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Value-Based Care Industry Outlook: How It Works, Why It Has Struggled, and Why Providers Are Still Poised to Succeed

May 2024

The Bottom Line: Value-Based Care Here to Stay

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The Bottom Line

Capstone believes there is a profitable path forward for value-based care (VBC) providers despite rising cost of care, risk score pressure, over-expansion, and other recent industry turmoil. Despite mounting negative headlines, demand for VBC providers is increasing, and payors are more willing than ever before to help providers become profitable through extra quality bonuses or carve out of supplemental benefits from risk.

We believe value-based care providers will benefit from continued membership growth momentum as payors look to continue shifting enrollees into VBC full-risk arrangements to mitigate risk.

Recent Medicare Advantage reforms, namely the v28 risk model revision, will have outsized revenue headwinds on VBC providers in 2025 and 2026. However, we believe these headwinds can be mitigated through intentional geographic placement and investing in risk adjustment.

Capstone believes these developments will have implications for several notable VBC companies, including Optum, Oak St. Health, Duly Health and Care, Cano Health, and ChenMed—many of which have publicly traded debt. This deck tackles key questions about the industry, its recent troubles, and the path ahead.

Example VBC Providers

Source: Capstone analysis, Capstone outreach
Note: RAF= risk adjustment factor, MA= Medicare Advantage, VBC= value-based care

Key Value-Based Care (VBC) Questions

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- **How Does VBC Work?** Value-based care (VBC) providers receive a capitated payment– a predictable, upfront, set amount of money– from insurers and use this to provide care to allocated beneficiaries. VBC arrangements are currently most prevalent in the Medicare Advantage (MA) program.
- **How do Stakeholders Feel About VBC?** Broadly, stakeholders are supportive of VBC. Payors view the arrangements as ways to mitigate risk exposure while providers see significant revenue upside. Lawmakers are largely unaware or indifferent to risk arrangements and support VBC.
- **Why Have VBC Providers Struggled Recently?** VBC providers have struggled due to utilization volatility, high spend on supplemental benefits, and overexpansion into new geographic markets without first establishing strong provider networks.
- **How Will v28 Risk Score Reform Impact VBC?** Capstone believes most VBC providers will experience larger headwinds from the v28 risk model than MA payors, as they have a less diversified risk pool and heavy reliance on risk scores targeted by v28.
- **How Is the VBC Provider – Payor Relationship Changing?** Historically, VBC providers have had little negotiating power with payors. However, payor reliance on VBC providers and recent VBC failures have shifted this dynamic. Capstone believes high-quality VBC providers will have more leverage going forward.
- **What is VBC in Traditional Medicare?** VBC providers can also contract directly with CMS in the Traditional Medicare program through accountable care organization (ACO) models such as ACO REACH. Traditional Medicare offers a different, but growing opportunity for VBC providers.

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How Does VBC Work in Medicare Advantage?

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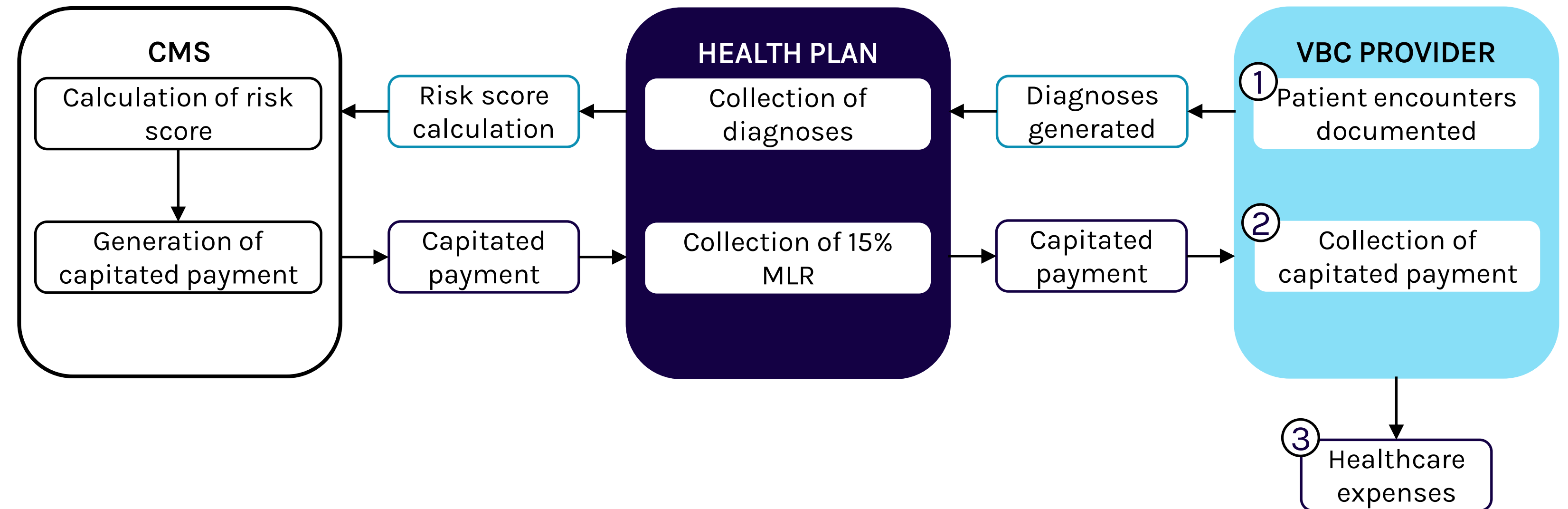
Value-based care (VBC) providers receive a capitated payment from insurers to provide care to allocated beneficiaries. VBC arrangements are currently most prevalent in the Medicare Advantage (MA) program.

VBC Overview

- Most VBC providers serve the Medicare population.
- Insurers transfer patients to VBC providers. In full-risk arrangements, they typically pass on 85% of the per member per month (PMPM) for that member to the provider. The providers then use their capitated payment to cover health costs.
  - 85% is the mandated medical loss ratio (MLR), or the minimum amount insurers must spend on patient care. Plans often retain 15% of the capitated payment because that is the maximum allowable amount.
- If healthcare costs exceed the provider's capitated payment, the provider must pay the difference. The provider keeps unused dollars if healthcare costs are below the capitated payment.
- There is no MLR for providers, meaning that in full-risk arrangements, both the upside (and downside) are far more significant.

VBC Role in the Medicare Advantage Ecosystem



① VBC providers assist with calculating risk scores by generating diagnoses via patient encounters. They are incentivized to optimize risk scores to increase capitated payments for themselves and the health plan.

② VBC providers typically receive 85% of the total capitated payment provided by CMS to the plan.

③ VBC providers use the 85% capitated payment to pay for healthcare expenditures. If expenditures exceed the amount received, the VBC provider pays the difference. If expenditures are less than 85%, it keeps the unused dollars. There is typically no cap on this upside/downside.

Source: Capstone analysis

What is VBC in Traditional Medicare?

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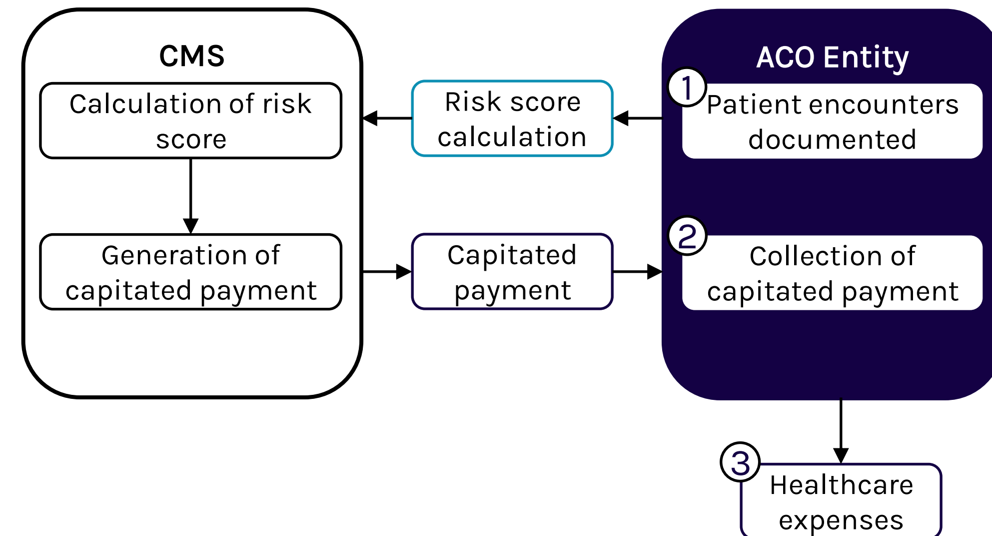
VBC providers can also contract directly with CMS in the Traditional Medicare program through accountable care organization (ACO) models such as ACO REACH. Traditional Medicare offers a growing opportunity for VBC providers.

ACO REACH Overview

- **ACO REACH Basics:** The ACO REACH program removes the Medicare Advantage middleman. VBC providers receive payments directly from the federal government in exchange for managing care in the Traditional Medicare population. ACO REACH financially incentivizes VBC providers to manage beneficiary care and prevent high acuity episodes such as hospitalizations.
- **ACO REACH Provider Risk:** VBC providers in the model receive a per-member per-month payment directly from CMS. The providers assume full upside and downside risk on that beneficiary, meaning any savings/losses generated are retained entirely by the provider. Providers must act like insurers by negotiating contracts directly with other providers in their geography. The biggest risk for ACO REACH providers is that patients end up with a provider they have no contract with, resulting in significant expenditures.
- **ACO REACH Limitations:** ACO REACH entities cannot manage care via prior authorization like in Medicare Advantage because beneficiaries in ACO REACH have not opted into the program. Put another way, MA beneficiaries opt into utilization management by choosing MA over Traditional Medicare. Beneficiaries in ACO REACH are aligned to the program based on primary care provider. This means that ACO REACH providers must tightly manage referral networks and have high patient engagement. Successful ACO REACH providers establish that patients should call them before seeking medical care of any kind.

VBC Role in the ACO REACH Ecosystem



1. VBC providers in ACO reach contract directly with CMS, cutting out an insurer in between like in Medicare Advantage. This places the onus on providers not only to diagnose conditions, but also aggregate and submit those diagnoses to CMS to accurately risk score beneficiaries.
2. VBC providers receive 100% of total capitated payment provided by CMS.
3. VBC providers use the capitated payment to pay for healthcare expenditures. If expenditures exceed the amount received, the VBC provider pays the difference. If expenditures are less than the capitated payment, it keeps the unused dollars

Source: Capstone analysis

How Do Stakeholders Feel about VBC?

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Stakeholders are supportive of VBC. Payors view the arrangements as ways to mitigate risk exposure, while providers see significant revenue upside. Lawmakers are largely unaware or indifferent to risk arrangements and support VBC.

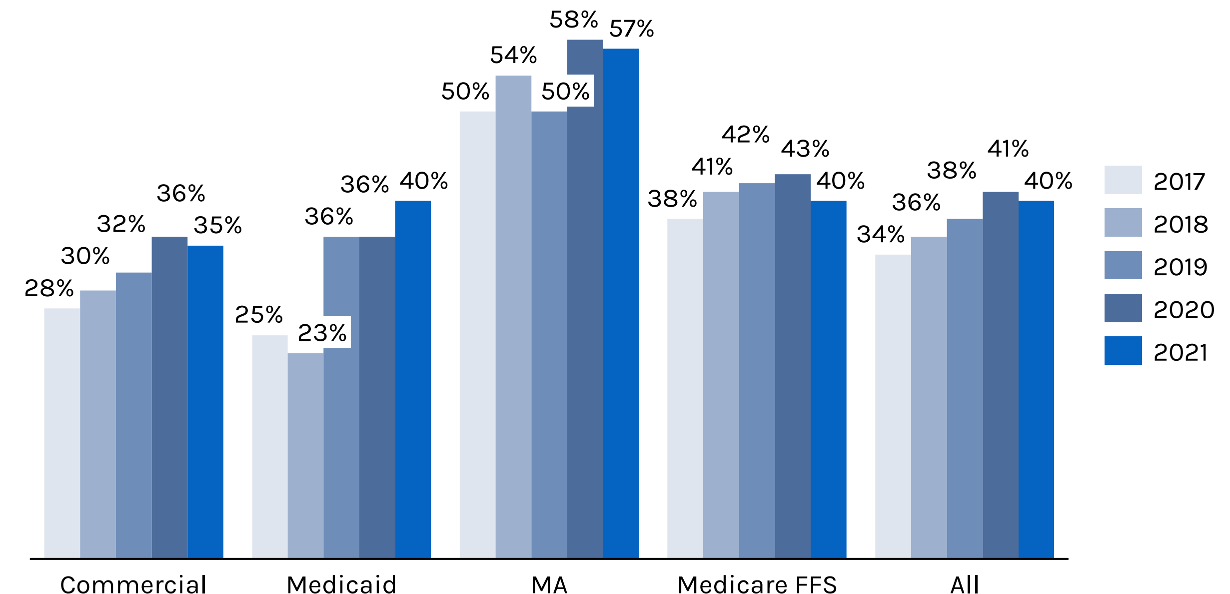
Value-Based Care

- **Payor/Provider Support for VBC:** MA payors and VBC providers view risk-bearing arrangements as advantageous for different reasons. Risk-bearing arrangements allow MA payors to retain their statutorily capped 15% of capitated payments without any exposure to risk. VBC providers, in turn, can obtain higher patient revenue by effectively managing care in full upside-downside risk models.
- **Policymaker VBC Sentiment:** Congress is still largely unaware of or indifferent to full-risk arrangements. Lawmakers generally support providers being more involved in care than insurers. Furthermore, it is widely recognized that payors are the primary drivers of increased adoption of VBC and policymakers do not want to discourage this investment, particularly with the Democratic goal of 100% of Medicare lives in VBC by 2030.
- **National Payor Sentiment**: In the VBC space, several large MA payors have either outright acquired or taken a majority stake in VBC providers. Private equity involvement in VBC also continues to grow. Given rate cuts in Medicare Advantage, valuations of VBC providers have compressed. However, attributed 'lives' are still highly valued.
- **VBC in Other Markets:** Medicare Advantage is home to the highest volume of value-based care arrangements; while more than 50% of MA lives are in some form of risk arrangement, around 10% nationally are in full-risk models. VBC penetration in MA varies significantly geographically. The popularity of VBC is rising in the ACA, Medicaid, and commercial markets. Recent Medicare Advantage reforms will likely push providers to seek value-based care arrangements in these other markets.

Lawmaker Positions For and Against VBC

For	Against
Provider involvement is preferable to payor involvement	Vertical integration allows for MLR manipulation
VBC can encourage greater care coordination	Payors operate as "middlemen" in full-risk

% of Lives in Risk-Arrangements by Payor Type*



Source: Capstone analysis, Capstone outreach
Note: * risk-arrangements can vary and do not mean full-risk

Why Have VBC Providers Struggled Recently?

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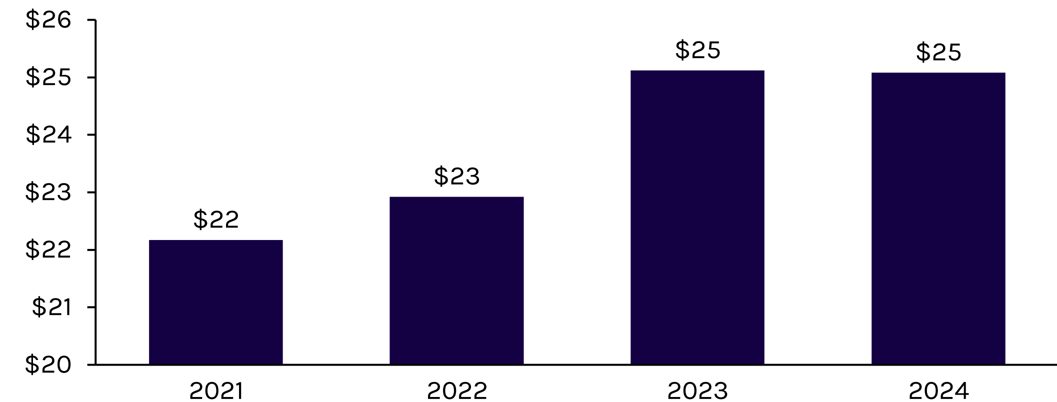
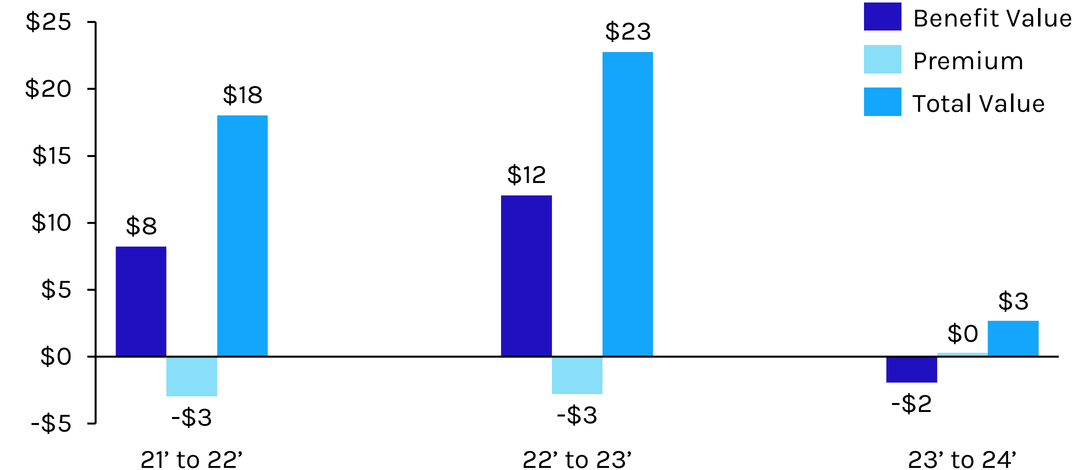
VBC providers have struggled due to utilization volatility, high spend on supplemental benefits, and overexpansion into new geographic markets without first establishing strong provider networks.

Value-Based Care Obstacles

- **VBC Headwinds:** As made public by the demise of Cano, VBC providers have struggled in recent years. Three primary factors have contributed to VBC providers' inability to remain profitable.
  - **Utilization Volatility:** VBC providers have struggled with utilization volatility without the same prior authorization and utilization management techniques in place that payors have. Utilization spikes following of COVID-19 in 2023 were particularly challenging.
  - **Geographic Expansion:** VBC providers have expanded too quickly without creating comprehensive networks and understanding population dynamics in new geographies. Geographic expansion is particularly difficult because of the importance of robust provider networks, particularly for specialty and high-cost provider types (post-acute). This overexpansion has led to profit loss and eventual retraction from those geographies.
  - **Supplemental Benefits Utilization:** VBC providers have blamed supplemental benefits such as flex cards, over-the-counter benefits, and dental coverage for high medical costs in recent months. Because benefits are set at the MA plan level, providers cannot control the actual benefits being offered but are responsible for managing spending. The rise in broker activity is partially to blame for the recent uptick in supplemental benefits spending, as is the growth in nontraditional supplemental benefits, such as gym memberships and transportation.
    - Recent reforms to MA are expected to cut supplemental benefits spending. However, plans are limited by how much they can cut benefits to avoid member whiplash. This limitation means VBC providers will likely face supplemental benefits volatility in 2025.

Medicare Advantage Supplemental Benefit Offerings





Source: Capstone analysis, Capstone outreach

How Will v28 Risk Score Reform Impact VBC?

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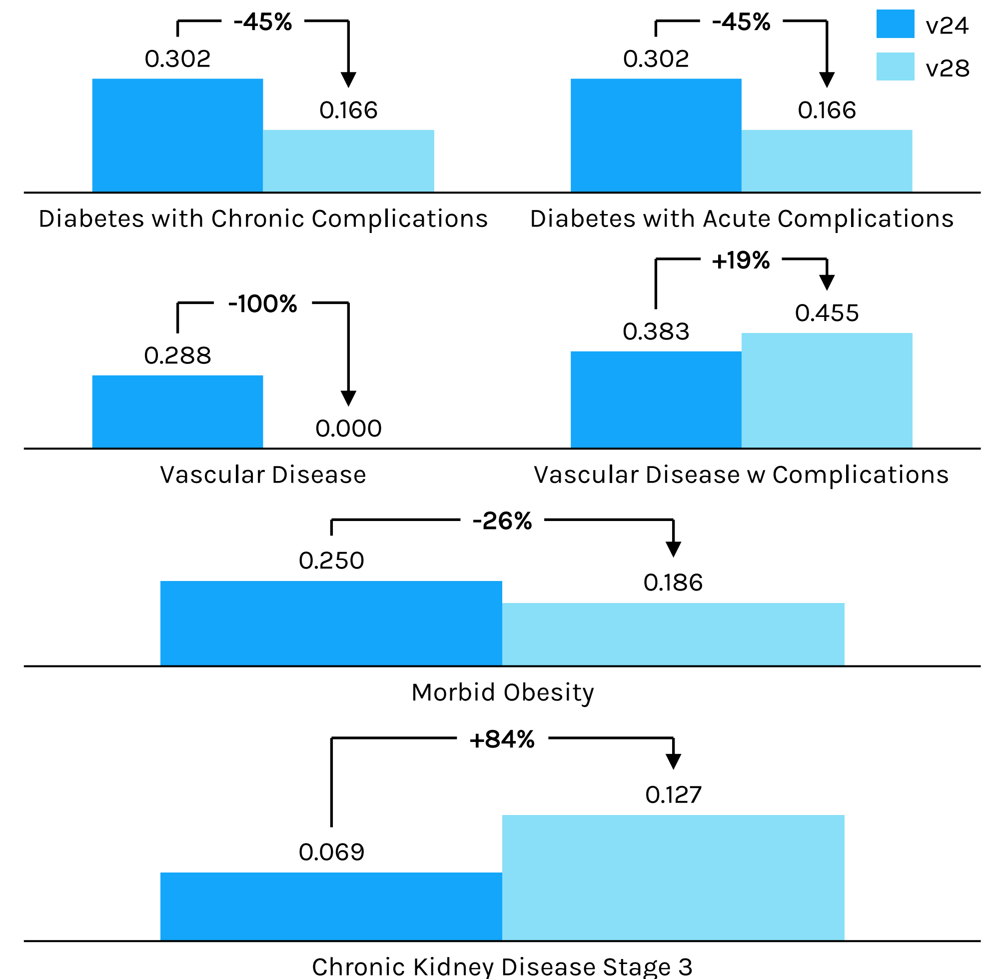
Risk Scoring in Value Based Care

- **Overall v28 Hit:** Medicare Advantage payors are expected to see overall benchmark payments decrease in 2025 because of the CY2025 Final Rate Notice. The rate notice updated overall aggregate benchmark payments to MA plans -0.16%.
- **VBC v28 Hit:** Because VBC providers typically get a set percentage of MA capitated payments (ex. 85%), they too will experience revenue declines. The v28 risk score reform is expected to have an outsized impact on VBC providers as compared to payors for a number of reasons.
  - VBC providers take only a portion of a national MA payors lives in a set geographic location (due to the VBC provider being grounded to their clinic locations).
  - Because of this, certain VBC providers can have risk pools that have an outsized reliance on one diagnostic condition vs the larger national risk pool a payor has. If the VBC's attributable population has a high prevalence of a condition that was targeted by the v28 risk model, overall sub-capitated benchmark payments to the VBC could decrease by more than -0.16%. Capstone has anecdotally heard of providers facing v28 hits ranging from 5% to 35%.
  - Conversely, VBC providers with a geographic footprint and attributable population with a prevalence of conditions boosted by the v28 risk models may see sub-capitated payments increase.
- **V28 "Losing" Conditions:** Conditions prevalent in many large VBC providers attributable to populations that are targeted by the v28 risk model are diabetes, vascular disease without complications, and morbid obesity.
- **V28 "Winning" Conditions:** Conditions that may increase benchmark payments for select specialty VBC providers are chronic heart failure and chronic kidney disease.

Conditions Prevalent in VBC, v24 RAF vs v28 RAF



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How Is the VBC Provider – Payor Relationship Changing?

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VBC providers have had little negotiating power with payors. However, payor reliance on VBC providers and recent VBC failures have shifted this dynamic. Capstone believes high-quality VBC providers will have more leverage going forward.

VBC Provider Leverage

- **How VBC Providers Help Payors:** In addition to taking on the risk associated with patient care, VBC providers help payors by 1) increasing star ratings and 2) optimizing risk scores. Recent reforms have made performance on these two factors more important as payors look to minimize headwinds.
- **VBC Star Ratings Impact:** VBC providers can increase star ratings in two ways:
  - Survey Responses: One of the major underlying data sets used to calculate star ratings is a patient experience survey known as Consumer Assessment of Healthcare Providers and Systems (CAHPs). The CAHPS survey asks questions directly related to provider-beneficiary interactions and questions asked. VBC providers can increase CAHPs performance by asking certain questions during patient encounters (for example CAHPs question: Did your provider ask you about fitness during your annual physical?")
  - Care Outcomes: Another major data set used in the calculation of star ratings is HEDIS. The HEDIS data set measures beneficiary health and outcomes in Medicare Advantage. By comprehensively managing care at the provider level, VBC providers can increase HEDIS measures.
- **Star Ratings Importance:** Star ratings performance correlates to the rebate dollars a plan receives to use on supplemental benefits, which in turn drive more enrollment as plans primarily compete with one another for MA beneficiaries through benefit offerings.
- **VBC Risk Score Impact:** Medicare Advantage payors rely on diagnoses from VBC provider interactions as the primary modality of risk scoring.
  - By accurately and comprehensively risk scoring, VBC providers can increase capitated payments to Medicare Advantage payors and themselves.

Shifting Leverage

- **Shifting Leverage:** The recent closure of many VBC providers has left payors with the realization that they need/want VBC providers to be successful. Capstone believes this newfound dynamic will increase leverage for VBC providers who are considered high-quality and assist payors with both star ratings and risk adjustment. In exchange, we believe payors will increasingly be willing to give these high-quality VBC providers new flexibilities and increased payments. We think VBC providers will primarily see relief from payors in two forms: 1) increased revenue and 2) supplemental benefit coverage.
- **Increased Revenue:** Most VBC providers in Medicare Advantage receive 85% of the MA payor's capitated payment because that is the amount required to fulfill the payor's medical loss ratio (MLR). Capstone believes payors will be willing to give more than 85% in the coming years if it guarantees the profitability of VBC providers and, therefore, ensures payors will continue to be able to offset risk to such providers. Anecdotally, we have heard of payors being willing to offer 86%-87% on the base payment. Alternatively, we have also heard of payors being willing to engage in quality bonuses where VBC providers can qualify for a 3%-4% bonus at the end of the year, pending patient experience and outcome measures.
- **Supplemental Benefits Coverage:** One of the primary headwinds cited by VBC providers in 2023 was a significant uptick in utilization of supplemental benefits, primarily flex cards and over-the-counter (OTC) spending. Capstone believes payors will increasingly cover the cost of these benefits, essentially carving out this risk from the VBC providers. Flex cards, OTC benefits, and dental benefits appear to be the most likely to be carved out from VBC provider arrangements near-term.

Source: Capstone analysis, Capstone outreach

Note: CAHPS= Consumer Assessment of Healthcare Providers and Systems

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