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Navigating the Massive VBC Transformation Creating Unprecedented Technology Demand

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Executive Summary

Value-based care represents the most significant transformation in U.S. healthcare delivery and payment in over 50 years. With the Centers for Medicare & Medicaid Services (CMS) targeting 100% of Medicare beneficiaries in value-based care arrangements by 2030, and the VBC market already valued at $4.01 trillion in 2024, this shift creates unprecedented demand for healthcare technology solutions.

This comprehensive white paper provides health technology leaders with actionable intelligence on the value-based care market opportunity, including:

- **Market Size and Explosive Growth:** $4.01T → $4.45T (18.23% CAGR through 2030)

- **CMS Policy Drivers:** 100% Medicare in VBC by 2030, 476 MSSP ACOs with 11.2M lives
- **Medicare Advantage Expansion:** 35.7 million beneficiaries (51% of all Medicare)
- **MSO Market Opportunity:** $124.97B → $209.25B (10.86-12% CAGR)
- **Technology Adoption Drivers:** Quality metrics, cost reduction, care coordination, analytics
- **Buyer Personas and Decision Criteria:** What VBC organizations actually need and will pay for

For healthcare technology companies, value-based care organizations represent ideal customers: they have clear quality and cost reduction imperatives tied to financial performance, substantial technology budgets, long-term commitment to solutions that work, and willingness to pay premium prices for genuine ROI.

However, successfully selling to VBC organizations requires deep understanding of contract structures, quality measure specifications, financial incentives, care coordination workflows, and decision-making processes unique to risk-bearing provider groups. Generic healthcare sales approaches fail in this sophisticated buyer environment.

JOYN Health's co-founders bring direct experience with VBC contracting, ACO operations, nursing care transitions, and healthcare technology implementation—providing both market intelligence and turnkey access to this high-value market segment.

This white paper equips health tech leaders with the knowledge needed to:

1. Understand the VBC market size, growth drivers, and opportunity segments
2. Navigate Medicare Advantage, MSSP ACOs, ACO REACH, and other VBC programs
3. Position technology solutions in the context of VBC financial incentives
4. Access VBC buyers through strategic distribution partnerships
5. Build sustainable competitive advantages in the VBC technology market

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1. Understanding Value-Based Care: Market Definition and Scope

1.1 What Is Value-Based Care?

Value-based care (VBC) represents a fundamental shift in healthcare payment and delivery models—from fee-for-service (paying for volume) to paying for value (rewarding quality outcomes and cost efficiency).

Traditional Fee-for-Service (FFS) Model:

- Providers paid for each service, procedure, visit, or test
- Financial incentive: Maximize volume of services
- Revenue increases with more visits, tests, procedures
- Quality and outcomes not directly tied to payment

- No accountability for total cost of care

Value-Based Care Model:

- Providers rewarded for quality outcomes and cost efficiency
- Financial incentive: Improve quality while reducing total cost of care
- Revenue tied to performance on quality metrics
- Shared savings or risk-based arrangements
- Accountability for patient health outcomes and total cost

1.2 The Value-Based Care Continuum

VBC arrangements exist on a continuum from minimal risk/reward to substantial downside risk:

Level 1: Pay-for-Performance (P4P)

- Small bonuses (1-5% of revenue) for quality metric achievement
- No downside risk
- Examples: MIPS (Merit-based Incentive Payment System), hospital value-based purchasing

Level 2: Shared Savings (Upside Only)

- Providers share in cost savings if spending below benchmark
- No penalty if costs exceed target
- Examples: MSSP Track 1, many commercial ACO contracts

Level 3: Shared Savings and Losses (Two-Sided Risk)

- Providers share in savings AND losses
- Moderate downside risk (5-10% of revenue at risk)
- Examples: MSSP Enhanced Track, ACO REACH Standard

Level 4: Full Risk/Capitation

- Providers receive fixed payment per patient (PMPM - per member per month)

- Full accountability for all care costs
- Substantial downside risk (100% of cost overruns)
- Examples: Global capitation, some Medicare Advantage delegated risk arrangements

Level 5: Risk-Bearing Provider Organizations

- Providers function as insurance entities
- Accept insurance risk directly from CMS or commercial payers
- Examples: Kaiser Permanente model, provider-sponsored health plans

Note: Technology needs and budgets generally increase as organizations move up the VBC continuum, with Level 3-5 organizations representing highest-value technology buyers.

1.3 Key VBC Program Types

Medicare Programs:

- **Medicare Shared Savings Program (MSSP)** - Largest ACO program, 476 ACOs, 11.2M beneficiaries
- **ACO Realizing Equity, Access, and Community Health (REACH)** - Advanced two-sided risk model, 103 ACOs
- **Medicare Advantage (Part C)** - Private insurance for Medicare, 35.7M enrollees (51% of Medicare)
- **Value-Based Insurance Design (VBID)** - MA plans offering enhanced benefits, 62 MAOs, 7M+ members
- **Next Generation ACO** - Ended 2021, transitioned to ACO REACH
- **Direct Contracting** - Renamed ACO REACH in 2023

Medicaid Programs:

- **Medicaid Managed Care** - Risk-based arrangements in many states
- **Medicaid ACOs** - State-specific accountable care models
- **Health Homes** - Care coordination for complex/chronic conditions

Commercial Programs:

- **Commercial ACOs** - Employer and health plan ACO contracts
- **Bundled Payments** - Episode-based payment (e.g., total joint replacement)
- **Commercial Shared Savings** - Various payer-specific programs

1.4 Market Scope: What's Included in the $4 Trillion VBC Market

The value-based healthcare services market includes:

Provider Services:

- Medical services delivered under VBC arrangements
- Primary care, specialty care, hospital services
- Post-acute care (skilled nursing, home health, hospice)
- Behavioral health and substance abuse treatment

Care Coordination Services:

- Care management and care coordination programs
- Transitional care management
- Chronic disease management
- Remote patient monitoring and telehealth

Management Services:

- MSO (Management Service Organization) services
- Practice transformation and optimization
- Physician quality and performance improvement
- Revenue cycle management for VBC contracts

Technology and Analytics:

- Population health management platforms
- Clinical decision support systems
- Quality reporting and analytics solutions

- Risk stratification and predictive analytics
- EHR optimization for VBC reporting
- Patient engagement technologies

Note: Market size figures vary by research methodology—some reports focus narrowly on provider services under VBC contracts ($4T range), while others include enabling technologies and services ($1-2T range). This paper presents both perspectives for comprehensive market understanding.

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2. VBC Market Size and Explosive Growth Projections

2.1 U.S. Value-Based Healthcare Services Market

2024 Market Size: $4.01 Trillion

This represents the total value of healthcare services delivered under value-based payment arrangements in the United States. To contextualize this figure: the entire U.S. healthcare system represents approximately $4.5 trillion in annual spending—meaning nearly 90% of healthcare spending is transitioning to or already operating under some form of value-based arrangement.

Source: Grand View Research, Value-Based Care Market Analysis (2025)

Alternative Market Sizing (Technology and Services Focus):

2025 Market Size: $1.93 Trillion

This figure focuses more narrowly on VBC-enabling technologies, management services, and care coordination programs rather than total medical spending under VBC contracts. This methodology better represents the addressable market for healthcare technology and services companies.

Source: Mordor Intelligence, Value-Based Care Market Analysis (2025)

Both figures are accurate—they simply define the market differently. For healthcare technology companies, the $1.93T figure is more relevant as it represents actual spending on VBC-enabling products and services rather than total medical care costs.

2.2 Growth Projections Through 2030

High-End Projection (Total Medical Spending Under VBC):

- **2024:** $4.01 trillion
- **2030:** $4.45 trillion
- **CAGR:** 18.23%
- **Dollar growth:** $440 billion over 6 years

Source: Grand View Research (2025)

Technology and Services Projection:

- **2024:** $1.93 trillion
- **2030:** $7.3 billion (technology segment)
- **CAGR:** 20.3%

Source: Mordor Intelligence (2025)

Conservative Analysis:

Even using conservative estimates, the VBC market is growing 2-3× faster than overall healthcare spending (which grows at ~5-6% annually). This differential growth creates massive opportunity for companies serving VBC organizations.

2.3 Growth Drivers and Market Dynamics

Policy-Driven Growth:

1. **CMS 2030 Goal:** 100% of Medicare beneficiaries in value-based care by 2030
    - As of January 2025: 53.4% of Traditional Medicare in accountable care relationships
    - 4.3 percentage point increase from January 2024
    - Requires converting remaining 46.6% over next 5 years
    - Aggressive timeline driving rapid market expansion

Source: CMS, Medicare Value-Based Care Strategy (2025)

2. **Medicare Advantage Growth:**
    - 51% of Medicare beneficiaries in MA (2025)
    - MA is inherently value-based (capitated payment model)
    - Projected to reach 60%+ by 2030
    - 35.7 million members (2025) growing to 45-50 million (2030 projected)

Source: KFF, Medicare Advantage 2025 Spotlight (2025)

Financial Performance Driving Adoption:

3. **Demonstrated Savings:**
    - **MSSP 2023 results:** $5.2 billion total savings generated
    - **Net Medicare savings:** $2.1 billion after paying ACO shared savings
    - **ACO shared savings earned:** ~$3.1 billion distributed to 476 ACOs
    - **Average per ACO:** $6.5 million in shared savings earned

Source: CMS Program Data, Lumeris Medicare ACOs Analysis (2024)

These results prove the VBC model works financially, encouraging more provider organizations to participate and increasing willingness to invest in enabling technologies.

Commercial Payer Adoption:

4. **Commercial payer VBC initiatives**
    - Major insurers (UnitedHealthcare, Anthem, Cigna, Aetna, Humana) all expanding VBC programs
    - Employer demand for cost containment driving adoption
    - Bundled payment programs gaining traction
    - Technology enabling commercial VBC contracts

Provider Consolidation Effects:

5. **Scale advantages in VBC**
    - Larger provider organizations better positioned for VBC risk
    - Consolidation creating entities with scale for population health management
    - Technology investments more viable at scale
    - MSOs enabling independent practices to participate in VBC

2.4 Market Segmentation: Where the Money Flows

By Program Type (2024 Revenue Share):

- **Shared Savings ACO Programs:** 31.51% of VBC market revenue
- **Medicare Advantage:** ~35% of VBC market revenue
- **Commercial VBC:** ~20% of VBC market revenue
- **Medicaid VBC:** ~10% of VBC market revenue
- **Other models:** ~3.5% of VBC market revenue

Source: Grand View Research (2025)

By Provider Type:

- **Hospital and health systems:** ~45% of VBC participants
- **Physician groups and IPAs:** ~35% of VBC participants
- **Community health centers:** ~8% of VBC participants
- **Specialty provider organizations:** ~7% of VBC participants

- **Other providers:** ~5% of VBC participants

By Geography:

- **Highest VBC penetration:** Northeast (65%+ of providers in VBC arrangements)
- **Strong VBC adoption:** West Coast (55-60% penetration)
- **Moderate VBC adoption:** Midwest (45-50% penetration)
- **Emerging VBC markets:** Southeast (35-40% penetration)
- **Rural markets:** Lower penetration but growing rapidly

Technology Implications:

Markets with higher VBC penetration show:

- Higher technology adoption rates
- Larger average deal sizes for VBC technology
- More sophisticated requirements (advanced analytics, predictive models)
- Greater willingness to pay premium prices for proven ROI

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3. CMS Policy Drivers and the 2030 Mandate

3.1 The CMS 2030 Value-Based Care Goal

In 2021, CMS announced an ambitious goal: **100% of Medicare beneficiaries in some form of value-based care arrangement by 2030.** This policy directive represents the most significant transformation in Medicare's 60-year history.

Current Progress (January 2025):

Traditional Medicare (Original Medicare, Parts A & B):

- **53.4% in accountable care relationships** (up from 49.1% in January 2024)
- **4.3 percentage point increase** year-over-year
- **Remaining to convert:** 46.6% still in pure fee-for-service

Medicare Advantage (Part C):

- **100% already in value-based arrangements** (MA is inherently capitated/value-based)
- **51% of all Medicare beneficiaries** in MA plans
- This means approximately **25-27%** of total Medicare is "automatically" meeting VBC goal through MA enrollment

Combined Medicare VBC Participation:

- **Total Medicare beneficiaries:** ~65 million (2025)
- **In MA (inherently VBC):** ~35.7 million (51%)
- **Traditional Medicare in ACOs:** ~11.2 million in MSSP + ~2.1 million in ACO REACH + other programs
- **Estimated total in VBC arrangements:** ~55-58 million (85-90%)
- **Gap to 100% goal:** ~7-10 million beneficiaries

Sources: CMS Medicare Value-Based Care Strategy; KFF Medicare Advantage Spotlight (2025)

3.2 Policy Mechanisms Driving VBC Adoption

CMS is using multiple policy levers to achieve the 2030 goal:

1. ACO Program Expansion and Innovation

Record 2025 MSSP Growth:

- **228 applications approved** for 2025 (55 new, 173 renewing)
- **Largest annual renewal** in 12-year MSSP history
- **476 total ACOs** participating in 2025
- **655,725 providers and organizations** participating
- **11.2+ million Traditional Medicare beneficiaries** covered

Source: CMS, CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives (2025)

ACO Program Enhancements:

- Improved shared savings rates (up to 75% of savings)
- Reduced entry barriers for new ACOs
- Advance investment payments for smaller ACOs
- Health equity adjustment factors
- Simplified quality reporting requirements

2. Quality Reporting Modernization (2025 Changes)

APP Plus Quality Measure Set:

The 2025 shift to APP (Alternative Payment Model Performance Pathway) Plus represents the most significant quality reporting change in years:

2025 Requirements:

- **6 total measures:** 4 eCQMs/Medicare CQMs, 1 administrative claims measure, 1 CAHPS survey
- **Mandatory APP reporting:** Begins 2025 (Web Interface sunset in 2024)
- **2028 expansion:** Will include 11 total measures with 5 new Adult Universal Foundation measures

Technology Implications:

- EHR systems must support eCQM/Medicare CQM reporting
- Data aggregation platforms needed for multi-site ACOs
- Quality measure calculation engines required
- CAHPS survey administration and tracking
- Real-time quality performance dashboards

Source: CMS Final Rule, MSSP 2025 Reporting Requirements (2025)

3. Payment Model Innovation

ACO REACH Model (2023-2026):

ACO REACH (Realizing Equity, Access, and Community Health) represents CMS's most advanced two-sided risk model:

- **103 participating ACOs** in 2025
- **All 50 states, DC, and Puerto Rico** covered
- **~2.1 million beneficiaries** enrolled (2023)
- **4-year commitment** (PY 2023 through PY 2026)
- **Higher shared savings rates:** 50-75% depending on model option
- **Higher risk:** Up to 100% of losses in high-risk options

Technology Requirements:

- Advanced risk stratification and predictive analytics
- Real-time claims data feeds
- Care management workflow platforms
- Provider performance tracking and attribution
- Financial forecasting and trend analysis

Source: CMS, ACO REACH Model Overview (2025)

4. Medicare Advantage Value-Based Insurance Design (VBID)

2025 VBID Model Participation:

- **62 Medicare Advantage Organizations** participating
- **48 states, DC, and Puerto Rico** covered
- **967 plan benefit packages (PBPs)** testing model
- **7+ million enrollees** eligible for additional benefits/rewards

VBID Innovations:

- Rewards for healthy behaviors (gym memberships, healthy food)
- Reduced cost-sharing for high-value services (preventive care, chronic disease management)
- Care coordination services beyond standard MA benefits

- Social determinants of health interventions

Technology Opportunities:

- Member engagement platforms
- Rewards and incentives tracking
- Healthy behavior monitoring (wearables, apps)
- Social needs screening and resource connection
- Care plan management

Source: CMS, Medicare Advantage VBID Model CY 2025 Participation (2025)

3.3 The 2030 Timeline: Urgency for Technology Investment

Remaining Timeline Analysis:

With 5 years remaining to convert 7-10 million Medicare beneficiaries from pure FFS to VBC:

Required Annual Conversion Rate:

- **1.4-2.0 million beneficiaries per year** must transition to VBC arrangements
- **~290,000 new ACO participants** per year (if ACO pathway)
- **~50-75 new ACOs** annually (at current average size)

Technology Investment Implications:

VBC organizations facing this timeline pressure will:

1. **Accelerate technology procurement** to meet quality reporting and care coordination requirements
2. **Pay premium prices** for solutions with proven ROI and fast implementation
3. **Prioritize integrated platforms** over point solutions to reduce vendor management burden
4. **Demand rapid deployment** (3-6 months vs. 12-18 months)
5. **Seek experienced implementation partners** with VBC domain expertise

The 2025-2027 Technology Investment Window:

Organizations must have technology infrastructure operational by 2027-2028 to succeed in 2030 VBC environment. This creates a **compressed 2-3 year window** for:

- Technology vendor selection
- Contracting and procurement
- Implementation and deployment
- Training and adoption
- Performance validation

This urgency creates exceptional opportunity for health tech companies positioned to serve VBC organizations with proven, rapidly deployable solutions.

3.4 State Medicaid VBC Initiatives

While Medicare drives VBC adoption federally, states are implementing Medicaid VBC programs creating additional market opportunity:

Medicaid Managed Care VBC:

- **42 states** with Medicaid managed care programs
- Many incorporating VBC requirements for MCO contracts
- Quality metrics and pay-for-performance increasingly common

Medicaid ACO Models:

- State-specific accountable care programs
- Examples: Oregon CCO, Massachusetts ACO, Vermont ACO

Dual-Eligible Programs:

- Special needs plans for Medicare-Medicaid dual eligibles
- High-cost, complex population requiring intensive care management
- Strong technology needs for care coordination across Medicare and Medicaid benefits

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4. Medicare Advantage: 51% of Medicare and Growing

4.1 Medicare Advantage Market Size and Growth

Medicare Advantage (MA)—private insurance coverage for Medicare beneficiaries—represents the largest and fastest-growing value-based care segment.

2025 Medicare Advantage Enrollment:

- **35.7 million members** enrolled in MA plans
- **51% of all Medicare beneficiaries** choosing MA over Traditional Medicare
- **Growth trajectory:** Up from 46% in 2023, 48% in 2024
- **Projected 2030 enrollment:** 45-50 million members (60%+ of Medicare)

Source: KFF, Medicare Advantage 2025 Spotlight (2025); CMS Medicare Advantage Rates & Statistics (2025)

Alternative Data Point: Some analyses cite 54% of eligible Medicare beneficiaries in MA (2024), showing measurement methodology differences but consistent growth trend.

4.2 Why Medicare Advantage Is Inherently Value-Based

MA plans receive **capitated payments** from CMS—fixed dollar amounts per member per month based on risk scores. This creates fundamental VBC incentives:

MA Plan Financial Model:

- **Revenue:** Fixed PMPM payment from CMS (risk-adjusted)
- **Costs:** All medical care costs for members
- **Profit:** Revenue minus costs minus administrative overhead

VBC Incentive Structure:

If MA plan reduces medical costs while maintaining quality:

- **Margin improves** (keep difference between revenue and costs)

- **Star Ratings increase** (quality bonuses from CMS)
- **Bonus payments earned** (5-star plans receive 5% bonus)
- **Member growth accelerates** (higher Star Ratings attract more members)

If MA plan fails to control costs or quality:

- **Losses incurred** (costs exceed capitated revenue)
- **Star Ratings decline** (penalty payments from CMS)
- **Member attrition** (low-rated plans lose members)
- **Plan viability threatened** (sustained losses force market exit)

This financial structure makes MA plans aggressive technology buyers—any solution that reduces costs OR improves quality generates immediate financial ROI.

4.3 MA Technology Needs and Spending

Medicare Advantage plans have substantial technology budgets driven by VBC imperatives:

Core Technology Requirements:

1. **Risk Stratification and Predictive Analytics**
    - Identify high-risk members before costly events
    - Predict hospitalizations, ER visits, chronic disease progression
    - Target interventions to highest-impact populations
    - Optimize care management resource allocation
2. **Care Management Platforms**
    - Case management for complex/high-risk members
    - Care coordination across providers and settings
    - Transitional care management (hospital to home)
    - Chronic disease management programs

3. **Provider Network Management**

- Provider performance analytics and scorecards
- Quality metric tracking and provider incentives
- Network adequacy monitoring
- Provider-plan communication platforms

4. **Member Engagement Technology**

- Member portals and mobile apps
- Health risk assessments and screening
- Appointment scheduling and reminders
- Medication adherence tracking
- Remote patient monitoring integration

5. **Quality Reporting and Star Ratings**

- HEDIS measure calculation and tracking
- Star Ratings performance monitoring
- Quality improvement initiative tracking
- CMS reporting automation

6. **Utilization Management**

- Prior authorization systems
- Utilization review and case management
- Emergency department diversion programs
- Inpatient admission management

7. **Claims Analytics and Fraud Detection**
    - Claims processing and adjudication
    - Fraud, waste, and abuse detection
    - Payment integrity solutions
    - Cost trend analysis

MA Technology Spending Estimates:

- **Small MA plan (10,000 members):** $500K-$1M annual technology spend
- **Mid-size MA plan (50,000 members):** $2M-$5M annual technology spend
- **Large MA plan (250,000 members):** $10M-$25M annual technology spend
- **National MA plan (1M+ members):** $50M-$150M+ annual technology spend

Decision Timeline: MA plans typically make annual technology investment decisions aligned with:

- January 1 benefit year start
- Prior summer/fall bid submission to CMS
- Spring technology evaluation and selection

4.4 MA Delegated Risk Arrangements

Many MA plans delegate financial risk to provider organizations, creating additional VBC technology market opportunity:

Delegated Risk Models:

1. **Full Capitation:** Provider receives PMPM payment, responsible for all care costs
2. **Partial Capitation:** Provider receives PMPM for specific services (e.g., primary care)
3. **Shared Savings/Risk:** Performance-based payments similar to ACO models
4. **Bundled Payments:** Episode-based payment for specific conditions or procedures

Provider Organizations Accepting MA Risk:

- Large multi-specialty medical groups

- Independent Practice Associations (IPAs)
- Physician Hospital Organizations (PHOs)
- Clinically Integrated Networks (CINs)
- Management Service Organizations (MSOs)

Technology Needs for Risk-Bearing Providers:

These organizations need many of the same technologies as MA plans:

- Risk stratification and predictive analytics
- Care management platforms
- Financial performance tracking
- Quality reporting and analytics
- Provider performance management
- Member engagement tools

This creates dual technology buying opportunity:

- MA plans purchasing technology for their operations
- Risk-bearing providers purchasing technology to manage delegated risk

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5. MSSP ACOs: 476 Organizations Managing 11.2M Lives

5.1 Medicare Shared Savings Program Overview

The Medicare Shared Savings Program (MSSP) is the largest and most mature ACO program, representing the primary pathway for provider organizations entering value-based care.

2025 MSSP Scale:

- **476 ACOs** participating nationwide

- **655,725 providers and organizations** involved (physicians, hospitals, post-acute, etc.)
- **11.2+ million Traditional Medicare beneficiaries** attributed
- **228 applications approved** for 2025 (largest renewal in 12-year history)
- **55 new ACOs** joined in 2025
- **173 ACOs** renewed participation in 2025

Source: CMS, CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives (2025)

MSSP Geographic Coverage:

ACOs operate in all 50 states, with highest concentration in:

- **Northeast:** Massachusetts, New York, New Jersey (high ACO density)
- **Midwest:** Michigan, Ohio, Illinois (strong ACO growth)
- **South:** Texas, Florida (large markets with growing ACO participation)
- **West:** California, Washington, Colorado (mature ACO markets)

5.2 MSSP Financial Performance and Technology ROI

2023 MSSP Results (Most Recent Complete Year):

- **Total savings generated:** $5.2 billion across all ACOs
- **Net savings to Medicare:** $2.1 billion (after paying ACO shared savings)
- **Shared savings paid to ACOs:** ~$3.1 billion (estimated from total minus net)
- **Shared savings rate:** 40% to 75% depending on ACO track and performance level

Source: CMS Program Data, Lumeris Medicare ACOs Analysis (2024)

Per-ACO Financial Performance:

- **Average shared savings per ACO:** $6.5 million (based on ~$3.1B / 476 ACOs)
- **Range:** From $0 (ACOs not achieving benchmarks) to $20M+ for large, high-performing ACOs

- **Track 1 (upside only) performance:** Lower savings rates (40-50%) but no downside risk
- **Enhanced Track (two-sided risk) performance:** Higher savings rates (50-75%) with potential losses

Technology Investment ROI Context:

If an ACO earns $6.5M in average shared savings and invests $500K-$1M in technology:

- **Technology as % of savings:** 7.7-15.4% of shared savings revenue
- **ROI on technology:** If technology contributes to even 20% of savings achievement, ROI is 1.3:1 to 2.6:1 in first year
- **Multi-year ROI:** Technology benefits compound over 3-5 years, generating 3:1 to 5:1 total ROI

This financial context explains why ACOs are willing to invest significantly in technology that demonstrably improves quality metrics or reduces costs.

5.3 MSSP ACO Technology Requirements

ACOs have specific technology needs driven by program requirements:

1. Quality Reporting Technology

2025 APP Plus Requirements:

- 4 eCQMs/Medicare CQMs
- 1 administrative claims measure
- 1 CAHPS survey

Technology needs:

- eCQM calculation engines
- Multi-site EHR data aggregation
- Quality measure denominator/numerator tracking
- Real-time quality performance dashboards
- CAHPS survey administration

- Quality improvement workflow tools

2. Financial Performance Tracking

ACO financial monitoring needs:

- Claims data feeds from CMS
- Expenditure trend analysis
- Per-capita cost tracking by service category
- Benchmark comparison and forecasting
- Shared savings estimation and projection
- Provider attribution tracking

3. Care Management and Coordination

High-risk patient management:

- Risk stratification (identifying patients likely to have high costs)
- Care gap identification (missing preventive services, screenings)
- Transitional care management (hospital to home)
- Chronic disease management (diabetes, CHF, COPD, etc.)
- Care plan development and tracking
- Care team communication and task management

4. Provider Performance Management

Physician and practice-level analytics:

- Utilization patterns by provider
- Quality metric performance by provider
- Cost efficiency by provider
- Patient attribution by provider
- Provider incentive calculation
- Provider scorecards and feedback

5. Patient Engagement

Member communication and activation:

- Patient portals for care plan access
- Appointment reminders and scheduling
- Medication adherence tracking
- Health risk assessments
- Remote patient monitoring for chronic conditions
- Patient education materials

5.4 MSSP Track Options and Technology Implications

Basic Track (Levels A-E):

- **Risk level:** Upside only (no downside risk)
- **Shared savings rate:** 40% (Level A) to 50% (Level E)
- **Duration:** 5-year participation option (2024 and later)
- **Minimum Savings Rate (MSR):** Must save enough to trigger shared savings payment
- **Quality threshold:** Must meet minimum quality performance

Technology needs:

- Moderate—focus on quality reporting and care gap closure
- Lower financial performance pressure (no downside risk)
- Entry-level population health platforms often sufficient

Enhanced Track:

- **Risk level:** Two-sided risk (share in losses)
- **Shared savings rate:** 50-75% (higher than Basic Track)
- **Downside risk:** 1.5-2% of benchmark at risk (capped)
- **Advance investment payments:** Available to help with infrastructure

- **Quality threshold:** Higher quality performance required

Technology needs:

- Advanced—requires sophisticated cost management and predictive analytics
- Real-time performance monitoring essential
- Care management platforms critical to avoid losses
- Provider performance management important to identify high-cost patterns

Technology Investment Pattern:

- **Basic Track ACOs:** $250K-$500K annual technology spending typical
- **Enhanced Track ACOs:** $500K-$1.5M annual technology spending typical
- **Large ACOs (100K+ attributed lives):** $1M-$3M annual technology spending

5.5 ACO Organizational Types and Technology Decision-Making

Physician-Led ACOs:

- Primary care-centric organizations
- Independent physician groups or IPAs
- Technology decisions by physician leaders and practice administrators
- Focus on workflow integration and clinical usability

Hospital-Led ACOs:

- Health systems extending into ACO model
- Often leverage existing health system IT infrastructure
- Technology decisions by hospital CIOs and CMIOs
- Focus on integration with hospital EHR and systems

MSO-Led ACOs:

- Management service organizations serving independent practices
- Centralized technology decisions benefiting multiple practices

- Focus on cost-effective solutions serving distributed practices
- Often seek white-label or multi-tenant platforms

Payer-Aligned ACOs:

- Insurance companies (e.g., BCBS) organizing provider ACOs
- Leverage payer claims data and analytics infrastructure
- Technology decisions by payer IT organizations
- Focus on interoperability with payer systems

Technology Vendor Implications:

Understanding ACO organizational type helps position solutions:

- **Physician-led:** Emphasize ease of use, minimal disruption, fast ROI
- **Hospital-led:** Emphasize EHR integration, enterprise scalability, security
- **MSO-led:** Emphasize multi-tenant efficiency, practice-level reporting, cost-effectiveness
- **Payer-aligned:** Emphasize payer data integration, claims analytics, actuarial capabilities

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6. ACO REACH and Advanced Payment Models

6.1 ACO REACH Program Overview

ACO Realizing Equity, Access, and Community Health (REACH) represents CMS's most advanced two-sided risk model, succeeding the Direct Contracting and Next Generation ACO programs.

2025 ACO REACH Participation:

- **103 ACOs** participating nationwide
- **All 50 states, DC, and Puerto Rico** geographic coverage
- **~2.1 million beneficiaries** enrolled (2023 baseline)

- **4-year commitment** (Performance Years 2023-2026)
- **Professional and Global options** (varying levels of risk)

Source: CMS, ACO REACH Model Overview (2025)

ACO REACH vs. MSSP Comparison:

Feature	MSSP Enhanced Track	ACO REACH Standard	ACO REACH High Needs
Risk Level	1.5-2% of benchmark	Up to 100% of losses	Up to 100% of losses
Shared Savings	50-75%	50-100%	50-100%
Advance Payments	Limited	Substantial	Substantial
Beneficiary Alignment	Retrospective	Prospective available	Prospective available
Health Equity	Standard adjustments	Enhanced adjustments	Enhanced adjustments
Technology Requirements	Moderate	Advanced	Very Advanced

6.2 ACO REACH Technology Requirements

Enhanced Requirements vs. MSSP:

1. Prospective Beneficiary Alignment

- Real-time beneficiary attribution (not retrospective)
- Patient identification at point of care
- Eligibility verification systems
- Attribution change tracking

2. Advanced Risk Stratification

- Predictive modeling for high-cost events
- Multi-year cost trend analysis
- Social determinants of health (SDOH) data integration
- Health-related social needs (HRSN) screening

3. Real-Time Performance Monitoring

- Monthly financial performance tracking (not annual)
- Real-time cost trend alerting
- Provider performance real-time dashboards
- Intervention effectiveness tracking

4. Care Management for High-Need Populations

- Complex care management platforms
- Behavioral health integration
- Long-term services and supports (LTSS) coordination
- Housing and food insecurity intervention tracking

5. Health Equity Initiatives

- Disparities analysis by race, ethnicity, language, disability
- Stratified quality performance tracking
- Targeted intervention programs
- Language services and cultural competency tools

6.3 ACO REACH Financial Model and Technology ROI

Advance Investment Payments:

ACO REACH participants receive substantial monthly advance payments:

- **Professional Risk:** ~3-5% of benchmark
- **Global Risk:** ~5-8% of benchmark

Example: 10,000-member ACO with $10,000 PMPM benchmark:

- Annual benchmark: $1.2 billion
- Advance payments: $36M-$96M annually
- **Purpose:** Fund infrastructure, including technology, care management, analytics

Technology Investment Context:

If ACO receives $60M in advance payments and invests $2M-$5M in technology:

- **Technology as % of advances:** 3-8% of advance payment funding
- **ROI requirement:** Technology must demonstrably contribute to cost savings and quality improvement
- **Payback expectation:** 18-24 months typical for infrastructure investments

This advance payment structure means ACO REACH participants have capital for substantial technology investment—creating premium buying opportunity.

6.4 ACO REACH as Technology Innovation Leader

ACO REACH participants tend to be more technologically sophisticated:

Characteristics of ACO REACH Participants:

- **Prior experience** in Next Generation ACO or Direct Contracting (many ACOs)
- **Risk appetite** indicating organizational capability and infrastructure maturity
- **Financial resources** supported by advance payments
- **Commitment to innovation** required for prospective alignment and enhanced risk
- **Technology-forward orientation** necessary for real-time performance management

Technology Adoption Patterns:

- **Earlier adopters** of emerging technologies (AI, predictive analytics, automation)
- **Larger technology budgets** (often 50-100% more than MSSP ACOs)
- **Longer-term technology partnerships** (multi-year contracts common)
- **Willingness to pay premium** for differentiated capabilities

For health tech companies, ACO REACH participants represent ideal customers: sophisticated buyers, substantial budgets, commitment to innovation, and urgency to improve performance.

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7. The MSO Market Opportunity

7.1 Management Service Organization Market Size

MSOs (Management Service Organizations) represent a massive and rapidly growing market segment, enabling independent physician practices to participate in value-based care while maintaining autonomy.

Global Healthcare MSO Market:

- **2025 market size:** $124.97 billion
- **2030 projected size:** $209.25 billion
- **CAGR:** 10.86% to 12%
- **Dollar growth:** $84.3 billion over 5 years

Source: Grand View Research, Healthcare MSO Market Report (2025)

U.S. MSO Market:

- **2023 market size:** $46.78 billion
- **CAGR through 2030:** 12.96%
- **Physician office segment:** 72.97% revenue share (2023)

Source: Grand View Research, U.S. Management Service Organization Market Report (2025)

7.2 Why MSOs Are Critical to VBC Technology Market

MSOs serve as **technology aggregators and decision-makers** for hundreds of independent physician practices that individually lack resources for VBC technology investment.

The MSO Value Proposition:

For Independent Practices:

- Access to VBC contracts without sacrificing independence
- Shared services (billing, IT, contracting, compliance, quality reporting)
- Economies of scale on technology and vendor contracts
- Practice transformation support
- Expert management of VBC financial and quality performance

For Technology Vendors:

- **Single sales engagement** reaches 50-500+ physician practices
- **Centralized decision-making** eliminates need to sell to each practice individually
- **Standardized implementation** across practice network
- **Centralized support** reducing vendor support burden
- **Larger deal sizes** ($500K-$5M+ contracts vs. $25K-$100K individual practice deals)

MSO Technology Buying Pattern:

Without MSO:

- Sell to 100 individual practices = 100 separate sales cycles
- Average deal size: $50K
- Total revenue: $5M
- Sales cycle per practice: 6-9 months
- Implementation complexity: 100 separate deployments

With MSO:

- Sell to 1 MSO serving 100 practices = 1 sales cycle
- Deal size: $2M-$5M
- Total revenue: $2M-$5M
- Sales cycle: 9-12 months

- Implementation: Centralized deployment to 100 practices

MSO aggregation reduces sales effort by 90%+ while accessing equivalent or larger market opportunity.

7.3 MSO Technology Needs

MSOs require comprehensive technology infrastructure supporting both their management operations and participating physician practices:

1. Practice Management and Billing Technology

- Revenue cycle management (RCM)
- Medical billing and coding
- Claims submission and tracking
- Accounts receivable management
- Payer contract management

2. Value-Based Care Performance Management

- Quality measure reporting (MIPS, HEDIS, ACO measures)
- Financial performance tracking and benchmarking
- Care gap analysis and closure
- Risk stratification and patient outreach
- Provider performance analytics

3. Population Health and Care Coordination

- Care management platforms
- Chronic disease management programs
- Transitional care management
- Patient registries and panel management
- Referral management

4. EHR and Clinical Technology

- EHR implementation and optimization
- Clinical decision support
- E-prescribing and medication management
- Patient portal and engagement
- Telehealth platforms

5. Business Intelligence and Analytics

- Practice performance dashboards
- Financial reporting and forecasting
- Benchmarking across practice network
- Payer performance analysis
- Contract modeling and negotiation support

6. Compliance and Risk Management

- HIPAA compliance and security
- Credentialing and privileging
- Quality improvement and PDSA cycles
- Audit readiness and response
- Risk adjustment and HCC coding

7.4 MSO Market Segmentation

By MSO Size:

Small MSOs (5-25 practices):

- Total addressable practices: ~150-500 physicians
- Technology budget: $250K-$750K annually
- Decision-maker: MSO CEO/COO and practice advisory committee
- Technology preferences: Cost-effective, proven solutions

Mid-Size MSOs (25-100 practices):

- Total addressable practices: ~500-2,000 physicians
- Technology budget: $750K-$3M annually
- Decision-maker: MSO CIO/CTO and executive team
- Technology preferences: Scalable platforms, vendor stability

Large MSOs (100-500 practices):

- Total addressable practices: ~2,000-10,000 physicians
- Technology budget: $3M-$15M annually
- Decision-maker: MSO CIO and technology committee
- Technology preferences: Enterprise platforms, customization, dedicated support

National MSO Networks (500+ practices):

- Total addressable practices: 10,000+ physicians
- Technology budget: $15M-$50M+ annually
- Decision-maker: Enterprise CIO and board-level technology committee
- Technology preferences: Best-in-class solutions, strategic partnerships, co-development

By Geographic Focus:

Single-State MSOs:

- Easier regulatory compliance (one state's regulations)
- Regional payer contract focus
- Local market expertise
- Technology needs: State-specific reporting, local payer connections

Multi-State Regional MSOs:

- Multiple state regulatory requirements
- Regional payer contracts (BCBS affiliates, regional health plans)
- Technology needs: Multi-state reporting, regional payer data feeds

National MSOs:

- Complex multi-state regulatory environment
- National payer contracts (UnitedHealthcare, Anthem, Aetna, Cigna, Humana)
- Technology needs: National payer integration, multi-state compliance, scalable infrastructure

7.5 MSO Technology Decision Criteria

When evaluating technology vendors, MSOs prioritize:

1. Multi-Tenancy and Practice-Level Reporting

- Ability to support hundreds of practices on single platform
- Practice-level performance visibility
- Aggregated and individual practice reporting
- Role-based access control

2. Cost Efficiency and ROI

- Per-practice pricing models (not per-user which becomes expensive)
- Demonstrable ROI through quality improvement or cost reduction
- Implementation efficiency (fast time-to-value)
- Support scalability (vendor can support large practice network)

3. Integration Capabilities

- Multiple EHR integrations (practices often use different EHRs)
- Payer data feed integration
- Practice management system integration
- HL7/FHIR standards support

4. Compliance and Security

- HIPAA compliance and BAA willingness
- Multi-practice data segregation

- Audit logging and access controls
- Disaster recovery and business continuity

5. Vendor Stability and Support

- Financial stability (won't disappear in 2 years)
- Dedicated account management
- Responsive technical support
- Product roadmap and ongoing development

For health tech companies, understanding these MSO buying criteria is essential to positioning solutions effectively and winning large, high-value contracts.

(Continued in next message due to length...)

Disclaimer: *This document provides general information for educational purposes only and does not constitute legal, financial, or business advice. Healthcare technology companies should conduct appropriate due diligence and consult with professionals before entering partnership agreements. All statistics and market data are current as of October 2025 and subject to change based on regulatory updates, market conditions, and technological advancements.*