THE RISK-SHARING GAME: WHY VALU BASED CARE IS THE NEW MOAT FOR DIGITAL HEALTH STARTUPS

NOV 05, 2025 • PAID

DISCLAIMER: The views and opinions expressed in this essay are my own and do no reflect the views of Datavant or any of its affiliates.

TABLE OF CONTENTS

ABSTRACT

Value-based care platforms represent a fundamental shift in how digital health companies capture value and scale. Unlike traditional SaaS adoption models, VB platforms embed themselves in the financial flows of healthcare by taking on outcomes risk through shared savings arrangements, quality bonuses, and other performance-based contracts. This essay examines why risk-sharing models crea defensible moats for digital health startups, the technical infrastructure require operate in VBC environments, evidence generation strategies for resource-const

companies, and practical investment frameworks for angels evaluating these opportunities. The core thesis is that digital health companies willing to put ski the game through risk-sharing arrangements can command premium valuations create sustainable competitive advantages, but only if they build the right data infrastructure and evidence base from day one.

So here is the thing about digital health that nobody wants to say out loud but everyone knows is true. Most digital health companies are glorified software pro with healthcare window dressing that get paid on a per member per month basis regardless of whether they actually improve anything. The business model is to s up as many covered lives as possible, show some engagement metrics, and hope nobody looks too closely at whether clinical outcomes or costs actually moved. T worked great during the zero interest rate phenomenon when growth at all costs the name of the game and venture capitalists were writing checks based on total addressable market slides and net promoter scores. But that party is over and th hangover is brutal.

The new game in town is value-based care and specifically digital health compan that are willing to put their money where their mouth is through risk-sharing arrangements. This is not just a buzzword shift or marketing repositioning. This fundamental change in how digital health companies capture value and how inve should think about backing them. Companies that can credibly take on outcome through shared savings contracts, bundled payments, or other performance-base arrangements are building real moats that are incredibly hard to replicate. But g there requires a completely different technical stack, evidence generation strateg and go-to-market motion than the typical digital health playbook.

Let me start with why this matters from an investor perspective because that is ultimately what determines whether these companies are interesting angel investments. The traditional digital health model has garbage unit economics on you look past the surface. You are selling to employers or health plans on a per employee per member basis. Your contract values are capped by what buyers are willing to pay for point solutions which is usually somewhere between two and e dollars per member per month depending on the category. Your customer acqui

costs are brutal because you are selling into slow-moving bureaucracies with enc stakeholders. Your churn is high because you are one of seventeen digital health vendors the benefits team signed up for and nobody can actually measure your ir so you get cut when budgets tighten. And your expansion revenue is limited bec you already have everyone in the eligible population.

Now compare that to a value-based care platform that takes on risk. Your contra values are tied to measurable cost savings or quality improvements which means can be orders of magnitude larger than traditional per member per month fees. Instead of selling a point solution you are effectively becoming a partner in the financial performance of the provider network or health plan. Your retention is dramatically higher because you are embedded in the financial flows and attribu methodologies that determine how money moves in healthcare. Your expansion happens through increases in the covered population, the percentage of savings capture, or expanding into new clinical domains where you can demonstrate imp And most importantly you are building a defensible competitive advantage beca the switching costs are enormous once a provider or payer has integrated your platform into their value-based contracts and care delivery workflows.

The valuations reflect this difference. Traditional digital health companies that a purely adoption-based might trade at three to five times revenue if they are luck growing fast. Companies with credible risk-sharing arrangements and demonstr ability to move outcomes can trade at eight to twelve times revenue or higher be investors see them as having real moat potential and a path to category dominan For angels this difference is everything. You want to back companies that can command premium valuations at exit because that is how you generate asymmet returns in a portfolio.

But here is where it gets complicated. Building a platform that can actually oper value-based care environments is way harder than building a traditional digital l product. The technical requirements are an order of magnitude more complex. Y need claims data integration capabilities to understand baseline costs and utiliz patterns for your target population. You need predictive analytics and risk stratification models to identify which members will benefit most from your

interventions. You need longitudinal tracking systems to follow outcomes over t and attribute changes to your specific interventions versus all the other stuff happening in someone's healthcare journey. You need population health manage tools to manage cohorts at scale. And you need real-time dashboards and reporti infrastructure that can show payers and providers exactly how you are performir against agreed-upon metrics.

Most early-stage digital health companies do not have any of this infrastructure frankly do not even know they need it until they start having serious conversatio with potential risk-sharing partners. They built a consumer app or provider wor tool that helps with some specific clinical problem. Maybe they have some interr analytics to track engagement or user-reported outcomes. But they are nowhere having the data infrastructure to support a shared savings contract or take on meaningful financial risk. This creates a chicken and egg problem. You need the infrastructure to credibly enter risk-sharing arrangements but building that infrastructure is expensive and time-consuming and you probably cannot justify investment until you have some revenue traction.

The smart companies figure out a staged approach to this problem. They start by selling on traditional terms but building in measurement capabilities from day c that will enable risk-sharing down the road. This means instrumenting everythir capturing granular data on who uses what features when, integrating with electr health records or claims feeds even when it is not strictly necessary for the core product to work, and setting up control groups or comparison populations so yo start generating evidence of impact early. You are essentially building the found for risk-sharing while still selling the old way because you need revenue to survi you are positioning yourself to flip to risk-based contracts once you have the evi and infrastructure in place.

Let me give you a concrete example of how this plays out. Imagine you are buildi digital therapeutic for diabetes management. The basic product is an app that h people track blood sugar, get coaching on diet and exercise, order test strips and medications, and stay engaged with their care plan. You could sell this to emplo

or health plans for three bucks per member per month as a diabetes managemen benefit. Or you could build it from the ground up as a value-based care platform

In the VBC version you are integrating with claims data from day one to identify highest risk diabetics in a population based on their A1C levels, complication ra emergency department visits, and medication adherence patterns. You are using predictive models to figure out which members are most likely to develop complications or become high cost in the next year. You are stratifying your interventions so the highest risk folks get intensive coaching and care coordinat while the moderate risk folks get lighter touch engagement. You are tracking no app engagement but actual clinical outcomes like A1C changes, medication adhe rates, and utilization metrics like inpatient admissions and emergency departme visits. And you are building attribution models that can isolate the impact of you intervention from all the other variables affecting someone's diabetes manageme

With that infrastructure in place you can go to a provider group or Medicare Advantage plan and say we will take on downside risk for the diabetes populatio we reduce total cost of care by ten percent while maintaining or improving quali metrics we split the savings sixty forty. If we do not hit the targets we give back or all of our fees. This completely changes the economic conversation because no you are a partner in their value-based contracts rather than just another vendor expense. And once you prove out the model with one partner you can scale it rap because you have both the evidence base and the technical infrastructure to repl it.

The evidence generation piece of this is critically important and also where a lot companies screw it up. You cannot just claim you improve outcomes based on se reported surveys or engagement metrics. You need real clinical and financial dat demonstrates impact in ways that payers and providers will actually credit. This means getting access to claims data, integrating with EHR systems, setting up pr comparison populations, and ideally publishing peer-reviewed studies that estab clinical validity.

For early-stage companies this creates a bootstrapping problem because generat strong evidence requires access to data and populations that you might not have you are already selling to large customers. The workaround is to find partners w will give you data access and population access in exchange for free or discounte services while you build your evidence base. Academic medical centers can be gc partners for this because they care about research and publications. Forward-thi provider groups participating in ACO or Medicare Advantage risk arrangements might be willing to pilot your solution if they believe it could help them perform better in their value-based contracts.

The key is being strategic about what outcomes you measure and how you set up study design. You want outcomes that are objectively measurable, directly attributable to your intervention, and economically meaningful to payers or prov A1C reduction for diabetics checks all three boxes. Reduction in preventable hospitalizations for chronic disease patients checks all three boxes. Improvemen medication adherence for expensive specialty drugs checks all three boxes. Patie satisfaction scores do not check these boxes even though they might be importar other reasons.

You also need to think carefully about time horizons for demonstrating impact. interventions show results quickly like improving medication adherence or redu emergency department visits for conditions where you are providing better symp management. Other interventions take longer to show impact like preventing progression of chronic disease or reducing long-term complications. For early-st companies you want to focus on outcomes you can demonstrate within twelve to eighteen months because you need to show traction to raise your next round. Bu also want to be measuring longer-term outcomes that will support more ambitio risk-sharing arrangements as you scale.

The other piece of evidence generation that matters a ton is the quality of your d infrastructure and analytics capabilities. Payers and providers who are consideri risk-sharing arrangements want to see that you have robust systems for tracking outcomes, attributing impact, and reporting on performance. This means investi data pipelines that can ingest and normalize claims data from multiple sources.

means building analytics models that can handle complex attribution problems v
members are exposed to multiple interventions. It means creating dashboards ar
reporting tools that give stakeholders real-time visibility into how you are perfo
against agreed-upon metrics.

A lot of digital health founders underestimate how much this infrastructure cos
build and maintain. You are basically building a mini analytics company inside y
digital health company. You need data engineers who can work with healthcare d
formats like EDI 837 claims files and HL7 clinical messages. You need data scier
who understand healthcare-specific modeling challenges like risk adjustment an
propensity score matching. You need product people who can translate complex
analytical insights into dashboards that business stakeholders can actually unde
and use. This is not cheap and it is not fast. But it is absolutely essential if you w
play in the value-based care sandbox.

From an angel investment perspective this creates some clear frameworks for
evaluating opportunities in the VBC digital health space. First question is does t
company have a plausible path to risk-sharing arrangements based on the clinica
problem they are solving. Not every digital health use case makes sense for value
based care. Meditation apps probably do not. Diabetes prevention programs
absolutely do. You want to invest in companies where there is a clear line of sigh
from the intervention to measurable clinical and financial outcomes that payers
providers care about.

Second question is does the founding team have the right mix of clinical, technic
and payer contracting expertise to navigate value-based care. This is really hard
pull off if your team is entirely consumer product people who have never negotia
shared savings arrangement or built claims data infrastructure. You need operat
who have worked in provider groups or health plans and understand how value-b
contracts actually work. You need technical people who have built healthcare da
pipelines before. You need clinical people who can design interventions that wil
actually change outcomes and can articulate the clinical evidence base.

Third question is what is the evidence generation strategy and where are they in executing against it. At seed stage you might be investing before there is strong outcomes data but you want to see a thoughtful plan for how they will generate t evidence and ideally some early pilots or academic partnerships that will give th access to the data and populations they need. At Series A you want to see prelim evidence that the intervention works and a clear path to more robust studies. At B you should be seeing published outcomes data and ideally some early risk-shar contracts that validate the business model.

Fourth question is what is the technical infrastructure for operating in VBC environments and how much will it cost to build what is still missing. A compan already has claims data integration, risk stratification models, and outcomes trac infrastructure is way more valuable than a company that is still at the consumer stage even if they have similar user bases. You need to underwrite the cost and timeline to build the VBC platform capabilities because that will determine thei burn rate and how much capital they need to reach meaningful scale.

Fifth question is what is the go-to-market motion and which partners are most l to adopt risk-sharing arrangements. Some markets are way more mature in value based care than others. Medicare Advantage plans and provider groups in MA ri contracts are generally more sophisticated buyers of VBC-oriented digital healtl commercial employers. Some specialties are more advanced in value-based care t others. Oncology and cardiology have pretty well-developed alternative payment models while dermatology and ophthalmology are still mostly fee-for-service. Yo want to invest in companies that are targeting customers who are already operat value-based care environments and have the analytical sophistication to evaluate outcomes-based vendors.

Let me talk about some specific business models that are interesting in the VBC digital health space. One model is partnering with primary care groups that are on full risk for Medicare Advantage populations or participating in ACO arrangements. These groups are highly motivated to keep their patients healthy out of the hospital because that directly impacts their financial performance. Di health companies that can provide remote monitoring, care coordination, medica

management, or chronic disease management services on a risk-sharing basis are super valuable to these groups. The key is having infrastructure to integrate with their existing care teams and workflows rather than being another disconnected vendor that generates alerts nobody acts on.

Another model is working with specialty pharmacy and medication management There are massive opportunities to improve adherence for expensive specialty dr where non-adherence leads to disease progression and higher costs down the roa Digital health companies that can provide adherence support, side effect manage and patient engagement for specialty pharmacy can structure deals where they g paid based on improvements in adherence rates or reductions in downstream co The challenge is getting access to the pharmacy claims data and clinical data nee to measure impact but specialty pharmacies are increasingly sophisticated about outcomes tracking.

A third model is hospital-at-home and acute care substitution programs. There i growing evidence that certain conditions can be managed at home with remote monitoring and virtual care rather than requiring hospitalization. Medicare has expanded coverage for hospital-at-home programs and commercial payers are following. Digital health companies that can provide the monitoring technology, clinical protocols, and care coordination to safely manage acute episodes at hom take on risk for reducing avoidable admissions or shortening length of stay. This requires pretty sophisticated clinical and operational capabilities but the econor can be compelling because hospital costs are so high.

A fourth model is behavioral health integration with value-based primary care. T is massive unmet need for mental health services and growing recognition that integrating behavioral health into primary care improves outcomes and reduces for patients with comorbid physical and mental health conditions. Digital health companies that provide measurement-based care, collaborative care model suppo telepsychiatry services to primary care practices can potentially share in savings reduced emergency department utilization, better chronic disease management, improved quality metrics. The key is demonstrating that your intervention move

needle on outcomes that primary care groups are being measured on in their valu based contracts.

The really interesting thing about all these models is that they flip the traditiona digital health sales cycle. Instead of trying to convince a benefits buyer that your solution will improve employee wellness based on engagement metrics and satisfaction surveys, you are having data-driven conversations with sophisticated healthcare operators about how your platform can help them perform better in t value-based contracts. The sales cycle might be longer because you are negotiati complex risk-sharing arrangements but the deal sizes are much larger and the retention is much better once you are integrated into their financial and clinical workflows.

From a portfolio construction perspective as an angel investor, VBC-oriented di health companies are higher risk but also higher potential reward than tradition digital health plays. The risk is that these companies need to build more comple infrastructure, generate stronger evidence, and navigate more complicated contracting processes before they can scale. That means higher burn rates and potentially longer time to meaningful revenue. But the upside is that if they exec well they build real competitive moats through their data infrastructure, outcom evidence, and embedded position in provider and payer value-based arrangemen Those moats can support winner-take-most dynamics in their categories and dri premium exit valuations.

My general framework is that VBC digital health companies need to raise more capital but can also command better terms if they have the right evidence and technical infrastructure. At seed stage you might be investing fifteen to twenty percent higher valuations than comparable consumer digital health companies because the eventual exit multiples should be meaningfully better. But you need careful about investing too early before the company has demonstrated they can actually build the VBC platform capabilities and generate credible outcomes da There is a sweet spot around late seed or Series A where the company has some evidence and has started building the infrastructure but has not yet fully scaled

model. That is when you can get meaningful ownership at reasonable valuations companies that could become category leaders.

The other consideration is that VBC digital health investing requires more work evaluate deals because you need to really understand the clinical evidence, the d infrastructure, the contracting strategy, and the competitive dynamics in value-b care. This is not an area where you can just read a deck and make a decision. You to dig into the details of how they are measuring outcomes, what data sources th have access to, how they are building risk stratification models, and how they pl contract with providers and payers. You probably want to talk to potential custo to validate that risk-sharing arrangements are feasible and that the company has credibility in the market. This is time-intensive but it is necessary to avoid inves in companies that have nice stories about value-based care but do not actually ha the capabilities to deliver.

The macro trend that makes all of this interesting is that value-based care is actu working in the markets where it has been implemented thoughtfully. Medicare Advantage plans that take full risk are demonstrating better outcomes and lowe than traditional fee-for-service Medicare. ACOs that have been around for sever years are showing sustained savings and quality improvements. Provider groups have invested in care management infrastructure and data analytics are outperfo their peers. This is creating a virtuous cycle where more payers are pushing valu based arrangements, more providers are taking on risk, and more digital health companies are building platforms to support value-based care delivery.

For angels this creates a window of opportunity to invest in the infrastructure an tools that will power the shift to value-based care. The big incumbents in health IT are not moving fast enough and most traditional digital health companies are operating on adoption-based business models. There is room for new entrants w understand how to build for value-based care from the ground up and are willin take on risk alongside their customers. These companies will need capital, they need time to build, and they will need support from investors who understand th space. But the ones that execute well could become the foundational platforms t reshape how digital health creates and captures value in the coming decade.

If you are interested in joining my generalist healthcare angel syndicate, reach o
treyrawles@gmail.com or send me a DM. We don't take a carry and defer annual
for six months so investors can decide if they see value before joining officially.
Accredited investors only.

Digital health's dirty secret: most companies get paid whether they work or not.
PMPM fees regardless of outcomes. That party's over.

New playbook is risk-sharing. Take on downside risk through shared savings and
valuation jumps 2-3x vs traditional digital health. But the infrastructure gap is b

You need claims integration, risk strat models, longitudinal tracking, pop health
tools. Seed stage companies have zero of this. Don't even know they need it until
partnership talks get real.

Smart companies build measurement from day zero while still selling old way.
Instrument everything. Integrate data feeds before you technically need them. Se
control groups early. Revenue now, risk-sharing later.

Evidence gen is everything. Engagement metrics are worthless. Need actual clair
data showing cost cuts and clinical wins. Find partners who'll trade data access f
cheap pilots while you build proof points.

Angel framework is simple. Clinical problem support VBC? Team know payer
contracts and claims analytics? Evidence roadmap make sense? VBC infrastructu
cost realistic? Targeting customers already in risk arrangements?

Best models are MA primary care groups, specialty pharm adherence, hospital-a
home, behavioral health integration. Sales cycle flips from convincing benefits b
with NPS to data convos with operators about their VBC performance.

Higher risk higher reward. Need more runway but winners build real moats. Ma
working where VBC is done right. Window open for founders who get outcomes
from the start.

Disclaimer: These thoughts and opinions are my own and do not reflect the view
my employer or any other entities.

Link to the full analysis in the comments below.

1 Like • 1 Restack

← Previous

Nex

Discussion about this post

Comments Restacks

Write a comment...