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INDUSTRY RESEARCH

The Value-Based Care Enabler Landscape

PitchBook is a Morningstar company providing the most comprehensive, most accurate, and hard-to-find data for professionals doing business in the private markets.

Executive summary

- Value-based care (VBC) enablers are companies that help independent medical groups and health systems transition from fee-for-service toward value-based contracting via wraparound services and affiliation with the enabler's network.
- We believe enablement is the most important mechanism by which the VBC transition will play out in the US over the next 5-10 years, for both primary care practices and health systems.
- Currently, the success of an enabler depends on its ability to gather enough attributed lives to increase operating leverage while simultaneously moving new partnership cohorts through the J-curve into profitability. In the future, enablers will compete on payer relationships and network quality.
- At present, VBC enablers report that they usually do not compete directly for partnerships. However, we believe competition will significantly increase within the next three years or so. Consolidation among enablers is also likely, though not imminent, while customer acquisition costs remain low.
- Enablers differentiate themselves along three different axes: target partner profile, target payer type, and degree of control. In this note, we profile six VC- and PE-backed enablers—Aledade, Equality Health, Pearl, UpStream, Vytalize, and Wellvana—and five publicly traded ones—agilon, ApolloMed, CareMax, P3 Health Partners, and Privia.

Introduction

VBC enablers are companies that help independent medical groups transition from fee-for-service toward value-based contracting via wraparound services and affiliation with the enabler's network.

The VBC enabler business model began to attract investor attention in the mid-2010s, and four companies, agilon, CareMax, P3, and Privia, went public in 2021. A fifth, ApolloMed, had been publicly traded on the OTC market since 2008 and on the Nasdaq since 2017. There are also several privately held enablers, of which the most important are Aledade, Equality Health, Pearl, UpStream, Vytalize, and Wellvana. Cumulatively, these companies have raised more than $570 million since 2022. This report focuses only on primary care and multispecialty enablers, but specialty enablers have also emerged in a number of categories, including Somatus (kidney care), Wildflower (maternity), and Karoo (cardiology).

The basic business model is as follows: The enabler builds a network of practices, primarily through affiliation but sometimes through acquisition. The enabler provides partnered practices with proprietary population health software with no subscription cost. Plugging into a standard EHR, this software typically guides providers on care pathways, prompts interventions for at-risk patients, and provides an analytical view of outcomes and contract performance. Aggregated/de-identified data from across the enabler's cohort is used for benchmarking. The enabler handles contracting and payer relationships via one or more accountable care organizations (ACOs). The enabler also offers services to facilitate the practice's transition toward value, which can include consulting/change management, white-labeled care coordination/case management, home care teams, and partnerships with other providers, such as behavioral health groups and skilled nursing facilities. Financially, the enabler shares in the upside resulting from value-based contracts and absorbs downside risk for its partnered practices. The classic model is for the enabler to take 100% downside risk and a cut in the vicinity of 60%-75% of shared savings, but there are numerous variations depending on the enabler and type of partnered practice.

Evaluating VBC enablers

Enablers differentiate themselves along three different axes: Target partner profile, target payer type, and degree of control.

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Target partner profile: All enablers partner with practices of a variety of different sizes, typically entering a new market with one or more beachhead physician groups before expanding via smaller partnerships. However, there is significant variation in focus. Vytalize and Equality Health specialize in working with small physician practices, while agilon is pursuing rapid scale by stacking up large physician group and health system partnerships. In the middle of the spectrum, Pearl, Wellvana, Aledade, and UpStream build networks through a combination of small and large practice partnerships. Pearl and Wellvana aspire to health system partnerships in the future.

Target payer type: Most VBC enablers focus on Medicare. Pearl and Aledade have most of their value-based attributed lives in the Medicare Shared Savings Program (MSSP) or commercial value-based contracts, while agilon, ApolloMed, P3, and CareMax focus on Medicare Advantage (MA). Pearl, Wellvana, and Vytalize all have

roots in ACO REACH but are expanding their MA footprints; of the three, Wellvana is farthest along in this journey. UpStream is about 50/50 ACO REACH and MA; Equality Health focuses on Medicaid and dual eligibles but also manages MA lives.

Payer type matters for several reasons. In terms of degree of risk—and potential for upside—MA capitation and the ACO REACH global track are the most advanced, while MSSP can involve minimal to moderate risk depending on which track is selected. Commercial value-based contracts vary widely but rarely involve global capitation. All government payer revenue is subject to stroke-of-the-pen risk, but this varies by type. Although MA capitation has traditionally been the most lucrative VBC arrangement for primary care (if successful), the 2024 final MA payment rule combined with recent star ratings modifications and RAD-V audit changes promise to tighten MA plan margins over the coming years, which will inevitably be passed down to providers. The ACO REACH program is currently being piloted through 2026; CMS could significantly modify the program in its next iteration. In Medicaid, reimbursement dynamics are largely determined at the state level, making risk diversification easy but staying abreast of the fragmented policy landscape difficult.

Degree of control: There is a range of different approaches to enablement partnerships. The most common method is for the provider to sign a multi-year contract to affiliate with a network managed by the enabler. There are many ways to structure these organizations, including as clinically integrated networks or independent practice associations (IPA)s. However, because enablers generally operate ACOs, the primary affiliation method is often a participating provider agreement (PPA). In some cases, enablers operate management services organizations (MSOs), which, depending on how the management services agreement is structured, can provide greater operational and financial control and/or allow the enabler to collect FFS revenue in addition to shared savings; this is Privia's model. ApolloMed and CareMax have built a tightly controlled "core" via acquisitions and/or de novo clinic openings before expanding peripherally via MSO or network affiliation. The core provides a proof of concept for the enabler's clinical model and typically outperforms more loosely controlled network affiliates.

Generally speaking, enablers must weigh the tradeoffs of tighter control resulting in more predictable performance in value-based contracts, versus a more flexible approach enabling rapid penetration of new markets. For example, agilon and Wellvana tend toward tighter alignment, while Pearl employs a light touch.

Enablers at the center of the VBC transition

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We believe enablement is the most important mechanism by which the VBC transition will play out in the US over the next 5-10 years. VBC fundamentally requires scale. As we have written elsewhere, the up-front investment required to achieve good value-based care is significant. Additionally, providers must have the financial capacity to absorb risk and must negotiate complex contracts with payers one-by-one and/or navigate the unstable landscape of CMS alternative payment model programs. Finally, an entity taking on risk in value-based contracts needs access to—and preferably some control over—a large network of specialists and skilled care and community services providers to manage patients longitudinally.

There are three ways to achieve scale as a VBC provider: aggregation, de novo expansion, and enablement. Each model has advantages and disadvantages, which we have discussed elsewhere. Our conviction around enablement stems from an assessment of the competitive landscape. In the scale game, Optum is the clear frontrunner, serving around 3 million members in capitated arrangements while rolling up multispecialty, home health, and behavioral health assets. UnitedHealth Group has spent more than $15 billion on major provider M&A deals since 2021, not counting the pending $3.3 billion deal for Amedisys.

Numerous PE-backed primary care roll-ups will eventually end up in the hands of one of these strategics. However, PE sponsors have not succeeded in rolling up primary care clinics at the pace they roll up procedural specialties such as dentistry, dermatology, and ophthalmology; fee-for-service primary care is a low-margin business, and moving an acquired practice onto enough risk to generate more revenue takes years of painstaking operational effort. Thus, scaled VBC provider assets are being acquired faster than they can be created. De novo expansion rates by the likes of Oak Street (CVS) and CenterWell (Humana) have likewise been modest, remaining solidly in the double digits of clinics per year. The only feasible way for Optum's competitors to reach comparable scale in VBC is through an enablement model. We would not be surprised to see a major strategic (e.g., CVS, Humana) acquire a VBC enabler within the next five years.

So far, our discussion has focused on ambulatory physician groups. Enablement will also become increasingly important for health systems. Several enablers, including agilon and Privia, have already announced health system partnerships. Optum also provides VBC enablement services to health systems. Kaiser Permanente's language around its Risant Health platform suggests an M&A-based health system enablement model, with Geisinger Health, already a leader in VBC, as the first of half a dozen or so acquisitions. But M&A cannot be the primary mechanism for health system VBC enablement due to antitrust concerns, not to mention the fact that many health systems are financially unattractive assets. We suspect that Risant may eventually begin to offer VBC enablement services after establishing a core of owned health systems and that other enablers will increasingly position themselves as health system partners.

Competitive outlook

At present, VBC enablers report that they usually do not compete directly for partnerships. However, we believe competition will significantly increase within the next three years or so. Although there is some room remaining for new Medicare-focused entrants, the window of opportunity is quickly closing. There is ample greenfield in Medicaid, where Equality Health is virtually alone.

Initially, enablers will differentiate in head-to-head competition based on the target practice's preferences in terms of software, support services, and alignment model, as well as the enablers' performance track records and willingness to share upside. Some practices will desire more hands-on support and financial stability, while others will look for a tech-first solution or help managing a specific population. The success of an enabler will be determined by its ability to gather enough attributed lives to increase operating leverage, while simultaneously moving new partnership cohorts through

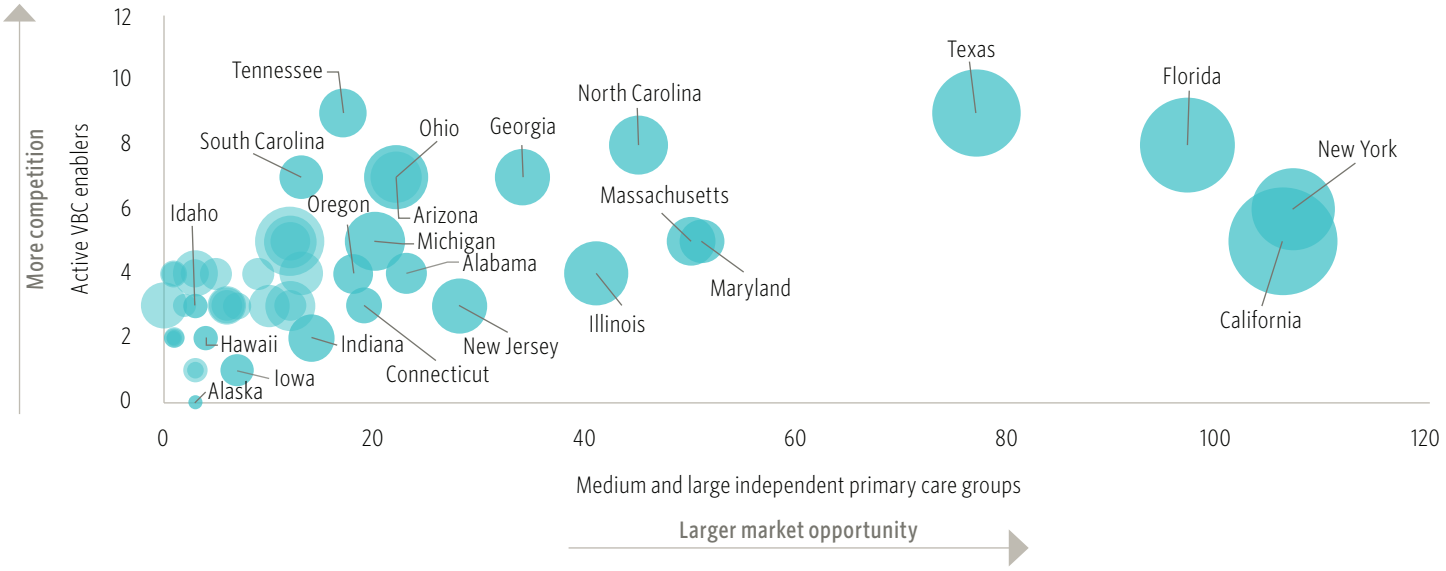
the J-curve into profitability. To achieve this balancing act, enablers must achieve predictable, replicable clinical results.

In the longer term, some larger and more sophisticated partners may begin to churn out of enabler networks. Having completed at least the early stages of a VBC transition, these groups may grow tired of splitting shared savings and instead wish to keep key enabler functions in-house, purchase population health software from a traditional vendor, and join a different ACO or convene their own. Additionally, downside risk can be mitigated through reinsurance. (This may be one reason why agilon, which tends to partner with large groups and health systems, typically signs 20-year partnerships.) At this stage, enablers will have two moats (other than contract terms) to retain their more sophisticated partners: payer relationships and network quality. They will likely need to create more flexible, bespoke partnership agreements to accommodate this dynamic.

Smaller practices are less likely to churn out of enabler networks in this way, but they are more vulnerable to provider demographic trends: Many Gen Y physicians in private practice are seeking retirement, while the providers currently graduating from medical school often prefer an employment model. In the future, enablers that focus on smaller partnerships may need to acquire partnered practices to facilitate provider retirements.

For these reasons, consolidation among VBC enablers is likely, although not imminent. In general, customer acquisition costs for enablers are very low, with significant same-market growth achievable via referrals among physicians, meaning there is little incentive for one enabler to acquire another at present. This will change as the market for VBC-ready physician groups becomes more saturated.

VBC enablement opportunity by state



Source: Definitive Healthcare and Kaiser Family Foundation • Geography: US
*As of June 15, 2023

Note: Bubble size equates to state population aged 65+. Includes primary care groups with more than 10 physicians located in Metropolitan Statistical Areas and Micropolitan Statistical Areas. VBC enabler activity is based on most recent disclosures.

VBC enabler presence by state

State	agilon	Aledade	ApolloMed	CareMax	Equality Health	P3 Health Partners	Pearl	Privia	UpStream	Vytalize	Wellvana
Alabama		✓					✓			✓	
Alaska											
Arizona		✓	✓	✓	✓	✓	✓				✓
Arkansas		✓		✓			✓			✓	✓
California		✓	✓			✓	✓	✓			✓
Colorado		✓	✓								
Connecticut	✓	✓						✓			
Delaware		✓						✓			
Florida		✓	✓	✓		✓	✓	✓		✓	✓
Georgia	✓	✓	✓				✓	✓		✓	✓
Hawaii	✓		✓								
Idaho		✓	✓				✓				
Illinois		✓					✓			✓	✓
Indiana		✓								✓	
Iowa		✓									
Kansas		✓								✓	✓
Kentucky	✓	✓								✓	
Louisiana		✓		✓			✓			✓	✓
Maine	✓	✓					✓			✓	
Maryland		✓	✓					✓		✓	
Massachusetts		✓	✓	✓			✓			✓	
Michigan	✓	✓					✓			✓	✓
Minnesota	✓	✓					✓			✓	
Mississippi		✓								✓	
Missouri		✓					✓			✓	✓
Montana		✓						✓			
Nebraska		✓									
Nevada		✓	✓			✓				✓	
New Hampshire		✓					✓			✓	
New Jersey		✓					✓			✓	
New Mexico		✓	✓				✓				✓
New York	✓	✓	✓	✓			✓			✓	✓
North Carolina	✓	✓	✓				✓	✓	✓	✓	✓
North Dakota		✓									
Ohio	✓	✓		✓			✓	✓		✓	✓
Oklahoma		✓					✓			✓	
Oregon		✓	✓			✓				✓	
Pennsylvania	✓	✓		✓			✓			✓	
Rhode Island		✓									
South Carolina	✓	✓	✓				✓		✓	✓	✓
South Dakota		✓									
Tennessee	✓	✓	✓	✓	✓		✓	✓		✓	✓
Texas	✓	✓	✓	✓	✓		✓	✓		✓	✓
Utah		✓	✓							✓	
Vermont		✓								✓	
Virginia		✓					✓	✓	✓	✓	✓
Washington		✓	✓							✓	
West Virginia		✓	✓				✓			✓	
Wisconsin		✓					✓			✓	✓
Wyoming		✓	✓								

Source: PitchBook • Geography: US
*As of June 15, 2023
*Note: Reflects most recently disclosed data. State list for Pearl is incomplete.

VC- and PE-backed enablers

Aledade

Founded: 2014

Geography: 48 states (all except AK, HI)

Attributed lives in downside risk: 2 million attributed lives in MSSP, ACO REACH, MA, Medicaid, and commercial value-based contracts (number in downside risk undisclosed)

Last financing: $260.0M Series F led by Lightspeed Venture Partners in 2023, reportedly valuing the company at $3.5B[1]

Key differentiation: Scale

Background and model: Aledade is the largest network of independent primary care practices in the US, operating in more states and managing more attributed lives in value-based contracts than any other VBC enabler. Founded in 2014, Aledade boasts a leadership team that includes former CMS, ONC, and HHS healthcare technology initiative leaders. Unlike peers such as agilon and Privia, Aledade did not go public in 2021 and has continued to raise large late-stage venture rounds, accumulating $678.4 million in equity investment to date. At the 2023 J.P. Morgan Healthcare Conference, Aledade announced it was now a Public Benefit Corporation, becoming the only VBC enabler (to our knowledge) to do so. Aledade acquired Iris Healthcare, which offers advance care planning services, in January 2022 and Curia.ai, an AI population health analytics tool, in February 2023. Recently, Aledade has focused on building risk prediction tools and clinical programs around chronic kidney disease.

Payer partnerships for scale: Aledade has achieved significant scale despite its focus on small- to mid-size independent providers; the company does not pursue health system partnerships. Aledade's payer partnerships have been key in the platform's growth. In 2022, the company partnered with Elevance to offer its capabilities to independent primary care practices in the payer's plan networks; it inked a similar deal with CareFirst in March 2023. Also in March 2023, Aledade announced a 10-year MA deal with Humana, providing a pathway to full risk. In addition to its payer relationships, Aledade works with existing ACOs.

Risk strategy: Aledade has traditionally focused on MSSP and has taken a conservative approach to moving its independent practice network gradually toward greater risk over time. Aledade has since expanded this approach to take on MA, Medicaid, and commercial contracts to capture more of its providers' patient panels and move toward greater risk. Aledade generated $475.0 million in revenue in 2022, a more than 50% growth rate over 2021.[2]

Equality Health

Founded: 2015

Geography: AZ, TX, TN

Attributed lives in downside risk: 630,000 (580,000 Medicaid and 50,000 Medicare, MA, and Dual Eligible Special Needs Plan members)

Last financing: Undisclosed financing from Finback Investment Partners in December 2021

Key differentiation: Medicaid focus

Background and model: While most VBC enablers focus on Medicare, Equality Health stands out with a Medicaid-first approach. Founded in 2015, Equality partners with small-to-midsize primary care practices located in underserved communities. On average, its partnered practices have Medicaid beneficiaries as around 50% of their patient panel. It has also begun to partner with Medicare-focused groups looking to delegate management of their Medicaid beneficiaries. Because the practices Equality works with operate on tight margins and are sensitive to workflow changes that might reduce patient volumes, Equality takes on full downside risk and provides incentive payments, tied to alignment with Equality's recommended workflows, to practices virtually from day one. In 2021, Equality acquired Daraja Services, an Arizona-based actuarial and informatics provider, to improve its risk stratification capabilities.

1 : "Aledade Raises $260 Million to Help Doctors Change How They Practice," Bloomberg, John Tozzi, June 21, 2023.
2 : "Aledade Secures $260 Million Series F Financing Round to Expand and Enhance Services for its Nationwide Network of Primary Care Practices," Aledade, June 21, 2023.

Managing Medicaid populations: Equality's focus on Medicaid beneficiaries gives unique shape to its care model. In Medicare VBC primary care, the typical playbook involves increasing annual wellness visits (AWVs) and screening adherence across the population to identify risk factors and route patients into chronic condition management programs. By contrast, successful population health management within Medicaid depends heavily on risk stratification, prioritizing interventions, and matching those interventions to the level of need because the level of unmet medical and SDOH needs is so high.

Care coordination is another area where Equality's approach diverges from the traditional Medicare model. Unlike many Medicare enablers, Equality does not provide case management services, since many managed care organizations (MCOs) do this already. Instead, they provide direct-to-member services delivered by field teams that include a nurse practitioner who provides medication review and orders services such as home health, DME, and wound care; an employed community worker, often bilingual, who visits patients and accompanies them in care settings to help with advocacy and care navigation; and chaplains, who assist not only with spiritual/emotional matters but also behavioral health challenges. Additionally, Equality recently completed its Arizona-based pilot of a home-based complex care program, which targets patients who have become disconnected from traditional care providers with the aim of returning them to regular care via their PCP or palliative care. This program layers on top of Equality's standard community worker-based care coordination and can involve short-term stabilization during a transition of care or longer-term, high-touch interventions to address health and SDOH needs. Equality intends to fully scale this program in Arizona by the end of 2023 before expanding it to other geographies.

Risk strategy: Around 90% of Equality's attributed lives are currently in two-sided risk models. States are increasingly including requirements in RFPs for MCOs to move covered lives into alternative payment models or into downside risk specifically. This has positioned Equality as a value-add partner for MCOs because Equality contracts allow them to meet the state-mandated quotas. In Arizona, Equality's mature market, the platform has introduced ACO REACH in addition to value-based contracts with MCOs. Equality has been EBITDA-positive since 2019.

Pearl

Background and model: The youngest entrant onto the VBC enabler scene, Pearl Health has grown rapidly by focusing on flexible implementation and centering its technology offering. The enabler signs shorter contracts than some of its competitors and does not embed RN case managers. It takes a flexible approach to PPAs, with the company's average take of shared savings around 50% but structures varying significantly. In some cases, sophisticated groups in full-risk contracts may partner with Pearl for software-only deals.

Pearl has partnered with a major diagnostics provider and recently announced a partnership with Story Health to deliver specialized care to patients with cardiovascular disease. Pearl is also pursuing opportunities for kidney care

pearl

Founded: 2020

Geography: 29 states, including AL, AZ, AR, CA, FL, GA, ID, IL, LA, ME, MA, MI, MO, NH, NJ, NM, NY, NC, OH, OK, PA, SC, TN, TX, VA, WV, WI

Attributed lives in downside risk: 40,000 (ACO REACH)

Last financing: $55.0M Series B in January 2023, led by Andreessen Horowitz and Viking Global Investors

Key differentiation: Software emphasis

partnerships. The company is also interested in partnerships around behavioral health and in health system JVs, which would give Pearl access to specialist networks but keep risk for those providers with the health system.

Focus on software: Pearl's population health software, which boasts a 92 NPS, allows providers to easily visualize their panels and aids in prioritization and increasing provider response time to patient inquiries. The company believes that its software could be adapted to support risk assessment and prioritization in specialty service lines in the future, in addition to primary care. In contrast to more hands-on partners, Pearl puts in a considerable amount of actuarial effort into selecting markets and partner providers based on their historical medical loss ratio, but then operates with a light touch, focusing on straightforward performance metrics such as AWVs and PCP involvement in admission, discharge, and transfer (ADT) events. The company is also working to develop machine-learning-guided clinical pathways and gaining CMS Qualified Entity designation.[3]

Risk strategy: Pearl currently operates three ACOs, one global and two professional; it prefers to move practices into the professional track in order to avoid CMS' 3% benchmark discount in the global program. Although Pearl's roots are in ACO REACH, it is working to move into MA, where it aims to share risk with payers rather than take on full risk.

UpStream Health

Background and model: Founded by Fergus Hoban, a pharmacist by training, Upstream got its start providing fee-for-service revenue enhancements before pivoting to a primary care enablement model. Today, UpStream partners with provider groups and focuses on chronic condition management, specifically engaging the highest-risk patients, which account for 65% of TCOC across the provider's panel. UpStream has achieved a more than 20% savings rate for engaged patients in the program. 60% of this savings rate is achieved through utilization control, while 40% is accounted for by risk adjustment enabled by greater engagement. The company takes on 100% of downside risk and shares upside via monthly quality-based payments to reduce financial uncertainty. In January, UpStream announced a multi-year partnership with Innovacceer to utilize Innovacceer's cloud, data integration, and application products.

Pharmacist at top of license: Upstream takes a high-touch approach to care services, physically embedding a pharmacist and RN care coordinator at each partnered primary care practice. The company also offers members 24/7 access to remote care navigation support. UpStream provides training for its pharmacists that emphasizes medication safety, closing care gaps, behavioral drivers of medication adherence, and close collaboration with physicians.

Risk strategy: Currently, UpStream's attributed lives are split roughly evenly between MA and ACO REACH.

UpStream

Founded: 2018

Geography: NC, SC, VA

Attributed lives in downside risk: 180,000 (MA and ACO REACH)

Last financing: $140.0M Series B, led by Coatue and Dragoneer Invesment Group

Key differentiation: Integrating pharmacists

3 : CMS' Qualified Entity Program allows organizations to use Medicare claims data to evaluate provider performance. Qualified Entities must adhere to rigorous privacy, transparency, and quality standards and report on findings publicly.

Vytalize

Founded: 2014 (launched enablement business in 2018)

Geography: AL, AR, AZ, CA, FL, GA, IA, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, NH, NJ, NV, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, VT, WA, WI, WV

Attributed lives in downside risk: 200,000 (MSSP and ACO REACH)

Last financing: $100.0M Series C in February 2023, led by Enhanced Healthcare Partners and Monroe Capital

Key differentiation: Focus on small primary care practices

Vytalize

Background and model: Founded in 2014 as a physician group in New York City, Vytalize differentiates itself from other enablers by its focus on partnering with smaller primary care practices. The company launched its shared savings enablement business in 2018. Vytalize has made two acquisitions: MedPilot, a patient engagement software provider, in 2021, and Independent Physician Association of New York (IPANY) in 2023. Vytalize is open to making additional provider group acquisitions, analogous to its purchase of IPANY, in the future, but is primarily focused on adding attributed lives via its network. The company is a primary-care-only enabler and generally pursues partnerships for SNF, home health, and behavioral health care, although some behavioral care is provided in-house. It signs contracts of variable lengths (longer contracts for more substantial relationships) and employs a market-rate shared savings split.

Working with small practices: Vytalize believes it has the lowest customer acquisition costs in the industry. It has tailored its offering to small practices in several ways. The company distributes shared savings payments to partnered practices monthly, rather than at year-end following CMS settlement, in order to support the operational investments smaller practices need to make to participate successfully. Its software can integrate with EHRs that serve smaller market cap practices. Vytalize emphasizes provider education by providing one-on-one coaching with independent "clinical peers," MDs with population health expertise, and by offering Vytalize University, a training program for both clinical and administrative staff. Providers earn financial incentives for participation in educational programs, and this participation is strongly correlated with shared savings in value-based contracts. In mature markets (about 50% of its current markets), the company equips practices with home-based primary care for high-risk patients, as well as RN care coordination. Finally, working with Vytalize can help larger primary care practices grow because the enabler facilitates connections to like-minded small practices.

Risk strategy: Vytalize aims to move its partnered practices toward full risk via graduation through MSSP to ACO REACH and believes it will accelerate its ability to execute this transition over time. Its acquisition of IPANY accelerated its entry into full-risk Medicare Advantage arrangements, and it intends to expand its MA risk contracting for partnered practices participating in ACO REACH. It is also interested in expanding into Medicaid and commercial in the future but is currently Medicare-focused.

wellvana

Founded: 2018

Geography: AZ, AR, CA, FL, GA, IL, KS, LA, MI, MO, NC, NM, NY, OH, OK, SC, TN, TX, VA, WI

Attributed lives in downside risk: 75,000 (55,000 in ACO REACH, 25,000 in MA)

Last financing: $84.0M late-stage VC round in March 2023, led by Heritage Group and Valtruis (Welsh, Carson, Anderson & Stowe)

Key differentiation: Boots-on-the-ground practice support

Wellvana

Background and model: Nashville-headquartered Wellvana began operations in 2019 as a platform of Martin Ventures, the family office of hospital executive Charlie Martin, via a partnership with a San Antonio-based VBC clinically integrated network. Wellvana has made a handful of practice groups as it enters new key markets, including an early buy of Dallas-based ACO Prime Health, and is open to similar acquisitions in the future. However, the company primarily builds its network via multi-year (usually five-year) PPAs. It typically takes a 75% split of shared savings from partnered practices and assumes 100% downside risk. Wellvana is focused on primary care but is actively courting health system partnerships; the participation of Memorial Hermann Foundation in the company's most recent fundraise points in this direction. It also seeks to build specialty provider networks in mature markets. On the tech side, Wellvana has an ownership stake in population health analytics provider Wiseman. Through this partnership, the company offers its proprietary population health software, Clarity, an EHR overlay ribbon that does not require providers to log into a separate system.

Boots on the ground: Wellvana employs a more hands-on strategy than other enablers working with partnered practices and has prioritized density in its markets over rapid expansion. The company employs practice transformation specialists in local markets; each specialist partners with 7-10 clinics and visits weekly to support ongoing clinical and operational improvements. Directors of clinical operations visit clinics monthly to review KPI metrics such as annual wellness visit attendance and gap closures as well as projected financial outcomes, while a corporate vice president visits quarterly for relationship management. Wellvana also provides white labeled care coordination and RN case manager services and is working on in-home care solutions.

Risk strategy: Wellvana ensures its physician network is mission-aligned through a stringent selection process for new relationships that involves reviewing three years of historical claims data. Building on this foundation, it aims to move its partnered practices toward full risk. It currently has 55,000 attributed lives in ACO REACH and 20,000 in MA via a growing relationship with Humana, but it anticipates shifting that mix toward MA over time. Wellvana takes a conservative approach to underwriting, prioritizing performance consistency and confidence in outcomes prediction over growth. It has achieved high single-digit savings rates in ACO REACH and believes it can move these into the low double digits in mature markets; for MA, Wellvana's savings rates are in the low 20s. The company expects to reach profitability in 2023.

agilon health

Founded: 2016

Geography: CT, GA, HI, KY, ME, MI, MN, NC, NY, OH, PA, SC, TN, TX

Attributed lives in downside risk: 488,000-495,000 (approximately 80% MA and 20% ACO REACH)

Market cap as of June 30, 2023: $7.2 billion

Key differentiation: Health system partnerships

apollomed

Founded: 1992 as Allied Physicians of California, an IPA

Geography: CA, NV, TX (MSO); AZ, CO, FL, GA, HI, ID, MA, MD, NM, NV, NC, NY, OR, SC, TN, UT, WA, WV, WY (ACO and enablement services)

Attributed lives in downside risk: 650,000

Market cap as of June 30, 2023: $1.5 billion

Key differentiation: MA capitation focus

Publicly traded enablers

agilon (NYS: AGL)

Although agilon was not the first company to enable VBC for independent providers, it has become the category-defining example. Nearly 1.5% of primary care physicians in the US are on the agilon platform,[4] and agilon's growing focus on health system partnerships frequently engenders comparisons with Optum's enablement capabilities. The company was created in 2016 by Clayton, Dubilier & Rice through a combination of a California-based Medicaid VBC company (Primary Provider Management) and a HI-based Medicare VBC group (MDX Hawai'i). Its anchor partnership was with Central Ohio Primary Care, the nation's largest independent physician group.[5] CD&R took agilon public in April 2021 at a $7.8 billion valuation and remains its largest shareholder. In February 2023, the company acquired mphrx, a FHIR-native population health platform, for $45.0 million.

agilon is a primary-care-only platform. The company works with independent practices but focuses on larger groups and health systems. In 2023 it announced a partnership with MaineHealth, and two additional large-scale partnerships, Premier Health and Holland PHO, will come online in 2024. Its basic model for physician group practices is to sign 20-year joint ventures and take 100% of downside risk and 60% of shared savings. It recorded $4.0 million in EBITDA in 2022 and projects $75 million-90 million EBITDA for 2023.

ApolloMed (NASDAQ: AMEH)

Like Privia, ApolloMed pursues VBC across all payer types, including MA, managed Medicaid, commercial, ACA exchange plans, and traditional Medicare, and is a multispecialty platform. However, unlike Privia, the platform is strongly MA-focused, deriving around two-thirds of its revenue from Medicare and 89% of its revenue from capitation income. ApolloMed then acts as a pseudo single payer for its provider network, reimbursing via a subscription model. In California, the company employs a vertically integrated model in which it partners with health systems to capitate both facility and professional fees, resulting in additional premium dollar capture.

The company divides its operations into three business lines: care delivery, care partners, and care enablement, which in Q1 2023 contributed about 8%, 85%, and 7% to the company's total revenue, respectively. "Care Delivery" refers to ApolloMed-owned primary and specialty care MSOs operating in California, Nevada, and Texas. "Care Partners" refers to the company's IPAs, ACOs, and California RKK-licensed plan.[6] It also encompasses several ancillary provider assets, including an ASC, imaging center, and diagnostic laboratory, in which ApolloMed has ownership stakes. "Care Enablement" refers to the wraparound services it provides to partnered practices (that may or may not be aligned with the company's own ACOs

4 : "Agilon Health: First Quarter 2023 Earnings," Agilon, May 9, 2023.

5 : "Scaled Growth Equity at Agilon Health," Capital Allocators, December 21, 2022.

6: In California, a Restricted Knox-Keen license is required to take full percent-of-premium capitation risk from payers.

and IPAs) and payers. The company's presence is most significant in the greater Los Angeles area. ApolloMed's Care Partners and Care Enablement business lines are profitable, and the company recorded $14.3 million in net income in the first quarter of 2023.

Caremax

Founded: 2011

Geography: AZ, AR, FL, LA, MA, NY, OH, PA, TN TX

Attributed lives in downside risk: 240,000 (90,000 MA, 110,000 MSSP and ACO REACH, 32,000 Medicaid, and 9,000 commercial)

Market cap as of June 30, 2023: $346.0 million

Key differentiation: All-in-one clinics

CareMax (NASDAQ: CMAX)

Prior to its $135.0 million acquisition of Steward Health's Medicare VBC business, CareMax was primarily a de novo clinic operator in the vein of Oak Street, Cano, and ChenMed, rather than a VBC enabler. As of Q3 2022, just prior to the Steward deal closing, the company had 54 medical centers across four states, supporting just under 40,000 MA members. With the Steward acquisition, CareMax reached 2,000 providers and 200,000 Medicare VBC beneficiaries across 10 states, with an additional 380,000 fee-for-sevice MA beneficiaries available to transition onto risk. CareMax supports its Steward clinics via MSO, making it an enabler in the core-periphery model of ApolloMed.

CareMax's target patient population is higher-risk than the average Medicare member and includes a significant proportion of dual-eligible members. In geographies where CareMax has density, such as south Florida, clinics offer not only primary care but specialty care, such as dentistry, cardiology, gastroenterology, and podiatry, with specialist physicians rotating among clinics. CareMax also supports wellness clinics offering SDOH services, such as access to social services, group therapy, fitness classes and wellness programs, and meals. Finally, CareMax centers improve access to care via home health and transportation to appointments. Many of these services are reimbursable via MA plans.

Because CareMax employs an intensive boots-on-the-ground approach, the company's near-term growth plans focus on organic member growth in existing clinics before expanding the MSO network outward and building de novo clinics in MSO geographies. CareMax has also taken a fairly aggressive approach to the VBC glide path, occasionally moving contracts into full risk earlier than originally planned based on an assessment of historical data.[7] The company recorded negative $0.1 million in adjusted EBITDA in Q1 2023 and expects adjusted EBITDA of $25 million-35 million for 2023.

P3 Health Partners

Founded: 2015

Geography: AZ, CA, FL, NV, OR

Attributed lives in downside risk: 101,000 (full risk MA)[8]

Market cap as of June 30, 2023: $339.0 million

Key differentiation: Regional density

P3 Health Partners (NASDAQ: PIII)

P3 was co-founded by Sherif Abdou and Amir Bacchus, both physicians, with its home market in Arizona. Abdou had previously built Nevada-based Summit Medical Group, a primary care physician group, into an IPA taking on value-based arrangements (before such a term existed) in the 1990s. Chicago Pacific Founders and Leavitt Equity Partners acquired P3 in 2018 and took the company private via reverse merger in 2021.

7 : "CareMax," Transcript, Jefferies Healthcare Conference, Brian Tanquilut et al., June 7, 2023.
8 : "P3 Health Partners," Barclays Global Healthcare Conference, March 2023.

P3 has focused on building density in local markets, amassing 2,600 providers across just five states, with Arizona its mature market. In 2021, P3 entered California's managed care market with its acquisitions of a Knox Keene-licensed health plan and IPA. The company is also pursuing health system partnerships. P3 recorded an adjusted EBITDA loss of $19.1 million in Q1 2023 and expects to be EBITDA positive by 2024.

Privia (NASDAQ: PRVA)

PRIVIA HEALTH

Founded: 2007 (first practice partnership in 2013)

Geography: CA, CT, DE, FL, GA, MD, MT, NC, OH, VA, TN, TX, and Washington DC

Attributed lives in downside risk: 162,440 as of March 31, 2023 (131,160 in MSSP/MDPCP and 31,280 in MA)[9]

Market cap as of June 30, 2023: $3.0 billion

Key differentiation: Multispecialty enablement

Unlike most of its peers, Privia focuses on enabling multispecialty provider groups in addition to primary care groups. The platform currently supports more than 50 specialties. Its partnered practices are not necessarily senior-focused, and Privia pursues value-based contracts with commercial and Medicaid payers as well as via the Medicare MSSP program and with MA plans. (Currently, the company only has downside risk contracts with commercial and MA payers and via the MSSP program; its Medicaid contracts are upside-only.) Privia has inked partnerships with health systems including Health First (2019), Novant Health (2022), and OhioHealth (2023).

Privia operates an MSO rather than a PPA model, recording fee-for-service revenue as well as taking a portion of shared savings or losses in value-based contracts. Currently, Privia's revenue is approximately two-thirds fee-for-service reimbursement and fees, and one-third value-based contract reimbursement and fees. However, commercially insured members will move onto Medicare or MA as they age if they remain with Privia providers.

Privia has also placed a greater emphasis on MSSP participation than many of its competitors and only began recognizing capitation revenue (as opposed to shared savings and care management fees) in 2022. Privia characterizes its conservative approach to risk as uniquely responsible; it is also A necessary because value-based contracting is not as well developed in most specialties as it is in primary care. According to J.P. Morgan equity research, another unique aspect of Privia's approach is that it shares both upside and downside MSSP risk with providers in its MSO. The company recorded $16.9 million adjusted EBITDA in Q1 2023 and has provided full-year 2023 guidance of $70 million-$74 million in adjusted EBITDA.

9: "Privia Health," J.P. Morgan Healthcare Conference, January 9, 2023.