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Healthcare Practice

Investing in the new era of value-based care

Recent trends appear to make a case for investing in value-based care. Here's why value-based models now show both the potential and propensity for growth.

by Zahy Abou-Atme, Rob Alterman, Gunjan Khanna, and Edward Levine

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Value-based care has evolved into a healthcare landscape of its own, with a wide range of organizations contributing to systematic changes that improve quality of care and outcomes while better controlling costs. Providers specializing in value-based care have become attractive to investors because of the distinctive quality of care that they can provide and the investable opportunity they present, with a diversity of risk levels and business models. By building on a decade of increasing value-based payment adoption—combined with enhanced value-based capabilities across payers, providers, employers, and other healthcare stakeholders—continued traction in the value-based care market could lead to a valuation of $1 trillion in enterprise value for payers, providers, and investors.[1]

Value-based care is emerging as a distinct healthcare landscape

Stakeholders in the healthcare community define value-based care differently. The Health Care Payment Learning and Action Network (LAN) includes performance, reporting, and even infrastructure in its first step of value-based care, while others note that these models fall short of delivering value (in quality or affordability) because they don't remedy the problems of fee-for-service healthcare.[2]

In this article, we take a more expansive definition of the value-based care landscape and include all care models that align provider incentives to quality or care cost-reduction. Though we recognize that improvements in care quality will vary considerably across models, based on our experience working with a wide range of providers, we assume savings ranges from a low of 3 percent in more limited quality-based models to a high of 20 percent in high-touch primary care groups taking fully capitated risk on Medicare Advantage members.

Value-based care investment quadrupled during the pandemic

Private capital inflows to value-based care companies increased more than fourfold from 2019 to 2021, while new hospital construction—a proxy for investment in legacy-care delivery models—held flat. While these are distinct forms of investment—with private equity seeking returns on enterprise value and construction debt funding seeking safer opportunities for more modest returns—it's noteworthy that private-capital inflows in value-based care assets rose from 6 percent of the capital investment in hospitals to nearly 30 percent within two years, as illustrated in Exhibit 1.[3]

Growth in valued-based care has accelerated from creating approximately $500 billion in enterprise value today and may be on track to reach $1 trillion as the landscape matures.

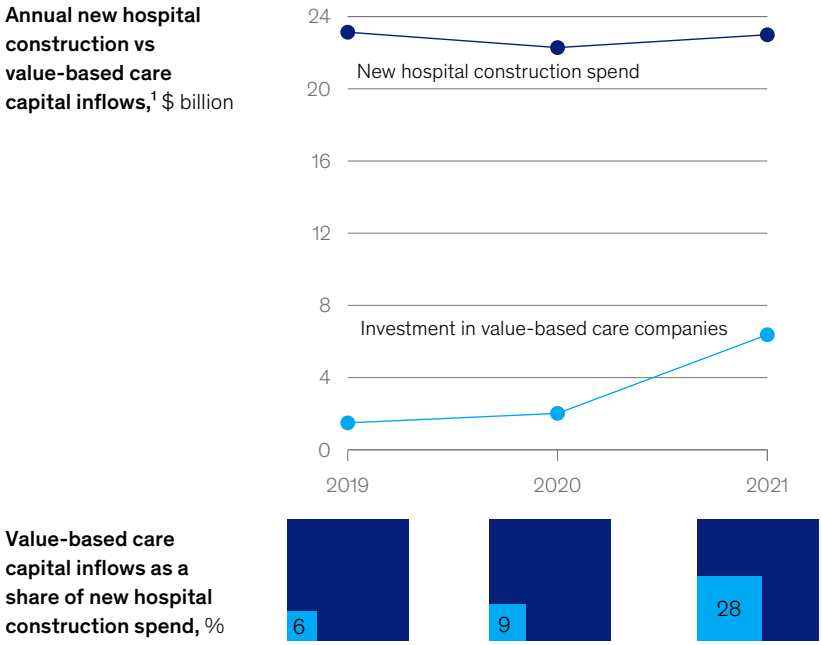
[1] Assumes approximately 160 million lives in value-based care models, accounting for $1.6 trillion to $1.7 trillion in medical spending, with medical cost savings ranging from 3–20 percent based on level of risk, of which 50 percent is realized as profit margin with a 12-fold to 15-fold valuation multiple applied.

[2] "Why 'pay for performance' hasn't worked," Center for Healthcare Quality & Payment Reform, accessed December 2022; David Raths, "Current, ex-MedPAC chairs ask: Is value-based care juice worth the squeeze?," Healthcare Innovation, October 1, 2020.

[3] PitchBook private equity and venture capital transaction data, accessed in spring 2022; McKinsey value-based care expertise.

Exhibit 1

Value-based care investment inflows have grown faster than capital expenditures on new hospital construction.



[1]Annual, not net of realized investments.
Source: Dodge Data and Analytics; PitchBook; McKinsey analysis

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The future potential of value-based care

Given the momentum we see behind value-based care investment, it's worth examining recent trends to understand the ways in which this landscape could potentially evolve. In imagining the value-based care landscape five years from now, the following scenarios seem possible—and not at all mutually exclusive:

Scenario 1: Value-based care growth will continue to accelerate

Growth in valued-based care has accelerated from creating approximately $500 billion in enterprise value today and may be on track to reach $1 trillion as the landscape matures (see Exhibit 2 and sidebar, "Our approach to estimating this $1 trillion opportunity"). Based on our research, this would likely be driven by a rising number of lives in all value-based care arrangements of 10–15 percent, with growth rates for lives in full or partially capitated contracts well above that (potentially 20–30 percent). Improved medical-cost-management performance from providers in value-based contracts—becoming more critical in the face of potential increases in medical-cost inflation[4]—could further support enterprise value creation, and the cumulative impact of these tailwinds may suggest positive downstream effects on patient health outcomes as well. In fact, some of the largest value-based care performance reviews have found that they correspond to improved outcomes, increased preventative care, and improved patient satisfaction.[5]

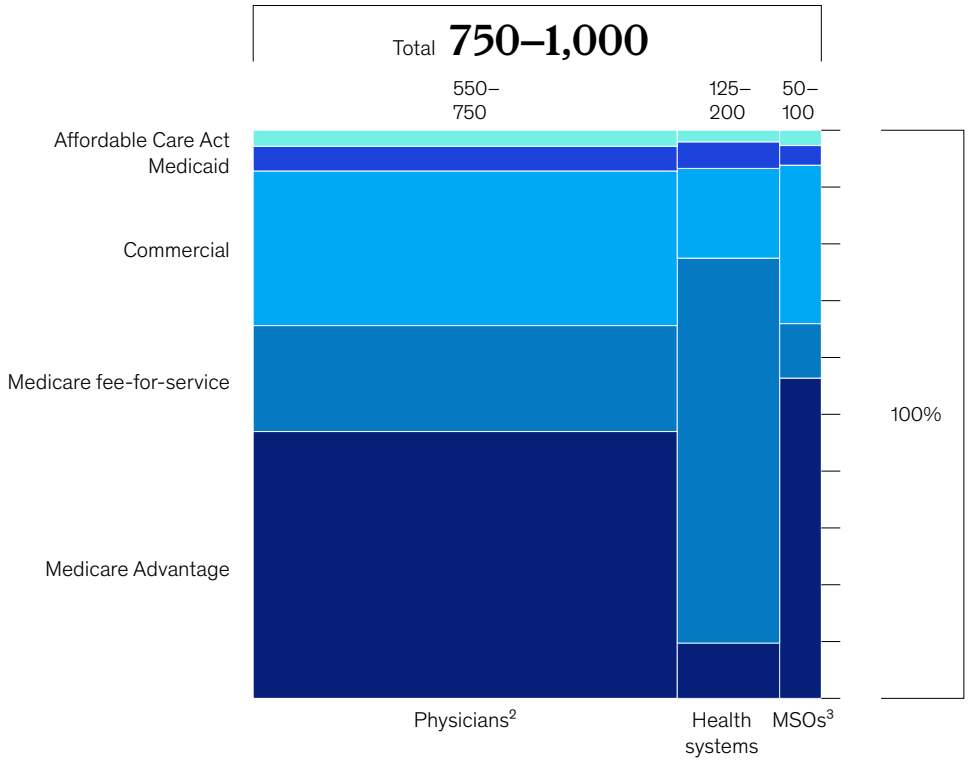
[4] Addie Fleron, Aneesh Krishna, and Shubham Singhal, "The gathering storm: The transformative impact of inflation on the healthcare sector," McKinsey, September 19, 2022.

[5] *Value-based care report: Physician progress and patient outcomes based on calendar year 2020 data*, Humana, 2021; "Physicians provide higher quality care under set monthly payments instead of being paid per service, UnitedHealth Group study shows," UnitedHealth Group, August 11, 2020.

Exhibit 2

Total valuations of value-based care assets could reach $1 trillion.

2027 enterprise value of the margin from value-based care adoption,[1] $ billion



[1]Assumes ~160 million lives in value-based care models accounting for $1.6 trillion–1.7 trillion in medical spending, with medical-cost savings ranging from 3–20% based on level of risk, of which 50% is realized as profit margin with a 12–15× valuation multiple applied.
[2]Primary care providers and specialty providers.
[3]Management services organizations and technology.

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Our approach to estimating this $1 trillion opportunity

To arrive at the $1 trillion enterprise value estimate, consider the following:

- Approximately 160 million total lives are in value-based care. According to McKinsey analysis, this represents an aggregated and triangulated view that draws on payer financial statements, publications, and press releases; Centers for Medicare & Medicaid Services data for Medicare and Medicaid; state regulatory agency publications; and extended discussions with internal and external healthcare leaders.
- There is a total medical spend for these lives at approximately $1.6–1.7 trillion, based on national spending levels.[1]
- There is 3–20 percent savings of medical spend, varying across lines of business and value-based payment models, our analysis found.
- There is a valuation of 12-fold to 15-fold on earnings before interest, taxes, depreciation, and amortization (EBITDA) applied to a 50 percent assumed margin on the generated savings, assuming the other 50 percent is required operational expenses for the provider to deliver the incremental services and preventative care necessary to realize these aggregate savings, according to our analysis. Review of public research and industry perspectives[2] suggests that valuations can vary widely based on secular and asset-specific factors but are often 12-fold to 15-fold EBITDA for at-scale physician platforms. We therefore assume this range in this analysis.

[1] Per member, per year spend calculations are from Centers for Medicare & Medicaid Services and commercial claims data sets (namely Truven).
[2] Sarah Pringle, "Skin in the game: OMERS readies sale of Forefront Dermatology," *PE Hub*, June 30, 2021; Claire Rychlewski, "How much is your doctor worth? Investors are trying to decide," *Forbes*, January 10, 2020.

Scenario 2: A handful of national platforms could take the lead, with sharp competition among them

Platforms could include integrated primary care, managed-services organizations (MSOs), and specialty-based care. While vertical integration may accelerate, these platforms may not necessarily be "walled garden" silos: a degree of collaborative interoperability will likely be necessary, potentially enabled by platforms specializing in a variety of patient populations.

Scenario 3: Distinctive operational capabilities could become prerequisites for successful value-based care providers

Distinctive operational, clinical, and analytical capabilities could increasingly become prerequisites for successful value-based care providers. These capabilities could range from new technology to the prediction of membership changes and points in between.

Scenario 4: Specialists may begin to adopt value-based care

Specialists appear to accelerate adoption of value-based care models as part of increasingly effective and scalable value-based care platforms. These models are already emerging in specialties like nephrology and oncology.

Scenario 1: Value-based care growth will continue to accelerate

In our experience, adoption of value-based care has accelerated in recent years, and this trend could continue in the coming years as payers, employers, and the government embrace these models.[6] For example, last year the Center for Medicare and Medicaid Innovation issued an ambitious goal to shift 100 percent of Medicare beneficiaries into an accountable-care relationship by 2030,[7] which we recently analyzed.[8]

Ultimately, our research suggests that the number of patients treated by physicians within the value-based care landscape could roughly double in the next five years, growing approximately 15 percent per annum.

Increased physician appetite for value-based models lies at the heart of this acceleration, but within the national community of one million licensed (if not necessarily working) physicians,[9] value-based care adoption remains uneven. Not all primary care providers find value-based models readily accessible, and in our experience, pockets of the market (notably those at institutions that focus on quaternary care rather than primary care) lag behind in adoption. Such physicians, particularly those affiliated with more academically oriented institutions, may require more peer-reviewed research (lacking today) before altering their practice models.[10] Nevertheless, some recent data suggest that the number of patients aligned with a primary care provider in a value-based care arrangement is increasing—and the associated outcomes are better than those in fee-for-service arrangements.[11]

These successes could power further growth, as physicians taking note of improved outcomes and other benefits become more interested in adopting value-based models. Growth could become disproportionately driven by the adoption of meaningful risk (full and partial cap) as these models mature. Our research suggests that the upward trend in the number of people receiving care in value-based models should continue across lines of business (Exhibit 3). This is one of the primary factors powering the growth in enterprise value associated with the value-based care landscape, potentially leading to a $1 trillion cumulative valuation.

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6 The McKinsey value-based care market model includes insights from more than 50 expert interviews, published third-party data (for example, payer value-based care reporting, payer financial filings), and publicly available data from government sources (Centers for Medicare & Medicaid Services, California Department of Managed Healthcare).

7 *Driving health system transformation: A strategy for the CMS Innovation Center's second decade*, Centers for Medicare & Medicaid Services, October 2021.

8 Zahy Abou-Atme, Stephanie Carlton, and Isaac Swaiman, "Looking ahead to the next decade of accountability for care delivery," McKinsey, November 9, 2022.

9 Katie Arnhart et al., "FSMB census of licensed physicians in the United States, 2020," *Journal of Medical Regulation*, July 2021, Volume 107, Issue 2.

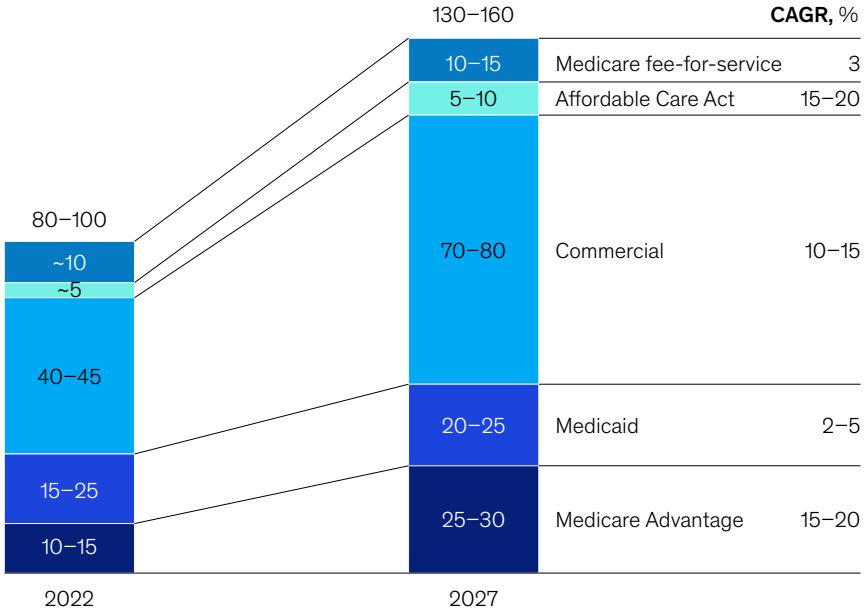
10 Yomi Ajao and Andrew M. Snyder, "Making value-based care more attractive to AMCs," *Academic Health Focus*, The Governance Institute, August 2021; Meg Bryant, "Academic medical centers face headwinds in shift to value-based care, Moody's says," Healthcare Dive, April 1, 2019.

11 *Value-based care report*, 2021.

Exhibit 3

Value-based care models are expected to grow across all lines of business.

Lives in all value-based care models,[1] million lives



[1]Includes pay-for-performance or quality to full capitation.

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Scenario 2: A handful of national platforms could take the lead, with sharp competition among them

A look at mature markets across the country may shed some light on where the risk-bearing provider market is heading. In Southern California, where health maintenance organization (HMO) approaches using independent physician associations and employed risk-bearing providers have been around for two decades, a consolidation of lives over the past five years has been driven by acquisitions, attractive offers to physicians, and member behaviors (Exhibit 4). Southern California may be unique in its value-based care adoption, but as more emergent markets in Florida and elsewhere catch up, their providers have displayed a similar acquisition strategy.[12]

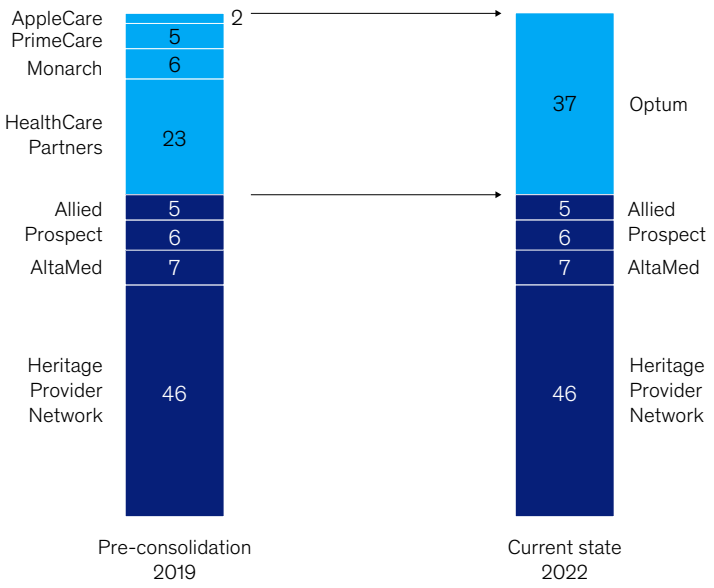
Based on data from Definitive Healthcare and the California Department of Managed Health Care, we estimate that 90 percent of Southern California's commercial and Medicare lives are in value-based contracts, as well as nearly 50 percent of its Medicaid lives, making this one of the more mature markets nationally.

[12] "Cano Health acquires University Health Care for $600 million and increases 2021 adjusted EBITDA guidance to over $100 Million," Cano Health, June 14, 2021; "Cano Health acquires Doctor's Medical Center for $300 million and updates guidance for 2021 and 2022," Cano Health, July 7, 2021; "Oak Street Health acquires virtual specialty care provider RubiconMD," Oak Street Health, October 21, 2021.

Exhibit 4

Consolidation of management services organization networks has accelerated in Southern California.

Risk-bearing provider consolidation in Southern California, % share



Source: Definitive Healthcare

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In the next five years, mature markets such as Florida and California will likely see increased competition among provider groups to further improve performance via more operationally and clinically complex levers. Successful providers will likely establish a strong presence with payers looking to delegate their growing memberships.

We have taken an expansive definition of value-based care in this article and included pay-for-quality, pay-for-performance, and similar models. Our experience suggests that private investment has focused on assets that take material financial risk on medical-cost management. This typically includes different types of physician groups, MSOs, independent physician associations, or other care delivery models, but has largely excluded hospitals and health systems in primarily pay-for-performance or pay-for-quality models. Through that lens, we observe investor interest primarily concentrated in three types:

— *Risk-bearing primary care groups* enter value-based care contracts with payers with an aim to take over the accountable care within capitated payments, either on professional and physician services or on a member's entire cost of care. In our experience, these providers often offer a higher-touch care model for a smaller patient panel than is typically seen in fee-for-service primary care. They spend more time with a smaller panel of patients than their fee-for-service peers, and they focus extensively on preventive care, condition management, and addressing patients' social determinants of health. The past two to three years have seen a rise of at-scale risk-bearing groups with high valuations. They offer a proven investment rationale for sponsors—recent corrections in public valuations notwithstanding—with clear levers for growth, operational improvement, and multiple exit opportunities.

— *Value-based care MSOs* have developed a compelling value proposition for independent primary- and specialty-care groups by facilitating the transition to risk through a combination of off-the-shelf tools and accompanying wraparound services, including payer contracting and practice transformation support. Successful MSOs can gain rapid scale when entering a new market, aggregating physicians and payer membership and quickly standing up risk-bearing entities or accountable-care organizations to take collective risk.

— *Risk-bearing specialty groups,* while currently less prevalent than their primary care counterparts, are increasingly carving out medical-cost risk in value-based models tied to their specific procedures and conditions. Adoption varies considerably across specialties: orthopedics and nephrology were among the earliest adopters, and traction is emerging in cardiology (more on nephrology below). These groups can ultimately participate in a wide range of risk models, from episodic bundles to specialist subcapitation models that offer an analogue for global or population-level risk.

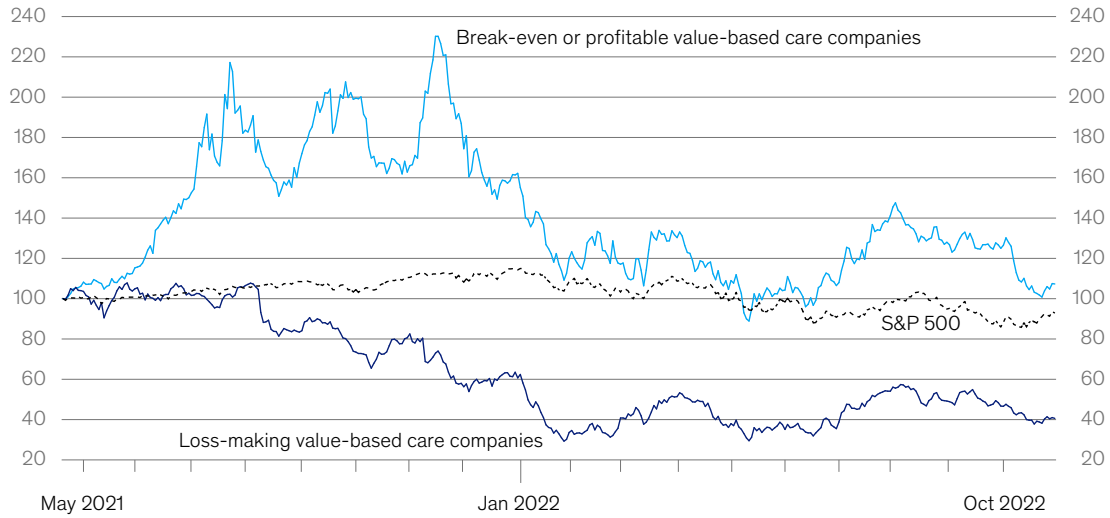
Scenario 3: Distinctive operational capabilities could become prerequisites for successful value-based care providers

As the market for value-based care providers has matured, public markets have driven market capitalization down substantially relative to the S&P 500 index, but with better results for those companies that have proven the ability to at least break even. Exhibit 5 shows trends over time.

Exhibit 5

Trends in the valuation spread between high and low performers in value-based care emerged as the market for these companies matured.

Stock prices of public value-based care players vs S&P 500, index (April 2021 = 100)



Source: S&P Global

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Scrutiny may rise as investors become increasingly discerning about providers' operational sophistication; providers that realize material savings will likely have clear and comprehensive clinical pathways that cover their members' needs and a well-disciplined clinical staff immersed in a common approach to care delivery supported by analytical insights. Training clinicians in these models often takes time, which can influence the balance between the growth and operational performance of value-based care organizations. Further, the operational foresight necessary to weather a pandemic or other force majeures is expected to become increasingly important.

That said, market watchers might reasonably propose an array of factors that make this analysis imperfect—rebounding utilization in the third year of the COVID-19 pandemic, market volatility from interest rate changes and attendant investor speculation, and public market skepticism of special-purpose acquisition company valuations chief among them. The divergence in enterprise valuations may create consolidation opportunities that accelerate the emergence of the national platforms relevant to investors, as detailed above.

With a variety of value-based care platforms, dormant value may be achieved from foundational "blocking and tackling" in analytics applications. In our view, predictive and truly advanced analytics, including artificial intelligence and machine learning,[13] hold substantial promise, but they may not be prerequisites for success in medical-cost management. This reflects both the complexity of the data and the enormity of the analytics challenge—past efforts to predict utilization (particularly emergency department and hospital inpatient utilization) have yielded few actionable insights. But there may be other opportunities for the application of value-additive advanced analytics[14] in predicting membership changes; providers may succeed in identifying drivers of patient churn and apply these to their own data on a forward-looking basis, developing mitigating interventions accordingly.[15]

The path to value creation is likely to rest on analytics, standardized clinical practices and operational workflows, and a package of member and physician services designed to reduce medical costs by avoiding unnecessary (or unnecessarily high-cost) practices. From our experience working with value-based care providers, mature markets may be entering a transition in which the low-hanging fruit in operational and clinical performance improvement has largely been picked, as evidenced by the publicly reported performance of provider groups (Exhibit 6).[16] This next wave of impact requires material capability building; many providers have already begun investing.

Scenario 4: Specialists may begin to adopt value-based care

Value-based care models have grown more intermittently among specialists than they have among primary care providers in recent years.[17] Across specialties, there has been a fundamental shift away from a predominantly utilization-management approach to specialty spend to one that aims to use analytics, care coordination, provider integration, and patient engagement to address avoidable spend more holistically. Two main models seem to be emerging:

— The *subcapitation model* has been focused on specialties with high value at stake, predictable condition incidence, and clear value-creation levers under specialist control (for example, oncology care pathway choice, initiation of dialysis). In these models, specialty-specific

[13] Solveigh Hieronimus, Jonathan Jenkins, and Angela Spatharou, "Transforming healthcare with AI: The impact on the workforce and organizations," McKinsey, March 10, 2020.
[14] Ankur Agrawal, Karl Kellner, Jay Krishnan, and Prashanth Reddy, "How healthcare services and technology companies can boost productivity with data and analytics," McKinsey, January 29, 2021.
[15] Scott Dresden et al., "Predicting avoidable emergency department visits using the NHAMCS dataset." *AMIA Annual Symposium Proceedings Archive*, May 23, 2022.
[16] "Investor & Analyst Day Presentation," Cano Health, March 4, 2021; Marlow Hernandez, "Redefining primary care to transform healthcare," Cano Health, 2022 Investor Day presentation, June 7, 2022; "J.P. Morgan 2022 Virtual Healthcare Conference," CareMax, January 13, 2022.
[17] "How providers can best confront the reality of value-based care," McKinsey, April 17, 2019.

Exhibit 6

Successful value-based care providers will increasingly need to look into more innovative levers to maintain value.

Sources of value for successful value-based care providers, and total cost-of-care savings, Medicare Advantage example, %

Low-hanging fruit
3–8

- Improve risk-coding accuracy to capture health status
- Reduce out-migration of in-network care to out-of-network providers
- Improve adherence of referrals to high-quality providers

The harder stuff
3–6

- Predict health risk status
- Manage use and mix of diagnostic testing, drugs for pharmacy, and procedures (surgical vs noninvasive)
- Reduce variable costs within specialties, and collaborate on scheduling and comanagement to increase patient access
- Shift to lower cost, efficient sites of care: select discharges from senior nursing facility to home, outpatient surgery to ambulatory surgery center, low-acuity medical admits to observation, emergency department visits to primary care physician
- Improve performance on Healthcare Effectiveness Data and Information Set, Centers for Medicare & Medicaid Services Star ratings measures, and in commercial-quality programs

Future innovations
3–5

- Leverage digital twin capabilities to identify required interventions to tackle future health issues
- Reduce preventable injuries, falls, etc, at home using remote patient-monitoring
- Reduce preventable exacerbations
- Reduce potentially avoidable hospital readmissions
- Reduce medically unnecessary inpatient admissions from emergency department

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spend is delegated to the risk-bearing entity, usually a benefit-management/care-management platform or a provider network. Either the payer or a primary care risk group can delegate this spend. Oncology, for example, has seen increased penetration of these models,[18] especially in markets where the presence of primary care risk delegation is high, with the risk-bearers generating medical cost savings mainly through the close management of specialty drug spend and the redirection of infusion to the highest-value clinically appropriate site of care.

— *Episode-based model* adoption is higher among specialties with a higher prevalence of expensive, clearly defined episodes. Orthopedics, with its high-cost, highly "episodic" joint-replacement procedures, is perhaps the most notable example,[19] but there is growing adoption in women's health (for end-to-end maternity journeys), cardiology, and oncology.

Nephrology has seen the most accelerated adoption of value-based care models in recent years, supported by Centers for Medicare & Medicaid Services programs and rules (for example, coverage of end-stage renal disease [ESRD], launch of Kidney Care Choices), but this has occurred through structures that more closely resemble those of primary care. In emerging nephrology models, risk-bearers assume the risks for the total cost of care (versus specialty-spend only) for members with chronic kidney disease or ESRD.[20] Current reimbursement

[18] "COA letter to CMS and CMMI requesting extension of OCM," Community Oncology Alliance, November 15, 2021; "Investor Presentation," Oncology Institute of Hope and Innovation, November 2022.
[19] *CMS Comprehensive Care for Joint Replacement Model: Performance year 4 evaluation report - Fourth annual report*, Lewin Group, September 2021.
[20] Gaurav Jain and Daniel E. Weiner, "Value-based care in nephrology: The Kidney Care Choices model and other reforms," *Kidney360*, October 2021, Volume 2, Issue 10.

rates, cost-savings potential, and multiyear ownership of the patient journey make the model economically and operationally viable for nephrology. These value-based models are in relatively early stages of development, but we observe that nephrology providers adopting them report substantial reductions in hospital admissions, readmissions, and dialysis crashes, as well as widespread adoption of in-home dialysis, both improving outcomes and reducing the cost of care delivery. There are other specialties (for example, oncology and some segments of cardiology) for which the economics could be similarly feasible.

Overall, diverse risk-sharing models continue to grow in specialty care. Exhibit 7 lists some of our expectations by specialty. Episodic and condition-based capitation models should thrive as they continue to propel improved medical cost performance, as should specialty subcapitation models. Enabling and accelerating this trend, specialty provider MSOs are developing (or integrating with) specialty benefit-management solutions to take on more population-level risk. Investors could capture this value by acquiring practices, MSOs, or both. In each scenario, strong secular growth tailwinds across most geographies may bolster the investment thesis.

Exhibit 7

Value-based care adoption is highest in primary care but other specialties see meaningful and growing traction.

Value-based care (VBC) adoption by medical specialty,[1] nonexhaustive

HIGH ADOPTION ◄——————————————————► LOW ADOPTION

Specialty	**Primary care**	**Nephrology**	**Oncology**	**Orthopedics**	**Women's health**	**Cardio-vascular**	**Behavioral health**
Description	Enables primary care to act as the "quarterback" and take full responsibility for patient health	Enables nephrologists to succeed in CMS[4] and MA VBC[5] focused on reducing CKD/ESRD[6] costs	Enables oncologists to prescribe an appropriate drug for the patient while maximizing practice margin from prescription	Large spend area with significant employer focus and increase in penetration of episodes	Pregnancy episodes particularly in Medicaid and increasingly commercial	Large spend area, particularly in MA, driving high inpatient and emergency department utilization; site-of-care shift for procedures	Episode-based models for facilities with more innovative approaches involving PCPs on integration of BH[8]/physical health
Applicable CMMI model	Primary care first, MSSP,[2] ACO REACH[3]	Kidney care choices, ESRD treatment choices	Oncology care model, enhancing oncology model	Comprehensive care for joint replacement, BPCI[7]	n/a	BPCI	n/a

[1]Proportion of money in specialty at risk. [2]Medicare Shared Savings Program. [3]Accountable care organization Realizing Equity, Access, and Community Health (REACH) model. [4]Centers for Medicare & Medicaid Services. [5]Medicare Advantage value-based care. [6]Chronic kidney disease/end-stage renal disease. [7]Bundled Payments for Care Improvement initiative. [8]Behavioral health.
Source: Centers for Medicare & Medicaid Services Alternative Payment Models program data; expert interviews and discussions with payer and provider senior executives

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Investors may continue to look to value-based care for strong growth. With double-digit growth in the penetration of value-based care models, value-based care could continue to present a strong investment thesis—the "$1 trillion prize" in enterprise value that McKinsey described almost ten years ago.[21]

These models hint at the possibility that by incentivizing improved patient outcomes and healthcare equity, value-based care players across the value chain (and the sponsors who back them) could continue to make gains. Competition will likely require operational effectiveness and differentiation, but whatever the approach may be, value-based care is a reality[22] with potential benefits for everyone from patients to clinicians to investors.

[21] Tom Latkovic, "Claiming the $1 trillion prize in US health care," McKinsey, September 1, 2013.
[22] "How providers can best confront the reality of value-based care," McKinsey, April 17, 2019.

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