, currently serving roughly 600,000 member lives. And, similar to Privia, the company partners with other technology organizations to augments its internal systems; for example, the company recently announced a partnership with HMS Holdings (HMSY $31.65; Outperform) to leverage the organization’s HMS Essette care management technology.

More recent entries also include providers like Aledade (which was co-founded by Dr. Farzad Mostashari—the former National Coordinator for Health IT at the Department of Health and Human Services, and is backed by Biomatics Capital, Venrock, ARCH Venture Partners, and Alphabet’s GV). In the Aledade model, providers fully maintain their practices, but pay Aledade a monthly fee of $1 per attributed at-risk beneficiary that the company helps manage (mostly Medicare Shared-Savings programs, like ACOs). In return for this membership fee, the practice receives support in designing and applying for risk-based programs (e.g., ACOs), a cloud-based population health management platform, and a variety of other services (shared practices, in-office consulting support, practice transformation assistance, etc.).

Publicly traded Evolent Health also participates in this space, having formed partnerships with several large physician groups (e.g., Georgia Physicians for Accountable Care with 630 physicians; SOMOS IPA with 300,000 at-risk lives in partnership with Evolent; and Hill Physician Medical Group, a Next Gen ACO partner). Of note, Evolent Health not only provides these members with various technology, TPA (third-party administrator), and care management services for a per-member per month (PMPM) fee, but has also become an owner (via minority investments) in several entities, with the capital infusion provided to offer balance sheet flexibility for these entities to take on financial risk.

Of note, physician-lead organizations have performed well in risk-based financial models, so we anticipate more growth in this space going forward (especially as Medicare requires more risk bearing over time, as discussed in the next section of this report). For example, a 2016 Health Affairs analysis showed that physician-lead MSSP (Medicare Shared-Savings Program) participants achieved shared savings at a rate greater than 30%—on par with integrated physician-hospital organizations and outperforming the less than 25% shared-savings success of hospital-only groups. Across groups, tenure in the program also lead to better results, which should encourage some patience with these evolving models, in our opinion. The analysis also found that the strong performance from physician-lead groups was a multi-year occurrence, leading to the conclusion that these groups are structurally well suited to deliver on the dual objective of higher-quality care with lower costs, on top of being nimble enough to quickly and cohesively make changes to care delivery.

Other organizations in the space include Alignment Healthcare (which both offers health plans in certain markets and partners with other plans in several other geographies, and is backed by General Atlantic and Warburg Pincus), ConcertoHealth (which operates exclusively in value-based care arrangements and reports more than a 30% reduction in hospital admissions and 17% reduction in readmissions; backed by Aboretum and Deerfield Management Company), Oak Street Health (which works with more than 45,000 Medicare patients throughout the Midwest [primarily taking on capitated payments for these lives], and operates roughly 40 care centers—Oak Street is also backed by General Atlantic), Iora Health (an integrated care provider operating in seven states, which has received more than $200 million in growth capital—including a $100 million funding round in May 2018 led by Flare Capital partners [an existing investor]), Landmark Health (which offers home-based medical care to roughly 80,000 lives across 13 states—including partnerships with a number of national/regional health plans and, again, is backed by General Atlantic [via a March 2018 funding round] as well as Francisco Partners [a founding investor]), and VillageMD (whose network now includes more than 2,500 physicians across seven markets who are responsible for around 500,000 lives and $2.8 billion in total health care spending; the company also highlights: “admissions and readmissions rates 20 to 45 percent lower than the community, Medicare costs 20 to 45 percent lower than the community, and commercial costs 15 to 20 percent lower than the community.” Of note, VillageMD is backed by Oak HC/FT and Athyrium Capital Management—the latter of which led an $80 million funding round in January of 2018).

We have also observed increasing momentum for financial sponsors building out regional or national platforms (e.g., Ares recent acquisition of DuPage Medical Group from Summit Partners for nearly $1.5 billion) or investing in single-specialty practices. Specialties like dermatology, ophthalmology, and gastroenterology, for example, are attractive because of stable consumer demand, a favorable mix of service types and related products provided, steady reimbursement characteristics, and both fragmented and scarce supply (small practices and not enough specialists). As an example of the growth of these transactions, Irving Levin Associates estimates that dermatology transactions were up roughly 50% in 2017 alone. Single-specialty platforms also allow for better deployment of technology, scaling administrative needs, and, with some regional density, better negotiations with payers.
Regarding the use of technology, Quality Systems (known for its ability to be customized for a wide variety of specialties) has talked about this theme as a positive driver of sales growth and Modernizing Medicine, a private company that delivers specialty-specific EHR and practice management technology (in particular focusing on the aforementioned specialties) has been one of the best growth stories in the healthcare IT in recent years; albeit, we also attribute the company’s success to its to cloud-based, touchscreen-native technology as well as its highly regarded automated billing features with underlying code written by physicians trained by the organization.

Lastly, we believe there is also increased interest in medical clinics inside of large employers—highlighted by the mid-August $165 million funding round to fuel expansion of Paladina Health (which was acquired from DaVita by New Enterprise Associates in 2018 for a rumored $100 million). Moreover, industry leaders like Premise Health (which was sold to OMERS Private Equity in July 2018 for what we believe was more than $1 billion, and is now operating more than 600 health and wellness centers across the country), QuadMed, and Marathon Health (backed by Goldman Sachs) all continue to see strong growth for their onsite clinic operations. We also note Amazon’s recent entry into the space, via a pending clinic for workers at its Seattle headquarters (with the company stating it is, ”starting small with a pilot, but is looking to expand the effort early next year.”)

So Why Are Physicians Moving to Novel Employment Models?
As discussed earlier (as well as in previous reports, including our second quarter 2017 Mosaic, “The Growing Prevalence of Physician Employment by U.S. Healthcare Providers”), physicians today face myriad challenges that make sustaining a successful individual practice increasingly difficult. More specific, increased legislative and regulatory pressure, competition from ancillary care providers, and difficult payer negotiations create increasing bottom-line pressure, while the accompanying administrative and documentation burden often create hours of extra work that quickly leads to burnout for individual practice owners.

Beginning with the first point, a number of legislative and regulatory changes—such as the Affordable Care Act, MIPS, Meaningful Use, myriad quality-reporting initiatives, etc.—enacted over the previous decade were created to encourage providers to increasingly shift to value-based, rather than volume-based, care delivery. However, in reality, compliance with these regulations also places a heavy cost- and time-investment burden on individual and small group physician practices—directly and indirectly—thus making it increasingly difficult to maintain independence.

For example, more than 90% of physicians surveyed in the ProCare Systems 2015 Independent Physician Outlook Survey (the most recent iteration of this survey) identified rising costs, increasing reimbursement pressure, and competition with major health systems for referrals as the most challenging aspects of running an independent practice, as shown in the exhibit below.

As mentioned above, novel legislation also requires physicians to document patient encounters on multiple levels to comply with myriad quality measures—creating an administrative burden that continues to take a toll on independent physicians, an
issue that was emphasized in an August 2018 Committee on Ways & Means report (Medicare Red Tape Relief) that highlighted that physicians now spend nearly two additional hours of paperwork for every hour they see patients.

Moreover, according to the 2018 Medscape Physician Compensation Report, 56% of physicians reported spending between 30 and 45 hours per week with patients, while 44% reported spending 17 or more hours on paperwork. This means, essentially, that nearly 50% of individual physicians spend at least one-third of their time on paperwork and administrative duties (as shown in the exhibit below).

Many physicians argue that this amount of administrative work is excessive, as it takes away time that the physician could otherwise be spending with patients to provide more quality and personalized care. Excessive paperwork also adds to an already busy work schedule, and is a driving factor behind increasing rates of physician burnout (which studies indicate is at an all-time high).

As a result, physicians are increasingly turning to employment models to ease this burden and improve quality of life, as larger physician groups or employers (including managed care organizations and larger providers) possess the necessary EHR and
administrative resources to help lift this burden from individual providers, allowing them to spend a larger portion of their day with their patients.

Second, the abovementioned regulations also create direct reimbursement pressure on independent practices by penalizing those that do not meet specified savings/quality targets—essentially forcing these physicians to compete with one another in a zero-sum game for reimbursement dollars.

Of note, to avoid these penalties, physicians have a few options, including:

1. Join an Alternative Payment Model (APM), such as a Next Gen ACO, to exempt themselves from the program; however, this typically is a difficult endeavor that often requires expensive IT investments; in addition, CMS only includes ACOs with “two-sided” risk models (both upside and downside risk) as qualifying APMs, thus forcing providers to bear more of the direct payment risk than older generation ACOs.

   Importantly, this compares with the vast majority of ACOs today that are “upside only” and do not penalize participants for losses. Moreover, **this trend will only intensify in the near future**, as the potential upward/downward adjustment to Medicare payment rates for physicians not in APMs will increase from 4% in fiscal 2019, to 5% in 2020, 7% in 2021, and 9% for 2022 and beyond.

Moreover, under MIPS, the amount of revenue that must fall under these APMs increases markedly over the coming years—from 25% of qualified Medicare FFS revenue in 2019–2020, to 50% in 2021–2022, and to 75% for 2023 and subsequent years, as shown in the exhibit below.

<table>
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<th>Percentage of Physician Revenue that Must Fall Under APM</th>
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<td><strong>Payment Year</strong></td>
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<td><strong>Percentage of Payments in APM</strong></td>
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*Source: CMS*

**Stated differently, both the exposure to risk-based models (as a percentage of total Medicare dollars received) and the potential reimbursement changes to providers will only intensify going forward—thus pushing a massive wave of providers into these APMs over the coming years, in our view.**

Again, we believe this could become a less attractive option for individual providers, as many do not possess the necessary capital or infrastructure to take on this risk. Moreover, even providers who do participate in these models likely will seek out operating partners that can offer balance sheet and technical support, such as Evolent Health, Privia Health, or Aledade, among others, which should create a material growth opportunity for these organizations going forward, in our view.

2. Sell to a larger entity (such as a managed care organization, national chain, or hospital system)—an increasingly popular choice, as it is much easier than spending the money to invest in IT or taking on the risk of payment penalties.

   In this scenario, the acquirer of the group takes on the payment risk and typically places practitioners on a salary/bonus system. The acquirer almost always has the IT and administrative support to run larger programs as well—thus eliminating this burden from the individual practitioners; however, it also requires independent physicians to give up much of their autonomy (a difficult proposition, especially for well-established practitioners).

3. Simply drop Medicare and Medicaid patients, and only accept cash payment or payment from commercial insurers (or working with a provider like MDVIP to convert to a concierge practice); however, this is a high-risk option that is highly dependent on patient demographics, and many physicians simply cannot afford to turn away new revenue (even low-margin Medicare and Medicaid payments).

Regarding the last point, according to the 2018 Medscape Compensation report (an annual survey of more than 20,000 physicians across nearly 30 specialties) 19% of physicians intend to drop insurers that pay poorly. However, 22% of
physicians said that they cannot afford to drop any payers regardless of how poorly they pay (an increase from 18% of physicians in 2017), as shown in the exhibit below.

![Will You Drop Payers that Pay Poorly?](image)

Source: 2018 Medscape Physician Compensation Report

In our view, provider reluctance to drop patients (even the low-paying ones) also stems partly from the lack of bargaining power associated with being an independent practice or small physician group, as these groups have limited leverage against large national payers. In addition, as mentioned above, independent and small group providers also have a tough time competing with larger health systems to obtain referrals, as many systems prefer to refer in-house, so generating novel patient revenue is often very difficult (especially as these providers are increasingly acquiring other provider assets that compete with these practices, creating a downward spiral that further forces groups to sell).

Furthermore, we believe other factors, such as student debt and other family obligations, influence newer independent and small group physicians’ appetite for risk. For example, increasing levels of student debt are forcing more recent graduates to choose employment over an independent or small group practice, as many opt for an immediate (and secure) paycheck rather than taking on the risk of self-employment.

To illustrate the magnitude of the student debt problem, we turn to the 2018 Medscape Physician Wealth and Debt Report survey, which notes that the average amount of student debt for recent med-school graduates is $190,000, and that more than 45% of physicians age 35-49 are still paying down student debt. Furthermore, student debt ranks as the third-most-common expense for physicians, behind only a mortgage and a car loan (as shown in the exhibits below).
Third, many independent physician practices are ill-equipped to manage a consumer-centric (rather than payer-centric) business. We often highlight the positive attributes of the shift toward a more consumer-centric environment (a topic we explore in depth in our annual Consumer-Centric Healthcare report); however, while such a marketplace is a clear positive for patients (as it lowers the price of care while simultaneously increasing the quality), many independent and small-group physicians are simply not equipped to thrive in this environment.

More specific, in a fee-for-service environment, providers generally rely on payers and established referral networks to obtain patients—and since the insurance company is responsible for the largest portion of the payment, and patients often see little-to-none of the bill, they are somewhat less selective when deciding where to receive care (as long as the provider is in the insurance network).

However, as the consumer-centric model begins to take hold and high deductible plans force patients to pay a greater portion of the bill, patients begin to act more like traditional consumers. As a result, providers are being forced to cater to more traditional consumer values, such as cost, convenience, and customer service, in order to attract/retain patients.
William Blair

While larger hospitals and managed care organizations have no problem investing in the latest technologies and marketing strategies to improve the customer experience, many independent and small group physicians do not possess the necessary skills or resources to manage this part of the business at scale. For example, many independent physician practices cannot afford to offer telehealth—a less expensive and much more convenient option than an in person visit for minor health issues such as a common cold or pink eye.

In addition, many of these practices do not possess the necessary customer relationship management (CRM) systems to perform simple marketing tasks that many larger organizations take for granted, such as search engine optimization (essentially strategies to appear at the top of a Google search), online bookings, or achieving positive Yelp reviews. As consumers turn to more familiar sources to shop for care—such as Google and Yelp—these tasks become more important for physicians to manage.

Again, to improve performance in these areas, we are starting to see independent practices respond by turning to vendors such as MDVIP or Privia, similar to the response associated with the risk-bearing ACO situation discussed above.

Lastly, the abovementioned trend of insurers and retailers consolidating the market likely will place enormous pressure on small practitioners going forward. More specific, while the competitive environment historically was other doctors in a given market, the new competition will be names like Walmart, CVS-Aetna, and UnitedHealth—all of which have massive scale (even relative to the largest health systems in the United States; e.g., the combined sales of CVS-Aetna will be roughly six times larger than HCA Healthcare [HCA $130.24; Market Perform]).

Again, these entities can (and will) increasingly steer customers toward their owned groups versus independent practices, which will make it difficult for any freestanding practices to thrive in the future (aside from those with unique qualifications, extremely loyal clientele, or in rural markets where there likely will be less pressure from consolidation). And as lives increasingly transition to Medicare Advantage plans (another megatrend that we expect to sustain momentum going forward), we believe this phenomenon will only accelerate.

In our view, this is perhaps the least obvious trend (at least today), as many physicians do not yet realize this as an existential threat to their current operating models. However, we believe this will soon emerge as the largest driver of the death of the independent physician practice over the coming years.

Our Take on Winners and Losers

In our view, there are several pure-play investment opportunities on the above discussed trends, as well as a number of providers that stand to benefit from selling point solutions or incremental service offerings related to the changing marketplace.

However, as it relates to winners and losers, we see the largest potential losers as acute-care operators—particularly those that remain focused on inpatient volumes to drive fee-for-service revenues. More specific, as provider consolidation continues, the key areas of focus will be on better managing patient care across the continuum, tightening provider networks, and reducing expensive acute-care utilization. Thus, providers that do not embrace value-based care stand to lose the most over time, in our view.

While they are outside of our coverage universe, we also believe manufacturers of commodity products or me-too medical devices with limited clinical differentiation could face pressure as this consolidation trend continues. Regarding commodity products, they likely will be purchased under hospital GPO contracts at lower pricing; regarding me-too medical devices (or higher-cost devices without proven benefits to outcomes), we believe the ability to drive physician alignment toward common device use (including the ability to now share savings and to provide risk-adjusted quality data to physicians) could affect a variety of vendors.

We also believe healthcare technology providers that solely focus on small group practices are at risk, as larger aggregators may seek to move these providers onto their existing IT platforms; conversely, we see larger HCIT vendors like Cerner (CERN $65.56; Outperform) and Epic as net beneficiaries of this trend given their large installed base and dual ambulatory/inpatient offerings.

In our view, ambulatory-focused vendors face more nuanced challenges and opportunities: they need to have breadth to address the unique needs of a variety of specialties but also the scalability to rollout efficiently across larger groups (i.e., better
to be customizable or specialty-specific and cloud-based in nature). Concomitantly, they need to offer the breadth of solutions to arm smaller, regional practices to compete with larger organizations (i.e., help those that have avoided selling) while also promoting the interoperability needed to support the additional technology layers often added by larger national practices (e.g., athenahealth and Quality Systems supporting Privia’s growth).

We also believe managed care organizations—especially those with larger Medicare Advantage books of business—will be net winners in the space; this includes organizations like UnitedHealth Group and Humana, among others.

As mentioned earlier, operators that focus on converting (or establishing) private practices to novel delivery models—such as Privia Health, One Medical, Oak Street Health, Aledade, Alignment Healthcare, ConcertoHealth, Iora Health, VillageMD, and MDVIP—also face a strong growth outlook, in our view. More specific, their practice support and care delivery models (which generally are built from the ground up to support a specific patient population—e.g., Oak Street Health and highly acute Medicare patients or One Medical and younger, healthier, privately insured individuals) should benefit from physicians’ desire to alleviate administration, reporting, and IT burdens of independent practice while focusing more on maximizing patient outcomes (thus driving more groups to join their practices). Conversely, the total market for these practices is shrinking each year as more hospitals/MCOs acquire practices and employ more physicians directly. Thus, we believe those entities that convert/establish practices (versus acquiring them) are set to have better returns going forward.

Telehealth providers like Teladoc, MDLive, and American Well should also thrive in this market, as a means to both load-balance physician supply and demand going forward and to help systems better manage care delivery and population health across their networks. And entities like Tabula Rasa Healthcare should thrive as they partner with larger entities (like MDVIP and various risk-based provider groups in areas such as PACE) to help lower the cost of care and improve outcomes through their medication management technologies and services.

We also see Evolent Health as a pure play investment on the trends, as systems and larger groups likely will increasingly engage the organization to develop networks, transition to value-based care, and to perform third-party administration (TPA) services when capitated contracts are captured.

Premier Inc. should also see increased opportunities in its performance services division from this trend; for example, the company recently launched a Physician Enterprise Collaborative (in the summer of 2018), and management recently indicated it was one of the most in-demand areas within the operating segment.

We also see a number of broader implications from this trend, as follows:

- More consolidation of group practices or individual physicians should afford larger health systems (or national group practice operators) increased negotiating leverage with commercial payers. For instance, after joining a national medical group practice, we believe commercial payment rates for physicians often increase—sometimes effective immediately—as they move under the national groups’ pricing umbrella. Payers are also more willing to work with larger vendors in narrower networks/value-based care partnerships, which should be a further boost to these providers, in our view.

- The acquisition of certain specialties (e.g., primary care, surgical specialists, where physicians have a choice of where to refer patients and/or where to perform higher-value procedures) can have drastic effects on local market shares. Therefore, we expect bidding for these groups to remain active and anticipate that many health systems and managed care organizations will continue to focus on employing/acquiring these practices over time.

- Conversely, for areas that do not directly affect patient volumes (e.g., radiology, emergency medicine, hospitalists, anesthesia, and intensive care, where the patient is already in the acute-care facility when these practitioners become involved), we see very little appetite for hospitals to acquire. Rather, we believe the national group practice operators will continue to consolidate these markets and then provide outsourced services to hospitals in these practice areas. We also see little appetite in the managed care world for such assets, other than for hospitalists—which can be leveraged to better manage patient care for health plan members that require some level of inpatient care.

- Again, for EHR vendors, the acquisition of group practices can be a double-edged sword. More specific, the consolidation of smaller practices could drive attrition at outpatient-only EHR vendors, especially if the health systems require acquired practices to drop an incumbent vendor to move to a different, integrated (acute and outpatient) EHR solution already in place at the system. Conversely, vendors with the ability to integrate effectively with existing inpatient solutions via
electronic data exchange and interoperability solutions may be able to thwart this risk. Moreover, larger technology providers with both robust acute and ambulatory solutions should see benefits.

- Similarly, we believe business services providers to the ambulatory care space could face more pricing pressure in the near future, as smaller practices move into larger health systems that either purchase products and services at discounted rates via group purchasing organizations (GPOs) or that will simply look to use their scale to bundle acute/ambulatory purchases at a discounted rate in the future. For example, Stericycle has seen some pressure related to this trend, as its small-quantity customers have been acquired by larger vendors seeking price resents.

- Healthcare technology vendors that provide solutions for quality reporting, workforce management and training, and clinical integration should continue to thrive in this market, especially for vendors that offer solutions traversing both the acute and ambulatory markets.

- Lastly, we believe consultancies that focus on clinical effectiveness, workforce integration and alignment, and overall workforce efficiencies should continue to thrive in this marketplace—as hospitals either look to maximize past investments in practice acquisitions, or seek alternative means to better align with independent physicians to drive market share or better manage the health of entire populations.

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DOW JONES: 26049.60
S&P 500: 2896.74
NASDAQ: 8017.90

Additional information is available upon request.

Current Rating Distribution (as of August 28, 2018):

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