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A Perspective on Key Trends Related to Virtual and Value-Based Care:

A Financial Perspective on Key Industry Trends

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Key Takeaways

A Perspective on Key Trends and Practical Realities Related to Value-Based Care

Virtual Care

- While aspects of COVID-related policies have not endured, COVID was nevertheless a catalyst for accelerating change within healthcare. For example, adoption of virtual care was meaningfully accelerated by COVID and this macro discussion of the right role and structure for virtual care is expected to continue.
- Virtual care presents significant potential benefits in the context of value-based care – reduced brick-and-mortar cost, avoidance of unnecessary hospital visit cost, more efficient & scalable labor models, etc.
- A key focus will be determining how to reimburse virtual care. Where will virtual care utilization and virtual reimbursement land in the context of these potential benefits weighed against inherent market inertia and resistance to change? Will payers stifle adoption of virtual care by reducing reimbursement for virtual care services commensurate with the lower direct cost of such care? Or will payers seek to incentivize virtual care adoption through favorable reimbursement structures in order to achieve potential ancillary, total cost of care cost reduction benefits of effective virtual care?

Hospital Adoption of Value-Based Care

- The migration from fee-for-service to value-based care is cumbersome for health systems and can require an overhaul of entrenched legacy strategies, operating models, and brick-and-mortar infrastructure.
- That being said, the migration from fee-for-service to value-based care within health systems is expected to continue forward. Health systems that do not retool their businesses for value-based care will, over time, be outcompeted or forced by payers to adopt value-based care.
- Highmark went from 70% fee-for-service and 30% value-based revenue in 2018 to 60% value-based revenue and 40% fee-for-service revenue in 2023.

Attributes of The Right Model for the Future of Value-Based Care

- Structural:
    - The market will continue to favor large, scaled platforms.
    - The market will increasingly favor diversified care providers versus single-specialty.
    - The market will favor integrated payer / provider platforms such as those that are being developed by CVS and UHC/Optum.
    - The market will continue to reward outpatient and virtual care.
    - Businesses that rely exclusively on heavy fixed asset, inpatient strategies will come under increasing pressure.
- **Health systems:** Closed or narrow networks will be required in some form if value-based care is going to proliferate across a broader portion of the health system market.
- Narrow networks will be supportive to controlling cost, care coordination across provider types, digital information transfer, etc.
    - Closed network example: Kaiser
    - Narrow network offering example: Highmark / Allegheny Health System offers a narrow network option, as well as a broad network option to its patient members. The narrow network option comes with a lower premiums for patient members and has proven to yield lower cost of care results.
- **Patients:** What role will patients play in the process? Currently, insurers have mostly relied on incentivizing providers – with a focus on primary care providers – to manage the cost of care. Experimentation with patient incentive structures related to patient adoption of and adherence to value-based care protocols will be an area for potential future focus & innovation.

Background

I've been in finance for 25 years now and most of my career in healthcare. I started my professional career in England, at Procter Gamble, and then spent time at GE Appliances and GE Capital. I moved to GE Healthcare back in 2000 and have been in healthcare ever since. I spent about 12 years at GE Healthcare and then moved to Fresenius Medical Care before my most recent role at Highmark. It's been an incredible journey. Healthcare - as we know, we are all consumers of healthcare - frankly, it's broken. It's a system that needs a lot of upgrade. So I think that presents a lot of opportunities for all of us to make an impact.

Few people have held such senior positions in both a large national payer, a large health system - that's the combination of Highmark - and thirdly a large outpatient services business, as I think of Fresenius, which is focused on diabetes and kidney care. And on top of that, one of, if not the largest global medical device business in GE. You've really had a unique, top of the mountain perspective on four very different markets within healthcare. What do you draw from that perspective? What do you draw from that experience as commonalities and differences between what are considered to be four very distinct markets all within healthcare?

That's a great question. If I could go back to my comment - we are all consumers of healthcare. If you put the patient or the consumer in the center, you'll see the solar system of healthcare revolves around med devices companies. GE Healthcare, as an example, makes MRIs, CT Scanners, X-rays, and then they sell it to the providers, say, hospitals. And then the hospitals get reimbursement from insurance companies, such as Highmark. So, the solar system that I'm talking about is med device companies manufacturing those products, then providers using those products to provide services to the consumers, and then getting reimbursements from insurance companies like Highmark. The overall economics at play is really fascinating. When I think about this dynamic, especially from the finance side, a lot depends on the contracts between the insurance companies and the provider entities, and then how those provider entities are able to fund or finance those medical devices, and the backend. So it's fascinating. It revolves around that solar system, and ultimately the consumer. The patient ends up paying in some shape or form, whether it is through our insurance premiums or copays or otherwise.

What are the greatest misconceptions that each of these stakeholder groups have about each other?

In my role at Highmark, I had an opportunity to see both sides - the provider side as well as the payer side. And I think the greatest misconception is when you think from the provider side, the belief is the payers are not paying us enough. The insurance reimbursement needs to be higher, and the providers would complain all day long about why their rates are low and that they should be paid more. On the payer side, the conception or the misconception is that the providers are inefficient, they have a lot of fixed assets that they need to operate more efficiently. This back and forth between the two sides leads to a lot of financial gymnastics. And, frankly, in my view, the truth is somewhere in between. You know, the providers in the post pandemic era need to be more efficient, need to think about how they're delivering those services and where they're delivering those services. And, in turn, the payers need to think about how they're reimbursing some the services that didn't exist before COVID, for example, digital care.

If you were in charge of the entire market and you could regulate change by Monday morning, what would you force all the stakeholders to do differently at a practical level? What new regulations would you institute that you think would lead to dramatic improvement in addressing the broken aspects of healthcare?

Just to give one data point to the audience before I answer that question. The US economy is roughly 25 trillion dollars, somewhere around that. And healthcare spend is roughly, 3 to 4 trillion dollars of that, so approximately one fourth of the total. You will see that healthcare spend is growing at 6 to 7% on an annual basis. We all know that the US economy is not growing at 6 to 7%. So, if you do the math, healthcare is very quickly going to become a big burden, especially Medicare, Medicaid, et cetera. And it's going to be unaffordable within the US economy. So that's my comment on healthcare being broken.

What can I do in order to change some of the regulations? In my view, it again comes from the consumer - what's best for the consumer, for the patient. As a consumer, I think I would like to have less surgical procedures. I would like to have minimally invasive surgeries and probably less hospital visits for myself. I would like to have more quality or higher quality of care at the least amount of copay or the least amount of payment for myself. When you boil down those things, what it translates to is what we now call as value-based care. In the past, hospitals or physicians were paid based on a number of procedures or scans. Now, the environment is shifting toward "is the patient healthy?" Are you keeping the patient out of hospital? Are you keeping the cost of care lower? And if all of those are yes, yes, and yes, that means you are delivering a good quality value to your patients. The hospitals get paid a fixed amount for doing that, which is what we call value-based care.

So, as a regulation, I would recommend we mandate that most of the providers need to participate in a value-based care arrangement with their peers, and march toward the value-based care objective.

How much value-based care success did you witness at Highmark?

At Highmark, we had a captive health system, Alleghany Health Network, and we were able to move the dial significantly in that network through value-based care. I think rough numbers were that when we started in 2018 on the value-based care journey, we were roughly 30% VBR and 70% fee-for-service. In 2023, we flipped it to the other way around were roughly 60% VBR and about 40% fee-for-service.

The challenges remained with all the other providers that Highmark contracts with. As a hospital, I'm used to doing scans, I'm used to doing surgeries, and I'm used to getting paid for it. That's the fee-for-service model. Now, you come in and tell me "don't do scans, unnecessary scans, and don't do unnecessary surgeries. Oh, by the way, do those surgeries if you have to but do them in an outpatient setting, not in an inpatient setting." That puts a big question mark on how I have run my hospital for the last hundred years. Do I need to redesign the infrastructure, the operating rooms, maybe some of the fixed costs that I have? And frankly, that's not easy. That's a very difficult and time-consuming process. So that's why the dial has moved slowly with other providers. But, frankly, the writing is on the wall and those who are embracing the value-based care trajectory and following it will survive. And those who resist this change, I believe, will become dinosaurs very quickly.

In the context of trying to push into value-based care, how does Highmark deal with the open network that it functions in, relative to a Kaiser closed network of hospitals, outpatient facilities and members? I imagine that the Highmark challenge is more complicated.

Yeah, absolutely. It's a good comparison when you think about Kaiser, it's closed system, as you said. If I'm a Kaiser Permanente insurance member, I can only go to Kaiser's hospitals to get my treatment done. Now, Kaiser is a big system, so they have lots of hospitals and access is not a problem. But, let's say I'm traveling to a different state, if I'm going to a different location where there isn't a Kaiser hospital – then, that presents a challenge to me because my insurance may or may not be in network there.

What Highmark does is offer both what we call narrow network and broad network. A narrow network is for someone who is a resident of Pittsburgh, Pennsylvania and has access to all the Alleghany Health hospitals. We offer them insurance that is quite attractive and give them those services in our footprint here. The broad network option offers more flexibility to our members. Let's say someone wants to travel to a different state or even different country and they want to be covered with their insurance. With the broad option, Highmark offers a care network in those states as well. The challenge there is that Highmark has to then go out and establish contracts with the hospitals that are not part of Highmark, and that's where the economics come in. Sometimes the rates for a broad network may not be as attractive as a narrow network insurance premium, but at least it gives access and optionality to our members, to all those providers.

Would you say, is it safe to assume that your narrow network performance from a value-based care standpoint was significantly stronger than it was in your broader network?

Absolutely. And in fact, data proves that the quality of care, the access, the economics are all much better in a narrow network. And that's why we promote the narrow network as much as we can. And, frankly, it is super convenient for someone who is a resident of Pennsylvania or Pittsburgh or the surrounding areas and doesn't travel much. It is the best insurance premium to have.

Taking a step back for a second and, and thinking again about all four businesses – payers, health system, services, med device - looking backwards and looking forward, what were some of the best strategic partnerships that you saw these very large institutions execute, and how does that inform where you think healthcare might go in terms of interesting and value generating strategic partnerships that others can think about replicating going forward?

A couple things come to mind. I think the first and foremost is what we are just talking about in regard to value-based care and the offering of capitated payments and then letting the providers manage the care of a patient. And I'll give you a couple of examples. Typically some of the older patients or patients with chronic diseases have other morbidities or other comorbidities. What it means is that if I'm a high blood pressure patient, I may have diabetes, I may have chronic heart condition, et cetera. And all of those conditions may or may not be linked. If you offer a capitated payment to a provider and, say, as an example, I'll pay you one thousand dollars per month and you take care of all the conditions of this patient, the providers can then wrap around their services around that member and provide services for high blood pressure or diabetes or chronic heart condition all together. I think that's probably the biggest impact in terms of partnerships - value-based care has made it where a patient is treated holistically versus individually for each disease.

The second thing I would say is digitization. I'm a big believer in digitization and, frankly, other industries have leapt ahead of healthcare. When you think about the banking industry, I don't even know where my bank branch is. I do everything electronically. When you think about shopping, Amazon. When you think about other industries, digitization has leapt far ahead of healthcare. And, frankly, pre-COVID, we were all used to going to a hospital, seeing a physician in person, sitting in a waiting chair for half an hour. I think, post COVID, we are increasingly used to having a video call with our physicians or, replacing an unnecessary hospital visit with a video call. We can just take a phone call or do a video call.

Did you start to see some of the shift and the benefits, the cost savings, productivity improvements, access of a virtual footprint while at Highmark or Fresenius?

Absolutely. I think the biggest benefit is you don't need a dedicated nurse or a dedicated physician to stand by every patient. You can have maybe one nurse attending five or six patients because they are doing virtual calls. The other savings would eventually be that you won't need all of the fixed assets, the brick-and-mortar buildings - you can reduce that as well.

From a patient point of view, it's a huge convenience. I don't have to drive half an hour every day and then go to see my physician, wait in the waiting room. It's a huge time saving as well. As long as the cost, as long as the care, the quality of care is the same, what you'd encounter when you actually go and see your physician.

I think that's been the challenge in the past, consistently attractive reimbursement levels for virtual care and confidence in the actual quality of that care. Do you see a lot of progress on both fronts?

Yes. One of the good things Highmark did during COVID is that we matched the online reimbursement with in-person reimbursement. So, if you were doing a video call with a physician, the reimbursement was the same as if you were going to see a physician in-office. The benefit of doing that was it became economically as attractive to the providers to do a video call with the patients as to ask them to come onsite. And that shifted the dynamics significantly. I believe the video visits went up something like 4,000% post COVID. So, I do see the shift happening. But I'll say there is a lot more to be done.

We've seen some of those regulations from the federal government that were relaxed during COVID that facilitated virtual care return back to pre-COVID levels that acted as an impediment to virtual care. So, I take the point we're not quite where we were in COVID where it was greenfield for virtual care, but still a lot more virtual care utilization today than where we were in 2019. It still appears to be two to three times the volumes that we saw before COVID.

Right. If I may just add one more point. The biggest risk of going to a hospital is what we call hospital acquired infections. You walk in a hospital and you come out after a day or two with an infection. That risk is one hundred percent eliminated through virtual care.

I would agree with you that the days of virtual care representing less than 5% of volumes across a large market like the U.S. are probably long gone. It will be interesting to see where it nestles out, where it stabilizes. Is it 30%, is it 50%, is it 90%?

Going back to your role as the CFO at, at all three institutions – GE, Highmark, Fresenius - which of the many businesses that these companies were in stay with you as great businesses to be in within healthcare? And, which do you look back and say, wow, that business was incredibly difficult, complex, unstable, volatile? What are your favorites and what are your least favorite businesses within healthcare, given that you've seen so many over the years?

I would say they're all great in their spaces but let me share with you that I think Highmark is probably the most complex. I say that because Highmark has both payer and provider challenges. You see the economics between the two sides and, obviously, the consumer or the patient is in between. I would say that Highmark is embarking on a journey, what we call living health, to simplify that. I think we have made a lot of progress in the last four years, and we are on to something big, something huge in the future. So I would say Highmark certainly is on top of the list.

Fresenius was also very complex, but mostly on the provider side. With GE I would say what I learned there and what I admire about GE is the global nature of the business. I'll give you one example. One X-Ray machine has 300 parts that ship from 25 different countries to be assembled in Milwaukee, Wisconsin. You can imagine how much complexity you have when you have 25 countries involved in manufacturing one X-ray machine. A lot of complexity, a lot of globalization. One other thing I noticed is that we were competing with some of the most innovative countries, such as China and India and Brazil, where the same equipment can be produced at 1/10th the cost.

What do you think about the CFO position within healthcare? How has it changed? How has it been misconstrued by CEOs within healthcare?

I think that CFOs within healthcare have a very tough job. Obviously, I'm biased, but I'll give you my perspective. Not only you are managing the finances of the company, but you are also working within macroeconomic factors. Whether it is CMS regulations, whether it is reimbursement from the government, payers and then on top of that, you have things like rising interest rates or higher inflation wage costs going up. So you are constantly on that hamster wheel, not only looking at the economics of your company, but also watching out for all of the macroeconomic factors that might impact your company. I know I'm biased, but I would say healthcare CFOs have a tougher job than other industrial CFOs.

And, the second part of your question, you know, how is it misconstrued by non-finance people? I think non-finance people might be thinking that the CFO job is to come in, report your numbers and move on to the next month. Frankly, that's not how I have operated and that's not how CFOs operate in healthcare. You are not only making sure numbers are reported, right, but you're also looking for risks and opportunities around the corner and what's coming down the pike so you can plan and prepare your organization for that.

COVID was a great example where a lot of healthcare systems went through a very, very tough time - those CFOs who were proactive looking down the pike were very successful, those who were not frankly did not succeed.

Why do you think there's so much turnover in the CFO position within healthcare?

I think part of it is opportunity and part of it is if you look at the CFO roles, I would say they are pressure cooker roles. They have a lot going on, whether it is internal reporting, external reporting. There is only so much runway. Yesterday I was reading a report - an average S&P 500 CFO lifespan is roughly 3.5 years. So, it's a combination of things, a combination of the pressure they are in and also opportunities that present to them.

When you talk about changing the dynamics of the cost of healthcare, you speak very well about the providers and you speak very well about the insurance companies. Alignment with the patient is always something that's tricky and we don't really have a great model for creating an incentive for the patient beyond taking good care of yourself, which seems obvious, but consumer behavior proves us wrong every day. Any thoughts on what will be evolving in terms of trying to get patients to buy into value-based care, as we move from the Medicare population into the broader population?

You hit the nail on the head. This is probably the biggest question that our healthcare industry is grappling with. You might have seen recently that there are a lot of acquisitions in the primary care space. CVS acquired Oak Street and Signify Health, and Amazon acquired another primary care business. OptRx is acquiring a lot of physicians. Why are they doing that? Because physician offices are the first door that patients enter into healthcare systems. And what they're trying to do is exactly what you said. My physician tells me that I have these conditions - I have a high blood pressure, diabetes, on the cusp of getting a heart disease - and I need to change my lifestyle and eat right, exercise, take care of myself. The physician is very engaged with the patient in offering advisors and maybe connecting me with a couple of digital tools that might help me adhere to my care plan. The hope is that I may not develop the diseases down the road, and I may not end up in a hospital. I may not become a big consumer of health down the road. So that's why these companies are getting into the physician offices. And I believe to engage patients we need to start from the front door, the inter healthcare system, which is physician offices.

Do you see a scenario in which if I go to the doctor and I take better care of myself, that my premiums would go down or I would be incentivized materially. To use a bad analogy - maybe if I'm a good driver, my insurance goes down and if I'm a bad driver my premium goes up?

Yeah - one thousand percent. I agree with you. In fact, the example I gave where CVS is acquiring these companies, CVS has Aetna Insurance Company.

The reason why they're getting into the physician offices space is because they want to lower the cost of care so that they can lower their premiums that you and I pay, which makes them more competitive.

So, I'm absolutely certain that if you are a good driver in this case, you can demand a lower premium. You can show your history to your health insurer and they'll be willing to offer you a lower premium insurance. That time is already here, some insurance companies are offering that and others are quickly following.

That's going be a meaningful change in the industry. And that will drive a lot of change in patient behavior you would think overnight. So that is a very interesting point. From your perspective, Saurab, who's got it right? In terms of the big model, the big synergy model combining the payer business model with the provider business model, with the digital model, the right pharma model? Who is connecting these building blocks correctly and who is on their way to learning a very difficult lesson? Is it Walgreens, is it Walmart, is it CVS, is it Amazon, is it Apple? Who's creating a business model for the future that you think is likely to win out?

At the present moment, I don't think anyone has figured it out. And hence the comment, healthcare is broken.

I should probably offer the United/Optum as well and some of the, the large health system aggregators out there, such as Ascension and Kaiser.

Exactly. So at the present moment, nobody's got it right. But every big healthcare company, and even large non-healthcare companies, are trying to get into this space to fix it. Who's got as close to right? I think CVS and probably United/Optum. CVS is acquiring all these physician offices now, through Signify Health and Oak Street, where they paid tens of billions of dollars for these acquisitions to get into the physician office market. Optum is the biggest physician offices owner in the country. They own almost 20% of the total physician population. So I think between the two, they are definitely making the right moves and I think they will be ahead of others like Amazon and Walmart. I think those two are absolutely getting into the right place.

Walgreens I don't believe has made a payer play yet. CVS started on the payer play, with Aetna and then, the pharma investment as well. Whereas UHC started from the provider perspective and has been migrating up the provider scale at an incredible pace for years. So, you like the combination of payer plus provider - do you think the retail footprint, traditional retail footprint, driving traffic, knowing traffic is a critical piece. Can you create a large integrated health platform without owning big box retail stores that sell, sell you pencils and vegetables?

Yeah. That's where the consumerism of healthcare is going. You know, if you think about what Walmart is doing, and what CVS is doing with MinuteClinics, they're trying to capture patients when they walk into their store for blood screening, for blood pressure tests and things like that and take it from there. That's where the retail part of healthcare is heading. I don't think any of the large,

traditional companies like CVS or Optum or Amazon would ever want to own a big provider system because, I can tell you from my experience, provider systems are huge capital commitments. I mean, you are talking of billions of dollars of assets.

So you think that you think that they will stay away from anything inpatient while they still build meaningful scale in outpatient?

Absolutely.

And the more virtual outpatient gets, the happier they'll be.

Exactly.

And what keeps them away from the inpatient side is the fixed asset component.

That's right. Fixed assets. And it's not just a one-time fixed asset. You know, you have to keep your facilities state of the art, you have to buy new MRIs and CTs. There's a lot of cost involved in owning big box provider systems. And, I think that's why these companies will shy away.

I mean, commercial real estate really has a lot to worry about. You know, you've seen the death of retail, now the death of office and we're describing a contraction in healthcare retail footprint as well. You sort of run out of ideas. All you're left with is residential.

Since we're talking about acquisition of primary care, a statistic was shared that upon acquisition of a physician practice by a health system, cost goes up within the next year around 20%. If these big box stores are in acquisition mode, how are they going to acquire them and keep costs down?

It is going to present a challenge where the cost is initially going to go up. What they have to do is think about their operating model differently. How are they going to migrate the services that were being done inpatient to an outpatient setting? And I'll give you a few examples. Can we do knee surgery or hip surgery or some of these optional surgeries in an outpatient setting? Not just do it in outpatient setting, but do it at a lower cost than what we were doing in inpatient setting. And therein lies the challenge. How do you bring in your cost down? How do you do more of these in an outpatient setting? So your reimbursement is lower, but your cost of operations is also lower. That's the shift these hospitals are facing. I don't think it is going to happen overnight, but it is going to happen in a matter of time. The second thing I'll say is that the payers are and will continue to force them to figure this out. I know the reimbursement landscape is changing where some of the payers are paying a lower rate of reimbursement for inpatient surgeries or mandating them as an outpatient right away. So hospitals don't really have a choice. They have to take these cases in an outpatient setting.

When you think about the primary care physicians and the specialists, specialists are very late to the game at this point when it comes to value-based care. You see a couple bundled payment programs out there across orthopedics, oncology, obstetrics. Can you shed some light on where you think this is going from a specialist perspective, and how we can get this to align? Because I'll tell you, the primary care physicians that I'm talking to feel that the weight of the world of value-based care rests on their shoulders.

I'll go back to my Fresenius days. A chronic kidney disease patient or a diabetic patient may end up in a dialysis situation and there are stages before they end up in a dialysis situation. There are five stages of diabetes. The way Fresenius was operating in a specialist setting, if you are signing up to a value-based reimbursement and you have a capitated payment, and let's say the capitated payment is one thousand dollars per month, the incentive for a Fresenius specialist is to keep those patients out of dialysis. If they keep them out of dialysis, they will have lower cost of care. Not only does the primary care physician win, but the specialist also wins because their bonuses are aligned to the cost of care. So, I would say certain disease states are aligning faster than others and CKD is one of them. There are others, let's say chronic heart failure or neurological diseases, where specialists are still far from value-based care.

What can management companies do to run physician offices more efficiently?

I would point to a couple places. In my experience, when you think about the journey of a patient from primary care to a specialist to a hospital, there's a lot of paperwork, there's a lot of manual work, there's a lot of care coordination that needs to happen. And today, typical nurses spend two-thirds of their time on paperwork and one-third of the time on actual clinical care. If I'm a physician management company,

I would look at opportunities to streamline processes, digitize as much paperwork as possible, leverage artificial intelligence, and support care coordination.

When a patient goes from a primary care to a specialist to a hospital, is the data traveling with that patient and can we take out some of the historical inefficiencies - process inefficiencies, as well as cost inefficiencies - out of the system so that we spend less time and less dollars in taking care of those patients.

We have seen small primary care practices benefit from value-based care by participating in large IPAs and sharing in some of the savings associated with a successful IPA program and as well as ACOs. Do you think that small single-specialty practices will start to see that kind of upside, that kind of incentive to facilitate more value-based care participation?

This is just my opinion, but I think there is going to continue to be consolidation in this industry and the single practice specialties will struggle to survive on their own and keep their economics intact. If they go on the value-based care journey, they'll have to join hands with other like-minded providers. At the end of the day, value-based care's common thesis is reducing the cost of care while still continuing to provide highest quality of care. When you aim to reduce the cost of care, scale matters. So, I think the single specialties will probably have to join hands with other like-minded providers and get on the VBC journey. Otherwise it'll be very difficult for them to survive.