

RESEARCH REPORT

Why Value-Based Care Implementations Fail

The operating-model gap between payment reform and clinical transformation

Prepared for Executive Leadership

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RESEARCH REPORT

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01 | EXECUTIVE ANALYSIS

Executive Summary

The contract may be signed, the dashboard may be built, and the technology may work, yet care delivery can remain materially unchanged.

CENTRAL CONCLUSION Value-based care fails when leaders treat a financing mechanism as if it were an operating model. Sustainable performance requires simultaneous redesign of incentives, clinical workflow, professional behavior, data use, patient partnership, and governance.

The evidence does not support the proposition that value-based care is inherently ineffective. CMS reported that 75% of Medicare Shared Savings Program (MSSP) accountable care organizations earned performance payments in performance year 2024, while Medicare saved \$2.5 billion relative to benchmarks. Performance, however, was uneven: low-revenue ACOs and organizations with a stronger primary-care orientation produced substantially greater net per-capita savings than comparison groups (Centers for Medicare & Medicaid Services [CMS], 2025). The strategic question is therefore not whether value can be created, but why some organizations institutionalize the required behaviors while others achieve contractual participation without transformation.

Six findings for executive leaders

- Payment alignment is necessary but insufficient. Residual fee-for-service economics can continue to reward volume within an ostensibly value-based portfolio.
- The most common implementation pattern is partial adoption. Hospitals often implement one or two visible components, such as outcome measurement, dashboards, or a quality team, without the reinforcing system required for durable change (van Staalduinen et al., 2022).
- Clinician engagement is an operating requirement, not a communication activity. When physicians and frontline teams do not own pathway redesign, new information rarely changes routine decisions.
- Data maturity is frequently confused with decision maturity. Interoperability, attribution, and timeliness matter, but analytics create value only when embedded in accountable workflows.
- Patient-centered measurement is not equivalent to patient partnership. Organizational-level co-design and shared leadership remain rare in value-based initiatives (van der Voorden et al., 2023).

- Implementation must be governed as a measurable clinical capability. Adoption, fidelity, reach, acceptability, sustainability, and equity should be monitored alongside cost and quality outcomes (Damschroder et al., 2022; Proctor et al., 2023).
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BOARD-LEVEL IMPLICATION: Do not approve the expansion of value-based contracts solely on actuarial opportunity. Require evidence that the can change work at the point of care and sustain that change across professional, operational, and financial boundaries.

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What the Current Evidence Shows

Success is demonstrable but contingent, heterogeneous, and sensitive to organizational form.

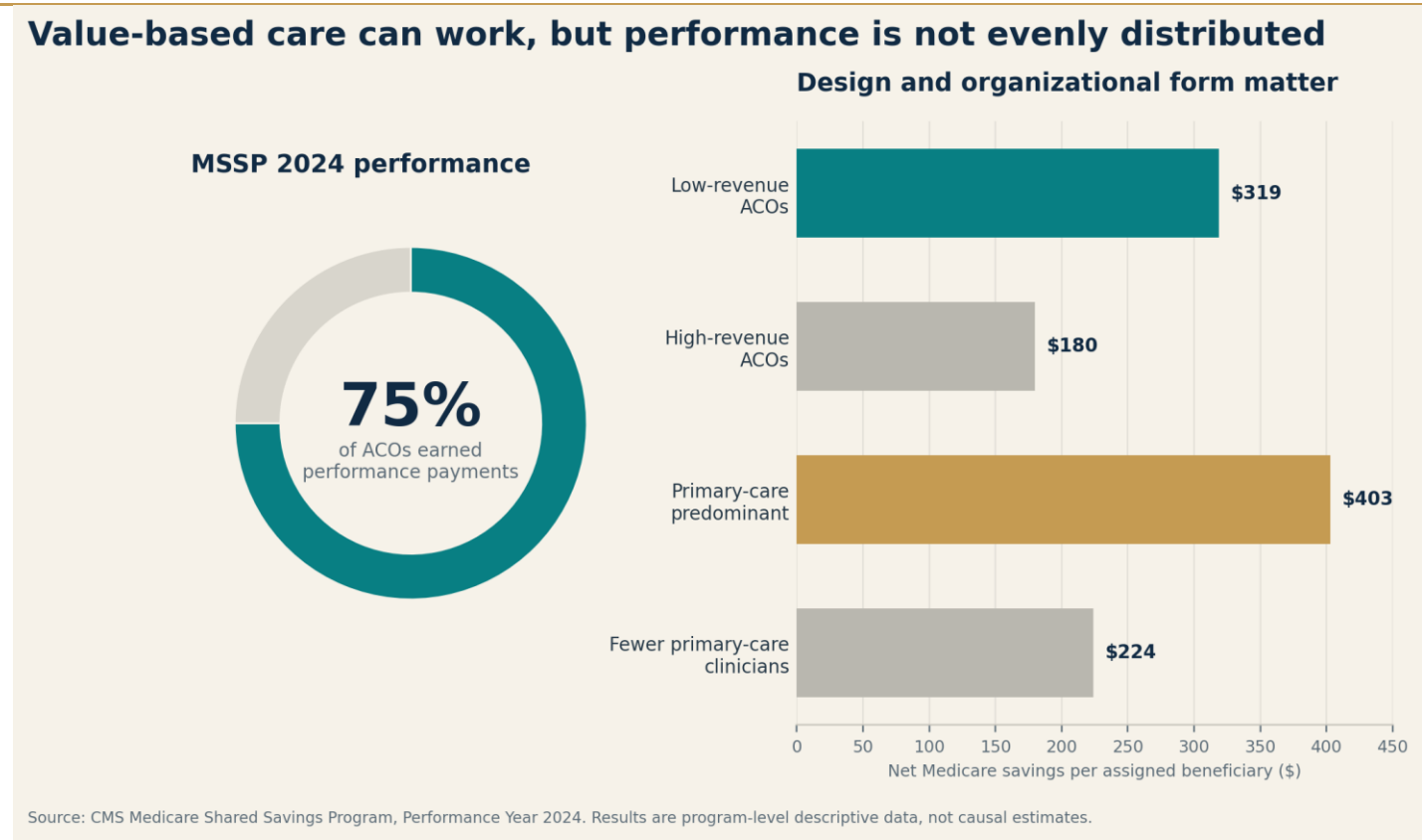


Figure 1. Current MSSP performance and organizational differentiation

Source: CMS (2025), Performance Year 2024 Financial and Quality Results.

CMS's 2024 results are an important counterweight to simplistic failure narratives. Seventy-five percent of 476 MSSP ACOs earned performance payments totaling \$4.1 billion, and Medicare saved \$2.5 billion relative to benchmarks. However, 25% did not earn performance payments, 16 ACOs owed shared losses, and per-capita results differed markedly by organizational type. Low-revenue ACOs generated \$319 in net savings per beneficiary compared with \$180 for high-revenue ACOs; predominantly primary-care ACOs generated \$403 compared with

\$224 for ACOs with fewer primary-care clinicians (CMS, 2025). These descriptive differences do not prove causality, but they signal that governance, proximity to primary care, capital structure, and delivery-model design shape performance.

Evidence synthesis approach

This report is a targeted rapid evidence synthesis, not a formal systematic review. It integrates recent systematic and scoping reviews, empirical implementation studies, implementation-science frameworks, and authoritative CMS performance data. Priority was given to peer-reviewed literature on implementation mechanisms rather than commentary on the aspiration toward value-based care. Definitions vary, much implementation evidence is observational, and program results are descriptive; convergence across evidence streams is therefore more decision-relevant than any single study.

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The Failure Architecture

Seven mechanisms interact to produce an operating-model gap.

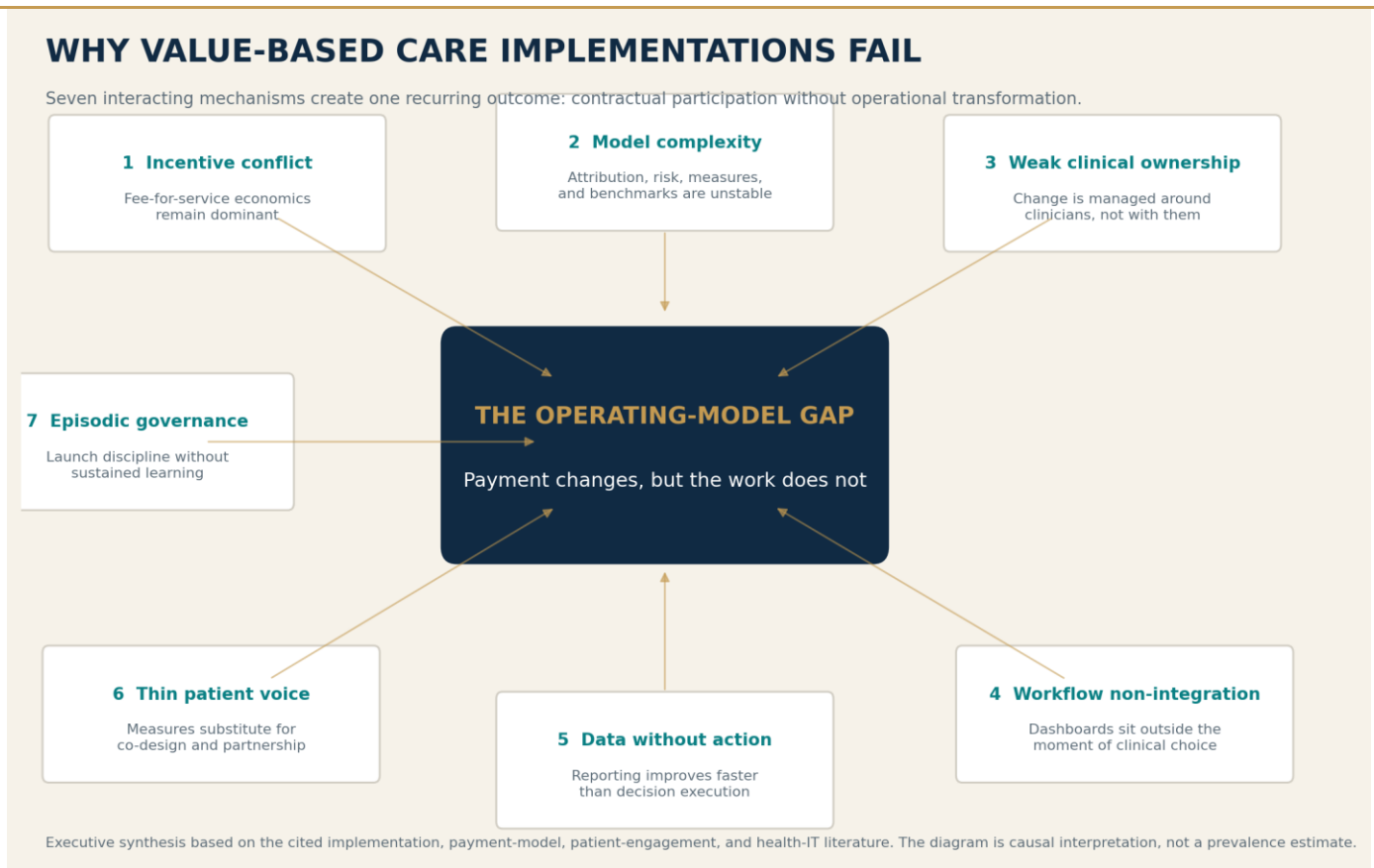


Figure 2. The operating-model gap in value-based care

Executive synthesis of the cited implementation, payment-design, health-IT, and patient-engagement literature.

The literature repeatedly describes implementation as partial, interpretively variable, and weakly evaluated. In a scoping review of 62 publications, most hospitals implemented only one or two components of the value agenda;

implementation strategies were rarely described and evaluated even less often (van Staalkduin et al., 2022). A 2025 review similarly identified inadequate funding, continued reliance on fee-for-service, professional resistance, weak information infrastructure, limited outcome capture, and organizational structures poorly suited to multidisciplinary care (Khalil et al., 2025).

FAILURE IS SYSTEMIC. No single barrier explains performance. Incentive conflict amplifies resistance; poor data increases friction; workflow friction weakens clinician trust; weak trust reduces adoption; low adoption makes financial performance appear to be a data or contracting problem.

04 | EXECUTIVE ANALYSIS

Economic Contradiction and Model Complexity

Organizations cannot consistently optimize volume and value with the same governance logic.

The dual operating system

Many health systems enter value-based arrangements, while the majority of revenue, productivity targets, capital allocation, and physician compensation remain anchored in fee-for-service. The organization is then asked to reduce avoidable utilization, while service lines are measured on volume and contribution margin. This is not merely an incentive-design defect; it is an unresolved enterprise strategy. Leaders may publicly sponsor value while operationally protecting volume, producing rational caution among clinicians and managers.

Contractual complexity disperses accountability.

Value-based purchasing programs differ in attribution rules, risk corridors, quality measures, benchmark methodology, reconciliation timing, and downside exposure. Pandey et al. (2023) found substantial variation in program design and effects across the literature. When contracts send different signals, clinicians experience value-based care as an administrative overlay rather than a coherent clinical strategy. Attribution lag and retrospective financial reconciliation further weaken the connection between today's decision and next year's result.

Risk can be mispriced or unfairly distributed.

Organizations serving medically and socially complex populations face a higher implementation burden and greater exposure to imperfect risk adjustment. Reviews of hospital value-based payment programs identify a credible risk of exacerbating disparities when models inadequately account for structural disadvantage (Kim et al., 2022). Financial risk may be transferred to clinical units without giving them the resources or authority to change the determinants of utilization.

EXECUTIVE TEST Can leaders identify, for each major value-based population, the specific economic behavior being rewarded, the legacy behavior still being rewarded, and the person accountable for resolving the contradiction?

Failure pattern	Observable symptom	Executive correction
Volume-value conflict	Service-line growth targets overwhelm utilization reduction	Define enterprise-level economic transition rules
Contract heterogeneity	Frontline teams receive multiple, conflicting measures	Create one clinically coherent internal scorecard
Delayed reconciliation	Low belief that daily choices influence results	Use leading operational indicators with monthly feedback

05 | EXECUTIVE ANALYSIS

Culture, Behavior, and Clinical Ownership

The decisive implementation unit is the care team, not the contract office.

Value-based care asks clinicians to alter established ordering, referral, documentation, follow-up, and team-practice behaviors. These behaviors are embedded in professional norms, local routines, specialty identities, and time constraints. A technically correct dashboard does not automatically overcome habit, clinical uncertainty, patient expectations, throughput pressure, or fear of missed diagnosis.

Engagement is not activation.

Traditional engagement often means informing physicians about a new model, inviting them to a committee, or presenting performance data. Activation is different: clinicians understand the model, believe the measures are clinically legitimate, possess the authority and resources to redesign care, and receive rapid feedback showing that new behavior improves outcomes. Gray et al. (2020) argue that transformation requires substantive physician leadership and engagement. Daniels et al. (2022), drawing on 43 interviews across eight hospital improvement teams, identified multidisciplinary engagement, medical leadership, practical team organization, organizational structure, and integration with existing improvement work as central determinants of success.

Culture becomes visible in local choices

- Whether variation is discussed as a learning opportunity or a threat to autonomy.
- Whether physicians trust risk adjustment, data lineage, and peer comparisons.
- Whether care managers can influence physician decisions or merely work around them.
- Whether leaders remove low-value tasks when they add new value-based work.
- Whether improvement teams can test, learn, and adapt without waiting for annual contract reconciliation.

LEADERSHIP IMPLICATION: Clinician resistance is frequently treated as a personal attitude problem. More often, it concerns legitimacy, workload, autonomy, resource adequacy, or unresolved incentive conflicts. Diagnose the mechanism before prescribing communication.

A practical behavioral architecture

Behavior	Trigger	Reinforcement	Measure
Use an evidence-based order pathway.	Decision support in the ordering workflow	Peer feedback + easy override review	Appropriateness and downstream yield
Close high-risk care gap	Daily actionable registry	Team ownership + protected capacity	Gap closure within the target interval
Coordinate after transition	Real-time discharge signal	Named owner + escalation rule	7-day follow-up and avoidable return

06 | EXECUTIVE ANALYSIS

Workflow Integration and Data-to-Action Failure

A dashboard outside the workflow is often a report about yesterday, not a decision tool for today.

The last-mile problem

Organizations commonly invest in population-health platforms, registries, risk stratification, and quality dashboards. The resulting information may be accurate yet operationally inert. It may arrive after the clinical decision, identify a population without assigning work, generate unranked lists, or require clinicians to leave the primary workflow. Health-IT literature shows positive associations with ACO participation but mixed relationships between technical capability and performance, reinforcing the distinction between infrastructure and use (Balio et al., 2019).

Four conversion failures

- Data → insight failure: the organization cannot reliably identify the patient, risk, opportunity, or causal driver.
- Insight → decision failure: the information is not presented at the time, place, and level of specificity required for action.
- Decision → work failure: no role, capacity, escalation path, or standard work converts the decision into execution.
- Work → learning failure: the organization cannot determine whether the action changed implementation fidelity, outcomes, or cost.

DESIGN PRINCIPLE Every metric should terminate in a named decision, owner, cadence, and escalation rule. If leaders cannot specify what changes when a metric changes, the metric is surveillance, not management.

Minimum viable operational data

Layer	Question	Illustrative measure	Cadence
Implementation	Are teams using the new model?	Reach, adoption, fidelity, override rate	Weekly

Layer	Question	Illustrative measure	Cadence
Workflow	Is work moving reliably?	Cycle time, backlog, and handoff failure	Daily/weekly
Clinical	Are outcomes improving?	Condition-specific outcomes and safety	Monthly
Financial	Is value being created?	Total cost, utilization, margin-at-risk	Monthly/quarterly
Equity	Who benefits or is burdened?	Access and outcomes stratified by population	Monthly

07 | EXECUTIVE ANALYSIS

Patient Value, Access, and Equity

Outcome measurement can still miss what patients value and what prevents them from receiving care.

Value-based care is often described as patient-centered, yet patient participation at the organizational level remains immature. In a systematic review of 21 studies, consultation via questionnaires or interviews was the dominant form of involvement; advisory roles, co-design, and collaborative teams were rare, and no examples of patients co-leading improvement committees were found (van der Voorden et al., 2023). This matters because leaders may optimize the outcomes they can measure while leaving navigation burden, access friction, affordability, trust, and functional goals insufficiently represented.

Three ways patient value is diluted

- Measure substitution: standardized quality indicators are treated as complete representations of value.
- Aggregation blindness: average improvement conceals differential access, burden, or outcomes across subpopulations.
- Operational exclusion: patients provide feedback but are absent when workflows, scheduling rules, and care pathways are redesigned.

Equity is an implementation property.

The updated CFIR explicitly strengthens attention to innovation recipients and equity-related determinants (Damschroder et al., 2022). For executives, this means equity cannot be relegated to retrospective stratification. Transportation, digital access, language, caregiving burden, housing instability, and distrust may alter reach, adherence, and outcomes. Payment designs that ignore these determinants can penalize organizations serving high-need populations or encourage risk selection (Kim et al., 2022). Cross-country evidence published in The Lancet Regional Health – Americas similarly identifies infrastructure limitations, data scarcity, fragmented systems, limited delivery capacity, and financing constraints as barriers to value-based implementation (Touchton et al., 2026).

EXECUTIVE REQUIREMENT: For every priority pathway, include patient partners in redesign, measure access and burden, stratify implementation and outcome metrics, and fund the nonclinical capabilities required to achieve the contracted result.

Questions the patient partnership should answer

- What does a good outcome mean to the people receiving this care?
- Where does the pathway create avoidable time, cost, uncertainty, or coordination burden?
- Which implementation strategies are feasible for patients with different resources and constraints?
- What unintended consequences would not be visible in claims or clinical outcome measures?

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The Radiology Operations Lens

Diagnostic value depends on appropriateness, access, quality, interpretation, and downstream action.

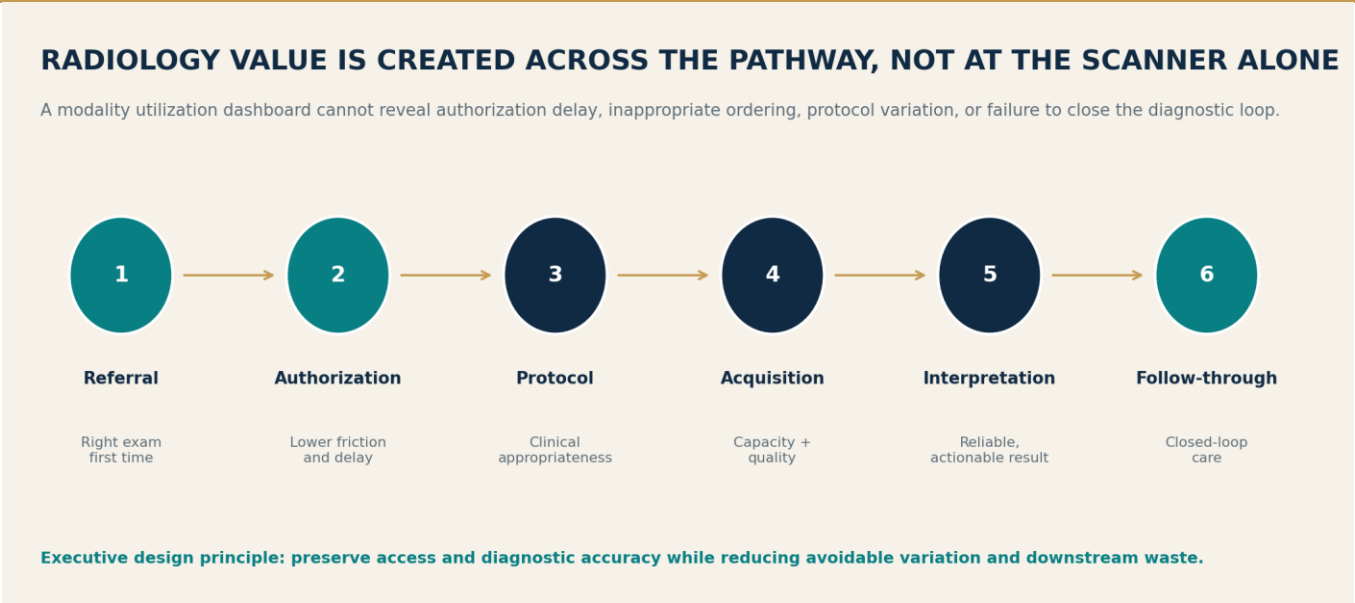


Figure 3. The end-to-end radiology value pathway
An executive operating model was developed for this report.

Radiology shows why value-based care cannot be reduced to utilization control. Imaging is both a cost center and a clinical decision infrastructure. Reducing scans without protecting access, accuracy, and follow-through can shift cost downstream; optimizing scanner throughput alone can preserve inappropriate ordering, delay, protocol variation, and an open diagnostic loop.

High-value radiology requires balanced measures.

Domain	Leading measure	Outcome measure	Failure risk
Appropriateness	Evidence-based ordering	Yield / avoided duplication	Friction replaces clinical review
Access	Authorization and scheduling time	Referral-to-result time	The necessary diagnosis is delayed
Operations	Protocol, start, completion	Reliability and pathway cost	Local throughput shifts system cost
Interpretation	Report and critical result time	Actionable accuracy	Speed displaces communication

Domain	Leading measure	Outcome measure	Failure risk
Equity	Access by geography and payer	Completion by population	The navigation burden is transferred

RADIOLOGY EXECUTIVE IMPLICATION: Manage the complete referral-to-result pathway. The largest value opportunities often sit in handoffs rather than image acquisition.

09 | EXECUTIVE ANALYSIS

Govern Implementation as a Clinical Capability

Outcomes are lagging indicators; implementation outcomes explain whether the model is taking hold.

The common governance error is to monitor cost and quality while assuming implementation is occurring. Implementation science separates the innovation from the context, process, and outcomes of implementation. The updated CFIR organizes determinants across the innovation, outer setting, inner setting, individuals, and implementation process (Damschroder et al., 2022). The implementation-outcomes literature emphasizes constructs such as acceptability, adoption, appropriateness, feasibility, fidelity, cost, penetration, and sustainability (Proctor et al., 2023).

The executive learning system

- Diagnose determinants before selecting interventions. Do not assume every low-performing site has the same barrier.
- Define anticipated implementation outcomes before launch and measure actual implementation outcomes during execution.
- Use rapid-cycle learning to adapt workflow while protecting the essential clinical function of the model.
- Separate implementation failure from innovation failure: a poorly implemented intervention cannot establish that the intervention itself is ineffective.
- Scale only after demonstrating adoption, fidelity, operational reliability, clinical benefit, and acceptable burden.

Governance forum	Primary question	Key participants	Cadence
Pathway huddle	What failed in today's work?	Frontline team, physician lead, operations	Daily/weekly
Implementation review	Are adoption and fidelity improving?	Clinical, operational, data, patient partner	Biweekly/monthly
Value portfolio review	Are outcomes, cost, and equity moving together?	Executive sponsor, finance, quality, contracting	Monthly/quarterly
Board oversight	Is enterprise risk aligned with capability?	Board, CEO, clinical, and financial leadership	Quarterly

GOVERNANCE STANDARD A value-based program should never be reported as 'green' because the contract launched on time. Green means the new care model is being used reliably, is producing intended outcomes, is financially sustainable, and is not creating an inequitable burden.

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Executive Readiness Scorecard

Use the scorecard before contracting, before scaling, and during quarterly governance.

Rate each domain from 1 (absent or unreliable) to 5 (institutionalized and demonstrably effective). A high actuarial opportunity should not compensate for weak operating-model readiness. Any score of 1 or 2 in clinical ownership, workflow integration, data reliability, patient/equity design, or governance should trigger a constrained pilot rather than enterprise expansion.

Domain	Fragile	Developing	Institutionalized	Score
Strategy & economics	Volume/value conflict unresolved	Transition rules exist for some lines	Portfolio economics and incentives align	__ / 5
Clinical ownership	Sponsor-driven; low physician trust	Selected clinical champions engaged	Distributed clinical leadership owns redesign	__ / 5
Workflow integration	Parallel manual work	Partial integration; variable sites	Standard work embedded at the decision point	__ / 5
Data-to-action	Retrospective, disputed, unassigned	Usable dashboards; inconsistent action	Timely signals tied to owners and escalation	__ / 5
Patient & equity	Feedback after design	PROMs and selected consultation	Co-design plus stratified reach/outcomes	__ / 5
Implementation learning	Milestones only	Adoption tracked inconsistently	Determinants, fidelity, adaptation, and sustainability were measured	__ / 5
Governance	Annual reconciliation focus	Monthly performance review	Integrated clinical-financial learning system	__ / 5
Scale capacity	No protected capability	Central team supports selected pilots	Repeatable pathway and site enablement model	__ / 5

INTERPRETATION 32–40: ready to scale with continued surveillance. 24–31: targeted scaling with explicit remediation. 16–23: pilot only. Below 16: redesign the operating model before assuming additional risk.

The thresholds are an executive decision aid developed for this report, not a validated psychometric instrument. Organizations should adapt definitions, evidence requirements, and escalation rules to their portfolio and regulatory environment.

Executive Recommendations and Roadmap

Move from contract implementation to operating-model transformation.

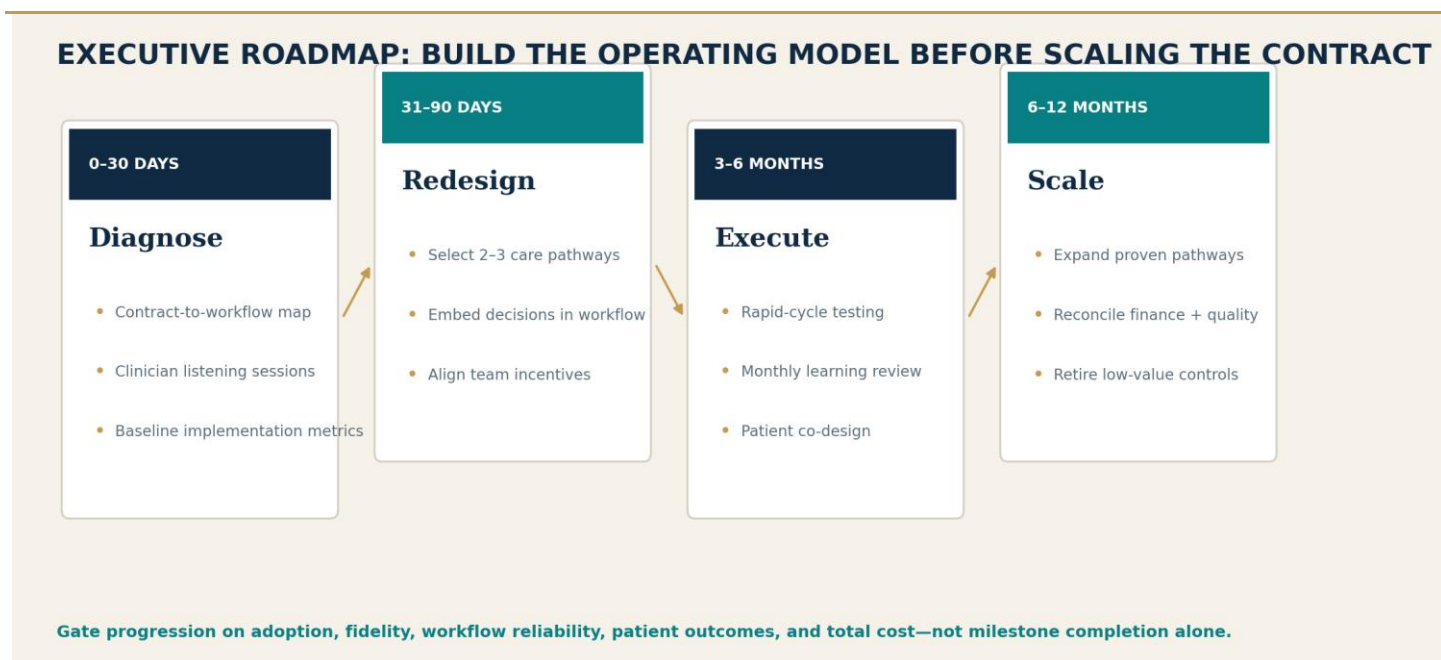


Figure 4. A staged operating-model roadmap

An executive implementation roadmap was developed for this report.

Seven recommendations

- 1. Make the economic transition explicit.** Map where fee-for-service and value incentives conflict, revise internal scorecards, and define how leaders will manage revenue displacement.
- 2. Organize around priority patient pathways.** Select a small number of clinically and financially material populations; redesign end-to-end work before adding broader contract scope.
- 3. Build physician and frontline ownership into governance.** Give clinical leaders real authority over pathway design, measures, resources, and adaptation, not ceremonial sponsorship.
- 4. Embed intelligence in workflow.** Convert every analytic signal into a timely decision, including owner, standard work, capacity commitment, and escalation rule.
- 5. Measure implementation as rigorously as outcomes.** Track reach, adoption, fidelity, burden, acceptability, feasibility, and sustainability before interpreting lagging cost results.
- 6. Co-design with patients and stratify for equity.** Include patients in workflow redesign and test whether access, burden, and outcomes differ across populations.
- 7. Scale through learning, not mandate.** Expand only when the model demonstrates clinical legitimacy, workflow reliability, outcome improvement, and sustainable economics.

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Questions for the Executive Team and Board

Govern the organizational capability, not only the contract portfolio.

- 01** What care-delivery behaviors must change for each major contract to succeed, and where are those behaviors currently measured?
- 02** Which legacy financial incentives contradict the value strategy, and who owns the resolution of the conflict?
- 03** Can frontline clinicians explain the clinical rationale, operational workflow, and feedback loop for the model?
- 04** What proportion of identified opportunities is converted into completed work, and where does conversion fail?
- 05** How are patient priorities, navigation burden, and equity incorporated before pathway design is finalized?
- 06** Which implementation outcomes are reviewed before cost and quality results, and what action follows deterioration?
- 07** What evidence must be present before the organization expands risk, population scope, or geographic scale?

Conclusion

Value-based care is often framed as a choice between better contracts, better technology, or better processes. The evidence suggests that this framing is too narrow. Contracts set the economic direction; technology increases the capacity to observe and coordinate; and processes define the intended work. None, by itself, produces sustained behavioral change. Implementation succeeds when leaders create an internally coherent system in which clinical purpose, professional identity, workflow, information, incentives, patient partnership, and governance reinforce one another.

The most important executive shift is therefore conceptual: value-based care should be governed as an enterprise operating model transformation, not as a payer program. Organizations that make this shift can use contracts as catalysts for learning and redesign. Organizations that do not may continue to sign agreements, build dashboards, and report measures while the underlying care system remains substantially unchanged.

FINAL TAKEAWAY: The technology can work. The process can be documented. The contract can be signed. Value appears only when the organization changes what people do, how work moves, and how learning is governed.

References

Balio, C. P., Apathy, N. C., & Danek, R. L. (2019). Health information technology and accountable care organizations: A systematic review and future directions. *eGEMS*, 7(1), 24. <https://doi.org/10.5334/egems.261>

- Centers for Medicare & Medicaid Services. (September 29, 2025). Medicare Shared Savings Program accountable care organizations: Updated performance year 2024 financial and quality results. <https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf>
- Coyne, J., Gutman, R., Ferraro, C., & Muhlestein, D. (2024). Financial performance of accountable care organizations: A 5-year national empirical analysis. *Journal of Healthcare Management*, 69(1), 74–86. <https://doi.org/10.1097/JHM-D-22-00141>
- Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated Consolidated Framework for Implementation Research is based on user feedback. *Implementation Science*, 17, 75. <https://doi.org/10.1186/s13012-022-01245-0>
- Daniels, K., Rouppe van der Voort, M. B. V., Biesma, D. H., & van der Nat, P. B. (2022). Five years' experience with value-based quality improvement teams: The key factors to a successful implementation in hospital care. *BMC Health Services Research*, 22, 1271. <https://doi.org/10.1186/s12913-022-08563-5>
- Gray, C. F., Parvataneni, H. K., & Bozic, K. J. (2020). Value-based healthcare: "Physician activation": Healthcare transformation requires physician engagement and leadership. *Clinical Orthopedics and Related Research*, 478(5), 954–957. <https://doi.org/10.1097/CORR.0000000000001234>
- Kaufman, B. G., Spivack, B. S., Stearns, S. C., Song, P. H., & O'Brien, E. C. (2019). Impact of accountable care organizations on utilization, care, and outcomes: A systematic review. *Medical Care Research and Review*, 76(3), 255–290. <https://doi.org/10.1177/1077558717745916>
- Khalil, H., Ameen, M., Davies, C., & Liu, C. (2025). Implementing value-based healthcare: A scoping review of key elements, outcomes, and challenges for sustainable healthcare systems. *Frontiers in Public Health*, 13, 1514098. <https://doi.org/10.3389/fpubh.2025.1514098>
- Kim, H., Mahmood, A., Hammarlund, N. E., & Chang, C. F. (2022). Hospital value-based payment programs and disparity in the United States: A review of current evidence and future perspectives. *Frontiers in Public Health*, 10, 882715. <https://doi.org/10.3389/fpubh.2022.882715>
- Pandey, A., Eastman, D., Hsu, H., Kerrissey, M. J., Rosenthal, M. B., & Chien, A. T. (2023). Value-based purchasing design and effect: A systematic review and analysis. *Health Affairs*, 42(6), 813–821. <https://doi.org/10.1377/hlthaff.2022.01455>
- Proctor, E. K., et al. (2023). Ten years of implementation outcomes research: A scoping review. *Implementation Science*, 18, 31. <https://doi.org/10.1186/s13012-023-01286-z>
- Steinmann, G., Daniels, K., Mieris, F., Delnoij, D., van de Bovenkamp, H., & van der Nat, P. (2022). Redesigning value-based hospital structures: A qualitative study on value-based health care in the Netherlands. *BMC Health Services Research*, 22, 1193. <https://doi.org/10.1186/s12913-022-08564-4>
- Teisberg, E., Wallace, S., & O'Hara, S. (2020). Defining and implementing value-based health care: A strategic framework. *Academic Medicine*, 95(5), 682–685. <https://doi.org/10.1097/ACM.0000000000003122>
- Touchton, M., Arreola-Ornelas, H., Arizmendi-Barrera, K. A., Vargas Enciso, V., & Knaul, F. M. (2026). Drivers and barriers for the implementation of value-based healthcare in Latin America: A cross-country qualitative policy analysis. *The Lancet Regional Health – Americas*, 53, 101307. <https://doi.org/10.1016/j.lana.2025.101307>
- van der Voorden, M., Sipma, W. S., de Jong, M. F. C., Franx, A., & Ahaus, K. C. T. B. (2023). The immaturity of patient engagement in value-based healthcare: A systematic review. *Frontiers in Public Health*, 11, 1144027. <https://doi.org/10.3389/fpubh.2023.1144027>
- van Staalduinen, D. J., van den Bekerom, P., Groeneveld, S., Kidanemariam, M., Stiggelbout, A. M., & van den Akker-van Marle, M. E. (2022). The implementation of value-based healthcare: A scoping review. *BMC Health Services Research*, 22, 270. <https://doi.org/10.1186/s12913-022-07489-2>

EVIDENCE NOTE The literature uses value-based care, value-based healthcare, value-based purchasing, accountable care, and alternative payment models in overlapping but nonidentical ways. This report synthesizes implementation mechanisms across these related domains while preserving program-specific claims.