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Unlocking Opportunities in Healthcare: Physician Consolidation and Investment Trends

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Key Takeaways

Physician Consolidation – Despite Headwinds, The Investment Wave is Not Over

Despite recent headwinds, physician MSOs are expected to remain an area ripe for investment due to fundamental market attributes

- Size of the market.
- Prevailing market inefficiencies.

The core underlying premise for physician consolidation remains intact, which is:

- Given the consolidation of health systems and health plans, the physicians have to find a vehicle upon which to have a more relevant seat at the table.
- We need to go from a cottage industry to something that's much more sophisticated in terms of its organization in its ability to access capital, its ability to invest in systems and all the other things that I think you need to be successful over the long term.

Execution-related headwinds, while commonly talked about, are likely to dissipate and are not as fundamental. More so than execution challenges, the next ten years of investment in the physician market are likely to be different from the last ten years due to:

- **Government Balance Sheet:** The government has become a material payer and purchaser of healthcare services, and its balance sheet condition will require improvement. This may result in pockets of market dislocation along the way, such as reimbursement cuts. Investors will have to be even more focused on the attributes of the market they are targeting – i.e., where does the specialty fit on the cost curve? How diversified are the revenue streams within the target market?
- **Technology:** Technology innovation, such as AI, that will help to drive correction of some of the prevailing market inefficiencies.

M&A markets in the physician MSO space will begin to reopen as investors face the need to monetize holdings. But, longer-term, the buyer universe for larger MSO platforms will need to diversify to sustain a healthy marketplace conducive to continued investment in the space.

- Healthcare private equity investing is still very robust – a lot capital is being raised.
- That being said, I think we're a little stuck right now though. I do think that these investments that were made over the last five years probably still being held at overly optimistic valuations.

This will change as the pressure to recycle capital mounts. The LPs, they're looking now to get liquidity back on the investments they made and these funds. I think the pressure to start cycling capital is going to pick up here in 2025, 2026, but the capital's there, so people are lining up.

- While the bid ask spread logjam is expected to self-correct, a more fundamental question that investors will confront is who and how big is the buyer universe as these MSOs become larger in scale. Answering that question will be important to sustaining continued investment in the physician MSO space.
  - When I'm sitting there and I'm $125 million of EBITDA, who buys the business? And that's a question that I don't think anyone's got any confidence in right now. And I'm not sure the default is always either Optum or take it public. I'm not sure many of these organizations should be public entities. So, there's going to have to be alternatives beyond that those two options. That's the biggest challenge right now. Like I said, I don't think it's necessarily the execution. Certainly there's been some level of miss on execution, but I don't think that that's the fundamental issue.

Hospital systems could re-emerge as an attractive buyer of / partner to physician MSOs.

- I'd love to see health systems winning alongside the MSO space. I think they're natural bedfellows. It just hasn't quite fully manifested yet. And I do think if that was to happen, then you solve the Optum problem overnight because you've got so many natural next step partnership and ownership models. It's almost like creating another public market.
- We think there's a real rich vein of opportunity to think about partnership with some of these large health systems who've got great brand names.
  - I do think that the level of uncertainty that these systems are facing is as big today as ever.
  - They do have capital, but they've also, I think what we've observed is their humility has risen.
  - I think there's an understanding that, one, we can't own and fund everything. And, two, and probably more importantly, we're not very good at operating certain things. Ambulatory, lower dollar operations, generally speaking are not businesses that health systems have been particularly good at operating.

Select examples of hospital partnerships:

- TPG / Medquest / Novant.
- TPG / GoHealth / 11+ health systems.
- TowerBrook / Ascension.

- That being said, health system partnerships are slow moving, come with execution risk and at a minimum will take time to manifest.
  - In the case of TowerBrook / Ascension - that is a model that's been 15 years in the making and the first five years was just conversation.
  - The history with health systems has not been great relative to physician ownership. That's where I think there's got to be some partnership, something to balance that because they have not done a great job and I think they would admit that to themselves. Figuring out a way to be in alignment with physicians without necessarily employing physicians is the next stage of opportunity.

Background

I joined Cain in 2010, so just over 14 years ago. For the last couple of years, I've taken over leadership of the firm. Prior to that, just general investment banking coverage, mostly on the provider side of the world. Prior to that, Iwas at Jeffries for a number of years, and then various other firms. As you know, as you look back over your career, oftentimes it's this series of random events that gets you to this point. I was assigned to the healthcare group as a young banker, and it was a bit of a random assignment, but I quickly found an affinity for it and fell in love with it. Probably, in part, because my mom was a nurse, so there was something in the blood that drew me to healthcare. And, I think the other thing probably is my liberal arts education. The thing I tell the young folks that join our firm is I love healthcare because of its complexity and all that influences healthcare, whether it's social contracts we have, whether it's government and politics, or the markets - it makes for certainly a very interesting industry and it's really one that's ever-changing. And obviously, as you know, it's quite large. So that's me in a nutshell.

Cain Brothers is a healthcare focused investment bank. Our 42 years of history originally started serving the not-for-profit side of healthcare. I'd say over the last 25 years, that's pivoted to not only serving not-for-profits, but to also serving the for-profit side of the healthcare ecosystem. And it makes us a little bit unique - we've got a lot of connectivity between all constituents. Within healthcare, we focus predominantly on M&A advisory - buy-side, sell side, strategic relationships and helping put partnerships together. The one area of healthcare that we don't cover is biotech and biopharma. Everything else within the healthcare ecosystem is an area of coverage for us. And the last thing, we've now been under the auspices of KeyBank for the last, almost, eight years now. So that's added additional capabilities to us beyond our traditional advisory work. We now use KeyBank's balance sheet to help in financing situations, where appropriate, as well as in equity capital markets. So that's who we are. We've got about 85 investment banking professionals within Cain Brothers, so a relatively large group that, as I said, covers a lot of the healthcare ecosystem.

Interview

To kick things off, you've done about 150 transactions as I read the website over the past five years, so incredibly busy. You've seen it all. What works in healthcare services? What do you remain very excited about despite some of the headwinds? What's attracting the most interest today in terms of outside capital, outside investment, and what do you worry about?

Well, all of it excites me, generally speaking. Having said that, and we'll get into it, some areas definitely have some level of headwinds - physician consolidation being one of those. We should talk about that in a little bit more detail that, despite the headwinds, I still think the physician market makes a ton of sense from an investment point of view.

As you know, I think that one of the biggest attractions to healthcare from an investment point of view is certainly the size, the innovation, the application of technologies. But at its core, the inefficiencies.

Often there's a fair amount of administrative inefficiency and things done in a certain way that probably could be re-engineered in a more efficient way. I think that that's what drives a lot of investment - how can we improve efficiencies within a very complicated industry. I still think that there's a lot of inefficiencies out there. You talked about headwinds. I do think that the government budget and the government balance sheet, which has now become such a significant payer and purchaser of healthcare services, is not in great shape. And so I think that that's an overarching headwind. But, I do think offsetting that headwind are opportunities to create more efficiency within the healthcare delivery system. So, despite what I think will be probably some reimbursement cuts, tightening of all of this, some level of dislocation, I think it's actually going to be an incredibly rich time to invest and find those efficiencies. There's certainly going to be some dislocation along the way, but overall I still remain quite optimistic. But, I do think we're definitely going to have to not assume that old ways of doing things and old paradigms are going to continue on a go-forward basis. I do think there's probably going to be more change in the next 10 years than we've had for quite some time. I do fundamentally believe that the government budget situation will drive some of that. And then obviously we're getting to the point where technology, particularly AI, I think we'll probably have some opportunities to help drive some of these efficiencies that we're talking about.

Are there clinical specialties that you are more favorable of? Are there specialties that almost regurgitating how the market feels that you are more skeptical of? Do you think of it in those terms, strong specialties, weaker specialties, stronger plays, weaker plays, things that you stay away from, things that your team focuses on? Or do you view the whole industry collectively of physician consolidation?

On the physician consolidation side, I do think that I've now been doing this long enough where I've lived through a few cycles. The first one, which was done in the nineties and was done out of the context of public equity, and public entities weren't a great vehicle upon which to effectuate consolidation. But, the investment premise then held true. The investment premise this time around holds true. I do think that private equity is probably a better capital source to effectuate some of this. Having said that, it is transitory capital as well looking for beginning and an end, which traditionally has been five years. I'm not sure that five years is the right horizon to do some of this work, but I do think that given the consolidation of health systems, given the consolidation of health plans, the physicians have got to find a vehicle upon which to have a more relevant seat at the table. And I think that that was the idea. I still think it holds true. I still think that we need to go from a cottage industry to something that's much more sophisticated in terms of its organization, its ability to access capital, its ability to invest in systems and all the other things that I think you need to be successful over the long term. I still think that holds true. But, as you know, each one's a little bit different. Each specialty's got different dynamics that are driving it. We look at all of these in a very singular fashion relative to where does that specialty fit in? I mean is it hospital-oriented? Is it ambulatory-oriented? Does it have lots of ancillaries or not? I mean there's all sorts of dynamics that play that you have to think about. I would say from a private equity point of view, they've generally focused on ambulatory specialties and ones where there's reasonable opportunity to create value through facilitating the movement of or monetizing tertiary revenue streams, stuff like that. Obviously creating some level of efficiencies within the providers, but as I said, I look at each one individually. Some are more challenging than others. You do have to think about where the puck is going to. I do wonder, and we've talked about this as a group, will we see more consolidation? I think it was a question you had around multi-specialty groups versus the single specialty consolidation. Single specialty consolidation has certainly been easier to do in certain cases. I think it makes sense because you've got like-minded physicians thinking about the same issues, but I do wonder longer term, just what's the most efficient way to deliver care and is that in a multispecialty group? I think we can debate that. Certainly, seeing very good multispecialty groups, but they have their own set of challenges as well.

I do wonder from a valuation perspective. Because I know from an operational and strategic perspective, everyone on this call wrestles with when to focus and when not to focus, and I think the challenge in that question, the reason why it remains a bit of a paradox is there's benefits and costs to both always. But, from a valuation perspective, is it easier to present an asset to sell that's single specialty focused versus multi-specialty complex? I would imagine with single-specialty, the question of scalability is a little bit easier. We'll just do more of the same. What are your thoughts?

Yeah, I think that's right. I think the path to growth is probably a little bit more obvious when you talk about single specialty. Each one's a little bit different, but I generally think that multi-specialty is probably overall more efficient operation, generally speaking. I think that multispecialty is a vehicle upon which it's easier to take and manage risk. So, in certain circumstances, I think if we're talking about risk-bearing my gut that the multispecialty is probably a little bit easier vehicle upon which to do it. The challenge with multi-specialty is that there are not tons of them. So from a private equity or investment point of view, it is hard to see the path to growth because obviously a lot of them have used the strategy of buy a platform and then do acquisitions. The path to acquisitions is not nearly as obvious if you're taking a multi-specialty approach to building a business. So that's where the biggest challenge is. And as you know too, every market's different relative to risk. Some markets are much more advanced in the passing of risk between a payer and a provider and other. It's very, very immature. So clearly, I think the southern California groups, some of the Texas, certainly the South Florida groups, they've been taking risk and managing risk for a long, long time and do it quite well and quite efficiently. Other markets, they're not nearly advanced on that front. I think that's the other challenge from an investment point of view people grapple with relative to what do I start with and what am I'm building towards? And that's where it's a little bit easier.

I do think you have almost two different pathways here. For groups that want to perfect six sigma, repetition, perfection, quality control, then more focus is typically the path. For groups who want to take on the harder challenges in healthcare, which are always there for all of us to take on - how do you solve for coordinated care – then multispecialty is typically the path. Where we are in the cycle at a given time - easy capital, highly rewarding capital for ambitious business plans or highly constrained capital and highly punitive for ambitious business plans, are the public markets open or are they closed? – these things need to be taken into consideration. But it is interesting. There's room for everyone in healthcare, no question.

Where are we in the cycle right now today and I mean literally today versus last month versus six months ago? Are we still facing as many headwinds as we did six months ago? Is the private equity community moving back? And I know we talk in terms of almost secular cycles. You referred back to the public markets in the nineties. I view it as sort of all lesser evils, right? Nothing's perfect. And, if not private capital from private equity, then what do we think is going to substitute for that and all the investment that's necessary in healthcare? Are we moving into a happier times with an easier, less restrictive capital investment environment? What are your thoughts?

Yeah, good question. Well, I think first of all, all of us have need to recognize that this period from 2021, and probably even prior, to early 2023 was probably once in a lifetime as it relates to incredibly cheap capital and just a voracious desire to put that capital to work. I think we're now going to be what I would call more normalized relative to the cost of capital. We are seeing rates start to lower as certainly the Fed eases. But, I don't think we're going back to where it was, but that's okay. I think some of the dislocation that we've been dealing with is the result of probably overly euphoric, overly optimistic investing. So I think the financing markets are there, the equity is certainly there as it relates to private equity. There was just an article earlier this week I think in PitchBook that healthcare private equity investing is still very robust, lot capital being raised, which I think speaks to the point I was raising earlier.

There's still lots of opportunity for investment and create returns through providing more efficiencies in the market.

I think we're a little stuck right now though. I do think that these investments that were made over the last five years probably still being held at overly optimistic valuations. I think for a lot of businesses that have been brought to market or could come to market, there's probably still a little bit of difference between the bid and the ask as it relates to valuation. And I think the private equity is trying to navigate that. They don't want to be the first one, but what will happen is the pressure to recycle capital. And I do think that that's coming. It is definitely starting. The LPs, they're looking now to get liquidity back on the investments they made and these funds. And so that pressure will, I think start clearing the decks, start cycling and folks that are holding a business on their books that 13 times will just realize, "Hey, I got to sell this. It's going to sell at 10 times or 11 times and I'm going to move on." And the return on this fund is going to be 1.7 times. I just think that, yeah, I think the pressure to start cycling capital is going to pick up here in 2025, 2026, but the capital's there, so people are lining up. We're just going to have to get the last messages of this wild party that we've had over the last five years put to bed and move on. And that's starting to happen.

It is interesting that private equity is really, when you phrase it that way, no different to the lender community. You can only forebear for so long.

Correct.

So, what they've done is they've bought themselves one to two years of inactivity. Let's just sit on the assets and look for brighter days, lower interest rates, the return of enthusiasm, a less punitive regulatory environment. AB 3129 just passed in California. It's sitting on the governor's desk. This was three days ago, but the friendly PC model within California survived. It wasn't going to survive in the first draft. So, the difference between six months ago and today is quite material as far as the legal community is concerned. And you can read the document yourselves - selling an asset in California six months ago, good luck. Selling one today in California - more likely there's reason for hope. California is always idiosyncratic. So, has it really changed that much? But you can only forbear for so long. At some point the ownership in private equity has to, like you said, change hands.

Correct. And I think that, as I said, particularly if we're going to talk about physician consolidation, it is complex. These are complex organizations. I don't think that a three to five year investment horizon makes sense for those organizations. I think it takes a little bit longer to create something of lasting value. I think it's there, but it does take time and I don't think private equity has done themselves any help in terms of the political backlash. I think it's overblown, but there's certainly aspects to it that I'm sure have wholesome truth. And so I am going to be interested to see where this goes, but I do think someone's got to help facilitate the consolidation. I don't think the consolidation is all about increasing rates, et cetera. It's not just private equity - I mean everyone tries to improve their negotiating leverage within a transaction, whether it's not-for-profit or for-profit. But generally speaking, when we see books, most of these investments are not based on how do we jack up rates. It's more around how do we create efficiency, et cetera.

Yeah, I mean one point of argument I would offer is if MSOs are doing good in the community, why didn't they form 20, 30, 40, 50 years ago? Why does it take the emergence of private equity capital to really offer that third component? And it's not like hospitals and practices haven't been around for over a century. So, it does raise the question - does the market need a third constituent to take a very favorable view? But related to that - you look at all of healthcare, you do transactions in all of healthcare and you speak to the investment community – so, you occupy quite a rare seat. I know your conference down in Nashville, you're the only group I know that hosts a hospital private equity conference where you invite the nation's leading health system CEOs to spend a few days with the country's leading private equity investors. And I've attended both those conferences this year and last year when you kicked it off. It's really an amazing event. So, you can look at the provider aggregation MSO development category and compare it to relative to other asset classes, other markets within healthcare to invest in. And so, the question is - how are we doing relative to those other investment opportunities, whether it's healthcare, it, nonprofit for-profit health systems, post-acute care life sciences? Has the MSO opportunity taken sort of an irreparable step backwards here, forever tarnished in the eyes of private equity because of, frankly, the warnings that we've always offered - which is that, "hey guys, this is hard. It's not going to be easy. I don't care what the offering memorandum says, it's going to be hard. It's always hard aggregating physicians." Are we in a place where we're going to be taking a valuation step down forever in a day because of the last three years' worth of missed expectations? Or is this from your perspective and broad experience just par for the course - some of the noise and some of the potholes that any journeyman goes through as they embark?

That's a complicated question. I still believe strongly that consolidation within the physician community makes sense. I think everyone's a little bit different. I think there's probably some models of consolidation that have not worked great. I think that there were probably unrealistic expectations set by absurd valuations, which was set by, as I said earlier, just incredibly cheap capital and expectations of how quickly you could flip it. Where would you go? I think the biggest issue right now is that a lot of these organizations are doing fine, but the private equity community is saying, "I like it, but if I now invest in this business, who do I sell it to?" That I think is the biggest challenge right now is we started with a practice, we built a nice single specialty rollup. It's a nice business. Maybe it's held a few little struggles, but generally speaking, I think these have performed okay, it's now a $40 or $50 million EBITDA business, multi-state, got some infrastructure thinking about selling. And the question is, okay, I want to go out. Who's the natural buyer? The assumption is, generally speaking, it's going to be private equity to take it to the next phase of growth.

And the challenge then is, okay, I buy at $40 million of EBITDA and I want to double or triple the size of the business - when I'm sitting there and I'm $125 million of EBITDA, who buys the business?

And that's a question that I don't think anyone's got any confidence in right now. And I'm not sure the default is always either Optum or take it public. And I'm not sure many of these organizations should be public entity. So, there's going to have to be alternatives beyond that those two options. So that's the biggest challenge right now. Like I said, I don't think it's necessarily the execution. Certainly there's been some level of miss on execution, but I don't think that that's the fundamental issue. Back to your point though, that's where this conference, we think there's a real rich vein of opportunity to think about partnership with some of these large health systems that you said who've got great brand names. They do have capital, but they've also, I think what we've observed is their humility has risen. And I think there's an understanding that, one, we can't own and fund everything. And, two, and probably more importantly, we're not very good at operating certain things. And ambulatory lower dollar operations, generally speaking are not businesses that health systems have been particularly good at operating. So, I think there's definitely much more openness. I think there's much more opportunity to think about that complexity then comes into just the structures and how do you create a structure that can last over time, but at the same time have maybe multiple owners over the course of that ownership. And so that's where there are complexities to get into. But as you know, there's lots of interest on both sides. We were pleasantly surprised at how many health system executives came to that conference, which to me, spoke to this openness - there's a level of humility we can't do everything, but the more to come on that it's still early, but there's activity happening around those fronts for sure.

Yeah, I think, look, everyone is a genius retrospectively and all of us struggle with prospective forecasting. So, all of us sitting here today I think believe in an AI technology revolution that's going to change everything over the next 10 years in healthcare. Expectations couldn't be higher. I mean, this phone call is all going to be handled by some kind of artificial intelligence form within a few years' time – we won't even need to do this - someone will just speak for us. Expectations are at that level. Meanwhile, we might be staring at the next wave and not even recognize it. Health system partnerships might be the next literal wave. The way that health systems adopted the ASC model in order to facilitate the ambulatory buildup. In some cases, they did it happily in partnership form. In some cases, it was done to them depending on how restrictive CON conditions were from one state to the next.

But, it happened nonetheless. And I will say this - in more cases than not, health system partnership in the ASC surgery center revolution that took place across the country became the predominant model. And now, in fact, health system independent surgery center buildup is the dominant model. So, these things happen in stages. I do think it's interesting that I didn't see much health system partnership with practices when I first started in healthcare 15 years ago. It was very binary and asymmetric huge multi-billion dollar business buys tiny $5 million revenue business. That's always going to be asymmetric. I was speaking at your conference and the big question was, what has private equity done for health systems? Well, they created MSOs, thank you very much. You're welcome. And so the MSOs are really grown up practices that can actually engage in symmetrical discussions and even partnerships with health systems. And I think we're at the beginning stages of that. You have a wonderful example in TPG, Novant and MedQuest. Do you want to maybe touch on that case study?

So I mean just as a case study, Novant large system down in the southeast had bought probably 10 years ago a business called MedQuest, which was an outpatient imaging center operation. They contributed additional facilities, left it somewhat independent from the overall Novant operations, tried to find synergies where they could, but once again, this was an outpatient patient operation that they couldn't optimize on their own. Probably driven on two fronts - an ability to efficiently operate was one motivation and the other is obviously outpatient imaging is relatively capital intensive. So, I think that led to "how do we more efficiently capitalize this business, fund this business? Is there a way to create a partnership or bring a partner into that to help fund it as well as improve the operations?" And so, TPG, the private equity firm who's got a history of doing these types of deals - GoHealth being one in particular - had been working on that conversation for quite some time and ended up being able to negotiate essentially a one-off deal. So we helped TPG in that and their goal is to take that and then go to other health systems and help them with the same value levers of, "Hey, let this entity elongate your capital by letting us help fund that in partnership with you and potentially improve operations." I agree with you. I think we're going to see more of that on the physician side. I think we should see more of that on the physician side with health systems, just in terms of operations. But I do think risk transference onto providers is a good thing actually when done right.

I do think that if you can move the cost benefit analysis closer to the decision making between both the financial side as well, the clinical side, I think you get better decisions.

Generally speaking though, I think that that's another place where MSOs in partnership with systems could be quite powerful. But, it's complicated. I do think that we should see more of that and I think it will come, but it's going to take some time.

What is the appetite for a $500 million revenue MSOs to engage in a multi-year negotiation with a health system surgery center? De Novo surgery centers take one and a half to two years starting from scratch. So there is a timeline to it, but there's a certain certainty to it. And so, what amongst this plethora, almost like this buffet of different business opportunities, when you add up everyone, what falls into the category of highly likely, high visibility, relatively contained timeline surgery centers take one and a half to two years. They rarely take 3, 4, 5 years. Those are anomalies. When you enter a category that you don't know whether you're going to execute a cardiovascular exit from a health system in one year, two year, five years or 10 years - I can think of a sponsor that's been working on this for four years now. I continue to interact with the CEO who's still waiting for the deal to get done four years later. That's not scalable. What is scalable is certainty. All the MSO leaders that are out there embarking on unproven first time collaborations for their respective field are facing significant friction. Health systems enjoy certainty more than anything. They actually love repetition. If they can be the 50th system to engage in a certain type of deal or arrangement that's been done many times before successfully, then that makes everyone's lives that much easier. But we need to get to that point. So this is the hard part where a lot of models haven't been proven out yet.

It is the hard part. But, I would tell you I think the openness to taking more risk on the health system side is increasing. And obviously each one's a little bit different, each situation's a little unique, but overall, just based on our conversations, I do think that the level of uncertainty that these systems are facing is as big today as ever.

I think that it is the catalyst for them to be more open to taking risk and trying to innovate.

But it does take time. There's no question about it. I mean everyone puts up TowerBrook's relationship with Ascension as somewhat of a model to follow. But, that is a model that's been 15 years in the making and the first five years was just conversation. So these things take time and as you said, you look like a genius in hindsight. But, I think the effort will be rewarded. It may not be completely clear right now. And, sure, the easy answers are the ones that you said where is relatively certain and the path forward is relatively obvious. But I do think, as I said, the environment of uncertainty, the openness to new ideas is as big today as ever when it comes to health systems and even some of the largest health systems are feeling these things. The openness to innovate is bigger than ever. And I do think that physician partnerships and MSOs should be part of that conversation.

I think the Towerbrook case study is excellent. It speaks to a suggestive path forward that I think is replicable, which is the night and day difference between approaching a health system with no prior history of working together and approaching a health system with a 10 year history of providing their core billing function as you embark on a whole new journey of let's go build 400 surgery centers together. I've seen that before, a founding group that partners with a Piedmont Health System in Georgia, but they spent the prior decade building urgent care centers for that same health system before they embarked on the latest version, which is a primary care build out for that health system. Having that history of doing something with the health system and then a lot of that friction dissipates, not all of it. You're still left with a systemic inefficiency and dysfunctionality and multiple leadership structure that stays but night and day difference between arms' length and inside baseball when you're dealing with health systems.

No doubt. Just clearly some of those attributes that you were just describing, the health systems are true. I think that some of it honestly is just the result of being large, complicated organizations having nothing else to do, but that it's just a result of that. But everything in life, the more communication, the more you do, the more trust is developed, the more that that friction abates and you can then really start doing some really innovative things. I think the ones where we've seen the best outcomes are the ones that really have good governance and good communication and good partnership and that then leads to other partnerships, more innovation, et cetera. Because that foundation of trust has been built and alignment. And, it's funny, we both see a paradigm today where MSOs reach a certain size, they're obviously going to trade with Optum. And we ask the question, well, is that sustainable? Well, clearly not. And we had Walgreens for a while, but that's gone too. So, I think this is one of those temporary idiosyncrasies. We're going to laugh at this phase. And I think the next wave, I hope it is health systems. I really do - sort of my personal bias. I'd love to see health systems winning alongside the MSO space. I think they're natural bedfellows. It just hasn't quite fully manifested yet. And I do think if that was to happen, then you solve the Optum problem overnight because you've got so many natural next step partnership and ownership models. It's almost like creating another public market.

So I think there is a gravitational pull in that direction. It's just the transition is very hard.

It's very hard. It has been interesting how a few other health plans have taken on the Optum strategy. I've always been kind of perplexed by that, to be honest with you. They've obviously done a great job, but we haven't really seen anyone else successfully do that with any kind of scale. I do think we've got to come up with some alternatives relative to Optum in terms of end state ownership. We've seen examples of MSO businesses - USACS, which is US Acute Care Solutions. They ended up partnering with private equity, Welsh Carson, obviously built scale infrastructure,

access to capital, all those things and are now on a path to eventually sell it back to the physicians. I think there's some real elegance to that. The physicians had a partnership share and a small practice, and now they're a shareholder in a much larger organization. I said I think there's some elegance to that. I'm not sure that that applies to every specialty and whatnot, but I do think that there are going to be some opportunities for that as well. And like being a partner at a big accounting firm, I'm now or shareholder in a big accounting firm. Now I'm a physician shareholder in a much, much larger organization that has got, as I said, these tools and capabilities to effectively compete but still has that ethos of a physician organization. That to me is somewhat compelling. But I also feel, to your point, some of these opportunities with systems will be compelling as well. The history with systems has not been great relative to physician ownership. That's where I think there's got to be some partnership, something to balance that because they have not done a great job and I think they would admit that to themselves. That too is an area where they've not really done a great job.

Figuring out a way to be in alignment with physicians without necessarily employing physicians is the next stage of opportunity.

I don't know if you call it horizontal or vertical integration. I think there's arguments for both, but as far as the payer community is concerned, I think it is tough to imagine much more coming out of them than what we've currently seen. The Anthems/Elevance and the Aetnas of this world, these are episodic and highly inconsistent endeavors. The VillageMD transaction. Okay, so that doesn't speak to a wave that speaks more to sort of a testing of the waters while you're busy having fun in your core business model, which is selling insurance and dealing with the government and reimbursements and building your network. They always seem awfully busy to me being what they are, which is an insurance company. Whereas, actually Optum, anecdotally, I know some of the original C-suite there and their ownership of the provider space is an accident. It wasn't intentional. They actually bought an asset that came with some providers and rather than force the issue and say, well, we don't own providers, they took them on. And so that's how they ended up owning providers accidentally as part of an acquisition and 50 to a hundred thousand providers later, they're the largest provider employer in the country. It is funny how these things work out, but if you talk about a wave, then you really have to look at a large constituent like private equity, like health systems that have an enormous amount of capital and that has thousands of corporate entities. In the case of private equity, I count about 700 active investors funds that are interested in healthcare service investments. I don't count three, right? Health systems, you can think in terms of hundreds of hospitals, you can think in terms of still five plus thousand. That's a lot of targets, that's a lot of potential partnerships for everyone on this phone call and everyone in SCALE Community to consider. It's just a wave that hasn't arrived yet.

I think the one other constituent that you didn't talk about or highlight is employers. And I think that they have definitely grown, their frustration level has gotten to the point where they're no longer relying on plans to manage and innovate. We've seen a fair amount of activity there. It's still early. I don't know where that will go because obviously an employer's got a particular point of view relative to their needs. I don't know if it's comprehensive enough to make meaningful difference other than perhaps maybe on the primary care and some of the first level healthcare, but I do think that we are seeing a fair amount of activity around employer health related stuff, formation of network contracting, et cetera. I do think that that's another potential constituent that should be considered when thinking about the next wave of innovation.

That is interesting. And also there's different circles to this, right? There's concentric circles and an employee investing in a B2B component, a service provider into healthcare services as opposed to the clinical part. The actual delivery of care is also some version of what you're describing.

Correct.

I was just curious with regard to one of your statements that healthcare systems challenged with operating ambulatory care systems. Yep. What's your sense why that is? Is it mindset?

I think it's mindset. I think it's cost structure. I think obviously it depends on what clinical capability we're talking about. As you know with some of these, they're more retail customer service oriented. I think health systems are terrible at patient centricity, generally speaking and patient attraction. But at its core, as you know, a lot of them have large union contracts. I don't think that they're great at operating businesses that have lower dollars - really good at the high dollar centralized stuff, but some of these other things are just not quite as good at, and I think they've come to the conclusion that they're probably not that great at it. And so that's where there's more openness to partner to innovate.

If a surgery center is a hub and the network practices are the spokes, they tend to be unable to execute on that because that typically requires a partnership model. A system or a hospital opening a surgery center tends to be entirely self-reliant. There is no hub, there is no spoke. The surgery center is just an extension of its existing employed physician volume base. And so, if they have the volume, then redirecting their providers to go use the extra capacity tends to work, albeit at what is described as a higher average unit cost. Everything is high average unit cost, so it feels less successful, but at least it's busy. If they don't have the volume, and there's many cases of this too, they're stuck because what they won't do is open up ownership and partnership and co-management governance to a network of neighboring practices the way that any other surgery center normally would come join my center, I have plenty of room, here's 20% ownership for you. They will do that in terms of other ASC management partnerships, they will do it with other large entities, but they tend to not view practices in that light because they tend to not enter into relationships with practices that are ownership driven.

Question from Guest: I've been looking at these physician partnership with health system and we've been through multiple iterations with large systems looking to partner. It's really great observation in terms of the potential utility these partnerships offer. Where I'm at today is that there's a fundamental problem for health systems relative to large practices, and that is the larger practices or successful practices are still driven by cash. They're still in a taxable environment and a lot of the largest systems are not. And, for the health systems, their efficiency is more about utilization and capping that, right? Advocate is great example of that. They function as an insurance company that wants to temper production, whereas if they want to partner with a typical physician practice, their initiative is to increase production. And so there's a bit of a conflicting position in the partnership that an MSO can handle. If you don't have clarity on which one of those two things you're going to aim for, you're not going to have a healthy partnership. It's not going to work.

I couldn't agree more on multiple levels. You're following two different religions. And so I would phrase that maybe a little bit differently - for-profit, nonprofit partnerships don't really work. You're following two different religions. One is expense orientated. How do we bulk up with even more expense with even more balance sheet assets? And the other is bottom line driven. How do we measure performance based on margin and earnings and growth in both? And they're speaking two totally different languages. Where I've seen it work well is, to your point, where the need to achieve other goals is weighty enough, large enough that it overcomes those obstacles. I have to get my doctors out of here now like a MedQuest imaging buildout from a health system that leads to a new MSO launch because they wanted imaging to be its own MSO. If the urgency is there, the nonprofit pushes forward and foregoes all kinds of things. Physician ownership takes over, private equity inclusion, etc. The other way I've seen it work is where health systems create for-profit assets that they're owners of that support their nonprofit larger parent company. And then they start to speak the same language, right? The measure of success is how much EBITDA can flow from this for-profit vehicle that I'm a JV partner of into my nonprofit entity. But in most cases, the resistance is enormous. Very different ownership structure and corporate structure.

I agree with that. I mean, that's what makes this journey so complicated, so frustrating, is you have businesses that are much more volume motivated because volume drives efficiencies. But that could be completely counter to a payer, or Advocate in this situation, that presumably has got some level of risk associated with that. So, they're trying to tamper volume down. We've got to find the sweet spot there. Don't know exactly what that is, but that is what makes it so frustrating.

But my point overall is the mother of invention is necessity and I think necessity across a bunch of different fronts is rising.

I do think that I continue to go back to the government now is such a large influencer over healthcare. They're a large purchaser of healthcare and the government just cannot continue to print money the way it has without consequences. Obviously, the inflation we've been dealing with is one of those consequences. It is going to require resources being utilized in a much more efficient way, which is the necessity, and that's going to create innovation. And I said, I do think the next 10 years, I think you admit that as well is going to be more change than we have seen in quite some time.

The government put a lot of pressure on practices, borderline drove them out of business. Those practices reacted by aggregating the government is starting to put a lot of pressure on systems. I think systems left alone remain incredibly difficult to partner with. I think systems pushed into very difficult revenue paradigms – it will be amazing how easy they're all of a sudden going to be to partner with. But I still think you're left with the other suggestions, which is you're eating an elephant, one small bite at a time. What's the least amount that you can do with that given system? Not the most amount. That's the way that I would approach it. How do you develop a relationship of trust? And the last piece is the symmetrical relationship leads to symmetry and communication. Speaking the same language. We always had this conversation with all of our Boards,

all the physician Boards that we used to be part of back in the old days in Frontier before we exited. And the conversation was always, imagine that you're in the front page of the Wall Street Journal. Would you do what you are recommending we do or can we take a more conservative approach? Health systems have been on the front cover of the Wall Street Journal for the last a hundred years. Their risk averse approach is because from their paradigm perspective, they are the most important brand in their market, number one. And as these MSOs, and I know in your case, this is very relevant to you, you speak that language, right? So you would sound a lot closer to them than a freshly minted new brand MSO that a private equity just created by buying the latest round of practices in pickup market. And I think that's interesting too.

Guest: I think the name of the game, you guys touched on AI in the future. I think the name of the game in the employer market like that was touched on before. It's the market sorts itself out when things become stagnant. And I think in the employer market, the margins are to be had because there's a lot of utility and waste in that area. And so, if you can come up with a partnership, and I don't care if it's the hospital or whatever and things like that where you can manage risk and you can incorporate AI into risk management, I think that's going to be a key differentiator for any practice, whether you're have an alignment or not. If you can't do that, then you're going to be on the menu rather than the table.

I think that's very well said. We're going to end on that point. The market tells you how special you are. It's unavoidable.