

The Hidden Complexity of Moving from ACO Programs to Medicare Advantage

As the ACO REACH program approaches its sunset and many organizations reassess their long-term participation in the Medicare Shared Savings Program (MSSP), provider groups across the country are evaluating their next step in value-based care. For many, Medicare Advantage (MA) appears to be the natural next stage.

At first glance, the transition seems straightforward. Organizations that have succeeded in MSSP or ACO REACH have already built many of the capabilities required to manage population health: controlling total cost of care, managing high-risk populations, and performing against quality measures.

But Medicare Advantage introduces a level of operational complexity that many organizations underestimate.

Unlike CMS-administered ACO programs, Medicare Advantage operates through a fragmented ecosystem of plan-specific contracts, data sources, and financial arrangements. Success depends not just on managing utilization and outcomes, but on navigating a fundamentally different operating model.

The organizations that succeed in Medicare Advantage will not be those that simply replicate their ACO playbook, but those that intentionally redesign their operating model to manage fragmented data, contract-specific performance requirements, and revenue structures driven by risk adjustment and Stars performance.

The good news is that many of the core capabilities that drove ACO success still matter. The challenge is adapting those capabilities to a more fragmented, contract-driven environment where data, quality programs, and revenue mechanics all function differently.

What Carries Over from ACO Success

Provider organizations that have succeeded in ACO REACH or MSSP have already built several foundational competencies that translate well to Medicare Advantage.

Most notably, they have experience managing **total cost of care**, performing against **defined quality measures**, and deploying **care management strategies**

for high-risk populations. Many have also developed strong capabilities around **reducing ED and inpatient utilization**, leveraging **claims-driven population health analytics** to guide interventions, and operating under **downside risk**.

These capabilities remain critical in MA. However, the critical differences lie in how the data arrives, how performance is measured, and how revenue is ultimately generated.

Where the Operating Model Changes

While ACO programs benefit from standardized infrastructure, Medicare Advantage introduces significant variability across plans, contracts, and data feeds.

1. Data Fragmentation

In ACO REACH and MSSP, organizations typically receive standardized data through CMS sources such as CCLF and BCDA. Medicare Advantage introduces **multiple payors delivering data in different formats**, often with varying levels of completeness and timeliness. This fragmentation creates significant operational overhead in data ingestion, normalization, and analytics.

2. Attribution Becomes Contract-Specific

Patient attribution in ACO programs follows a standardized CMS methodology. In Medicare Advantage, attribution can vary significantly by plan and contract. Organizations must therefore track and manage attribution across multiple contracts simultaneously, which is something many ACO operating models were never designed to support.

3. Quality Measurement Drives Revenue

Quality programs also shift significantly. ACO REACH includes a relatively small set of standardized measures, while MSSP relies primarily on eCQMs. Medicare Advantage introduces **plan-specific quality expectations tied directly to Stars performance**. Measures such as HEDIS, CAHPS, and pharmacy adherence directly influence revenue and growth, making quality performance a central financial driver.

4. Financial Models Become More Complex

ACO programs rely on relatively predictable shared savings formulas. Medicare Advantage contracts often include **capitated payments and plan-specific financial arrangements**, requiring more sophisticated performance monitoring, forecasting, and contract-level reconciliation.

5. Risk Adjustment Becomes a Core Revenue Driver

Risk adjustment plays a different role in Medicare Advantage than in ACO programs. In MSSP and ACO REACH, HCC risk scores primarily adjust benchmarks used to measure shared savings performance, with CMS placing limits on coding-driven increases. In MA, RAF scores directly influence capitated revenue. As a result, accurate documentation, prospective risk identification, and provider engagement around HCC capture become core operational capabilities.

Setting the Foundation for Medicare Advantage

For organizations preparing to expand from ACOs into Medicare Advantage, two strategic investments are particularly important.

1. A Scalable Population Health Analytics Platform

Success in MA requires infrastructure capable of handling **multiple payors, multiple contracts, and multiple data formats simultaneously**. Organizations should invest in a population health analytics platform that can normalize disparate data sources and support operations across MSSP, MA, and other value-based models.

This kind of platform enables organizations to maintain a **single operational view of population health**, even as program requirements diverge.

2. A Partner with Deep Value-Based Care Expertise

Technology alone is rarely sufficient. The shift from standardized CMS programs to plan-specific MA contracts introduces operational challenges that many provider organizations may be encountering for the first time.

Partnering with an organization that brings extensive operational experience in value-based care — beyond just software expertise— can help providers navigate contracting nuances, execute effectively on quality and performance measures, and manage the transition with greater confidence.

The Organizations That Will Win

The provider organizations that succeed in Medicare Advantage will be those that recognize early that MA is not simply an extension of ACO programs but a fundamentally different operating environment.

The core principles of value-based care remain the same: improving outcomes, managing total cost of care, and delivering coordinated care to high-risk populations. But success in Medicare Advantage requires new operational capabilities that go beyond the standardized infrastructure of CMS-administered programs.

Organizations must be prepared to operate across multiple payors, manage contract-specific attribution and quality programs, and navigate revenue models that depend heavily on risk adjustment and Stars performance. Just as importantly, they must build the data infrastructure necessary to unify fragmented payor data into a single operational view of population health.

Those that approach Medicare Advantage as simply another value-based contract often struggle to adapt. Those that treat it as an opportunity to evolve their operating model will be positioned to thrive.

As ACO REACH comes to a close and MSSP participation continues to evolve, many organizations are evaluating their next step in value-based care. The leaders will be those investing now in the infrastructure, analytics, and operational capabilities required to succeed in what comes next.

Ursa Health helps value-based payor and provider organizations turn complex healthcare data into meaningful action. Our connected platform brings together a trusted healthcare data foundation, continuous data integrity monitoring, AI-powered decision guidance, and intervention-focused workflows so teams can identify what matters, prioritize where to act, and measure impact over time. Built for the realities of healthcare data and value-based care, Ursa enables organizations to implement genuine care transformation that yields value-based care clinical and financial success.

To learn more, reach out to us at info@ursahealth.com.