# Value-Based Care: Top Trends & Market Perspectives

April 28, 2026

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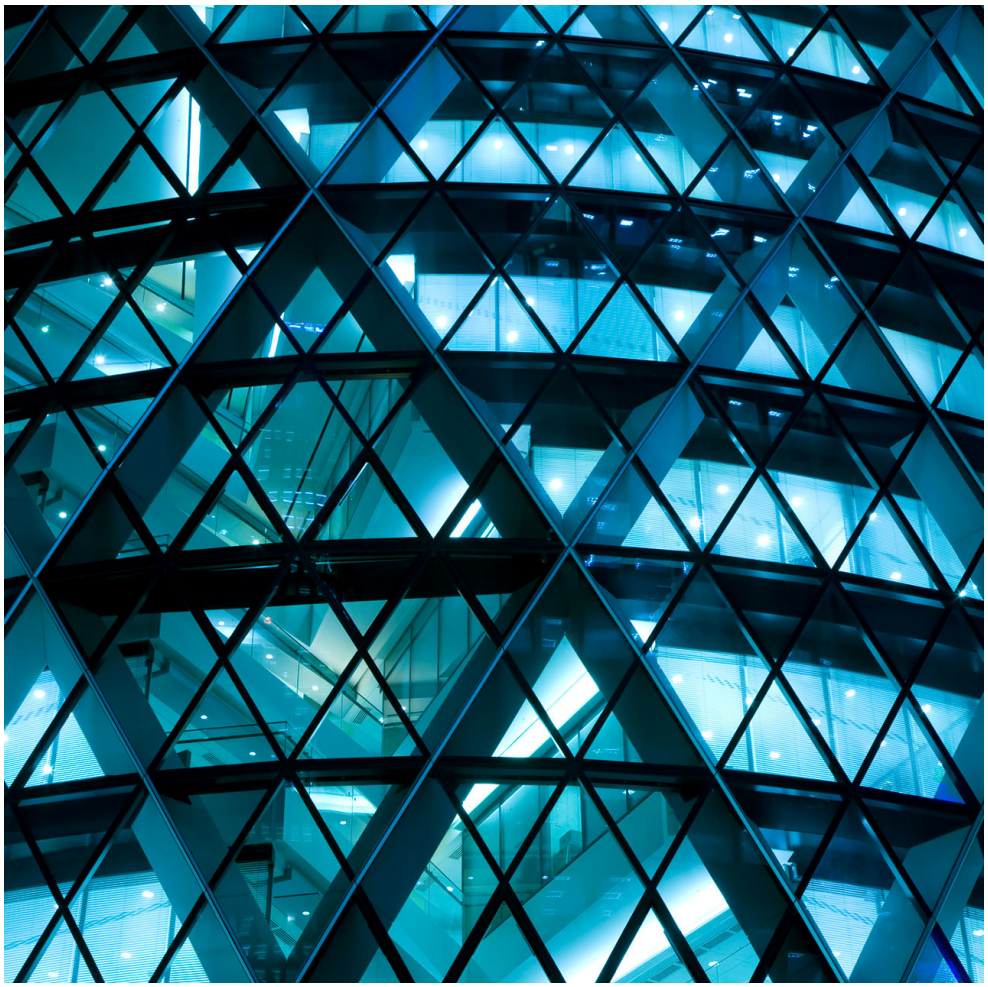
# Learning Objectives

1. Discuss key trends shaping the delivery and financing of value-based care (VBC) and their implications for hospitals, health systems, physician practices, and post-acute providers.
2. Identify common challenges and success factors observed across VBC strategies in the market.
3. Apply leading practices to help strengthen an organization's VBC approach.







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# Introductions

# Meet the Presenters


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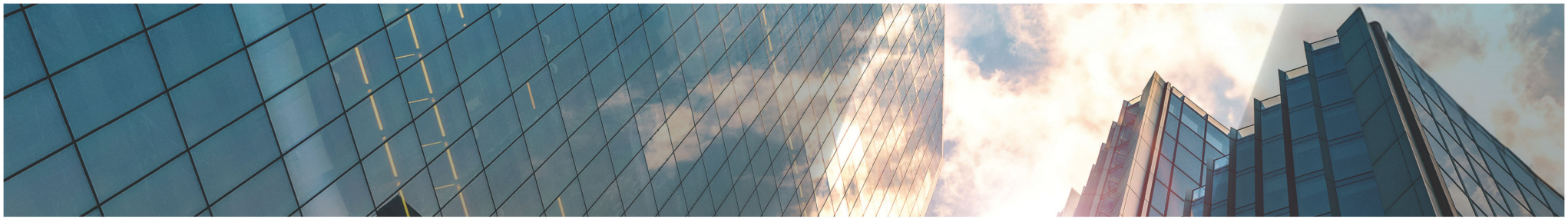

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Combined Revenue (2025*)

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Combined Countries & Territories

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*As of 8/31/2025

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**#6**

Largest Healthcare Consulting Firm (2025)

**89**

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# Overview &
# Market Perspectives

# Key Terms Defined

## Population Health
The “Vision”

Population health describes the health outcomes of a group of individuals and patterns of health determinants.

## Value-Based Care (VBC)
The “Framework”

VBC is a framework for restructuring healthcare systems around the globe with the overarching goal of value for patients.

## Alternative Payment Model (APM)
The “Vehicle”

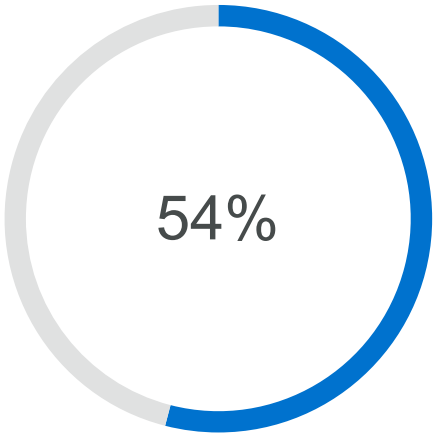
An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

While both VBC and population health aim to improve health outcomes, population health emphasizes addressing health determinants through preventive care and community-based interventions, while VBC focuses more on reducing healthcare costs through performance-based incentives.

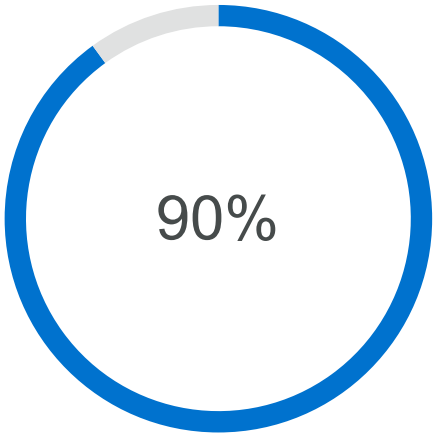
APMs are a common vehicle for implementing both VBC and population health strategies.

# VBC Market Perspective
# **Providers**

## Some executives are preparing for the future, and some aren't.




More than half of respondents have <10% of reimbursement at risk or don't know the extent of their risk exposure.*




The vast majority (90%) of payors believe that at-risk revenue will grow or stay the same in the future.**

Sources:
*Mindsets 2026 Healthcare Executive Leadership Report
**HCPLAN 2025 Measurement Effort

## Three Categories of Unprepared

**A** | Industry trends and others' beliefs about at-risk contracts are either wrong or don't apply here.

**B** | Already great and highly capable despite low exposure; waiting for the market to catch up.

**C** | Financial position is so strong that the organization can withstand potential revenue reductions from at-risk contracts.





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# VBC Market Perspective
## **Payors**

Payors point to providers as a barrier to APM adoption.

**1** | Provider willingness to take on financial risk

**2** | Provider ability to operationalize

**3** | Provider interest/readiness

Source: HCPLAN, 2025 Measurement Effort Results

# VBC Industry Trends

## Payor Pressures Driving Accelerated VBC Adoption

- As medical costs continue to rise, payors are shifting focus from negotiating rates with providers to transferring risk.

## Shift From Voluntary to Mandatory APMs

- CMS views mandatory models as necessary to reduce selection bias and slowed adoption.
- Providers should expect increased exposure to risk.

## Expansion & Evolution of ACOs

- Sharp ACO beneficiary growth in 2026.
- Health systems are positioning ACOs as a core delivery platform for managing total cost of care.

## Fading of Upside-Only Models

- Payors expect providers to be responsible for some level of downside risk.
- Providers who aren't prepared face increased margin pressure or network exclusion.

## Spotlight on Specialists

- Specialist behaviors are critical to driving total cost of care.
- New and emerging models will target specialists more directly and aim to integrate with primary care.

## Acceleration of AI & Predictive Analytics

- Success in VBC requires real-time analytics, early risk stratification, and forecasting.

# Payor Pressures Driving Accelerated Risk

Both governmental and commercial payors **face sustained growth in medical costs** at the rate of 7–9% per year, largely driven by:

- High-cost specialty drugs
- Increased utilization post-COVID
- Aging population

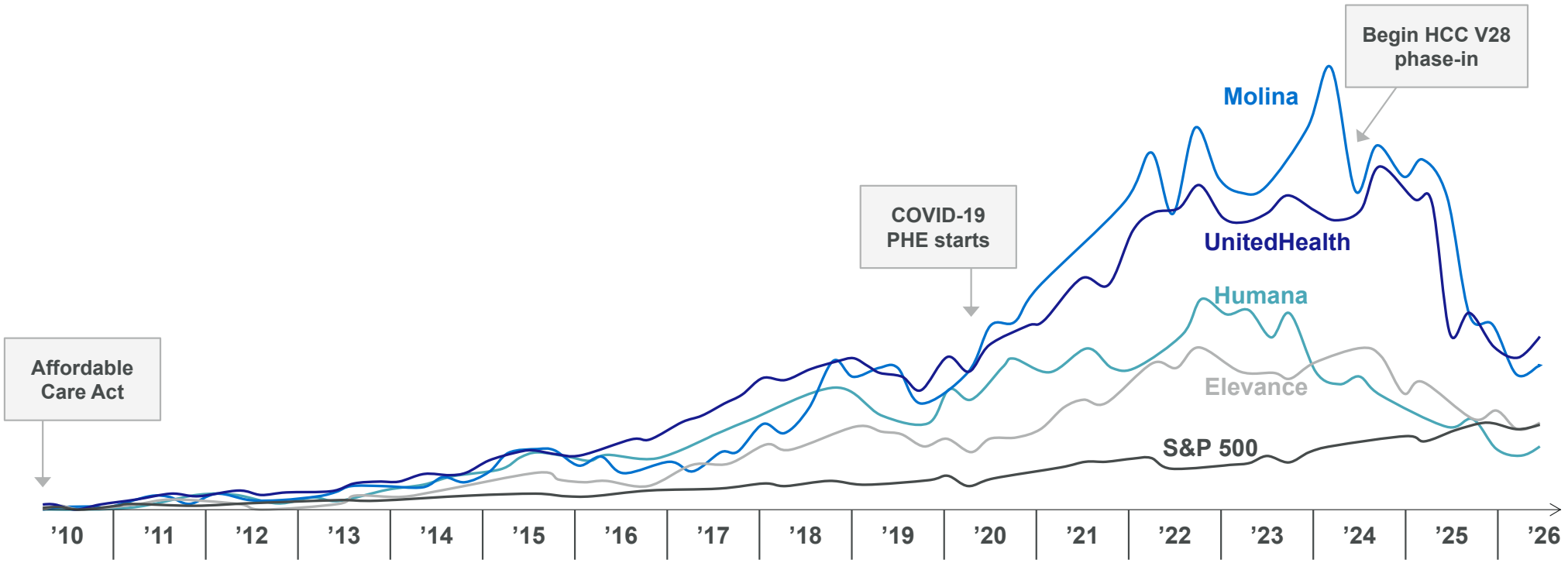
As they grapple with the new cost realities, payors are increasingly looking to **transfer risk to providers** to drive down costs as opposed to merely negotiating rates.

Expect more total cost of care arrangements, bundled payments, and capitation/global budgets to be introduced as **cost containment mechanisms rather than quality experiments.**

Source: PwC

# Payors' Roller Coaster Ride
## **Major Medicare Advantage Players**

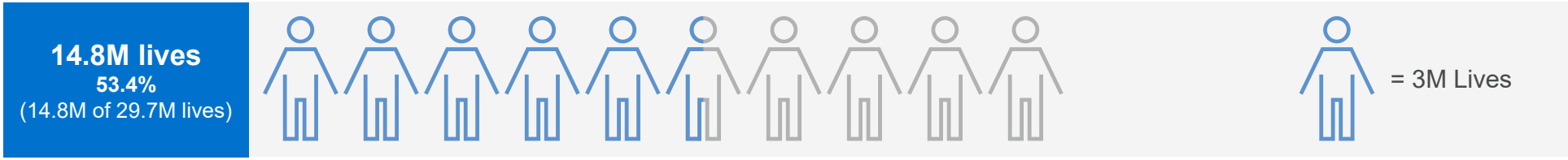
Pressures related to increased cost (MCR) and reduced revenue (HCC V28) have challenged payors.




Source: NYSE

# CMS Policies Underpin Payor Pressure

- CMS is continuing toward its goal of having 100% of Medicare beneficiaries in an accountable care relationship by 2030.
  - As of January 2025, only 53% of Medicare beneficiaries are enrolled in a VBC arrangement.




- The **expansion of mandatory models and normalization of downside risk** in ACO-type arrangements will increase over the next 3.5 years as Medicare seeks to close the gap.

## Impact to Commercial Payors

- Commercial payors typically take their cues from Medicare policy.
  - More aggressive public payor policies reduce friction for payors mandating VBC participation.
- As providers invest to succeed in Medicare VBC models, it becomes easier to enter commercial VBC arrangements.

Source: "CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives," cms.gov, January 15, 2025.

# Voluntary vs. Mandatory APMs

Mandatory APMs favor scalability and measurable savings, while voluntary APMs favor early adopters with historically advantageous performance.

## Voluntary Models

- **Examples:** MSSP, BPCI-A
- Optional participation
- Ability to exit early
- Suitable for testing new payment concepts before broader expansion
- Susceptible to selection bias

## Mandatory Models

- **Examples:** TEAM, CJR, ASM, CJR-X
- Required participation for a defined set of providers
- Reduces selection bias
- Produces results that are more generalizable for nationwide policy decisions
- More challenging for participants who aren't prepared to accept risk

# CMS Signals Shift Toward More Mandatory Payment Models

- CMS Innovation Center (CMMI) leadership says mandatory payment models are necessary to accelerate adoption of VBC.
- Mandatory models reach more providers, particularly those not currently succeeding in voluntary models.
- Voluntary participants engage with models until they're unprofitable, then withdraw.

## Rationale for Mandatory Models

- Mandatory models counteract fee-for-service incentives that reward volume over value.
- Progress toward VBC has been slow through voluntary pathways alone; poor performers tend to exit voluntary models.

## Recent & Planned Mandatory Model Activity

- *NEW* Model Announced: CJR-X, starting on October 1, 2027.
- CMMI proposed three mandatory models in 2025, the highest number in a single year, including:
  - Ambulatory Specialty Model (ASM), Global Benchmark for Efficient Drug Pricing (GLOBE), and Guarding U.S. Medicare against Rising Drug Costs (GUARD).
- In addition, 743 hospitals began participating in the Transforming Episode Accountability Model (TEAM) on January 1, 2026.
- Push toward mandatory models has been consistent across multiple administrations.

"Mandatory models are going to have to be part of the equation."

- **Abe Sutton, CMMI Director**, on how to get more providers to participate in value-based care*



*In remarks at the Health Care Value Week Conference, March 3, 2026, hosted by Accountable for Health



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# New Mandatory Model Announced
# **Comprehensive Joint Replacement Expanded (CJR-X)**

Model Start
**October 1, 2027**

Projected CMS Savings
**$725M**

Participation
**Mandatory for 2,500 Hospitals**

Post-Discharge Window
**90 Days**

- CMS is proposing to enact CJR-X, an expansion of the previous CJR Model that ended in 2024.
- CJR-X would mandate all hospitals* nationwide to participate in episodes of care, with no specified end date for the model.
- The model holds hospitals accountable for the total cost of care for a 90-day episode for patients undergoing a lower extremity joint replacement procedure.
- Inpatient and outpatient episodes included with site-neutral target prices.
- Minimum quality thresholds must be met to share in gains.
- Current TEAM participants are not eligible to participate until the end of the model (December 2030).

*Except those participating in the Transforming Episode Accountability Model (TEAM) or located in Maryland

# BPCI Advanced (BPCI-A) Model Evaluation & Outcomes

## BPCI-A illustrates the limits of voluntary episode-based models.

**2018:** CMS launched the Bundled Payments for Care Improvement Advanced (BPCI-A) Model to reduce Medicare spending while maintaining or improving quality through episode-based financial accountability.

**Model Year (MY) 1–3:** Hospitals and physician group practices could voluntarily opt in and select individual clinical episodes for participation.

**Early Results:** Favorable target pricing and selection bias led to $180M in net CMS losses, with limited improvements in quality or patient experience.

**Program Redesign (MY4):** CMS restructured target pricing and introduced Clinical Episode Service Line Groups (CESLGs), eliminating the ability to select individual episodes.

**Impact on Participants:** Financial performance deteriorated as target prices tightened, reducing upside opportunity.

**Participation Decline:** Between MY4–MY5, 30% of participants exited the model—most owing repayments to CMS.

# Expansion & Evolution of ACOs

What began as a voluntary model is becoming a core operating requirement.

### Continued Growth

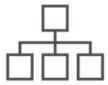
ACOs are positioned as a long-term element of Medicare's cost and quality strategy.

### Broader Accountability

ACOs are being asked to move beyond primary care performance and into enterprise-wide care redesign.

### From Participation to Performance

Policy emphasis is moving beyond "getting providers into ACOs" and toward demonstrating sustained savings and quality improvement.



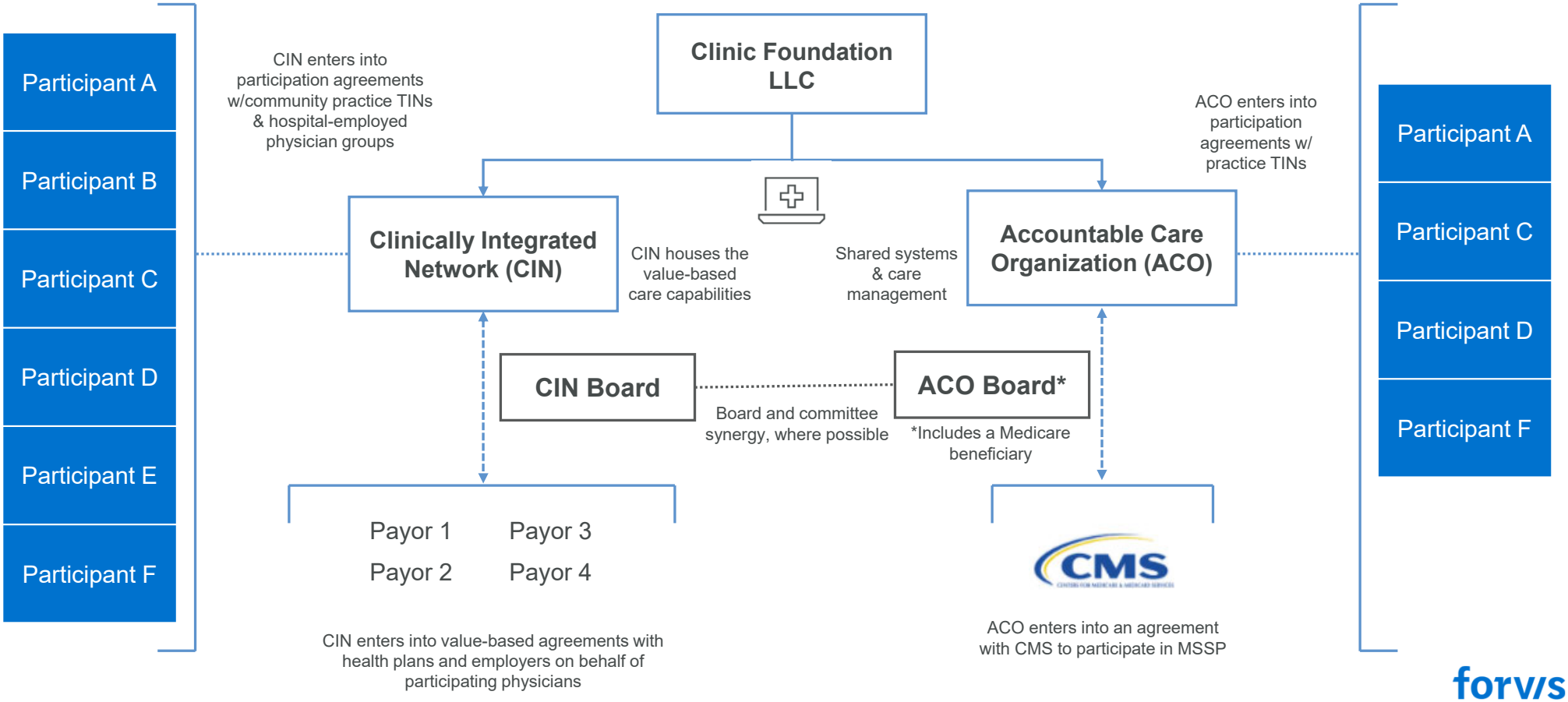
### From "Program" to "Platform"

Leading organizations use ACO infrastructure as a foundation for multiple risk arrangements, not a single CMS model.

### More Financial Risk

ACOs are expected to take on greater downside risk over time, with fewer pathways to remain upside-only.

# ACO-CIN Alignment Example



# Medicare Shared Savings Program (MSSP) ACO Fast Facts
## **Nationwide**

Following a prolonged plateau, ACO attribution increased sharply in 2026 while continuing to maintain savings to Medicare.

| Year | # ACOs | # Aligned Beneficiaries | Savings to Medicare | % ACOs Earning Shared Savings |
|---|---|---|---|---|
| 2020 | 513 | 11.2M | $1.9B | 67% |
| 2021 | 475 | 10.7M | $1.7B | 58% |
| 2022 | 482 | 11.0M | $1.8B | 63% |
| 2023 | 453 | 10.9M | $2.1B | 69% |
| 2024 | 480 | 10.8M | $2.4B | 76% |
| 2025 | 476 | 11.2M | -- | -- |
| 2026 | 511 | 12.6M | -- | -- |

Source: "2026 Medicare Accountable Care Organization Initiatives Participation Highlights," cms.gov, February 4, 2026.





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# What's Different About ACOs in 2026 vs. 2020?

ACOs have shifted from optional pilots to a core Medicare accountability model for cost, quality, and financial risk.

| | ACOs in 2020 | ACOs in 2026 & Beyond |
|---|---|---|
| **Role in Medicare Strategy** | Viewed as pilots testing accountability | Core, long-term Medicare delivery model |
| **Financial Risk** | Mostly upside-only or limited downside | Two-sided risk increasingly expected |
| **Benchmarking & Pricing** | Favorable, slowly rebased | Tighter, more frequent rebasing |
| **Care Model Expectations** | Care coordination focus | Advanced, clinically integrated models |
| **Data & Analytics Requirements** | Retrospective insights sufficient | Near-real-time analytics required |

# New ACO Model Announced
# **Long-Term Enhanced ACO Design (LEAD)**

- CMS recently released a request for applications to the LEAD Model, launching January 2027 through 2036.
- LEAD intends to appeal to a broader mix of providers, particularly those who have not participated in ACOs or have dropped out due to financial and operational barriers.
- CMS also seeks to engage specialists and rural-based practices through this model by providing enhanced, flexible cash flow payments.

## Differences Between MSSP & LEAD

| | MSSP | LEAD |
|---|---|---|
| **Timeline** | 5 years with annual application cycles | 10 years |
| **Payment Structure** | Fee-for-service with retrospective reconciliation | Primary care and total care capitation payments with reconciliation |
| **Risk Structure** | One-sided risk options with glide path to two-sided risk | Two-sided risk, similar to ACO REACH |
| **Benchmarking** | Historical benchmark with periodic rebasing & regional adjustments | No rebasing over 10 years |
| **Role of Specialists** | Limited (mostly PCP driven) | Explicit specialist integration, including episodes of care (CARA) |
| **Targeted Participants** | Broad range of participants; commonly utilized by new ACOs | Current REACH participants, high-cost ACOs, rural providers |

# Fading of Upside-Only Models

## What's Changing?

- VBC arrangements with upside-only risk are increasingly disappearing.
- Payors of all types expect providers to be accountable for downside risk.
- Risk is shifting from optional participation to a key contracting requirement.

## Why Does This Matter?

- Performance gaps are widening between risk-ready and risk-averse participants.
- Margin pressure increasing for providers without strong risk discipline.

## Strategic Implications

- Success going forward will requires actuarial rigor, operating discipline, and real-time performance analytics.

# Four Categories of VBC Payments

| Category 1 | Category 2 | Category 3 | Category 4 |
|---|---|---|---|
| **FEE-FOR-SERVICE – NO LINK TO QUALITY & VALUE** | **FEE-FOR-SERVICE – LINK TO QUALITY & VALUE**<br><br>**A**<br>**Foundational Payments for Infrastructure & Operations**<br>*e.g.*, care coordination fees & payments for HIT investments<br><br>**B**<br>**Pay-for-Reporting**<br>*e.g.*, bonuses for reporting data or penalties for not reporting data<br><br>**C**<br>**Pay-for-Performance**<br>*e.g.*, bonuses for quality performance | **APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE**<br><br>**A**<br>**APMs With Shared Savings**<br>*e.g.*, shared savings with upside risk only<br><br>**B**<br>**APMs With Shared Savings & Downside Risk**<br>*e.g.*, episode-based payments for procedures and comprehensive payments with upside and downside risk | **POPULATION-BASED PAYMENT**<br><br>**A**<br>**Condition-Specific Population-Based Payment**<br>*e.g.*, per-member, per-month payments, payments for specialty services, such as oncology or mental health<br><br>**B**<br>**Comprehensive Population-Based Payment**<br>*e.g.*, global budgets or full/percent of premium payments<br><br>**C**<br>**Integrated Finance & Delivery System**<br>*e.g.*, global budgets or full/percent of premium payments in integrated systems |



Source: HCPLAN 2025 APM Measurement Effort



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# VBC Payments for All Lines of Business

In 2024, nearly 30% of all healthcare payments were tied to downside risk models, up from previous years.

**CATEGORY 1**
**FEE-FOR-SERVICE**
**NO LINK TO QUALITY & VALUE**

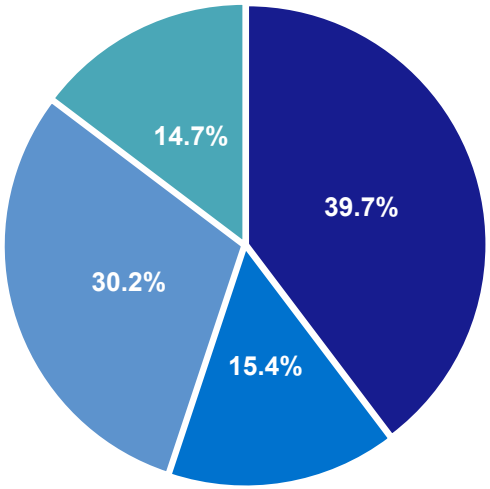
**39.7%**

**CATEGORY 2**
**FEE-FOR-SERVICE**
**LINK TO QUALITY & VALUE**

**15.4%**

## Payments in All Lines of Business

CY 2024 Data Year




**87.5% of the market represented in the survey**

Based on 58 health plans, 2 states, and Original Medicare

**CATEGORY 3**
**APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE**

| 3A | 3B |
|---|---|
| Upside Rewards for Appropriate Care | Upside & Downside for Appropriate Care |
| 16.2% | 14.0% |

**CATEGORY 4**
**POPULATION-BASED PAYMENT**

| 4A | 4B | 4C |
|---|---|---|
| Condition-Specific Population-Based Payment | Comprehensive Population-Based Payment | Integrated Finance & Delivery Systems |
| 4.1% | 5.2% | 5.4% |

**28.7%** APMs With Downside Risk (Categories 3B, 4A, & 4C)



Source: HCPLAN 2025 APM Measurement Effort



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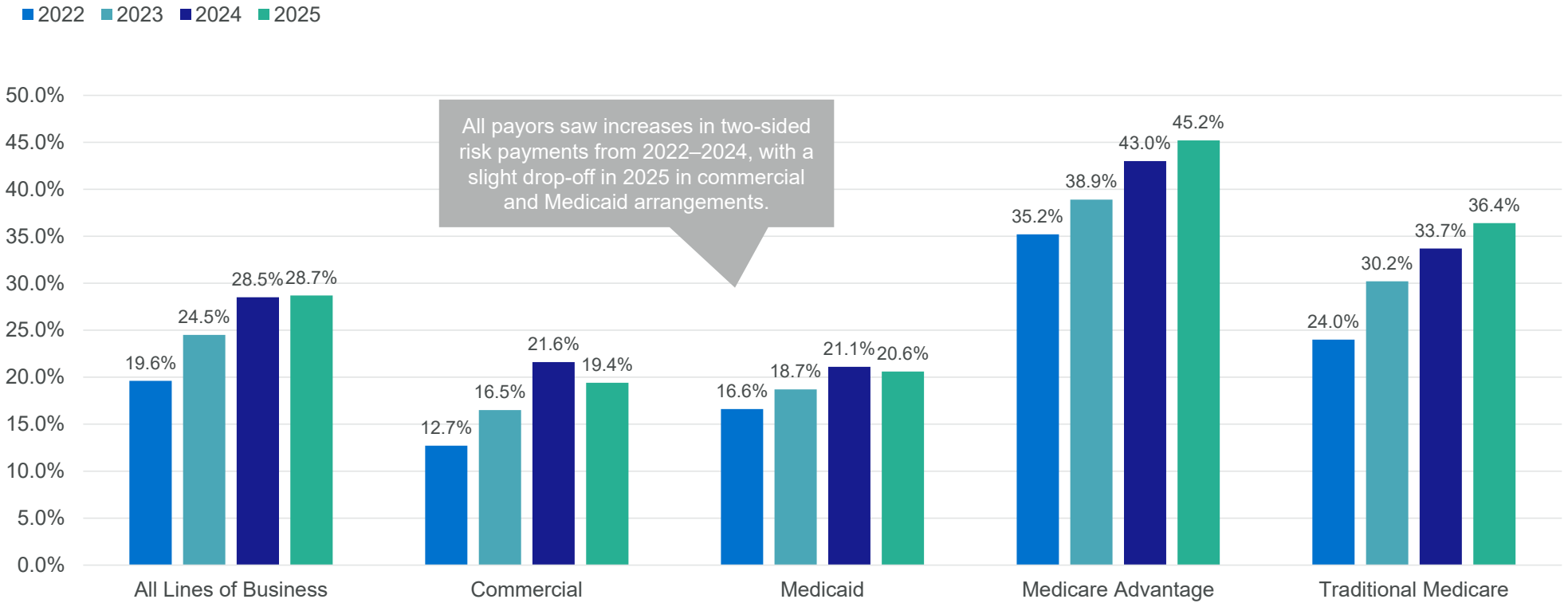
# Payments Tied to Downside Risk Increasing Year-Over-Year

## 2022–2025 U.S. Healthcare Delivery Payments in Two-Sided Risk APMs by Payor




Source: HCPLAN 2023, 2024, 2025 APM Measurement Effort

# Spotlight on Specialists

## Why This Matters

- Over 60% of U.S. healthcare spending is generated by specialists, but most VBC infrastructure is built on primary care. [1]
- Variation in specialist practice patterns is a key source of cost and performance volatility.
- VBC models cannot succeed in meaningful cost reduction without aligning incentives to specialists.

## What's Coming Next

- New models and commercial contracts are now focusing on high-impact specialties, including:
  - Oncology, cardiology, nephrology
  - Surgical subspecialties
- As specialists become more engaged, more emphasis will be placed on integrating with primary care, including shared accountability, co-management, and episode-based approaches.

## Recent CMS Activity

**Ambulatory Specialty Model (ASM)**

- Begins January 1, 2027
- Mandatory for selected geographies
- Two-sided risk
- Focused on heart failure and low back pain
- Practice-level accountability

**Transforming Episode Accountability Model (TEAM)**

- Launched January 1, 2026
- Mandatory for selected geographies
- Two-sided risk
- Focused on five surgical episode groups
- 30-day episodes

[1] Source: "Expanding value-based care: The essential role of specialists in long-term success and patient outcomes," medinsight.com

# Specialist-Focused VBC Arrangements

### Bundled Payment Models

BPCI-A, CJR-X, TEAM, commercial bundles

### Specialist Co-Management Models

Joint hospital-physician governance with incentives for quality and efficiency; co-management agreements for cardiovascular, orthopedic, and spine surgeries

### Condition-Specific Longitudinal Models

ASM, EOM, KCC, CARA module in LEAD, specialty medical home models

# Acceleration of AI & Predictive Analytics

- The adoption of tools that allow for real-time visibility into performance is now table stakes for success in VBC.
- The rise of artificial intelligence (AI) allows providers to identify high-risk patients early, shifting care management models from reactionary to proactive population health.
- Health systems and ACOs are becoming more reliant on accurate forecasting tools to predict performance against cost and quality benchmarks as earnings volatility increases.

Only 8% of healthcare executives think they have mature analytics capabilities, yet 80% believe having high-quality data is a top priority.

Source: “Advanced Analytics to Succeed in Value-Based Care Contracts & APMs,” cedargate.com, 2023.





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# Strategic Implications for Health Systems

# The Fourth Business Cycle of VBC

⚠ COVID pandemic interrupted normal operations; VBC put on pause/regressed in some areas

## 1 2011–2015

- Gradual dabbling in APMs
- Mandatory program losses are part of business model
- Financial results are irrelevant

## 2 2016–2020

- Be on the APM list
- Invest only for now (temporary)
- Top-line in-model financial results must be positive

## 3 2022–2025

- VBC is permanent & growing
- Shift from Medicare FFS to MA models
- Build capabilities for long-term population health success

## 4 2026–????

- Downside risk expected
- Financial winners & losers emerging with meaningful financial impact
- VBC is an imperative capability





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# Next Steps for Health Systems

Medicare has settled on its VBC architecture for the foreseeable future: more downside risk and fewer chances to opt out. Commercial plans will follow suit.

## Most health systems have already considered …

- How does VBC fit into our overall vision?
- Are we prepared for downside risk, or are we relying on historic tailwinds?
- Do our incentives and governance align with the VBC goals we say we're pursuing?
- If APM activities increase over the next one to two years, where are we at risk, and where can we win?

# What Health Systems Should *Really* Be Asking

1. Are our physicians financially aligned with downside risk, or are they insulated from it?
2. Can we manage risk at scale?
3. How will we recognize revenue (or loss) derived from at-risk arrangements in our financial statements?
4. Do our care models support *intentional* results in VBC?
5. Are our VBC results the product of intentional care and management discipline, or luck?
6. Are we capturing the fee-for-service revenue for VBC activities like CCM and TCM?
7. How do our reimbursement decisions impact value-based care? *e.g.*, 340B, site-neutral, provider-based billing
8. Do we have the right bus driver to lead a value-based enterprise, or are we still running it like fee-for-service?

# Next Steps
# **Pursuing Value-Based Care**

## Evaluate your organization's performance in VBC models:

- Understand areas of opportunity
- Improve alignment with specialists, service lines, & hospitals
- Increase collaboration between primary care & specialty care
- Prepare for future mandatory APMs

## Build value-based capabilities to manage patients.

## Evaluate data on an ongoing basis to identify performance trends.

Value-based care is permanent and growing, with payors and providers both aligned on the need for more patients to be in accountable arrangements.





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# Questions?



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