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Richard Close | Analyst | Canaccord Genuity LLC (US) | rclose@cgf.com | 615.490.8501
Brian Hoffman | Associate | Canaccord Genuity LLC (US) | bhoffman@cgf.com | 212.849.3975

US primary care: the beginning of a revolution

The primary care market is ripe for disruption. Today, the US spends an estimated $260 billion on primary care, which is less, as a percentage of total healthcare spending, than most other economically developed countries. This has real consequences for the health of our nation. In the US, roughly a quarter of the population does not have access to a primary care physician, and those that do must wait a month on average to schedule an appointment with a new doctor. The chronic underinvestment has exacerbated physician burnout and enabled a system that often leaves patients frustrated and unsatisfied with their primary care options. Meanwhile, there is a great body of research that proves that greater use of primary care is associated with better quality and lower costs, while improving both physician and patient satisfaction.

A new wave of primary care companies has emerged in recent years seeking to right-size and evolve the primary care industry. These companies are implementing new primary care models that benefit all stakeholders. New primary care models take advantage of value-based care, promote physician well-being and engagement, improve the patient experience, provide enhanced services, and lower costs for employers and payers. When looking at the landscape of new primary care companies, there are a variety of models emerging: some companies offer memberships to their patients, some focus on the Medicare population and others on commercial/employer populations, some employ physicians and others partner with physicians, some partner with health systems or employers, and some offer on-site employer clinics.

Regardless of the model, there are a few characteristics that primary care companies have in common. From the physician perspective, these models offer an improved work environment that enables them to spend more time with and provide better care to their patients while benefiting from the resources of a larger, experienced primary care company. From the patient perspective, these models offer better access to care, enhanced digital engagement, virtual care, and an overall improved level of satisfaction.

Given the vast size of the primary care market and significant opportunity to drive cost savings, it should be no surprise that private equity and venture capital has rushed into the primary care market in recent years. **One Medical (ONEM)** is the one publicly traded company in the primary care space, while private companies such as **Iora Health**, **Oak Street**, **Privia Health** and **VillageMD** have each raised capital in recent years and are also leading the evolution in primary care. In this report we highlight a total of 14 innovative primary care companies, which also include: **Aledade, ChenMed, Crossover Health, Forward, Marathon Health, MDVIP, Paladina Health, Partners in Primary Care** and **Premise Health**. Additionally, we note that there are virtual primary care upstarts such as Firefly Health and Galileo and more established telehealth companies such as Doctor on Demand, MDLive, and Teladoc that have rolled out virtual-first primary care offerings to their employer and payer customers (although we do not highlight these companies in this report).

In this report we dive into the current state of the primary care market, why it is ripe for disruption, and how companies are actively evolving the market to next-generation primary care models. We also provide a brief overview of the companies listed above and how they are differentiated in this fast growing market among new primary care models.

For important information, please see the Important Disclosures beginning on page 25 of this document.

The new primary care

Over the last several years, new business models and platforms have emerged as the market for primary care and practice management has evolved. Numerous studies show that primary care is an important component to the overall healthcare system and can play a critical role in bending the cost curve while improving health. However, as primary care has developed in recent decades, access to primary care is an obstacle and exacerbated by physician burnout, a shortage of primary care clinicians, and underinvestment in the primary care market (when compared to other developed countries). Despite the implementation of the Affordable Care Act that led to 20 million adults gaining insurance coverage, access to primary care in the US has not necessarily improved. According to an article in The Lancet, in 2015, roughly 76.4% of individuals in the US had access to a primary care provider compared to 76.8% in 1996. Furthermore, many primary care clinicians work under the restrictive operating environment of the hospital employed model or are faced with administrative and capital hurdles of a small physician-owned practice. This has contributed to low job satisfaction and burnout, which further contributes to primary care access challenges.

In response to many of the challenges faced by the primary care market, new primary care companies have emerged, seeking to promote physician well-being and engagement, enhance the patient experience, and provide better care at a lower cost. Increased physician engagement and patient satisfaction will benefit key stakeholders in the healthcare system; employers and insurers benefit from improved health of beneficiaries and employees, which lowers healthcare costs and improves productivity. As we will explore in this report, there are a variety of new primary care companies that have been created in recent years such as next generation physician practice management organizations, direct primary care (DPC) and employer primary care, senior care, and virtual primary care platforms.

From the patient perspective, the new primary care business models are attractive. These organizations typically offer increased access to care, enhanced means of engagement, better quality care, and an overall improved patient experience. From the provider perspective, these new forms of primary care offer an improved work environment that enables physicians to provide better care to their patients and with the backing of a larger, better resourced organization solely focused on primary care. Additionally, providers can spend more time with patients and truly focus on care, which as we will explore later in this report is very important to physicians. Many primary care physicians in traditional settings are bogged down with administrative duties and inefficient workflows that impinge productivity and quality. We expect next-generation primary care platforms will play a key role in the efforts to meet consumers' demands for a healthcare system that works like every other part of our lives, at the tips of our fingers.

Given the outlook that access to primary care is likely to get more challenging, new expect new models will facilitate increased access to care and more robust levels of patient engagement. Innovative service and tech-enabled models are not only likely to continue to gain in acceptance by employers and healthcare consumers, but also clinicians seeking to better model to engage and treat patients.

COVID-19 pressures primary care

COVID-19 has devastated our health system and our economy and impacted the way of life for nearly everyone in the US. It has dramatically impacted the way that patients seek care. People are staying home and deferring care. In just two months, nearly 1.5 million healthcare workers lost their job due to the pandemic, according to a report by Altarum. The Commonwealth Fund published a report showing that visits as of the first week of April to primary care physicians was down ~50% from pre-COVID levels. As of May 10, visits were down 25% from pre-COVID levels.[1]

In a fee-for-service world, if patients don't go to the doctor, the doctor doesn't get paid. This is the unfortunate reality for many healthcare providers today. During this time, we have also seen an explosion in virtual care utilization as it steps in to fill the void of in-person care. While virtual care helps, it cannot fully offset the volume decline many providers are facing. Many small primary care practices are facing financial struggles, and it could take a long time for a full recovery. Some experts are concerned that "primary care could really collapse" due to financial strains from the pandemic.[2]

While the pandemic is forcing organizations to rethink how they operate, it is also shining a light on the divide between business models that can thrive under the circumstances (i.e., a scaled-back way of life) and those that cannot. Business models such as Zoom, Amazon, Netflix, and Teladoc have been clear winners. There are also winners and losers in primary care.

One main initiative of many new primary care companies is the evolution toward value-based care. Companies such as VillageMD, ChenMed, and Iora Health take on risk with their payers, whether it be Medicare Advantage or with commercial insurers. If these primary care companies are getting paid a lump sum per patient, their business is not dependent on the volume of visits or procedures, and thus their revenue base has been relatively protected during the pandemic. Another initiative of new primary care companies is to utilize next-generation technologies such as patent portals, mobile applications, remote monitoring and telemedicine. Primary care companies that can connect to their patients virtually have been much better equipped to maintain relationships with their patients during stay-at-home orders.

The US will get past COVID-19 and the headwinds will fade in the rear-view mirror. However, the flaws of the fee-for-service model and outdated business practices of primary care have been starkly highlighted. What happens and when in response to the pandemic is not so certain. Fee-for-service physician practices could be scarred by the terrible experience of the pandemic so much so that they sell out to hospitals. Or perhaps this is the moment when the traditional practice takes the seemingly riskier option and embarks on the transition to value.

From horse and buggy to telemedicine – a primer on the history of primary care

During the early 1800s, many doctors visited their patients via horse and buggy. Healthcare in the US was unstructured as there were no medical schools, no formal medical training, and no system to ensure quality of medical care. The American Medical Association (AMA) was eventually founded in 1846 and by the early 1900s a structured medical education system in the US began to develop.

The idea of primary care was developed in Europe following World War I as the region was struggling to cope with significant healthcare and financial burdens. In 1920, a report was published by Britain's Council on Medical and Administrative Services, headed by Sir Bertrand Dawson, that recognized the organization of medicine in the UK at the time was failing to provide quality care to all citizens. In this report, Dawson recommended preventative care be provided to all patients in primary health centers by general practitioners (i.e., primary care), and more complex care to be provided in secondary health centers or hospitals (i.e., secondary care).[3] Notably, it was not until after World War II that the UK began to implement some of the foundational aspects of primary care that were detailed in Dawson's report.

In the US, a major changed occurred in 1935. Medical degrees were standardized for all physicians while specialization degrees became based on extended graduate education. As a result, the practice of medicine became a profession of the upper class and a friction emerged between general practitioners and specialists.[4]

Despite these changes, it took another 20 years for change to emerge within the US. During the 1930s through the 1960s, the number of people attending medical school grew at a lower rate than the overall US population. Consequently, negative trends emerged in the US including a shortage of physicians, inaccessibility of medical care in rural geographies and inner cities, increased cost of care, depersonalization of medicine, and the fragmentation of care. In response to these harmful trends, several prominent American healthcare policy organizations began to advocate for needed investment and focus on primary care in a similar fashion to the Dawson report. In the 1960s there were two major reports in the US that highlighted the need for primary care. In 1966, a report by the American Medical Association's Ad Hoc Committee on Education for Family Practices, headed by John Millis at the time, published a report recommending that every individual have a primary physician. A second report, also published in 1966, was the Council Report on Education for Family Practice, headed by William R. Willard at the time, and stated that reform was needed to place greater focus on family medicine to balance out the (at the time) overemphasis on medical specialization.[5] In 1969, Family Practice was approved as a new medical specialty. Since then, family medicine and other forms of primary care have flourished. However, growth in primary care clinicians has been outpaced by the overall population growth in the US while investment in primary care is lagging other developed countries, which has resulted in physician shortages and inadequate access to care, which we will explore more in this report.

Since the rapid growth of primary care begin in the 1960s and 1970s, trends in hospital-ownership of physicians appear to swing like a pendulum. Prior to the 1980s, most physicians worked in hospitals where they held a great deal of influence over the hospital administration. The market changed in the 1980s with the advancement of technology and the introduction of DRG (billing) codes. Technology enabled physicians to provide care outside of the hospital, while DRG codes reduced the number of people admitted to hospitals and reduced the average length of stay for most patients. Meanwhile, hospitals introduced service lines (e.g., surgery, radiology, podiatry, endocrinology, etc.) and complex hospital care became the responsibility of specialists rather than primary care physicians. The pendulum swung back during the 1990s as hospitals began buying up physician groups. Most of the acquisitions during the 1990s were primary care practices, and during the 2000s hospitals began buying up specialty groups as well. Physician practices sought hospital ownership to defray administrative and operational headaches, payer and reimbursement pressure, and technology capital requirements. Hospital acquisitions of physician groups picked up again following passage of the Affordable Care Act which put additional onerous technology and operational requirements on providers. The Physicians Advocacy Institute and Avalere Health reported that hospital employed physicians increased 63% from mid-2012 to mid-2016 while the number of hospital-employed physician groups grew by 100%. About 44% of US physicians were employed by a hospital or health system in 2018, which is nearly double the 25% reported in 2012.

Today, the trend appears to be swinging back in the opposite direction toward non-hospital ownership as physicians grapple with high levels of burnout and the emergence of other employment options. While physician practice consolidation is still occurring, the trend appears to be tapering off. A June 2019 article in Medical Economics noted the pendulum swing on employment by stating "we are witnessing the move toward employment slowing, and the tide beginning to turn." Furthermore, studies by the American Medical Association also show that the hospital-employment trend has slowed over the last several years. We are interested to see how COVID-19 may impact the trend of physician group ownership by hospitals. It is plausible to see a scenario where due to financial strains, health systems could look to form relationships with primary care organizations or transfer clinicians to an affiliate organization over time.

Defining primary care

To summarize the definitions of primary care by the American Association of Family Physicians and the World Health Organization (WHO), primary care is intended to be a comprehensive set of healthcare services to prevent and manage an individual's health, and as the first line of care it is an integral component of an individual's and a community's health. Primary care providers will typically screen patients for all major health-related conditions and help manage those conditions. They provide continuity of care, manage medications, and identify behavioral health conditions as well.

Specifically, the AAFP defines primary care as "*care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern*." The AAFP states that primary care services should include: "*health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings*."[6]

The WHO states that primary care is to be comprehensive and life-long: primary care "*provides whole-person care for health needs throughout the lifespan, not just for a set of specific diseases. Primary health care ensures people receive comprehensive care – ranging from promotion and prevention to treatment, rehabilitation and palliative care – as close as feasible to people's everyday environment.*" From a macro perspective, the WHO states that primary care "*is the first level of contact of individuals, the family, and community with the national health system… It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community*." [7]

Understanding the primary care market and why it is ripe for disruption

Primary care is proven to lower spend and improve health; it is an integral component of the US healthcare system.

There is a great body of evidential research showing the benefits associated with greater use of primary care: better quality of care and health outcomes, lower utilization of high acuity care such as hospitalizations and emergency room visits, higher patient satisfaction, and lower overall costs. As defined above, primary care is the first element of the healthcare process, and through it, clinicians manage the well-being of individuals today while also managing the challenges that threaten their future well-being. While primary care providers manage individuals, they are to a large extent effectively managing the broader community as well. In this sense, primary care is important in the prevention of health threats such as epidemics and antimicrobial resistance. [8]

Below we highlight several research studies that demonstrate the financial and clinical benefits of primary care:

- A study conducted in 2004 showed that if every American used a primary care physician as their usual source of healthcare, total healthcare costs in the US would decrease by 5.6% for annual savings of $67 billion, with improved quality of care provided.[9]
- An analysis in the state of Florida showed that a one-third increase in the supply of family physicians was associated with a 20% lower mortality rate from cervical cancer.
- A study conducted in 1999 showed that primary care and income inequality both had a strong influence on life expectancy, mortality, stroke mortality, and post-neonatal mortality.

- A study conducted in 2003 based on 11 years of state-level data showed that the supply of primary care was significantly associated with reduced mortality and completely offset the adverse effect of income inequality.
- In England, a study conducted in 2002 showed that each additional general practitioner per population of 10,000 was associated with a 6% decrease in mortality rates. [10]
- A study conducted in North Carolina found that 60% of patients who went to an emergency room had problems that could have been addressed in a primary care clinic for a savings of 320-720%.[11]

It should also be mentioned that primary care plays an integral role in managing the health of individuals with chronic conditions. According to the CDC, people with chronic and behavioral health conditions account for roughly 90% of the $3.5 trillion spent on healthcare in the US.[12] Given their high cost, it is critical to provide comprehensive care for this population in order to reduce overall costs. Given the massive size of this market, chronic care presents a potentially lucrative opportunity for primary care (we will discuss this in more detail later).

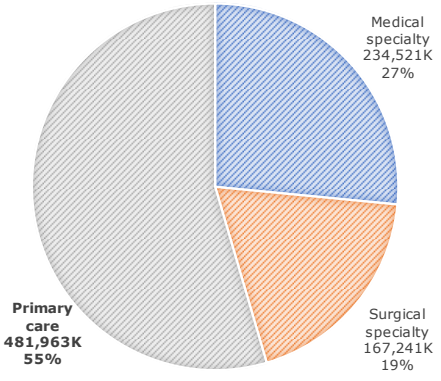
Figure 1: Patients with chronic conditions who visited a primary care physician during 2014.

Condition	Patients	Visited PCP	% visited PCP
Hypertension	62,170,492	52,086,268	**84%**
Diabetes	25,663,376	22,019,702	**86%**
Asthma	19,047,216	15,723,148	**83%**
Arthritis	15,379,356	12,487,497	**81%**
Glaucoma	4,193,069	3,109,622	**74%**
Congestive heart failure	1,976,929	1,675,103	**85%**
Multiple sclerosis	695,295	528,726	**76%**
Parkinson's	541,854	508,272	**94%**

Source: Graham Center, Canaccord Genuity

The market is large. We estimate there are ~300-350K primary care physicians in the US that account for ~55% of all office-based physician visits, and total spend in the US is ~$260 billion.

Figure 2: Primary care accounts for 55% of all office-based physician visits in the US.



Source: National Ambulatory Medical Care Survey, 2016

According to One Medical and the 2019 Patient Centered Primary Care Collaborative report, it is estimated that the total spend in the US on primary care is $260 billion, with ~61%, or $159 billion, coming from the commercial market.

With respect to the number of primary care physicians in the US, Kaiser Family Foundation estimates there are roughly 480K. The Agency for Healthcare Research and Quality (AHRQ) estimated the number of primary care physicians to be much lower, around 209K.[13] We believe the actual number is somewhere in between these two numbers in the range of 300K-350K.

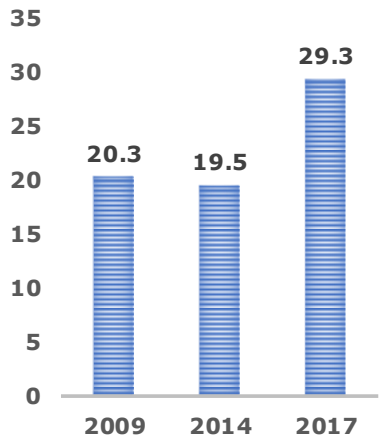
Digging into the data a bit more, Kaiser Family Foundation estimates that today there are just over 1 million physicians in the US. Of those, roughly 52% are specialists and the remaining 48%, or 480K, are primary care physicians. The Kaiser Family Foundation includes in its definition of primary care the following specialties: internal medicine (198K), family medicine/general practice (139K), pediatrics (88K), obstetrics and gynecology (Ob/Gyn) (54K), and geriatrics (1K)[14]. There are two explanations for why the Kaiser data might overestimate the actual number. First, many primary care practices do not include Ob/Gyn physicians, who are included in the Kaiser data. Also, it is likely that there are tens of thousands of physicians included in the Kaiser data who are currently retired or not currently practicing in the primary care setting. Excluding the 54K Ob/Gyns and an estimated 80K physicians who are either retired or not practicing in primary care settings would imply <350K practicing physicians.

The AHRQ data we believe is accurate because it does not include Ob/Gyn and also takes into consideration the estimated number of physicians who are retired or not practicing in primary care settings, but the data is based on the American Medical Association Physician Masterfile from 2010, thus it is 10 years old. Assuming growth of the primary care physician workforce by 4% per year from this base of 209K in 2010, it would imply there are 300K+ primary care physicians today.

According to the National Ambulatory Medical Care Survey (NAMCS), in 2016 there were 884 million visits to physician offices in the US. NAMCS also estimates that about 55% of those visits (482 million) were to primary care physicians. The NAMCS does not break down all of the primary care specialties but does provide the following information: in 2016 there were 202M visits to general and family practice physicians; 136M visits to pediatric physicians; and 82M visits to internal medicine physicians.[15]

Despite primary care comprising a large component of the US healthcare system, the US underspends on primary care compared to other developed countries.

Figure 3: Average wait time (in days) for appointment with primary care physician



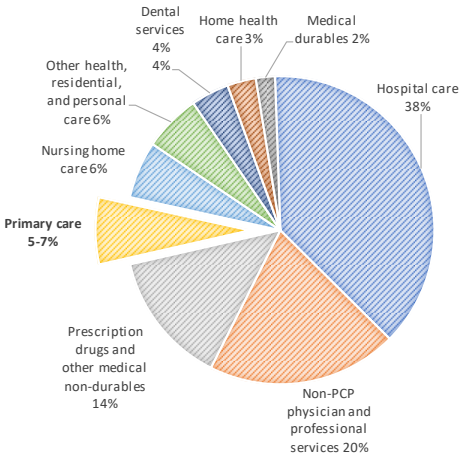
Source: Merritt Hawkins, Canaccord Genuity

Several reports estimate that somewhere in the range of 5-9% of total healthcare spend goes toward primary care. According to a July 2019 report by the Patient-Centered Primary Care Collaborative in collaboration with the Robert Graham Center, it is estimated that 5-7% of personal healthcare spending in the US goes toward primary care.[16] Another report by the Milbank Memorial Fund, showed that in 2014 primary care accounted for 8.6% of total medical and prescription drug spending among 10 large commercial insurers. Allocation to primary care is even less in Medicare. According to a study published in JAMA, it was estimated that less than 5% of total Medicare fee-for-service spending in 2015 went toward primary care services. Notably, when looking at particular sub-segments within Medicare, such as those over the age of 85 and those with medical complexities, an even smaller percentage of total spending was for primary care.[17]

When compared to other economically developed countries, the US ranks poorly with respect to the overall quality of healthcare system and specifically ranks poorly for access to and investment in primary care. According to a 2019 policy brief by the Organization for Economic Co-operation and Development (OECD), OECD countries spent on average 14% of total healthcare spending on primary care services.[18] This is roughly double the amount that is spent on primary care in the US. The underspending for primary care in the US relative to OECD countries has led to many experts calling for increased funding and spending on primary care in the US.

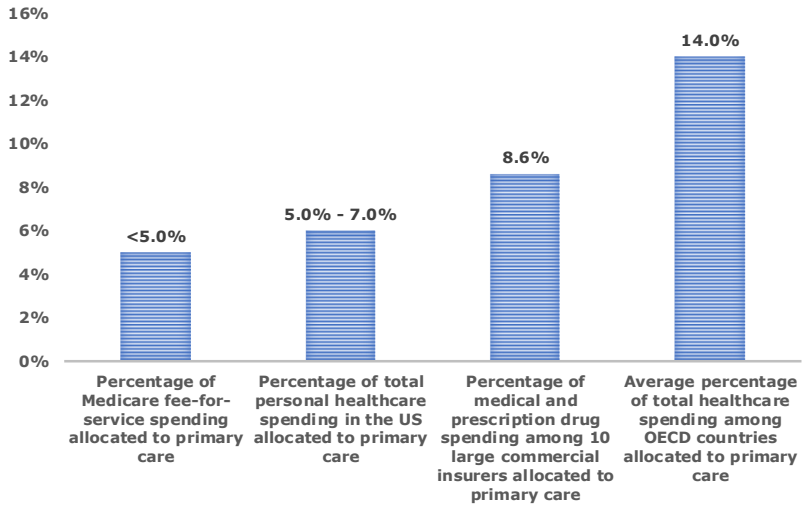
Underinvestment in primary care has resulted in a shortage of primary care physicians and inadequate access to care. According to an article in The Lancet, in 2015, roughly 76.4% of individuals in the US had access to a primary care provider compared to 76.8% in 1996. Furthermore, a report by Merritt Hawkins shows that in 2017 it took an average of 29.3 days for a new patient to schedule an appointment with a family medicine physician, up from 19.5 days in 2014.[19] The Association of American Medical Colleges (AAMC) estimates that access will get worse over time. By 2032 it is estimated that the US will have a shortage in the range of 21,100 to 55,200 primary care physicians.[20] Poor access to care can result in a worsening of an individual's health condition and could ultimately lead to more expensive care in the future.

Figure 4: Spending on primary care services in the US is estimated to be 5-7% of total national healthcare expenditures.



Source: Patient-Centered Primary Care Collaborative and the Robert Graham Center, Canaccord Genuity

Figure 5: OECD countries allocate on average 14% of total healthcare to primary care. The US lags the OECD with various studies showing that average allocation to primary care is 5-9% of total healthcare spending, with an even lesser amount allocated to primary care within the Medicare fee-for-services population.



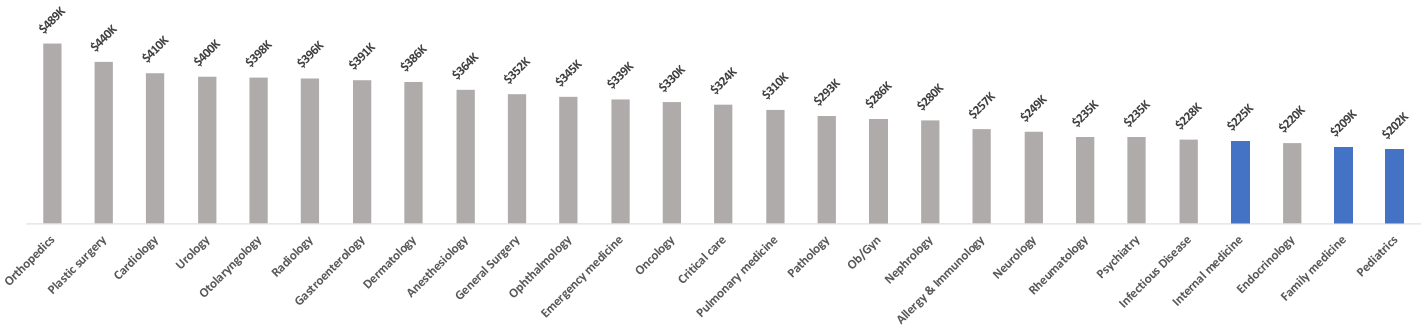
Source: July 2019 report by the Patient-Centered Primary Care Collaborative in collaboration with the Robert Graham Center; Milbank Memorial Fund; JAMA; 2019 policy brief by the Organization for Economic Co-operation and Development (OECD)

Primary care physicians earn less than other specialty physicians.

Average pay for primary care physicians is at the very low end of the range when compared to other physician specialties. According to a Medscape ranking of 27 specialties by average salary, pediatrics is the lowest paid at $202K per year, family medicine/general practice is the second lowest at $209K, and internal medicine is the fourth lowest at $225K. An orthopedist makes on average $498K which is more than 2x that of an internist or general practitioner.[21]

As we will explore later in this report, a pillar of the new primary care models is a focus on a physician's work-life balance and ability to spend more quality time with patients. Considering primary care salaries are below that of most other specialties, it should not be surprising that primary care physicians would be more inclined to improve their work-life balance.

Figure 6: Average salaries for primary care physicians are among the lowest compared to other specialties.

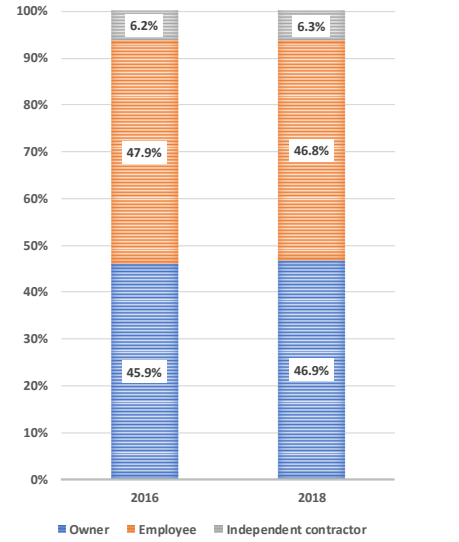


Source: Medscape Physician Compensation Report 2019

Less than 50% of primary care docs have ownership in their practice.

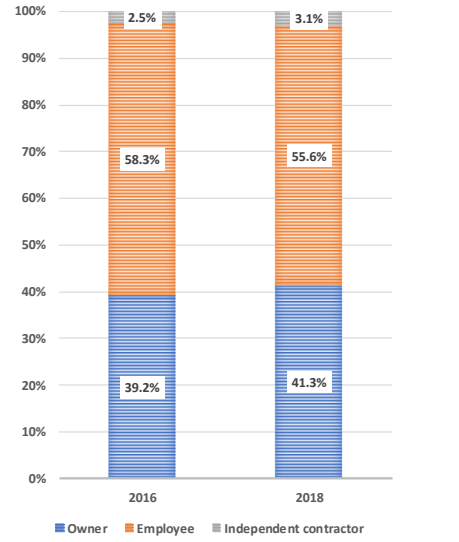
According to a survey by the American Medical Association, less than half of primary care physicians had an ownership stake in their practice. Data shows ownership status for various medical specialties, and specifically highlights ownership status for three primary care specialties: general internal medicine, pediatrics, and family practice. In 2018, it was estimated that 47% of general internists had an ownership stake in their practice, 41% of pediatricians had ownership, and 38% of family practice physicians had ownership. When comparing the same survey to 2016 data, both general internists and pediatricians on average showed a modest increase in the likelihood they had an ownership stake in their practice. Family practitioners, on the other hand, showed a meaningful decrease from 47.6% in 2016 to 37.5% in 2018, as who had an ownership stake in their practice.

Figure 7: General internal medicine – 46.9% of physicians were owners of their practice in 2018, UP from 45.9% in 2016



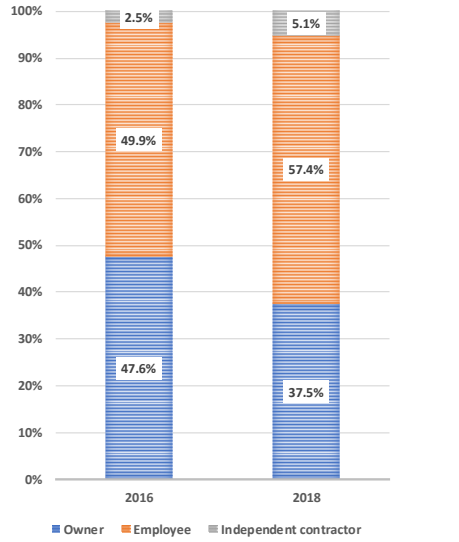
Source: American Medical Association 2018 survey, Canaccord Genuity

Figure 8: Pediatrics – 41.3% of physicians are owners of their practice in 2018, UP from 39.2% in 2016



Source: American Medical Association 2018 survey, Canaccord Genuity

Figure 9: Family practice – 37.5% of physicians are owners of their practice, DOWN from 47.6% in 2016



Source: American Medical Association 2018 survey, Canaccord Genuity

Physician burnout is common and has real consequences.

Physician burnout is essentially the feeling of frustration and losing satisfaction and a sense of efficacy in one's work as a physician. In recent years, there has been an increasing focus on physician burnout, what causes it, what impact it has, and how it can be addressed. Because physician burnout is so common and has real negative consequences, it has become a focal point for many of the new primary care companies. Some of the more frequently cited causes of burnout include the following: working with electronic health records (EHRs); managing regulatory and insurance requirements; a lack of control over the healthcare system; managing a chaotic environment; and time pressure to adequately provide quality care. Time spent with patients is an important aspect. A survey funded by the Agency for Healthcare Research and Quality (AHRQ) found that half of physicians reported time pressures when conducting physical examinations, a third of physicians needed at least 50% more time with patients, and a quarter of physicians needed at least 50% more time with patients for follow-up appointments.

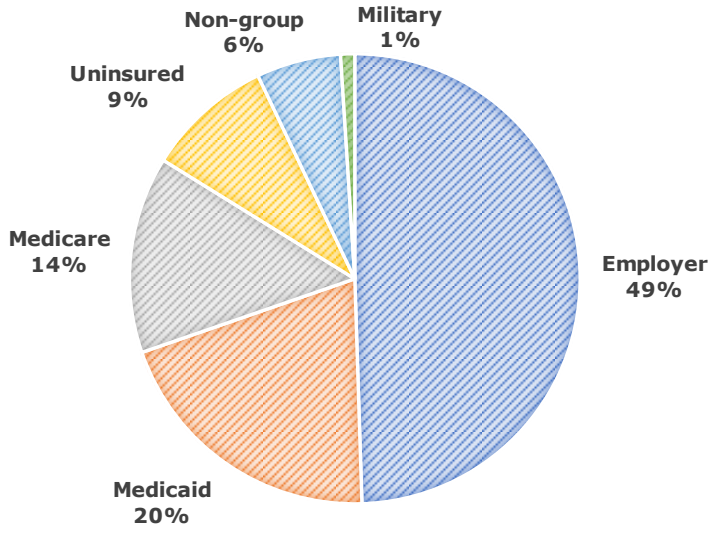
Over the years there has been a plethora of research and survey work that illustrates and quantifies the issue of physician burnout. A 2018 survey by Merritt

Hawkins found that 78% of surveyed physicians felt burnout at least sometimes.[22] Another study published by the Mayo Clinic in 2016 shows that every one point increase in physician burnout (on a seven point scale) will result in a 30-40% likelihood that physicians decrease their hours worked over the next 24 months.[23] According to a report by Harvard, physician burnout is estimated to cost the healthcare industry $4.6 billion per year through turnover and reduced clinical hours. From a qualitative perspective, it was also shown that burnout results in negative clinical and organizational outcomes, which for example could be in part due to negligence or errors. The Harvard report goes on to offer several solutions for addressing physician burnout, such as providing behavioral health support for physicians, improving EHR standards with a focus on usability, and ensuring physician wellness is a priority at the executive level of any organization.[24] The AHRQ study mentioned above also recommends some interventions to mitigate physician burnout, such as regular meetings with key stakeholders to discuss physician work-life balance, improving team work within a practice, and utilizing staff to manage administrative functions for physicians. As we will discuss later on in this report, mitigating physician burnout to improve the quality of life, productivity, and the quality of care physicians provide has become a major focus for primary care companies.

Insurance market creates a sizeable opportunity for employer-focused and elderly-focused primary care.

Many of the new primary care companies focus on specific segments of the market based on source of health insurance. According to the Kaiser Family Foundation, the largest insurance market is the employer market, insuring approximately 49% of the US population (~157 million Americans). The second largest market is Medicaid (65 million Americans or 20% of the population) and the third largest is Medicare (44 million Americans or 14% of the population).[25] Non-group insurance is the fourth largest market and accounts for ~6% of the population. The non-group segment would include any individuals who purchase insurance directly from payers, such as the individual (ACA) market (i.e., individual exchange).

Figure 10: Distribution of health insurance across the entire US population



Source: Kaiser Family Foundation, Canaccord Genuity

Regulatory and reimbursement changes pave way for new primary care models and alignment with payers.

In recent years, the federal and state governments have introduced new legislation and programs in efforts to increase the investment in primary care. This should come as no surprise given that there is a broad collection of research demonstrating the benefits of primary care coupled with the current state of underinvestment in primary care in the US. Below we will discuss some of the important federal programs, and highlight some innovative strategies at the state level to promote increased investment in primary care. The transition to value-based care looks certain to continue over the coming years and the initiatives like those highlighted below are likely to continue gaining traction.

At the federal level, many value-based Medicare programs have been introduced in recent years that promote value over volume, which inherently places an emphasis on primary care. One important program is Medicare Advantage, under which Medicare pays commercial insurers a capitated rate to provide care for that individual. Under this program the insurer has incentive to provide better care and minimize unnecessary care. Primary care has thus become an important component to Medicare Advantage. Today, roughly 1/3 of all Medicare beneficiaries (22 million people) are enrolled in Medicare Advantage plans. Another important federal initiative is the Accountable Care Organization (ACO). Developed in 2012, an ACO is a group of providers (e.g., physicians, hospitals, long-term care specialists, etc.) working together to provide better, more coordinated care for a patient population. ACOs typically manage a population of Medicare fee-for-service beneficiaries. Primary care is an important strategy and focus for ACOs, so much so that there are companies such as Aledade that specifically partner with primary care practices to help build successful ACOs. Also launched in 2012 was the Comprehensive Primary Care (CPC) initiative. The CPC enables primary care practices to operate under certain guidelines intended to improve the overall quality of care and lower costs, and in return the practices are paid management fees and have opportunities for shared savings.

At the state level, there are also initiatives to drive increased investment in primary care. The state of Rhode Island, for example, required that commercial insurers increase their spending on primary care by 1% per year from 2009 to 2014, and as a result primary care spending increased from $47M to $74M over that time period. Several years ago, the state of Oregon passed legislation requiring that certain commercial insurers must have a minimum spending on primary care of 12%.[26] Even at the commercial level, payers are entering into value- and risk-based contracts directly with providers.

Characteristics of new primary care models

The emergence of new primary care models comes at a time when the current model is broken and is ripe for disruption. These next-generation models seek to improve the quality of care for patients, eliminate physician burnout and improve the work-life for physicians, and lower the overall cost of care. There are a variety of models and strategies by which primary care companies can achieve these goals and correct for the shortfalls of the current system. For example, new primary care companies are using telemedicine and remote patient monitoring to solve the problem of inadequate access to care. Technologies can be used to improve the patient experience and facilitate practice management. And a strong emphasis on physician engagement and reducing the number of patients to be seen in a given day can go a long way to mitigate physician burnout. Over the next few pages we will explore in more detail some of the innovative models and strategies that are emerging in the new primary care environment.

Innovative membership and partnership models.

Traditional primary care is generally based on a basic fee-for-service model. Typically, patients would seek out a primary care doctor and go in for services as needed. In contrast, many new primary care companies offer innovative and alternative payment models to attract and retain patients. One of the more popular models is membership-based. Under a membership-based model, patients can be a member of a primary care practice for a set monthly, quarterly, or annual membership fee. This fee would cover a range of basic and preventative services that could include 24/7 virtual care, in-office routine care, labs, care coordination and more. The offering of services inclusive in the membership should drive greater patient utilization, which ultimately should result in improved health outcomes and member retention. Two prominent membership-based primary care companies include **One Medical** and **Forward**. One Medical offers a membership of $199/year and Forward offers a membership of $149/month ($1,788/year).

Membership with a primary care company could be paid for directly by the patient or through a sponsorship by an employer, health plan, or provider. Numerous studies have shown that access to primary care can improve outcomes and lower costs, thus it should not be surprising that many employers and health plans would want to incentivize their members to utilize primary care services. According to the 2019 Business Group on Health's survey of large US-based employers, 49% of companies plan on pursuing an advanced primary care strategy in 2020. Furthermore, 34% of companies plan on providing primary care through on-site or a near-site health center, while 24% of companies are looking to contract directly with primary care providers in their market.[27] As such, many primary care companies drive their membership through partnerships with organizations. The economic models are varied, but generally the employer or health plan might pay a membership fee to the primary care company through monthly or annual fees, similar to the direct model discussed above.

Two key physician models: employment and partnership.

When it comes to the physicians, primary care companies can either employ them or partner with them. Both the employment and partnership models offer their own compelling value proposition, thus depending on the unique interests and goals of the physician practice and the primary care company, one of the models may be better suited than the other.

Under the physician employment model, the primary care company would own the physician practice and thus employ the physicians. This type of company could be built either through the acquisition of an existing physician practice or by establishing a practice from scratch. The employment model would represent a company that is a true primary care provider. Under the practice partnership model, the primary care company would not own the practice or employ physicians, but instead would partner with a physician practice.

Under both models, the physicians would receive a wide range of assistance from the primary care company, such as technology, consulting, and financial resources. Depending on the structure of the model, the primary care company would hold a certain degree of control over the practice that could include setting standards and protocols in clinical care delivery. We expect this control to be greater under the physician employment model. Regardless of the structure, the collaboration between the primary care company and the physicians is critical given that the ultimate goal is to evolve the practice toward a better way of care.

Both models present characteristics that could be attractive to both physician and the primary care company. The employment model would be attractive to a primary care company that wants to have full control over the business, while a physician practice with capital constraints could benefit from selling to a larger, better capitalized organization. On the other hand, the partnership model might be attractive to companies that recognize there are benefits to not employing the physician and thus only want limited control. For example, consider the scenario where an older physician who is close to retirement exhibits productivity declines.

Under the partnership model, the primary care company would not be subsidizing that physician and would most likely be shielded from any negative impact (i.e., revenue reductions) caused by the productivity decline. The partnership model could also be an attractive option for a physician practice that has long-established roots in its community and wants to remain independent, yet partner with a larger primary care company to benefit from the greater availability of resources.

Focus on specific populations drives efficiencies of scale.

As opposed to the traditional "family practice" that might take patients from a variety of backgrounds, there are some new primary care companies that are focused on targeted populations. Focusing on specific populations would result in a pool of patients with similar care needs, and would enable a primary care provider to structure and organize their practice to best align with that given population. The provider could implement technology or protocol tailored to that population, which could drive efficiencies and ultimately lower costs and improve care.

Economically, there is an opportunity for meaningful cost savings when grouping together high-cost patients, thus it is intuitive that some new primary care companies are targeting the elderly and people with chronic conditions. From a macro perspective, these are two costly populations that have significant overlap. People with chronic conditions account for roughly 90% of healthcare spending in the US, and at least 80% of the elderly have at least one chronic condition. Access to comprehensive primary care is proven to improve care and lower costs, thus there is a great opportunity for providers to focus primary care on high cost populations.

There are numerous strategies a primary care provider can implement when focusing on a targeted population. For those focusing on the Medicare and chronically ill patients, primary care companies will typically couple primary care with intensive preventative care. We expect technology to play a major role for many of these companies. Data analytics tools can be used to stratify patients by risk to identify those at higher risk of complications and to make sure that adequate care is provided to all. This can ensure that many patients will receive better levels of care than they have in the past. For example, a diabetic patient would receive regularly scheduled eye appointments. Or an elderly individual at risk of kidney or bladder infection would get lab results to monitor those conditions. Furthermore, some primary care physicians could seek to influence downstream providers for their chronic care patients (i.e., other specialists such as an endocrinologist for a diabetic) which could eliminate gaps in care and improve the health of the patient. For example, a physician could collaborate with hospital clinicians to ensure that after a hospital discharge, the patient receives care at home with PCP supervision rather than an LTACH or SNF. While managing downstream providers would require a more involved approach, it could be facilitated by having a greater quantity of patients with similar care needs.

Creating a positive environment for physicians with strong engagement and buy-in.

A central focus of nearly all primary care companies is to create a positive and engaging environment for physicians. This has become a focus area for primary care companies because of the high levels of burnout and frustration that is common among physicians today. Through these efforts, primary care companies can attract physicians who are facing burnout and create a positive environment where those physicians are more likely to provide better care to their patients.

There are several strategies to create an engaged physician workforce, all of which require alignment between clinicians, patients, and the primary care company. One solution is to create a physician governance structure that empowers physicians and ensures the practice is aligned with physician needs. Another strategy is to ensure that physicians have a manageable patient case load and have sufficient time to spend with each patient. As discussed above, about a third of doctors surveyed by AHRQ stated they needed at least 50% more time with their patients. Additionally, many primary care organizations offer physicians the opportunity to be paid on a

salary, thus they are not dependent on generating volume and are empowered to spend more time with their patients. Not only do these strategies minimize burnout among physicians, but they allow the physicians to provide better care for their patients.

Modernizing and standardizing primary care with technology.

Nearly all physician practices have adopted electronic health records in the decade-plus following the HITECH Act of 2009, yet there remains considerable opportunity for additional technology adoption in the primary care setting. Technology could be utilized across all clinical, financial, and operational aspects of a provider's business to drive standardization, improve the quality of care, lower costs, and boost physician engagement and patient satisfaction. Furthermore, technology will be critical to a practice successfully evolving toward value-based payment models. Below we highlight some areas where next generation primary care will likely be making technology investments.

- Data warehousing, data analytics, risk stratification, reporting capabilities.
- Revenue cycle management, billing, accounting, value-based care payment models, payer contracting.
- Clinical: Electronic health records, telemedicine, work-flow processes.
- Operational: Patient in-take, e-prescribe, scheduling.

Improving the patient experience and providing enhanced services.

Enhancing the patient experience and improving the quality of care is a core focus of new primary care models. By doing so, primary care companies can improve the quality of health and life of their members, which should ultimately drive lower costs, while also retaining their patient base. There are a wide range of enhanced services that primary care companies can offer to patients, which include but are not limited to:

- regular check-ups, especially for those with chronic conditions;
- same-day and next-day appointments;
- 24/7 care options with telemedicine options;
- patient engagement tools such as a patient portal and on-line scheduling capabilities;
- transportation to and from appointments;
- remote patient monitoring;
- home visits as needed;
- ancillary services to maintain a healthy lifestyle such as nutritionist consultations, yoga, behavioral health screenings, and more.

Standardizing payer contracts and entering value-based care arrangements.

Payer contracting is a big task for any healthcare provider and a task made more difficult when considering the opportunity to enter value-based care arrangements. This challenge is even more pronounced for small providers with fewer resources. Larger primary care companies can bring expertise to payer contracting and enter into more favorable contracts for the provider. With respect to value, there are a variety of alternative payment models in which primary care providers can participate. The transition to value can take several years given the major changes that must be implemented within a physician practice, such as altering clinical workflows, changing physician behavior, and adapting coding and billing practices. For any providers looking to improve and renegotiate their contract and transition to value, larger primary care companies can be a huge asset.

Leading primary care companies

Over the next few pages we provide a brief company description for 14 of the leading primary care companies in the US. As we explored above, there are a variety of business models we have seen among the primary care companies, differentiated by their target patient population, physician employment model, or patient membership model. We group these 14 companies into four broad categories based on their business model, while recognizing that there are many characteristics that overlap between the categories. These four categories are companies focused on senior care, companies focused on employer or work-site care, membership-based companies, and companies that partner with primary care practices. Notably, there is some overlap between these categories. For example, One Medical operates a membership-based primary care program but also operates employer clinics.

Figure 11: We segment the primary care market into four broad business model categories.

Senior care	Employer / work-site	Membership-based	Partnership
ChenMed	Crossover Health	Forward	Aledade
iorahealth	Marathon Health	One Medical*	Privia Health
Oak Street Health	Paladina Health	MDVIP**	MDVIP**
Partners in Primary Care	Premise Health		VillageMD***
	One Medical*		

Source: Canaccord Genuity
*One Medical operates a membership-based model and on-site employer clinics.
**MDVIP partners with physician practices and supports their adoption of a membership-based model.
***VillageMD both employs and partners with physician practices.

Aledade

HQ: Bethesda, MD **Founded:** 2014

Known investors: Venrock, ARCH Venture Partners, Biomatics Capital, GV, Maryland Venture Fund, Echo Health Ventures, OMERS Growth Equity, CVF, Meritech Capital Partners, California Medical Association

Aledade partners with primary care practices to build accountable care organizations (ACOs). Aledade does not own or manage any practices; the company helps its PCP ACO partners shift to value-based care models while remaining independent and improving the care they provide. Customers include physician practices of all sizes, from solo practitioners to large multi-specialty groups and federally qualified health centers. Aledade provides its ACO partners with workflow optimization tools, data analytics, policy and ACO expertise, quality reporting tools, and payer contracting services and software. In 2018, Aledade's ACOs showed meaningful improvements: hospitalizations, ED visits, and the number of skilled nursing stays were reduced by averages of 6%, 6% and 17%, respectively. Today, Aledade operates ACOs across 27 different states that care for 840,000+ patients in 550+ primary care practices. The company manages more than $7.3 billion in healthcare spending. Most recently, Aledade raised $64M in a Series C round led by new investor OMERS Growth Equity. In conjunction with the Series C round, the CEO of Aledade announced that the company is growing revenue by over 60% and expects to reach profitability in 2020.

ChenMed

HQ: Miami, FL

ChenMed is a physician-led primary care company focused on providing services to moderate- to low-income seniors with complex chronic conditions. ChenMed brands include Chen Senior Medical Center, Dedicated Senior Medical Center, and JenCare Senior Medical Center. Today, the company operates more than 70 primary care practices in 10 states (FL, GA, IL, KY, LA, MO, OH, PA, TN and VA). Most centers are located in urban areas with a high density of moderate- to low-income seniors. While ChenMed is primarily primary care, the company also has a wide variety of specialists on staff and works with specialist partners in the community. Services include walk-in appointments, expanded hours, frequent and unrushed medical visits, on-site medication, labs, x-rays, acupuncture, and transportation to and from clinics for patients in need. ChenMed takes on full risk for its Medicare patients, and accordingly physician staff salaries include quality components such as shared savings and bonuses. The company has demonstrated quality results for its patient population including high adherence to drug treatment plans, lower hospitalization and readmission rates, improved LDL levels for patients, improved HgbA1c levels for diabetics, and high net promoter scores. In December 2019, ChenMed announced plans to expand into five new markets (Cleveland, Cincinnati, Memphis, Orlando and St. Louis) while continuing to expand within its existing markets. Within these five new markets, the company plans to open a total of 20 medical practices.

Crossover Health

HQ: Aliso Viejo, CA **Founded:** 2012

Known investors: Norwest Venture Partners, Gumet Point Capital

Crossover Health is a primary care provider focused on the self-insured employer market. Through the company's on-site or near-site health centers, Crossover provides a wide range of primary care services, in addition to behavioral health services, health coaching, acupuncture, physical therapy, and optometry services. A core focus of the company is delivering an enhanced member experience. This is accomplished by using a whole-body approach to health care and providing digital health technologies, a member portal, enabling providers to spend adequate time with patients, and offering virtual care. Some of the primary care services include preventative care, on-site labs, full-service referral coordination, women's health and family planning, chronic illness management, and more. In February 2019 the company acquired Sherpaa Health, a virtual primary care company that also had care navigation and care management services. Sherpaa's capabilities included curating specialist networks in geographies across the US, and developing structured care plans that could be prescribed to members to ensure quality outcomes. Currently, the company is piloting a new model with Comcast where patients will be assigned a "virtualist" in addition to their physical care team; the virtualist will be the member's first point of contact for quick issues like questions or prescription refills.

Some of the company's notable customers include Visa, LinkedIn, Microsoft, Comcast, Square, Symantec, and Broadcom. Crossover has physical locations in California, Texas, and New York City. Crossover is paid a fixed monthly amount for each of its members, which enables its providers to work outside of the misaligned incentives of the fee-for-service model. The company's proven results include 30% healthcare savings for engaged members, 50% lower utilization of urgent care, 2-4x fewer referrals to high-cost specialists among engaged members, and 20% savings in prescription spend.

Forward

HQ: San Francisco, CA **Founded:** 2016

Forward is a membership-based primary care company. For a $149 per month fee, members receive unlimited visits with primary care physicians, 24/7 access to virtual care, wellness monitoring (for sleep, exercise, stress, etc.), generic prescriptions, vaccinations, and a variety of testing (genetic, blood, body scans, etc.). The company has built various proprietary technologies including a custom EHR system, a body scanner, and real-time blood testing. Patients are encouraged to visit Forward several times a month, which is more common with traditional primary care physicians. Because Forward is focused only on preventative primary care, in the event that a patient needs to see a specialist, Forward will refer the patient out to other providers. Forward currently operates in the following markets: San Francisco, Los Angeles, New York City and Washington, DC.

Iora Health

HQ: Boston, MA **Founded:** 2010

Known investors: F Prime, Polaris Partners, .406 Ventures, Flare Capital Partners, GE Ventures, Khosla Ventures, Rice University, Temasek, Humana, Devonshire Investors, Premji Invest, Cox Enterprises

Iora Health operates primary care practices throughout the country with a focus on the senior (Medicare) population. The company's approach to primary care is centered on three key strategies: 1) team-based care; 2) payment system based on improved health and outcomes, not volume; and 3) technology built around people and health, not generating higher billing codes. Under the team-based care approach, each patient works with a team consisting of a provider, a nurse, a health coach, and others. Through the team-based approach, Iora places an emphasis on making sure that patients see the right specialists to ensure quality and comprehensive care is provided. Patients benefit from 24/7 access to care, same-day and next-day appointments in person as well as by phone and video, onsite labs, fully integrated behavioral health services, yoga classes, health coaching, and transportation to and from appointments as needed. Furthermore, Iora has built a proprietary collaborative care platform/electronic health records system, called Chirp, which is designed to enable patients to schedule appointments, access medical records, and communicate directly with their care team.

Today, the company operates 48 practices in TX, NC, CT, NH, NY, GA, MA, CO, WA and AZ. In February 2020, the company raised $126M in a Series F founding round. Proceeds from the latest capital raise will be used to bolster the company's proprietary care platform (Chirp), to become a certified Medicare electronic health records company, and to "optimize its care network."

Marathon Health

HQ: Winooski, VT **Founded:** 2005

Known investors: Eideard Venture Capital, Goldman Sachs, General Atlantic

Marathon Health operates onsite workplace health centers for its employer customers. Through its clinics, Marathon provides a range of services including primary care, preventative care, chronic condition coaching, and occupational healthcare. Other ancillary services include wellness coaching, prescription management, referral coordination and case management. Marathon's health

centers provide roughly 90% of the services that typical primary care physicians would provide. Marathon has a proprietary technology platform called Health Engagement System that includes a range of clinician facing and member tools to improve clinical workflows and drive high member satisfaction and engagement. Some of these tools include clinical decision support, a member portal, secure messaging, ePrescribing, workflow support tools, coaching protocols, online scheduling, interactive fitness and nutrition tools, and more. Furthermore, employer customers can tailor Marathon's clinics and services to meet its unique needs.

MDVIP

HQ: Boca Raton, FL **Founded:** 2000

Known investors: Procter & Gamble, Summit Partners, Leonard Green & Partners

MDVIP offers membership-based primary care through a national network of 1,000+ primary care physicians. MDVIP partners with existing physician practices that want to transition their practice to a membership-based model and benefit from the technology, operational, and financial support of a larger company with expertise in primary care. MDVIP does not own or employ its physicians; they are partners (i.e., affiliates) and thus remain independent. The company is focused on improving the work life of its physician partners by ensuring that physicians have smaller caseloads and thus can spend more time with their patients. Patient members pay an annual membership fee that gives them access to the MDVIP Wellness Program, while all other services would be billed to insurance as normal. The Wellness Program offers a range of preventative care services such as health screenings and diagnostic tests, nutrition and fitness plans, 24/7 access to physician care, and an on-line/mobile member portal. In addition to taking individual members, the company also partners with health systems and employers to enroll eligible patients into an MDVIP-affiliated practice. The company currently serves ~325,000 patients across 45 states and D.C.

Oak Street Health

HQ: Chicago, IL **Founded:** 2012

Known investors: General Atlantic, Harbour Point Capital, Newlight Partners

Oak Street Health is a primary care provider focused on the senior (Medicare) population. Oak Street targets areas where there is a lack of quality primary care options, which tends to correlate with low- to moderate-income geographies. The company's first location opened in Chicago in 2013, and today Oak Street has 54 locations across eight different states (IL, MI, OH, RI, TN, IN, NC, PA). Oak Street Health offers a variety of enhanced benefits to its patients that include spending more time with providers, same-day and next-day appointments, a 24/7 patient support line, rides to and from appointments, social events and activities, assistance with navigating Medicare benefits, behavioral health specialists and at-home services. Patients typically have a care team that consists of a primary care doctor, a nurse and a patient relations manager (who typically helps patients manage insurance and benefits).

The company takes Medicare fee-for-service patients but is predominantly focused on value-based care arrangements for Medicare and dually eligible individuals. Oak Street works with all the major Medicare Advantage payers. The company receives a portion of the MA premium and manages all downstream care and costs for its patients. This structure aligns the interests of Oak Street and its patients to ensure

patients receive the right amount of care at the right time, avoiding the volume-driven incentives within the existing fee-for-service model. Oak Street leverages its internally developed analytics platform, Canopy, to drive its clinical outcomes. Since its founding in 2012, the company has achieved a 41% reduction in hospital inpatient visits vs. Medicare benchmarks.

1Life Healthcare (One Medical)

(ONEM : NASDAQ : $32.46 | BUY)

HQ: San Francisco, CA **Founded:** 2002

Known investors (prior to IPO): Benchmark Capital, Pinnacle Ventures, DAG Ventures, Oak HC/FT, Maverick Capital, Google Ventures, Redmile Group, JP Morgan Asset Management, Carlyle Group

1Life Healthcare operates under the brand "One Medical" a membership-based primary care services provider. For a $199 per year fee, members receive 24/7 access to digital health services, same- or next-day in-office routine care, and lab/immunization services. In-office services are comprehensive and cover preventive men's and women's health, LGBTQ+ care, pediatrics, sports medicine, and well-being programs. The company offers a mobile app that can be used for virtual care, scheduling appointments, and monitoring health data. For patients who may need additional services, One Medical has a network of provider partners to coordinate specialist care. One Medical also partners with employers that pay a discounted membership fee on behalf of their employees, while 71% of employer partners also cover the membership fees for employees' dependents. One Medical clinicians are paid a salary to avoid any misaligned incentives that are often the result of fee-for-service reimbursement.

The company currently serves ~455K members in 10 markets in the US. The company most recently entered Portland, OR in March 2020. One Medical has previously announced planned openings in Atlanta, GA and Orange County, CA in 2020 and Austin, TX in 2021. One Medical typically serves working-aged, commercially insured individuals. The company has a strong NPS of 90+ and 47% of members digitally interacted with One Medical during the first three quarters of 2019.

One Medical went public through an IPO under the corporate name 1Life Healthcare and began trading on January 31, 2020. The company issued 17.5M shares at $14 per share to raise a total of $245M. On May 27, 2020, the company issued $275M in 3.0% convertible senior notes due 2025, which was upsized from the initially announced amount of $250M.

Paladina Health

HQ: Denver, CO **Founded:** 2011

Known investors: NEA, Oak HC/FT, Alta Partners, Greenspring Associates

Paladina Health employs primary care physicians and offers primary care services through partnerships with health systems, employers, government entities, and school systems. Paladina operates a "direct primary care" model, meaning that it does not accept insurance, and receives a fee from its partner customers. Paladina Health does not pay its physicians on a fee-for-service basis, rather, physicians are compensated based on three metrics: (1) patient experience; (2) cost savings; and (3) health outcomes. Under this model, each provider sees 70% fewer patients than a traditional primary care provider, thus allowing greater facetime with patients. On average, Paladina physicians spend 35-40 minutes with a patient, which is meaningfully more time than the average 7-10 minutes for traditional fee-for-

service primary care. Paladina also utilizes referral management, telemedicine, and 24/7 access to care, all of which help control costs through a reduction in utilization of high-cost care (i.e., ER and urgent care). Furthermore, Paladina employs data analytics and population health management to stratify patients into three tiers (low risk, rising risk, high risk) that help better manage patients.

One area of focus for Paladina has been government entities and school systems such as the State of Colorado and Akron Public Schools. This customer segment should be a good fit for direct primary care given there is likely less turnover within the employee base. The company has also been effective in partnering with health systems. In August 2019, Paladina stood up a joint venture with St. Louis-based SSM Health to target employers in SSM markets, beginning in St. Louis. SSM has roughly 40K employees and delivers care in Illinois, Missouri, Oklahoma, and Wisconsin. In addition to actively seeking employer customers, the joint venture's primary care services will be available for SSM's own employees and dependents.

In June 2018, Paladina Health was acquired for ~$100M by New Enterprise Associates (NEA) from its then owner DaVita. A follow-up round of financing totaling $165M was completed in August 2019 by NEA, Oak HC/FT, Alta Partners, Greenspring Associates, and other strategic investors. In January 2019, Paladina acquired Activate Healthcare. The combined entity provides primary care services to ~170K patients throughout 18 states.

Partners in Primary Care.

Partners in Primary Care

HQ: Louisville, KY **Founded:** 2014

Partners in Primary Care is a subsidiary of Humana and is a senior-focused primary care company. The company is focused on providing personalized care and an excellent patient experience. Given the nature of the elderly population, Partners in Primary Care is particularly focused on treating and managing chronic and acute conditions. The company provides a member portal and offers same day appointments for urgent care. The company has 47 locations in SC, NC, TX, KS/MO, NV, and SC and treats roughly 40,000 seniors. In February 2020, Humana and private equity firm Welsh, Carson, Anderson & Stowe announced a $600 million joint venture to develop primary care centers that will treat Medicare Advantage patients. This joint venture will be operated by Partners in Primary Care and is expected to more than double the company's footprint over the next three years. The company announced on June 2 details to its expansion plan that called for 20 new centers across two new markets (Las Vegas and Shreveport-Bossier City, LA) and an existing market in Houston.

Premise Health.

Premise Health

HQ: Brentwood, TN **Founded:** 2010

Known investors: OMERS

Premise health is a direct healthcare provider, meaning it provides on-site, near-site, and virtual care for employers. The company operates over 600 wellness centers, all of which are in close proximity to employer customers. Premise provides a wide range of preventative, therapeutic, and lifestyle health and wellness services, going well beyond typical primary care. Some of these services include physical and occupational therapy, dental, vision, radiology and lab services, behavioral health, women's health, travel and vaccine health, wellness coaching, fitness and nutrition. Given the wide range of services that Premise offers, the company customizes each of its wellness centers to best fit its customer's need. The company also has a strong focus on utilizing technology to streamline its clinical workflows and enhance

the patient experience. Through the member portal, patients can make same-day appointments, access virtual care, message providers, pay bills, sync their smart devices, and more. The wide-ranging services, use of technology, and focus on the patient experience has enabled Premise to achieve impressive accolades with a net promoter score of 91 and a HEDIS ranking in the top 5% of nationwide healthcare providers. Additionally, Premise has demonstrated results that include a 37% reduction in inpatient admissions, $15M reduction in workers compensation costs, and a 27% gross savings in the total cost of care.

Privia Health

HQ: Arlington, VA **Founded:** 2007

Known investors: Health Enterprise Partners, Pamplona, Brighton Health Partners, West Street Capital Partners, Morgan Noble Healthcare Partners

Privia Health is a national physician organization that partners with primary care and select specialist physician practices, health systems, payers and employers. Privia operates Privia Medical Group (physician-led multi-specialty medical practice) and the Privia Quality Network (physician-led ACO) in each of its markets. Through a management services organization (MSO), Privia provides all services needed to support its physician practice partners. Importantly, Privia does not employ physicians; all practices remain independent.

Physician partners can maintain their independence while benefiting from Privia's resources, which include: a full array of cloud-based technologies such as data analytics, telehealth capabilities, a patient portal, practice management, and revenue cycle management tools. By providing these tools to optimize their business, Privia enables clinicians to maximize performance and spend more time focusing on patient care. Furthermore, providers can leverage Privia's value-based care offerings and payer contracting capabilities to participate in value-based programs and reimbursement models while also continuing to participate in fee-for-service. Privia helps its partners to grow their practice over time, which in turn drives growth for Privia.

Privia's footprint includes 2,500+ healthcare providers who care for 2.6M+ patients across five markets: Mid-Atlantic (Maryland, Virginia, and DC), Georgia, Florida, north Texas (Dallas and Ft. Worth), and south Texas (Houston, San Antonio and Austin). The company benefits from a recurring revenue model with a gross revenue run-rate that has recently surpassed $1.2B. Privia is profitable and employs a capital efficient model that has enabled it to build significant scale as it expands operations into new regions through a flexible yet profitable new market expansion strategy. Most recently, the company announced an expansion into middle Tennessee through the strategic partnership with Premier Medical Group, a large multi-specialty physician practice with 35 physicians and 15 full-time non-physician providers, in addition to its partnerships with two health systems (Health First in FL and Children's Health in Dallas, TX).

VillageMD

HQ: Chicago, IL **Founded:** 2013

Known investors: Oak HC/FT, Athyrium Capital Management, Kinnevik, Town Hall Ventures, Adams Street Partners

VillageMD provides primary care services through its employed/owned primary care physician practices and through partner primary care physician practices. In total,

the company has 2,900 employed or partner primary care providers through independent practices, hospital-owned practices, and hospital-affiliated practices. VillageMD typically acquires or partners with existing physician practices that have a full panel of patients and want to be successful under both fee-for-service and value-based care. The company has patient populations across Medicare Advantage, Medicare fee-for-service, Medicaid and commercial insurers.

VillageMD offers its primary care physicians a wide range of technologies and services that enable the practices to improve care, lower costs, and operate effectively in a value-based care environment. Specifically, VillageMD's offering includes care management services and strategies, data analytics, home-based primary care services, value-based contracting and management, a proprietary operating system (docOS), and other services to help physicians grow their practice. The docOS operating system drives care flow in a more structured way by utilizing data combined with clinical rules to provide clinicians with information at the point-of-care, and thus enable data-based decisions and improved clinical outcomes. docOS integrates with 50+ EHR and 80+ payer claims systems. Furthermore, the company provides an infrastructure and resources to its physicians, enabling them to be proactive in managing patient care across the healthcare continuum by influencing and coordinating with their patient's other non-primary care providers to ensure optimal health outcomes.

VillageMD currently operates in nine markets including Chicago, Houston, Indianapolis, northern Indiana, Michigan, New Hampshire, Kentucky, and Georgia. The company's most recent market, Phoenix, was announced in early January, adding approximately 60 employed providers. VillageMD's management team has stated that it continues to diligently research new markets and target physician practices that it believes can be successful with the VillageMD business model.

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Date and time of first dissemination: June 19, 2020, 05:07 ET

Date and time of production: June 19, 2020, 05:07 ET

Distribution of Ratings:

Global Stock Ratings (as of 06/19/20)

Rating	Coverage Universe		IB Clients
	#	%	%
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Hold	182	22.86%	39.56%
Sell	18	2.26%	38.89%
Speculative Buy	116	14.57%	68.97%
	796*	100.0%	

*Total includes stocks that are Under Review

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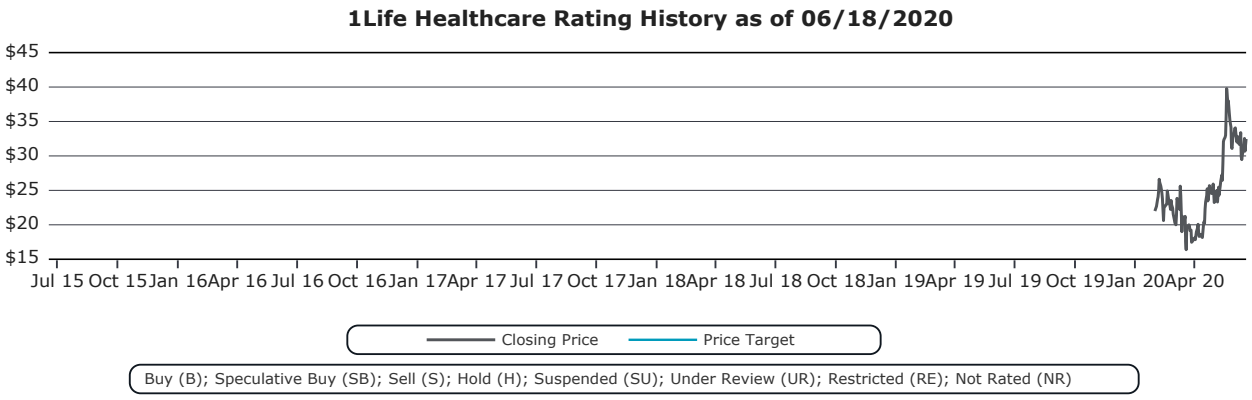

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