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The Monthly Newsletter from Covalence HEALTH

FEBRUARY 2026

In this issue ...

What's New at Covalence HEALTH

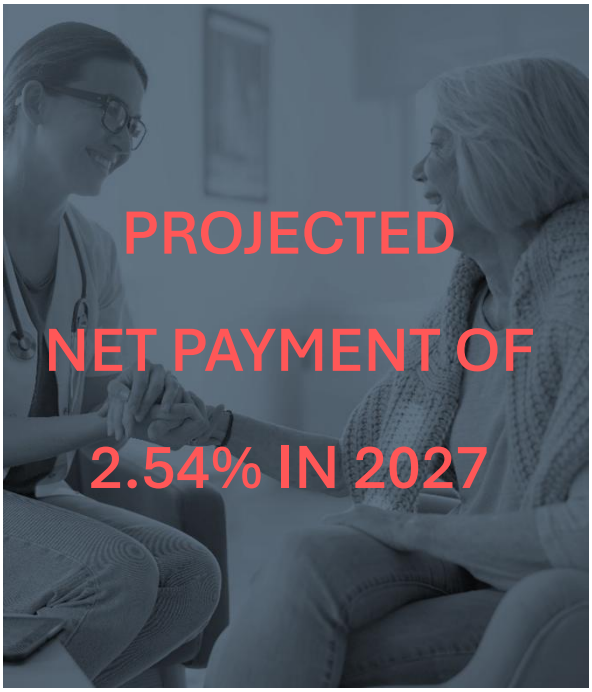
We're kicking off 2026 with a fresh look and a bold step forward. Covalence Health has launched new branding and a redesigned website that better reflects who we are and how we work.

We're also excited to introduce our Commercial Operating System—a proprietary methodology built from decades of healthcare experience that helps our clients move from strategy to execution, fast.

And we're thrilled to welcome Giovanni (Gio) Infante-Still as our first partner, bringing even more depth and firepower to the team.

Be sure to visit our new site—it's your go-to destination for insights, blog posts, and upcoming webinars on the policy changes and industry trends shaping healthcare. It's a big year ahead, and we're just getting started.

VISIT US AT WWW.COVALENCEHEALTH.COM >



CMS Releases 2027 Medicare Advantage and Part D Advance Notice

The proposed policies project a modest net average year-over-year payment increase of 0.09 percent, representing over $700 million in additional Medicare Advantage payments to plans in CY 2027.[1] However, when CMS factors in the estimated risk score trend in MA driven by coding practices and population changes, the expected average change in payments increases to 2.54%.[1] CMS expects MA risk scores to increase on average by 2.45% due to underlying coding trend alone.

A 2.54% increase is still well below previous years. MA plans enjoyed 5.06% increase in 2026 and an average increase of 5.15% over the past four years.

READ THE COMPLETE ANALYSIS >

Getting RHTP Right: Why Partner Selection and Program Management Matter Most

With all 50 states now awarded first-year funding under the Rural Health Transformation Program—averaging roughly $200 million per state—attention has quickly shifted from application to execution. And for state leaders, execution is where the real anxiety lives. Implementing the RHTP will require new policies, processes, and staff, and states only have a short period of time to get these established and running. States are grappling with how to stand up governance structures, staff program offices, and—most critically—select the right implementation partners through a rigorous RFP process. Some states have moved quickly: New Jersey was among the first to issue a request for applications, while Nevada announced its grant RFP timeline stretching into late 2026, and Missouri has published a phased schedule for RFIs and proposals across the first three quarters of the year. For many others, the clock is ticking and the path forward is far less defined.

States that choose the wrong partners or fail to build accountability into their contracts risk more than just poor outcomes.

The stakes around partner selection couldn't be higher. CMS will adjust states' technical scores for future funding based on implementation progress, achievement of stated policy goals, and performance on program metrics. In other words, states that choose the wrong partners or fail to build accountability into their contracts risk not just poor outcomes but reduced funding in years two through

five. This makes the RFP process more than a procurement exercise—it's a strategic decision that will determine whether a state's transformation plan actually delivers results. States need partners who bring domain expertise, operational readiness, and the ability to move at the speed the program demands.

Equally important is how states structure ongoing program management and measurement. Future program success will depend on states' ability to collect data and report on progress, requiring real-time monitoring, reporting, and analysis of program activities and outcomes. This is where many state programs historically stumble—strong plans on paper that fall apart in execution due to inadequate oversight, unclear success metrics, or a lack of infrastructure to track and course-correct in real time. The states that will get the most out of RHTP funding are those that treat program management not as an afterthought but as a core competency—one that ensures every dollar is deployed with purpose and every initiative is measured against meaningful benchmarks.

CONTACT US TO LEARN HOW TO LAUNCH YOUR RHTP INITIATIVES ON THE RIGHT FOOT >

Healthcare AI Implementation: From Pilots to Scale

The promise of AI in healthcare has never been greater—and neither has the noise. With hundreds of AI-powered solutions flooding the market across clinical decision support, revenue cycle management, population health, and administrative automation, healthcare organizations face a daunting challenge before they even get to implementation: figuring out what's worth their time. Vetting AI vendors alone can consume months of leadership bandwidth, and without a clear strategy and roadmap in place first, organizations risk chasing shiny tools that don't align with their priorities, don't integrate with their systems, or don't solve the problems that actually matter most. An AI strategy isn't a luxury—it's the difference between a scattered collection of pilots that never scale and a deliberate path toward enterprise-wide transformation.

Just as important is resisting the temptation to simply drop AI into existing workflows. Too many organizations approach AI as a plug-and-play replacement for a manual step—automating a form, accelerating a review, or flagging an exception within a process that was designed for a pre-AI world.

That approach captures a fraction of AI's potential. The real value comes from rethinking workflows entirely with AI as a foundational capability, not an add-on. What would care coordination look like if predictive models informed outreach before a patient ever missed an appointment? How would utilization management change if AI could synthesize clinical data and recommend determinations in real time rather than supporting a human reviewer one case at a time? These are fundamentally different questions than "where can we plug in a bot?"

Organizations that get this right will share a few things in common: they'll start with a strategy tied to measurable outcomes, invest the time upfront to evaluate solutions rigorously rather than reactively, and have the courage to redesign how work gets done rather than simply digitizing the status quo. Those that don't will find themselves two years and several failed pilots later, still searching for ROI. The window to get ahead of this curve is now—and it starts with a roadmap, not a vendor demo.

ACA Subsidies and Marketplace Uncertainty: What It Means for Healthcare Payors, Providers, and the ~ 22 Million Americans that Received Enhanced Premium Subsidies in 2025

The expiration of enhanced ACA premium tax credits on January 1, 2026 has sent shockwaves through the healthcare marketplace. About 22 million Americans received enhanced premium subsidies in 2025, and their premiums more than doubled on average in 2026 due to the lapse. ACA sign-ups for 2026 are already down by over one million people compared to the same time last year, marking the first decline since 2020. But the full picture is still coming into focus—many returning enrollees have a grace period through March 31 to catch up on premium payments, meaning the true enrollment fallout won't be clear until mid-year. Estimates suggest that 7.3 million people could leave the ACA marketplace in 2026, with roughly 5 million of them going uninsured entirely. Congress continues to consider measures that could reinstate some version of the subsidies, but nothing has passed, leaving consumers and the industry in a holding pattern.

For healthcare consumers, the impact is immediate and personal. The "subsidy cliff" has returned, making people ineligible for any financial assistance if their household income exceeds 400% of the federal poverty level. Middle-income families and older adults not yet eligible for Medicare are especially exposed, facing monthly premiums that may simply be unaffordable. Many are being forced to choose between downgrading to thinner coverage with higher out-of-pocket costs or dropping insurance altogether—decisions that inevitably lead to delayed care and worse health outcomes.

The ripple effects for payors and providers are just as significant. Insurers face the prospect of adverse selection as younger, healthier enrollees drop coverage, leaving a sicker and more expensive risk pool

behind. ACA marketplace insurers are raising premiums by a median of 18% in 2026—the largest rate increases since 2018—driven by a combination of rising healthcare costs, GLP-1 drug utilization, and the subsidy uncertainty itself. For providers, particularly safety-net hospitals and health systems serving vulnerable populations, a surge in uninsured patients means rising uncompensated care and increased financial strain. The bottom line: until there is legislative clarity on ACA subsidies, every corner of the healthcare ecosystem—from kitchen-table budget decisions to hospital balance sheets—is operating under a cloud of uncertainty that demands close attention and contingency planning.

CMS Innovation Center Value-Based Care Models: What's Changing and What's Ahead

The CMS Innovation Center is in the midst of a significant reset. In March 2025, CMS announced the early termination of four value-based care models—Primary Care First, Making Care Primary, ESRD Treatment Choices, and the Maryland Total Cost of Care—projecting approximately $750 million in savings from the move. The rationale was straightforward: evaluation reports and financial forecasting showed these models were increasing Medicare spending rather than reducing it. An interim evaluation of Primary Care First, for example, found that it did not reduce hospitalizations and had increased Medicare expenditures by 1.3%, with 27% of initial participants leaving the model by its third year. CMS was clear that these terminations don't signal a retreat from value-based care, but rather a shift toward models that demonstrate real savings and align with the current administration's priorities around accountability, competition, and disease prevention.

At the same time, the Innovation Center is moving aggressively on new models. 2026 is shaping up to be a pivotal year, with newly announced models including

- ACCESS for chronic care
- ELEVATE for whole-person care approaches
- and LEAD—widely viewed as the successor to ACO REACH—which introduces a planned 10-year model beginning in 2027 with total cost of care accountability and capitated population-based payments

CMS also finalized two mandatory bundled payment models, including:

- TEAM, which launched January 1, 2026 and places hospitals at financial risk for 30-day surgical episodes.
- Meanwhile, the AHEAD model has been extended through 2035, with CMS planning to open it to additional states

The message is clear: the Innovation Center is narrowing its portfolio to models that push providers toward greater financial risk and measurable outcomes.

The broader trajectory of value-based care remains significant despite these shifts. CMS recently announced that the proportion of Medicare beneficiaries in accountable care relationships with primary care providers surpassed 50% in 2024, and between October 2022 and September 2024, approximately 57 million individuals were affected by or received care through a CMMI model. The Medicare Shared Savings Program (MSSP) continues to serve as CMS's flagship ACO initiative, though the administration is pushing participating organizations to take on downside financial risk sooner. For providers, payors, and healthcare organizations, the takeaway is that value-based care isn't going away—it's getting more demanding. Those who haven't already invested in the infrastructure, data capabilities, and care redesign needed to succeed under risk-based models should be moving now, before the next wave of model applications closes.

CASE STUDY ON HOW COVALENCE HEALTH SUPPORTS INVESTORS IN VALUE-BASED CARE >

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