The Re Ac Ti O N

75 186.21	89 227	22 47.867	8 15.999	7 14.007
Re	Ac	Ti	O	N
Rhenium	Actinium	Titanium	Oxygen	Nitrogen

The Monthly Newsletter from

APRIL 2026

In this issue ...

- What's New at Covalence Health
- Health Investment Corner: Q1 2026
- Senior Care Investment Trends (Special Investor Segment)
- CMMI LEAD Model: The 10-Year ACO Bet
- Hospitals Bracing for a Second Reconciliation Round
- Medicare Advantage Network Fractures Accelerating
- Nebraska Goes First on Medicaid Work Requirements
- CMS Delays BALANCE Model; GLP-1 Bridge Extended Through 2027
- FDA & Health Policy: What's Changed

What's New at Covalence HEALTH

Our podcast, **The Outer Shell**, will launch later this month. Our first three episodes go deep on CMMI's LEAD model and value-based care strategy -conversations every provider, ACO, and healthcare investor needs to be having right now. Subscribe and listen wherever you get your podcasts.

This issue of The Reaction is our most comprehensive to date, covering the LEAD model RFA and its May 17 deadline, a special investor segment on senior care M&A, the second reconciliation threat, Medicare Advantage network fractures accelerating, Nebraska's Medicaid work requirement launch, GLP-1 policy shifts at CMS, and the FDA's most significant regulatory overhaul in decades. A lot has moved. Here's what you need to know.

VISIT US AT WWW.COVALENCEHEALTH.COM >

Healthcare Investment: Q1 2026

The defining investment theme of Q1 2026 is straightforward: capital is concentrating, not dispersing. Deal volume is down 22% year-over-year, but total deal value is up 50%. Investors are writing fewer, larger checks -and they are being ruthless about where those checks go.

AI represents 46% of all healthcare investment, but the smart money is not chasing the category. It is chasing proof. Administrative applications -revenue cycle management, prior authorization, ambient documentation, and payment integrity -are attracting capital because the ROI is measurable today, not theoretical. OpenEvidence closed a $250 million Series D at a $12 billion valuation. Behavioral health continues its run, with Talkiatry and Grow Therapy both crossing the billion-dollar valuation threshold in Q1 alone. The era of growth-at-any-cost is over. Fundamentals are back.

Medicaid exposure is the single most consequential risk variable in every portfolio conversation right now. The OBBBA's $1 trillion in cuts over ten years sounds like a long-horizon problem -but Nebraska just became the first state to implement work requirements eight months ahead of schedule, and a second reconciliation vehicle targeting healthcare savings is already taking shape in Congress. Hospitals are staring at up to $25 billion in annual revenue losses. Rural health clinics, behavioral health facilities, and FQHCs are the most exposed. Investors are not waiting for the math to play out -they are repricing Medicaid-heavy assets now.

The structural shift to lower-cost care settings is accelerating and generating real deal flow. Post-acute care, ambulatory surgery, and urgent care are attracting the largest acquisitions in healthcare services. Private equity is moving from capital preservation to active deployment, with scalable platforms, strong clinical integration, and regional density commanding premium valuations.

Two emerging opportunity sets are getting serious attention. Women's health is the most cited whitespace -historically underinvested despite strong demand, with opportunity spanning fertility, menopause, cardiology, and oncology. GLP-1 policy sequencing is reshaping competitive dynamics across managed care, retail health, and digital health simultaneously.

The through-line is straightforward: policy uncertainty is not paralyzing capital -it is directing it. The biggest risk in this environment is not picking the wrong asset. It is underestimating how fast the

reimbursement landscape is moving and building a thesis that assumes the past will look like the future.

CONTACT US TO DISCUSS HEALTHCARE INVESTMENT STRATEGY >

SPECIAL INVESTOR SEGMENT:

Post-Acute & Senior Care Investment Trends

Q1 2026: Capital Is Racing the Demographic Clock

Post Acute and Senior Care M&A is running at a structurally elevated pace. Q1:26 saw 231 publicly announced acquisitions -up 25.5% year-over-year from Q1:25. The buyer mix is shifting fast. With virtually no new development since 2022, institutional investors are competing aggressively in M&A because acquisition is the only path to growth.

- **Clarion Partners Is the Name to Watch.**** No single buyer has been more active. Clarion closed acquisitions in California (198 units), Phoenix (multiple deals), and added Legacy House of Avondale (169-unit AL/MC in Phoenix MSA) -all within a six-week window. They are building scale fast in Sun Belt markets.
- REITs Are Repositioning -Away from SNFs, Toward Private Pay.** National Health Investors divested a $560 million skilled nursing portfolio to concentrate on private pay seniors housing. Sabra Health Care REIT is on pace to exceed $1 billion in 2026 investments. CareTrust REIT has already deployed nearly $1 billion year-to-date with a $450 million near-term pipeline.
- New Entrants Are Arriving.** Investcorp -a global alternative investment firm that exited senior care in 2008 -has re-entered with acquisitions in Massachusetts, California, and New York. National Healthcare Properties launched an IPO of 38.5 million Class A shares. The demand side of this market is broadening.
- Pricing Records Are Being Set.** New per-unit price records in Chicago, New York State, and Wyoming in the past two weeks alone. A 128-bed Wyoming SNF at 61% occupancy still set a state per-bed record -which tells you how thin the supply of available assets is.

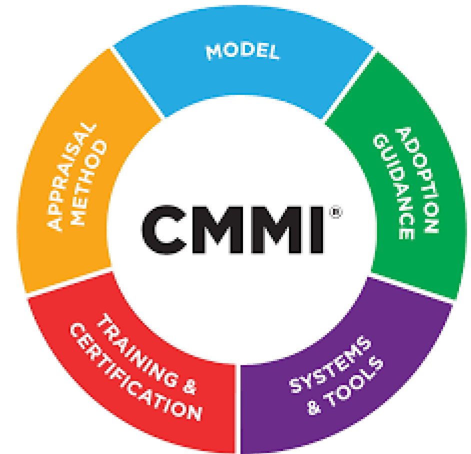
© 2026, Covalence Health, LLC

- The PR Problem: KFF Health News published research linking REIT ownership to SNF care quality and the story is circulating. This is an emerging reputational risk for institutional owners that the industry is beginning to take seriously.

CONTACT US FOR SENIOR CARE MARKET INTELLIGENCE >

VALUE-BASED CARE

CMMI LEAD Model: The 10-Year ACO Bet



Most of the value-based care conversations in 2026 have focused on what CMS is walking away from. What's gotten less attention is what CMS is building toward -and LEAD is the clearest answer to that question.

LEAD -the Long-term Enhanced ACO Design -is CMMI's newest ACO-focused model, set to launch January 1, 2027, following the conclusion of ACO REACH. With a 10-year performance period, it is the longest model CMS has ever tested. The administration is done running four-year experiments that don't generate compounding returns. LEAD is a bet on durability.

The model directly addresses the two biggest reasons ACOs fail or never form in the first place. Under ACO REACH, organizations that achieved savings saw their future benchmarks diminished through periodic rebasing -the "ratcheting effect" -which discouraged long-term investment. LEAD eliminates rebasing entirely for all 10 years. On specialist engagement, LEAD introduces CARA -CMS-Administered Risk Arrangements -which enables specialists to share risk in defined care episodes with CMS handling reconciliation, significantly lowering the barriers to meaningful specialist participation.

Today, 74 ACOs are participating in ACO REACH, serving Medicare beneficiaries across all 50 states, DC, and Puerto Rico. Every one of them faces a decision: apply for LEAD by the May 17, 2026 deadline or find another path forward in 2027. For new entrants -health systems, independent practices, FQHCs, and rural providers -the full application requires demonstrating readiness for a decade-long commitment and two-sided financial risk.

LEAD offers two risk tracks: a Global option with 100% shared savings and 100% downside risk, and a Professional option with 50% upside and 50% downside risk. The model also introduces a Medicare-Medicaid integration component targeting the approximately 30–50% of dually eligible beneficiaries who access Medicare through traditional Medicare -a population chronically underserved by every prior ACO model.

The practical implication is straightforward: LEAD is the primary vehicle through which CMS will advance total cost of care accountability in traditional Medicare for the next decade. Organizations not

© 2026, Covalence Health, LLC

in LEAD will compete for patients and market position against those that are -without access to capitated payment flexibility, specialist risk-sharing infrastructure, or beneficiary engagement tools that fee-for-service cannot replicate.

At Covalence, we are going deeper on LEAD and value-based care strategy in the first three episodes of The Outer Shell, our new podcast launching this month. If accountable care is on your agenda for 2027, these are conversations you don't want to miss.

CONTACT US TO DISCUSS YOUR LEAD MODEL STRATEGY >

Hospitals Bracing for a Second Reconciliation Round on Top of OBBBA Cuts

The C-suite conversation that dominated Q1 has gotten heavier in Q2. Hospitals were already stress-testing against what Congress delivered in the OBBBA -up to $25 billion in annual revenue reductions projected by Kodiak Solutions, and $68.5 billion in hospital revenue at risk over 2026 and 2027 per Premier's estimates -and now they are preparing for a second round.

Republicans are pursuing a second reconciliation vehicle to fund border security and immigration enforcement estimated at up to $200 billion, with healthcare savings serving as a primary offset. The timeline is aggressive: lawmakers are aiming to pass legislation within 60 to 90 days. Senate Budget Committee Chair Lindsey Graham has pledged to have reconciliation done by June 1.

The compounding effect is severe. Because the OBBBA is projected to increase the federal deficit, CBO projects it would trigger about $500 billion in mandatory reductions in Medicare spending between 2026 and 2034 -including a 4% cut in payments to hospitals -unless Congress acts. RAND projects $664 billion in state Medicaid budget reductions over the decade.

States are not waiting for Washington to finish the math. Iowa raised its Medicaid MCO tax rate from 0.925% to 3.5% retroactively to January 1 to offset a projected $90.6 million deficit. About 22 other states are pursuing similar insurer tax strategies before any federal ban takes effect.

The investment implication is already priced in among sophisticated players: Medicaid-heavy provider assets are being repriced downward in real time. The second reconciliation threat is not a tail risk. It is the base case.

READ THE FULL ANALYSIS AT COVALENCEHEALTH.COM >

© 2026, Covalence Health, LLC

Medicare Advantage Network Fractures Are Accelerating

The MA market is fracturing from both sides simultaneously, and the pace is picking up. At least 21 health systems have severed ties with MA plans in 2026, citing prior authorization volume and reimbursement disputes. The names on that list are not marginal players: Mayo Clinic went out of network with most UnitedHealthcare and Humana MA plans. Mass General Brigham moved most primary care providers out of network with UnitedHealthcare and BCBS Massachusetts MA plans. Mount Sinai went out of network with Anthem MA. New York-Presbyterian is operating under extensions with UnitedHealthcare that have pushed the out-of-network date to May 1.

On the plan side, the retreat is equally significant. UnitedHealthcare exited 109 counties, Humana exited 194 counties and two states, and Aetna exited 100 counties and one state for 2026. The narrative that MA is a stable, growing market is no longer accurate.

While CMS reported that average monthly premiums dropped to $14 in 2026, average premiums weighted by actual enrollment increased by nearly 22% for general enrollment plans, per Morgan Stanley analysis. Cheaper on paper, more expensive in practice.

For providers, the revenue mix implications are significant. Systems that go out of network with major MA plans will see volume shifts. Those shifts will land differently depending on geography, payer mix, and local MA market competitiveness. The 2027 MA Final Rule -which CMS finalized at a 2.48% net payment increase -provides some relief, but it does not reverse the structural pressure that is driving these network breaks.

CONTACT US FOR MA STRATEGY AND MARKET INTELLIGENCE >

© 2026, Covalence Health, LLC

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
Nebraska Medicaid Work Requirements (MWR)
Qualifying Activities

Nebraska Goes First on OBBBA Medicaid Work Requirements

As of May 1, 2026, the national experiment officially began. Nebraska became the first state to implement Medicaid work requirements, eight months ahead of the January 1, 2027 federal deadline. About 70,000 Medicaid enrollees in the state must now meet an 80-hour monthly work, school, or community service requirement -though enforcement will be phased, with the first group facing review being those with eligibility periods ending July 31, 2026.

Between 28,000 and 41,000 Nebraskans are estimated to be at risk of losing coverage by the time full implementation is complete. The state is not adding administrative staff to manage the program. Montana plans to follow in July, Iowa in December, and all remaining expansion states are required to be live by January 1, 2027.

Nebraska is the canary. Every health system with rural or safety-net exposure, every Medicaid MCO, and every investor with provider assets in expansion states should be watching enrollment data closely over the next 90 days. The CBO projects approximately 5.2 million Americans could lose Medicaid coverage nationally by 2034 due to work requirements alone.

The question is not whether coverage losses come. It is how fast and how concentrated they are -and whether hospital systems and MCOs have built that exposure into their financial models. Most haven't.

LEARN MORE ABOUT HOW WE HELP OUR CUSTOMERS WITH POLICY CHANGE>

© 2026, Covalence Health, LLC

CMS Delays BALANCE Model; GLP-1 Bridge Extended Through 2027

The BALANCE Model was the vehicle CMS was using to test GLP-1 coverage in Medicare Part D. On April 21, CMS announced it would not launch in 2027 as planned. Instead, the existing GLP-1 Bridge program will be extended through 2027, with Part D beneficiaries getting $50-per-month copay access to Wegovy and Zepbound beginning July 1, 2026.

The competitive implications are immediate. The $50 copay floor erodes the pricing advantage that telehealth-first platforms built their GLP-1 business models around. Direct-to-consumer digital health companies that structured their value proposition around access and price arbitrage are now competing directly with traditional Medicare on price -and they will lose that comparison in most markets.

Centene's decision to participate in the Medicare GLP-1 Bridge signals that MCOs have made a strategic judgment: GLP-1 access is a membership retention tool and a margin management lever, not just a clinical benefit.

The oral GLP-1 pipeline -with Novo Nordisk's oral semaglutide already launched and Eli Lilly's orforglipron under accelerated FDA review -will only compress this timeline further. By 2027, the GLP-1 market structure will look materially different than it does today. Payers, platforms, and manufacturers that have built static assumptions into their models are the ones most exposed.

FDA & HEALTH POLICY: What's Changed

The FDA under Commissioner Marty Makary is moving faster and more aggressively than any recent predecessor. The headline action: the agency dropped the long-standing two-pivotal-trial standard for new drug approvals, moving to a single adequate and well-controlled study as the new default. Makary

© 2026, Covalence Health, LLC

and FDA vaccine chief Vinay Prasad published this shift in the New England Journal of Medicine in February -calling the two-trial requirement a relic of an era when biological understanding was more limited. This is one of the most significant regulatory policy shifts in decades.

Simultaneously, the FDA has integrated AI into employee workflows, approved new AI-powered diagnostic devices, and qualified the first-ever AI drug development tool under 21st Century Cures Act authorities. The National Priority Voucher program offers accelerated one-to-two month reviews for drugs aligned with administration health priorities. Eli Lilly's oral GLP-1 orforglipron has already received one of these vouchers, putting its approval timeline weeks behind Novo Nordisk's oral semaglutide rather than months.

Despite leadership turbulence and large-scale layoffs that created uncertainty for some drug developers, the FDA still approved 46 new medicines in 2025 -below recent peaks but ahead of historical norms. The direction of travel under Makary is deregulatory speed, AI-assisted review, and evidence flexibility.

For investors, pharma, and health technology companies, this FDA is a tailwind -if you have a compelling mechanism and a clean trial. If you are relying on legacy regulatory strategy, it is time to revisit your assumptions.

CONNECT WITH US:

(571) 310-1021

info@covalencehealth.com

https://www.covalencehealth.com/contact-us

https://www.linkedin.com/company/covalencehealth

© 2026, Covalence Health, LLC