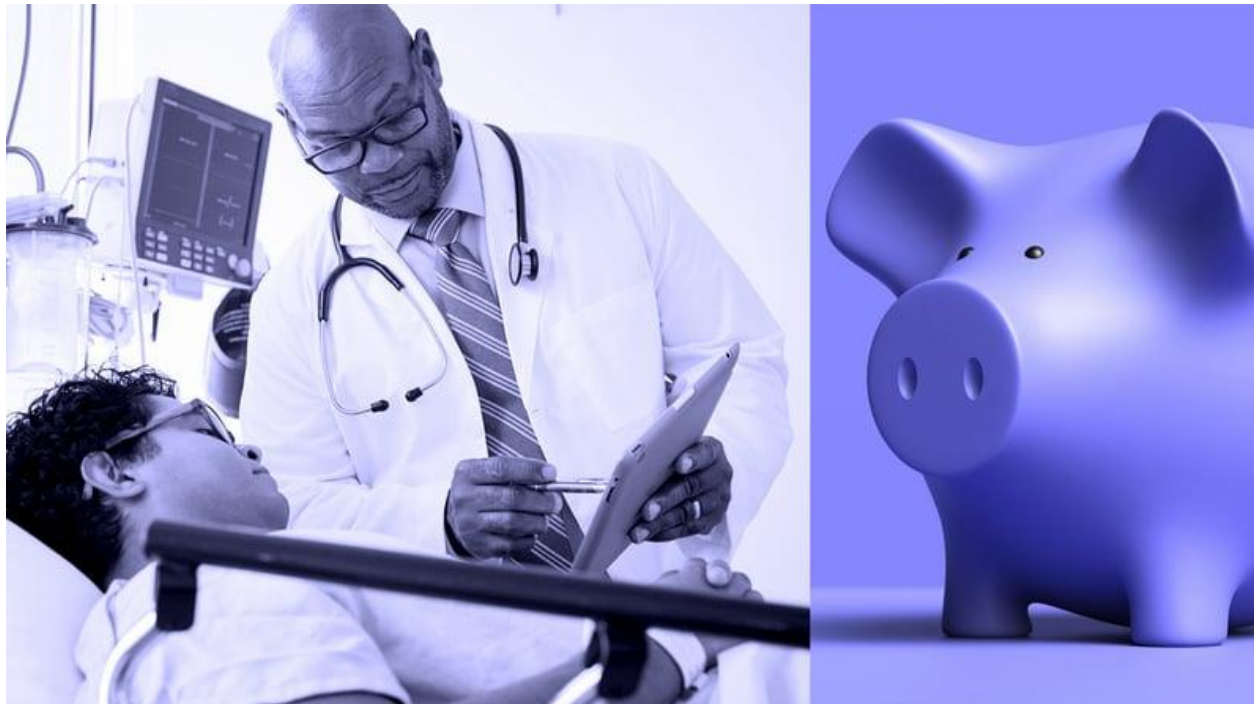


Why more providers are enlisting value-based care consultants

[Hayley DeSilva](#)



Growing interest in value-based care is prompting more health systems to hire consultants to smooth the transition from the traditional fee-for-service payment model.

Fee-for-service reimbursement has reigned as the go-to way of delivering and paying for care. Value-based care is intended to produce better patient outcomes while controlling costs because it focuses on preventative care.

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Primary care is seen as a good starting point for the adoption of value-based care because it is often the first point of contact between a doctor and patient. By focusing on preventative care and coordinating with other providers, the theory is it will lead to better overall patient health and lessen the need for more complex, more expensive care.

But shifting to a value-based care model can be bumpy and involves waiting longer for payments because they are tied to performance metrics. Enter companies like Navvis, Premier, VMG Health and Aledade, among others, which are contracting with systems like Allina Health, Advocate Health, SSM Health, Tufts Medicine, Bon Secours Health and others.

In some cases, the consultants work with hospitals to build the models. In other cases, they provide services like peer-to-peer training programs for physicians, data analytic platforms and care management services.

"A lot of health systems right now across the country, they're in some pretty daunting financial situations," said Courtney Fortner, president and CEO of Navvis. "They're looking for margin recovery and how do they sustain themselves as a system, as a hospital, before they can even really make investments in value-based care."

Prospects for the model took a big step forward when Kaiser Permanente acquired Geisinger Health to form [Risant Health](#), with the goal of creating a national network focused on value-based care. Risant [acquired](#) Cone Health in December.

SSM Health doubled down on value-based care in 2017 after Laura Kaiser was named CEO. She previously had been chief operating officer at [Intermountain Health](#), an early adopter of the model.

"When she came here to SSM Health, there were parts of the organization that were engaged in value-based care, [population] health types of initiatives, but there wasn't a standard approach to it across all four states," said Dr. Tim Johnson, vice president of clinical integrations for St. Louis-based SSM. "We looked at how do we want to take care of patients? What's the best way to take care of patients? What's best for our communities? Where do we think things are going financially? It made a lot of sense for us to kind of jump all in on value-based care."

SSM partnered with Navvis in 2019, which led to the development of a singular system that combined and tracked patient data and outcomes. The two organizations also developed seven programs centered around acute care transitions, which included strategizing on how patients would receive medications between visits and transportation to visits, among other things.

Navvis also advised SSM Health on how to prepare staff for the shift, restructure its medical group leadership, change its physician compensation model and contract with payers, Johnson said.

Between 2019 and 2023, SSM tripled its value-based care revenue, Johnson said. It also has improved its ambulatory quality measures, he said.

Other providers also are bringing in consultants to gather data, establish timelines, train staff and speed up the process.

"It takes a while to change the culture of a health system toward value-based care and sometimes outside help can accelerate that change and can bring tools and expertise and

knowledge that the health system needs and would benefit from," said John Harris, a managing director at VMG Health.

Value-based care is expected to continue to grow. A 2022 report from consulting firm McKinsey and Company said companies engaged in value-based care could create \$1 trillion in enterprise value by 2027, compared with \$500 billion in 2022.

In the last five years, the [Centers for Medicare and Medicaid Services](#) has [pivoted](#) toward rewarding providers based on health outcomes, and since then many commercial insurers have or are starting to follow suit.

"The market pressure that [providers are] feeling from payers, as well as the world where their margin and their financial resiliency can be improved through value-based models, it's really catalyzing groups to move into these programs kind of much more aggressively and with more of a longer-term view than they had historically up to now," said Seth Edwards, vice president of strategic collaboratives at Premier.