

A RESEARCH WHITEPAPER

Has Value-Based Care Delivered Value?

Promises, Performance, and Open Questions

44.9%

of U.S. healthcare payments ran through alternative payment models in 2025, yet the verdict on value remains unsettled.

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About This Whitepaper

APRIL 23, 2026 · FOUR SESSIONS · HELD UNDER THE CHATHAM HOUSE RULE

This insights report is the result of the UNC Center for the Business of Health's recent 2026 Value-Based Care Research Symposium, outlining the top challenges and opportunities explored among expert panelists and contributors from the healthcare industry, clinical practice, academia, and government. On April 23, 2026, the Center hosted this annual symposium under the Chatham House Rule, convening leaders to examine a central question: *Has value-based care delivered value?* The event was organized around four sessions: an academic panel on definitions and evidence, a panel on successes and enabling factors, a panel on structural barriers, and a fireside conversation on GLP-1s as a pressure-test case study for VBC. Because all panels operated under the Chatham House Rule, statements drawn from the symposium are attributed only to the convening as a whole, never to named individuals or roles, while quantitative and policy claims are independently sourced in the footnotes.

Executive Summary

Value-based care (VBC) often commands strong support across payers, providers, and policymakers. The premise is simple: reward better outcomes, not more services. Adoption has grown steadily since the Affordable Care Act's passage in 2010. Alternative payment models accounted for 44.9% of U.S. healthcare payments in 2025, up from 40% in 2021.¹ Yet after more than a decade of federal investment, dozens of pilots, and billions in implementation spending, the verdict from the symposium attendees strongly indicated that VBC is not delivering on its intended promises at scale.

Across the symposium, participants consistently described VBC's shortfalls as structural and unbound from the necessary incentives to make it work in practice. There are too many models; they are often inconsistently applied and short-lived, and they are also vulnerable to gaming. Most importantly, VBC manages utilization while leaving prices and administrative cost, the actual drivers of U.S. health spending, largely intact. VBC's aspirational language has also provided cover for market consolidation that raises prices, which deepens the problems the framework was meant to solve.

The analysis below describes six primary structural problems the symposium examined.

TABLE 1 · SIX STRUCTURAL PROBLEMS EXAMINED AT THE SYMPOSIUM

THEME	CORE PROBLEM	CONSEQUENCE
Definition problem	No shared definition of VBC	Fragmented implementation
Performance gap	Minimal net savings at scale	Policy credibility erodes
Structural blind spots	Price ignored; utilization targeted	Cost drivers left intact
Coordination failure	Administrative overload	Provider exit from models
Incentive distortion	Gaming, adverse selection	Evidence base corrupted
Primary care underinvestment	Fee-for-service chassis unchanged	Reform foundation absent

Participants converged on a consistent set of conditions they believe are necessary for future success, spanning three levels of the healthcare system:

- **Model design:** Mandatory participation, two-sided risk, standardized benchmarks, and longer model horizons
- **Structural:** Greater physician leadership, sustained primary care investment, and behavioral health integration
- **Systemic:** Increased attention to pricing, market consolidation, and generalizable model design

The Promise of Value-Based Care

For decades, the United States has spent far more on healthcare than peer nations while delivering similar or worse outcomes on most population health measures.² The explanation is well established: prices are higher, administrative overhead is enormous, and the fee-for-service (FFS) payment system rewards the volume of services over other priorities. Value-based care emerged as the reform framework to address these failures by restructuring payment around outcomes rather than activity. Unlike FFS, VBC assigns financial risk to providers, health systems, or payers, who are rewarded or penalized based on performance against quality and cost metrics.³

VBC has roots in the managed care experiments of the 1970s and 1980s, but its current form took shape under the Affordable Care Act (ACA), which authorized the Center for Medicare and Medicaid Innovation (CMMI) in 2010 to test alternative payment models.⁴ Since then, CMMI has launched dozens of models across Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). For most of the past decade, federal policy was organized around a goal of moving all traditional Medicare beneficiaries into an accountable care relationship by 2030. CMMI leadership has since stepped away from that target in favor of a savings-first agenda.⁵

The policy logic is straightforward. If providers are held accountable for the total cost and quality of care, they will reorganize delivery to prevent illness, reduce redundancy, and eliminate low-value services. Shared savings create an incentive to improve, and over time the system learns what works and scales it. This logic has proven harder to execute than to articulate, and it rests on assumptions that do not accurately reflect how healthcare is practiced in the U.S.

The evidence accumulated over fifteen years tells a consistent story: modest gains in selected programs, near-zero net savings system-wide, persistent scaling failures, and a set of structural incentive problems the models were never designed to solve. Meanwhile, VBC has become the organizing language of U.S. health policy, which means its failures have too often been rationalized, reframed, or attributed to implementation issues rather than design. The summary that follows reflects how the symposium examined the design.

The Definition Problem

No Shared Framework, No Shared Accountability

Ask ten people in a room what value-based care means and you will get ten different answers. Symposium panelists reached no consensus on a definition. The disagreement runs deeper than terminology and reflects a real structural problem. Among practitioners, researchers, and policymakers, VBC was described in several competing ways:

A series of contractual relationships in which a payer transfers financial risk to a third-party intermediary to encourage efficiency. Under this view, VBC is primarily a risk-transfer mechanism. As one panelist put it, “it’s a risk transfer, not a transformation.”

An aspirational framework that names an end goal (“value”) without specifying the means to achieve it. The word does persuasive work that the underlying policy cannot.

A context-dependent instrument whose meaning shifts with the partner. What VBC means for a Medicaid managed care organization differs fundamentally from what it means for a Medicare accountable care organization (ACO), a commercial payer, or an integrated delivery system. As one panelist framed it, the definition is ultimately a question of design and implementation.

“ *VBC is the latest in a series of health policy fads that promises to fix American healthcare. It describes an aspiration rather than a framework.* ”

This fragmentation has direct consequences. When each stakeholder operates using a different definition, implementation becomes incoherent, evaluation becomes too complex, and expectations misalign at every contractual boundary. A payer's shared-savings program for primary care groups and a hospital system's practice acquisitions to capture downstream revenue often travel under the same VBC label.

What Patients Value Is Not What Models Measure

The misalignment extends to patients, most acutely in Medicaid populations. When Medicaid beneficiaries are asked what they value, the answers are consistent: help navigating a complex system, continuity with a trusted provider, and integrated care that addresses behavioral health and social complexity alongside medical needs. These priorities do not map cleanly onto quality metrics, utilization targets, and financial benchmarks that define VBC contracts. The result is a system in which value is defined by the payer, measured by intermediaries, and experienced by patients who are rarely asked their input.

The Performance Gap

Shared Goals, Underwhelming Results

The stated goals of VBC are not in dispute. Lowering costs while improving or maintaining quality is a proposition payers, providers, and patients can all affirm. However, the evidence does not support the claim that existing models have achieved these goals.

The Congressional Budget Office (CBO) concluded that CMMI's activities increased net federal spending by approximately \$5.4 billion between 2011 and 2020. CBO had projected savings when the center was created. CMMI spent \$7.9 billion operating its models over that first decade, and those models reduced benefit spending by only \$2.6 billion.⁶ CBO projects a further \$1.3 billion increase over the center's second decade. A 2026 Government Accountability Office (GAO) audit found that only four of roughly fifty first-decade models were certified for national expansion.⁷

The Medicare Shared Savings Program (MSSP), the largest and most established ACO model, produced gross savings on the order of 1%. After incentive payments to participating organizations, net savings were negligible. Panelists described regional benchmark adjustments that “moved the needle” only because CMS was, in one participant's words, “feeling more generous.” They concluded that the benchmarks themselves are not persuasive on close examination.

“*If you squinted you might see value, but it's hardly there.*”

There are bright spots. Some physician-led ACOs have produced consistent shared savings over multiple years. Certain CMMI outputs have proven durable; social-determinants-of-health screening protocols now embedded in hospital workflows began as a model requirement. The evidence shows that models improve as organizations learn, and that longer participation correlates with better results. The decisive question, though, is whether VBC can work at scale. To be truly successful, models need to work beyond high-performing, self-selected organizations operating under controlled conditions. There has yet to be scale across a heterogeneous provider landscape with representation of the full distribution of patient populations. On that question the honest answer was no. As one panelist put it, VBC has been “the paradigm” for a decade, and that decade has been largely a wash.

The Rhetorical Cover Problem

Despite underwhelming results, VBC’s durable political popularity is itself important to acknowledge. Value is difficult to oppose. This language has provided cover for activities the evidence does not endorse. VBC has been invoked to justify vertical integration between payers and providers, practice acquisitions by large health systems that can charge more for the same services the day after closing, and the proliferation of third-party intermediaries that extract margin without drastically improving care. The logic is circular. Integration is justified as enabling VBC, and VBC is justified as delivering value. The evidence, however, shows that consolidation raises prices and that VBC has not produced meaningful net savings. The framework has helped legitimize the current market structure it was meant to reform.

Structural Blind Spots

Managing Utilization While Ignoring Prices

VBC rests on a specific theory of what ails U.S. healthcare: too much care, delivered at too many visits, for conditions that could be prevented. Reduce unnecessary utilization and costs fall. This theory does not match the comparative data. On average, the United States uses less healthcare than peer nations, with fewer physician visits and shorter hospital stays, yet pays substantially more for individual services.^{8,9} Price, not utilization, sits at the root of high U.S. expenditures.¹⁰ VBC does not address prices or constrain what hospitals, specialists, or drug manufacturers can charge. Its incentives reduce the volume of services, a modest lever applied to the wrong variable.

“The real problems are prices and our laissez-faire approach to technology adoption. We have been obsessed with moral hazard and inattentive to the international evidence.”

Why Price Regulation Remains Off the Table

The political barriers are well understood. Every dollar of national health expenditure is someone's income, and hospital systems, pharmaceutical manufacturers, and physician specialty groups have organized interests and political capital that protect revenue. The ACA passed in part because it deliberately avoided price controls and worked instead through delivery-system reform. Panelists invoked the Clinton health plan, the Health Security Act of 1993, as the historical precedent. In their assessment it was a well-designed bill with genuine cost controls that became a political failure. The lesson the policy community took from it was to avoid the price conversation rather than to approach it differently.

The consequence is a reform framework engineered to operate inside the existing financial structure of the system, including its prices, its administrative architecture, and its fragmentation, while trying to generate value through better incentive design. That is a next-to-impossible problem to solve from the inside. There are signs of movement. Price caps and site-neutral payment (paying the same rate for a service whether it is delivered in a hospital or a physician's office) are discussed more openly in 2025 and 2026 than at any point in two decades, and CMMI's 2025 strategy explicitly contemplates site-neutral payments across care settings. They sit outside the VBC framework, and they are the reforms VBC alone cannot deliver.

PRESSURE TEST · GLP-1S

The symposium's fireside discussion used GLP-1 medications as a test case of the VBC premise that better outcomes should lower cost. These drugs can improve health substantially, but they do so by adding spending to meet massive patient demand rather than by reducing the volume of care, the lever VBC is designed to pull. They also concentrate costs in the present, while any offsetting savings accrue over a horizon far longer than most VBC contracts measure. Participants observed that a therapy that is at once high-volume, high-cost, and outcome-improving is precisely the case current VBC models are least equipped to absorb.

Coordination and Administrative Failure

Complexity as a Design Flaw

Value-based care models are complex. They vary considerably across payers, use a significant number of benchmarks and quality metrics, run on different timeframes, and generate conflicting administrative requirements. Administrative fragmentation is itself a major driver of U.S. health spending, estimated at 15% to 20% of total expenditures.¹¹ VBC layers new reporting and infrastructure demands on top of a fee-for-service billing system that is already at capacity. The costs are concrete:

- Substantial upfront investment in health information technology, quality-reporting infrastructure, and case-management staff hired specifically to absorb the new burden.
- Ongoing work to track performance across multiple contracts with different and sometimes contradictory rules. One payer's requirement can directly conflict with another's.
- Delayed payments that create cash-flow problems, particularly for smaller and independent practices.
- Model cancellations that strand practices mid-implementation; when CMMI pulls a model, trust in adopting the next one declines.

In 2022, 91% of primary care physicians reported spending too much time on administrative work.¹² The result is that VBC, a field built to reduce waste, has built a sizeable apparatus to manage the waste it creates.

“Pilot-itis” and the Generalization Problem

CMMI has launched more than 100 models in fifteen years, and few have produced generalizable results. One representative case involved EMTs and paramedics delivering care. A single site performed very well, could not be replicated elsewhere, and the model was discontinued. Generalizability was treated as an afterthought rather than a design criterion. The accumulation of pilots without generalizable evidence carries real costs. It consumes administrative capacity, breeds institutional fatigue, and produces a misleading evidence base in which selective successes are amplified while representative failures are underweighted. Panelists named the syndrome directly, they called it “pilot-itis.”

The Intermediary Paradox

VBC complexity has spawned a class of management intermediaries, such as ACO enablement companies and similar organizations that help practices navigate contracts, manage metrics, and report to payers. They play a real role in making VBC operationally viable for practices that could not otherwise manage the requirements. They also introduce a paradox. The administrative burden that makes intermediaries necessary is the same burden that consumes the savings the models were meant to generate. Building a cottage industry to manage complexity does not reduce that complexity. It redistributes the cost and extracts margin that was supposed to reach patients and practices. As one participant observed, coordinating quality metrics and implementation across payers can be precisely what hurts an enabler’s incentive to simplify.

Incentive Distortion

The One-Sided Risk Problem

Most VBC models are structured so that downside risk falls on someone other than the entity whose behavior most needs to change. Hospitals do not want to reduce hospitalizations. Specialists do not want to reduce procedures. In the words of one panelist, the models are designed to reduce costs “on someone else’s turf,” where “one party’s profit is another party’s waste.” This is why voluntary models consistently underperform models with mandatory participation and two-sided risk, in which providers can lose money, not only earn bonuses. When organizations can choose whether to participate based on expected financial performance, the resulting evidence skews toward positive results and is organizationally unrepresentative.

Gaming and Adverse Selection

Voluntary participation enables two forms of systematic distortion. Under adverse selection, organizations that expect to lose money under a model simply do not participate. The model is then evaluated on a subset predisposed to succeed, which overstates its real effectiveness. Under gaming, organizations that do participate learn to optimize for measured outcomes rather than actual health. They upcode diagnoses (record patients as sicker than they are) to inflate risk scores, select healthier patients for the populations they are accountable for, and exploit benchmark methodologies. These are documented and predictable responses to the incentive structure. As panelists put it, it is hard to design an incentive that strategic players cannot bypass, and “shenanigans around selection” are widespread.

“*It is easier to undermine the spirit of the program through upcoding or selecting patients than to deliver the change the model intends.*”

CMMI's May 2025 strategic refresh acknowledged both problems explicitly. The strategy rests on three pillars, namely evidence-based prevention, patient empowerment, and choice and competition, under a foundational commitment to “protecting the federal taxpayer.” It signals that future models will require downside financial risk, with at least some of that risk borne by providers themselves rather than by conveners or enablers.¹³ Panelists generally viewed this as the right direction, while noting that, by the policy community's own assessment, it is politically difficult to sustain: the savings-generating mandatory designs are precisely the ones that have historically been softened to voluntary before launch.

The Zero-Sum Reality

VBC literature tends to frame cost reduction as a win for everyone, in which payers save, providers earn shared savings, and patients get better care. In reality, reducing cost in healthcare means reducing someone's revenue or increasing costs for consumers. Fewer hospitalizations means lower hospital revenue, and fewer referrals means lower specialist income. Participants described this as the political-economy reason VBC has tended to avoid mandatory structures and two-sided risk. In this assessment, confronting the distributional question directly is a precondition for an honest accounting, and the habit of framing VBC as universally beneficial obscures the tradeoff at the center of the debate.

Primary Care as the Underinvested Foundation

The Evidence Is Clear; the Policy Is Not

Primary care is the highest-leverage point in the system for reducing cost, improving population health, and preventing expensive downstream utilization. The research is consistent across populations and contexts.^{14,15} Yet primary care accounts for roughly 35% of all healthcare visits and only about 5% of total spending.¹⁶ VBC depends on primary care to function as the coordinator of value across the continuum. The U.S. primary care system is not structurally capable of playing that role under current conditions.

A System Not Built for Success

The specific failures are well documented:

- Patient panels are at or past sustainable limits, making meaningful care management operationally impossible.
- Specialist reimbursement continues to substantially exceed primary care reimbursement. The Medicare fee schedule anchors this gap and influences commercial rates well beyond Medicare, which creates a pipeline problem in which graduates rationally choose specialty careers for higher pay and earning potential.
- The FFS chassis is fundamentally incompatible with population health management; practices cannot survive financially by doing more prevention and less episodic billing.
- VBC administrative requirements fall hardest on small and independent practices, which are more likely to treat underserved populations.
- Behavioral health and social complexity are dominant cost drivers for high-need patients and are increasingly demanded by both clinicians and consumers. They remain structurally excluded from most VBC contracts.

“ We don’t have a system where primary care can succeed, even when the physicians are doing exactly what they are supposed to be doing. Every practice now needs a partner just to handle the requirements.”

Consolidation and the Vanishing Independent Practice

The difficulty facing independent primary care has accelerated a corporate acquisition wave. Roughly 20% to 30% of primary care physicians remain independent, and that share is declining.¹⁷ Two distinct dynamics that are often conflated deserve specific attention:

HORIZONTAL CONSOLIDATION

Smaller practices merging into larger groups primarily to absorb the health information technology, reporting, and administrative requirements that VBC participation demands. This is partly a defensive response to complexity, and it is commonly associated with higher prices and mixed quality outcomes.

VERTICAL INTEGRATION

Payers, health systems, and integrated payer-provider organizations acquiring practices to control the care continuum and capture downstream revenue. From an antitrust standpoint this is more difficult to evaluate than horizontal consolidation, yet it is permitted in part because the framing holds that it enables the integration and data-sharing VBC is said to require. The research links it to higher prices and mixed quality outcomes.

The result is a difficult irony. Physician-led ACOs consistently outperform hospital-led ACOs, yet the market dynamics that VBC has accelerated are structurally eliminating the model that performs best. CMMI’s 2025 emphasis on supporting independent and physician-led participation is a direct, if belated, response to this.

Two Tests of Integrated Value-Based Care

If value-based care works anywhere, it should work inside an integrated system that owns both the insurance plan and the providers who deliver care. When one organization collects the premium and pays for the treatment, the incentive to prevent illness and avoid waste sits on a single balance sheet instead of on opposite sides of a contract. Two systems, a generation apart, test whether that theory holds in practice. One is value-based care's longest-running example. The other is among its newest.

Geisinger • The Mature Test

For more than two decades, Geisinger Health System in central Pennsylvania was the example everyone cited. It paired roughly ten hospitals with a health plan covering 600,000 members, and it used that structure to do what VBC promises. Its ProvenCare program offered a fixed price and an effective warranty on elective procedures such as cardiac bypass surgery, absorbing the cost of avoidable complications rather than billing for them. Its ProvenHealth Navigator medical-home model pushed resources toward primary care and chronic-disease management. These were real results, durable enough to be studied and copied across the field.¹⁸

And yet, in March 2024, Geisinger gave up its independence, becoming the inaugural member of Riant Health, a value-based care platform created by Kaiser Permanente.¹⁹ The lesson cuts both ways, which is why it belongs here. VBC's clinical logic was vindicated: integration did produce measurably better care. But the most accomplished integrated system in the country still concluded it could not sustain the model alone, and the resolution was consolidation into a far larger entity, the very market dynamic this whitepaper identifies as a driver of higher prices. Even the strongest case for VBC ended in the structural pattern VBC was meant to transcend.

Peak Health · The Live Test

Where Geisinger is the mature test, WVU Medicine's Peak Health is the live one. Beginning in 2021 as a plan for the health system's own employees, Peak Health is a provider-led insurer now owned jointly by three West Virginia not-for-profits (WVU Medicine, Marshall Health Network, and Valley Health) and is the only West Virginia-based company offering Medicare Advantage plans sponsored by in-state providers. It has since extended that Medicare Advantage offering across the state and into neighboring Pennsylvania for the 2026 plan year.²⁰

Peak Health is significant precisely because of where it is being attempted. West Virginia is a largely rural state with a high burden of chronic illness and a population that relies heavily on Medicare and Medicaid, the kind of setting in which national VBC models have historically struggled to generalize, and populations that stand to gain most if the model works. Peak Health brings together the structural features that recurred throughout the symposium discussion: provider-led rather than hospital-system-led accountability, integration of plan and care delivery, and a coordinator close to the patient. Whether those features produce sustained value in a high-need, lower-margin market is genuinely unresolved, and it would be premature to claim otherwise. That is the honest reading: Geisinger shows the model can deliver clinical value but may not, on its own, deliver financial self-sufficiency; Peak Health is the test, now underway, of whether it can deliver across a heterogeneous, population-representative community.

Why These Two Cases Matter

Taken together, the cases bring into focus the themes that ran through the symposium. Integration is the structure under which VBC has its best chance, and it still has not resolved the field's central tension: better care and lower costs are not the same achievement, and the second has proven far harder than the first. The conditions participants associated with success (provider- and physician-led models, sustained primary-care investment, and candor about the distributional tradeoffs) are visible in both stories. So are the headwinds.

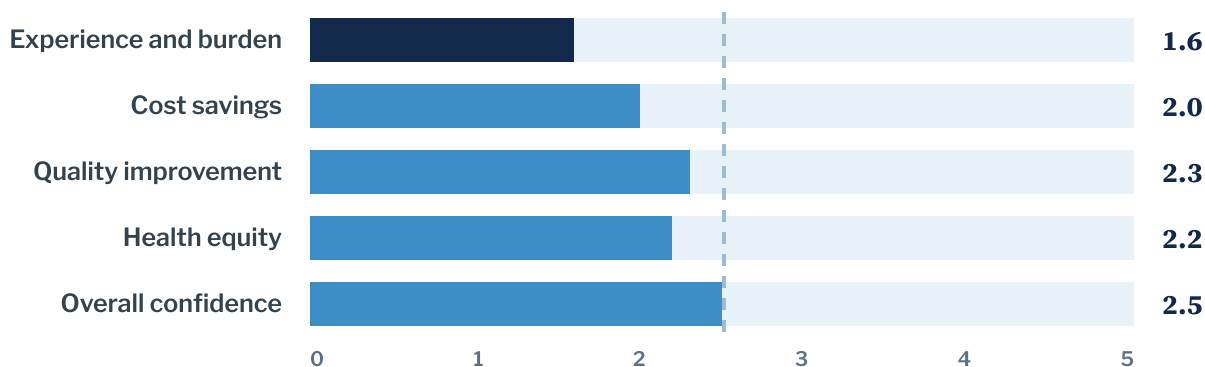
What the Room Actually Thought

The symposium's live audience poll captured the tension running through every panel. Attendees were asked to rate VBC across five dimensions and were invited to revise their answers as the discussion progressed. They landed below the neutral midpoint on every measure, averaging 2.2 overall on a five-point scale. The lowest score, 1.6 for “experience and burden,” points to where the work remains.

FIGURE 1 · LIVE AUDIENCE POLL

How attendees rated value-based care

Mean response on a 0–5 scale · April 23, 2026



Symposium live audience poll, April 23, 2026. “Experience and burden” scored lowest at 1.6, with an overall average of 2.2, below the neutral midpoint of 2.5 on every dimension.

Enabling Future Success

Participants broadly agreed that the goal of value in healthcare is the right one, even as they questioned whether the current VBC framework is well designed to achieve it. Much of the closing discussion focused on the conditions that panelists associated with stronger performance, and on the distance between those conditions and current practice. The themes below summarize the conversation; they describe what was discussed rather than prescribe a single course of action.

TIER 01**Model Design**

- Mandatory participation for high-impact models
 - Two-sided risk with material downside borne by providers
 - Standardized benchmarks and quality metrics across payers
 - Extended model horizons (10+ years)
-

TIER 02**Structural**

- Physician-led ACO structures as the default
 - Sustained primary care investment and panel-size limits
 - Mandatory behavioral health and social-complexity integration
 - Reduction of avoidable third-party administrative layers
-

TIER 03**Systemic**

- Price regulation as a necessary complement to VBC
 - Anti-consolidation enforcement and site-neutral payment
 - Generalizability as a precondition for model launch
 - National coordination of payer VBC standards
-

On Model Design

Participants most often pointed to mandatory participation as the potential highest-impact change. They noted that voluntary models produce biased evidence and structurally cap impact, and that the political difficulty of mandating participation is precisely why the status quo persists. Panelists observed that mandatory models with genuine two-sided risk, where leadership bears material consequences for poor performance, change the incentive calculus in ways that shared savings alone do not. Several also emphasized benchmark and metric standardization, noting that when payers use different methodologies, timeframes, and data sources, no practice can rationally optimize across multiple relationships at once.

The discussion also returned to model duration. CMMI's forthcoming Long-term Enhanced ACO Design (LEAD) Model, replacing ACO REACH at the end of 2026, carries a 10-year downside-risk structure from day one, the longest performance period tested to date.²¹ Participants noted that a decade-long horizon lets organizations absorb upfront investment, learn, and produce durable change, whereas short windows can manufacture false “failure” signals and erode institutional commitment just as progress begins.

On System Structure

Several participants favored physician-led models as a default and cautioned against using VBC framing to justify acquisitions that raise prices. On primary care, the discussion emphasized sustained investment independent of VBC contract performance: panel-size limits, movement toward reimbursement parity with specialty care, and direct support for behavioral health integration were described as conditions for the system to function as VBC assumes it will. As participants repeatedly observed, adding another administrative layer to a system already at capacity does not, on its own, produce value.

On the Broader System

A recurring point in the discussion was that VBC does not touch prices, and so cannot, on its own, resolve the U.S. cost problem. Participants discussed price-related measures (site-neutral payment, anti-consolidation enforcement, and transparency in hospital and specialty pricing) as addressing the drivers of U.S. cost excess more directly than utilization-management models do. The international comparison drew similar caution: panelists noted that countries achieving genuine value had made explicit collective decisions about tradeoffs, including what the system will provide, what it will cost, and how costs are distributed. The U.S. has largely avoided those decisions.

“ If we talk about value enough, we don’t have to make the hard decisions.”

A Closing Note

The researchers, clinicians, healthcare executives, policymakers, and practice leaders who informed this summary expressed genuine conviction that better healthcare is achievable. Their assessment was directed at the framework rather than the aspiration. Participants noted that VBC has produced real learning, some of it durable, and that the physician-led ACOs now outperforming merit continued study. They also observed that the field has tended to market small wins as larger than they are, to attribute structural failures to implementation, and to use aspirational language in place of harder distributional questions. With CMMI now stepping away from its 2030 accountability target in favor of a savings-first agenda built on downside risk, participants viewed the coming years as consequential. This whitepaper records that discussion as a summary of the symposium rather than a set of recommendations.

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A Note on Sources

Quotations from symposium participants are drawn from primary research notes and attributed only to the convening, consistent with the Chatham House Rule. All quantitative and policy claims are sourced in the notes below, drawing on the Congressional Budget Office, the Centers for Medicare & Medicaid Services and CMMI, the Government Accountability Office, the Commonwealth Fund, the Peterson-KFF Health System Tracker, the Health Care Cost Institute, the National Academies of Sciences, Engineering, and Medicine, KFF, and peer-reviewed research in JAMA and the Milbank Quarterly. Figures on alternative-payment-model adoption are from the Health Care Payment Learning & Action Network (HCP-LAN).

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