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Taking Inventory: Investment Opportunities in Value-Based Care

Executive Summary

Value-based care (VBC) represents a meaningful opportunity for investors to reduce costs and improve patient outcomes. Existing data on VBC models indicate which approaches and types of organizations perform well compared to baseline fee-for-service (FFS) payment structures. Investors and policymakers have focused particularly on organizations that specialize in providing population-level VBC because these organizations can manage high levels of financial risk while also creating opportunities to improve care and generate savings.

This paper provides an overview of the Medicare VBC market and estimated total addressable market (TAM) for clinical care providers, describes opportunities for growth in this market, and outlines important considerations for investing in key market players.

VBC programs that have been most successful tend to be led by providers, have significant experience with VBC, and are large enough to meet market-specific demands while having sufficient data capabilities. Further, more systematic analysis is needed to identify drivers of profitability and growth.

Background

VBC can be defined as healthcare that is provided and paid for based on patient outcomes per unit cost, instead of compensated based on quantity of services provided. Population-level VBC models fall within a broader spectrum of alternate payment structures and are implemented by organizations that are responsible for the coordination, provision, and total costs of care for a broad group of patients. The analysis presented in this paper focused on two examples of this type of VBC model: (1) accountable care organizations (ACOs) in the Center for Medicare & Medicaid Services' (CMS) Medicare Shared Savings Program (MSSP) and (2) primary care providers paid in a capitated manner via delegated global risk arrangements with Medicare Advantage (MA) plans.

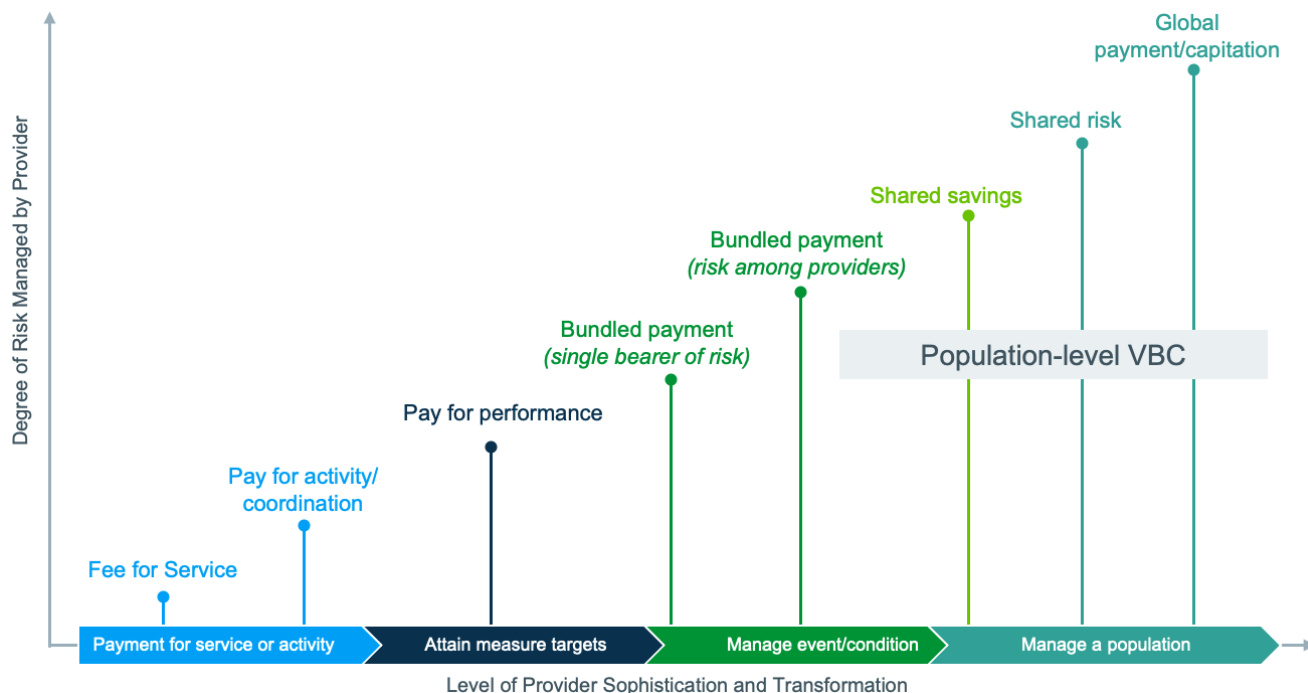


A single entity may be participating in both payment model types simultaneously, and the most successful VBC organizations often do. Other recent [typologies](#) outlining the broader, more complex web of entities participating in primary care- or population health-focused VBC models likewise indicate the layered nature of these organizations as they evolve and grow, either organically or through mergers and acquisitions. Avalere’s analysis focuses separately on MSSP ACOs and providers in MA global capitation arrangements to effectively demonstrate each program’s market size and opportunity for investment.

Population management approaches such as VBC date back to the health management organization movement of the 1970s. However, factors such as the passage of the Affordable Care Act (ACA), the looming insolvency of the Medicare Trust Fund, the COVID-19 pandemic and concerns it provoked about traditional reimbursement models, and the spread of provider burnout have led to a resurgence in the size and the popularity of VBC models.

Value-based payment models fall along a continuum of risk, and each model requires a different level of provider sophistication and preparation to manage accompanying risks. Figure 1 illustrates this continuum, which begins with FFS reimbursement tied to quality performance and culminates with global capitation—the most sophisticated existing payment structure. MSSP ACOs and MA global risk arrangements are situated on the risky end of this continuum, with variation depending on the amount of money providers risk losing if they exceed their target expenditure (i.e., their “benchmark”).

Figure 1. VBC Continuum¹



¹ Although episode-based payment arrangements remain a critical component of the shift to VBC, their smaller scale and focus on specialty care place them outside the scope of this analysis.

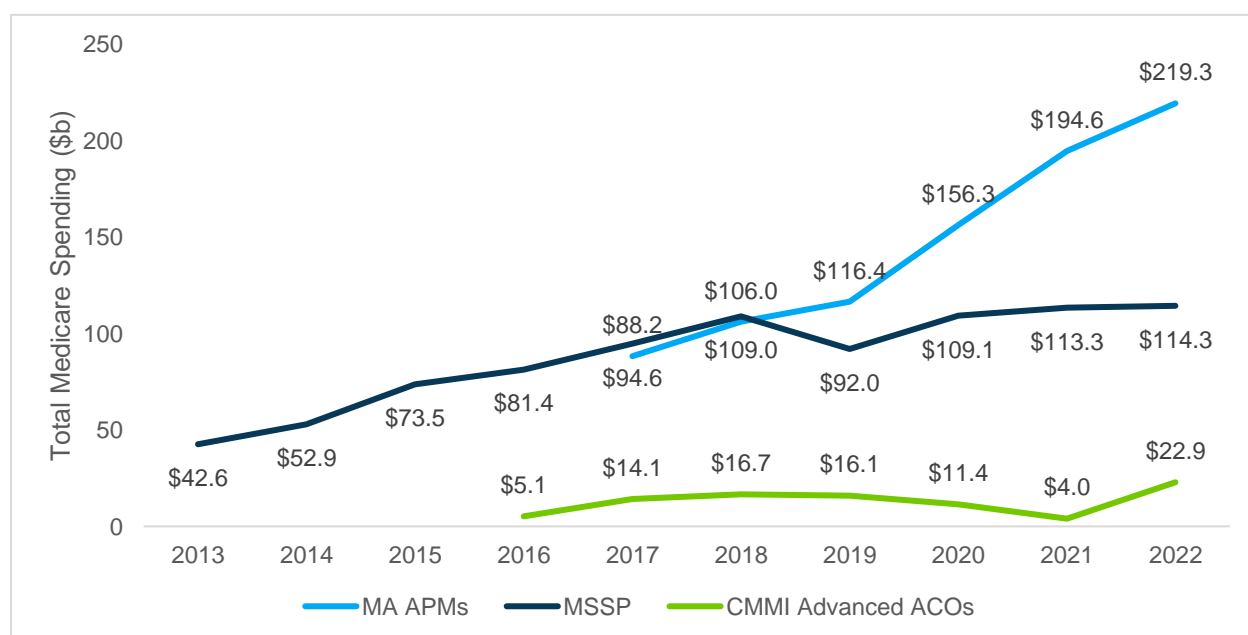


Recent growth in the number of new entrants and the size of existing participants in population-level VBC arrangements may result from proliferation of complementary technology, shifts in organizational cultures, government-sponsored model opportunities, and achievement of better patient outcomes and increased profitability via use of these arrangements.

Relative TAM and Current Trends

As organizations in VBC arrangements have grown, so has the TAM for population-level VBC. Figure 2 shows the growth of MSSP ACOs, Advanced Centers for Medicare and Medicaid Innovation (CMMI) ACOs, and MA alternative payment models (APMs) in terms of the dollar amount of total Medicare spending.

Figure 2. Medicare Spending on Population-Level VBC programs



MSSP

The MSSP is a permanent ACO program within traditional Medicare that emerged from early successful CMMI models. It contains multiple tracks that vary in risk level. Although the number of individual MSSP ACOs has declined since the 2019 implementation of the Pathways to Success program, which forced ACOs into downside risk earlier in their agreement period than usual, the number of beneficiaries receiving care from participating providers continues to increase. This trend corresponds with a TAM that exhibited a 7% compound annual growth rate (CAGR) from 2016–2021. A substantial proportion of Medicare dollars flows through the MSSP; in 2020, approximately 30% of FFS Medicare beneficiaries were attributed to an MSSP ACO.²

² Analysis of [KFF Medicare Enrollment data](#) and [MSSP 2020 Program Participation data](#).



In the recently released [2023 Medicare Physician Fee Schedule \(MPFS\)](#), CMS proposed the first significant changes to the MSSP since 2019, and the largest changes to the methodology for setting expenditure benchmarks since program inception in 2012. CMS sought to grow the program by making it easier for providers to participate and succeed in MSSP ACOs; indeed, CMS aims to enroll all traditional Medicare beneficiaries in an accountable care relationship by 2030. These proposals, including upfront capital for relatively small ACOs located in underserved communities and a longer glide path toward downside risk for new entrants, are likely to grow the program's TAM significantly beginning in 2024.

CMMI Advanced ACO Models

Born of the ACA, CMMI develops, implements, tests, and then recommends scaling a variety of healthcare payment and delivery models within federally funded programs. The earliest ACO model that CMMI tested—Pioneer ACO—achieved savings and was ultimately scaled nationally to what is now the MSSP. It also informed subsequent, more advanced ACO models, such as the Next Generation ACO Model (2016–2021) and the current ACO Realizing Equity, Access, and Community Health (REACH) Model, profiled below.

ACO REACH: Launching in 2023 as the re-envisioned Global and Professional Direct Contracting (GPDC) program,³ ACO REACH provides the first opportunity for providers to take global risk for beneficiaries in traditional FFS Medicare. Because the model launched so recently, there is limited program data available to estimate the true TAM. However, using participation data from CMMI, the program's size by number of participants has quadrupled since its inception in 2020 (Figure 3). With CMMI indicating that no more cohorts will be added, this number has likely plateaued; however, the relative size of each participating REACH ACO measured by number of attributed beneficiaries will likely grow until the model ends in December 2026.

Notable data points⁴ about current participation in the GPDC Model include:

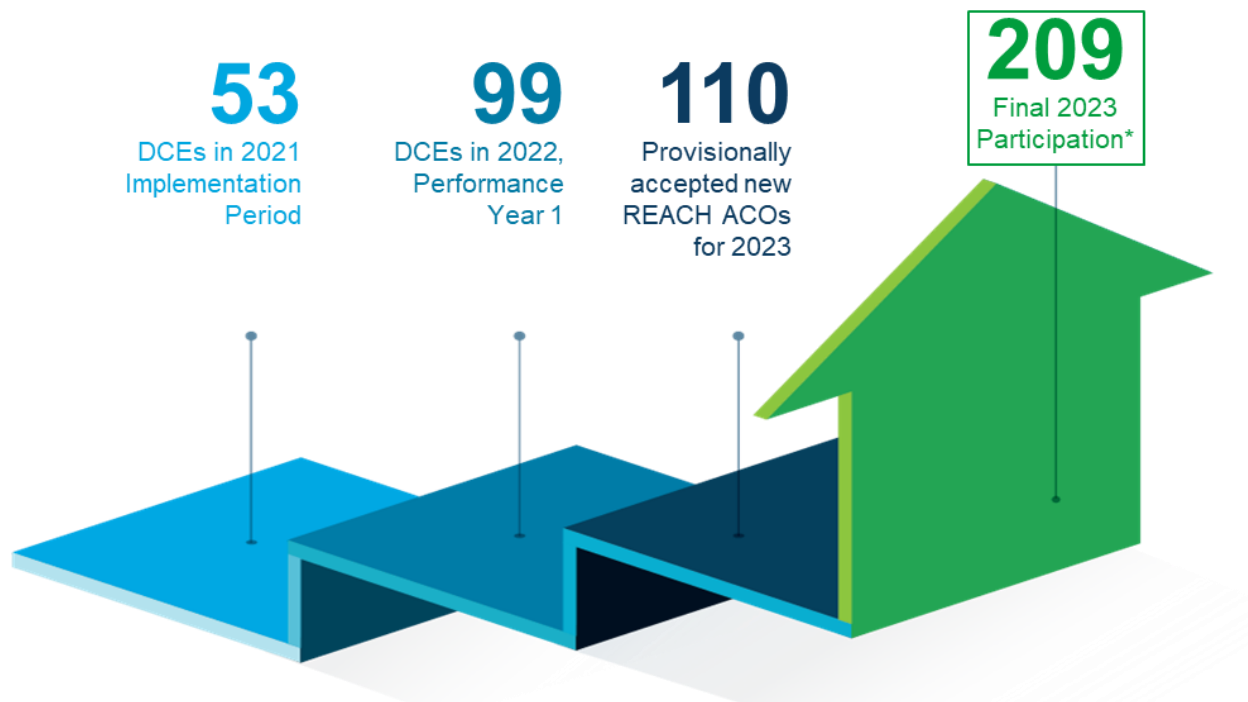
- 56% of all aligned beneficiaries are in a provider-led ACO; 23% are in ACOs led by payers, and ~22% are in venture/managed care organization (MCO)-led ACOs.
- The largest 10 Direct Contracting Entities (DCEs) comprise greater than 50% of the total market; the top three (all academic health systems) comprise 20% of the DCE market.
- The total size of the ACO REACH market in 2022 is approximately 20% of the MSSP, accounting for approximately 4% of the overall Medicare FFS market.

³ CMS initially launched the GPDC Model in 2019 under the Trump administration; however, after significant public discourse and calls for model reform, the Biden administration relaunched the model as the ACO REACH Model to begin in 2023. Original DCEs are permitted to continue participating in the rebranded program and become "REACH ACOs" if they meet all program qualifications by 1/1/2023.

⁴ Validate Health [presentation](#) to National Association of ACOs members, August 2022 (membership required).



Figure 3. Direct Contracting/ACO REACH Participation, 2021–2023⁵



*Assumes all 99 DCEs meet new ACO REACH requirements and remain in the program beginning in 2023.

These trends have generally remained stable in [recently released data](#) on the 2023 REACH ACO cohort, although private payer representation is minimal among new participants. Avalere will analyze ACO REACH further in future insights once additional program data become available.

Although CMMI models are experimental and thus have relatively small TAMs, they are a leading indicator of where VBC trends may go in the future among private payers and are therefore important to consider within any VBC investment strategy.

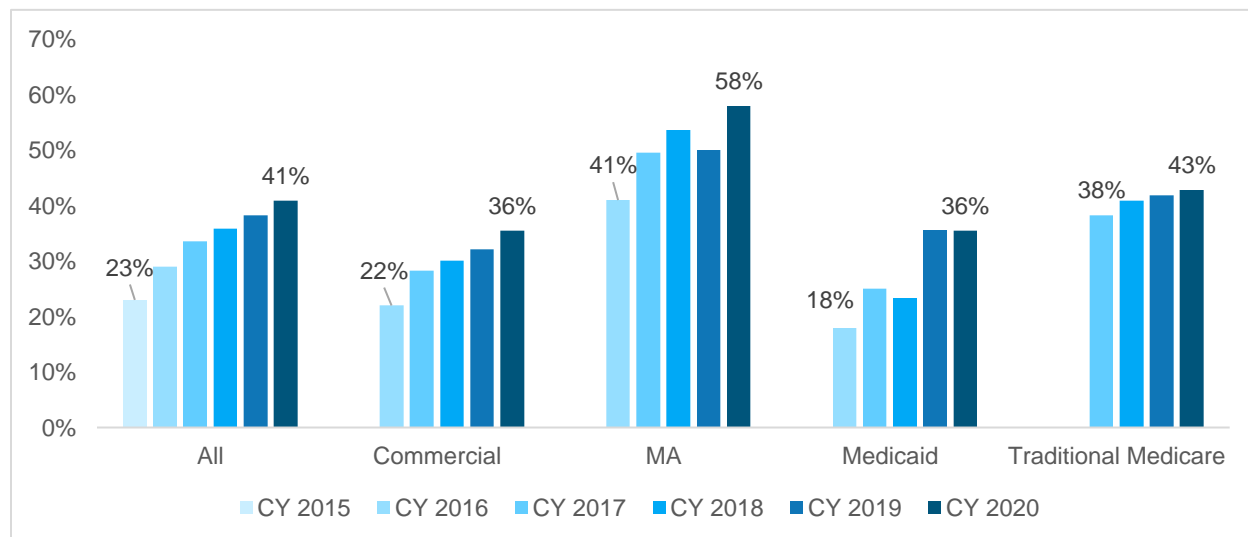
MA APMs

Data validating the true TAM for MA APMs are limited because financial arrangements between MA payers and their VBC providers are private. However, evidence from the Healthcare Payment Learning and Action Network (HCPLAN) suggests that the percentage of healthcare dollars flowing through APMs in MA grew by 17% from 2015–2020 (Figure 4). Avalere analysis indicates that the dollar amount has grown even more significantly, as depicted in Figure 2 above, because of the increase both in MA spending and in the proportion of that spending flowing through APMs since 2017.

⁵ CMMI. [ACO REACH](#) and [GPDC](#) model information.



Figure 4. Uptake of Risk-Based APMs by Different Payers, as a Percentage of Healthcare Dollars, 2015–2020 (HCPLAN 2021)⁶



As shown in Figure 4, although the proportion of spending through APMs has increased in recent years across almost all payers, the fastest growth in VBC has occurred in MA. Growth among commercial insurers has lagged in comparison as a result of lacking incentives and the complexities of employer customers; however, recent efforts by large employers such as [Walmart](#) and [JPMorgan](#) to shift toward value-based care may accelerate growth.

Several compounding factors have contributed to the recent rise in population-level VBC within MA, including:

- Increasing provider maturity and comfort with risk
- Increased revenue stability through VBC participation, particularly during and after COVID-19
- Increasing number of enabler-type entities such as Management Services Organizations to facilitate participation in VBC arrangements
- Provider consolidation enabling greater data integration
- The ability in MA to customize VBC arrangements, which is not an option in MSSP and CMMI models
- Payer desire to reduce per capita spend
- Growing provider interest in VBC participation, including from providers in traditional FFS

Although the TAM of each of these VBC models continues to grow, the simultaneous proliferation of new entrants, disruptors, innovative partnerships, and M&A activities has created a constantly shifting marketplace of investment opportunities. However, not all VBC participants are equivalent, and not all will be successful in generating savings while maintaining quality of care for patients. Below, Avalere provides a preliminary framework for analyzing participants in these models to determine the likely high performers.

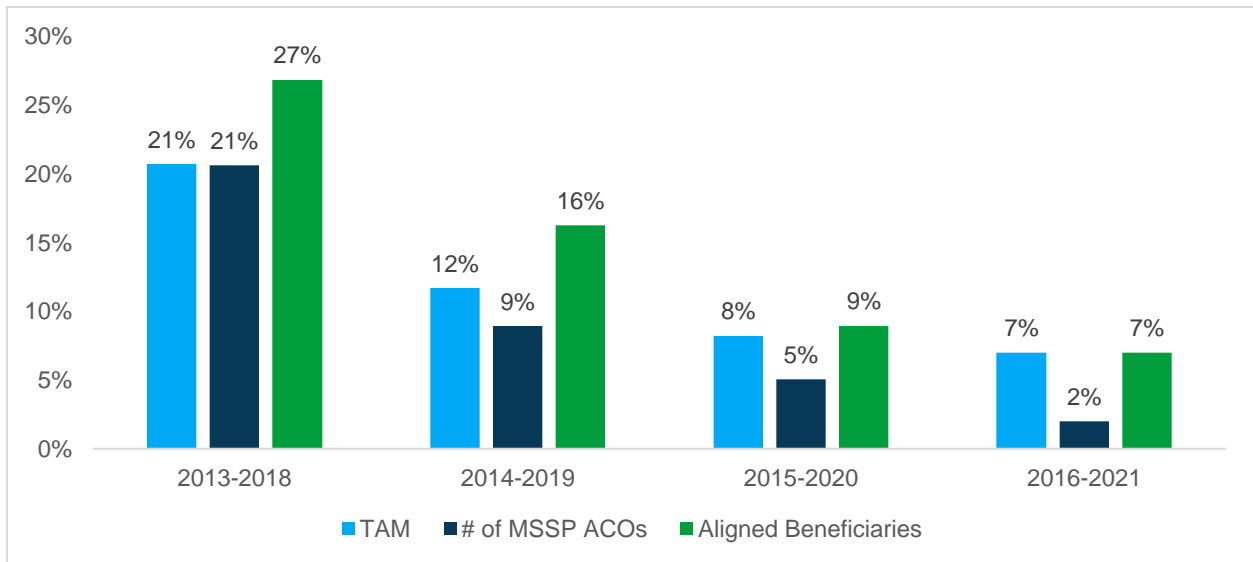
⁶ HCPLAN. [APM Measurement: Progress of APMs 2020-2021 Methodology and Results Report](#). Last accessed September 29, 2022.



Identifying Opportunities in MSSP

CMS regulates the MSSP through annual rulemaking associated with the MPFS. Given the model's longevity and permanence, there is a significant amount of publicly available MSSP participation and performance data that can be used to analyze growth trends over up to 10 years, including the TAM size,* the number of participating ACOs, and the number of aligned Medicare beneficiaries in the program (Figure 5).

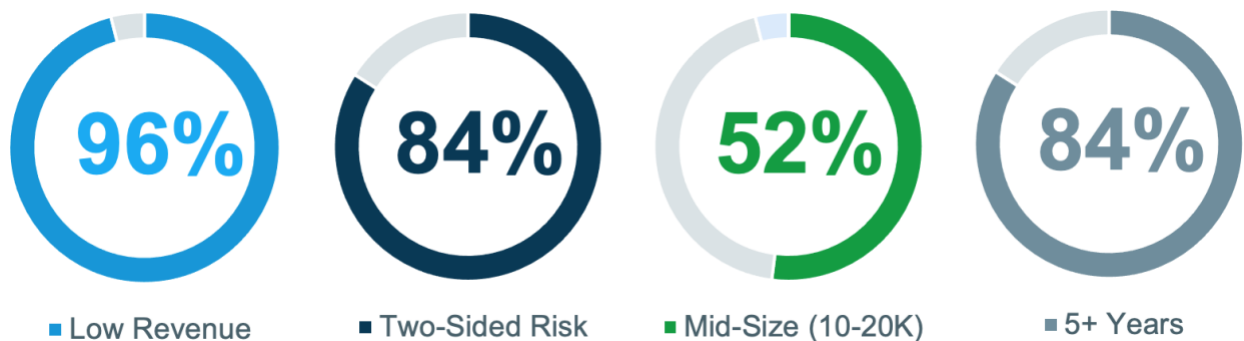
Figure 5. 5-Year CAGRs, Across MSSP Program Statistics



*MSSP TAM is estimated as the combined performance year benchmark for all participating ACOs

Avalere's analysis of the top performers in 2021 by earned shared savings per beneficiary provides useful insight into the characteristics of successful ACOs. Top ACOs are physician led, midsized, and have several years of program experience (Figure 6). These ACOs achieved nearly 5 times the level of per-capita savings than the overall ACO cohort average (\$1,052 vs. \$214). These trends are consistent with those seen in performance data from previous years.

Figure 6. Characteristics of Top 25 MSSP ACOs in 2021



More information about performance trends and potential explanatory factors can be found in Table 1.



Table 1. MSSP Performance Trends

Top ACO Statistics, 2021	Potential Rationale
<p>24 of the top 25 ACOs were designated low revenue (i.e., “physician led”), despite only accounting for approximately half all ACOs.</p>	<p>Aligned Incentives: Low-revenue or “physician-led” ACOs are better aligned with high quality, low-cost care than their hospital-led counterparts, given the focus on reducing institutional care through lower readmissions and lengths of stay.</p>
<p>84% of the top performing ACOs assumed downside risk, compared to 41% of the total cohort. Within that 84%, of which 76% are in the Enhanced Track.</p>	<p>Greater Risk, Greater Reward: ACOs that take risk for their patient population (i.e., by committing to reimburse Medicare if they exceed their benchmark price) are rewarded with greater earning potential when they achieve savings.</p>
<p>More than half of the top 25 ACOs are considered midsized, with 10,000-20,000 beneficiaries; 44% are small (<10,000); only 1 of the 25 is considered large (>20,000). The average number of beneficiaries for the cohort was 21,314.</p>	<p>Goldilocks Principle: Although ACOs of all sizes can achieve success, the “Goldilocks principle” applies: ACOs that are too large may struggle to consistently implement quality and cost-saving initiatives across their entire patient populations of patients and physicians, whereas smaller ACOs may struggle to invest sufficiently in the infrastructure needed to consistently perform well.</p>
<p>The vast majority of the top 25 ACOs have been in the program since 2017 or earlier. Approximately one-third of top performers started 9-10 years before 2021. Just three top-performing ACOs (12%) entered the program in 2020.</p>	<p>Delayed Gratification: Prior research established that ACOs—both within the MSSP and in other CMMI models—are less likely to achieve savings during their first years participating in the model compared to later years, because of start-up costs and delayed realization of quality improvements inherent in many preventive or chronic care improvement initiatives.</p>

Analysts can also segment ACOs by patient population characteristics such as enrollment type and average risk score. No clear trends emerge when viewing data at the patient level; ACOs with a sicker, more diverse population have achieved savings similar to those achieved by ACOs with less complex patient populations.

Looking ahead, CMS may finalize significant MSSP changes that it has proposed, which could create favorable participation conditions for several types of organizations, such as:

- Small physician-led ACOs, particularly in rural or underserved areas, newly eligible for add-on payments
- New entrant ACOs with high spending patterns
- Existing ACOs that have recently achieved significant savings in the program and that will now be less impacted by the “race to the bottom” under new benchmarking method

To effectively identify investment opportunities in the ACO domain, investors must use a data-driven approach informed by investor-specific considerations and a historical understanding of program trends.



Identifying Opportunities in MA APMs

Public information is scarce on specific contracted arrangements with private MA plans. However, the market for APMs within the MA program is clearly growing (it totaled more than \$156 billion in 2020). When isolated, however, population-level APMs only accounted for approximately [22%](#) of MA payments in 2020. This distinction is likely due to the complexities faced by providers that shoulder global risk or total cost of caring for their patient population.

Although many growing organizations focus on providing total-risk population health—including high-profile groups such as Oak Street, ChenMed, Iora, VillageMD, and Landmark Health—these organizations account for a relatively small fraction of care provided to MA beneficiaries. However, as MA APMs continue to spread and as the MA population grows—MA enrollees are projected to reach [almost 70%](#) of the overall Medicare population by 2030—this segment will continue growing.

When evaluating these businesses as potential investments, investors must systematically assess how these businesses approach VBC and the regulatory environments in which they operate to ensure all necessary information is available. For example, in early-stage strategic review of potential investment targets, some important considerations include:

- Markets of operation, including MA saturation and participating plans
- Historical participation in federal VBC models, including achievement of shared savings and reasons for exiting programs as applicable
- Existing and future contracts with payers
- Access to data, actuarial expertise, and sophistication of IT infrastructure

Key questions to ask a potential investment target may include:

- What is your experience managing downside risk either for specific services or for the total cost of care in an entire population?
- What business arrangements do you use to support VBC (e.g., employed vs. contracted physician models, delegated managed care responsibilities, or legal status [ACO vs. independent practice association vs. MCO, etc.]?)

Conclusion

Although similar strategies may be used to identify investment opportunities in each of these programs, each investor must also consider differentiators to determine which model type best complements its overall investment strategy. Considerations such as acquisition size, current portfolio, and preferred investment approach may influence which program is an investor's ideal point of entry into the market. Table 2 provides a selection of benefits unique to each model.



Table 2. Benefits of Investing in Each VBC Model Type

	MA	MSSP
Benefits of VBC Participation	<ul style="list-style-type: none"> • More flexibility in contracting arrangements, providing more control to participating providers • Greater potential upside due to administrative steps such as risk adjustment and coding intensity • Access to per-member per-month capitated payments enhances ability to invest in key infrastructure needed to succeed 	<ul style="list-style-type: none"> • Federal payer provides more stability (i.e., no need to renegotiate contracts with multiple plans every 1-2 years) • Growing popularity and newly proposed provider-friendly nature of model • Fewer utilization management limitations (e.g., prior authorization, network restraints) • Given the program is still driven by underlying FFS claims payments, inherently less risk and less upfront capital required
Best in Class Criteria	<ul style="list-style-type: none"> • Culture of value • Data infrastructure • High-risk patient panel • Favorable market dynamics • Strong relationships with payers • Willingness to take global risk 	<ul style="list-style-type: none"> • Culture of value • Data infrastructure • Experience in the program • Strong physician leadership • Appropriate size relative to market • Policy and actuarial expertise

Potential investors should combine quantitative data and evidence-based criteria to evaluate the characteristics of individual organizations and understand the policy and regulatory outlook that will impact those organizations' chances of success.

Methodology

The calculation of TAM for each model involved the following assumptions:

- MSSP: TAM was considered the total Part A/B benchmark of all participating ACOs in the performance year, as provided annually by CMS in [public use files](#).
 - For 2022, the 4-year CAGR (2017–2021) was applied to project the TAM.
- MA: The percentage of payments in HCPLAN category 3 and 4 APMs was multiplied by the total Medicare dollars spent in MA, minus the medical loss ratio (MLR) assumed to be retained by the health plan. (e.g., in 2020, the calculation was \$317.1B x 85% x 58.0% = \$156.33).
 - For 2021 and 2022, the 3-year CAGR was applied to the percentage of payments flowing through risk-bearing APMs, applied to the [2022 Medicare Trustees' Report](#) projections (minus MLR).
- CMMI Advanced ACOs: Next Generation ACO (2016–2020) and GPDC/ACO REACH (2021–2022) were combined given their similar structure and role in the ACO landscape
 - The 2021 GPDC TAM was calculated using published data; 2022 was projected given unpublished Validate Health data indicating that ACO REACH is approximately 20% the size of MSSP.

