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Analyzing the Expanded Landscape of Value-Based Entities

Implications and Opportunities of Enablers for the CMS Innovation Center and the Broader Value Movement

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Authors and Acknowledgements

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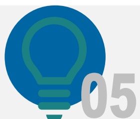

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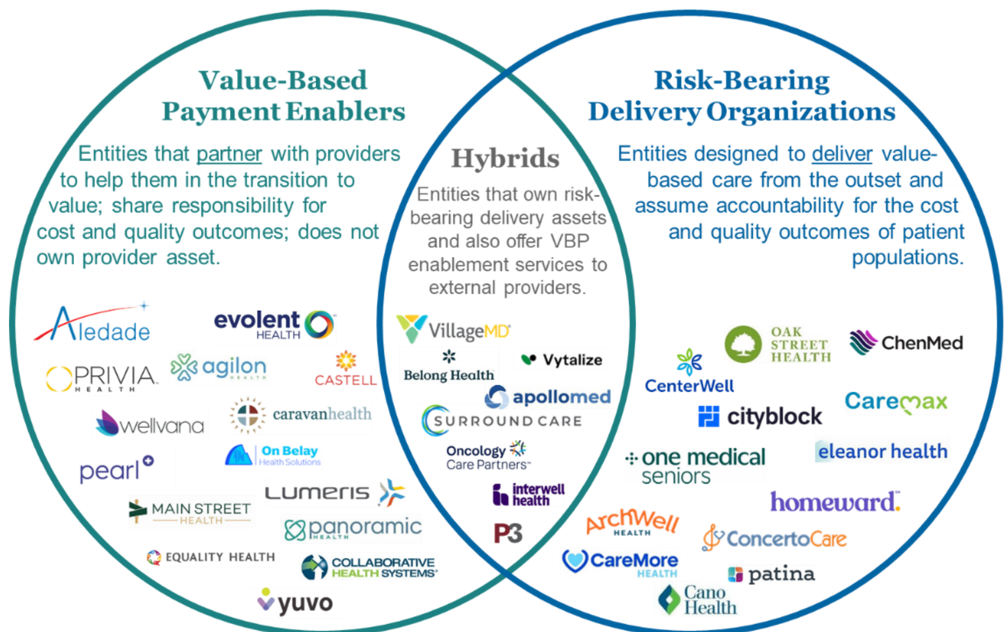
01

Executive Summary

As the U.S. healthcare system has moved to adopt more value-based payment (VBP) arrangements over the last decade, models have matured and there has been a sustained investment from both the Center for Medicare & Medicaid Services (CMS) and for-profit entities supporting these initiatives.

At the start of the movement, value-based arrangements primarily involved traditional providers and payers engaging in relatively straight-forward and limited contractual arrangements. In recent years, the industry has expanded organically to include a broader ecosystem of **risk-bearing care delivery organizations** and **provider enablement entities** with capabilities and business models aligned with the functions and aims of accountable care (see Figure 1 & Figure 2).



Risk-bearing care delivery entities offer physicians additional avenues to participate in accountable care and opportunities to practice medicine in coordinated, team-based environments. While risk-bearing care delivery organizations differ from traditional fee-for-service (FFS) providers in that they are designed to manage the total cost and quality of care for populations from the outset, CMS does not recognize them in any distinct way within Medicare alternative payment models (APMs). Provider enablement organizations, on the other hand, have a less clear role in CMMI models; because they are non-provider entities, they are eligible to participate in some, but not all, models.

For provider organizations seeking to remain independent while also undergoing the challenging and capital-intensive work of transitioning from FFS to value-based payment models, there is a growing market of new options. The growth and availability of enablement entities that are designed with the explicit purpose of helping providers to overcome barriers to participation and whose own financial success hinges on the success of their provider partners, could represent a promising path toward achieving accountable care. Armed with technology, expertise, capital, and scale, many of these organizations are well positioned to support providers in the transition, including inexperienced providers that have yet to engage in accountable care, as well as existing participants looking to adopt more sophisticated models requiring new capabilities and with greater levels of financial risk.

Though the number and size of value-based enablement entities has grown in recent years their participation in CMS models is not new. Several of these entities have been supporting providers in the Medicare Shared Savings Program (MSSP) for the better part of a decade, including Collaborative Health Systems, Caravan, Evolent, Aledade, Privia, and many more. However, despite promising signals from these early adopters with sizable covered populations and strong MSSP performance track records, this market is still nascent and in flux. The introduction of new, attractive total cost of care CMS Innovation Center models, along with increasing opportunities to assume global risk in Medicare Advantage, have stimulated new entrants, mergers, and strategic partnerships among existing entities, and significant capital investments among large payers, retailers, and private funders. The impact of this activity on beneficiary care, provider satisfaction and performance, and prices is yet to be determined.

As CMS works to scale adoption of accountable care, there will be tradeoffs that policymakers and providers must weigh in selecting enablement partners to support the transition. However, little formal research has been conducted on the role, growth, and impact of these entities to date, and publicly available information is limited and largely curated by the entities themselves. This space is opaque and rapidly shifting, making it difficult to track.

To support CMS and other industry leaders in understanding the expanding ecosystem of new value-based entities, we developed a framework for classifying and sizing this market by conducting a landscape assessment involving extensive secondary research into publicly available information on more than 120 entities and 60 primary interviews with entity leaders, providers, and policy experts, and developed a set of guiding principles and policy recommendations, which are detailed in this report.

Figure 1. Growth of New Entities Over Time (2011-2023)

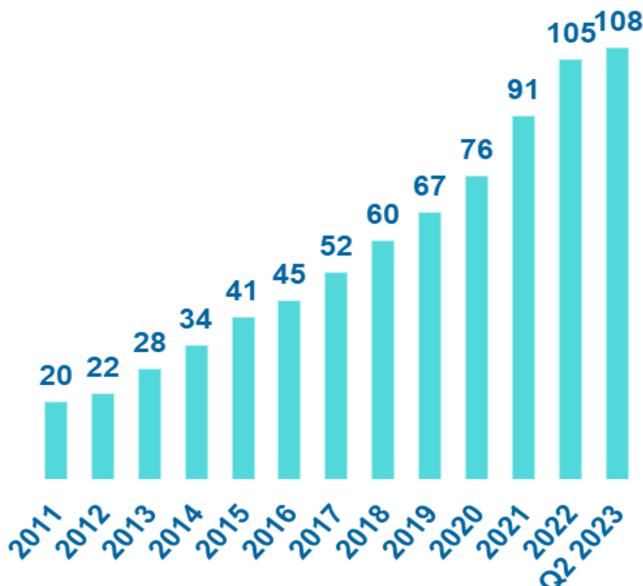
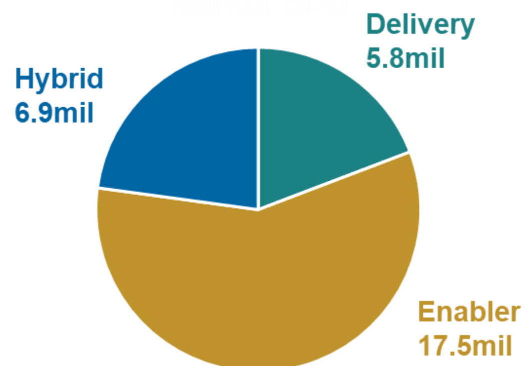


Figure 2. Estimated Number of Value-Based Covered lives by Entity Type



NOTE: Numbers based on authors' analysis. Entity inclusion and exclusion criteria are defined in detail in ***Segmenting the Expanded Value Ecosystem*** *on page 14, with more on our sizing methodology in the* ***Appendix****. This market is evolving rapidly, with new entrants and mergers among existing entities. Our manual tracking goes through Q2 of 2023, and though it represents a thorough investigation of the market, minor gaps are likely given limitations of publicly available information and the shifting environment.*

Project Goals

This report aims to:

- **Create better understanding** for CMS leaders and other stakeholders on the landscape of emerging value-based entities by segmenting and sizing the market.
- **Establish a set of guiding principles** to characterize the attributes of entities that are most aligned with CMS priorities.
- **Investigate the role of these entities** within CMS and CMMI models and the broader VBP market and consider potential benefits and risks of their growth.
- **Offer recommendations to CMS** on how to best engage with this expanded ecosystem in support of their efforts to scale accountable care.

The guiding principles describe the optimal competencies and characteristics demonstrated by enablement entities that indicate they are aligned with CMS, provider, and patient goals. The Guiding Principles section of this report (see page 48) provides additional context describing why these principles matter along with ideas for how model designers and providers might assess an entity's alignment with each attribute.

1. **Payer Agnostic or "Flexible" Payer Approach:** The entity directly or indirectly supports provider success in value-based care regardless of payer type.
2. **Shared Success:** The entity's and the provider's success are aligned with patient outcomes in accountable care.
3. **Enabling Care Delivery Transformation:** The entity's offerings and approach to partnership primarily enable care delivery transformation, rather than provide only administrative efficiencies, technology solutions, and/or financial services.
4. **Financially Viable Business Model:** The entity should have a sustainable business model that can support its mission.
5. **Provider Autonomy:** The entity elevates the leadership, voices, and experiences of physicians and other clinicians, ensuring providers play a significant role in determining how care is delivered and how their practices are run.
6. **Inclusion:** The entity has an approach that is flexible and adaptable to meet the needs of providers with varying levels of experience in accountable care and can serve beneficiaries who have historically been underrepresented in VBP models.

Building on these guiding principles, we offer recommendations that will help CMS further their goals by recognizing that enablers are key partners in scaling the adoption of accountable care. These recommendations, detailed on page 53, are aligned with the guiding principles and are organized into the two broad categories outlined below and discussed in-depth in Policy Implications & Recommendations.

Just as CMS helped to cultivate broad industry alignment around the shift from FFS to accountable care over the last decade, the agency now has an opportunity to help shape the evolving market of value-based entities going forward.

Recommendations

Driving New and Sustained Provider Participation to Advance Accountable Care

- Encourage enablers to invest in underserved communities through partnerships with safety net providers.
- Expand access to primary care capitation.
- Learn from the tactics of VBP entities that have experience implementing the elements outlined in CMS' specialty strategy.
- Signal to hospitals and health systems that outcomes-based payment reforms are inevitable.
- Leverage the private sector to accelerate innovation and investment in Medicaid.

Ensuring High-Quality Partnerships for CMS and Providers

- Continue to allow for enabler participation in alternative payment models with more detailed vetting of applicants.
  - Include scoring algorithms aligned with the guiding principles.
  - Require descriptions of sustainability and implementation plans and audit those plans multiple times during the model.
  - Require all applicants to describe their clinical care model.
  - Establish data analytics requirements for enabler participants.
- Simplify provider participation in models.
- Support providers on enabler partner selection.

01

Background

The Role of CMMI in Shifting the Landscape

The Centers for Medicare & Medicaid Services (CMS), through the CMS Innovation Center (CMMI) and its authority to test alternative payment models (APMs), has led the shift from fee-for-service (FFS) to value-based payment (VBP) over the last decade.[1] The Innovation Center's impact extends beyond the participants and beneficiaries aligned with CMS models to influence the broader market, driving private sector innovation and investment in value-based arrangements for Medicare Advantage (MA), Medicaid, and commercial populations, within a relatively short timeframe.[2]

Achieving 2030 Goal and Beyond: Attracting New Providers While Also Advancing the Movement

After the first decade of testing, the Innovation Center is shifting its focus from broad experimentation to scaling adoption of accountable care.[3] CMS has set the ambitious goal of having **all Medicare beneficiaries and the vast majority of Medicaid enrollees in an accountable care relationship[i] by 2030** and is taking steps to accelerate adoption. [4,5]

These efforts have been largely well received and are expected to increase participation in CMS model opportunities; however, to achieve its 2030 goal, CMS will need to seek innovative ways to engage more clinicians, as well as other payers, in accountable care. To do so, CMS and its Innovation Center must **reach providers that have yet to participate** in total cost of care models—including different provider types with unique barriers to participation—while **retaining existing participants**, many of which have been engaging in Medicare APMs for several years. These two camps will have different challenges, needs, and expectations of CMS.

What is accountable care?

CMS' primary vehicle for value transformation, **accountable care models**, include groups of providers that work together to assume responsibility for the total cost and quality outcomes of a defined patient population. (See Figure 15 in the Appendix for more on the evolution of Medicare ACO models.)

Reaching New Providers

While the specific types of support and model options may vary based on the provider type or market circumstance, all providers who have yet to engage in value-based payment models will need pathways, support, and sufficient time to transition from FFS into total cost of care accountability. These changes are difficult and require significant investments of time and resources, often while facing the competing priorities of the FFS system.[6,7] Without the

[i] According to CMS, accountable care relationships in traditional Medicare include beneficiaries "attributed to an accountable care organization (ACO) through either a CMS Innovation Center model or the Shared Savings Program." CMS has yet to clarify how it will define and measure accountable care relationships in MA and Medicaid.

support needed to overcome the high barrier to entry, the chasm between clinicians who are engaged in accountable care and those who are not will widen.

Retaining Existing Participants

Although early adopters are generally more advanced than those who have yet to engage in value, they still have needs of CMS, including designing and administering the next generation of payment models.

To sustain and scale their participation in accountable care, existing participants are now looking to CMS to advance model designs from FFS-based shared risk arrangements to more sophisticated and predictable models involving prospective payments, greater levels of risk and reward, and more sustainable and predictable benchmarks that are not based on historical spending. With greater financial risk and the shift to prospective payment, having timely access to data and enhanced flexibilities to engage beneficiaries and partners in creative ways becomes even more important to success, particularly as many participants in CMS and CMMI models are also working to assume total cost of care accountability in MA and increasingly for Medicaid and commercial populations.[8] CMS recognizes that aligning these efforts will be critical to achieving accountable care success at scale.[9]

Common Barriers to Accountable Care Among Different Provider Types

Small physician groups and safety net organizations

- Lack of access to capital to invest in needed infrastructure.
- Difficulty navigating the operational complexity of transformation.

Specialists

- Fewer available/willing partners or model options, relative to PCPs.
- Less financial or competitive pressure to leave FFS.
- Greater reliance on partnerships along the continuum to manage patients' holistic care needs.

Hospitals/Health Systems

- Powerful inertia of status quo.
- High fixed costs and debt obligations further reinforcing a reliance on FFS revenues from services that are intentionally reduced under VBP (e.g., ED visits, admissions, and select high-paying service lines).
- Dilemma of shared performance with unaffiliated providers who have unequal capabilities and capital, requiring added investment while ensuring all partners "pull their weight."

Introducing the Expanding Value Ecosystem

In response to the sustained investment and attention to value-based payment and delivery transformation over the last decade, the industry has been evolving rapidly. At the start of the movement, VBP primarily involved traditional providers and payers engaging in relatively straightforward and limited contractual arrangements. In recent years, the value movement has expanded organically to include a broader ecosystem of entities and partnership models including:

- **Risk-bearing care delivery organizations explicitly designed to assume accountability for the total cost and quality of care for populations from the outset.**
- **Enablement entities that partner with providers to assist them in the transition from FFS to risk and, unlike a typical vendor or consultant relationship, assume accountability for provider performance under value-based arrangements.**

These concepts are not new. Management services organizations (MSOs) and risk-bearing intermediary entities, like independent practice associations (IPAs), have existed for decades.[10] Several of the organizations in this expanded value ecosystem have decades-long histories, often beginning as an MSO, an IPA, or some other

provider or payer entity and acquiring new capabilities over time following a strategic shift to focus on value-based care, such as ApolloMed and HarmonyCares,[ii] which originated in the early 1990s.[11,12]

Moreover, these types of entities are not new to CMS APMs. MSO-like entities, such as Collaborative Health Systems and Evolent, have been helping providers to participate in the Medicare Shared Savings Program (MSSP) since the beginning of the model.[13,14] Similar organizations were supporting providers in managing the cost and quality outcomes of populations long before the inception of the MSSP, the CMS Innovation Center, or our current conception of value-based care. Similarly, examples of risk-bearing providers designed to assume cost and quality accountability for high-needs populations—like CareMore[iii] and ChenMed, launched in 1993 and 2003, respectively[15,16]—have existed for decades and have even been influential in informing some CMMI model designs.

Drivers of Recent Growth Among New Value-Based Entities

Though risk-bearing care delivery and physician enablement entities are not novel, growth among existing and new entities dedicated to value-based payment and delivery transformation has accelerated rapidly in recent years (see Figure 12 on page 45), driven by a number of factors including increasing opportunities to engage, investor and provider confidence in the longevity of the value movement, and a natural maturation of the market.

Drivers of Growth Among Value-Based Entities

Strong signals from federal and state governments that value-based care is here to stay.

- CMS/CMMI actions and priorities indicating future direction and continued commitment to VBP across administrations.
- New attractive model options aligned with MA (e.g., ACO REACH, KCC, etc.) and favorable changes to existing programs to better serve providers (e.g., MSSP).
- States incorporating VBP targets into managed Medicaid programs.

Increases in capital investments.

- COVID windfall for payers and retailers leading to significant capital investments in care delivery assets and services geared toward VBP.
- Record PE/VC investment in recent years due to low interest rates.

Growth and evolution of the MA market.

- Growing senior, high-needs population with many opportunities to improve care.
- Aligned incentives and flexibilities in MA program to care for new types of beneficiaries and in new ways.
- Relative financial generosity in MA, creating significant profit opportunity for entities.

Growing demand for transformation.

- Growing demand among consumers and clinicians for changes in the delivery of care that are better supported by APMs relative to FFS (e.g., multidisciplinary care teams, longer visit times, expanded access to care in the home and community, etc.).
- Mounting competitive and financial pressures facing incumbents, leading some to prioritize value transformation.

Organic maturation of value movement.

- Better understanding of the needed capabilities, operational strategies, and clinical programs when managing populations.
- Improvements in data and technology to understand population needs, project performance, and support high-value care with greater confidence and efficiency.
- More opportunities to engage in capitated models with predictable cash flow to invest and engage partners in creative ways.
- Increased appetite for risk sharing among providers and vendors leading to demand for new capabilities and experienced partners.
- Larger talent pool of leaders and funders with direct experience in value transformation.
- Greater appreciation for the difficulties and costs of trying to navigate this shift alone.

[ii] HarmonyCares was known as U.S. Medical Management until rebranding in October 2022.
[iii] CareMore was rebranded as Carelon Health effective January 1, 2024.

The Potential Opportunities of the Expanded Ecosystem for CMS

As pressure to participate in accountable care mounts, providers will look to join existing accountable entities or form new ones. Joining an existing entity may come with trade-offs, such as requirements to adopt new technologies or processes, sacrificing autonomy, or implications for other partnership and growth opportunities. Forming a new accountable entity, however, has a high barrier to entry—particularly for those with limited experience and resources. With these two options—join or create an accountable entity—many FFS providers will seek out external partners with additional actuarial, financial, or operational expertise to help them navigate this decision. Even with expert support, these providers may be limited based on the available partnership options in their market or the ability to secure the capital needed to establish a new accountable entity from the ground up.

Given the administrative and regulatory complexity of navigating this transition, along with mounting financial and competitive pressures facing independent providers and the need for scale in VBP, some providers opt to sell or merge with larger entities, rather than attempting accountable care transformation.[17] Some providers are acquired by larger, savvier organizations with the explicit intention of pursuing value-based care, but the increase in market consolidation resulting from these acquisitions may lead to higher prices, running counter to the goals of accountable care.[18,19] For provider organizations seeking to remain independent while undergoing the challenging and capital-intensive work of transitioning from FFS to VBP, there is a growing market of entities that can provide the tools and scale needed for success in accountable care without contributing to increased consolidation.[20]

Armed with technology, expertise, capital, scale—and, importantly, aligned financial incentives—many of these organizations are well positioned to support providers in the transition to VBP. This expanding ecosystem of value-based organizations could provide a path forward for providers that have been hesitant to participate in a CMS model or enter other value-based arrangements. These entities also may be well positioned to support existing accountable care participants in assuming greater levels of financial risk and adopting more sophisticated models.

However, despite the rapid growth in recent years, this market is still nascent and in flux. Some of these entities have demonstrated impressive outcomes, including success in Medicare models, whereas others have struggled.[21,22,23] The strength and longevity of individual entities has yet to be determined.

Though still new and evolving, the landscape has progressed enough that these types of entities are now an established fixture of the healthcare system, made possible largely because of CMMI's influence in fostering broad buy-in and private sector engagement in VBP over the last decade. CMS and its Innovation Center have an opportunity to help shape this new market to align with the goals of the agency, beneficiaries, and taxpayers as it works to scale accountable care over the next decade.

Potential paths forward for provider organizations:

- Provider acts as their own "general contractor," managing multiple vendor relationships and investing in internal population health teams.
- Provider partners with VBP enabler.
- Provider merges with or is acquired by larger, savvier operator that may or may not engage in VBP.
- Provider remains in FFS.

Project Overview and Objectives

The purpose of this work is to help CMS better understand the landscape of emerging value-based entities, including the different types of organizations, their relative sizes, and the roles they play in supporting providers. This report describes the market and offers recommendations for engaging with these entities to increase participation in CMMI models and accountable care more broadly. This nine-month project included three components: a landscape assessment, development of overarching principles, and discussion of policy recommendations. This section includes a high-level overview of our approach, with additional details on our research process and sizing methodology in the Appendix.

To meet the objectives of this work, we first established the criteria for the types of organizations to include in the landscape assessment of the expanded VBP ecosystem (see below for inclusion and exclusion criteria).

We leveraged our internal expertise and cataloging of the VBP market to aggregate an initial list of relevant entities, established a loose framework for organizing the entities that met initial screening criteria, and determined the priority fields for investigation to build a database.

Following this groundwork, the research team undertook a robust secondary research process that involved collecting publicly available data on approximately 120 entities-of-interest, including information on company founding, ownership, size, target populations, footprints, offerings, business models, and more.

To supplement and validate the publicly available information, we conducted a series of primary interviews with current and former entity leaders, providers, and policy experts. In total, the research team conducted more than 60 interviews, including 52 with current and former entity leaders and providers—prioritizing interviewees with direct experience working for or with multiple organizations—as well as eight interviews with current and former leaders of CMS and CMMI. The final element of the landscape assessment was to segment and size the market based on the findings from primary and secondary research, leveraging data from entity interviews as well as information from Pitchbook,[iv] company websites, and supporting materials to estimate the number of lives covered under value-based contracts. Interviews played a key role in informing these estimates, as publicly reported figures were often inflated.

Concurrently, the research team developed an initial set of guiding principles with considerations for entity participation in CMMI models that prioritized the interests of CMS, providers, taxpayers, and patients. These principles were derived through a collaborative and iterative process informed by the landscape assessment as well as the interviews with CMS and other subject matter experts.

Lastly, the research team synthesized and analyzed the outputs of the first two workstreams to inform policy recommendations for CMS.

Inclusion and Exclusion Criteria for Entities Studied

To be considered relevant to our research objectives, entities had to meet the following criteria:

- **Serve traditional Medicare, MA, and/or Medicaid populations.** Entities that are focused solely on commercial populations were excluded
- **Operate in population-based, total cost of care APMs—**not only bundled payment models.
- **Focus on primary care and/or select specialties that are relevant to total cost of care models** (i.e., nephrology, oncology, behavioral health, cardiology, palliative care). Those exclusively focused on specialty areas geared toward episodic models (e.g., MSK) were excluded.
- **Share accountability for cost and quality outcomes.** Business models must be aligned with provider performance in total cost of care arrangements. Vendors that support VBP but do not share accountability for outcomes were excluded.

[iv] PitchBook is a financial data and software company that specializes in research, analytics, and data pertaining to private equity, venture capital, and mergers and acquisitions activities.

02

Market Landscape

This section details findings from our landscape assessment and includes the following:

Segmenting the Expanded Value Ecosystem 14

- **Introduces our classification framework** for categorizing emerging value-based entities and offers examples of companies across categories
- **Shares topline sizing estimates** for the number of VBP-covered lives represented in each group
- **Acknowledges other important distinctions** within and across broad categories by outlining notable sub-segments

General Observations and Themes Across Segments 19

- **Details the top five similarities** shared by entities regardless of their segment

Segment Overview: VBP Enablement Entities 25

- **Describes the most common offerings of VBP enablers** and how they differ from other third-party partners
- **Covers VBP enabler strategies** for targeting and partnering with providers
- **Outlines provider experiences with VBP enablers**, including the reasons they seek partnerships, how they evaluate and select an enabler partner, and the reasons for ending enabler partnerships

Segment Overview: Risk-Bearing Delivery Organizations 36

- **Describes how risk-bearing delivery organizations differ** from traditional provider organizations
- **Characterizes how these entities operate**, including care delivery approaches, populations served, and growth strategies

Challenges Among VBP Enablers & Risk-Based Delivery Entities 39

- **Details the challenges these entities face** in securing VBP contracts with private payers and effectively scaling operations

Entity Engagement in CMS and Innovation Center Programs 40

- **Provides the historical context** for these entities' participation in total cost of care models and how it has evolved

Landscape Evolution and Expectations for the Future 43

- **Projects how the landscape will change** as entities adapt their offerings and strategies to meet the needs of providers, differentiate in the market, and effectively scale

Segmenting the Expanded Value Ecosystem

Options for segmenting the market of emerging value-based entities could include categorizing organizations based on their target populations, contracted payer types and payment models, scope of services, ownership, and more.

In deciding how to segment this market, we reviewed the available published and gray literature and considered existing industry terms and classifications,[24, 25, 26] including the labels interviewees used in describing these entities. Where possible, we sought to build on prior research, though studies of this landscape are limited.[27, 28, 29] To our knowledge, this work represents the most comprehensive assessment of this market to date.

To segment the landscape, we sought to develop a framework that would help CMS, clinicians, researchers, and other stakeholders understand the key distinctions between these entities, while being flexible enough to accommodate the nuances and fluidity of this rapidly evolving space.

We elected to segment entities based on their core business models (enablement versus care delivery) and provider focus (primary versus specialty care). Figure 5 on page 17 depicts this segmentation matrix and includes a sampling of entity logos to illustrate the types of organizations that fall into each category.

Market segmentation is the process of subdividing a market into groups based on shared characteristics, enabling a more comprehensive understanding than can be achieved by evaluating the market in aggregate.

The primary reasons for segmenting a market are to:

- Create a framework that allows for a shared understanding of the market,
- Enable comparative sizing of the market, and
- Assess/inform implications, which may differ along segments.

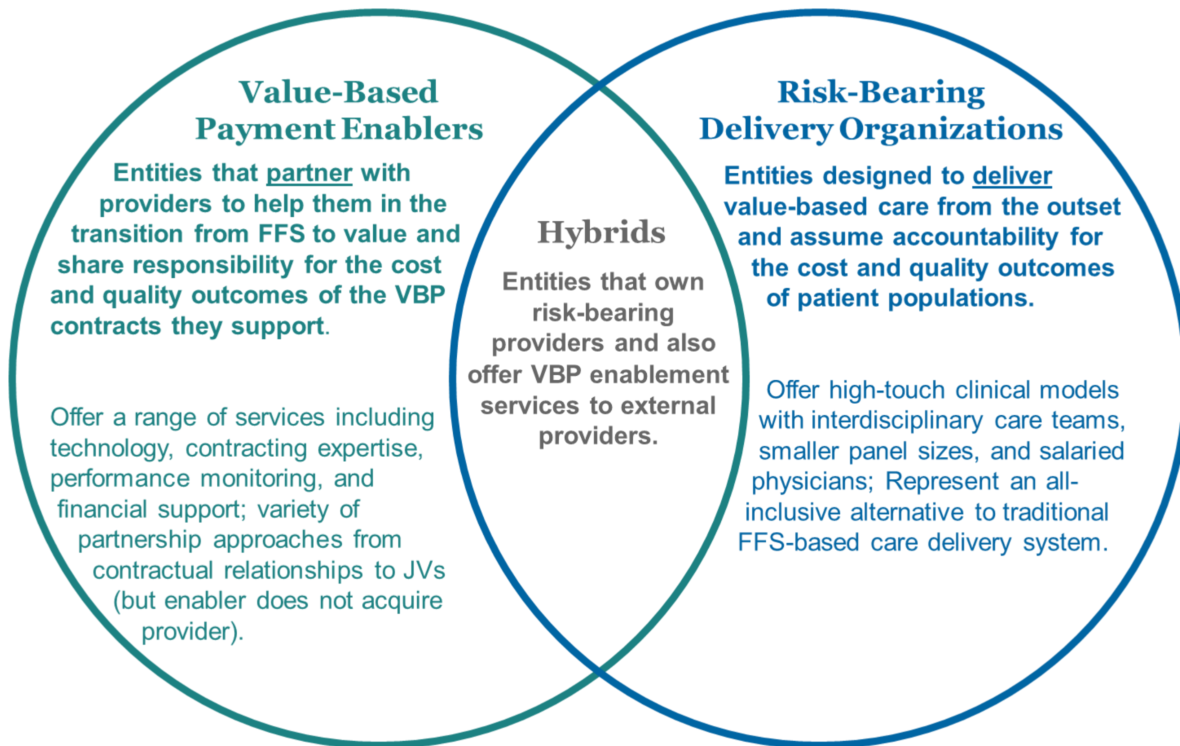
- **Business Model:** Does the entity enable independent[v] providers to deliver value-based care, or does it employ providers who deliver care in this way?
- **Provider Focus:** Does the entity largely focus on supporting primary care providers in managing the total cost of care for populations, or does it focus on supporting specialty providers in managing the total cost of care for select populations or conditions?

Segmenting Entities by Business Model: Enablement vs. Care Delivery

The primary way to distinguish between entities in the expanded value-based ecosystem is based on their relation to providers and involvement in the direct provision of care. While these entities share similar competencies and objectives, as they are all focused on achieving success under accountable care, a key distinction is whether the entity is designed to support independent providers in navigating the transition from FFS to value, or if the entity is designed to deliver value-based care through employed providers. Figure 3 introduces high-level descriptions of each market segment by business model. We elaborate on each of the segments and share specific examples of organizations in the sections below.

[v] In this context, "independent" refers to providers that the partner entity does not own or employ.

Figure 3. Market Segments by Core Business Model



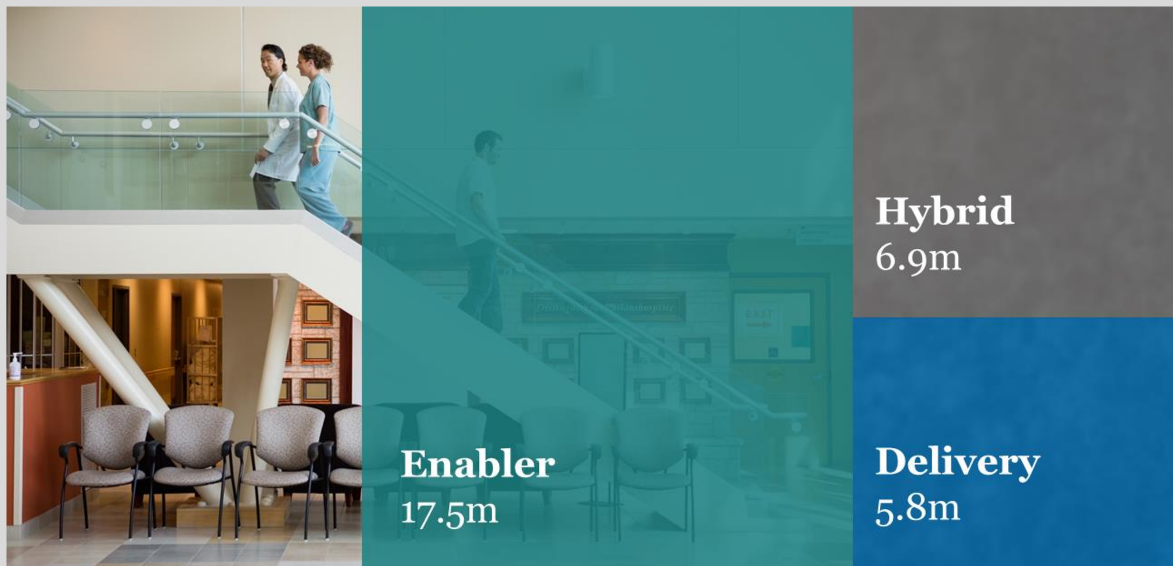
- **Enablement:** These organizations are not involved in the direct provision of care but have business models centered on partnerships with external providers to assist them in adopting value-based arrangements with public and private payers by supplying technology, supporting change management, negotiating contracts, and more. Though VBP Enablers vary with respect to their specific offerings and approaches to provider partnership, inherent to all organizations in this segment is the alignment of the entity's business model with provider performance in accountable care.
- **Care Delivery:** Rather than incrementally transitioning from FFS, these entities are designed to directly deliver value-based care, often assuming global risk for the total cost of care of select high-needs populations. These risk-bearing delivery organizations represent an all-inclusive alternative to traditional FFS-based providers, offering high-touch clinical models led by interdisciplinary care teams and robust wraparound services that address patients' clinical and social needs.
- **Hybrids**: Given the similar strengths and capabilities needed to support providers in succeeding under accountable care regardless of whether they are owned or affiliated, some organizations pursue both business models. In studying the market, we identified a few different approaches among hybrid entities and acknowledge that the lines between enablement and care delivery are evolving rapidly.

Entities identified as hybrids in our segmentation largely include companies that own provider assets and offer enablement services as two relatively distinct parts of the business, though their care delivery and enablement arms may leverage similar capabilities and platforms or take advantage of other synergies. We also identified examples of hybrid entities that primarily function as VBP enablers but with approaches to provider partnerships that extend beyond typical contractual relationships or co-owned joint ventures (JVs) to also offer practices the option of being partially or fully acquired by the enabler entity.

Hybrid entities include companies that started with the intention of offering both enablement services to external providers and delivering value-based care directly through owned provider assets. More common, however, are hybrids that started in one segment and expanded the scope of their capabilities and focus over time either organically or through acquisitions. For details about this growing trend of entity expansion/diversification and specific examples, see **Landscape Evolution and Expectations for the Future** on page 43.

Figure 4 shows the estimated number of VBP-covered lives by each type of entity.

Figure 4. Estimated Value-Based Covered Lives by Segment



*NOTE: This market is evolving rapidly, with new entrants and mergers among existing entities. Our manual tracking goes through Q2 of 2023, and though it represents a thorough investigation of the market, minor gaps are likely given limitations of publicly available information and the shifting environment. For details on the sizing methodology, see the **Appendix**.*

Segmenting Entities by Provider Focus: Primary Care versus Specialty Care

In addition to segmenting the market by core business model, these entities can be further classified based on their focus on primary care physicians (PCPs) and general populations versus a focus on specialists and specialty populations.

- **Primary care-focused entities** largely serve primary care clinicians and practices, prioritizing robust primary care as the foundation of their accountable care strategies. While primary care is the focus, these entities may also partner with or employ some specialty providers, especially clinicians who are involved in managing common chronic conditions. Because of the overlap in provider types, the best way to distinguish between primary care- and specialty care-focused entities is that primary care entities assume responsibility for the total cost and quality of care for **general populations**.[vi]
- **Specialty-focused entities** have a relatively narrow focus on a select specialty area. Most market activity centers on disease states where specialists tend to manage the majority of patients' care needs over an extended period of time—such as chronic kidney disease and cancer—as these conditions are well suited for population-based, total cost of care accountability (relative to specialties with more limited patient interactions or

[vi] In this context, "general populations" refers to populations not specific to a particular disease state.

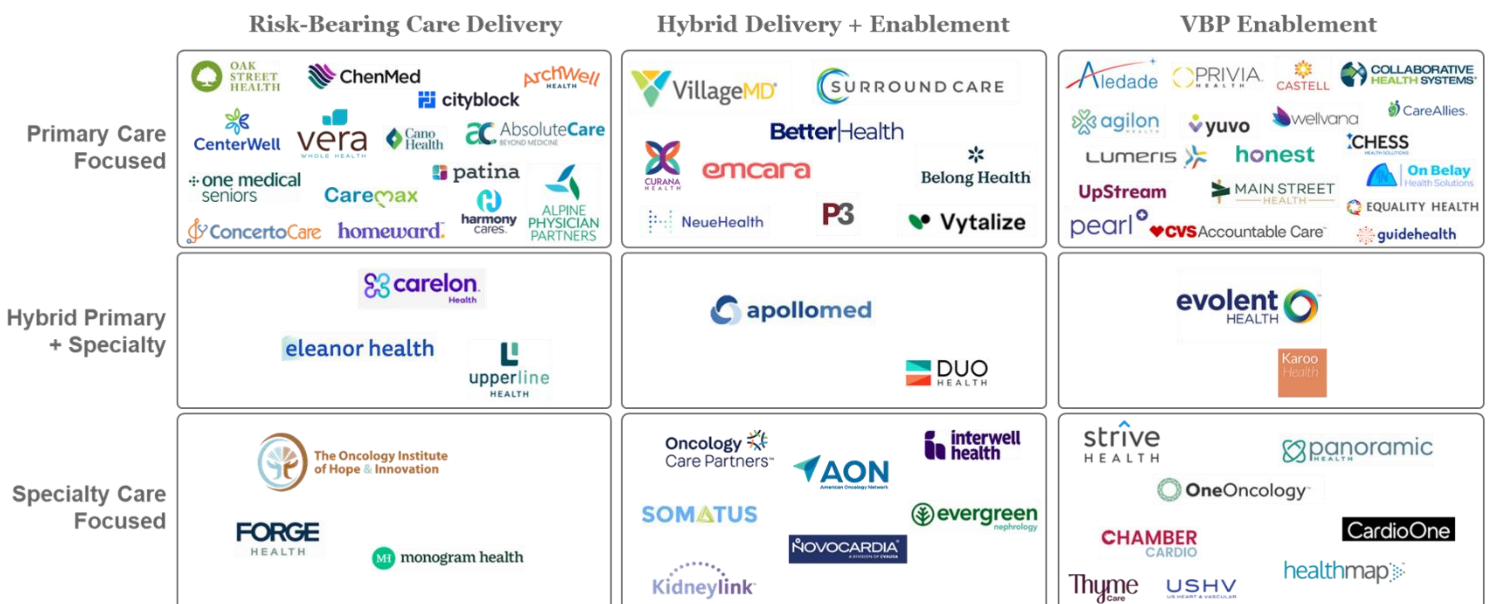
clinical scopes). Entities in this segment also assume responsibility for the total cost and quality of care but typically for **select subpopulations or conditions**.

In our segmentation, two different types of **hybrid primary + specialty entities** were identified in the market:

1. One type of primary/specialty hybrid includes entities that partner with or employ primary care and specialty providers to assume accountability for populations that are **broader than those narrowly defined by a specific disease state/diagnosis but have greater and different clinical needs than the general population**. An example of this type of hybrid organization is Karoo Health, a VBP enabler focused on populations with cardiovascular disease where the enabler's clinical model hinges on close collaboration between PCPs and specialists. Another presentation of a primary + specialty hybrid is Eleanor Health, a risk-bearing provider that assumes total cost of care accountability for patients with complex behavioral health needs.
2. Another type of primary/specialty hybrid entity in our segmentation includes entities that have **discrete primary care-focused offerings/service lines for general populations, as well as specialty-focused offerings for specialty populations**. An example of this type of hybrid organization is Evolent, a VBP enabler serving health plans and providers that initially focused on primary care through partnerships with health systems and medical groups to support their value transformation efforts. In recent years, the company has been increasingly expanding and prioritizing its specialty solutions across multiple specialty areas with brands such as New Century Health (oncology and cardiology).[30]

Figure 5 illustrates the broad segments by business model and provider focus and includes a sampling of entity logos to illustrate the types of organizations that currently fall into each category.

Figure 5. Entity Segmentation Matrix with Sampling of Organizations



NOTE: See Segmenting the Expanded Value-Based Ecosystem for explanation of our approach. Entity placements based on known company details gathered through public materials and/or confirmed in interviews as of Q3 2023 and are subject to change. Not all organizations included in our analysis are represented.

Acknowledging Sub-Segments

Segmenting the evolving market of value-based entities into broad buckets based on core business model (i.e., enablement vs. care delivery) and provider focus (i.e., primary care vs. specialty care) offers a helpful framework for understanding the landscape, assessing the relative size of each segment, and for identifying the general similarities and differences between like organizations. Though the segments offer helpful high-level groupings, it is important to acknowledge other meaningful differences among entities. The Market Sub-Segments callout below describes these sub-segments at a high level. Examples of how these differences manifest in the market are woven throughout the remaining this section. While these distinctions are more nuanced and difficult to assess quantitatively relative to the higher level segments, sub-segments may represent important distinctions for CMS, providers, and other stakeholders to understand. As such, many of these concepts are reflected in the Guiding Principles on page 48.

Market Sub-Segments

The following sub-segments describe variations among the entities within and across segments.

- **Payer/Program Focus.** Is the entity focused on a single payer/program or multiple? If the latter, what was their entry point and expansion path?
- **Patient Breadth.** Does the entity assume cost and quality accountability for all patients in a given population, or do they carve out a specific cohort (e.g., high-needs patients)?
- **Investor Interest.** Is the entity publicly listed or private? What sources of funding have been used?
- **Independence.** Is the entity independently owned or is it a subsidiary of a larger entity such as a payer, retailer, health system?
- **Asset Ownership.** Does the entity own all of the assets used to enable/provide high-value care, or does it subcontract or partner with other vendors/enablers to deliver these services?
- **Diversification.** Is value-based care enablement or delivery the sole focus of the entity or is it simply one offering among a suite of services/divisions?
- **Clinical Staff Employment.** Does the entity employ “core” clinical staff (e.g., MDs/DOs, APPs, etc.) or “supplemental” clinical staff (e.g., care coordinators, medical assistants, etc.)?
- **Offering Focus.** Does the entity differentiate itself with its clinical offerings, technological offerings, or administrative offerings? Does it offer similar services in FFS/transactional context as well as VBP partnerships? *(Enablement only)*
- **Ownership of Risk.** Does the entity or the provider group directly hold the insurance risk? *(Enablement only)*
- **Preferred Partners.** Does the entity primarily partner with one provider type (e.g., independent primary care practices, FQHCs, etc.), or does it partner with multiple types of providers and various practice configurations? *(Enablement only)*
- **Practice Growth Strategy.** Does the entity build de novo practices or acquire existing FFS practices with the intent of transitioning them to VBP? *(Care delivery only)*

The entities studied varied significantly, both across segments and even among organizations of the same category. However, most entities in this space shared some notable characteristics and tactics. **The sections below outline the high-level, general similarities among most organizations in the expanded VBP ecosystem before offering a deeper dive into each segment,** including the common characteristics and important distinctions between the entities within and across categories.

General Observations and Themes Across Segments

In the course of our research, we identified several general similarities across most of the entities in this space, as they all are focused on helping providers achieve success in accountable care and, therefore, tend to have similar strategies and use similar approaches to population health management.

General Commonalities Across Segments:

1. Similar Prioritization of Target Providers and Geographies
2. Priority Populations and Sequencing
3. Hybrid, High-Touch Clinical Models
4. Ownership and Use of Technology Assets
5. Funding, Investor Confidence & Payer/Retailer Interest

Trend #1: Prioritization of Providers and Geographies

For the past several years, most VBP enablers and risk-bearing delivery organizations seem to be prioritizing the same types of providers and using similar criteria to evaluate new markets for expansion.

"Tier 1" Providers – In general, many value-based entities have been focusing on reaching similar types of providers and using similar qualitative and quantitative criteria to evaluate them. Several interviewees described the growth in recent years as the "first wave" of provider aggregation for value-based care, specifically among entities focused on primary care and nephrology, with other provider types and specialty areas now beginning to pick up. (For more on this, see the Landscape Evolution and Expectations for the Future section on page 43.)

Organizations focused on primary care, whether through enablement partnerships or acquisition, reported using similar general criteria for "tier 1" primary care practices, which include:

- **Large and mid-size independent primary care practices,** as well as majority-PCP multi-specialty groups
- **Serving large and growing Medicare populations,** including both FFS and MA beneficiaries
- **Some experience in VBP** or a cultural alignment with value

Kidney care-focused organizations, both enablers and risk-bearing delivery organizations, shared similar considerations, focusing on practice size and market share, a Medicare-heavy payer mix, and a commitment to and understanding of value among practice leaders.

"Tier 1" Geographic Markets – Similarly, in recent years, most value-based entities have tended to use similar criteria to evaluate new geographic markets for expansion, including:

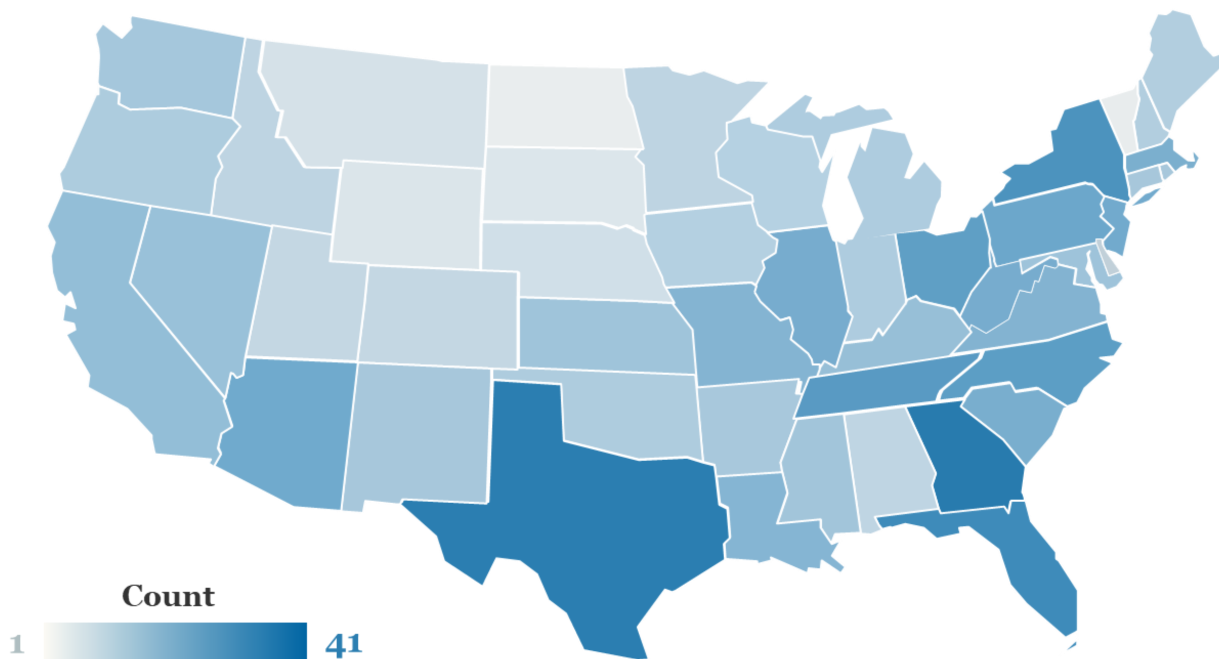
- **Market size and growth opportunity.** Entities are looking for a minimum threshold of lives (i.e., total addressable market), alongside large and growing MA and FFS Medicare populations.
- **Payer attitudes towards VBP.** An important consideration that nearly all interviewees raised is the presence of willing health plan partners, whether through established, existing relationships with payers or simply the presence of "VBP-friendly" plans, which are more likely to share risk. For example, multiple interviewees mentioned a preference for markets in which Humana is more dominant than UnitedHealthcare, as the former is perceived as a more VBP-friendly payer partner. Interestingly, interviewees shared differing views about whether regional or national payers were more receptive to value-based contracts.
- **Provider performance.** Most entities use Medicare claims data to assess utilization trends before deciding which markets to enter and which providers to approach. Though entities across segments analyze market performance, enablers and delivery entities appear to view provider performance differently. Where enablers see struggling providers as an indication of an attractive market with opportunities to improve provider

performance, risk-bearing delivery entities are generally less interested in entering low-performing markets, whether through acquiring low-performing practices or building new practices to recruit providers.

- **Competitor presence.** According to interviewees, the presence of existing value-based entities within a market does not necessarily deter others from entering, but most do consider market saturation and the availability of Medicare beneficiaries who are not already aligned with an accountable care entity. Entity leaders shared differing perspectives about the presence of competitors when evaluating a new market, though these strategic differences did not vary based on segment or along other obvious lines. For example, Optum's presence is a deterrent for many entities, whereas others see Optum's entry into a market as a catalyst that will encourage incumbents to prioritize their own value strategies.

Figure 6 shows the known market presence of VBP enablers and risk-bearing delivery organizations at the state level. Given the similar expansion criteria that most value-based entities use—including the importance of large and growing Medicare populations and opportunities to drive savings relative to historical costs/performance—the concentration of these organizations in states like Texas, Florida, Georgia, Arizona, is to be expected. As the landscape matures, entities are beginning to prioritize "tier 2" geographies (discussed in Landscape Evolution and Expectations for the Future on page 43).

Figure 6. Heat Map of Entity Presence by State

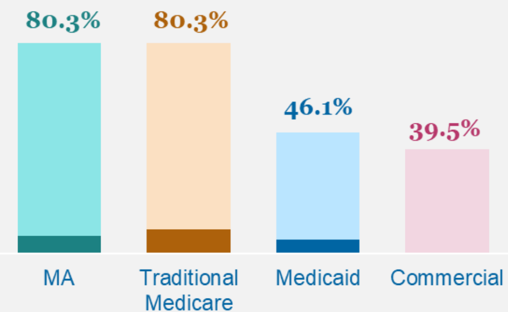


NOTE: This map represents publicly available data of states where 108 VBP enablers, risk-bearing delivery, and hybrid organizations have a known market presence as of Q2 2023. Some organizations do not disclose their market footprint. Importantly, it represents the number of discrete entities, not covered lives.

Trend #2: Similar Target Populations and Sequencing

Though the target patient populations vary among entities (detailed in the segment overviews below), most VBP enablers and risk-bearing delivery organizations are serving Medicare populations.[vii] Notably, most entities include MA risk as central to their growth strategy, given the large and growing MA population and more financially favorable program dynamics. Some entities exclusively focus on MA populations, but most organizations also serve—or support providers who serve—FFS Medicare beneficiaries, largely through the MSSP and/or CMMI initiatives such as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH), Kidney Care Choices (KCC), and some Enhancing Oncology Model (EOM).

Figure 7. Population Focus of VBP Enablers, Risk-Bearing Delivery, and Hybrids



NOTE: This data, derived from public sources and interviews, shows the distribution of VBP entities across various lines of business. The dark portion of each bar represents entities exclusively dedicated to that line (21% focus on a single line of business). Entities exclusively targeting commercial populations were not included in the research.

Generally, primary care-focused enablement and delivery entities prioritize populations in the following order when seeking value-based contracts:

1. Medicare (traditional Medicare and/or MA)
2. Medicaid managed care
3. Commercial/self-insured/ employer

Among specialty-focused entities, Medicare populations are also prioritized first. Whether they begin with traditional Medicare or MA depends on the specialty and the availability of CMMI model opportunities (i.e., the existence of a relevant APM and/or whether an existing model is open to new applicants). Unlike primary care-focused entities, leaders of specialty-oriented organizations ranked commercial populations well above Medicaid.

Figure 7 shows the known population focus by line of business (LOB) across all VBP entities studied. Most organizations (79%) are working across multiple LOBs, with only 21 percent of sampled firms working exclusively within one line of business.

Trend #3. Hybrid, High-Touch Clinical Models

Whether they are directly involved in the provision of care (i.e., risk-bearing delivery organizations) or partner with external providers to support their care delivery processes (i.e., VBP enablers), most entities use or facilitate hybrid, high-touch clinical models that support physicians by helping to fill gaps and augment care teams. Many do so through patient navigators and other clinical extenders, supporting practice staff in conducting proactive outreach to patients and caregivers following care transitions or when a patient is identified as being at risk of escalating medical, behavioral, or social needs. Even among enabler entities that do not employ these clinical extenders directly, they often support practice staff through streamlining clinical workflows (e.g., generating prioritized outreach lists, support identifying high-value referrals for specialty care or community services, etc.) and automating administrative tasks (e.g., tracking for time-based chronic care management [CCM] or remote patient monitoring [RPM] services, etc.) to allow clinical personnel to optimize patient time.

[vii] The scope of our research focused on entities serving Medicare and/or Medicaid populations. Organizations that focused exclusively on commercially insured or cash-pay populations, of which there were relatively few, were excluded. Though fewer value-based organizations exclusively target these populations—relative to those that also serve Medicare populations—growth among VBP enablers targeting self-insured employers appears to be increasing.

Organizations across segments work to enable or provide expanded access to care by supporting extended hours and additional access points. While specific approaches vary, most entities offer or support virtual care services, such as telehealth visits for patients, telemedicine consults with specialists, and other digital health solutions for asynchronous care and communications. Additionally, many VBP enablers and risk-bearing delivery entities have expanded in-home care capabilities, often leveraging partnerships with home health-focused vendors.

Trend #4: Ownership and Use of Technology

Effective use of data and health information technology (HIT) is critical to success when assuming accountability for entire populations. Unsurprisingly, given their similar goals of supporting clinicians in accountable care relationships, these value-focused entities tend to use similar types of technologies to understand the needs of the attributed population, support high-value decision making, and coordinate care across care teams and settings. In general, the types of HIT solutions utilized by VBP enablers and risk-bearing delivery entities are somewhat similar to the population health capabilities one would expect of a highly sophisticated ACO but tend to be more robust in terms of capabilities, in the richness of data sources (e.g., clinical data from multiple EHRs, hospital event notifications, labs and pharmacies, insights from practice-generated and payer claims, regional HIEs, SDOH data, etc.), and more thoughtfully integrated into clinical workflows. Many of these entities also leverage technology to streamline key administrative and financial functions like traditional MSOs.

Most of these entities position themselves as "tech-backed," and many boast proprietary, homegrown solutions while others use the platforms of existing HIT vendors. The callout box on homegrown technologies shares a sampling of entities with internally developed technologies to illustrate the range of purpose-built solutions among these organizations based on public materials. Though not all entities develop homegrown technologies, among those that do, the common thread is an effort to better address provider pain points with solutions designed to support value-based care workflows rather than FFS billing.

> Because entity business models are aligned with provider performance in VBP, they are motivated to build or identify payer-agnostic products that work for clinicians and care teams trying to manage populations. However, providers report wide variation in the quality and value of these products.

Sampling of Homegrown Technologies

Examples of homegrown technologies among VBP enablers & risk-bearing delivery entities include:

- **Aledade's** decision-support solution, the "Aledade App", combines data from multiple sources to provide an integrated view of a patient's medical record and intuitive access to prioritized information to help inform patient- and population-level decisions.
- **ApolloMed's** proprietary "Value-Based Enablement Suite" includes a robust point-of-care app for providers and a patient-facing app for scheduling, communications, accessing personal health data.
- **ChenMed** employs software developers to create tech solutions in-house, including custom decision-support software, homegrown EHR, digital patient ID cards, etc.
- **ConcertoCare**'s population analytics platform called "Patient3D" supports proactive identification of rising-risk patients.
- **Iora** built a proprietary collaborative care platform and EHR called "Chirp" which offers open communication between the care teams and patient-facing access to medical records and shared notes.
- **Oak Street's** decision-support platform, "Canopy", integrates data from multiple sources to support care teams in informing treatment decisions, including an Inpatient Review app for transitions in care.
- **Pearl Health**'s decision-support solution is designed to help providers to quickly identify at-risk patients and forecast needs across a patient panel.
- **Stellar Health's** "Stellar App" is a web-based, point-of-care tool with an incentive structure that promotes completion of granular actions.
- **VillageMD** created primary care-centered operating system called "docOS" that unifies and normalizes patient information across EHRs, insurers, hospitals and post-acute care settings.

Descriptions based on public materials and inclusion is not an endorsement or assessment of the technologies.

Although many entities point to their homegrown solutions as differentiators, few have an entirely proprietary HIT infrastructure. Interviewees described instances in which some organizations that we believed to have homegrown technologies based on publicly available information simply licensed other vendors' solutions, white-labeled under the entity's name.

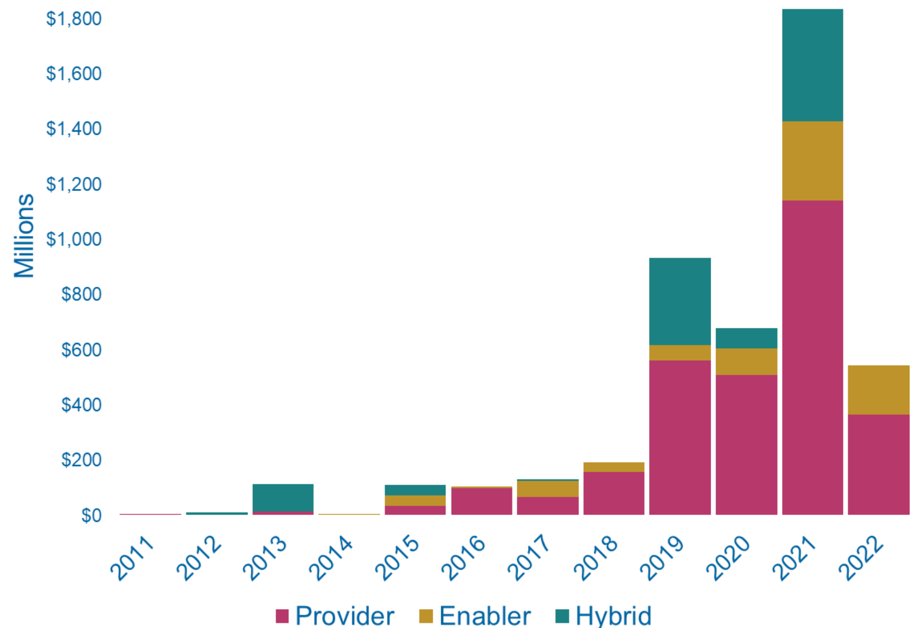
Regardless of whether they use homegrown technology, most of these entities directly employ data analysts and informaticists to with the goal of minimizing the administrative burden and friction borne by physicians, clinical teams, and practice administrators.

Trend #5. Funding, Investor Confidence, and Payer/Retailer Interest

Most entities depend on outside capital and investment to fuel growth. Some of these organizations are operating at significant losses. For example, Oak Street Health and One Medical held successful initial public offerings (IPOs) in 2020, despite posting net losses of $109 million[31] and $45 million[32] in 2019, respectively. CVS[33] and Amazon[34] later acquired these entities at high valuations. Investor confidence in the ability of value-based organizations to eventually turn a profit appears to outweigh the current operational challenges of implementing value-based care at scale.

PE and VC firms' investment in these types of entities has grown substantially in recent years (see Figure 8). Total private equity investment activity, defined as the total amount of capital raised from both private and institutional investors (the latter encompassing angel, growth, and venture capital funds), grew at a five-year compound annual growth rate (CAGR) of 75.3 percent prior to the pandemic. Despite exhibiting a subsequent deep decline, much like investor activity in the healthcare world at large, investor interest in this space seems to be robust and growing with the shifting emphasis on value-based delivery models.

Figure 8. Private Investment Funding by Company Type



NOTE: Based on Pitchbook data for identified companies and may not be comprehensive of all transactions as it does not track private or non-disclosed

As the value market matures, the number of investment partners with a specific focus on value-based payment and delivery transformation is growing. Notable VBP-focused funders include Oak HT/FT, Townhall Ventures, Valtruis (a value-focused portfolio company of Welsh, Carson, Anderson & Stowe[35]), Rubicon Founders, and Deerfield Management Company.

While most entities are privately owned, both enablement and risk-based care delivery segments include entities that have gone public through IPOs or special-purpose acquisition company (SPAC) deals. See Figure 9 for examples of entities that have gone public in recent years.

Both VBP enablement and risk-bearing delivery segments have garnered attention from payers and large retailers (see Figure 10 for a sampling of value-based entities owned by payers and retailers). National payers and retailers have made some notable acquisitions in recent years, but not all payer-owned entities were purchased. Some were

incubated internally and launched by the payer years ago and are now gaining traction, largely because of increased investment and attention to the ripening environment for value-based care.

Similarly, some large health systems are investing in value-focused enablement companies through their venture capital arms, such as Memorial Hermann's recent investment in VBP enabler Wellvana,[36] or launching their own separate entities to offer VBP enablement services to other providers, applying lessons from their own experiences in value transformation. Examples of health system-owned enablers include Intermountain's Castell and Atrium's CHESS,[viii] both of which are supporting providers in CMS accountable care models, including the MSSP and ACO REACH, among other types of value-based contracts with public and private payers.

Figure 9. Sampling of Publicly Traded Value-Based Entities

Name (segment)	Public Year
agilon (enabler)	IPO 2021
American Oncology Network (hybrid)	SPAC 2022
ApolloMed (hybrid)	IPO 2008
Babylon (delivery)	SPAC 2021; returned private via merger in 2023
Cano (delivery)	SPAC 2020
Caremax (delivery)	SPAC 2020
Evolent (enabler)	IPO 2015
Oak Street (delivery)	IPO 2020
One Medical (delivery)	IPO 2020
P3 (hybrid)	SPAC 2021
Privia (enabler)	IPO 2021
Signify (enabler)	IPO 2021
The Oncology Institute (hybrid)	SPAC 2021

Figure 10. VBP Enablers and Risk-Bearing Delivery Entities Owned by Payers and Retailers

Payer/Retailer Parent Co.	Entity Name (Segment)
Amazon	- One Medical (delivery) ○ One Medical Seniors FKA Iora (delivery)
Bright Health	- NeueHealth (hybrid)
Blue Cross of NC	- Alo (enabler)
Blue Shield of CA	- Altais (hybrid)
Centene	- CHS (enabler)
Cigna	- CareAllies (enabler)
CVS/Aetna	- CVS Accountable Care FKA Active Health Management (enabler) - Oak Street (delivery) - Signify (enabler) ○ Caravan (enabler)
Elevance	- Carelon (hybrid)
HCSC	- Innovista (enabler)
Humana	- CenterWell (delivery) - Conviva (delivery)
Independence Blue Cross	- Tandigm Health (enabler)
Kaiser Permanente	- Risant (hybrid)
UHG	- Optum (hybrid)
Walgreens	- VillageMD (hybrid)

[viii] Cornerstone Health Enablement Strategic Solutions (CHESS) was founded in 2012 by North Carolina Baptist Hospital, Cornerstone Health Care, and Laboratory Corporation of America. Following a series of mergers, the company is now owned by Atrium Health Wake Forest Baptist and LapCorp.

Segment Overview: VBP Enablement Entities

VBP enablers center their business models on supporting providers seeking to adopt and succeed in value-based contracts. More specifically, VBP enablers, as defined in this report, refer to entities focused on enabling provider success in payment models involving accountability for the quality and total cost of care for defined populations. In other words, the VBP enablers discussed in this report focus on accountable care models, not on episodic models like conveners.

To qualify as a "VBP enabler," as defined in this report, an entity must:

- ✓ Focus on total cost of care models, not (only) bundles.
- ✓ Have aligned financial incentives/shared accountability for provider performance under VBP.
- ✓ Offer robust breadth of population health capabilities, including strong focus on clinical transformation.

Other terms sometimes used to describe these entities include:

- *Physician Enablement Platforms*
- *ACO Management Partners*
- *ACO Conveners or Enablers*
- *Affiliate Provider Platforms*

How do VBP enablers differ from other third-party partners?

There is a vast market of vendors and consultancies that serve care delivery organizations. While some healthcare services and technology companies offer contingency-based pricing for their products or certain performance guarantees, what differentiates VBP enablers from other healthcare vendors—even those with similar capabilities—is the **breadth of their offerings and the nature of their relationships** with providers.

VBP enablers partner with providers to support the full scope of their strategic, operational, financial, and administrative needs when assuming accountability for the cost and quality outcomes of patient populations through risk-based contracts with public and/or private payers.

Despite the heterogeneity of the VBP enabler market**,** inherent to all organizations in this segment is alignment of the financial incentives between the provider and the enablement partner. If the financial arrangement between the provider and the third-party organization is not tied to the provider's performance in accountable care, we do not consider that entity to be a VBP enabler.

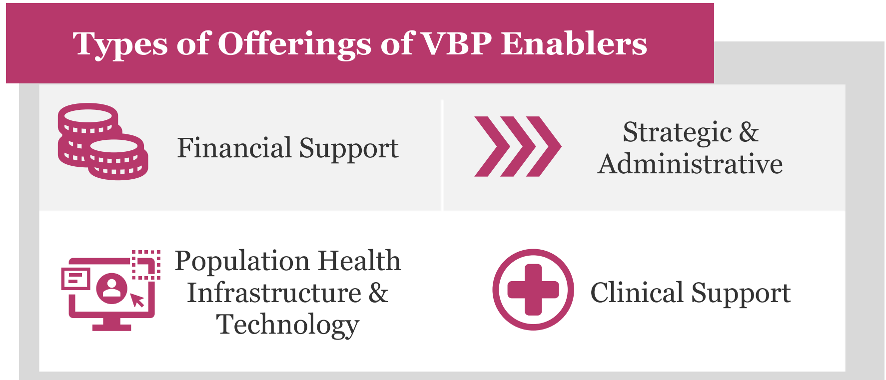
Using this definition, we identified and investigated approximately 70 companies classified as VBP enablers and enabler/delivery hybrids by reviewing publicly available materials (e.g., websites, press releases, pitch decks, articles, conference presentations, etc.), gathering information on their enablement offerings, provider partnership models, payer/model experience, ownership, and more. To further investigate their approaches and to validate and build on the available information, we conducted primary interviews with current and former leaders of VBP enablement companies, prioritizing interviewees with experience working within multiple entities, and a sampling of their provider partners. The synthesis below includes common offerings among VBP enablers, provider partnership strategies, and providers' assessment of enablers.

Common Offerings Among VBP Enablers

At face value, most VBP enablers appear to offer similar services, generally resembling those of a sophisticated MSO with additional capabilities to support care delivery transformation, quality improvement, and with explicit expertise in negotiating value-based contracts.

A detailed investigation of enablers' offerings was not the primary focus of our research, but we believe that a better understanding of these services may be helpful to CMS, as well as state policymakers and payers, in identifying opportunities to support providers through centralized services, payment model designs, and other policies. The similarities in services that VBP enablers provide, particularly those that serve the same types of providers and populations, reflect the common pain points and unmet needs of providers trying to successfully adopt accountable care today.

The general similarities in enabler offerings are also an indication that the value movement is maturing. Entities have a clearer sense of the capabilities needed to manage the health of populations, where providers are most likely to have gaps, and how to fill them.



The offerings of VBP enablers can be grouped into four high-level categories: financial, strategic and administrative, population health infrastructure and technology, and clinical. We summarize these categories at a high-level below, but it is important to acknowledge that the types and extent of services that an enabler offers can vary based on the needs of the provider partner and the nature of the partnership. Our research showed that few enablers offer a single, standardized set of services to all their provider partners.

Furthermore, while most enablers seem to market similar solutions, interviewees with direct experience working for or with multiple enablers report wide variability in the quality and value of their offerings. These findings are consistent with prior research on ACO management partners from 2018[ix,28] and suggest more work is needed to help providers to evaluate their options.

Financial Support

One important function of VBP enablers is their ability to help providers overcome financial barriers to participation and success in accountable care. With far more access to capital than a typical FFS-based provider—particularly small, independent practices and others with cash flow constraints—enabler entities often help cover the costs of needed investments in population health infrastructure and personnel and protect providers from potential losses under downside risk arrangements.

Access to capital to support needed investments in infrastructure.

Many enablers offer upfront funding to cover the costs of needed infrastructure, including technology and personnel. The amount of and approach to these financial investments often depends on the nature of the partnership. The longer and more comprehensive the partnership terms, the more willing an enabler is to invest.

- **Some enablers fund infrastructure investments without any cost-sharing for the provider.** For example, as part of its offering, Aledade pays to implement its technology platform and build interfaces with each practice, regardless of their EHR. Aledade's practice partners use more than 50 different EHR systems. The company spends approximately $2 million annually to build these interfaces, each with about 90-day implementation timelines. Despite the financial and operational implications, Aledade covers these costs to mitigate added administrative burdens on practices and to streamline data sharing.
- **Other enablers help to fund operating expenses,** such as hiring additional nurse care managers and other needed personnel to support population health functions such as chronic care management, care coordination across settings, and home visits. In many cases, while the enabler may help to hire and fund the FTEs, those costs are often reconciled from future savings.
- **Some enablers allocate a set amount of capital to fill gaps in operational and clinical capabilities** that the provider and enabler mutually agree upon. For example, as part of its partnership terms with some

[ix] Notably, our inclusion criterion specifying that non-provider entities must share accountability for cost and quality outcomes to be considered a "VBP enabler" differs from the looser definitions used in earlier research on this topic. (Murray et al.)

providers, agilon commits a pool of funding that can be used for investments in primary care over the duration of the long-term partnership. The enabler and provider partner have an equal say in how these dollars are spent, having equal representation on the governing board. Investments in primary care, such as home-based palliative care programs or virtual pharmacy capabilities, are funded entirely by agilon and not deducted from shared savings.

Protection from downside risk.

Arguably more important than upfront funding is an enabler's willingness to protect providers from significant losses that could occur depending upon the specifics of the downside risk arrangements and relevant regulatory requirements. Most commonly, enablers absorb part of the risk, with some splitting the repayment amount at the end of the performance year and others fully covering the loss settlement with the payer and partially recouping those payments through adjustments to future savings payouts. We discuss additional nuances around risk ownership in the "Partnership Models" section below.

Even if a provider organization feels confident in its ability to enter a downside risk track/model based on consistent, strong performance in upside-only arrangements, it may have difficulty satisfying the model's repayment mechanism requirements. Having the backing of a well-funded enabler partner with access to reinsurance coverage or other stop-loss protections can help providers satisfy these requirements and avoid potentially catastrophic losses.

Strategic and Adminstrative Support

VBP enablers have capabilities and functions similar to MSOs. In fact, most enablers own an MSO or evolved from one. Some entities operate exclusively as VBP enablers in partnerships involving shared accountability for outcomes, whereas others also may offer MSO services to other clients in traditional fee-based model.

VBP enablers act as management partners and take on key administrative functions to support provider operations. Common offerings of this type among VBP enablers include:

- Payer Contracting and Network Strategy
- Claims Adjudication and Processing
- Education and Training
- Credentialing
- Outreach and Marketing
- Revenue Cycle Management
- Reporting (e.g., quality, health equity plans, etc.)
- Compliance
- HR, Hiring, Personnel Management
- Group Purchasing

Like MSOs, enablers often take on front- and back-end administrative functions to allow provider partners to focus on the clinical aspects of care. Additionally, enablers often are seen as critical strategic partners, collaborating closely with provider leadership teams to develop a road map for their value-based payment and delivery transformation efforts.

Given their aligned incentives with provider performance, a desire to grow value-based lives under management, and explicit expertise in VBP, enablers can play a critical role in helping provider partners evaluate model options and negotiate risk-based contracts with private payers. Not only do they have contracting expertise and relationships with national and regional payers, but VBP enablers also help providers tap into broader networks and take advantage of the larger scale to secure value-based contracts with private payers otherwise unwilling to delegate risk. Depending on the partnership model (described on page 32), the enabler may negotiate all payer contracts directly on behalf of the provider or may function as strategic advisors in seeking and advancing value-based contracts by evaluating the terms and leveraging their relationships and brand strength to bring payers to the table.

The importance of scale when assuming financial responsibility for populations is not a new concept or exclusive to accountable care. Among health insurers, for example, even the smallest plans cover hundreds of thousands of lives. VBP enablers help providers connect to broader networks to achieve the scale needed to reduce volatility in

risk-based arrangements without consolidating under common ownership. These dynamics are often observed in Medicare ACO models.

> *"When [Direct Contracting] was announced, I knew I would've been in over my head. If we didn't already have a partner to evaluate which option was better, we would have had to pay a consultant to help us figure it out. Not only that, but [the enabler] was invested in the outcome of that choice."*
>
> – COO of health system-affiliated medical group

In the early years of the MSSP, enablers like Caravan (which originally targeted rural providers) and Aledade (which still almost exclusively targets independent primary care practices) led multiple MSSP ACOs composed of provider participants across different geographic markets aggregated into a single ACO to achieve the minimum threshold of attributed beneficiaries. Following the accelerated shift to downside risk, some physician-led ACOs left the program, merged with larger multi-specialty provider groups, or began working with an enabler partner.[37,38] Meanwhile, many existing enabler-led ACOs were consolidated into larger groups to prepare for risk. For example, Caravan went from 38 ACOs in participation year (PY) 2019 to 12 ACOs in PY 2020, combining participants into larger ACOs to mitigate losses driven by population volatility.[39] In general, Medicare ACOs have increased in size over the years[39] as the programs mature and require greater levels of risk. The relative sizes of REACH ACOs also reflect this trend.

Enablers also leverage sophisticated data modeling to curate provider networks to optimize benchmarks and performance. Using data to optimize the likelihood of financial returns is also not exclusive to VBP enablers or accountable care models but simply a reality of private actors responding to the incentives that regulators and the broader market have created.

An often underappreciated benefit of VBP enablers is their focus on CMS APMs, which often include staff dedicated to following policy developments and understanding the full policy landscape. Enablers take on the responsibility of studying the ins and outs of CMS model options—as well as the available value-based programs of other public and private payers—helping to distill the relevant information for providers and practice leaders.

Population Health Infrastructure and Technology Support

For many providers, support accessing and using the data and technology needed to manage the health of a population is the most compelling factor in deciding to partner with a VBP enabler rather than tackling these decisions and investments alone. Regardless of the provider type, the patient population, payer, or payment model, all healthcare delivery organizations must invest in new health IT capabilities when transitioning from FFS to VBP. Accountable care requires that provider organizations understand the needs of their aligned patient population, leverage data analytics to risk stratify the population to identify anticipated future care needs, and efficiently deploy limited resources to proactively intervene before avoidable utilization escalates. Achieving these objectives is dependent on effective tools.

Many enablers are, at their core, technology companies, developing their own purpose-built solutions ranging from decision-support tools optimized for clinical workflows, to communications and patient engagement platforms, to EHRs. By developing their own technology solutions, enablers are attempting to fill market gaps left by traditional HIT vendors whose products are oriented around FFS. Because enablers' business models are aligned with provider performance in VBP, they are motivated to build payer-agnostic products that work for clinicians and care teams trying to deliver population health.

Some VBP enablers require provider partners to use their technology, whereas others make tools available to providers that lack existing solutions. Among enablers that require providers to adopt their tech solutions, there is variation in how those costs are covered and in the quality of their offerings.

Though support with data analytics and the technology infrastructure to support population-level accountability is among the top reasons for collaborating with a VBP enabler, provider interviewees placed little emphasis on enablers' unique or superior technology. For many, the HIT-related value proposition of partnering with an enabler is multifactorial. VBP enablers help providers by:

- **Identifying what data and technology solutions are needed** to support the clinical care model and back-end operations
- **Vetting vendors to identify the best/optimal solutions** available on the market
- **Negotiating better pricing** with vendors than providers can alone
- Taking on the responsibility of **chasing down and integrating claims from contracted payers**, along with other data sets
- **Employing personnel like data analysts and actuaries** to efficiently produce actionable reports, help clinicians and administrators make sense of the data, and troubleshoot issues

Examples of enablers that do not require providers to adopt new HIT:

Navvis – Instead of building their own solutions, they license tools from various vendors they consider best in class. Because Navvis often partners with more experienced providers, many already have existing pop health capabilities. Instead of making them start over or migrate to new systems, Navvis' enablement model is designed to accommodate providers' existing data infrastructures.

Vytalize – The enabler prides itself on *not* being a technology company. Instead of pushing a single homegrown platform, Vytalize works with over 100 HIT vendors, including the tools of other VBP enablers. There are similarities in the vendor solutions used within regions, but the enabler's thesis is that one-size-fits-all is not an effective strategy at scale, but instead requires a high level of customization.

Stellar – It doesn't technically require providers to use its platform, but Stellar does pay providers (in the form of "Stellar Value Units") to engage with the technology. The platform is a point-of-care decision-support tool with micro-incentives for users to complete certain tasks, integrated in clinical workflows.

Independent FFS providers transitioning to value without an enabler must function as their own general contractors, managing multiple vendor relationships and the internal staff needed to make use of the data. This model can work well for large clinically integrated networks (CINs) or experienced IPAs, but for most independent practices, this approach is prohibitively difficult and expensive, particularly as they adopt additional and more advanced value-based contracts with multiple payers.

Clinical Supports

Though not directly involved in the provision of care, many VBP enablers offer wraparound clinical services, either through staff whom the enabler employs or through contracted partners. More important than making available added services, VBP enablers offer clinical support by helping providers transform care delivery processes in ways that lead to better patient outcomes and experiences of care than are possible under the traditional FFS paradigm. Enablers should have an *intentional* clinical model, designed and led by physicians, with input from multidisciplinary care teams, patients, and caregivers. Successful enablers start with a clear clinical intention and center their offerings and partnerships in ways that best facilitate those care delivery changes.

- **Examples of clinical supports leveraging enabler-employed personnel:**
  - Most enablers help to facilitate **expanded access to care** through various means, with common support services including nursing care hotlines (e.g., Privia, CVS, VillageMD, Vytalize, etc.) and patient-facing apps for virtual visits and asynchronous communication. Also common are enabler-driven programs that support providers' **chronic care management** efforts by stratifying the population to identify patients in need of proactive intervention, providing care management staff to conduct outreach or facilitate transitions of care, and often supplying RPM solutions.

- Many enablers provide **pharmacy-focused clinical support services** using different approaches. For example, Mainstreet Health embeds navigators in clinics and pharmacies to help support care coordination, and its app allows patients to connect with navigators for assistance with same-day refills and other needs. UpStream Health employs clinical pharmacists that are embedded directly into primary care practices for face-to-face visits with patients and to support PCPs in managing patients with complex chronic illnesses. Aledade employs pharmacy technicians who conduct outreach to patients identified as having potential barriers to filling medications and enroll them in mail-order prescription delivery programs or address other barriers to adherence.
- Among specialty-focused enablers, many offer **patient navigation and wraparound clinical services** to augment practice capacity and coordinate care. While most of these organizations describe similar services in marketing materials, interviewees described varying degrees of clinical integration between enabler-employed clinicians and specialty practice partners. Among the more high-touch, integrated clinical models is Duo Health, which exclusively operates under global risk arrangements with C-SNP and other MA plans. Recognizing that many patients with chronic kidney disease "crash" into dialysis because of under-diagnosis and lack of previous care by a nephrologist, Duo moves beyond care coordination services to employ multidisciplinary care teams that offer concierge-level primary care, in partnership with nephrology practice partners.

In addition to leveraging employed personnel, some enablers—particularly those engaged in prospective payment models like ACO REACH or that receive capitated payments from MA plans—contract with point solutions vendors to make services available to their provider partners and at-risk patients. Common examples include partnerships with home health vendors, diabetes management solutions, medically tailored meals, transportation services, etc. Moreover, because enablers have the added leverage of scale and business models predicated on achieving savings in accountable care contracts, many seek to negotiate outcomes-based pricing or other risk-sharing arrangements with these point-solution partners.

Partnering with specialty care management

As the market matures, VBP enablers are increasingly partnering with specialty care management partners and other point solutions. Large entities often contract with multiple partners and can compare their effectiveness across the network.

Added benefits:

- ✓ Streamlines the vendor selection process for providers
- ✓ Potential to identify winning solutions more efficiently by elevating effective partners
- ✓ Explore the next frontier of value-based contracting, sharing accountability with downstream partners

Provider Partnership Strategies

Unlike traditional vendor or advisory relationships, enablers' financial incentives are aligned with providers' cost and quality performance in accountable care contracts. Therefore, VBP enablers are motivated to help their provider partners succeed. Nonetheless, the level of investment and approach depends on the type of provider and the nature of the partnership.

Target Providers and Partnership Trends

By far, most enabler activity to date is focused on **primary care practices** that serve a high proportion of Medicare beneficiaries. VBP enablers are an attractive option for providers who want to join or form an accountable entity and recognize they cannot do it alone but want to maintain their independence and autonomy in delivering clinical care. The desire to remain independent while still engaging in alternative payment models is the largest driver of VBP enablement partnerships. Not only do primary care practices tend to have more of the needs that enablers address (e.g., less capital to invest in upfront infrastructure, insufficient size to participate alone, etc.),[38] shifting from FFS to VBP models is an easier sell in primary care relative to specialty and acute care, particularly as MA growth and increased risk-sharing gives practices more attractive economics from prospective payments. Payment models that better reward and facilitate coordinated, team-based primary care—relative to the current FFS system in which payments are most limited to primary care physicians, despite their outsized role in population health—are attractive to primary care physicians.[40] Data on the use of VBP enablers among accountable care participants is limited, but research suggests that among "enabled" ACOs, primary care practices have been the dominant focus of enabler partnerships for more than a decade.

> *"We all started with MSSP and as other contracts were presented as options by [enabler] we thought, 'why not? We are already providing this better care, why not do the same things for our commercial patients as well?'"*
>
> – Rural primary care physician leader partnering with an enabler

Some enablers have focused on relatively small independent primary care practices that need considerable support (e.g., Aledade, Vytalize, etc.), including those in rural markets (e.g., Caravan[x], Mainstreet Health, Netrin, etc.), whereas others have focused on larger independent physician groups with demonstrated competencies and performance results (e.g., agilon, Genuine Health Group, P3 Health Partners, etc.). Some enablers have focused on optimizing primary care practices as part of broader clinically integrated networks involving multiple affiliated or owned provider groups, including health systems (e.g., Navvis, Privia, VillageMD, Lumeris, etc.). VBP enablers that have entered the market in recent years—such as Pearl, Honest Medical Group, Wellvana, On Belay Health Solutions, UpStream, and Alo—also are targeting independent primary care providers, suggesting that a sizable market opportunity still exists.

Far fewer enablers have targeted **health systems and hospitals**, but some evidence suggests that this activity is increasing. For example, some enablers that have historically focused exclusively on primary care practices are now engaging in enablement partnerships with health systems. The most notable example is agilon, who began partnering with health systems on MA transformation in 2022 and has since announced additional long-term health system partnerships.[41,42] Other enablers are reaching more health systems by expanding or adjusting their partnership models to accommodate new types of hospital-friendly arrangements, such as Privia's "Care Partners" offering in which Privia partners with a health system's employed physicians and creates a new medical group to recruit independents to the CIN.[43] Lastly, the recent activities among well-funded new entrants focused on health system transformation, such as CVS Accountable Care[44,45] and Kaiser's Risant Health[46], are also indications that hospital-focused enablement is increasing. Enablers that historically have served health systems include Navvis, Lumeris, Premier, and Evolent, although Evolent has since shifted its focus to independent primary care and more recently to specialty care. Navvis and Lumeris remain active in this space.

Among specialty-focused VBP enablers, the largest area of investment and accountable care activity has been in **kidney care**. Kidney-focused enablers include a range of upstarts (e.g., Duo, Strive, Monogram, Evergreen, Somatus, etc.) and some incumbents, including dialysis players who have spun off VBP enablement and risk-based care delivery arms (e.g., Fresenius' InterWell [which acquired enabler Cricket],[47] DaVita's VillageHealth, and U.S. Renal Care's Kidneylink), as well as technology companies and MSOs that pivoted to focus on value-based kidney care following CMS-driven innovations (e.g., Panoramic Health, Healthmap Solutions, etc.). Some enablers partner with independent nephrology practices, while others partner directly with MA plans or other risk-bearing entities that

[x] Caravan started with a focus on rural populations but has since expanded its offerings to new markets.

own global risk. As with primary care providers, multiple drivers contribute to the explosive growth in value-based nephrology partnerships, but chief among them is CMMI models, which represent the lion's share of the VBP-covered lives within most of these organizations. Some enablers, however, work exclusively with MA plans. (See the section **Entity Engagement in CMS and Innovation Center Programs**, page 40, for details.)

Relative to chronic kidney disease, fewer VBP-focused entities are focused on **oncology care**, though there is some activity. Oncology-focused VBP enablers exclusively target community-based oncology practices (not hospital-owned or affiliated), citing hospitals' unyielding focus on drug rebates with high margins and an aversion to value-based transformation. Entities in this space largely focus on medical oncology, although some work with hematology, radiation oncology, surgical oncology, and palliative care providers. Some newer oncology entities focus fully on VBP, such as Thyme Care, which partners with health plans and risk-bearing providers to offer data-driven navigation and wraparound services and assumes accountability for outcomes, as well as Oncology Care Partners (OCP), an MA-focused value-based community oncology platform that is pursuing both practice affiliation and acquisition approaches for risk-based oncology care. Some larger, more established oncology-focused entities take an affiliation-only approach in which VBP represents a relatively small portion of their offerings among a broad spectrum of support services (e.g., OneOncology). Others primarily acquire practices, assuming full risk for the cost and quality outcomes of oncology care (e.g., The Oncology Institute).

> *"Oncology's core issue is the lack of desire or pressure to move away from industry norms. I think the issue is that people know how to make money in oncology, and they don't want to re-learn it. Like how hospitals didn't switch to ASCs. People are hesitant to change until they are forced."*
>
> – SVP, oncology-focused entity

Partnership Models

Some VBP enablers follow a relatively standard partnership model, whereas others offer multiple options that vary widely. Even among organizations that appear to follow a single partnership approach, interviewees were skeptical that any VBP enabler has a standard model, noting the specific terms and details fluctuate based on negotiations.

Despite the nuances in these contracts, interviewees highlighted some common points of distinction in enabler partnership models and issues arising from differences in which entity owns the risk. Though interviewees reported consistent insights regarding the types of partnership models that enablers use, we did not review detailed contract terms. These arrangements are complex, opaque, and evolving, but broadly speaking, the depth of partnership between a VBP enabler and a provider client can range from a straightforward contractual agreement to an involved joint venture relationship.

> **How long do partnerships between VBP enablers and providers last?**
>
> Partnership terms between VBP enablers and provider partners can range from 1-2 years (e.g., Stellar, Pearl, InterWell, etc.) up to 20 years (e.g., agilon). The most common seems to be 3-5 years (e.g., Privia, VillageMD, Aledade, etc.) before renewal.

- **Contractual Agreements:** The most common approach to enablement partnerships includes negotiated contractual agreements between the enabler and provider entity. Specific contract terms vary considerably regarding the services offered, performance measurement, how savings/risk are spilt and paid/recouped, the duration of the partnership, potential exclusivity clauses, and more. In addition to outlining the distribution of savings/losses from value-based contracts with payers—with most gain-sharing agreements split relatively equally or slightly favoring the provider—some enablers charge additional fees throughout the performance year, including administrative fees, per member per month (PMPM) fees for lives under management, and cost sharing for operating expenses such as enabler-employed staff on loan through contracts with large health systems.

> *"[VBP enablers] say they have a general system, but every contract is unique and opportunistic."*
>
> – Market President, employment experience with multiple enablers

- **Single-TIN Contracting:** Fewer enablers aggregate provider practices under a single-TIN medical group to negotiate all payer contracts on their behalf. Providers may technically retain ownership of the practice, but their patients' medical records, the physicians' credentials, and even practice branding becomes tied to the enabler.
- **Joint Ventures:** Some enablers, like agilon and Evergreen Nephrology, form a new risk-based entity (RBE) with the provider that they equally own, govern, and fund. In other cases, the enabler may own all of the RBE, covering all operating costs and the downside risk but sharing the savings with the provider (e.g., UpStream, Duo, etc.).

The nature of the partnership terms—particularly responsibility for the insurance risk in payer contracts—is paramount, as it has implications for a provider's ability to eventually graduate from its enabler and may have implications for other market forces, including impacts on unit price negotiations.

- **Enabler owns payer contracts.** Increasingly common are partnerships in which the enabler holds the insurance risk, contracting directly with payers. This dynamic is most often seen in Medicare models where the enabler 'owns' the contract with CMS but also exists with other payer types in which the enabler wholly or partially owns the risk-bearing entity. This type of partnership model appears to be growing across other lines of business.
- **Provider owns payer contracts.** Fewer examples are available of enablers that do not own the insurance risk on behalf of their provider partners but still share accountability for cost and quality outcomes, essentially functioning as robust, value-based management and strategy partners without creating a new legal entity. One notable example is Navvis, which largely serves health system-led CINs with VBP experience that are less concerned about exposure to downside risk or a need for capital. Navvis' long-term partnership model focuses not on aggregating lives for market share to negotiate risk-based contracts directly on behalf of the CIN, but rather uses a payer-agnostic approach, deployed across the entire population with the assumption that all FFS lives will eventually move into VBP.
- **Enabler offers both approaches.** Many enablers appear to offer both partnership models, even deploying both approaches within the same CMS accountable care programs depending on provider needs. In these cases, the enabler may own the risk and contract directly with CMS for some accountable entities, while enabling other accountable providers as an external operating partner without assuming the insurance risk or owning the contract. PSW is an example.

This dynamic also exists across payer types. Some payer-agnostic enablers may own the insurance risk when contracting directly with CMS within an accountable care program but may not play the same role when supporting their provider partners in securing value-based contracts with other payers. For example, Aledade's practice partners typically begin in the MSSP, with Aledade owning the contract with CMS. After gaining experience in accountable care, Aledade then helps its practices negotiate value-based contracts with MA, commercial, and Medicaid payers. In these instances, Aledade helps practices secure VBP contracts with other payers but is not involved in FFS unit price negotiations. This approach appears to be more common among payer-agnostic enablers than Privia's single-TIN medical group approach in which the enabler leads all payer negotiations on behalf of providers regardless of whether they are value-based.

While most VBP enablers claim to be payer-agnostic (or at least aspire to be), some enablement entities focus exclusively on one payer type. Depending on the nature of the partnership, an enabler that is willing only to assume accountability for a single population or line of business can limit a provider's ability to achieve accountable care success at scale. Understanding who owns the contract with the payer is a critical distinction with implications for providers' long-term VBP goals.

Provider Assessment of Enablers

Why do providers seek partnerships with VBP enablers?

Provider leaders interviewed reported a variety of reasons for pursuing an enabler partner. In some cases, the provider entity was interested in participating in accountable care for the first time—often in response to the activities of market competitors or the availability of new model options—and sought the help of an experienced partner. As the value movement matures, more common are partnerships driven by a provider organization's desire to improve its performance within existing value-based contracts or to grow its participation in VBP by moving a greater portion of its patient population under risk-based arrangements. Among interviewees with the latter motivators (i.e., improving performance or scaling participation), some providers were handling their value-based payment and delivery transformation efforts in-house but recognized the need for additional support. Another provider had been working with multiple external vendors and partners to address various needs but found the holistic offerings and aligned financial incentives of an enabler more manageable.

Seeking Enabler Partners

Reasons providers seek enabler partners:

– Interest in **forming or joining an accountable entity** with a recognition they can't do it alone but wanting to remain independent/autonomous.

– A need to **improve performance** within existing value-based contracts, and an appreciation for the level of effort and expertise needed.

– A desire/need to **scale their participation** in value-based payment across payers and lines of business to reach the tipping point of covered lives/revenue through accountable care arrangements, and a lack of leverage, relationships, or technical expertise to secure risk-based contracts from private payers.

As provider organizations grow their participation in accountable care, their ability to secure risk-based contracts with private payers becomes a critical factor in sustaining their initial investments in population health and aligning care delivery approaches with outcomes-based payments across their patient panel. Some provider organizations may succeed in navigating their initial move into accountable care but later struggle to secure risk-based contracts with private payers. In these cases, providers may seek the help of an enabler partner to tap into the larger scale and relationships needed to negotiate value-based contracts with MA plans and other commercial payers.

In some cases, the new capabilities required to take on more sophisticated models or products can motivate provider organizations to partner with enablers. For example, some provider leaders we interviewed sought an enabler partner when shifting from the MSSP—a relatively straightforward FFS-based shared savings/losses model—to ACO REACH—a full-risk, prospective payment model with more opportunities and flexibilities but greater operational and methodological complexities. In another case, the provider organization's foray into joint MA health plan products led it to seek the assistance of an enabler with the new skills required.

How do providers evaluate and select enabler partners?

Once a provider leadership team is aligned around the need to identify a VBP enabler, they may pursue a variety of approaches. The callout box on selecting enabler partners lists the common strategies used to identify enabler partners, according to insights from interviews, although interviewees consistently emphasized the significant role relationships play in these decisions. Existing relationships between a member of the provider leadership team and the enabler and/or the positive experiences of an enabler client with whom a provider executive has a relationship seem to be common factors influencing partnership discussions.

Selecting Enabler Partners

Common approaches to selecting an enabler partner cited by provider and enable interviewees include:

Provider-led methods:

- Posting competitive RFP
- Relationship-based
- Word-of-mouth

Enabler-led methods:

- Targeted outreach/marketing
- Via anchor partners

In other cases, provider leaders may solicit proposals via a competitive RFP process, seeking a wide range of candidates or limiting to a select number of enablers in the region or that are attractive to the provider for other reasons. While approaches vary, RFPs commonly include questions regarding an enabler's **offerings** (e.g., what people/processes/technology the enabler can bring to bear), **implementation approach** and **timeline** (e.g., what steps will be taken to roll out the offerings and how quickly), **ability to engage in VBP** (e.g., the types of models and payers for which the enabler can help to secure value-based contracts), **streamlined HIT vendors** (e.g., the number of additional HIT vendors required for implementation), as well as **competitive pricing** and **contract duration**. After reviewing RFP responses, providers may invite the enabler for informal discussions before conducting deeper due diligence. Application periods and model timelines can play a role in accelerating provider evaluations and decision making. For example, one interviewee described the decision to bypass the typical RFP process to quickly find a partner that would help the organization build the provider network in time to submit the participant list to CMS.

Both enabler and provider interviewees agreed that, in general, providers are becoming savvier shoppers when it comes to evaluating prospective enablement partners. As the VBP market matures, many provider leaders have a better understanding of the specific gaps they need an enabler's help in filling. They know what types of offerings and capabilities to look for and now have a greater number of prospective partners from which to choose. However, practices' sophistication for evaluating partners varies widely. Even among more sophisticated provider organizations, many still need help navigating their options.

> *"80 percent of the capabilities, like tech, care model, dashboarding, etc. are very similar. Maybe 20% of VBP company capabilities are truly differentiated. More of what's driving these partnerships is the number of physicians aligned, and 'who you know,' rather than their capabilities".*
>
> – Senior Strategy Leader, employment experience with three value-based kidney entities

Why do providers end a relationship with an enabler?

Given the newness and opacity of this market, it is difficult to gauge how often and for what reasons provider-enabler relationships form or dissolve. Relationship endings are particularly difficult to track as they are rarely announced publicly. Anecdotes from interviews regarding providers' satisfaction with their enabler partners revealed a range of experiences (see **Sampling of Deidentified Provider Vignettes Regarding Dissatisfaction in Enabler Relationships** in the Appendix on page 59). In general, reasons for feeling frustrated with, or even terminating, relationships included a lack of trust/understanding about the contract terms, a desire to expand VBP contracts or capabilities outside of the enabler's competencies or purview, or a mismatch between what was promised and what the enabler can deliver. These findings were consistent with earlier research[29] on this topic. While specific examples highlighted in the Appendix focus on provider frustrations, interviews also revealed highly satisfied provider partners who would not have been able to engage in or advance their accountable care strategies without their enabler.

Segment Overview: Risk-Bearing Delivery Organizations

Risk-bearing delivery organizations represent an all-inclusive alternative to traditional providers in the FFS-based health care system, offering a range of services (e.g., primary care, labs and imaging, select specialty services for common chronic diseases, dental care, etc.) and population health programs through interdisciplinary teams and partners. Though most organizations in this segment are focused on primary care, a small, but growing, number are focused on specialty care.

Risk-bearing delivery organizations discussed in this report include provider entities designed to operate under value-based payment from the outset.

How do risk-bearing delivery organizations differ from traditional providers?

Unlike a traditional primary care-focused physician groups that have incrementally moved up the risk ramp from FFS to VBP, many of these risk-bearing delivery entities are designed to operate under population-level value-based payment models from the start. In some cases, these risk-bearing delivery entities build de novo practices from the ground up, whereas other entities wholly or partially acquire existing FFS practices and transition them to risk.

Though all VBP-oriented practices apply similar care delivery and population health strategies, these risk-bearing delivery entities are distinct from incumbent practices in a few ways:

- **Greater use of homegrown technology relative to typical FFS providers**
- **Non-productivity-based compensation models**
  - Physicians are usually salaried with performance-based bonuses.
  - Some entities align all compensation models with value-based outcomes, from executives to front-office staff.
- **Creative clinic layouts and asset-light delivery models**
  - Open floor plans for group visits and socializing
  - Greater emphasis on home- and community-based care
- **Clinicians/practices are supported by centralized clinical and administrative functions**
  - As with VBP enablers, robust population health management capabilities to support clinical teams

Care Delivery Approaches

These entities leverage a hybrid care delivery model, offering access to care both virtually (often through proprietary apps) and in-person (often in thoughtfully designed brick-and-mortar clinics). Among organizations that build new clinics, practices tend to be located in convenient, central locations near retail districts, transportation routes, or worksites and are designed with open floor plans to comfortably accommodate group visits and care team huddles. To manage their patients, these providers use high-touch care models, with smaller panel sizes and longer and more frequent touchpoints. PCPs are supported by multidisciplinary teams, leveraging advanced practice practitioners, registered nurses (RN) case managers, care coordinators, patient navigators, clinical pharmacists, dietitians, and social workers and other behavioral health specialists. Patients have access to their care teams as needed—often with same-day visits or asynchronous communication—and receive frequent proactive reminders or inquiries about their care.

As with other healthcare organizations, entities in this segment are expanding their in-home care capabilities to support patients and caregivers in low-cost, convenient settings and a growing cohort of home-based innovators is emerging, each with slightly different approaches to optimizing in-home care. These risk-based organizations include startups launched in recent years, such as Patina, Accompany Health, Emcara, Upward Health, and myLaurel, as well as entities with longer histories, including HarmonyCares and Upward Health. National payers are investing heavily in this space, with notable examples including UnitedHealth's acquisition of Landmark Health via Optum,[48] Humana's acquisition of Heal Health,[49] and CVS/Aetna's investment in WellBe Senior Medical.[50]

In addition to contracting with health plans, some of these entities also contract with health systems or other at-risk providers to assume accountability for a subset of high-acuity patients. Relatedly, some established risk-bearing primary care entities are beginning to engage in sub-capitated arrangements with high-value specialists. See **Landscape Evolution and Expectations for the Future** on page 43 for details.

Target Populations

To succeed in full-risk primary care, provider organizations must clearly define which patient populations they will serve. Clinical models and organizational competencies and capabilities will differ based on the patient profiles and care needs of the population, as well as the payment policies and partnership opportunities each payer type presents.

Many organizations in the advanced primary care market were designed to serve seniors with complex care needs who require a high degree of support. Organizations like ChenMed, Oak Street Health, and ArchWell Health largely focus on MA members with high medical and social needs and have optimized their care delivery models for these populations. Similarly, some organizations like CareMore Health, InnovaCare, and ConcertoCare focus on MA members, but also have expertise serving Medicaid and dual populations. For example, ConcertoCare has an especially strong focus on dually eligible patients, many of whom are homebound with multiple chronic conditions and behavioral health needs. More than 80 percent of ConcertoCare's patients have three or more chronic illnesses, and nearly 50 percent have a mental health diagnosis.[51] On the specialty side, 20 percent of kidney-focused risk-bearing delivery entity Monogram's patients are dually eligible.[52]

Focus on senior population:

Most risk-bearing delivery entities are largely or exclusively focused on seniors, given the alignment with accountable care and growing Medicare population. Some were designed to serve this population, while others have pivoted or expanded to reach them.

Many advanced primary care providers that serve dually eligible populations begin by serving non-dual seniors and expand to include risk-based arrangements with D-SNP payers. Other entities were designed to assume accountability for Medicaid populations from the outset. Examples of these Medicaid-focused entities include Cityblock Health, Waymark, Accompany Health, and AbsoluteCare which assumes full risk for a subset of Medicaid MCOs' sickest members.

In some cases, risk-bearing delivery entities originally focused on serving young and healthy commercial populations but have since expanded or pivoted to focus on serving seniors or other higher-needs patients under risk-based contracts (e.g., Vera Whole Health, One Medical [via "One Medical Seniors" FKA Iora Health], Carbon Health, etc.).

Growth Strategies

In some cases, risk-bearing delivery entities build de novo practices from the ground up (e.g., ChenMed, Oak Street, Homeward, Sanitas, CenterWell, OneMedical Seniors, Gather Health, etc.), whereas other entities wholly or partially acquire existing FFS practices and transition them to risk (e.g., Alpine Physician Partners, Hopscotch, Sevi Health, etc.). Some entities, such as CareMax and VillageMD, pursue both avenues. Each approach comes with different challenges, but both are capital intensive.

Building de novo medical centers allows the entity to intentionally design all aspects of the clinic from layout to branding and staffing, but it takes time to hire new clinical staff and build out a panel of new patients that is large enough to engage in value-based arrangements. Building out new patient panels can be especially difficult in small and rural markets with smaller populations who tend to prefer trusted, established organizations, over new and unknown brands. Transitioning an acquired FFS-based practice to VBP comes with its own challenges, similar to those that enablers face but with the added benefit of greater control over employed physicians and care teams.

A delivery entity's ability to aggregate enough lives is essential to triggering risk. Until panel sizes are large enough, payers continue to reimburse on a FFS basis—a major challenge that multiple interviewees cited. In one instance, the delivery entity had announced a value-based partnership with a regional payer for tens of thousands of MA lives. More than two years into the partnership, the organization had less than 1,000 aligned patients—still far short of the required numbers to trigger the risk arrangement with the health plan. The need to quickly grow lives under management is one factor that encourages some entities to acquire existing practices rather than or in addition to building net new.

> *"In hindsight, an enablement approach would have been much easier than building new clinics. Getting paid on a FFS basis while trying to develop a reputation for delivering value-based care—and actually doing it—does not work."*
>
> – Senior leader with employment experience at multiple risk-bearing entities

A growth strategy that some organizations have pursued is partnering with other healthcare stakeholders to **develop co-branded clinics**, including with **payers** (e.g., Sanitas and BCBS of Texas,[53] Dedicated Senior Medical Centers [ChenMed subsidiary] and BCBS of Michigan[54]) or **health systems** (e.g., One Medical and Hackensack Meridian[55]).

Most of the entities studied have relatively small footprints, with fewer than 50 medical center locations, but some well-funded risk-bearing delivery entities have amassed hundreds of clinics through acquisitions and organic growth. For example, Humana's CenterWell, whose clinicians provide care to more than 285,000 seniors at nearly 300 clinics across 15 states, plans to open 50 additional centers by 2025.[56] CVS's Oak Street has nearly 200 centers across 25 states.[57] Following its acquisitions of Starling and Summit Health-CityMD, VillageMD boasted a combined 680 locations in 26 markets, though the hybrid VBP enabler/risk-bearing delivery entity announced plans to close 60 underperforming clinics in 2024[58] despite a 23% year-over-year increase in full risk lives,[59] highlighting the potential pitfalls of rapid expansion. Cano Health is also pruning its footprint of 126 medical centers (down from 169 mid-2023)—including selling its 30 centers in Texas and Nevada to Humana[60]—amid public financial struggles.[61] Interviews with three physician leaders with experience practicing for one or more of these large primary care chains revealed the implications of rapid growth from a clinician's perspective. While overall employment experiences among physician interviewees was positive, some shared frustrations with the lack of support and 'changing goalposts' when adjusting to aggressive growth targets. In contrast to the rapid growth strategies of other entities, risk-based primary care veteran ChenMed has grown much slower, reaching roughly 100 medical centers in 15 states after two decades.

Some interviewees are adjusting their growth expectations, citing MA risk adjustment changes; however, the largest parent companies appear to be doubling down on primary care practice assets, with Optum now employing or affiliating[62] with 10 percent of all physicians[xi] and CVS positioning its health services arm—which includes Oak Street and its enablement assets (Signify and CVS Accountable Care)—as key to the organization's future growth.[63]

[xi] Optum's unique structure and strategies resulted in their exclusion from this analysis of emerging VBP-focused entities. While excluded from our segmentation and sizing, Optum's presence in the market was a factor mentioned by several interviewees.

Challenges Among VBP Enablers & Risk-Based Delivery Entities

The specific challenges facing these entities may vary by segment, populations, and other circumstances, but interviews with entity leaders across segments consistently revealed similar existential threats.

- **Securing VBP contracts with private payers.** Even as demand for VBP increases among providers, payers are limiting its growth. The pressure to grow fast and aggregate enough lives to force payers to the table to offer capitated payments—or any type of risk arrangement—was a major theme throughout interviews. Almost all interviewees cited difficulties securing VBP contracts with other payers among the top challenges facing these entities. Entity leaders had different opinions about which types of payers are better partners (i.e., regional or national payers) and whether the issue is more about payer *willingness* or *ability* to offer these arrangements. Willingness may be driven by margin considerations where, without significant risk borne by the provider (more risk than some are ready to take), private plans may not find it worthwhile to engage. If, however, the issue is payer capability to design and administer risk-based contracts, this represents a significant market failure. While CMS plays an important role in driving VBP adoption, private payers will determine whether VBP can successfully scale.

> ***Securing VBP contracts with private payers***
>
> *"What [CMMI has] to do is make it lucrative enough for entities [...] to aggregate [lives] which gives market power to those aggregators to force the hand of the commercial payers."*
>
> – President at hybrid entity
>
> *"Sometimes there are payer limitations. We talk with payers and they like what [we're] doing, but the payer doesn't have the manpower or expertise to set up a capitated offering. Many payers haven't even kept up."*
>
> – Senior director of operations at large enabler
>
> ***Effectively scaling operations***
>
> *"You can only go so far built on smart people without a system built to scale [...] the rush to grow overlooked this."*
>
> – Medical director with employment experience at multiple risk-bearing entities
>
> *"It is hard to win in [the Medicaid] population with that much heterogeneity."*
>
> – Senior VP with employment experience at multiple risk-bearing entities

- **Effectively scaling operations.** Because of the importance of scale in securing risk-based contracts with health plans, these entities are focused on growth. Entities that have gone public or those backed by private funding face additional pressures of growing on a timeframe that meets investor expectations.

  Some organizations—particularly risk-bearing delivery entities that went public too quickly—have struggled or failed due to haphazard growth strategies coupled with weak clinical or operating models.[21,22,232123]

  The challenge of scaling operations is not only the result of poorly implemented business models, but also the inherent challenge in aggregating value-based lives. Even entities that have had overall success have been right-sizing their footprints to accelerate the path to profitability.

  Enablers face unique challenges in scaling because of the varying needs and infrastructures of provider partners and difficulty aggregating enough lives within a single region to convince payers to offer VBP contracts. While acquiring practices is more capital intensive, interviewees generally agreed it was an easier model to scale.

> **Themes Among Entities with Known Challenges Scaling Operations**
>
> - Prioritize quick growth before establishing a disciplined operating model.
> - Attempt to address heterogenous populations/providers/markets, each requiring different capabilities without a clear picture of how they'd come together.
> - Toxicity within leadership teams and company cultures.

Entity Engagement in CMS and Innovation Center Programs

The risk-bearing delivery organizations described in this report are treated as any other provider organization in terms of their engagement in Innovation Center models. Participation options for VBP enablers, on the other hand, vary based on model criteria set by CMS (see Figure 16 in the Appendix). Within some CMS and CMMI accountable care models—including those focused on the general population (e.g., MSSP and ACO REACH) and specialty populations (e.g., KCC, EOM)—the agency has allowed enabler entities to participate directly. Figure 11 on page 42 for a list of models that allow enabler participation and examples of enablers that are participating.

Other models prohibit enablers from direct participation, including CMMI's advanced primary care initiatives (e.g., CPC+, Primary Care First, Making Care Primary), which require provider practices to be the entity contracted with CMS. Nonetheless, enablers may still partner with organizations that participate in these models and could potentially craft risk-based arrangements between themselves and the provider organization, but they would not be the party held accountable for cost and quality outcomes from CMS's perspective.

Types of criteria used to determine CMMI model eligibility

- Entity type
- Size
- Medicare-enrollment status
- Geography

Attributes not used to determine model eligibility

- Ownership
- Financial backing

Participation Trends in General Total Cost of Care Models

Enablers have been prevalent participants in the MSSP since its inception, with Collaborative Health Systems[xii] supporting nine of the first 27 ACOs. Other early adopters included Caravan, Evolent, and Aledade, each supporting over a dozen MSSP ACOs within the first few years of the program.[20, 25] Of note, these early enabler participants are still actively engaged in the MSSP and other Medicare APMs.

At the start of the MSSP, some stakeholders feared that only hospital-dominated systems would participate in the program.[64] Instead, physician group-led ACOs have been and continue to be the most dominant and successful participants.[65] While formal research is limited, there is some evidence to suggest that enablers have played a key role in facilitating physician group participation in the MSSP.[xiii, 27] We did not formally assess the prevalence and performance of enabler-led MSSP ACOs; however, our research and interview findings suggest their engagement in the MSSP has only grown, primarily among physician-led ACOs.

Why aren't all entities participating in CMMI models?

Most entities are engaged in CMMI models, but some do not. Reasons cited by interviewees include:

- Limited application cycles leave some new entities no window in which to apply.
- Model methodologies may not be seen as financially viable for the entity.
- Many entities see more financial opportunity in MA.
- Some entities focus on populations (e.g., Medicaid) with fewer available model options.

As total cost of care models have evolved, these entities have increased their investment and activity in the space. While few enablers participated in the Next Generation ACO (NGACO) model, there was a major uptick in Global and Professional Direct Contracting (GPDC) engagement. Not only is GPDC—which became ACO REACH—more financially favorable and flexible than previous models, it was specifically designed to encourage creative

[xii] When the first cohort of MSSP ACOs was announced in 2012, one-third of the 27 ACOs were CHS partnerships. CHS is an MSO, then owned by Universal American Corporation and now a wholly owned subsidiary of Centene.
[xiii] Of note, our inclusion criterion specifying that non-provider entities must share accountability for cost and quality outcomes to be considered a "VBP enabler" differs from the looser definitions used in earlier research on this topic. (Murray et al.)

downstream partnerships and to spur private sector investment in primary care[xiv] by engaging more types of entities than had historically been included in CMMI initiatives.[66] These new entities included enablers that founded or accelerated their launch explicitly in response to the opportunity presented by GPDC, according to interviewees, as well as several organizations that had been largely or solely focused on MA populations (e.g., agilon, Iora [now One Medical Seniors], P3, Oak Street, etc.) or otherwise unable to participate in CMMI models, such as those led by payers (see the callout to the right).

The expansion in the types of organizations allowed to participate in the GPDC led to criticism from some stakeholders concerned about the impact of private capital on providers and beneficiaries and the potential to funnel beneficiaries into MA products. In reopening the model, CMMI could have prohibited these non-provider entities from participating, but ultimately decided to allow these entities to continue in the reimagined ACO REACH model, adding additional guardrails aimed at addressing these concerns.[67]

Examples of payer-owned entities in ACO REACH (as of PY23)

- **Alignment Health's** Alignment Health ACO
- **Bright Health's** three NeueHealth-branded REACH ACOs
- **Cigna's** CareAllies Accountable Care Solutions
- **Clover's** Clover Health Partners (dropped out)
- **CVS/Aetna's** CVS Accountable Care Organization
- **Humana** has two REACH ACOs: one through their CenterWell care delivery arm (CenterWell Care Solutions) and one branded as Humana Direct Contracting Entity.
- **UnitedHealth/Optum's** CareMount Value Partners IPA and Reliant Medical Group, Inc.

Of the 271 applications to join ACO REACH in 2023, only 128 (47%) were provisionally accepted, representing a lower acceptance rate than previous Innovation Center models.[68] Though CMMI succeeded in drawing more provider participation, application data show VBP enablers/MSOs maintained high interest in the model. While CMS accepted additional enabler-led participants (e.g., Lumeris, Pearl, Vytalize, CHS, Aledade, agilon, etc.), no new payer-led REACH ACOs joined.[69]

In interviews, CMMI leaders generally believed this application process, in which more careful application criteria were used rather than blanket bans, was successful and could potentially be applied to other models.

Dual MSSP and ACO REACH Participation

ACO REACH brought in several enablement entities new to Medicare models, some of which are now also participating in, or plan to participate in, the MSSP.

Many existing MSSP participants are also applying their experience to engage in ACO REACH, expanding the portfolio of ACO model options available to their provider partners. Examples of entities participating in both the MSSP and ACO REACH in 2023 include Aledade, Privia, CHS, Lumeris, Curana, VillageMD, HarmonyCares, Genuine Health Group, Vytalize, Wellvana, and others.

Benefits of Participating in Multiple CMS Models

Benefits of VBP enabler participation in multiple CMS APMs include:

For Providers:

- ✓ Offers an opportunity to participate in most appropriate model option based on projected performance and readiness without shifting partners or going it alone.
- ✓ Outsources complicated evaluation and modeling of optimal model/track to enablement partner – an entity invested in the outcome of that decision.

For CMS:

- ✓ Allows enabler to help CMMI test advanced APMs and provide constructive feedback about how new designs compare to concurrent experiences in the MSSP, which elements should be incorporated, adjusted, etc.

[xiv] In a speech at the MACRA Summit in June 2019, Adam Boehler discussed the Primary Cares Initiative, representing the start of a new generation of models not built on a FFS chassis and stated that the agency anticipated the models would lead to increased private capital investment in primary care innovation.

In addition to the potential benefits of dual participation for providers and CMS outlined above, there may be consequences of enabler entities participating in only one accountable care model option. Multiple interviewees cited the example of a large REACH ACO that recruited hundreds of providers, and after poor performance, significantly culled its participant list, dropping low-performing providers in an effort to improve performance in the model, leaving many providers without options to participate in accountable care. This dynamic is neither new nor exclusive to ACO REACH. Public examples of enablers dropping some provider participants while maintaining and expanding other relationships are evident across multiple CMS accountable care models.[70]

Regardless of the potential benefits of dual participation, if opting to participate in multiple models, enablers must ensure they have the capabilities and systems needed to operate under each arrangement (e.g., global cap competencies are different than those needed for FFS-based shared risk models).

Participation in Specialty-Focused Total Cost of Care Models

CMMI models shape the decisions of private actors and can catalyze market transformation. This dynamic is apparent in the differences between nephrology and oncology markets. CMMI's kidney care models—the Comprehensive ESRD Care (CEC) model and its successor, Kidney Care Choices (KCC)—have driven significant industry investment, including influencing the creation of new entities (e.g., Evergreen) and driving multiple others to pivot in order to take advantage of model opportunities.[xv] Examples include Panoramic, which operated as a nephrology MSO for 15+ years (Global Nephrology Solutions) before pivoting to focus on risk-bearing business following CMMI's announcement, and InterWell Health, a value-based nephrology network and enabler, facilitated through Fresenius' acquisition Cricket Health.

> *"Ultimately, it's the oncologists in the community practices' decision whether to participate [in CMMI models] If anything, [CMMI has] really disincentivized practices from participating [in EOM].*
>
> – Regional Market Lead, Oncology-focused entity

The oncology market, in contrast, has not seen CMMI models drive private market activity to the same degree. Prospective participants have viewed model options for oncology—the Oncology Care Model (OCM) and its successor model, the Enhancing Oncology Model (EOM)—less favorably because of model methodologies and broader industry dynamics. Interviewees representing oncology entities that have participated in CMMI models, as well as others who have yet to engage, shared similar opinions about the barriers to widescale adoption of VBP in cancer care.

Figure 11. Examples of Enablers/Hybrids Participating in CMMI Models

Model	Allowed to Participate	Examples of Enablers/Hybrids in Model
MSSP	Yes	Aledade, CareMax, Collaborative Health Services, CHESS, CVS, Evolent, Genuine Health Group, HarmonyCares, Lumeris, Main Street Health, Privia, Signify, Vytalize, Wellvana, etc.
ACO REACH	Yes	Agilon, Aledade, CareAllies, CareMax, Castell, CVS, CHESS, HarmonyCares, Iora, Lumeris, NeueHealth, On Belay, P3 Health Partners, Pearl, Upstream, VillageMD, Vytalize, Wellvana, etc.
KCC	Yes (CKCC)	Evergreen, InterWell, Panoramic, Somatus, Strive, etc.
EOM	Yes	The Oncology Institute, American Oncology Network, etc.

[xv] Other policy actions outside of CMMI models, including the opportunity for individuals with ESRD to enroll in an MA plan, rather than traditional Medicare, have driven market activity in the nephrology market.

Landscape Evolution and Expectations for the Future

As the landscape continues to evolve, we expect continued evolution of entities' offerings and strategies to meet the needs of providers, differentiate in the market, and effectively scale.

Entities will experience continued growth, including in new areas:

- **Primary care and kidney entities now targeting "tier 2" geographies.** Given the similar considerations of primary care- and kidney-focused entities over the last few years, existing players and new entrants are beginning to target "tier 2" providers and geographies—generally smaller practices and smaller markets.
- **VBP beginning to reach new specialty areas and settings.** Meanwhile, growth among other specialty-focused entities is just beginning to pick up. Growth areas include value-based cardiology (e.g., Karoo, Heartbeat Health, CardioOne, Story Health, US Heart & Vascular, etc.), behavioral health (e.g., Forge, Rippl, etc.) and entities focused on high-needs patients located in assisted living, skilled nursing, or long-term care (e.g., Curana, Sevi Health, MyPlace Health, etc.).
- **Growth among niche entities with particular focus on underserved providers and populations.** Additionally, building on recent trends, we anticipate growth in the number of enablers explicitly focused on safety net providers and underserved populations. Examples in this space include FQHC-focused enabler Yuvo Health, as well as CINQCARE and Suvida, which are dedicated to serving Black and Brown and Hispanic communities, respectively.
- **Stronger appetite among health systems for support.** Health systems seem to have a growing appetite for these partners, driven by financial pressures and competitive threats from new entrants. Consequently, some health systems are prioritizing their value transformation efforts. Furthermore, because more than half of primary care physicians are now employed, mostly by hospitals,[17] many health systems are seeking the support of VBP enablers to optimize their owned and affiliated physician networks for accountable care.

Expect fluidity as existing entities expand or shift their strategies to reach new segments.

Because both segments need similar capabilities, entities are increasingly expanding their offerings and business models to reach or pivot toward new segments.

- **Enablers expanding into risk-bearing care delivery.** Some enablers with robust clinical offerings parlay those capabilities into their own delivery organization. For example, SNP-focused enabler, Belong Health, recently announced the launch of its own medical group to help partners address chronic care gaps and offer clinical solutions as a separate business unit.[71] Recent examples of enablers acquiring provider assets for learning and other synergies include Navvis, an enabler that acquired high-performing independent physician group Esse Health to form Surround Care in 2022.[72] Navvis will apply lessons from Esse as a "best practice incubator" to support its enabled partners. Vytalize expanded into care delivery through its acquisition of an IPA partner though an investment in April 2023.[73] Other enablers branch into care delivery as a shift in strategy. For example, VillageMD began squarely in enablement before adjusting its approach to also acquire practices. The hybrid entity appears to be focusing on its owned risk-bearing care delivery

side more than new enablement partnerships going forward, but is continuing to adjust its practice footprint following robust growth.

- **Risk-based delivery organizations expanding into enablement.** Organizations that began as delivery entities include Cityblock, a Medicaid-focused risk-bearing delivery organization that is testing the waters as an enabler, using ACO REACH as its first foray into enabling external partners. Oncology Care Partners is also testing both approaches. The specialty-focused hybrid began by acquiring a community-based oncology practice to get more experience and build out enablement capabilities.

Hearing CMMI's call for greater specialty integration in accountable care, we anticipate growth among multispecialty-focused organizations to accelerate.

Examples of this trend exist in the market and depict different approaches:

- **Expansions and pivots among existing entities.** Some organizations that initially focused on a single specialty area are now expanding into the polychronic space (e.g., Monogram), while others that have largely focused on primary care transformation are shifting to prioritize specialty VBP (e.g., Evolent). Several entities are expanding into the nephrology space, with Signify Health adding in-home testing for chronic kidney disease to its offerings[74] and Oak Street Health entering into a joint venture with InterWell Health to offer primary care services in dialysis centers.[75]
- **Growth among new entrants.** New organizations are emerging that are designed with a multispecialty focus from the beginning (e.g., Karoo, Duo, BridgepointMD, etc.).

Expect more sub-capitation and other risk-based partnerships between enablers/delivery entities and downstream partners.

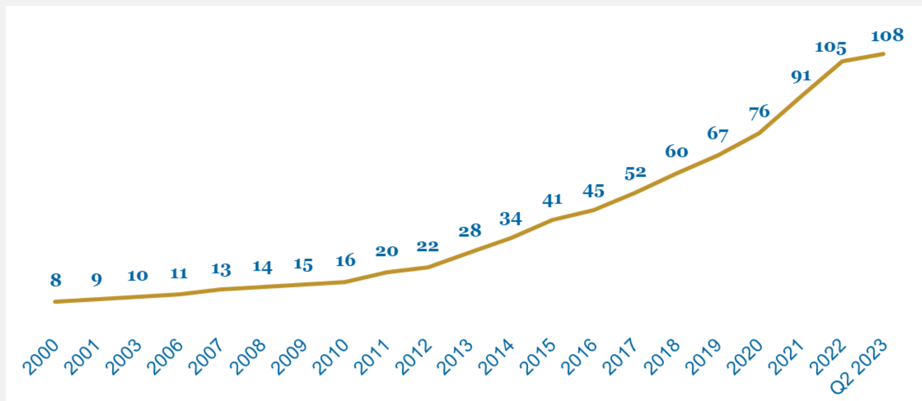
As the market matures, enablers and risk-bearing care delivery entities are increasingly partnering with specialty-focused organizations and other point solutions. Large entities often contract with multiple partners and can compare their effectiveness/impact across the network. For example:

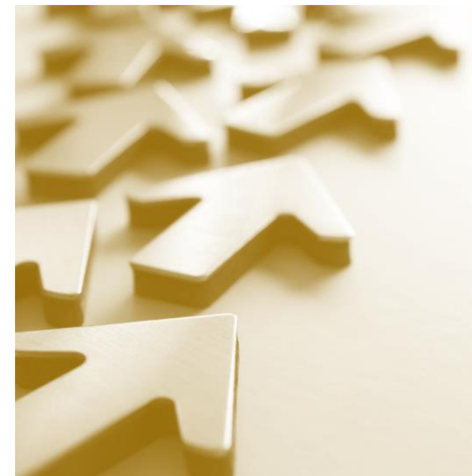
- **Risk-bearing primary care entities are increasingly engaging in sub-capitation with capable specialty partners.** For example, The Oncology Institute assumes risk for the cost of patients' oncology care through agreements with risk-bearing primary care providers like CareMore and P3, which have capitated contracts with MA health plans.
- **PCP-focused enablers are increasingly focused on facilitating value-based specialty partnerships.** Some VBP enablers are pursuing specialty strategies that build on robust primary care as the foundation for total cost of care management with nested specialty partners that share incentives and key infrastructure. Examples include Pearl's partnership with cardio company Story Health[76] and Aledade's partnership with DaVita subsidiary VillageHealth[77] on advanced CKD.
- **As large entities with national footprints assess different specialty-specific point solutions across their networks, the fragmented vendor market may consolidate.** Payers frequently use this "bake-off" approach to pilot new partners and programs. Agilon is comparing results of different home health partners across its network to see which vendor produces the best outcomes. Aledade was so pleased with the experiences and outcomes of advance care planning solution Iris Health that it acquired the company.

Following a period of rapid growth, expect consolidation.

- **As the value market matures, the leadership teams of new entities often include former executives from earlier VBP companies,** allowing them to apply lessons (see the callout on leaders founding new entities below). This trend is expected to continue among new entrants entering the market.
- **After a period of rapid growth, the market is likely to eventually consolidate** as winning entities get acquired and others fail.
  - Interviewees felt some organizations were designed with the specific purpose of growing just large enough to attract buyers.
  - Figure 12 helps illustrate this acceleration by depicting the number of known value-based entities since 2000. Even in a market characterized by frequent mergers and acquisitions, the number of discrete entities meeting our research criteria grew at a 16.9 percent compounded growth rate over the past decade (2012−2022).

Figure 12. Growth in Entities, 2000−2023





Leaders Founding New Entities

As the value market matures, the leadership teams of new entities often include former executives from earlier VBP companies, allowing them to apply lessons. Examples include:

- **Patina:** founded by Iora co-founder
- **Belong Health**: co-founded by former Eleanor founder
- **Duo:** co-founded by former leaders of Signify and agilon
- **Sevi Health:** founded by former Cityblock leader
- **Curana:** led by former Evolent leader
- **Accompany:** founded by former Blue Cross NC and CMMI leader
- **Gather Health:** co-founded by former VillageMD leader
- **Guidehealth:** co-founded by former Upstream CEO and CMMI leader
- **Chamber Cardio:** co-founded by a co-founder of Pearl Health

03

Discussion & Considerations

Potential Benefits and Risks of Growth Among These Entities

CMS has encouraged private sector innovation and engagement in the national movement toward VBP. Recognizing that the needs of providers would extend beyond CMS's capabilities or purview, the agency has long sought to foster an environment in which private sector entities are encouraged to understand and meet the needs of providers to successfully participate in APMs.

Though CMS interviewees affirmed the intentional creation of this market, their opinions differed with respect to the broader role and impact of these entities. Though interviewees generally agreed that they can play an important role in advancing the move to value, they had mixed views about whether the implications of their participation are appreciated. Figure 13 summarizes these benefits and risks.

Enablers represent a promising opportunity and are a reality of the healthcare system, but CMS and providers should be aware of two important considerations:

1. **The quality, expertise, and offerings of enabler partners varies widely.** As we've seen with provider participants, it takes a few years to learn how to succeed under VBP models. Enablers will face a similar learning curve, but often with higher stakes given the larger scale. Some enablers have been operating for years and have successful track records, but new entrants without proven approaches continue to enter the space. The guiding principles outlined herein can help CMS and providers evaluate which partners will best support providers in their transition to value-based care.
2. **VBP enablers will be unable to overcome the existing obstacles of the accountable care movement without certain changes.** Even if CMS and providers select the optimal enablement partners that are most aligned with their goals, absent mandatory models and greater payer participation and alignment, enabler growth will be opportunistic and focused on short-term gains without achieving the benefits of accountable care at scale.

As CMS and the Innovation Center continue to advance adoption of accountable care—particularly among safety-net providers and other inexperienced or under-resourced provider organizations—CMS leaders recognize that these enabling entities have a role to play. One current official shared, "Under the right terms and conditions, working with [an enabler] might be a better option than putting these safety-net organizations at greater risk." Instead of seeking blanket policies to prohibit certain types of organizations from participating, CMS is focused on better understanding the ownership and governance of these entities, as well as their relationships with providers that participate in APMs, while ensuring that the regulatory environment and model design ensures all entities participate in their models as intended.

Figure 13. Entity Benefits and Risks

Stakeholder	Benefits	Risks
Providers	– These entities can provide access to capital, expertise, and other resources to support VBP adoption. – Unlike traditional relationships with external partners, enablers are financially invested in provider's success. Many provider organizations already use vendors or consultants to better understand and participate in VBP without these aligned incentives in place. – These entities can create options for different employment models outside volume-based FFS (e.g., salary vs RVUs) to support different models of care delivery. – Options introduced by these entities may indirectly affect offerings from other organizations and health systems as they compete for talent. – More providers investing in total cost of care should create more opportunities for partnership to improve local/regional outcomes for acute care utilization (e.g., emergency department visits, hospital admissions, and readmissions) for which hospitals are accountable in existing Medicare programs. – These entities offer providers an avenue for aggregating enough lives to minimize volatility and meet minimum lives thresholds for participation in CMS/CMMI models without requiring consolidation under common ownership. – As entities increasingly partner with specialty-focused organizations and other point solutions, they can help streamline the vendor and specialty referral selection process, elevating effective partners.	– Entities with PE funding or shareholder may drive decisions around resources and operations that are not in the best interest of the provider or patients they serve. – It is difficult for providers to evaluate the quality of potential enabler partners, most of which offer similar services. – Entities may drop providers, leaving them without VBP partners, due to company failures, pivots, or other financial interests. – It is difficult to isolate the drivers of savings in VBP models to determine whether an enabler partner is responsible for driving performance or if the provider would have earned savings regardless. In either case, providers must split the shared savings with the enabler based on predetermined agreement. – Entities may be more sophisticated, have more resources, and/or more visibility into favorable contract options, than the provider partner, creating the potential to enter providers into unfair arrangements. – Entities offering alternatives to status quo operations and competitive compensation will increase competition for talent and may lead to higher personnel costs and "brain drain" among incumbents.
CMS and CMMI	– Supporting participation of these entities can create pressure on incumbent organizations to change and further adopt VBP. – Entities can fill gaps and help providers enter value-based arrangements in which they may otherwise not participate. – These entities can provide an opportunity to scale VBP without consolidating providers under common ownership. – These entities can provide an opportunity for CMS to learn from the value-based contracts entities enter (e.g., how they do sub-capitation, share accountability with downstream partners). – Enablers can play a role as a neutral convener of multiple organizations. Hospitals have conflicting interests when playing this role; they have little control over independent providers, which makes them hesitant to enter into shared financial accountability and face the inherent conflict of balancing VBP participation with maximizing FFS revenue.	– With more support and/or focus on entities, large corporations may enter the market and spur consolidation that could negatively impact coverage, access, and choice for beneficiaries. – Nascent markets can create tumult and uncertainty, which could negatively impact providers and beneficiaries as entities fail or leave the market. These companies can rebrand, be acquired, and make other changes that make them difficult to monitor and regulate. – Some entities are increasingly targeting underserved populations and markets, but most are focused on the same areas, limiting opportunities to bring new providers and new lives into value. – A bad experience with an enabler partner can taint a provider's view of value-based care, ultimately stalling adoption and buy-in in transformation.

Stakeholder	Benefits	Risks
Patients	– Many of these entities are creating clinical models that are designed to serve patient needs more holistically. – Physicians and care teams may spend more time and attention on patient care, as enabler partners take on additional administrative functions and support clinical workflows. – Many entities make available additional wellness programs or patient-facing technologies to access care and information.	– Similar to the concerns that arise for providers, entities with PE/VC funding may drive decisions that are contradictory to the best interests of beneficiaries.
Payers	– Many payers lack the capabilities needed to structure and administer effective value-based contracts. Entities with value-based contracting expertise can advance payer capabilities. – Greater support for and availability of capable provider networks for value-based health plan products.	– Specific payers becoming overly dominant through entity acquisitions, leading to bad-faith negotiations with less dominant payers. – Providers may disintermediate payers by directly contracting with purchasers if they achieve sufficient sophistication.

Guiding Principles

Weighing the benefits and risks of enabler growth is a multifaceted and complex assessment that must incorporate a range of stakeholder perspectives. Our review of the market landscape and qualitative interviews with current and former leaders of CMS, current and former leaders of these entities, and a sampling of providers with whom they have partnered, revealed themes about the benefits and risks of enablers that evolved into the principles outlined in this section.

The primary reason for developing principles is to provide a structure for identifying organizations and/or organizational characteristics that align with CMMI strategic objectives and most effectively contribute to the goal of having all Medicare beneficiaries and most Medicaid beneficiaries in accountable care relationships by 2030 and to do so in a way that aligns with CMMI's broader priorities to develop a pathway toward equitable, sustainable system transformation.

The guiding principles also align with CMMI's five strategic objectives: (1) drive accountable care, (2) advance health equity, (3) support care innovations, (4) improve access by addressing affordability, and (5) partner to achieve system transformation (see Figure 14 in the **Appendix**).[4]

1 **Payer Agnostic or "Flexible" Payer Approach:** The entity directly or indirectly supports provider success in value-based care regardless of payer type.

Why it Matters

Meaningful and lasting care delivery transformation requires aligned efforts across a provider's patient panel. Provider organizations and individual physicians should not have to drastically change how they practice depending on their patients' insurance coverage. Evidence from CMMI, industry experts, and researchers suggests that meaningful delivery transformation requires that organizations can apply care models and clinical workflows across a broader portion of patients.[78] Not only does it benefit the provider when multiple payer contracts are aligned to facilitate and reward high-value care delivery, but this payer-agnostic approach also benefits other patient populations, regardless of coverage incentive structure. One of the broad

themes from CMMI's review of value-based payment models was that successful efforts in changing care delivery extended beyond the center's models, as spillover effects from care transformation efforts focused on one patient population benefit others.

Ideally, an enabler entity can support its provider partners in value-based arrangements with multiple payers, including government and private plans. Many established enablers may begin by supporting a provider partner in one payer contract or program, later helping them secure additional VBP contracts with other payers as they become ready.

This principle does not necessarily mean that an entity must work with all payer types, as there may be valid reasons for not doing so, including limits in value-based care models offered by other payers or a focus on unique population. In cases where an entity does not work with all payer types, they should at least ensure they are not hindering efforts around overall practice- and system-wide transformation. Additionally, a smaller entity focused on fewer lines of businesses can provide competitive pressure to larger, more consolidated entities that may have the scale to support all payers.

Questions for Consideration

- *What payer types and/or populations are supported?*
- *What experience does the entity have engaging with various payer types?*
- *What payer-focused services are provided by the entity (e.g., contract negotiation/application support, relationships with payers to help secure value-based arrangements, regulatory/compliance/technical expertise specific to payer type, etc.)?*
- *Is the entity's partnership model, support services, and care delivery transformation approach aligned with the provider's broader population health efforts? Even if the entity is not directly supporting all payer types, does the partnership help or hinder efforts to serve all patients equally?*

2 **Shared Success:** The entity's and the provider's success are aligned with patient outcomes in accountable care.

Why it Matters

VBP is designed to align the financial interests of stakeholders that might otherwise have competing priorities. To be considered a VBP enabler, as defined in this report (as opposed to an MSO, physician aggregator, or other type of management partner), the entity's business model must be aligned with the cost and quality outcomes of its provider partners and by extension the contracted payer and, most importantly, the patient. This "shared success" should be a core component of the entity's business model, where the entity only wins when the providers succeed in VBP models.

It is crucial to distinguish between the entities that share aligned incentives with the provider, the patient, and CMS versus traditional vendor relationships, which are primarily transactional. Many vendors may provide services that support value-based care (e.g., data analytics, care management), but if their business models are not aligned with the cost and quality outcomes of accountable populations, they lack the same degree of alignment with CMMI objectives.

Questions for Consideration

- *Is the entity's business model aligned with provider performance under accountable care arrangements? How are financial incentives aligned across the entity, provider, and payer (CMS)?*
- *Is the aligned financial arrangement with the entity fair and favorable to the provider? Is it transparent?*
- *How is success defined in the contract?*

3

Enabling Care Delivery Transformation: The entity's offerings and approach to partnership primarily enable care delivery transformation, rather than provide only administrative efficiencies, technology solutions, and/or financial services.

Why it Matters

The goal of VBP models—reducing costs and improving the quality and experiences of care—requires fundamental changes in the delivery of care that are difficult to make or unrewarded under FFS. Other types of offerings, including administrative efficiencies, technology solutions, and financial services can be important factors in helping a provider to adopt and succeed in value-based arrangements. However, all offerings should be intentionally designed and implemented to achieve a specific end—transforming the delivery of care in ways that reduce unnecessary utilization, improve clinical quality, and advance the health of populations.

Entities can support providers with wraparound clinical services, either through employed staff or through contracted partners, can help to streamline clinical workflows, or support care transformation in other ways. More important than making available added services, VBP enablers offer clinical support by collaborating with providers to transform care delivery processes in ways that lead to better patient outcomes and experiences of care than are possible under the traditional FFS paradigm. Entities should have an intentional clinical model, designed and led by physicians with input from multidisciplinary care teams, patients, and caregivers. Successful entities start with a clear clinical intention and orient their offerings and partnerships in ways that best facilitate/enable those care delivery changes.

Questions for Consideration:

- *What is the entity's clinical model? Do they have a plan for how care will be delivered differently to drive outcomes? (Can the entity offer detailed explanations of clinical programs, staffing structures, interventions, etc.)*
- *Are the other elements of the entity's offerings (e.g., administrative supports, technology, financial services, etc.) designed to build on/facilitate the intentional care delivery model?*
- *Is the entity's clinical model informed by evidence-based guidelines for high-quality, culturally competent care?*
- *Are the entity's mission and care philosophies aligned with those of the provider organization?*
- *Is the entity flexible in adjusting the clinical services according to the provider's existing capabilities and gaps?*

– *How does the entity educate and engage with physicians and care teams? How do they help to facilitate engagement with patients and caregivers?*

4 **Financially Viable Business Model:** The entity should have a sustainable business model that can support its mission.

Why it Matters:

Many of these entities have significant levels of private equity backing, large valuations, and questionable profitability. While private funding is not necessarily a problem, and is often needed to scale operations, the long-term sustainability of these entities absent additional funding is often uncertain.

The recent growth of new entrants in this space means many entities have yet to prove their viability. Some churn among the participants in CMS and CMMI accountable care models should be expected, but it should not be the result of an entity's financial instability. When an entity fails, providers and beneficiaries can be left in the lurch. While any type of organization can fail, the rapid growth of these entities and potential overinvestment with no track record poses higher risks. To mitigate potential disruptions in care relationships and providers' accountable care transformation efforts, entities should have a sustainable business model or path to sustainability.

Questions for Consideration:

– *Is the entity growing at a sustainable pace?*

– *How long has the entity been in business?*

– *Does the entity have some track record for success under accountable care or similar efforts?*

– *For private entities, what level of private investment are they receiving and from where?*

– *For public entities, does their valuation align with the fundamentals?*

– *What type and level of experience does the management team have?*

5 **Provider Autonomy:** The entity elevates the leadership, voices, and experiences of physicians and other clinicians, ensuring providers play a significant role in determining how care is delivered and how their practices are run.

Why it Matters

To truly enable changes in the delivery of care, entities must put physicians and care teams at the center. When done well, delivery transformation enabled by VBP models should improve not only patients' outcomes and experiences, but also the experiences of clinicians and care teams. Prioritizing physician leadership and engagement will improve the success of the partnership, foster trust, and enable physicians to practice according to their strengths and patient needs.

Entities that support providers in VBP and delivery transformation without assuming ownership of the provider, can help to offer independent practices additional avenues to engage in

accountable care—an alternative to market consolidation that may hinder patient access, choice, and affordability. Even among entities that do employ providers, these organizations can foster physician autonomy and leadership.

Questions for Consideration:

- *Are physicians and clinicians in positions of leadership/governance? How were these clinicians selected? What roles do they play in decision making?*
- *Are providers able to continue to practice medicine in a way that aligns with their values and optimal patient outcomes?*
- *Are providers able to maintain independence if desired?*
- *Is the entity responsive to physician feedback?*

6

Inclusion: The entity has an approach that is flexible and adaptable to meet the needs of providers with varying levels of experience in accountable care and can serve beneficiaries who have historically been underrepresented in VBP models.

Why it Matters

Optimally, entities would seek to engage a range of providers regardless of their experience with VBP and delivery transformation. Entities that solely focus on providers of a select size or level of sophistication may be cherry picking providers or otherwise curating accountable care networks based on optimal chances of financial success, regardless of the entity's own care transformation efforts. To continue to advance VBP in healthcare requires bringing in providers with a range of experience and sophistication. Many enabler entities are uniquely positioned to support providers at varying levels of capability and offer an opportunity to expand participation among those that have yet to engage in APMs.

Additionally, entities focused on or able to serve beneficiaries who have not historically been included in value-based care, are particularly aligned with CMMI's goals.

Questions for Consideration

- *Which types of providers are being served (e.g., independent physician groups, FQHCs, IPAs, health systems)?*
- *Does the entity collaborate with providers operating at varying degrees of sophistication and readiness for risk?*
- *Which beneficiary populations are being served? If the entity focuses on underserved areas, how does it adjust its approach to meet the needs of those communities?*

Policy Implications & Recommendations

As CMS works to accelerate adoption of accountable care to achieve its 2030 goal and beyond, the agency must find ways to bring in new providers who have yet to engage meaningfully in these models while also retaining current participants and advancing model designs for the next phase of VBP and delivery reform.

Further exploration into the approaches these new companies use could provide lessons for CMS on how to achieve their goals, including potential insights into their recruitment and communication strategies and lessons from their experiences helping providers to engage in Medicare APMs to date. Furthermore, CMMI may have opportunities to explore model partnerships with such entities to attract specialists, safety net providers, health systems, and other clinicians looking to join an accountable entity with lower barriers to entry.

Below we outline a series of recommendations for CMS to further their goals and recognize that enablers are key partners in achieving success in value-based care. These recommendations are aligned with the guiding principles and focus on two areas: 1) **driving new and sustained provider participation** and 2) **ensuring high-quality partnerships for CMS and providers**.

Driving New and Sustained Provider Participation to Advance Accountable Care

Bringing in new providers who are not yet participating in accountable care, including safety net providers, specialists, and hospitals/health systems requires different approaches. Accountable care models, particularly those with prospective payments and flexibilities to address holistic drivers of health, are more conducive to meeting the needs of a population than FFS or FFS-based models with enhanced payments. Helping safety net organizations and other providers to gain access to these models, with the support and protection of experienced partners, may be an attractive option for some organizations. This approach accelerates the adoption of accountable care in a way that limits additional burden and financial pressure on providers to implement alone.

Recommendations

- **Encourage enablers to invest in underserved communities through partnerships with safety net providers**—in alignment with the guiding principles—through methodologies that account for social acuity and screening criteria that require/prioritize entities with meaningful safety net participation.
- **Expand access to primary care capitation.** Access to capital is a key part of many enablers' offerings and a need among many providers. CMS knows this and has evidence from the ACO Investment Model (AIM) to indicate that providing upfront funding to small/low-revenue ACOs is a win-win. Recent updates to MSSP have incorporated these lessons, reintroducing advanced payments. Among AIM participants that needed this funding, however, were ACOs supported by enablement partners, indicated that upfront funding is good but

insufficient to support small primary care practices. Outside of these advance payments, FFS-based APMs like MSSP don't offer the flexible cash flow needed to invest in care transformation on an ongoing basis. Expanding access to primary care capitation would provide more opportunity to make these investments. Even with this flexible funding, practices may not know how to operationalize these revenue cycle changes or where to effectively deploy these funds; enablers can play an important role here by helping practices know where to invest for the greatest return on investment.

Enablers may be particularly effective influencers in bringing in **specialists** and potentially **health systems** into accountable care over the next decade, whether through direct partnership or their indirect influence as competitive threats to FFS-entrenched incumbents. To date, most enablers and risk-bearing delivery organizations have focused on primary care practices, but established organizations with experience bearing full risk through global capitation with MA plans are increasingly engaging in sub-capitation and other downstream risk arrangements with specialists. According to interviewees, many primary care-focused entities are working to integrate specialists into accountable care workflows and are exploring creative partnership approaches. Specialty integration remains a relatively new frontier, and hospital ownership of specialists presents significant barriers to adoption in some markets.

Still, the activities of many VBP enablers and risk-bearing delivery organizations align with elements of the Innovation Center's specialty strategy for value-based care.[79] CMS should seek to learn from the tactics (including productive methods and lessons from failures) of VBP entities that have some experience implementing the elements CMS has identified in its specialty strategy. These entities are largely unencumbered by hospital incentives for referral volume and high-paying specialty service lines, have highly sophisticated data analytics, and often have large networks of primary care practice partners to explore different approaches.

Recommendations

- **Learn from the tactics of VBP entities that have experience implementing the elements outlined in CMS's specialty strategy,** including methods for encouraging high-value referrals by providing access to data on specialists' cost and quality outcomes as well as other indicators of value (e.g., appointment wait times, patients' experiences of care, willingness to share data/coordinate with primary care team, etc.), as well as use of e-consults and clinical pathways for select conditions involving multiple specialists.
- **Signal to hospitals and health systems that outcomes-based payment reforms are inevitable.** Build on the momentum driven by the competitive pressures of VBP primary care entities. Health systems should begin preparing for this future state by gaining experience in voluntary APMs available in their communities.

CMMI models are powerful catalysts for driving industry investment and have driven this activity in Medicare, including FFS Medicare and MA. However, value-based innovation and investment in Medicaid has been limited. CMMI's 2030 goal aims to bring most Medicaid beneficiaries into accountable care.

Recommendation

- **Leverage the private sector to accelerate innovation and investment in Medicaid.** Assuming accountability for Medicaid beneficiaries requires different capabilities and a capital-intensive care model. Given less lucrative economics, patient churn, and difficulties scaling, investment in VBP enablement and risk-based delivery organizations focused on Medicaid populations has been limited to date. By designing models with sufficient incentives and supports, private sector entities could help to drive adoption of accountable care among providers serving these populations.

Ensuring High-Quality Partnerships for CMS and Providers

CMS should incorporate lessons and feedback from participants in its latest Innovation Center models, which represent a new class of APMs not built entirely on FFS (e.g., GPDC/REACH, PCF, KCC) and include robust enabler participation. CMS should provide clear signals to participants about future opportunities to allow them to plan for what comes next and begin outreach to other provider types.

We recommend that CMS not restrict enabler engagement in models, as long as the organization adheres to the guiding principles; however, the agency should seek to level the playing field for non-enabled providers wherever possible.

Recommendations

- **Continue to allow for enabler participation in APMs with more detailed vetting of applicants.**
    - **Use scoring algorithms aligned with the guiding principles (clinical care plan, financial arrangements, leadership teams, etc.).** The application process should provide CMMI with the necessary information to understand how well a potential participant aligns with the guiding principles. Some of this information is already collected in current processes, but opportunities exist for CMMI to better assess an entity's suitability. The use of each principles' example considerations can provide guidance on the types of questions to consider adding.
    - **Require participants to describe their sustainability and implementation plans for model participation. Audit participant plans multiple times during the model.** Because of the growth pressures these entities face and rapidly evolving landscape, CMMI should consider how it can ensure continued adherence to the plans originally provided in the application process and potentially require additional submissions or updates between performance years if an accountable entity's participant list grows substantially, asking to describe how it plans to support newly enrolled providers and their beneficiaries.
    - **Require all applicants to describe their clinical care model.** This could be a way for CMS to ensure all participants have an intentional care model while also gathering data on the care delivery strategies of accountable entities, how they differ and how they are evolving over time.
    - **Establish data analytics requirements for enabler participants.** The ability to aggregate and analyze data to help inform population- and patient-level decision making is among the top reasons why providers partner with a VBP enabler. However, multiple interviewees stressed the varying quality and added value of different enablers' data analytics capabilities. To ensure enabler participants are equipped to support their provider partners in CMMI models, CMS could require that certain necessary data analyses be calculated and submitted to CMS regularly.
- **Help providers participate in models without an enabler partner if they do not want one. For those that do, support providers in understanding attributes to look for.**
    - **Simplify provider participation in models sans enabler partner.** Make model requirements easy to understand and to compare across model options/tracks and provide greater predictability and transparency to participants.
    - **Support providers in enabler partner selection**. Providers are slowly becoming savvier shoppers when evaluating potential enabler partners, but several factors can complicate this process. CMS could support providers by requiring enablers to publish more information about past performance results or downstream partnerships in Medicare models. Additionally, through its learning and diffusion systems or

the LAN, CMS could help providers to enter equitable partnerships by developing resources, such as a checklist of criteria for providers to consider when evaluating potential enabler partners, examples of fair contract terms, guiding principles for governing the partnership, etc.

Areas for Future CMS Research

- **Evaluate model performance along participant subgroups.** As CMS has begun more rigorously evaluating model impact on specific beneficiary subgroups[80] as part of the agency's increased focus on health equity, a similar approach can be applied to model participants. Model participants are increasingly diverse, offering new services (e.g., enablers), providing care in new ways (e.g., home-based care groups, advanced primary care organizations), and are increasingly owned by new types of organizations (e.g., retailers, payers). Studying performance along these lines can provide insights into how these differences contribute to the success of moving the market toward value-based care.
- **Evaluate how model design and rules affect different subgroups.** The increasing diversity of participant types increases the potential for model designs and rules to unfairly impact some groups more than others. As an example, ACO REACH marketing rules can penalize groups that don't have a traditional brick-and-mortar operation like home-based care groups.
- **Evaluate provider turnover in models.** With access to the list of providers entities employ or partner with, CMS could evaluate provider movement in and out of the model, providing insight into entities that have high turnover rates. This analysis could point to entities that are aggressively attempting to optimize participant lists or those with high rates of provider dissatisfaction. One interviewee noted providers in CKCC were leaving and/or joining another entity because they wanted a different partner.
- **Evaluate opportunities to appropriately support providers in comparing their options.** One function that VBP enablers offer is assistance in comparing VBP options. Given the data on providers that CMS has access to, this may be a function the agency has the capability of providing. Determining the information providers need and how to best provide them with this information in an accessible format would help scale VBP participation.

Conclusion

Through its models, priorities, and messaging, CMS has helped to create broad buy-in for the shift to accountable care and has fostered private sector innovation and investment, cultivating the environment for new types of entities that are specifically designed for a value-based ecosystem.

From risk-bearing delivery organizations whose business models hinge on effective population health management and longitudinal patient relationships, to VBP enablers that provide the population health functions needed to succeed in accountable care while sharing responsibility for those outcomes, these entities are creating more opportunities for clinicians to deliver the type of coordinated, proactive, whole-person care that is not supported in a FFS system.

Fundamentally, alternative payment models aim to support high-value care by aligning incentives across payers and providers, and by extension patients and purchasers. In some ways, these entities may represent a natural evolution in the shift to a value-based healthcare system by extending that alignment of incentives to include the third-party partners that offer the tools and services needed to operate in this environment.

However, while they may be aligned in principle, this is a relatively new and evolving market with diverse and untested actors. As existing entities expand their capabilities and new organizations enter the market with innovative approaches, the lines delineating these entities will only become blurrier. We believe the Guiding Principles outlined in this report will provide a useful lens for evaluating these entities throughout this evolution.

These organizations can be meaningful partners in advancing CMS' goals by helping providers who would otherwise be unable to participate to access needed support and achieve the scale that accountable care demands. They also have the potential to lead to further fragmentation and the siphoning of earned savings away from providers and communities, among other unknown implications.

As this landscape changes and expands, CMS and its Innovation Center must carefully consider how these types of entities participate in its models while also leveraging these important partners for learning and advancing adoption. Just as CMS helped to cultivate the broader industry's alignment around the shift from FFS to accountable care over the last decade, the agency now has an opportunity to shape the evolving market of value-based entities going forward.

Appendix

Additional Figures

Figure 14. Guiding Principle Alignment with CMMI Strategic Objectives

CMMI Strategic Objectives	Drive Accountable Care	Advance Health Equity	Support Innovation	Address Affordability	Partner to Achieve System Transformation
Payer-Agnostic Approach	X				X
Shared Success	X		X		X
Enable Care Delivery Transformation	X	X	X	X	X
Financially Viable Business Model	X				X
Provider Autonomy			X		
Inclusion	X	X			

Figure 15. Evolution of Medicare Accountable Care Models

The MSSP is CMS's permanent ACO model, but the agency continues to assess new and advanced accountable care approaches via the Innovation Center. Each iteration applies lessons from predecessor models, industry input, and increasingly MA.

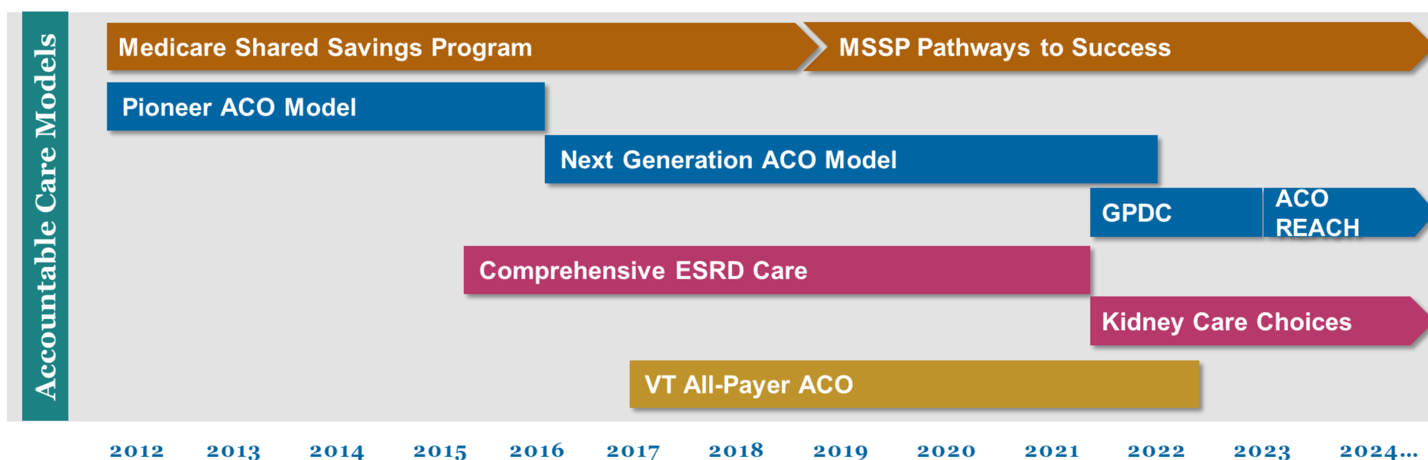


Figure 16. Eligibility Criteria for Enabler Participation in CMMI Models

Model	Enablers/ Hybrids Allowed to Participate	Eligibility
Medicare Shared Savings Program (MSSP)	Yes	Eligible participants are Medicare-enrolled providers and/or suppliers who form or join an ACO and have at least 5,000 Medicare fee-for-service beneficiaries assigned to their ACO.
ACO Realizing Equity, Access, and Community Health (ACO REACH)	Yes	The ACO is not required to be a Medicare-enrolled provider or supplier, but all participating providers must be.
Kidney Care Choices (KCC)	Yes (for CKCC)	Comprehensive Kidney Care Contracting (CKCC) Option: The Kidney Contracting Entity (KCE) itself is not required to be a Medicare-enrolled provider or supplier, KCE participants must be. Kidney Care First (KCF) Option: The applicant must be a Medicare-enrolled entity (i.e., physician practice or professional corporation) that bills Medicare for physician services rendered by one or more nephrologists by the start of the performance period.
Enhancing Oncology Model (EOM)	Yes	Participants must be a Medicare-enrolled physician group practice (PGP).
Making Care Primary (MCP)	No	Eligible participants are Medicare-enrolled organizations that provide primary care services to a minimum of 125 Medicare beneficiaries.
Primary Care First (PCF)	No	Eligible participants are *practices* with primary care practitioners, at least 125 attributed Medicare beneficiaries, experience in value-based care, and other requirements.

Sampling of Deidentified Provider Vignettes Regarding Dissatisfaction in Enabler Relationships

Note: Many providers expressed only positive experiences with their enabler partners. The benefits of enablers shared by interviewees are woven throughout the "Segment Overview: VBP Enablement Entities" section of this report.

Provider Type	Health System-led CIN
Impetus for VBP	Desire to form an ACO in response to market competitors joining the MSSP and aligning with community PCPs, thereby affecting specialty referral patterns. At the time, the system had some experience with bundled payments but no population health infrastructure. Leadership believed the industry was moving toward value and saw the NGACO model as an opportunity to learn and differentiate themselves from the MSSP ACOs in the area.
Reason for selecting the enabler	Health system leaders recognized they needed external support to inform and fund the work (e.g., data analytics, care management program, network curation, etc.) but, with the tight application window, did not have time to solicit proposals. Instead, a member of the leadership team was a former colleague of an employee at the enabler and set up a meeting. The enabler was eager to enter the market and willing to be flexible. They moved quickly to sign multi-year contract. They did not investigate other potential options.
Reasons for ending the partnership	Shortly into the partnership, **health system leaders realized that they had an incomplete did understanding of the contract terms and believed the enabler was intentionally vague/misleading** about how losses would be deducted from future savings payments. "They said they would protect

Provider Type	Health System-led CIN
	against downside risk, and that wasn't really true." Even though the health system was successful in its first year and did not incur losses, leadership was disillusioned with the enabler and lost trust, deciding to exercise their option to terminate the agreement after one year. Of note, the health system always intended to leverage an enabler in establishing its population heath infrastructure and learning best practices, with the ultimate goal of eventually handling these functions in-house. **Despite ending the enabler relationship sooner than anticipated, the CIN has continued to engage in VBP contracts with public and private payers, crediting that growth and success to the strong foundation the enabler helped them to quickly establish**.
Interviewee reflections/advice to other providers	*"Once you've defined what you need, identify the companies that can fill those gaps, then talk with their current clients to make sure they can do what they say they can do. Get the whole story."* *"Protect your relationships with physicians. Be transparent and forthcoming about why decisions are made – this helps to maintain their trust when inevitable pivots occur. Enablers have expertise, but sometimes messaging should come from internal leaders."* *"Ensure your leadership team is committed to the transition regardless of initial performance or specific partnerships."*

Provider Type	Large Multi-Specialty Medical Group Affiliated with Academic Medical Center
Impetus for VBP	Leadership had been following the value movement from a distance since the ACA. When MACRA was enacted, the Advanced APM bonus opportunities and reporting exemptions from MIPS drove the group to engage in VBP models, beginning with the MSSP.
Reason for selecting the enabler	Medical group leadership sought a partner with (1) an established track record/evidence of successful outcomes, (2) a high degree of expertise in Medicare models and broader VBP opportunities to inform the medical group's strategy, and (3) an existing presence in their market. "We were looking for a true partner. Someone with skin in the game and capabilities to not just get us started but to help us over the long haul." After evaluating two options that met their criteria, leadership selected an ACO enabler and signed a five-year contract.
Reasons for considering ending the partnership	Through its enabler relationship, the medical group continues to participate in Medicare APMs and has expanded its portfolio of accountable care contracts across multiple payers. At the time of our interview, the group was approaching its contract renewal with the enabler. Despite being generally satisfied with the relationship, **medical group leadership was on the fence about potentially seeking another option to help secure risk-based contracts with large, self-insured employers in their market**—a gap of their current enablement partner—but did not want to go through the major hassle of undoing the relationship and planned to renew. Of note, **the enabler initially expressed an ability to do this, but ultimately lacked the relationships and capabilities to deliver**.
Interviewee reflections/advice to other providers	"*If possible, seek partners that have national expertise and perspective as well as a deep understanding of the local market. Relationships with national payers are helpful to open doors, but these contracts are implemented regionally."* *"This is not so much advice for other providers, but just want to acknowledge that it's getting a lot harder not to consider selling practices to Optum or other specialty aggregators. They're offering so much money. That's been an unexpected benefit of our partnership with [enabler] – feeling united against Optum."*

Provider Type	Large Health System-led CIN, Early Adopter of ACO Contracts
Impetus for VBP	The ACO was formed in 2012, with the MSSP as its first foray into accountable care. Over the last decade, the ACO has since secured VBP contracts with Medicaid, MA, and commercial/employer payers with nearly 300k lives under value-based arrangements.
Reason for selecting the enabler	Following financial pressures from COVID-19 and workforce challenges and a desire to diversify revenue and get closer to the premium dollar, health system leadership sought a partner with specific expertise and relationships in MA market. Other desired attributes included protection from downside risk and a willingness to make financial investments in the health system. In lieu of a competitive RFP process, the system selected an enabler partner based on existing relationships.
Reasons for frustration with the partnership	Some leaders of the organization are disheartened by the enabler partner's exclusive focus on one line of business (i.e., MA), despite the fact that the ACO has risk-based contracts across Medicare FFS, Medicaid, and commercial populations. This exclusivity leads to redundancies, as the ACO continues to support population health efforts across other lines as well as jointly covering the operating expenses of the MA-focused initiatives. While still early, the enabler has yet to secure more favorable VBP MA contracts than the system had gotten on their own.
Interviewee reflections/advice to other providers	*"Always good to have comparison. We should have done an RFP or expanded our review to see if an LOB-agnostic approach would have been better or if others in the MA space would be better. Getting clear around a set of guiding principles that will govern partnership (e.g., we care about all patients, can't have a distinct operating model for different lines of business)."*

Research Approach and Sizing Methodology

This appendix includes the types of information collected in the secondary research process, the types of interviewees targeted, the list of organizations represented in the interviews, and additional details on the sizing methodology.

Secondary Research Fields

Type of Information	Detailed Information
Basic Information	Company name, short description, website, year founded
Ownership	Parent company and whether the company is private or public
Size	State footprint, number of employees, number of practices and/or providers, number of VBP-covered lives, revenue
Target Population	MA, Traditional Medicare, commercial, disease-based, other, and/or population-agnostic
Target APM Types	Population-based/ACOs, episodic models/bundles, specialty TCOC, and/or other
Target Client Types	Independent PCPs, hospitals, health systems, multispecialty groups, FQHCs, payers, and/or purchasers; primary client type; "value-readiness" of target clients
Owned Operational Assets	Technology solutions, provider/care delivery assets

Offerings	Grouped into clinical, technology, financial, and administrative services
Business model	Financial model, type of risk-sharing offered

Interviewee Types

Type of Target	Description
Entity Targets	Current and former leaders of select value-based entities (i.e., enablers and risk-bearing delivery organizations), prioritizing interviewees with experience at multiple organizations.
Provider Targets	Two types of provider interviewees: 1. Leaders (physician leaders or administrators) of a care delivery organization (e.g., medical group, health system, etc.) that **chose to partner with a VBP enabler** to gather candid perspectives on the selection process and partnership experiences. 2. Physicians who previously practiced in a FFS setting but are now **employed by an advanced primary care company** to learn about the benefits and drawbacks of both practice settings and their employment experience.

Interviewed Organizations

The entity interviewees included current and former representatives of the following companies:

- AbsoluteCare
- Accompany Health
- agilon
- Aledade
- Alpine Physician Partners
- Belong Health
- BridgepointMD
- Cano Health
- CareMore
- Chamber Cardio
- ChenMed
- Cityblock
- Curana
- CVS Accountable Care Organization
- Duo Health
- Eleanor Health
- Evergreen Nephrology
- Evolent
- Gather Health
- Genuine Health Group
- HarmonyCares
- Homeward Health
- Hopscotch Health
- Iora
- Karoo Health
- Lumeris
- Monogram
- Navvis/Surround Care
- Oak Street
- Oncology Care Partners
- OneOncology
- Patina
- Panoramic Health
- Pearl
- Privia
- Sevi Health
- Signify/Caravan
- Somatus
- Stellar Health
- Strive Health
- Thyme Care
- UpStream Health
- VillageMD
- Vera Whole Health
- Vytalize
- Waymark

Sizing Methodology

Data Sources

The following sources were used to source data for the sizing analysis:

Source	Description
Pitchbook	Pitchbook is a financial data and software company that provides information on the private equity, venture capital, and mergers and acquisitions (M&A) markets. It offers a comprehensive platform with data on companies, deals, investors, and various financial transactions in the private and public markets. Pitchbook was used to obtain the following entity information: parent company and whether the company is private or public, investment activity (funding round type, dollar amount, and investors), and annual revenue.
Company Websites	Company websites were used to obtain information on state footprints, number of employees, number of practices and/or providers, number of VBP-covered lives, and other information whenever unavailable from other sources.
Other Supporting Materials	Other supporting materials issued by the entity or reputable research institutions were leveraged to obtain information. These sources may include investment documents, promotional materials, or materials shared directly by the company for the purpose of this report.
Primary Interviews	Primary interviews with key stakeholders, industry experts, and relevant individuals within the field were conducted to gather insights, validate data, and acquire additional information for the sizing analysis. In interviews with company leaders, we tried to pressure test numbers found publicly to ensure accuracy when possible.

Addressing Data Integrity

Data collection yielded information about our sample list of entities that provided varying levels of data integrity. Entity records were categorized into three groups:

Record	Description
Complete Records (n = 60)	Records of entities for which current information was found regarding patient lives under management. For these entities, data capturing lives under management were found through primary and secondary research, and no additional data imputation was necessary. Information from complete records was used to derive growth of lives over time (three-year CAGR [compounded average growth rate]) [xvi] for the main entity categories; VBP enablers, VBP providers, and VBP hybrids. These growth factors are used in imputation of missing data points below.
Records containing robust historical data (n = 9)	Records of entities for which robust historical data was found containing past information on number of patient lives under management over time, but which did not contain information regarding current number of lives under management. For said records, a growth factor was applied to previous years to extrapolate the total number of lives under management. Said growth factors were derived from a combination of the CAGR of the entity's lives under management over the preceding three years, as well as the CAGR growth factors for the three main entity types created from complete entity records. The lower of the two factors being used to create a "low" estimate, and the larger of the two to create a "high" estimate, allowing reasonable variation to be incorporated in the analysis.

[xvi] CAGR, or Compound Annual Growth Rate, is a measure that represents the annualized growth rate of a business over a specified time, accounting for compounding.

Records containing sparse historical data (n = 21)	Entities for which only single historical data points were uncovered. In these cases, entities of comparable size and scope for which complete records were found were used to approximate total lives under management, similarly to category #2.
Records containing no historical data, and no comparable firms (n = 18)	Firms that did not contain robust historical data on lives under management, and for which no comparable firms could be leveraged to approximate the current number of lives, were excluded from the market sizing analysis. In instances where no information is available on total lives being managed, but where panel size and number of clinicians is provided, we calculated an approximation using panel size multiplied by the number of clinicians. Panel size assumptions differed based on company-type as follows: – APC Panel Size: 400 lives per clinician – Enabler Panel Size: 250 lives per clinician

Limitations

- Entities cover lives at different levels of value-based payment. Some entities (e.g., Duo) cover lives solely under global capitation arrangements, while others may only include lives under "value-light" pay-for-performance arrangements or upside-only shared savings arrangements. Because of this, reported value-based lives are not always directly comparable across organizations.
- There may be a bias that emerges from the private companies that decide to report lives versus those that do not. If only the fastest growing and most successful groups are reporting lives, using these numbers for imputation may lead to an overestimation of the number of lives covered by entities that don't publicly report data.
- Entities often report the number of value-based lives based on plans and aspirations, rather than true numbers. When able, reported numbers were confirmed with interviewees.
- The historical rate of growth may not be indicative of the rate of future growth.
- In cases of cross-entity partnerships, lives may be double counted depending on entity reporting. For example, Vytalize.an enabler, is a client of Stellar, another enabler. Another such instance illustrating this phenomenon occurs with the partnership between Oak Street and Strive Health.

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