PitchBook

Value-Based Care Drives Technology Opportunities

Medicare to accelerate adoption of VBC technology and payment models

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Introduction

The launch of direct contracting (DC) by the Centers for Medicare & Medicaid Services (CMS) in 2021 could accelerate adoption of value-based care (VBC) payment models. As VBC incentivizes preventive and continuous care, we believe these new payment initiatives could lead to increased investment opportunities for startups devising technologies focused on these care methodologies. While VBC is not a new concept, it has struggled to gain traction in the industry. This new DC effort could catalyze acceptance and use.

Traditionally, healthcare providers in the US are paid for services rendered, fostering a system that values quantity of services provided regardless of their quality or outcome. However, as healthcare costs continue to soar—with US healthcare spending estimated at $4.0 trillion in 2020 and forecast to reach $6.2 trillion by 2028[1]—insurers, employers, and providers increasingly recognize that fee-for-service models may not be sustainable. Using a VBC approach, providers have more skin in the game, as their earnings and losses are directly linked to the quality of care and patient outcomes. This lessens the financial risk traditionally assumed by insurers and payors, while incentivizing providers to keep costs low and treat patients well.

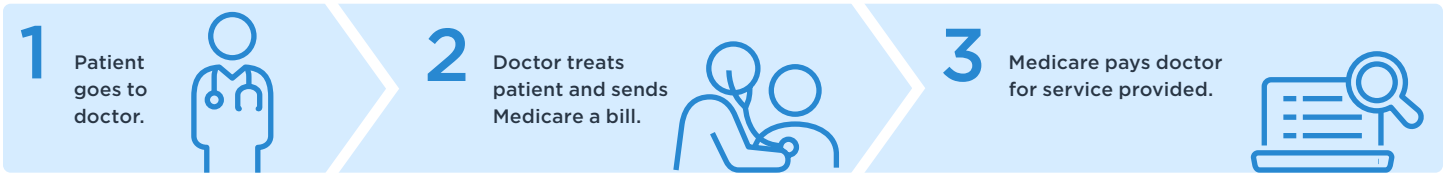
This note examines the impact VBC could have on the market for healthtech startups that could be supportive of VBC strategies.

1: "National Health Expenditure Projections, 2019–28: Expected Rebound In Prices Drives Rising Spending Growth," Health Affairs, Vol. 39, No. 4, Sean P. Keehan, et. al., March 24, 2020.

Published on March 26, 2021

Payment model diagrams

Fee for service (historical model)



Direct contracting

DC as a catalyst for VBC

The purpose and development of DC

The introduction of DC has stimulated recent discussion about and potential for uptake for VBC. To encourage providers to engage in VBC and to offset skyrocketing healthcare costs in the US, CMS has been working to develop alternative payment models. In 2015, the agency launched an Accountable Care Organization (ACO) prototype for kidney failure patients after realizing end-stage kidney disease was consuming 7% of the Medicare budget. ACOs consist of healthcare providers that convene to better coordinate the care for a patient population and assume collective responsibility for the cost of care. In recent years, hundreds of ACOs focused on care types beyond just kidney disease have emerged across the US, generating $1.2 billion in total net savings to Medicare in 2019.[2]

Leveraging best practices and lessons learned from ACOs, the CMS Innovation Center developed a Direct Contracting Entity. The payment model allows traditional providers to assume patient risk based on different risk corridors for Medicare Parts A and B providers, as shown in the accompanying figure on the next page. DC enables the creation of capitated contracts, which represent fixed, pre-arranged monthly payments to physicians, clinics, or hospitals based on treatment types and patient counts. In the traditional fee-for-service model, providers could continue billing insurance companies regardless of how often a patient receives treatment. DC sets a maximum payout for certain treatments. CMS launched the Geographic DC model at the start of 2021. If successful, this effort will task innovators with managing Medicare spend across whole regions.

2: "Performance Year 2021 Medicare Savings Program Accountable Care Organizations, The Centers for Medicare & Medicaid Services," January 11, 2021. Accessed March 16, 2021.

Medicare payment models

Source: PitchBook

Blue Rock Care

Blue Rock Care is a PCP that treats patients via home visits, telehealth, and in-person clinics. Until recently, it played in the margin, but DC enables it to take a higher-risk approach. The company plans to begin by engaging in CMS' professional risk agreement before transitioning to a global risk agreement. Blue Rock Care prides itself on its usage of state-of-the-art technology that enables the company to expand and scale. Indeed, the company is a model of the emerging healthcare technology stack, which includes patient management systems, communications portals, data analytic platforms, telehealth platforms, remote patient monitoring capabilities, and modern payments and billing technology. In addition, management views high-quality electronic medical record systems that improve collaboration among specialists, standardize workflows, and provide reporting capabilities as critical to providing VBC. Still, Blue Rock Care views itself primarily as a services company providing care, not a technology provider.

How DCs affect PCPs

Previously, some Medicare Advantage (MA) plans such as those provided by Clover Health engaged in professional and global risk agreements with primary care providers (PCPs). Under these agreements, CMS makes capitated payments to insurers, who then establish secondary capitated payment contracts, either global or professional, with the PCPs. As these stipends are pre-set based on various risk corridors or geography, PCPs make or lose money to the extent that the cost to provide care is below or above the pre-set stipend level. This effectively incentivizes VBC as providers seek to keep costs below capitation levels.

The new DC model eliminates intermediary insurers and allows PCPs to contract directly with CMS, increasing care providers' ability to control the management of patients and potentially increasing revenue opportunities to the extent that care-related costs can be kept below reimbursement amounts. Subsequently, we believe DC could further drive adoption of VBC processes. One loophole in this system is that PCPs could be on the hook for payments to other care providers should a patient choose to go elsewhere. This, however, provides another incentive for PCPs to find ways to keep patients from leaving, not just by providing good care, but also by using financial incentives such as gift cards and waiving co-pays.

CMS suited for VBC system

VBC may be a good fit for CMS given its senior-focused role in the US healthcare ecosystem. Traditional patients that are not covered by Medicare stay with a private health insurer for only five to 10 years due to changing jobs, moving, and so on. As a result, insurers are not incentivized to invest in preventive healthcare as they are less likely to be held financially responsible for expensive treatments that could occur later in the patient's life or that could have been avoided with pre-emptive measures. On the other hand, Medicare is the final provider for most seniors in the US, meaning CMS can expect to bear the burden of high-cost treatments that often afflict the elderly, for whom co-morbidities are more common. For this reason, CMS has relatively stronger incentives to implement VBC systems, which could drastically improve the agency's bottom line, while also improving the health continuum of care for seniors. As mentioned earlier, we believe DC will incentivize providers to engage in VBC and increase focus on care coordination through care delivery innovation.

Additionally, Medicare is well suited to adopt VBC because:

- It is the nation's single largest payor for healthcare; projections indicate over 80 million Medicare beneficiaries by 2030.
- Elderly tend to experience common set of illnesses.
- Medicare spending per enrollee is two to three times as costly as private health insurance comparables.
- It services a rapidly growing customer base that includes not only beneficiaries but also MA plans and Medicare-approved providers.

VBC has thus far struggled to gain traction among private insurers, but CMS often leads private insurer trends. Medicare has had a significant impact on the evolution of the healthcare industry, and it has helped shape the current payor system. For example, CMS drove the shift from cost reimbursement to the use of premiums, which led to the implementation of new payment technologies now used by private insurers. For this reason, it is likely that startups focused on enabling VBC for CMS may eventually see their market opportunity expand to include private insurers as they enter the industry over the next decade.

Market opportunity

Despite slow adoption to VBC, current market estimates suggest the VBC payment market, which is currently valued at roughly $1.5 billion in 2020, will reach about $4 billion in 2025 at a CAGR of 15%.[3] VC investors are pouring money into this rapidly developing space. With generally low startup capital requirements, companies in the industry often need to capture less than 1% of the market to provide investors with a 3x return.

3: "Value-Based Care Payment Global Market Report 2021: COVID-19 Growth and Change to 2030," The Business Research Company, January 2021.

Emerging technologies poised to benefit from VBC adoption

Implementing VBC will require providers to invest in new technologies and adopt new ways of doing business. For example, physicians must be able to identify and understand a patient's current condition and provide proactive interventions that can prevent, or at the very least, decrease the severity of downward trends and acute events. To accomplish this, physicians need better data, inference capabilities, predictive modeling, and treatment options, which generally implies the use of software, data analytics, AI & ML, and next-generation diagnostics. Startups seeking to utilize data contained in existing systems are affected by stringent Health Insurance Portability and Accountability Act (HIPAA) requirements and legacy healthcare IT providers (for example, antiquated EHR systems, internal accounting, billing, equipment/supplies status and ordering, and so on). However, new rules and advancements in data science and ML have increased data mining opportunities. We believe companies that can protect, extract, and best utilize data will experience the most success.

Several startups have joined the space with a mission of developing infrastructure designed to support PCPs transition to value-based care and risk-based models. For example, Wellvana, a tech-enabled services company, provides a suite of services including clinically integrated software, administrative and financial support, and leadership resources. As PCPs are actively being acquired into larger hospital systems, Wellvana seeks to help independent offices remain private and competitive.

In addition, patient engagement portals and dashboards, telehealth, home visits, mobile health applications, and remote patient monitoring devices can help physicians engage with and care for patients at lower costs. A few of the specific technologies poised to benefit from adoption of VBC are outlined in the remainder of this section.

Chronic illness targeted solutions

Startups that are geared toward specific issues common among Medicaid's patient population are set to benefit from VBC adoption as CMS becomes an early adopter. For example, Cricket Health and Somatus support individuals with kidney disease, a common illness among Medicare patients, through a combination of remote patient monitoring devices, in-home dialysis, and coordination with care teams over digital networks. Startups enabling at-home care are well positioned to serve immobile Medicare patients, patients that require continuous care, and nonMedicare patients in rural areas. For example, Tomorrow Health allows patients access to in-home healthcare equipment and supplies.

Care management platforms

Technology that is HIPAA complaint, ensures patient privacy, and connects care teams can drive efficiency, transparency, and cost reduction. VirtualHealth developed HELIOS, a platform that enables collaboration across the patient's entire care team.

Population health management platforms

These platforms improve preventive care by enabling organizations to analyze the physical, social, and economic conditions that may affect health. Population health technology relies on advanced analytical techniques, such as AI-based predictive analytics, powered by claims data, self-reported consumer data, electronic health records, census data, and social determinant data. Abacus Insights helps care providers curate and organize unstructured healthcare data from multiple sources to improve care analysis.

Supplemental benefits and the social determinants of health (SDoH) products

SDoH is an emerging class of "nonhealthcare-related" benefits (for example, food security, transportation to hospital, in-home support) that can have an impact one's health. The capitated payment model of DC has enabled MA advantage plans to cover SDoHs and will now permit PCP to do the same. Furthermore, several employers are now offering these benefits, further increasing market size. Unite Us, Healthify, and Signify Health assess member needs and curate networks of SDoH suppliers. ChenMed, an MA provider, connects individuals with food pantries, delivers diapers and food to immobile patients, and provides transportation to/from medical appointments.

Recent VC deals for VBC-focused companies

Company	Last financing date	Total raised ($M)	Last financing size ($M)
VillageMD	January 6, 2021	$1,316.0	$1,025.0
ZocDoc	February 11, 2021	$504.0	$150.0
Iora Health	January 31, 2020	$382.3	$126.0
Aledade	January 19, 2021	$306.7	$100.0
ConcertoCare	September 3, 2020	$163.9	N/A
Apixio	December 8, 2020	$46.9	N/A
Upward Health	March 2, 2021	$24.3	N/A

Source: PitchBook | **Geography:** Global
*As of March 23, 2021

Outlook

Over the near term, we expect Medicare will be the primary driver of VBC payment models. As it has done in the past, Medicare will likely catalyze the adoption of new technology standards within the industry, such as remote patient monitoring, telemedicine, patient management platforms, and data analytics. These technologies have the potential to reduce the cost of care and enable better, personalized treatment while still allowing fee-for-service reimbursement models. However, the urgency to decrease US healthcare costs and improve patient care is likely to drive long-term investment opportunities for VBC investors focused on this industry. While we anticipate healthcare technology to continue to be dominated by a few large players, startup exit opportunities are likely to exist via M&A and more limited IPOs. Over the long term, the VBC reimbursement model is likely to expand to private insurers, dramatically increasing the addressable opportunity for technology providers.

Appendix

Key healthcare incumbents with VC investment arms

Parent company	HQ location	Venture arm
Ascension	St. Louis	Ascension Ventures
Cleveland Clinic	Cleveland	Cleveland Clinic Ventures
Henry Ford Health System	Detroit	Henry Ford Innovations
Intermountain Healthcare	Salt Lake City	Intermountain Ventures Fund
Jefferson Health	Philadelphia	Jefferson Innovation
Johns Hopkins	Baltimore	Johns Hopkins Technology Ventures
Kaiser Permanente	Oakland, CA	Kaiser Permanente Ventures
Lafayette General Health	Lafayette, LA	Healthcare Innovation Fund
Mayo Clinic	Rochester, MN	Mayo Clinic Ventures
MemorialCare	Long Beach, CA	MemorialCare Fund
NewYork-Presbyterian	New York City	NYP Ventures
Northwell Health	New York City	Northwell Ventures
Orlando Health	Orlando	Orlando Health Ventures
OSF HealthCare	Peoria, IL	OSF Ventures
Partners HealthCare	Boston	Partners Innovation Fund
Providence	Renton, WA	Providence Ventures
Texas Medical Center	Houston	TMC Venture Fund
UnityPoint Health	West Des Moines, IA	UnityPoint Health Ventures
University Hospitals	Cleveland	UH Ventures
UPMC	Pittsburgh	UPMC Enterprises

Source: PitchBook | **Geography:** North America
*As of June 30, 2020