SURVIVING CHAOS

Private Practices Facing New Realities

2026 UPDATE

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PART ONE

First… the why in this discussion

The landscape has shifted — but the pressure on private practice has not.

Not necessarily new… but severely impactful

Overhead keeps climbing

Labor, supplies, rent, tech — all up since 2020.

Reimbursement lags

Commercial payers and government programs trail inflation.

Regulatory complexity

Prior auth, MIPS, information blocking, HIPAA cyber rules.

Market consolidation

Hospitals, insurers, and Optum continue to absorb practices.

Patient expectations

Consumerism is here to stay — convenience and price matter.

Workforce strain

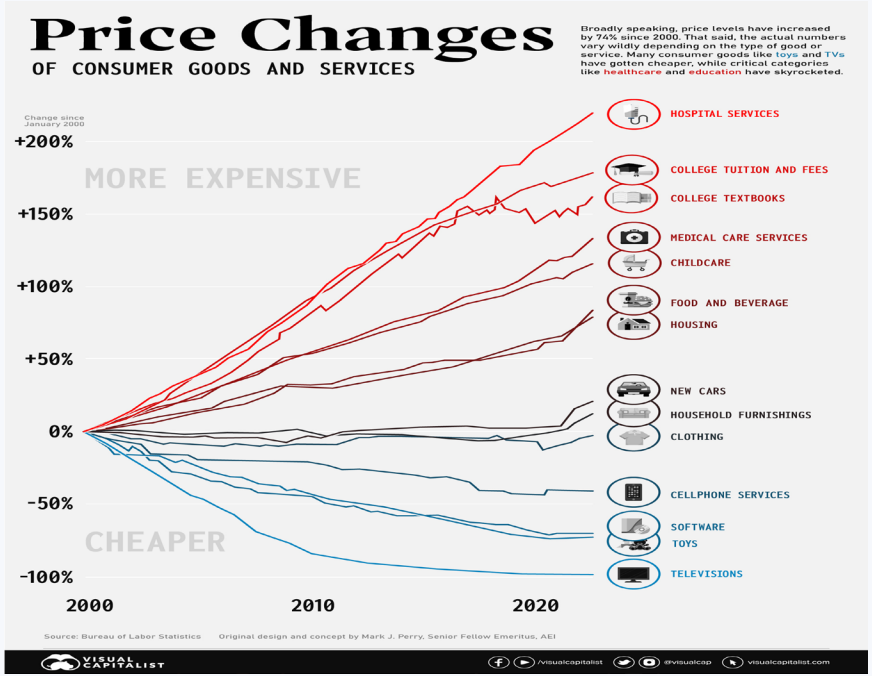
85% of physicians report feeling overworked; burnout persists.

PART TWO

Highlighting the chaos

Costs, revenue, and the players behind the pressure.

Overhead — a doctor's favorite word



+33% — Medicare physician payment decline vs. inflation, 2001–2025 (AMA)

14 hrs/wk — Practice time on prior authorizations

2–3 hrs — Documentation per hour of patient care

85% — Physicians report feeling overworked (Doximity 2025)

Source: Visual Capitalist, 2024 cumulative price changes chart; AMA; Doximity 2026 Report

What specifically is driving this?

Labor costs

Nursing shortages and wage inflation post-COVID still haven't settled.

Supplies & equipment

Biologics, implants, and tech continue to outpace general inflation.

Regulatory compliance

Information blocking, HIPAA cybersecurity rules, No Surprises Act disputes.

Malpractice premiums

Rates hardening again after a decade of relative stability.

Cybersecurity

New cost center after Change Healthcare — insurance, tools, staff.

Tech debt

EHR upgrades, AI pilots, interoperability mandates — all on practice P&L.

Real-world pressure: the 2024–2025 reality

BECKER'S
ORTHOPEDIC REVIEW

How inflation is impacting orthopedics

Orthopedic

Claire Wallace - Thursday, February 15th, 2024

"Inflation, healthcare labor, and other costs of providing medical care are growing faster than reimbursement for healthcare services."

— Rothman Orthopedic Institute, announcing 5% workforce reduction (2024)

AND SINCE THEN…

Duly Health & Care
PE-backed group downgraded by Moody's amid layoffs and compensation cuts (2024).

Envision Healthcare
$7B+ bankruptcy — a PE-era cautionary tale physicians still reference.

Hospital systems themselves
Steward, Mercy Iowa, others — bankruptcies reshaping entire regional markets.

Let's not forget revenue

Payer leverage

Continued pressure on successfully negotiating with commercial payers — now often dominated by 1–2 regional carriers.

Government programs

Flat (or negative) reimbursement in Medicare and Medicaid — with the 2026 'efficiency adjustment' wiping out the congressional pay bump for 7,000+ specialty codes.

Medicare Advantage & Medicaid MCOs

Continue to grow share — bringing prior auth, risk adjustment games, and narrower networks.

Coding & denial games

Denial rates climbing; AI-driven denial engines on the payer side require practices to respond in kind.

Those who have the gold… make the rules

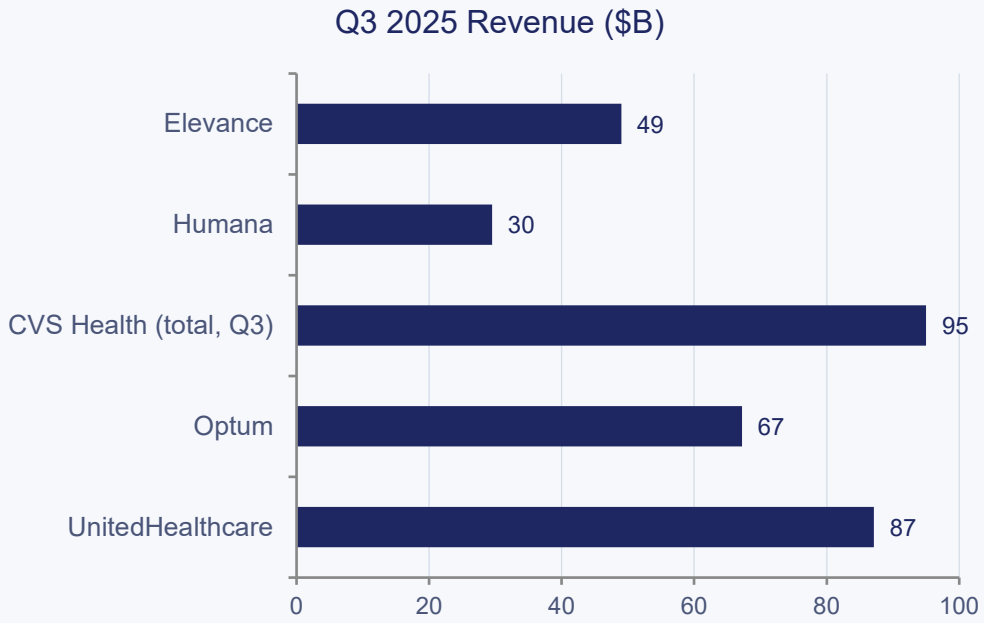
In markets where UnitedHealthcare holds 25%+ share, Optum-owned practices are paid

61% more

than non-Optum practices receive from UnitedHealthcare — a direct pricing advantage for the payer's own providers.

Source: Health Affairs study, cited in Becker's ASC Review (2025)

The payers keep growing



WHAT THIS MEANS

UnitedHealth parent
Net income fell 62% YoY in Q3 2025 — but still booked $2.3B profit for the quarter.

Optum's physician affiliation
~90,000 physicians — roughly 10% of U.S. physician workforce.

All 10 of the largest U.S. health insurers
have acquired physician practices or MSOs in recent years.

Sources: Becker's Physician Leadership (Oct 2025); GAO-25-107450; Medical Economics (2026)

An impact that we all feel downstream

US healthcare

Majority of debtors to US hospitals now people with health insurance

Analysts say a 'sea change' occurred in the American healthcare system from when only a tenth of debt came from the insured

Jessica Glenza

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Thu 11 Jan 2024 08.00 EST

WHY THIS MATTERS FOR YOUR PRACTICE

~100M

U.S. adults carry medical debt — the leading source of debt in collections.

High-deductible plans shifted care cost onto patients. That unpaid balance flows back to providers — hitting small practices hardest.

2025: Medicaid redeterminations pushed ~20M off rolls; coverage churn continues.

Source: The Guardian (2024); KFF / Urban Institute analyses (2024–2025)

It's not just the private carriers

Alabama Medicare 99213 allowable — illustrative trend

Year	2000	2010	2020	2024	2026
Non-Facility Allowable	$43.79	$63.68	$71.06	$82.30	**$85.90***
Facility Allowable	$31.66	$47.62	$49.88	$60.39	**$62.50***

In real (inflation-adjusted) dollars, Medicare payment has fallen 33% since 2001. The 2026 'efficiency adjustment' wipes out the 2.5% congressional bump for most specialty codes.

**2026 figures are illustrative — based on CMS 2026 conversion factor of $33.40 (non-APM); confirm local GPCI/RVU in your jurisdiction.*

PART THREE

Where is this chaos taking us?

The consolidation landscape has shifted — but hasn't slowed.

Is the independent physician becoming endangered?

2012

60.1%

of physicians in private practice

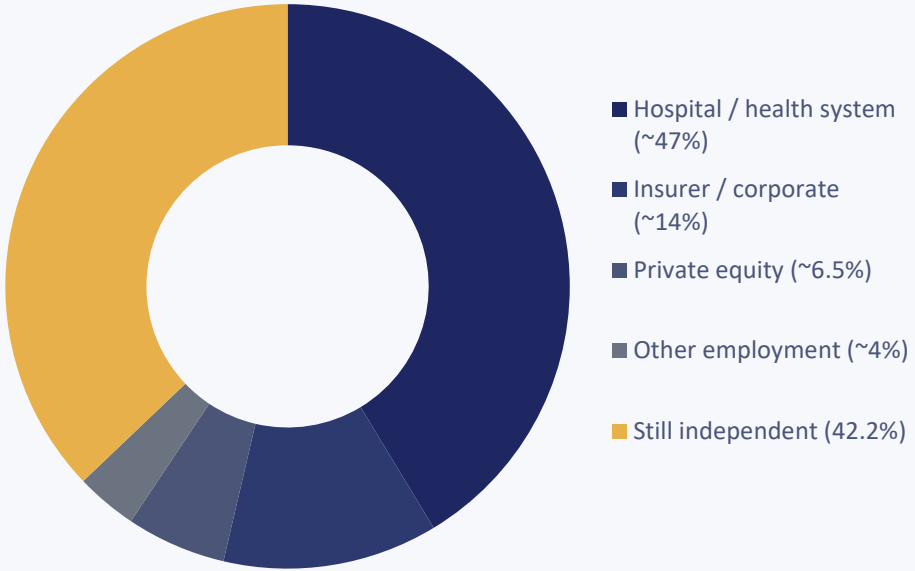
2024

42.2%

less than half — for the first time ever

Source: AMA Physician Practice Benchmark Report, 2024 data

Where are the physicians going?



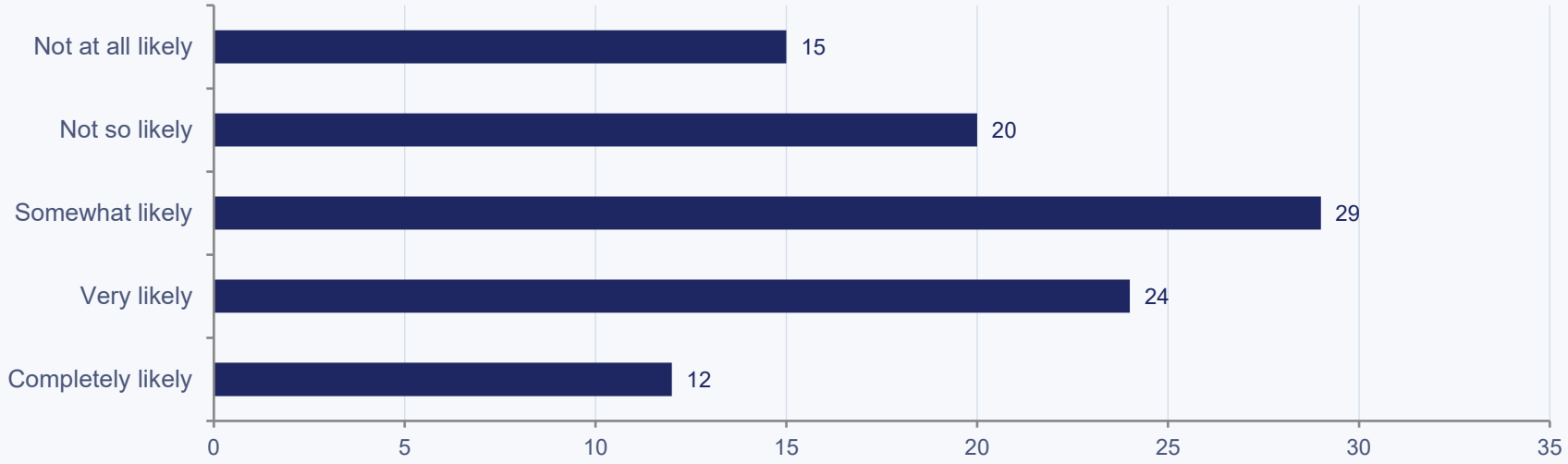
KEY TAKEAWAYS

- Hospital systems still the dominant acquirer.
- Insurer/corporate share growing fastest — especially Optum.
- PE is small (~6.5%) but concentrated in gastroenterology, dermatology, ophthalmology (>30%).
- Rural + Midwest leading: 66% consolidation in the Midwest; 58% in rural areas.

Sources: GAO-25-107450 (Sept 2025); AMA Practice Benchmark Report; Health Affairs

The sellout impulse is real — and growing

How likely are you to sell your stake in your practice or retire in the next 5 years?



Majority of independent owners say it's at least somewhat likely they'll exit in the next 5 years.

Illustrative — based on industry survey data from Tebra, MGMA, and AMA trend reports

Local alignment matters

Practice ownership — the shift

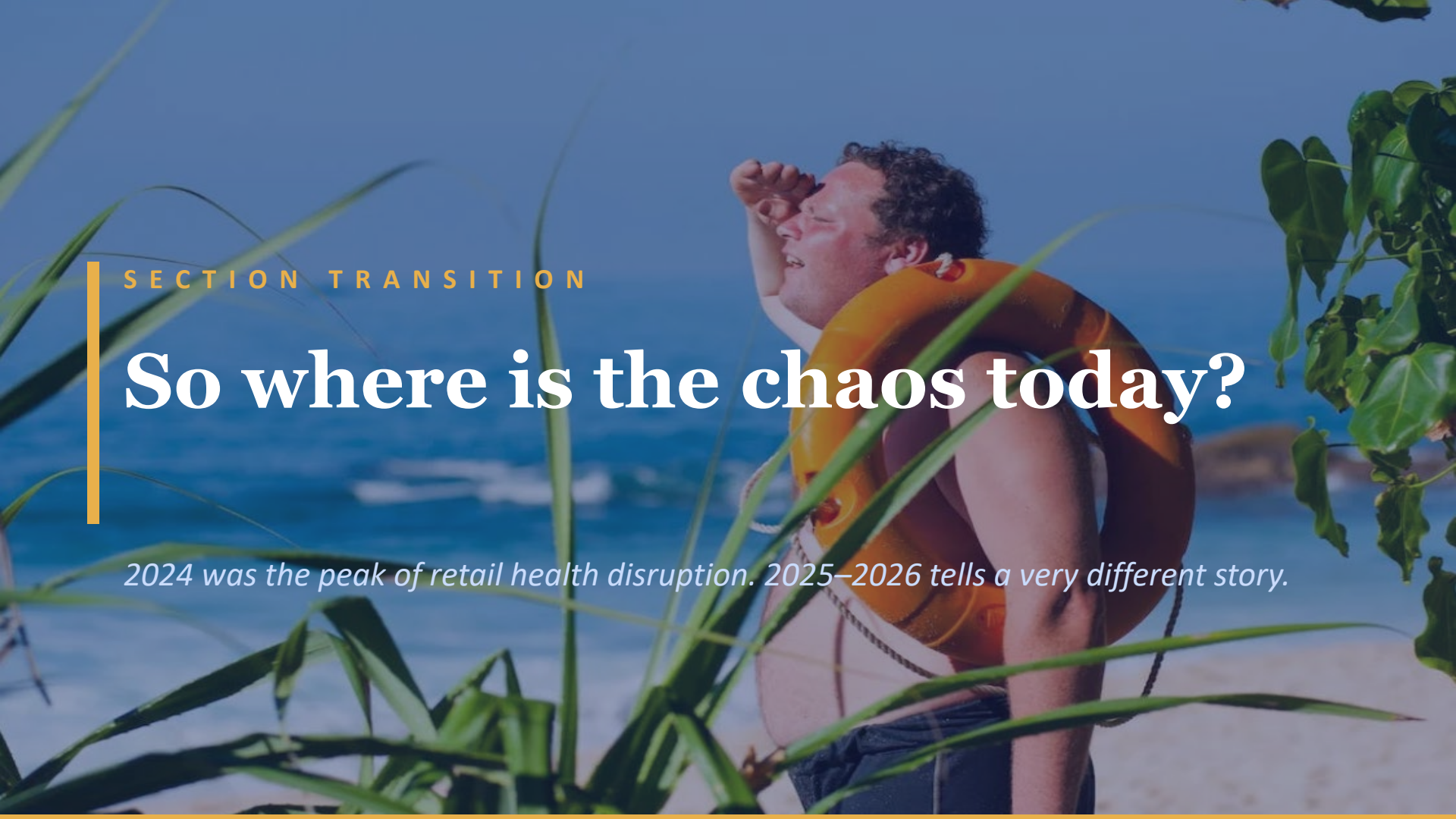
Over the last decade, the share of physicians in private practices fell from **60% to 46.7%**. The share working in hospitals or in practices at least partially owned by a hospital or health system rose from **23.4% to 41.8%** between 2012 and 2022. GAO's 2025 analysis confirms at least **47%** of U.S. physicians are now employed by or affiliated with hospital systems — and the share of practices at least partly owned by a **private equity group** grew from about 4% to 6.5% over roughly the same period. The trend is not theoretical — it is happening in your market.

Sources: AMA Practice Benchmark Report (2024 update); GAO-25-107450 (Sept 2025)

THE GOAL

Serving the community

Every survival strategy has to come back to this. If we lose it, we lose the reason.



SECTION TRANSITION

So where is the chaos today?

2024 was the peak of retail health disruption. 2025–2026 tells a very different story.

Corporate America → Chaos → The Pivot

2019–2023
The Land Rush

Walmart, Walgreens/VillageMD, Amazon/One Medical, CVS/Oak Street all bet big on retail clinics.

2024–2025
The Retreat

Walmart closed all 51 clinics. Walgreens wrote down $5.8B and closed 160+ VillageMD sites. CVS closed 16 Oak Street clinics.

2025–2026
The Pivot

Retail giants narrow their scope. The real consolidation shifts to payer-owned primary care (Optum) and value-based Medicare Advantage plays.

Sources: CBS News, Axios, Healthcare Dive, KFF Health News (2024–2026)

The retail clinic scoreboard

Company	2023 plan	2025–2026 reality	
Walmart Health	51 clinics + national telehealth	CLOSED — April 2024	✗
Walgreens / VillageMD	600+ VillageMD clinics planned	160+ closed; $5.8B write-down	✗
Amazon / One Medical	Aggressive nationwide expansion	Still operating; layoffs	~
CVS / Oak Street Health	300+ clinics target	230+ operating; closing 16; $5.7B impairment	~
UnitedHealth / Optum	Payer-owned primary care	EXPANDED — ~90,000 affiliated MDs	✓

Walmart's retail footprint is massive — but a retail chain is not a primary care business.

Retail giants discovered that selling groceries ≠ running a sustainable primary care business. The pivot is to higher-margin, integrated, payer-owned models.

Sources: Healthcare Dive, Becker's, KFF Health News, Fierce Healthcare (2024–2026); Yahoo Finance map

The real story: payer-owned primary care

4.2%

of Medicare primary care services now delivered by payer-operated practices (up from 0.78% in 2016)

~90,000

physicians affiliated with Optum alone — roughly 10% of U.S. physicians

WHY THIS IS DIFFERENT FROM RETAIL

Payer ownership integrates risk and delivery. Optum can **steer patients to its own ASCs, bill UnitedHealthcare 17% more than rivals for the same services,** and capture risk-adjustment coding in Medicare Advantage.

In some counties Optum now controls >35% of primary care. Nationally, **15% of Americans live in counties where payers control >10% of primary care**.

A second trend: the PE-to-payer pipeline — PE firms restructure practices, then flip them to consolidators like Optum or Ascension.

Sources: Health Affairs; Medical Economics (2026); Healthcare Brew (Feb 2026); GAO-25-107450

And private equity? Why are they in the space?

Fragmented market

Most specialties are still a patchwork of small groups — easy rollup targets.

Steady demographic demand

The 65+ population keeps growing. So does Medicare Advantage.

Tech arbitrage

Small practices can't invest in AI, data, or RCM tech. PE platforms can.

Return on investment

3–7 year holds with leveraged exits. $2,987 average income decline for physicians post-acquisition.

The PE playbook: rising prices, repeated sales

PRICING EFFECTS

+11%

Average commercial price increase at Optum-acquired ASCs, per Health Affairs study (2026).

PE acquisitions of physician groups grew **600%+** between 2012 and 2021.

THE TWO-STAGE PIPELINE

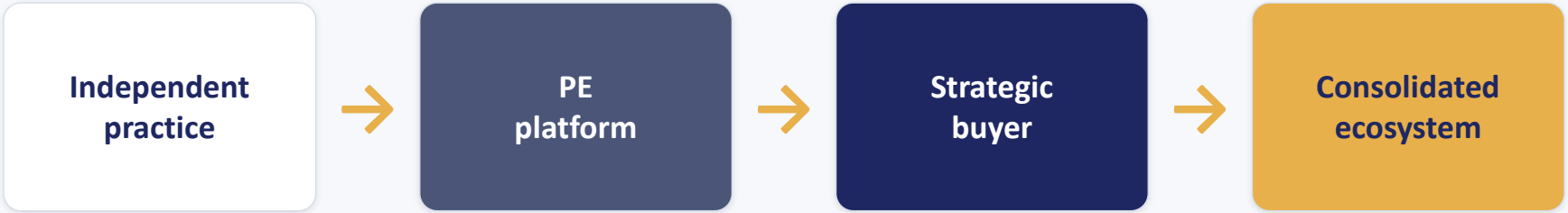
Stage 1: PE buys a fragmented specialty group, adds operational scale, raises prices.

Stage 2: 3–7 years later, PE flips the restructured platform to a strategic buyer — often a payer (Optum), health system, or larger PE rollup.

Result: *the physician who 'sold to PE' may end up working for a health insurer.*

Sources: Health Affairs; Healthcare Brew (Feb 2026); PwC US Healthcare Deals Report (Dec 2025)

Connecting the dots



Optum Health's 2024 revenue exceeded $100B. Its physician footprint is now the largest in the U.S. — ***bigger than any hospital system, bigger than any PE rollup.***

Sources: UnitedHealth Group 2024 10-K; Becker's Physician Leadership (Oct 2025)

Change Healthcare — the wake-up call

15B
healthcare transactions/yr disrupted — 1 in 3 U.S. patient records

77%
of practices reported service disruption

55%
of physicians used personal funds to cover practice expenses

$6.3B
in claims value delayed in the first 3 weeks alone

WHAT IT TAUGHT US

Consolidation creates single points of failure.
UHG bought Change; an MFA gap brought down the whole system.

Vendor diversity is not optional.
A backup clearinghouse is a survival requirement, not a nice-to-have.

Days cash on hand is a strategic metric.
Practices with <30 days cash were most at risk of closure.

Sources: AMA; AHA; HFMA running coverage; USC Price / JAMA Health Forum (2024–2026)

The 2026 Medicare Fee Schedule — a mixed signal

+2.5%

One-time congressional bump for 2026 (via One Big Beautiful Bill Act)

−2.5%

"Efficiency adjustment" applied to 7,000+ non-time-based codes (surgeries, procedures, imaging)

$33.40

2026 non-APM conversion factor (up from $32.35 in 2025)

SPECIALTY IMPACT UNDER THE FINAL RULE

- **37% of oncologists** face cuts of 10–20%
- **81% of infectious disease physicians** face cuts of 5%+
- **56% of internists** face cuts of 5%+
- **Office-based practices** get +5% PE bump; facility-based practices see −7%

Sources: CMS CY 2026 PFS Final Rule (Oct 31, 2025); AMA analysis (Nov 2025); Healthcare Dive (Nov 2025)

AI is the first tool that's actually helping

81%
of physicians now use AI professionally — up from ~38% in 2023 (AMA, 2026)

75%
of physician AI users report reduced administrative burden (Doximity, 2026)

69%
report better patient care and outcomes from AI-assisted work

2–3 hrs
documentation per hour of patient care — the primary AI target

TOP PHYSICIAN AI USE CASES (2026)

29% Ambient scribes / voice documentation

39% Literature search & standards of care

28% Chart summarization

19% Patient portal message drafting

growing Prior authorization support

growing Denial & appeal automation

A new movement: the independent resistance

The middle path is emerging

A new generation of physician-led **platforms, MSOs, and independent-preserving groups** are building alternatives to hospital employment and PE sales.

The goal: pool back-office scale and capital, keep physician ownership and clinical autonomy.

EXAMPLES

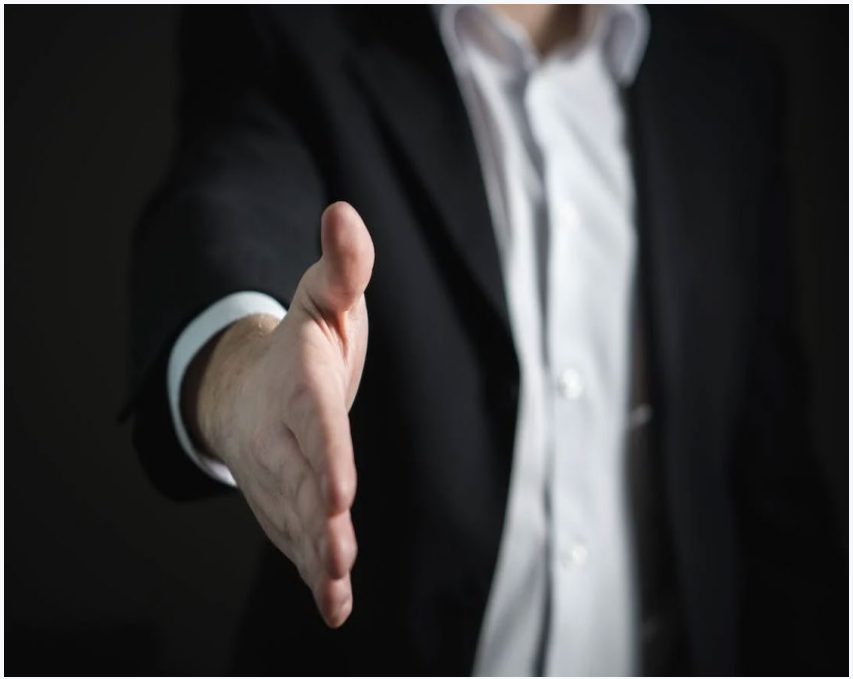
Pelto Health Partners
Physician-led MSO model to help small/mid groups stay independent.

Articularis Healthcare Group (AHG)
Clinically integrated rheumatology — explicitly free from PE, insurance, and hospital ownership.

At least 7+ other 2025 launches
Independent-preserving platforms across specialties (per Becker's, 2025).

Sources: Becker's Physician Leadership (Jul 2025); company communications

The question isn't whether to consolidate



THE QUESTION IS:

Who will be your buyer — or your partner?

Hospital. Insurer. PE. Physician-led MSO. Or strategic independence. The choice — and the terms — are still yours if you act deliberately.

PART FOUR

How do we survive?

Eight strategies — updated for the 2026 reality.

Learn and adopt value-based care

Join or build a local ACO / CIN

If one doesn't exist in your market — build it. MSSP still pays shared savings; newer REACH models offer direct contracting.

Use data analytics to find high-risk patients

You don't need a data team of 20 — but you do need a story about how you lower total cost of care.

Direct-to-employer contracting

Self-insured employers are actively seeking alternatives to traditional carriers. Bundle and compete.

Lean into specialty value-based care

Oncology (EOM), cardiology, MSK bundles — 2026 introduces mandatory specialty models from CMS for heart failure and low back pain.

Focus on technology — and embrace AI

Ambient AI scribes

The single highest-ROI investment a practice can make in 2026. Doximity: 75% of adopters report reduced admin burden.

Patient engagement & portals

Two-way messaging, self-scheduling, online intake — now baseline expectations, not differentiators.

Telehealth & RPM

Expanded permanently in 2026 PFS for hospital/SNF settings; home-based after-hours telehealth billing ended — know the rules.

AI-driven RCM & denials

Denial rates are climbing. AI claim scrubbers and automated appeal engines level the playing field against payers' AI.

Cybersecurity investment

MFA everywhere, offline backups, alternate clearinghouses, incident response plan. Change Healthcare made this mandatory.

Interoperability

Info blocking rules have teeth. Prepare for TEFCA-based exchange and more payer data demands.

Emphasize operational efficiencies

Know your top 5 denials

Simple but essential — AND what you are doing to address each. Put a physician champion on it.

Use analytics to make processes more efficient

Even basic PM system reports beat gut feeling. What are your front-end clean claim and first-pass collection rates?

Technology is shared with patients

Can they self-schedule, complete intake online, ask questions via portal, check in digitally?

Staffing ratios & top-of-license work

MAs, nurses, APPs — is everyone working to the top of their license? AI scribes free up physician time too.

Lean into consumerism — what is the patient experience?

Are your patients satisfied? Have you asked?

Not a once-a-year survey — continuous, actionable, reviewed in leadership meetings.

Do your patients want to be involved in their care?

Most do. Shared decision-making tools, visit summaries in plain English, transparent pricing.

What does the patient expect?

Convenience, price transparency, digital access. Retail set the expectation even as retail retreated.

Engagement = retention = margin

A $300 primary care visit has an acquisition cost. Keep the patient — or Optum will.

Be different — specialize and niche

When you're part of the crowd, you have to stick out

What do you do that Optum's primary care clinic down the street doesn't?

What services make you unique?

Can you capitalize on them — BETTER or CHEAPER — without sacrificing quality and profitability?

Unique certifications

Patient-Centered Medical Home, disease-specific certifications, board specialties — paid more by some payers.

Care model innovation

Direct primary care, concierge hybrids, subscription specialty, cash-pay niches — all viable for the right practice.

Be adaptive — engage and empower yourself

Stay up to date as widely as possible

Medicare payment policy, AI in medicine, payer strategy, labor trends — you can't delegate awareness.

Engage with colleagues and peers

Specialty societies, MGMA, ACMPE, local IPAs — knowledge compounds in community.

Sign up for 'news' across all facets of the industry

Becker's, Healthcare Dive, Medical Economics, Fierce Healthcare, AMA Morning Rounds. Five minutes a day.

Invest in leadership development

The practices that survive aren't the biggest — they're the best led.

Alignment — strategic partnerships

Are there others in your community who want to come together?

Merger with a peer group — still independent, but bigger. Same owner type; similar culture.

Are there physician-led MSOs or platforms you should join?

Pelto, AHG, and 7+ similar 2025 launches offer scale without selling to PE or hospitals.

Are there employers who want to work with you directly?

Direct primary care and bundled specialty arrangements are growing with self-insured employers.

Who is your biggest threat? How do you align around it?

If Optum is next door, partnering with peers may be more urgent than you think.

Build financial and operational resilience

90+ days cash on hand

Change Healthcare taught us: when a single vendor goes down, cash reserves decide who survives.

Vendor redundancy

Backup clearinghouse, alternate payment processor, documented manual fallback workflows.

Cyber insurance + incident response plan

Know who to call at 2 AM. MFA on everything. Offline backups tested quarterly.

Diversified payer mix

Avoid single-payer exposure >35% where possible. Govern Medicare Advantage contracts actively.

What about hybrid survival?

Most surviving practices will not pick one strategy

They'll combine: a base of commercial fee-for-service, a growing ACO or risk-based contract, direct-to-employer arrangements, cash-pay specialty services, and selective partnerships.

They'll invest in AI and cyber like utilities.

They'll protect cash flow and governance — the two things that determine whether you have choices or not when the letter from Optum arrives.

The hybrid practice of 2026 is intentional, data-literate, and paranoid in a healthy way.

DISCUSSION

Cam, how might this strategy look in our market?

Let's walk through your practice's specific position — consolidation exposure, payer mix, technology readiness, and resilience.

If we have time… validation of these themes

GAO-25-107450

Sept 2025 report confirms hospitals, insurers, and PE have all taken meaningful shares — and that consolidation drives higher prices with unclear quality impact.

AMA 2026 Physician AI Survey

81% of physicians now use AI professionally, up from ~38% in 2023. Use cases are shifting from novelty to workflow integration.

CMS CY2026 PFS Final Rule

Locks in efficiency adjustment; rebalances PE toward office settings. Changes the math for every specialty.

THANK YOU

Questions welcome — and encouraged.

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