PitchBook Data, Inc.
John Gabbert Founder, CEO
Nizar Tarhuni Vice President, Institutional Research and Editorial
Paul Condra Head of Emerging Technology Research

Institutional Research Group
Analysis

Rebecca Springer, Ph.D.
Lead Analyst, Healthcare
rebecca.springer@pitchbook.com

Data
Collin Anderson
Data Analyst

pbinstitutionalresearch@pitchbook.com

Publishing
Designed by **Chloe Ladwig**

Published on March 14, 2024

Contents

Introduction	1
Definition and scope	2
Our assertion: Enablement as the primary mechanism of VBC transition	2
Competition	4
Profitability and consolidation	8
Specialty care strategy	8
Technology	9
Alternative enablement models	10
VC- and PE-backed enablers	12
Publicly traded enablers	24

INDUSTRY RESEARCH

The Value-Based Care Enabler Landscape: 2024 Update

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

Introduction

Value-based care (VBC) enablers help healthcare provider organizations transition from fee-for-service into alternative or value-based payment models by providing technological, administrative, and clinical resources and sharing in the economics of alternative payment models. For an introduction to the VBC enablement model, readers should begin with our July 2023 analyst note.

Since writing the previous note, we have tracked several newer entrants into the VBC enablement space, such as Oasis Health Partners, Honest Medical Group, and Yuvo Health, as well as rapid scaling by others, notably Main Street Health, that had largely flown under the radar. We are also expanding our scope slightly to include Lumeris, an established industry player whose multipopulation approach differs from the other companies highlighted here but, as was pointed out to us following the July 2023 note, is close enough to warrant inclusion. Each company's profile has been updated from the previous note with new developments and analysis. Our emphasis is on providing in-depth analysis of the privately held enablers.

We are also taking the opportunity to update our overall analysis of the space as well as our competitive landscape mapping. As we discuss at greater length later in this note, the landscape has already become more crowded over the past eight months, and competition for provider partnerships is increasing. The window of opportunity for successfully launching new enablers, especially in Medicare, is closing faster than we previously anticipated.

Definition and scope

The term "VBC enablement" has picked up steam recently, and we see a broad range of companies describing themselves in this way, from technology platforms to management services organizations (MSOs) to physician aggregators. This note seeks to provide deep, evaluative insight into a high-growth market niche. To this end, we maintain a tight definition of VBC enabler: a company that assembles networks of providers via partnership agreements and, in some cases, acquisitions; supplies them with technological, clinical, and administrative support; and then enters into VBC contracts on behalf of those networks and shares the resulting financial upside with providers.

We exclude companies that exclusively or primarily acquire providers or build clinics. We also exclude companies that enter value-based contracts directly with payers without aggregating provider networks and sharing upside, companies that deploy VBC-oriented solutions but do not aggregate lives and negotiate their own contracts, companies that are subsidiaries of payers, and companies that build networks and manage populations on behalf of self-insured employers. Several examples of alternative models are discussed briefly in what follows. For this note, we are also focusing on primary care-centric VBC enablers. We plan to publish a similar note focused on specialty care enablers in the future. Readers interested in a broader landscape view are encouraged to review the comprehensive policy paper recently published by Health Management Associates and Leavitt Partners.[1]

Our assertion: Enablement as the primary mechanism of VBC transition

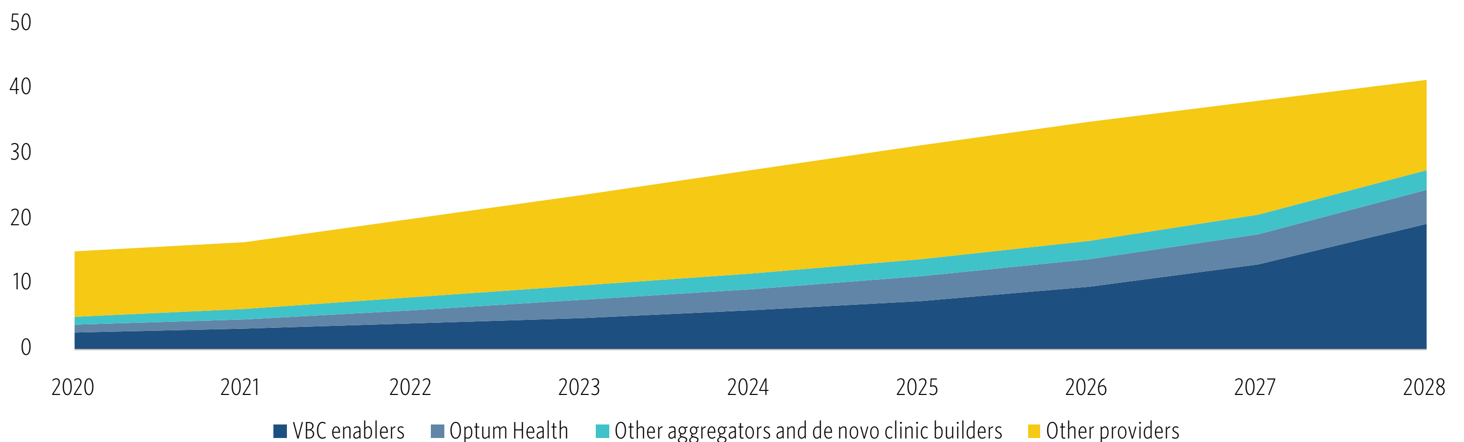
In the previous note, we wrote that enablement is the most important mechanism by which the VBC transition will play out in the US over the next five to 10 years. We stand by this assertion, which is based on the following logic: Profitable risk management fundamentally requires scale, and enablement is by far the most capital-efficient way to achieve that scale for any organization that does not already have a significant market share (or, to put it bluntly, for any organization other than Optum). This holds equally true across health systems, large provider groups, and small providers, although the dynamics vary by provider type, as we discuss in greater detail in the previous note.

Since publishing the July 2023 note, we have been presented with various rebuttals to this assertion, primarily hinging on the fact that most VBC enablers are currently unprofitable, and some lack an immediate path to profitability. It bears clarifying that in the July 2023 note, and in this note, we are not arguing that all VBC enabler businesses are sound ones, or that any investment in the space will yield an attractive return. In fact, we predicted in the previous note, and continue to predict, consolidation in the enabler market.

1: "Analyzing the Expanded Landscape of Value-Based Entities," Health Management Associates and Leavitt Partners, Kate de Lisle, et al., February 2024.

What we did assert was that VBC enablement would be the most important mechanism of the VBC transition in at least the medium term because it has the potential to bring large swaths of the provider landscape that would otherwise be unable to take on downside risk into VBC readiness. VBC enablers collectively managed an estimated 4.9 million Medicare lives in downside risk as of the end of 2023, compared with 4 million for Optum (primarily in Medicare Advantage [MA] but including other payer types) and an estimated 2.3 million Medicare lives for clinic aggregators and de novo models (such as ChenMed and Oak Street Health) combined. Based on HCPLAN payments data, we estimate that an additional 13.8 million Medicare lives are currently attributed to downside risk models via a highly fragmented landscape of health systems, physician groups, and other industry players. Using historical growth trends and baking in a 3% annual CAGR step-down going forward, we estimate that VBC enablers will collectively manage 19.4 million Medicare lives in downside risk, or around 28% of MA members and Medicare Part A and Part B enrollees, by 2028.

Projected Medicare lives covered by downside risk arrangements by VBC entity type (millions)*



Source: PitchBook • Geography: US • *As of February 28, 2024

The profitability question does raise second-order risks for our thesis, however, especially in today's circumspect fundraising environment. For the enablers that remain unprofitable, eventually one or more of the following things will happen: Their growth will slow significantly; they will start taking a greater share of upside economics from providers, which would in turn slow or reverse growth; they will be acquired; or, in the worst-case scenario, they will shut down operations entirely. There is also another, separate risk, which we highlighted in the July 2023 note: that providers, especially the most sophisticated (and therefore most risk-taking and revenue-generating) groups, will eventually decide to forgo enablement altogether in favor of managing their VBC programs in-house and keeping upside.

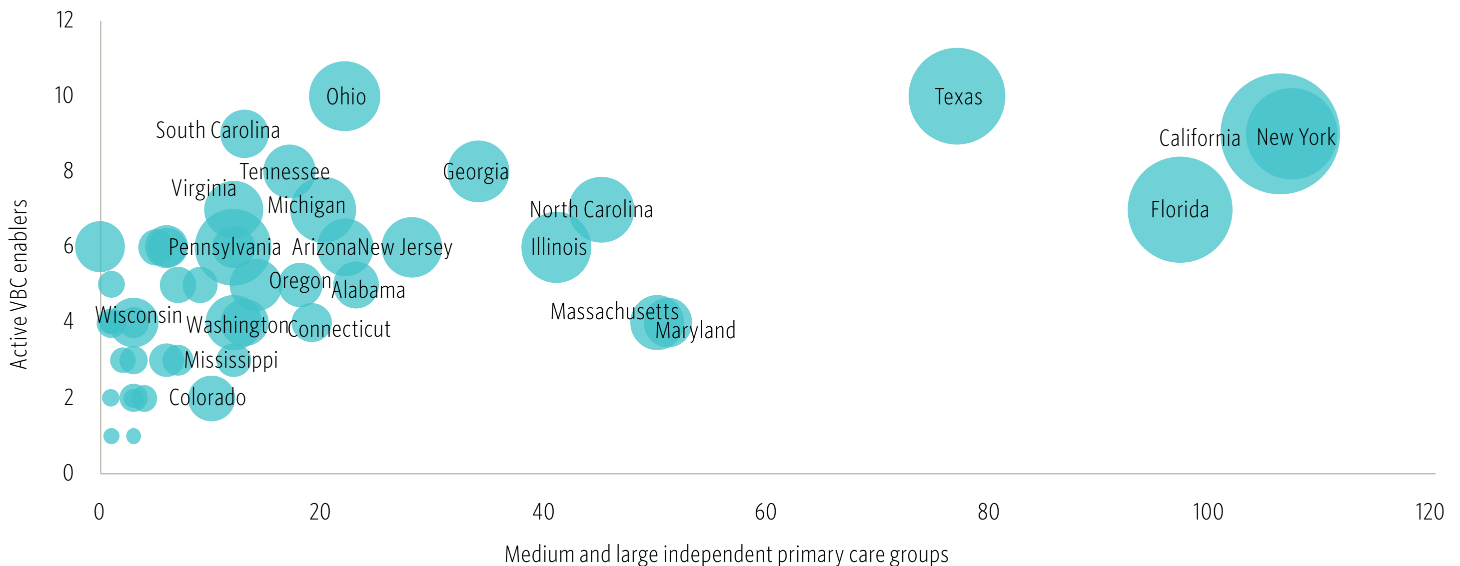
In the face of these risks, some enablers are nevertheless at or within sight of financial sustainability. Not all VBC enablers will succeed, but we believe enough will. And when we survey the landscape of options primary care providers face in pursuing VBC—and the options the Centers for Medicare & Medicaid Services

(CMS) faces in pursuing its 2030 goal of having every Medicare beneficiary in a total cost of care arrangement—we continue to see enablement as the most investable strategy to execute at scale.

Competition

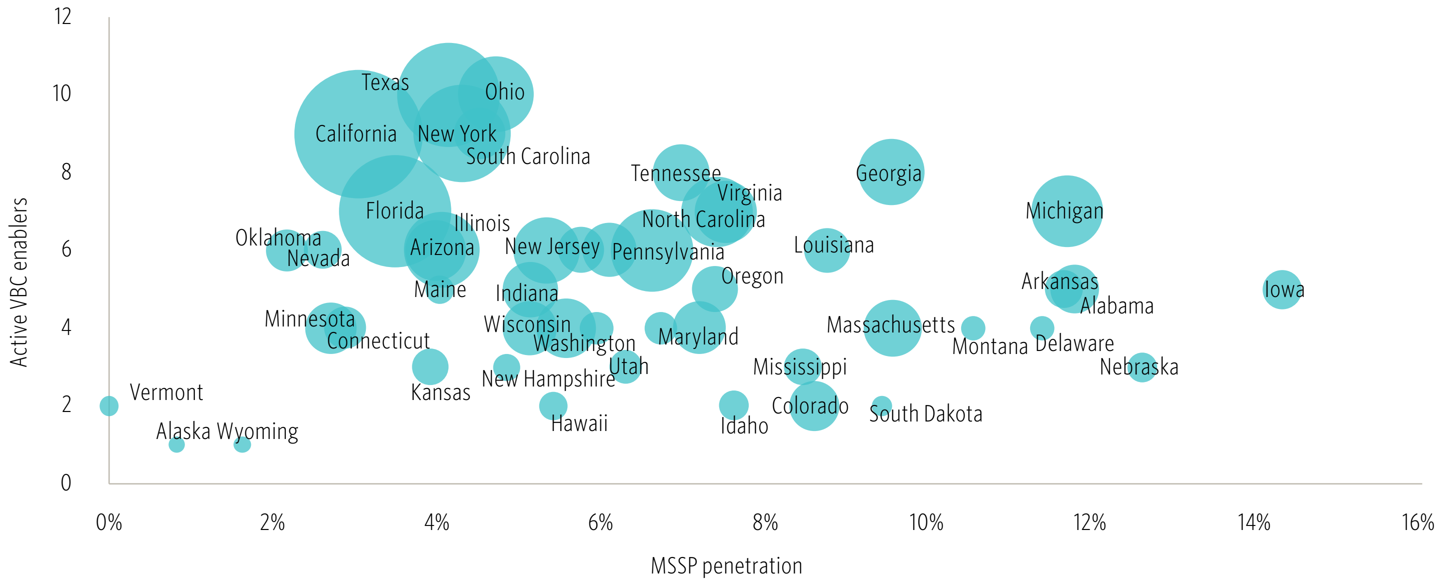
When we ask VBC enabler management teams what level of competition for provider relationships they are seeing, we receive heterogeneous responses. While the market is by no means saturated, it is clear that competition has increased significantly even in the past year; by our estimate, the number of Medicare lives managed by VBC enablers in downside risk grew around 20% from 2023 to 2024, and the average state now has 4.8 active primary care enablers. Among providers—including both large provider groups, smaller clinics, and health systems—there is broad awareness of a growing array of VBC options. Providers may evaluate enablers based on a range of different criteria, including the economic split offered, level of clinical and administrative support, technology quality, network quality, and historical performance. Accordingly, enablers have taken different approaches to "winning" new relationships by doubling down on their strengths in one or more of these areas. For instance, whereas a more established enabler may be able to offer built-out clinical resources in the prospective partner's geography, a newer entrant may offer sweetened economics or simply be a more attentive partner in hopes of secure anchor practices. We have also heard that practices are churning between different enablers in some markets due to subpar performance.

VBC enabler opportunity by state: Number of primary care groups*



Sources: PitchBook, Definitive Healthcare, KFF • Geography: US • *As of February 28, 2024
Note: Bubble size equates to the state population that is age 65 and older. The chart 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.

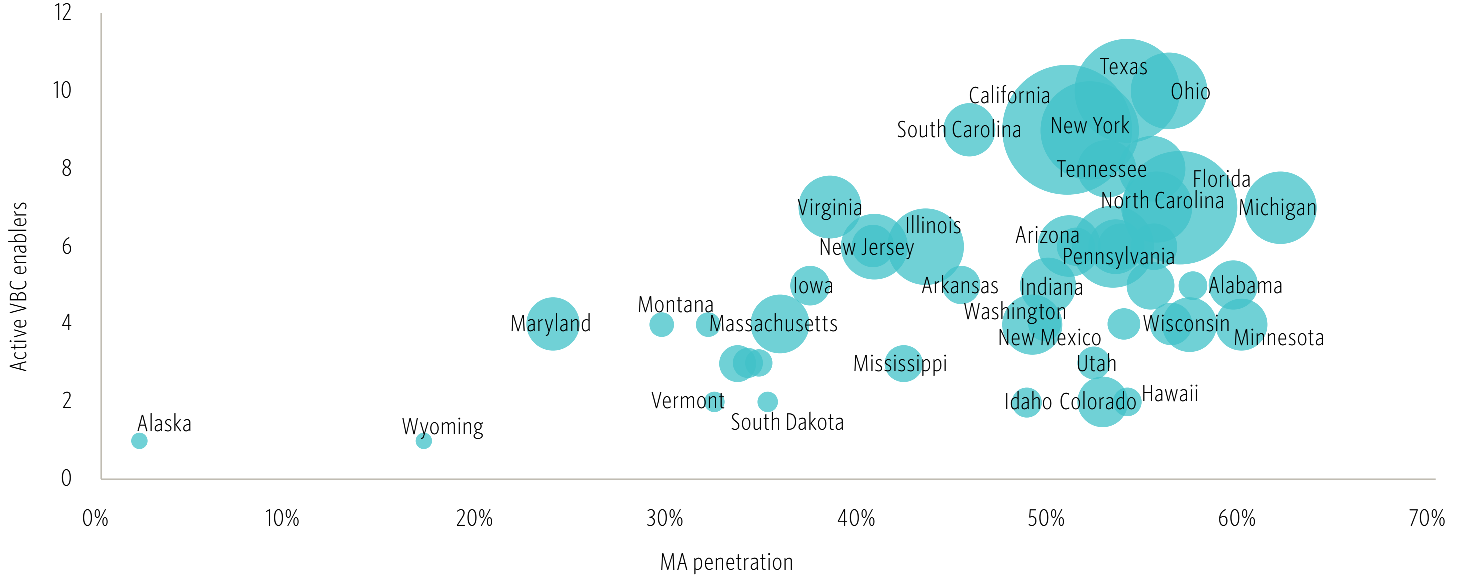
VBC enabler opportunity by state: Medicare Shared Savings Program (MSSP) penetration*



Sources: PitchBook, CMS NPI Registry, CMS ACO Participants, KFF • Geography: US • *As of February 28, 2024

Note: Bubble size equates to the state population that is age 65 and older. MSSP penetration is defined as the percentage of primary care provider groups affiliated with an MSSP accountable care organization (ACO). VBC enabler activity is based on most recent disclosures.

VBC enabler opportunity by state: MA penetration*



Sources: PitchBook, CMS, KFF • Geography: US • *As of February 28, 2024

Note: Bubble size equates to the state population that is age 65 or older. MA penetration is defined as the percentage of eligible people enrolled. VBC enabler activity is based on most recent disclosures.

VBC enabler presence by state*

State	agilon	Aledade	Astrana Health	CareMax	Equality Health	Honest Medical Group	Lumeris	Main Street Health	Oasis Health Partners
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		✓							
Washington, DC		✓							
West Virginia		✓						✓	
Wisconsin		✓							
Wyoming		✓							

Source: PitchBook • Geography: US
*As of February 28, 2024
Note: Reflects most recently disclosed data. State lists may be incomplete.

VBC enabler presence by state (continued)*

State	On Belay	P3 Health Partners	Pearl Health	Privia	UpStream Health	Vytalize	Wellvana	Yuvo
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			✓	✓		✓		
Washington, DC	✓		✓	✓				
West Virginia			✓			✓		
Wisconsin			✓			✓	✓	
Wyoming								

Source: PitchBook • Geography: US
*As of February 28, 2024
Note: Reflects most recently disclosed data. State lists may be incomplete.

Profitability and consolidation

Achieving profitability as a VBC enabler requires a delicate balancing act. Taking on greater risk significantly increases financial upside but requires scale in a given market as well as strong data visibility and clinical controls to ensure that risk is appropriately underwritten. On a basic level, each new cohort takes roughly three years to reach maturity before it can help to cash flow new geography expansions. The cost to enter a new geography depends on the level of clinical resources being deployed as well as the timing of key relationships. In general, the preferred model for more resource-heavy enablers is to enter new geographies with at least one large provider partnership as an "anchor" and, in MA, at least one key payer relationship in place. To cite one publicly available benchmark, agilon has reported that its acquisition cost per member is between $400 and $600, blended across existing and new geographies. While slower, density-focused growth has been the most common way enablers achieve financial sustainability (examples include Astrana Health, which is profitable, and Equality Health, which is EBITDA positive), enablers that have taken a broader geographic approach have also gotten within striking range (for instance, Aledade is at break-even EBITDA, and one other scaled enabler will reach positive cash flow in 2024).

In addition to navigating the profitability balancing act, many VBC enablers experienced additional financial headwinds in 2023 as a result of two forces: the version 28 (V28) MA risk adjustment model and elevated utilization, which also affected payers and other risk-bearing entities. V28 effects are being felt across the MA industry but are concentrated among players managing higher-risk populations. Higher utilization in the first half of the year has been attributed to working through pent-up demand for elective surgeries post-pandemic, but several payers also reported utilization spikes in late 2023 with causes yet to be determined. Publicly traded enablers and payers are underwriting with the assumption that increased utilization will continue in 2024. Assuming privately backed enablers follow suit, we expect to see growth slow moderately across the board at least in early 2024 until trends stabilize.

In light of these challenges, we have predicted that there will be two VBC enabler acquisitions in 2024, representing either whole enablement companies or significant assets, which could be technology, owned providers, or provider networks. Enablers will look to sell if their growth stalls at subscale or if they or their investors cease to see a viable path toward profitability. Based on our conversations with market participants, we believe the most likely buyers are other enablers. The rationale for buying another enabler—assuming the pricing is attractive—is becoming more compelling as competition increases, both as an antidote to rising customer acquisition costs and as a potential defensive play designed to eliminate a competitor in specific markets. As we have detailed elsewhere, other buyer types, including healthcare-involved retailers, MA plans, and digital health companies, are possible but significantly less likely buyers in the short term.

Specialty care strategy

Specialty care—specifically, managing individuals with chronic conditions and other high-cost specialty care needs—represents a growing area of focus for primary

care-based enablers. Approaches to specialty care vary significantly among VBC enablers. Aledade prefers to develop care pathways and clinical programs for specific populations in-house, although it may also engage point solution technology vendors. Aledade has spent years building out its chronic kidney disease (CKD) program. Vytalize Health takes a network approach to specialty care, creating value-based preferred provider contracts with post-acute and specialist providers. Wellvana is testing models to delegate risk for certain populations to value-based specialist providers. Pearl Health has announced multiple partnerships with specialist providers, including Story Health and Vori Health. Finally, while most Medicare-focused enablers concentrate their specialty strategy efforts on categories such as post-acute, CKD, cardiovascular, musculoskeletal, and oncology, those that tend to work with underserved populations, such as Oasis, tend to have different priorities, topped by social determinants of health (SDOH) and behavioral health. As another example, Equality Health has identified mental health, high-risk pediatrics, and maternity as specialty priority areas for its Medicaid managed care organization (MCO) partners.

Technology

By definition, all VBC enablers offer their partner practices a technology suite. This typically includes risk stratification, risk coding, care gap closure, clinical admission/discharge/transfer and referral workflows, and clinical and contract performance analytics capabilities. Additional capabilities may include predictive modeling, patient engagement, and specialty care pathways. It is clear that there is wide variation in technology quality in the market, but it is also difficult to make one-to-one comparisons. An enabler that seeks to be less clinically invasive may focus on streamlining hierarchical condition category (HCC) coding, while an enabler focused on clinical outcomes may deploy sophisticated predictive algorithms for high-risk populations. Enablers are also limited technically by the size of the practice they partner with, which correlates with the quality and number of different electronic health records (EHRs) used as well as data quality. The recent plight of agilon, which significantly undershot its 2023 medical margin forecasts, has underlined the importance of maintaining accurate and real-time data on patients' emergency department and inpatient utilization.

We have been struck lately by the number of healthcare IT companies—in areas as diverse as specialty algorithms, remote patient monitoring, revenue cycle, and more—that have told us they view ACOs and VBC enablers specifically as a new and strategically important sales market. Although not all of these vendors will be successful, we do foresee significant development in VBC enabler technology capabilities in the next few years. Some VBC enablers prefer to partner with third-party vendors and in some cases white-label products into their own branded technology solutions; others have built homegrown systems and acquired technology point solutions along the way to augment them. Additionally, numerous companies already have a strong foothold, such as Datavant and Innovaccer (population health analytics); Juxly, Redox, and Healthjump (cross-EHR connectivity); Vim (payer-provider data middleware); and Navina (AI point-of-care decision support).

As the VBC enabler landscape grows more competitive, technology—both in terms of ease of use and quality and actionability of insights—will become an increasingly important differentiator. The providers partnered with enablers, especially the larger and more sophisticated groups, will demand best-in-class technology suites and may be tempted to go it alone if the enabler's own software is subpar. This effect will be accentuated as AI clinical documentation, chart review, clinical workflow, and care navigation tools become ubiquitous.

Alternative enablement models

Finally, we would be remiss not to mention the growing range of primary care enablement models that do not fit the definition used in this note but are showing significant promise. The three companies briefly highlighted below are an illustrative, and far from exhaustive, sample of early-stage companies in this category.

Full-network clinical support—Arkos Health: Created in 2020 from the merger of Curavi Health, CarePointe, and US Health Systems, Arkos is a VBC company that deploys clinical support across a payer's network to improve quality measures and reduce costs. Arkos deploys in-market clinical and coordination staff and prioritizes the highest-risk individuals for proactive engagement, and typically takes full or partial risk on medical loss ratio performance targets. The company has achieved quality and coding outcomes comparable with those of more concentrated risk-bearing entities while engaging the majority of a payer's TINs. Arkos currently manages 550,000 lives across MA, Medicaid, and ACA (Affordable Care Act) exchange plans, of which around 400,000 are at risk.

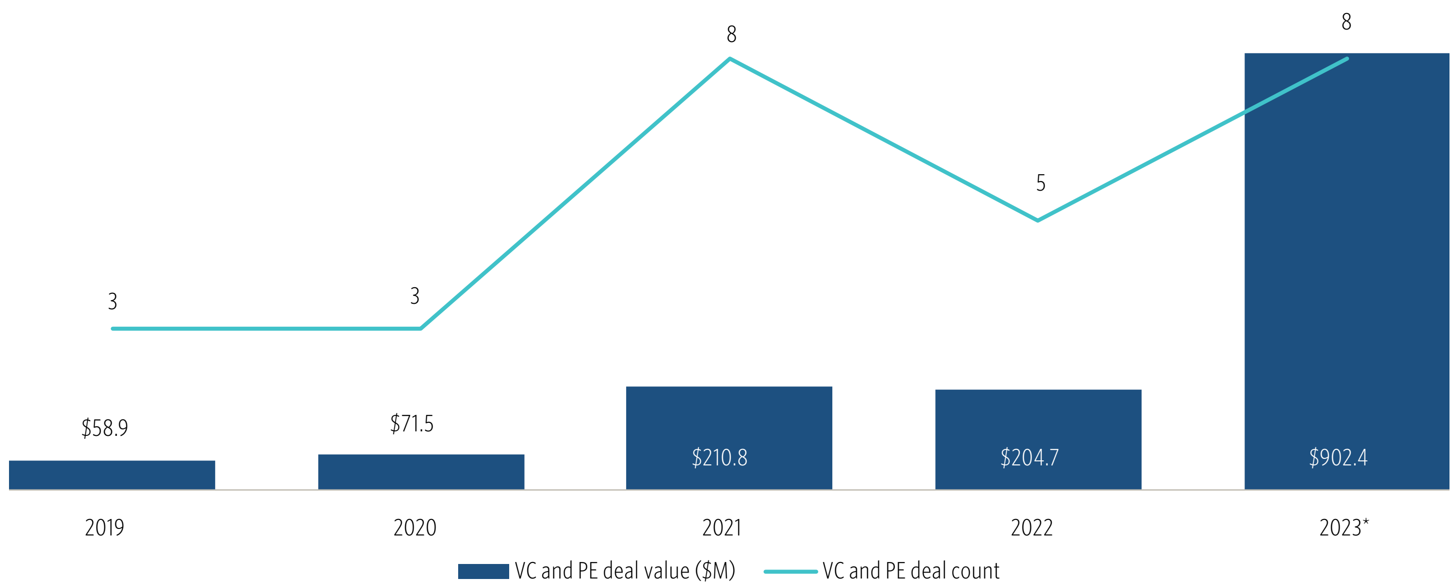
Community-based organization (CBO) enablement—Pair Team: Founded in 2019 and backed by Next Ventures, Pair Team provides technology and care management support to CBOs and contracts on their behalf to enable them to receive reimbursement revenue for engaging with high-risk Medicaid members, including people experiencing homelessness, those with severe mental illnesses, and people with disabilities. Pair Team effectively creates a CBO network that can provide SDOH support while reconnecting members to, and guiding them through, the healthcare ecosystem. The company also provides virtual primary care and behavioral health services directly to members via its medical group and coordinates with in-person care providers, hospitals, and emergency departments. Pair Team works through Medi-Cal's Enhanced Care Management model as well as through value-based contracts with MCOs. It expects to develop downside risk contracts in the future as its first cohort, formed in June 2022, matures. Pair Team is currently operational in California and will soon expand into New York.

Behavior change incentives—Stellar Health: General Atlantic-backed Stellar Health was founded in 2018 and aims to financially incentivize provider behavior change. Stellar contracts with payers and other risk-bearing entities that assign underperforming providers to the program, of which Stellar signs about 50% to 80% depending on market density. The Stellar platform, which is available as an EHR ribbon via a partnership with Vim, prompts providers and other care team members to perform incremental actions that will result in improved patient outcomes and

better performance in value-based contracts. These actions are rewarded with "Stellar Value Units," or SVUs, which have a dynamic monetary value intended to gamify progress. SVU payments are made monthly and are split between the practice, providers, and other participating users such as medical assistants and front-office staff. Stellar currently helps manage over 1 million lives.

We will be watching with interest to see how these and other alternative models interact with the traditional VBC enablement ecosystem. Clinical support companies like Arkos compete directly with VBC enablers in the sense that the enabler carves out lives from a payer's network that would otherwise be managed by Arkos, though we could also envision a company like Arkos contracting with another risk-bearing entity such as a traditional VBC enabler to provide clinical resources at scale. Stellar's software could complement a VBC enabler's tech stack as a stopgap for underperforming providers but is probably more likely to be brought on by payers to assist providers that are not already aligned with a VBC enabler, making the solution competitive with traditional enablement. Finally, we can see a CBO-focused enabler like Pair Team partnering with traditional VBC enablers to address SDOH needs, likely via delegation of the highest-need portion of the attributed population.

VBC enabler VC and PE deal activity



Source: PitchBook • Geography: US • *As of February 28, 2024
Note: Includes disclosed deal values only.

VC- and PE-backed enablers

Aledade

Founded: 2014

Geography: 48 states (all except AK, HI)

Lives in downside risk: 1.2 million (MSSP, ACO REACH, and MA)

Last financing: $260.0 million Series F led by Lightspeed Venture Partners in 2023, reportedly valuing the company at $3.5 billion[2]

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. This scale is doubly impressive in light of the fact that Aledade does not pursue health system partnerships. Founded in 2014, Aledade is a public benefit corporation and boasts a leadership team that includes former healthcare technology initiative leaders from CMS, the Office of the National Coordinator for Health Information Technology, and the Department of Health and Human Services. 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. 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 and is open to opportunistic tuck-in acquisitions. The company offers centralized clinical resources to its partner practices including pharmacy teams, end-of-life planning (via Iris), and a CKD management program currently implemented by more than half the practices in Aledade's network.

Growth 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. It does not have a significant footprint in ACO REACH. However, the company's presentation at the 2024 J.P. Morgan Healthcare Conference highlighted its relatively untapped opportunity in MA: Of Medicare-covered patients affiliated with Aledade's partner practices, 24% are MA members not currently covered by Aledade contracts. The 10-year partnership that Humana and Aledade inked in March 2023 is a promising start in this endeavor, but assembling and administering additional MA contracts across 48 states will become incrementally more challenging as Aledade works through the low-hanging fruit.

In November 2023, Aledade announced a partnership with Anthem Blue Cross and Blue Shield in Virginia, focused on Medicaid but touching 150,000 Anthem members across Medicaid, MA, and commercial plans. In December, Aledade also announced its intention to form the first community-health-center-only MSSP ACO in Virginia. Aledade has a small presence in rural and underserved areas of Virginia organized around a 10,000-member MSSP ACO, Valley Health. We read these announcements together as pointing toward Aledade testing clinical and financial models for partnering with more practices that serve under-resourced populations—which would bring Aledade into more direct competition with Equality Health, Main Street, Oasis, and Yuvo.

Aledade stated in its 2024 J.P. Morgan presentation that it generated $675 million in revenue in 2023, up 39% from 2022. It also stated that it is at break-even EBITDA with "visibility" to gross margins at or over 30%. Aledade downgraded its EBITDA projection to break-even in its 2024 presentation from "positive since 2020" in its 2023 presentation.

2: "Aledade Raises $260 Million to Help Doctors Change How They Practice," Bloomberg, John Tozzi, June 21, 2023.

Our bottom line: Aledade raced ahead on horizontal scale in the independent provider space and now appears to be increasingly focused on growth via depth—that is, layering on additional payer contracts for its existing network. If achievable, 30% gross margins would benchmark impressively against competitors (compare, for example, 4% for agilon and 21% for Astrana). Aledade is at an inflection point that the rest of the industry should pay close attention to: Scale has brought operating efficiencies but also a need to expend more clinical and contracting resources in order to capture upside from a greater proportion of the patient panel.

Equality Health

Founded: 2015

Geography: AZ, LA, TN, TX, VA

Attributed lives in downside risk: 574,000

Last financing: Undisclosed financing from General Atlantic, Town Hall Ventures, and Finback Investment Partners in 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 Health partners with independent primary care practices located in underserved communities. On average, Medicaid beneficiaries represent around 50% of their partnered practices' patient panels. Because the practices Equality Health works with operate on tight margins and are sensitive to workflow changes that might reduce patient volumes, Equality Health typically assumes 100% of downside risk and provides incentive payments, tied to alignment with Equality Health's recommended workflows, to practices virtually from day one. In 2021, Equality Health acquired Daraja Services, an Arizona-based actuarial and informatics provider, to enhance its medical underwriting and analytics capabilities. In December 2023, the company partnered with Datavant to help automate care gap closure and risk coding across the many EHRs used by Equality Health's network practices.

Medicaid focus: Equality Health's focus on Medicaid beneficiaries gives a 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 Health's approach diverges from the traditional Medicare model. Unlike many Medicare enablers, Equality Health does not provide traditional case management services, since many MCOs do this already. Instead, it provides direct-to-member services delivered by field teams that include a nurse practitioner who provides medication review and orders services such as home health, durable medical equipment, and wound care; an employed community worker, often bilingual, who visits patients to secure support for SDOH needs and to help with advocacy and care navigation; and chaplains, who assist not only with spiritual/emotional matters but also with behavioral health challenges.

In Arizona, Equality Health has deployed a home-based complex care program, which targets the 3%-5% highest-risk patients who have become disconnected from traditional care providers with the aim of engaging, medically stabilizing, and returning them to regular care via their primary care provider (PCP) or palliative care. This program layers on top of Equality Health's standard community health 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 Health intends to scale this program to additional markets in 2024.

Growth strategy: Around 90% of Equality Health's attributed lives are currently in two-sided risk models or associated with contracts in new markets that include a glide path to two-sided risk. States are increasingly including requirements in Medicaid RFPs for MCOs to move covered lives into alternative payment models or into downside risk specifically. This has positioned Equality Health as a value-add partner for MCOs because Equality Health contracts allow them to meet the state-mandated quotas. The company believes that most of the membership impact resulting from Medicaid redeterminations following the end of the public health emergency were played through in 2023, leaving a high degree of confidence in growth projections for 2024. In Arizona, Equality Health's most mature market, the platform also has 50,000 lives, split relatively evenly between MA, dual-eligible beneficiaries, and ACO REACH. Going forward, Equality Health is seeking to add Medicare lives in additional markets and to build partnerships with Medicare-focused risk-bearing groups to manage their Medicaid populations.

In the longer term, Equality Health's vision is to become a convener for Medicaid population health point solutions by taking total cost of care economics. Medicaid VBC solutions are highly fragmented, with payers contracting with dozens or hundreds of vendors to carve out and manage specific populations in response to innovation requirements in state RFPs. In this vision, Equality Health would become a full-service VBC administrator for its MCO partners, allowing the payer to preserve primary care attribution logic while also deploying specialty population health solutions as an extension of their relationship with Equality Health.

Equality Health has been EBITDA positive since 2019. The company has historically grown at the pace of one new market per year, primarily funded via cash flows from its mature Arizona and Texas markets, but now plans to enter two markets per year for 2024 and 2025, barring additional capital infusions, which would accelerate that pace.

Our bottom line: Against the backdrop of an increasingly crowded Medicare landscape, Equality Health is well positioned as one of the only VBC enablers purpose-built for Medicaid, with specialized experience not only in clinical build-out but in actuarially sound MCO contracting. This success has been built on deep foundations in Arizona and Texas, and the company's key challenge in the near term will be replicating its model in new markets while accelerating growth and capturing economies of scale—especially if Medicaid VBC becomes more competitive in the coming years.

Honest Medical Group

honest

Founded: 2021

Geography: MI, NY

Attributed lives in downside risk: Undisclosed

Last financing: Undisclosed

Background and model: One of the newest VBC enablers, Honest sports an experienced founding team and a roster of several large physician group partnerships. Adam Boehler, CEO of Rubicon Founders, a Nashville-based healthcare firm that both invests in established businesses and partners with entrepreneurs to build companies, established Honest alongside Abe Sutton and Matt Kim. Boehler previously founded Landmark Health (acquired by Optum in 2021) and served as Director of the Center for Medicare and Medicaid Innovation (CMMI) and Deputy Administrator of CMS. Honest began operations in New York and entered Michigan in mid-2022 via a joint venture with Blue Cross Blue Shield of Michigan announced in April and a partnership with MedNetOne Health Solutions announced in June.

Our bottom line: Disclosed information on Honest is limited, but the company's initial payer and provider partnerships and experienced founding team point in a positive direction.

Lumeris

Founded: 2011

Geography: AR, CA, CO, IL, IN, KY, LA, MO, NJ, NY, OH, OK

Lives in downside risk: Unknown (2 million on the platform, of which more than 500,000 are in Medicare)

Last financing: N/A

Key differentiation: Multi-service-line partnerships

Background and model: By far the most established privately held enabler, Lumeris has been partnering with health systems to deploy multi-service-line, multi-payer-type VBC solutions for decades. Lumeris was formed by Essence Healthcare, a St. Louis-based payer that at the time managed care under the health maintenance organization capitation model. Essence currently has 70,000 MA beneficiaries across California, Illinois, Missouri, Georgia, Arkansas, Ohio, Kentucky, and Indiana. Essence's track record, which includes five-star ratings for its St. Louis plan in 2022, 2023, and 2024, gives Lumeris deep experience in managing risk. Lumeris acquired Forecast Health, a population health analytics provider, in 2017, and NaviNet, a payer-provider communication tool, in 2012 alongside three Blue Cross Blue Shield plans.

Long-term partnerships: Lumeris' model differs in several ways from the other enablers in our list. The company partners with health systems clinically integrated networks (CINs) and independent provider groups to enable VBC across all patient populations, including commercial, Medicaid, Medicare, and uninsured. The company generally signs eight-to-12-year contracts and seeks partners that display long-term, organizational commitment—not dependent on specific individuals—to VBC transformation. Lumeris then deploys technological, operational, and clinical resources via a variety of products that are customized to the partner's needs. Contract terms include growth commitments from both Lumeris and the partner organization to expand the organization's footprint of value-based lives, whether by growing the partner's network, convening additional partners, or converting existing fee-for-service lives to value-based contracts.

Growth strategy: Lumeris' fastest-growing line of business is downside risk arrangements, in which the enabler serves as the contracting entity in Medicare risk (MSSP, REACH, and/or MA). For example, in November 2023, Lumeris announced a partnership with Endeavor Health (formerly NorthShore – Edward-Elmhurst Health), a nine-hospital Chicago-area system. Lumeris will facilitate risk contracting, including in ACO REACH and MA, for Endeavor's CIN and will deploy its technology and clinical playbook across 7,000 physicians. The partnership comes at a time when Endeavor continues to integrate following its creation from a significant merger in 2021. Lumeris' revenue has increased by $1 billion annually for the past two years.

Our bottom line: Health systems are extremely heterogeneous in their VBC enablement needs: Some will prefer to forge their own path with technology-only solutions, some need help with network aggregation and contracting, and others are looking for support with long-term organizational transformation. While other enablers such as agilon, Privia, and Wellvana have established multiple health system partnerships, Lumeris fills a gap in the market with its customized and

comprehensive approach and proprietary technology suite. Lumeris appears to be leaning into its risk contracting service line; the company's payvider DNA should serve it well in this endeavor.

Main Street Health

Founded: 2021

Geography: 18 states as of October 2023 and growing to 26 in 2024, including AL, AR, IA, IL, IN, KY, LA, MI, MO, MT, NM, NY, OH, OK, SC, TN, TX, VA, WV

Lives in downside risk: Unknown

Last financing: $315.0 million early-stage round in October 2023, led by Oak HC/FT

Key differentiation: Rural providers at scale

Background and model: Main Street Health launched with a $27.0 million fundraise in 2021 but only recently burst into the limelight, securing $315.0 million in an October 2023 round led by Oak HC/FT with participation from Centene, Elevance, and UnitedHealth Group. The enabler is led by Brad Smith, former Director of CMMI and Deputy Administrator at CMS. Smith also founded and leads Russell Street Ventures, a Nashville-based healthcare investment firm, and co-founded both Aspire Health, which was acquired by Elevance in 2018, and CareBridge Health, which is also Oak HC/FT backed. Main Street's C-suite comprises former Aspire Health and public sector healthcare leaders.

Main Street Health aims to work exclusively with rural providers, a relatively untapped segment given the limited operational capacity of many rural providers and the difficulty of building geographic scale. Main Street's average clinic partner has 2.5 providers. Main Street's clinical model involves embedding care navigators within practices in addition to providing technology that supports patient engagement and gap closure.

Our bottom line: Main Street Health has provided little visibility into its operations and strategy so far. Brad Smith's leadership should give Main Street a close pulse on CMS policy directions. The speed at which Main Street has scaled rivals the pace of other well-capitalized enablers such as Pearl and Vytalize over the past few years, and we suspect that the company is prioritizing breadth over market density, especially given the relatively light clinical support model (non-RN navigators only). Still, achieving profitable unit economics with small rural providers will be no small feat, and we will be curious to see whether Main Street eventually diversifies upmarket as some of its peers, such as Vytalize, have.

Oasis Health Partners

Founded: 2022

Geography: GA, IA, SC

Lives in downside risk: Undisclosed (downside contracts with three MA plans)

Last financing: Early-stage venture round from GV and TripleAim

Key differentiation: Rural providers with density

Background and model: Like Main Street Health, Oasis Health Partners, which launched publicly in January 2023, focuses on enabling VBC for rural providers. Unlike Main Street, Oasis takes a high-touch approach to partnerships and is focused on building density in its markets and does not aspire to scale quickly into dozens of new states.

Oasis was founded by Brian Mathis, who previously held leadership roles at Sevita and Optum Care (now Optum Health), and Kari Severson Snaza, previously a leader at Mayo Clinic and UnitedHealth Group. The company works with rural provider groups spanning solos, midsize groups, federally qualified health centers (FQHCs), and health system-affiliated physicians. Oasis signs relatively short-term contracts in which it takes 100% of downside risk and splits upside 50/50. It provides regular cash flow advances to providers ahead of contract payout.

Hands-on with rural providers: Oasis prides itself on meeting rural providers where they are at through both technology deployment and clinical governance. On the technology side, partnerships begin with a listening-heavy discovery session followed by onboarding and system integration. Oasis has capabilities to integrate with not only myriad EHRs (40 are currently represented in its network) but also paper- and fax-based systems. Its technology focuses on risk stratification and coding, closing quality gaps, and clinical workflows, including transitions of care. In terms of governance, Oasis convenes state-level clinical counsels comprising providers, physicians, nurses, and other representatives from various practice types and localities. These counsels meet quarterly to share successes and challenges and set solution-development priorities at a local level. Oasis also places a "value partner," who provides administrative and care navigation support, within each of its partner practices. It does not currently deploy clinical resources but has explored having a clinic's value partner be a nurse practitioner, RN, social worker, or pharmacist who could take on additional value-add activities.

Growth strategy: Oasis believes that by building density through its high-touch model, it can move rural providers into risk relatively quickly—in a few years. The enabler expects to enter two new states in 2024. It generally enters markets with payer partners, which either supply a list of providers as a "license to hunt" or help identify specific problem markets and set up contracts into which providers can be recruited. Oasis currently has MA contracts only but intends to expand into MSSP and ACO REACH in the future. It is also interested in exploring partnerships to support patients' SDOH needs—such as food insecurity, transportation, and housing—as well as behavioral health needs. Oasis expects to raise additional funding in 2024 and to become cash flow positive in two to three years as its early markets mature.

Our bottom line: Oasis stands out with its deep commitment to partnering operationally with small and under-resourced providers (what other enabler has a paper- and fax-compatible technology solution?) and with its explicit aim of prioritizing density over new geography expansion. The company's key challenge will be scaling its internal implementation engine and governance resources while maintaining this personal touch. We have seen other enablers (such as Equality Health) build sustainable financial models within constrained geographic footprints and believe this is possible for Oasis, although we would be somewhat surprised if an investor like GV did not have grander ambitions for the company in the long term.

Founded: 2021

Geography: 18 states, including CA, DE, FL, GA, HI, MA, ME, NE, NJ, OH, OK, OR, PA, RI, SD, TX, and Washington, DC

Lives in downside risk: Undisclosed

Last financing: $6.5 million Series A in 2022 from .406 Ventures, Longitude Capital, and Maverick Ventures

On Belay Health Solutions

Background and model: Co-founded by CEO Andrew Allison, who previously led VBC strategies for Aetna, and Scott Early, On Belay is a VBC enabler that works with independent primary care groups, FQHCs, and health systems. The co-founders met when they worked together at Iora Health, now One Medical Seniors. Participating in both MSSP and ACO REACH, as well as MA in Massachusetts, On Belay deploys clinical resources including nurse care managers, social workers, and physical therapists to support its partner practices. It focuses on, but does not work exclusively with, FQHCs, and in May 2023 announced a partnership with the Association of Clinicians for the Underserved (ACU), giving On Belay exclusive partnership for enabling Medicare ACO models for ACU's network of centers. In October, the company announced partnerships with South Shore Health, a Massachusetts regional health system, as well Rapid City Medical Center, a large independent group in South Dakota, and Lone Star Circle of Care, a large FQHC in Texas.

Our bottom line: Disclosed information on On Belay is limited. However, the company appears to have greatest depth in Massachusetts, and it appears to have two obvious growth routes: first, replicating this depth via additional health system partnerships in additional states; second, pursuing additional relationships with ACU's network of FQHCs. We will be watching On Belay's progress as the cohort of enablers focused on underserved patient populations grows.

Founded: 2020

Geography: 43 states (all except AK, CO, KS, RI, SD, VT, and WY)

Lives in downside risk: 80,000 (ACO REACH)

Last financing: $75.0 million Series B in January 2023, led by Andreessen Horowitz and Viking Global Investors

Key differentiation: Software emphasis

Pearl Health

Background and model: 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 (around three years) and does not deploy clinical resources. It takes a flexible approach to sharing economics, 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's partnered practices receive shared savings commensurate with their own performance via individualized synthetic performance pools.

Pearl has pursued several specialty care partnerships, including a partnership with a major diagnostics provider entered in 2023, a partnership with Story Health announced in 2023 for specialty cardiovascular care, and a partnership with Vori announced in December 2023 for virtual-first musculoskeletal care. Pearl has also pursued kidney care partnerships and is interested in additional specialty areas, including behavioral health. In June 2023, Pearl announced a partnership with FQHC-focused enabler Yuvo Health (we highlight Yuvo later in this note) to contract for Yuvo's Medicare members.

Focus on software: Pearl's population health software, which boasts a 92 Net Promoter Score, allows providers to easily visualize their panels and aids in prioritization and increasing provider response time to patient inquiries, as well as improving care gap closures and HCC coding. 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 with 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.

Walgreens partnership: We wrote in depth about the significance of Pearl's partnership with Walgreens when it was announced in September. The deal represents the first significant partnership between a VBC enabler and a major retail healthcare player and is likely a harbinger for more to come as retailers both double down on their commitment to care delivery and come to terms with the difficulty of executing VBC at scale.

Walgreens has not taken an equity stake in Pearl. Initially, the two companies will realize data synergies—combining Pearl's clinical decision support software with Walgreens' pharmacy data, for instance—and sharing accountable care organization economics in certain markets. Pearl is not currently providing VBC enablement technology to VillageMD, although we view that as a logical evolution of the partnership if it continues to expand.

Growth strategy: Pearl's growth strategy is unique from most other enablers in that the company has sought to expand nationally from the start rather than building density in a few markets at a time—an approach enabled by the company's light-touch model. In the 2023 ACO REACH enrollment season, Pearl signed several larger provider groups. Amid growing competition, Pearl has prioritized entering economically sustainable contracts and encouraging independent providers to take on risk, resulting in net 2x growth in attributed lives during the most recent ACO enrollment season.

Pearl's roots are in ACO REACH, where it participates in both the professional and global tracks. In March 2024, Pearl announced a partnership with Wellcare (Centene) to move Wellcare MA contracts toward VBC. The partnership is live in North Carolina but has the potential to expand nationwide.

Our bottom line: In a market that appears to be drifting toward consensus around hands-on clinical change management as the path into risk, Pearl is swimming the other direction, prioritizing its software user experience as the key behavior change driver and making financial bets that it can confidently underwrite. In the future, Pearl's main competition may come more from software-as-a-service vendors than from other enablers as the company builds a top-of-class provider UX. Scaling in MA will be a key milestone for the company and will allow Pearl to add depth to its nearly national partner footprint.

UpStream

Founded: 2018

Geography: NC, SC, VA

Attributed lives in downside risk: 180,000 (MA and ACO REACH) as of January 2023

Last financing: $140.0 million Series B, led by Coatue and Dragoneer Investment Group

Key differentiation: Integrating pharmacists

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 total cost of care across the provider's panel. According to the company's 2023 J.P. Morgan presentation, 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. In January 2023, UpStream announced a multi-year partnership with Innovaccer to utilize Innovaccer'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.

Growth strategy: UpStream's attributed lives are split roughly evenly between MA and ACO REACH. The company takes on 100% of downside risk and shares upside via monthly quality-based payments to reduce financial uncertainty.

Our bottom line: UpStream has seen several key personnel moves in the last year, including the appointment of Lankford Wade, previously CFO of Summit Health/CityMD, as CEO in September and John Way as CFO in January 2024, and the company has shared little about its progress since presenting at the J.P. Morgan Healthcare Conference in 2023. Pharmacist-led clinical teams are a compelling clinical model but also a resource-intensive one, and we are eager to see how the economics of this model play out as UpStream scales.

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: 450,000

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

Key differentiation: Physician alignment

Vytalize

Background and model: Founded in 2014 as a physician group in New York City, Vytalize built its market footprint by focusing on small providers. 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. It signs contracts of variable lengths (longer contracts for more substantial relationships) and employs a market-rate shared savings split.

Provider engagement: Vytalize believes it has the lowest customer acquisition costs in the industry. It has tailored its offering to prioritize physician alignment 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, the company equips practices with home-based primary care for high-risk patients, as well as RN care coordination. The company has taken a network approach to specialty care, including innovative value-based partnerships for home health, skilled nursing, cardiology, orthopedics, nephrology, and oncology.

Growth 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 MA arrangements, and it intends to expand its MA risk contracting for partnered practices participating in ACO REACH. IPANY also has Medicaid and commercial VBC contracts that Vytalize intends to use as a starting point for future expansion outside of Medicare.

Vytalize tripled its Medicare lives under management during the last ACO enrollment season, with a focus on building density rather than entering new markets; its top growth markets were California, Florida, Georgia, Kansas, and New Jersey. The company's market strategy is also evolving from its foundations in small-provider-focused enablement. Around half of Vytalize's attributed lives now belong to large practices, and the company expects to continue growing both its large practice and small practice footprints over time. Vytalize began pursuing larger practices more actively due to the larger addressable market and financial upside potential that they represent and has found that its physician engagement model is equally effective at incentivizing behavior change within larger organizations.

Our bottom line: Vytalize's move upstream is one that the rest of the industry should take note of. Most enablers have picked a market size lane and more or less stuck with it. Although larger groups may present greater contracting complexity, building clinical wraparounds and technology enhancements for small groups is much more labor-intensive relative to the financial upside achieved. Assuming the company can deliver clinically and avoid intense competition, we expect Vytalize's financials to look increasingly attractive as the company deepens its 37-state network and improves its unit economics through larger partnerships. If its recent growth trajectory continues, Vytalize may rival agilon in scale by the end of 2025 and Aledade the following year.

wellvana

Founded: 2018

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

Attributed lives in downside risk: Undisclosed

Last financing: $84.0 million 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 group acquisitions 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. More commonly, Wellvana partners with a large provider group to enter a market and can structure anchor partnerships in multiple ways, including joint venture and MSO. Wellvana also builds right-of-first-refusal provisions into its contracts with independent providers to help preserve its network as practice owners retire and look to sell. For smaller practices, Wellvana's typical contract terms are five years, with a 75% split of shared savings and 100% assumption of downside risk. 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: We consider Wellvana to be one of the original "hands-on" enablers. The company employs practice transformation specialists in local markets; each specialist partners with seven to 10 clinics and visits weekly to support ongoing clinical and operational improvements. Directors of clinical operations visit clinics monthly to review key performance indicator 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. A clinical documentation team provides audited prospective and retrospective clinical documentation integrity support. On the clinical side, Wellvana employs registered nurses, medical assistants, licensed practical nurses, social workers, and other clinical staff to provide care coordination, transitions-of-care support, and patient engagement. Pharmacists and pharmacy techs provide medication adherence and reconciliation support, while midlevel clinical staff handle inpatient episode and discharge management and wellness appointments. Wellvana offers these clinical and administrative support services across all of its markets.

Growth strategy: Wellvana takes a conservative approach to underwriting, prioritizing performance consistency and confidence in outcomes prediction as it moves partner practices toward full risk. The enabler grew attributed and managed lives by around 3.5x to 4x from the beginning of 2023 to the beginning of 2024 and expects to double its footprint again in 2025. Wellvana's program split is roughly half ACO REACH and half MA. The enabler has also negotiated commercial and Medicaid contracts on behalf of its networks in specific markets and sees longer-term growth opportunities in Medicaid, including via its current MA partners.

Wellvana has had its sights set on health system partnerships for some time and in October 2023 announced it had partnered with AdventHealth to move the Florida-based system's primary care network's Medicare and MA lives into VBC. The Memorial Hermann Foundation is also an investor in Wellvana.

Our bottom line: Of the scaled, privately held enablers, Wellvana operates the most high-touch model. This level of staffing—coupled with the company's more conservative pacing into risk—point to a more capital-intensive model. However, we also believe Wellvana's model is likely to be one of the more sticky and de-risked in the long run due to the company's emphasis on building and closely managing high-quality networks. It is also important to recall that Wellvana owns more providers than other privately held enablers, which should provide an additional fee-for-service revenue base.

Yuvo Health

Founded: 2021

Geography: NY, OH

Lives in downside risk: Undisclosed (primarily Medicaid; ACO REACH via Pearl Health partnership)

Market cap as of February 28, 2024: $20.2 million Series A led by Mosaic General Partnership on June 7, 2023

Key differentiation: Exclusive FQHC focus

Background and model: Founded in 2021, Yuvo Health is the only VBC enabler we are currently tracking that partners exclusively with FQHCs. Yuvo's model is shaped by the unique regulatory, financial, and clinical characteristics of its FQHC partners. The company is a multi-line-of-business primary care enabler: It has downside risk contracts with Medicaid MCOs, the largest payer type for FQHCs, as well as upside-only MA contracts that it plans to convert to downside risk in the future. Yuvo also participates in ACO REACH via a partnership with Pearl Health.

Yuvo's model is to act as the risk-bearing entity and assume full downside risk for value-based contracts, with no participation or technology fees passed along to the FQHC. FQHCs are reimbursed by all payers via federally mandated encounter-based payments, although there is state-by-state variation in how these payments are structured. Payers may also enter alternative payment models with FQHCs but are required to make supplemental payments if total payments under an alternative payment model fall under what would have been achieved in the fee-for-service encounter-based payment system. Thus, FQHCs are legally unable to take on downside risk. Another key characteristic of FQHC encounter-based payments is that they are not risk adjusted. Yuvo deploys technology that not only allows FQHCs to track utilization across sites of care but also supports accurate risk scoring within alternative payment models.

Rather than distributing a cut of shared savings to its partners, Yuvo makes payments in exchange for incremental actions that it believes will lower the total cost of care, such as increasing appointment access, care gap closure, and even provider attendance at educational sessions. This payment structure includes a guaranteed payments floor provided minimum engagement requirements are met. The company's FQHC partners sign two-year contracts that auto-renew annually. The company believes its relationships will continue to be sticky as it delivers upside coupled with zero financial risk to its partners and differentiates via its exclusive FQHC focus.

The unique clinical model employed by FQHCs also shapes Yuvo's light-touch approach. As a condition of their qualification as FQHCs, Yuvo's partners already provide services specifically tailored to the communities where they are located, including services provided in the appropriate languages, specialty care, and social supports. Most FQHCs have interdisciplinary care teams that include licensed social workers and care managers. Therefore, unlike other enablers that may employ care navigators or social workers to enhance independent primary care practices' ability to engage with patients, Yuvo's goal is to scale and better financially compensate

the investments in patient engagement that FQHCs are already making. It does this through a combination of technology support, market-based performance management teams, and centralized population health and analytics resources, as well as by engaging community-based organizations as network partners.

Growth strategy: Yuvo's geographic strategy to date has been driven by Medicaid policy. The company's attributed lives are in New York, where an active 1115 demonstration waiver allows Yuvo's partners to be reimbursed for care management and social support activities. Yuvo entered its second market, Ohio, as part of the state's Medicaid RFP process that emphasized alternative payment models. Yuvo also works with state FQHC organizations and other aggregator organizations as part of its go-to-market strategy and has relationships with Advocates for Community Health (which includes the nation's 40 largest FQHCs) and the National Association of Community Health Centers.

Our bottom line: FQHCs represent a growing area of focus among VBC enablers, with Equality Health, Aledade, and On Belay also making moves. There is significant greenfield space, to be sure. As that greenfield is reduced, Yuvo's ability to compete against these larger players will depend on the trust it can build with the FQHC community, which has understandably approached enabler relationships with skepticism in the past. Yuvo is laser focused on earning this trust, and the company's light-touch model, in addition to being capital efficient, also avoids interrupting established provider-community trust relationships. Yuvo's challenge will be achieving scale—even more crucial when working with lower-margin Medicaid contracts, small Medicare panels, and patient populations that may be difficult to underwrite—while piecing together CBO relationships and timing state entries in line with managed care cycles policy developments.

Publicly traded enablers

Performance of VBC enabler stocks rebased to 100 on January 1, 2022*

Source: Morningstar • Geography: US • *As of February 28, 2024

agilon health

Founded: 2016

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

Lives in downside risk: 650,000

Market cap as of February 28, 2024: $2.6 billion

agilon health (NYS: AGL)

Although agilon was not the first company to enable VBC for independent providers, it has become the category-defining example. The company was created in 2016 by Clayton, Dubilier & Rice (CD&R) through a combination of a California-based Medicaid VBC company (Primary Provider Management) and a Hawaii-based Medicare VBC group (MDX Hawai'i). agilon agreed to sell the latter in October 2023. Its anchor partnership was with Central Ohio Primary Care, the nation's largest independent physician group. 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's stock plummeted in late 2023 after the company recorded higher-than-expected utilization.

agilon 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 -$95.0 million adjusted EBITDA in 2023 and projects -$60.0 million to -$15.0 million EBITDA for 2024.[3]

Astrana Health

Founded: 1992 as Allied Physicians of California, an IPA

Geography: CA, NV, TX

Attributed lives in downside risk: Unknown (900,000 VBC lives)

Market cap as of June 30, 2023: $2.1 billion

Astrana Health (NASDAQ: ASTH)

Like Privia, Astrana (formerly ApolloMed) pursues VBC across all payer types, including MA, managed Medicaid, commercial, ACA exchange plans, and traditional Medicare, and is a multispecialty platform. Astrana 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. In November 2023, Astrana agreed to acquire Community Family Care Medical Group, an Los Angeles-area independent physician association (IPA). In January 2024, the company announced a partnership with BASS Medical Group, a large multispecialty organization in the San Francisco Bay Area.

Astrana divides its operations into three business lines: care partners, care delivery, and care enablement, which in 2023 contributed 83.6%, 7.7%, and 8.7% of the company's revenue, respectively.[4] "Care delivery" refers to Astrana-owned primary and specialty care MSOs operating in California, Nevada, and Texas. "Care partners" refers to the company's IPAs, ACOs, and MA plan. It also encompasses several ancillary provider assets, including an ambulatory surgical center, imaging center, and diagnostic laboratory, in which Astrana 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 and IPAs) and payers. The company's presence is most significant in the greater Los Angeles area. Astrana recorded $60.7 million in net income in 2023 and is guiding to $61.0 million to $73.0 million for 2024.[5]

3: "agilon health Reports Fourth Quarter 2023 Results," agilon health, February 27, 2024.
4: "Form 10-K," US Securities and Exchange Commission, Astrana Health, December 31, 2023.
5: "Astrana Health, Inc. Reports Fourth Quarter and Year-End 2023 Results," Astrana Health, February 27, 2024.

Caremax

Founded: 2011

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

Lives in downside risk: Unknown (273,000 VBC lives across MA, Medicare, Medicaid, and commercial, of which at least 71,110 are in full or downside risk)

Market cap as of February 28, 2024: $26.0 million

CareMax (NASDAQ: CMAX)

Prior to its $135.0 million acquisition of Steward Health Care'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.[6] 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-service MA beneficiaries available to transition onto risk.[7] CareMax supports its Steward clinics via its MSO and is actively seeking to expand its MSO enablement services to other health plans, health systems, and physicians.

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 also 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. The company has guided to adjusted EBITDA of $15 million to $25 million for full-year 2023.[8]

P3 Health Partners

Founded: 2015

Geography: AZ, CA, FL, NV, OR

Attributed lives in downside risk: 118,000

Market cap as of February 28, 2024: $537.1 million

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 PCP group, into an IPA taking on value-based arrangements in the 1990s. Chicago Pacific Founders and Leavitt Equity Partners acquired P3 in 2018 and took the company private via reverse merger in 2021.

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 $22.0 million for the first three quarters of 2023 and has guided to adjusted EBITDA of $20 million to $40 million in 2024.[9, 10]

6: "SEC Filings Details," CareMax, November 9, 2022.
7: "Steward Value-Based Care Acquisition Investor Presentation," CareMax, June 1, 2022.
8: "CareMax Reports Third Quarter 2023 Results," CareMax, November 9, 2023.
9: "P3 Health Partners Announces Third-Quarter and Year-to-Date 2023 Results," P3 Health Partners, November 8, 2023.
10: "P3 Health Partners Reaffirms Guidance for 2023 and Announces Guidance for 2024," P3 Health Partners, January 9, 2024.

Founded: 2007 (first practice partnership in 2013)

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

Attributed lives in downside risk: 175,000

Market cap as of February 28, 2024: $2.4 billion

Privia (NASDAQ: PRVA)

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 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 that records fee-for-service revenue and takes 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. 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. 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 $23.1 million net income for full-year 2023 and has guided to $85 to $90 million adjusted EBITDA for 2024.[11]

11: "Privia Health Reports Fourth Quarter and Full-Year 2023 Financial Results," Privia Health, February 27, 2024.

COPYRIGHT © 2024 by PitchBook Data, Inc. All rights reserved. No part of this publication may be reproduced in any form or by any means—graphic, electronic, or mechanical, including photocopying, recording, taping, and information storage and retrieval systems—without the express written permission of PitchBook Data, Inc. Contents are based on information from sources believed to be reliable, but accuracy and completeness cannot be guaranteed. Nothing herein should be construed as investment advice, a past, current or future recommendation to buy or sell any security or an offer to sell, or a solicitation of an offer to buy any security. This material does not purport to contain all of the information that a prospective investor may wish to consider and is not to be relied upon as such or used in substitution for the exercise of independent judgment.