WHITEPAPER:
PRIMARY HEALTHCARE OVERVIEW & OPPORTUNITIES

PHOENIX MERCHANT PARTNERS

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Abstract

The objective of this report is to present an overview of opportunities in **Primary Care**, a fundamental part of the healthcare sector that has traditionally not been prioritized, but is experiencing renewed attention, innovation and growth. This paper covers:

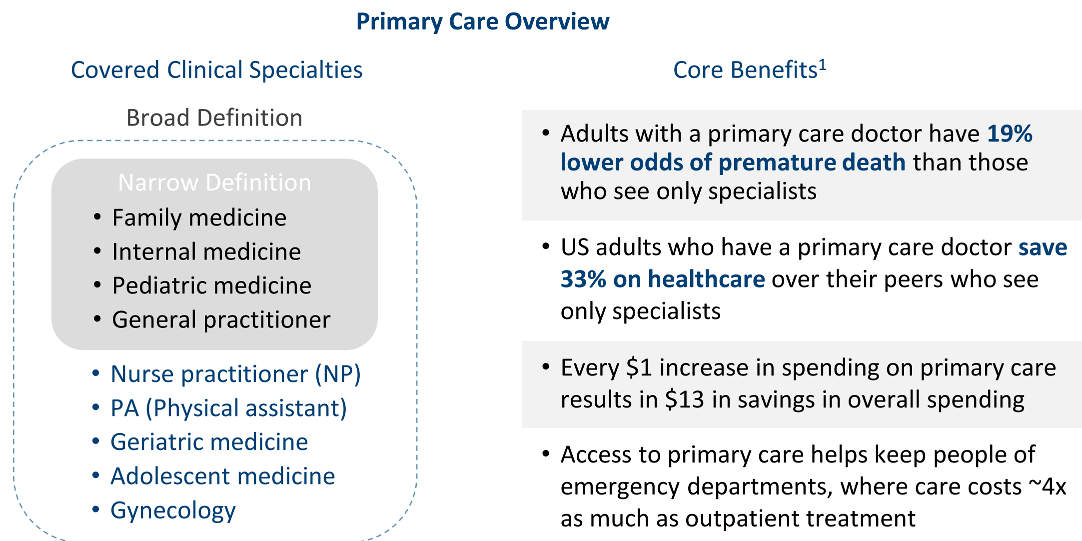
- An overview of primary healthcare services, their vital role in patient outcomes and the current state of the sector in the U.S.
- A brief summary of the primary care market and a proposed framework for assessing investment opportunities in the industry
- A description of the value-based care model that underpins the emphasis on primary care as a facilitator of holistic patient outcomes.
- A review of selected business models across the primary care ecosystem

Our analysis supports the view that the fragmented primary care market offers numerous opportunities for middle market businesses involved in the transformation of the sector. Specifically, we find the expansion of urgent care, and the "business services" model of VBC enablers to be of interest

What is Primary Healthcare?

Primary care covers a wide range of services focused on prevention, diagnosis, and treatment of non-emergency medical conditions. Primary care providers serve as first point of contact, referring patients to specialists within the healthcare system if needed. Primary care services include health screenings and regular examinations, management of chronic conditions as well as urgent care for minor injuries and non-life-threatening conditions. The services are delivered in private practices, clinics, community health centers and vertically integrated health systems.

Figure 1 – For Illustrative Purposes Only



Source: Primary Care Collaborative, 2020

Primary care is acknowledged as the basis of any high-performing health care delivery system. Due to early detection and treatment, coordinated care for chronic and complex conditions, and fewer

[1] National Alliance of Healthcare Purchaser Coalitions: "Advancing Primary Care - A Purchaser Playbook for Action", 2021

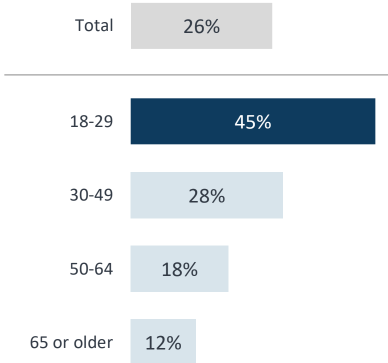
unnecessary and costly visits to specialists and emergency departments, healthcare systems with a strong primary care foundation report: better outcomes, higher patient satisfaction and lower costs[1]

Primary Care in the U.S.

Despite its importance, the U.S. healthcare system places less emphasis on access and quality of primary care compared to other developed countries. Primary care has historically been under-resourced due to an increasingly specialist oriented fee-for-service (FFS) compensation model, which is less conducive to the preventive and patient-centric approach associated with primary care. As a result, a significant proportion of the population does not benefit from consistent primary care.

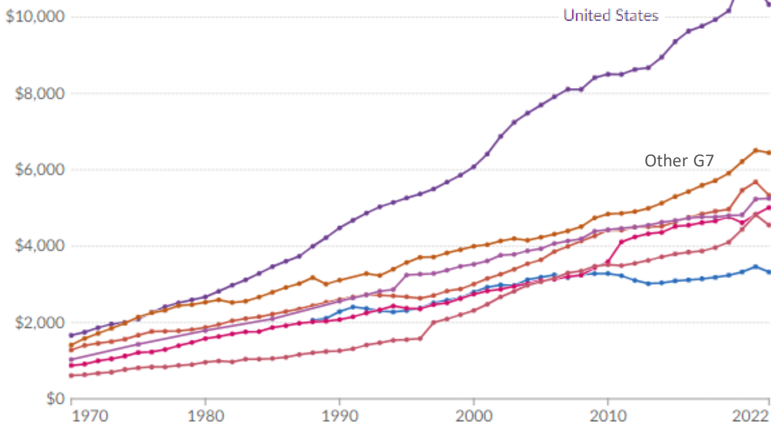
Figure 2 – For Illustrative Purposes Only

Proportion of U.S. population without Primary Care Doctor relationship



Source: : KFF Health Tracking Poll 2018

Health Expenditure per Capita



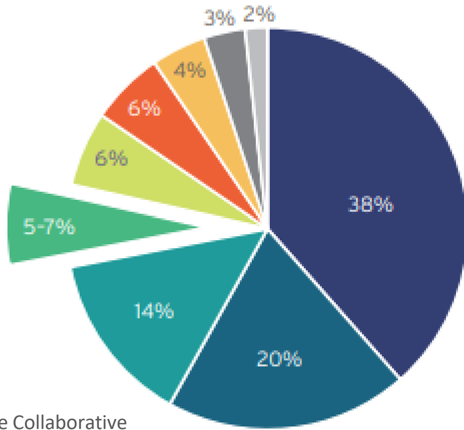
Source: OECD Health Expenditure and Financing Database

At $10,300 per capita, the U.S. has the highest health expenditure globally; however, it allocates only 5-6% to primary care, compared to an average 14% for all OECD countries[2].

Figure 3 – For Illustrative Purposes Only

2020 U.S. Healthcare Spending Breakdown

- Hospital care
- All other physician and professional services
- Prescription drugs and other medical nondurables
- Primary care
- Nursing home care
- Other health, residential, and personal care
- Dental services
- Home health care
- Medical durables



Source: Primary Care Collaborative

[2] OECD: "Health at a glance 2023: OECD Indicators", 2023

Coordinating, funding and improving primary care has become an important objective for the U.S. healthcare system, presenting an opportunity to reduce costs, enhance quality, and increase patient satisfaction

The Primary Care Market

At a 2023 market size of ~$240 billion, and projected to grow to ~$330 billion by 2032 (CAGR: 3.8%)[3], the primary care market is complex and fragemented. Key characteristics can be summarised as follows:

- **Strengths:** Covering about 50% of physician visits[4], primary providers influence downstream treatment and cost decisions for the healthcare system. An aging population and the resulting prevalence of chronic diseases drive increased demand for continuous non-urgent care. Simultaneously, greater public awareness of the importance of preventive care and early intervention supports the growth of primary care services.
- **Weakness:** Lower reimbursement rates under the traditional FFS model discourage the provision of primary care compared to specialist services. A fragmented market with coordination challenges between providers results in gaps in patient management. Fewer medical students choosing primary care as a specialty and uneven geographic distribution of resources limit access to primary services for a significant part of the population.
- **Opportunities:** Nontraditional organization, reimbursement and ownership models are gaining momentum and could capture as much as 1/3 of the U.S. primary care market by 2030[5]. Population specific offerings (e.g. diabetes management only) and enhanced technology adoption (e.g. telehealth integration, electronic health records, and remote monitoring) promise efficiency improvements. Consolidation of primary care practices is still in its early stages, compared to other clinical specialties[6].
- **Threats:** High levels of competition and fragmentation risk arise from various business models in their early stages of development. Given the complexity and granularity of the system, establishing scalable "one size fits all" solutions across payors and regions is challenging. Primary care providers are exposed to an evolving healthcare regulation and reimbursement environment.

Advanced Primary Care Models

Advanced primary care, sometimes called "Primary Care V2.0", refers to a highly accessible, consumer centric primary care practice with a modern technology stack. It represents an upgrade to the traditional FFS model that rewards quantity provision instead of focusing on prevention and patient outcomes.

Figure 4 – For Illustrative Purposes Only

Traditional Fee-for-Service Model	Advanced Primary Care
• Avg. 3 week wait for physician appointment	• Same/next day availability with virtual care
• Short, impersonal 5-10 minute visits	• >30 minutes interaction with physician
• Specialist referrals through health plan	• Direct referrals with partner system specialists

Source: One Medical

[3] Precedence Research: "Primary Care Physicians Market Size, Share, and Trends", Oct-2023
[4] National Center for Health Statistics: "National Ambulatory Medical Care Survey", 2019
[5] Bain & Company: "Primary Care 2030: Innovative Models Transform the Landscape", 2022
[6] KPMG: "2024 Healthcare and Life Sciences Investment Outlook", 2024

Primary Care Investment Framework

Phoenix evaluates investment opportunities across the primary care sector by assessing the following criteria for each business model and provider

Figure 5 – For Illustrative Purposes Only

Pillars of Primary Care Investment Thesis

Stakeholder Value	Improve patient and provider experience while adding value for payors, employers, and health systems
Market Segment	Growth potential in the sector; capacity to generate recurring and diversified revenue; effectiveness in customer acquisition and retention
Reimbursement Model	Alignment of business model with fee-for-value reimbursement trends that form the basis of value-based care systems
Partnership Opportunities	Potential for scaling the business via joint ventures and partnerships with employers, health systems, retailers and pharmacies

Given the complexity of the U.S. healthcare system, multiple appraoches exist within advanced primary care. The following section describes curent business models and evaluates them against our framework.

Value-Based Care (VBC) Systems

The shift from fee-for-service to fee-for-value reimbursement models has been one of the most significant sources of innovation in primary care.

Value-based medicine emphasizes patient-centered care, where providers are rewarded for quality of care rather than quantity of services provided.

The model aims to enhance patient outcomes, improve coordination, and reduce unnecessary medical interventions. Arrangements between providers, facilities and payors include:

- **Outcome-Based Contracts**: Agreements tie reimbursement to the achievement of specific health outcomes, incentivizing providers to deliver quality care efficiently
- **Shared Risk and Rewards**: Contracts include provisions for providers and payers to share the financial risks associated with patient care, as well as the savings from improved outcomes and cost reductions
- **Performance Metrics**: Contracts include performance metrics that align with care goals. Providers must meet specific patient outcome, cost saving, and care quality benchmarks for full reimbursement

This reimbursement structure diverges significantly from the traditional fee-for-service model, prompting organizational, administrative and data analytics advancements in the sector.

Primary Care Business Models

With the ongoing transition to value-based care, providers are implementing diverse models to address the needs of specific populations, payors and non-traditional participants, all while optimizing their services through technological innovation.

	Direct Primary Care (DPC)
Stakeholder Value	The DPC business model is centered around a direct financial relationship between patients and primary care practices. In this model, patients (and/or employers) pay a regular membership fee that covers a range of care services, including – Unlimited visits to primary care provider with extended and flexible scheduling – Comprehensive care, covering chronic disease management, minor procedures and direct specialist referrals. – Preventive care, covering routine check-ups, nutrition advice, physiotherapy and wellness programs To support the high level of access, DPC clinics employ a higher fraction of non-physician clinicians, including Nurse Practitioners and Physician Assistants
Market Segment	The U.S. direct primary care market is estimated[7] at $45 billion in 2023, and is projected to exceed $60 billion by 2030, growing at a CAGR of ~4.3%. DPC providers follow a value-based care approach, which allows them to generate net cost savings of ~$400 p.a. per participant[8] from avoided office visit fees, at-cost generic prescriptions, imaging, virtual care, and labs (excluding potential savings from reduced ED visits). This makes DCP an interesting proposition for employer-sponsored plans and as bolt on to high deductible plans. The growth of DPC providers is characterized by a long runway to profitability, given significant upfront investment and high customer acquisition costs. Drivers of revenue growth include coverage of dependents, expansion into professional shortage areas and partnerships with regional health systems.
Reimbursement Model	Revenue does not rely on insurance reimbursements, but rather on recurring fees from a diverse range of payers, including employer sponsored plans, consumer memberships, and fees from health system partners. DCPs are not reliant on government contracts.
Partnership Opportunities	While there is a significant whitespace opportunity for direct primary care across metropolitan areas, supported by regional professional shortages and demographic trends, collaborations enable participant growth. – Partnerships with health systems provide an expanded footprint, physician oversight, access to specialists and increased patient traffic – Partnerships with large, self-insured employers, e.g. in establishing on-campus/near-site primary care centers, help expand the patient population

[7] Allied Market Research: "Direct Primary Care Market Size, Share, Competitive Landscape and Trend Analysis Report" Mar-2024

[8] Olavi Group: "Direct Primary Care and its Impact on Healthcare Costs and Patient Experience" Feb-2020

	– Partnerships with retail giants, such as Amazon, offering convenient access to basic primary care, help expand reach and improve patient access

	Urgent Care+
Stakeholder Value	Urgent care centers are outpatient facilities that provide a wide range of services to patients requiring immediate medical attention, outside of the traditional emergency room and primary care physician models. These centers are typically staffed by advanced practice providers or physicians specializing in family medicine, internal medicine, or emergency medicine. While there is notable overlap in the conditions treated at urgent care centers and primary care practices, the differentiating factors include: – Longer business hours and availability on weekends and holidays – Walk-in service without the need for an appointment – Short-term, episodic treatment rather than continuity of care Increasingly, individuals are using urgent care centers as an alternative to their primary care providers. These centers are expanding their services to include e.g. the management of chronic conditions, physical exams, and vaccinations (Urgent Care+).
Market Segment	The market size, measured by revenue, of the urgent care centers industry was $46 billion in 2023[9], and is projected to grow at ~4.5% CAGR over the next five years. The market is highly fragmented. There are ~10,500 centers in the U.S. providing urgent care services[10], with the largest four players expected to account for just over 1.0% of industry revenue. Consumers prefer to access local facilities, allowing smaller companies to operate. Urgent care providers typically follow a de novo practice growth strategy. Expansion into an Urgent Care+ range of services drives recurring patient visits and incremental revenue, while reducing avoidable use of emergency rooms.
Reimbursement Model	Revenue primarily from commercial health insurance reimbursements. While government payers like Medicare/ Medicaid also cover urgent care, providers can negotiate favorable reimbursement terms with commercial insurers. In addition, certain operators target specific cash-paying demographics, such as millennials in urban markets.
Partnership Opportunities	Some operators partner with health systems. This model allows patients to receive appropriate care, without needing to choose between the emergency department or urgent care center. Self-insured employers typically include urgent care centers in their provider networks and negotiate discounted rates.

[9] IBIS World: “Urgent Care Centers in the US - Market Size” May-2024

[10] Definitive Healthcare: “How many urgent care centers are in each U.S. state?” Feb-2024

	Senior Care
Stakeholder Value	Medicare Advantage (MA) operates a value-based care model to deliver primary care to senior populations. MA insurance plans offer comprehensive benefit packages, including transportation, dental care, OTC allowances, as well as team-based care with frequent patient contact. They also provide care management programs that help patients understand their treatment and coordinate across multiple services. The healthcare network includes providers of senior primary care, specialized in rehabilitation, chronic conditions and skilled nursing services.
Market Segment	In 2023, 30.7 million people were enrolled in a Medicare Advantage plan, accounting for ~50% of the eligible Medicare population, and $454 billion of federal Medicare spending (net of premiums). Enrollment is highly concentrated among a few firms. Together, UnitedHealthcare and Humana account for ~50% of all MA enrollees nationwide[11]. MA insurers report much higher margins per enrollee than other health insurance markets. In 2021, MA insurers achieved a gross margin of $1,730 per enrollee[12], at least double the margins reported by insurers in the individual market ($745). Under the capitated reimbursement model, both the MA insurers and value-based primary care providers benefit from high revenue visibility and can enhance margins through efficient expenditure management.
Reimbursement Model	Under the Medicare Advantage model, the federal government transfers the risk of healthcare cost variability to private insurance companies via capitated payments. The MA insurers are responsible for developing coverage plans and contracting with healthcare providers. Center for Medicare & Medicaid Services — Federal agency within the U.S. Department of Health ↓ Risk adjusted capitated payment per member per month, based on actuarial analysis MA Insurance Plan — • Insurer **at-risk** for budget overruns, and benefits from cost efficiency. • Spend at least 85% of premiums on medical care and quality improvement ↓ ~50% **fee for service** reimbursement ↓ ~50% **risk/benefit sharing** value based reimbursement Healthcare Providers The MA business model is heavily regulated and dependent on government policies, therefore exposed to "stroke of pen" risk.

[11]KFF: "Medicare Advantage Insurers Report Much Higher Gross Margins Per Enrollee Than Insurers in Other Markets" Feb-2023

[12] KFF: "Medicare Advantage in 2023: Enrollment Update and Key Trends" Aug-2023

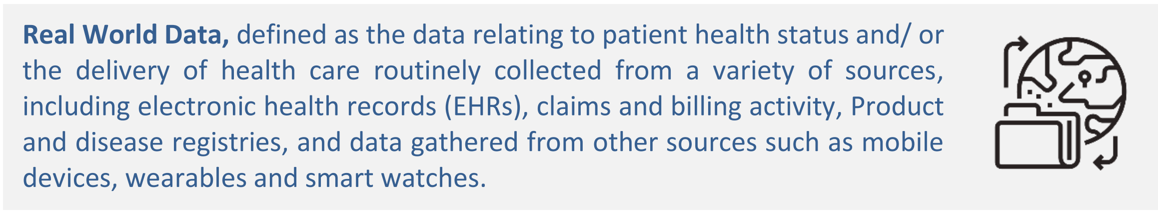
Partnership Opportunities	Specialist MA healthcare providers have partnered with big-box retailers (e.g. Walmart) to open clinics at selected locations, leveraging the stores' infrastructure to enhance patient access and achieve operational efficiency.

	Virtual Care
Stakeholder Value	The virtual care model aims to enhance patients' experience using advanced technologies and personalized care. The framework covers three categories[13].

Telehealth	
Synchronous (telemedicine)	• Live, two-way audiovisual interaction between patients and providers (e.g. video conference visits)
Asynchronous (store & forward)	• Non-real-time, patients submit information (e.g. medical records, symptoms) to providers, who process it later
Remote monitoring	• Collection of electronic personal health/medical data which is transmitted for review by a remote provider
Digital Therapeutics	
Complementary therapies	• Evidence-based interventions, delivered via digital platforms, to prevent, manage, or treat medical conditions (real world data)
Treatment optimization	• Optimize medication, extending the value of pharmaceuticals (e.g. improving adherence, monitoring side effects)
Care Navigation	
Self-directed care	• Patients accessing their information (e.g. secure website with 24-hour access to personal health information)
E-triage	• Tools that support in searching for and scheduling care based on symptoms/ conditions as well as price and quality

Since 2020 the adoption of virtual care has reached 80%, becoming the preferred channel for primary care applications such as prescription management and minor illness.[14].

Virtual primary care covers the spectrum from pure-play virtual to traditional primary care practices with digital capabilities. However, a blended model combining in-person with virtual aspects, while leveraging **real world data**, is preferred by both patients and providers.



[13] McKinsey: "Virtual health: A look at the next frontier of care delivery" Jun-2020

[14] Stanford Center of Digital Health: "Consumer adoption of digital health in 2022: Moving at the speed of trust" Feb-2023

Market Segment	The U.S. market for digital primary care, covering telehealth, digital therapeutics and care management is estimated at $30 billion in 2024, and projected to reach $45 billion by 2029, growing at a CAGR of ~8.5%[15]. Growth is driven by asynchronous telemedicine, with medical apps and messaging emerging as the dominant modalities. Higher margin services such as biometrics and genetic panels support additional revenue per visit.
Reimbursement Model	The COVID-19 pandemic permanently impacted the reimbursement for virtual care. Many insurers, including CMS, increased rates to match those of in-person visits; the range of eligible services was expanded, and regulation (e.g. geographic restrictions) was relaxed. Since insurance isn't required, virtual primary care can act as an effective, self-paid "backstop" for High Deductible Health Plans. Its reliance on digital information aligns with value-based care, allowing providers to enhance services using a comprehensive dataset.
Partnership Opportunities	Given consumer preference for digital prescription management (61% versus in-person visits)[14], major retail pharmacies like CVS and Walgreens partner with virtual care providers to enhance their services.

	Physician Groups
Stakeholder Value	Physician "super groups" are networks of primary care providers collaborating to achieve operational scale and retain autonomy. Typically structured as limited liability companies owned by physicians, these groups function under a single tax number (TIN) and are subject to regulation governing medical practices. Principal benefits for providers include: – Enhanced negotiating power with payers, and pharmaceutical suppliers – Additional technology resources (e.g. electronic health records) – Efficient revenue cycle management, administration and insurance – Expansion into ancillary services without self-referral constraint Patients benefit from improved services (e.g. extended hours) and pooled clinical resources (often multi-disciplinary) and coordination of care.
Market Segment	Private equity significantly influences the consolidation of medical practices. Single specialty platforms (e.g. cardiovascular, dermatology, dental) are commonly formed via PPM roll-up acquisitions. This strategy represents ~65% of the 788 healthcare services deals closed in 2023[16]. Primary care practices represent only ~5.0% of deals, due to historically lower reimbursement rates and state-by-state fragmentation. However, the growth of Medicare Advantage is attracting PE to primary care, since risk-adjusted coding allows providers to operate with greater margins.

[15] Statista: "Digital Health - Worldwide" Jun-2024

[16] Pitchbook: "Health Services Report" Q4-2023

Reimbursement Model	Physician groups benefit from the adoption of value-based care and contracting models that include financial risk and reward sharing. A pooled administrative infrastructure enables these groups to efficiently manage complex reimbursement schemes, while investments in data technology allow to measure and demonstrate the quality of patient care.
Partnership Opportunities	Partnerships with clinical specialist platforms and/or health systems enable primary care groups to participate in coordinated care initiatives, such as ACOs, and benefit from internal referrals. *Note: Accountable care organizations (ACO) are voluntary medical consortia that incentivize coordinated care by holding providers collectively responsible for the costs and quality of care delivered.*

Value-based Care Enablers help healthcare providers move from fee-for-service into value-based payment models by

- Assembling networks of providers via affiliation agreements
- Providing population health software and clinical resources
- Investing in administration technology (e.g. payments)[17] and processes
- Entering in VBC contracts on behalf of those (ACO) networks
- Sharing the resulting financial upside with providers, and absorbing downside risk

Value-Based Care **Enabler**
Affiliation contracts
Primary Care **Physician Groups**
Accountable Care Organization

The enabler model requires significant scale due to the substantial up-front investments needed to establish value-based care. Providers must have the financial capacity to absorb risk and access to a large network of specialists and service providers to manage patients longitudinally.

The sector's growth depends on preparing a large segment of providers, who would otherwise be unable to manage downside risk, for value-based care. In 2023, enablers collectively managed ~4.9 million Medicare lives in downside risk, a number that is projected to reach ~19.4 million, or around 28% of MA members and Medicare Part A/B enrollees, by 2028[18].

Conclusion

Despite its undisputed importance – "*primary care accounts for around 5% of US healthcare spending but directly affects care quality and cost across the other 95%*" [19] – the sector has historically been underfunded compared to specialist or hospital care.

However, the introduction of value-based care models is focusing healthcare delivery on preventative care, lower intensity interventions and whole-person well-being. This emphasis on holistic patient

[17] Phoenix Merchant Partners: "U.S. Payments Industry – Overview & Opportunities" Oct-2023
[18] Pitchbook: "The Value-Based Care Enabler Landscape" Q3-2023
[19] Pitchbook: "Healthcare Services Overview" 2023

outcomes is improving the reimbursement for primary care and driving innovation and growth in the sector.

Multiple business models have evolved from this realignment, each addressing specific aspects of the complex primary care landscape. Examples include (i) Direct Primary Care, (ii) Urgent Care+, (iii) Senior-Focused Primary Care, (iv) Virtual Care, and (v) the consolidation of physician practices into larger groups.

Phoenix believes the fragmented primary care market offers numerous opportunities for middle market businesses to capitalize on new organizational, reimbursement and ownership models. Specifically, we find the expansion of urgent care provision into primary care, as well as the “business services” model of VBC enablers to be of interest.

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