By Dr. Raj Lakhanpal and Rahul Lakhanpal

10 Value-Based Care Predictions for 2026

Dr. Raj Lakhanpal & Rahul Lakhanpal

Continuing our annual tradition, we invite you to explore some of the most relevant value-based care themes for health plans and health systems in the year to come. These predictions stem from many discussions with senior executives, field specialists, clients, consultants, growth investors, private equity firms, and collective observations from the RFPs we completed last year.

I remember when writing these predictions last year, there was a sense of uncertainty. President Trump had just won the election and appointed Dr. Oz to lead CMS. This year, I write noting things have not slowed down. In fact, over the last year, the Trump administration has moved quickly to push for change within CMMI, Medicaid, Rural Health, Drug Pricing, and Technology. These changes were significant and we expect 2026 to be a year of heavy planning and execution for health plans and risk-bearing providers.

Meaningful change in healthcare takes many years. Predictions reflect directional trends that continue to progress and evolve and, as such, many of the predictions we discussed last year still hold true for 2026. This year, we have elaborated on several past predictions based on new findings in 2025 while also introducing fresh perspectives.

As always, we welcome healthy discussion and feedback.

10 Value Based Care Predictions for 2026

Prediction 1
Medicaid value-based care becomes the fastest-scaling VBC market—driven by fiscal pressure, federal policy, and access realities

Prediction 2
Medicaid Consolidation Accelerates – but winners will be those who operationalize scale, not just buy it

Prediction 3
For providers, AI adoption rapidly expands. For health plans, AI adoption shifts to governed, use-case driven deployment

Prediction 4
Regional Plans with Medicare Advantage books reset for disciplined growth in 2H'26 and 2027

Prediction 5
GLP-1s and high-cost drug management force a rethink of total cost of care strategy for Commercial Health Plans

Prediction 6
Health plans and health systems recognize providers as the key to value-based care success and will focus on developing innovative solutions that support provider enablement

Prediction 7
Strong Performing Health Systems diversify from MSSP to look at other revenue generating

Prediction 8
Fraud, Waste, and Abuse shifts from retrospective recovery to proactive risk prevention

Prediction 9
Provider Enablement evolves into interoperability-driven performance management

Prediction 10
CMMI's 2025 reset signals redesign and commitment to value-based care

Prediction 1

Medicaid value-based care becomes the fastest-scaling VBC market—driven by fiscal pressure, federal policy, and access realities

We suspect that in 2026, Medicaid will emerge as the fastest-scaling value-based care market, driven less by experimentation and more by necessity. Redeterminations, sustained medical cost pressure, and state budget constraints are forcing Medicaid agencies and managed care plans to move beyond pilots toward value-based models that can operate at scale and demonstrate measurable impact. This pressure is increasingly visible in Medicaid earnings reports, where plans continue to cite margin compression, acuity mix shifts, and cost trend as central drivers of performance variability.

Federal and state policy signals are reinforcing this shift. Provisions tied to the **One Big Beautiful Bill Act (OBBBA)**, renewed federal focus on rural health and safety-net stabilization, and the continued expansion of **state-directed payments** has elevated access preservation as a central policy objective. In this environment, Medicaid VBC is increasingly viewed as a practical lever to align state-directed funding with accountability. States are using value-based frameworks to pair supplemental payments with expectations around total cost of care, quality performance, and access. Similarly, we have seen our health plan customers giving their provider networks more flexibility if they shift towards shared-risk agreements.

At the same time, Medicaid VBC is expanding beyond primary care into specialty domains where cost, access, and outcomes converge. Behavioral health, LTSS, maternity, oncology, and musculoskeletal care are emerging as priority areas, as states and plans seek to address high-cost utilization and persistent access gaps through more scalable specialty models. Success will hinge on plans' ability to operationalize attribution, manage episode economics, and support providers with consistent performance insight across fragmented delivery systems.

Prediction 2

Medicaid Consolidation Accelerates – but winners will be those who operationalize scale, not just buy it

Medicaid health plan M&A accelerated meaningfully in 2025 as sustained margin pressure, regulatory complexity, and capital constraints forced strategic decisions across the market. Transactions such as Medica's acquisition of UCare and CareSource's acquisition of Commonwealth Care Alliance illustrate a broader trend of not-for-profit plan consolidation.

In both cases, the sellers faced compounding pressures that made independence increasingly difficult. For UCare, rising medical cost trends, rate uncertainty, and the growing administrative burden of operating across multiple Medicaid programs strained their financial results. The economics of Medicaid, particularly post-redeterminations, made it harder to absorb volatility without broader balance sheet support and shared infrastructure. Similarly, while clinically innovative, CCA faced persistent margin compression driven by medical expense variability—increasing CMS and state oversight, and the capital demands of managing complex D-SNP and Medicaid populations at scale.

There are rumors of other Medicaid health plans being on the market. In all cases, value creation hinges on post-deal execution. The ability to rapidly integrate disparate data environments, normalize provider performance measurement, and execute value-based contracts consistently across fragmented state programs will determine whether scale translates into improved performance. That being said, one added consideration is increasing regulatory sensitivity; as plans grow larger, state oversight and political constraints may limit the efficiency gains typically associate with consolidation. Scale will need to be paid with local adaptability.

Prediction 3

For providers, AI adoption rapidly expands. For health plans, AI adoption shifts to governed, use-case driven deployment

In 2026, we suspect the AI adoption curve will continue to diverge between providers and health plans. In 2025, many risk-bearing providers were proactive in adopting AI to combat acute labor shortages and margin pressure. Use cases for providers included coding, scheduling, clinical documentation, and care management workflows. At the JPM Conference, AI was the buzz of town as both Anthropic (Claude) and OpenAI (ChatGPT) made timely announcements. Other platforms like OpenEvidence have focused on becoming the AI copilot for doctors. We expect AI adoption to continue to rapidly expand as providers are willing to take more risk on newer platforms.

We also expect that health plans will remain optimistic about AI's potential but will likely move cautiously. Regulatory scrutiny and internal compliance controls will constrain broad experimentation, forcing plans to prioritize narrowly defined, auditable AI use cases embedded within existing workflows. As a result, the most successful deployments will focus on quality improvement, risk identification, utilization management, and payment integrity—where AI augments decision-making rather than replaces it. The gap between AI ambition and operational readiness will persist, with progress measured less by the number of tools deployed and more by governed execution that withstands regulatory and clinical scrutiny.

Prediction 4

Regional Plans with Medicare Advantage books reset for disciplined growth in 2H'26 and 2027

Over the last few years, regional health plans have focused on rapid expansion in Medicare Advantage (MA). With many national plans opting to scale back or divest after announcing losses on their MA business units, many regional plans embraced the opportunity to increase MA membership. Unfortunately, these regional plans were met with utilization increases and v28 risk-adjustments leading to a whirlwind of challenges in 2024 and 2025. To offset these losses many regional health plans shifted their focus to other LOBs (i.e. Commercial).

In 2026, we predict that these regional health plans will focus on fundamental execution rather than rapid member expansion. Many health plans view the starting benchmark for MA profitability at >25,000 members. As this benchmark is hit, success will depend on tighter network optimization, quality and risk performance management, and disciplined bidding. The 2026 CMS Advance notice pushed these profitability thresholds even higher given flat YoY rates and ongoing risk score compression, making provider economics and data precision more determinative than membership scale alone. Plans with real-time visibility into provider-level and contract-level performance will be best positioned to restore MA as a sustainable growth engine.

Prediction 5

GLP-1s and high-cost drug management force a rethink of total cost of care strategy for Commercial Health Plans

The rapid growth of GLP-1 utilization has elevated pharmacy costs from a utilization management function. In fact, we have notably seen more plans listing GLP-1s in their top 5 highest cost drugs. In 2026, we believe these pressures will force plans to re-evaluate pharmacy coverage decisions in the context of downstream impacts on inpatient admissions, chronic disease progression, and long-term cost trajectories. Similarly, health plans will need to evaluate the correlation between GLP-1 utilization to longitudinal high-cost medical outcomes like diabetes, cardiovascular events, and avoidable utilization, while accounting for member churn and benefit switching. Given the novelty of GLP-1s, much of this data would be a form of extrapolation of correlation between medical, pharmacy, attribution, and financial data models. If performed poorly, this could result in higher costs in the short-term with questionable outcomes in the long-term.

Prediction 6

Health plans and health systems recognize providers as the key to value-based care success and will focus on developing innovative solutions that support provider enablement

Particularly in government programs, health plans and health systems must partner with providers to ensure success. Within the same geographies, each payer has a different set of needs and expectations from its providers. Research suggests that it would take a provider 27 hours per day to complete all the tasks that are asked of them(3). Coupling this with the demands of value-based care and potential technological mishaps results in very overworked providers. Key initiatives that can ease the strain include:

- Consolidating the breadth of value-based contracts into "standard" value-based contract templates can simplify risk-sharing arrangements. For example, standardizing quality metrics and risk adjustment around a few value-based models for certain provider types.
- Timely incentives, delivered monthly or quarterly, play a critical role in achieving objectives and keeping providers engaged and motivated.
- Automated provider enablement or operating committees can offer clear direction and support for providers.
- Interoperable solutions **(see prediction #8)**
- Specific AI use cases to enable providers on key focuses and improvement areas

While providers are ultimately responsible for delivering higher-quality care, health plans are creating teams to take on the responsibility for value-based success, ensuring information is presented in a user-friendly format, providers are supported, and all stakeholders are aligned. At SpectraMedix, we believe provider enablement will continue to be at the forefront of value-based care in 2026 and have augmented many of our products to better support payer/provider collaboration.

Prediction 7

Strong Performing Health Systems diversify from MSSP to look at other revenue generating

As we projected in 2025, health systems pushed for more revenue generation from MSSP. Many health systems who performed well in 2024 doubled down in MSSP and had strong financial results. The strongest results were again concentrated among physician-led ACOs and mature risk-bearing organizations operating in higher-risk tracks (SpectraMedix was glad to support two ACOs that were top 10 performers in MSSP). On the other hand, many hospital-led systems faced headwinds from benchmark volatility and regional cost pressures that diluted returns. From a policy perspective, CMS has reinforced its long-term commitment to MSSP through targeted refinements rather than structural overhaul—pushing incentives for higher-risk participation without eliminating the variability of shared savings economics.

As we look toward 2026, health systems increasingly view MSSP as table stakes and CFOs are pushing higher top-line budgets which may or may not be attainable. In order to hedge these returns, health system leaders must look at other components of their value-based portfolio, actuarial expertise, specialty care strategy, financial attribution, and other growth opportunities to continue to hit their top-line goals.

Prediction 8

Fraud, Waste, and Abuse shifts from retrospective recovery to proactive risk prevention

Recent Medicaid disruptions have highlighted the priority of having efficient Fraud, Waste, and Abuse (FWA) strategies. First and foremost, bad actors who abuse the system should be persecuted. Stealing money from the system and individuals who need it the most is unacceptable. Especially within Medicaid, where margins are tight and thousands of Americans are employed by not-for-profit health plans or safety-net hospitals. For example, recent Minnesota high-profile fraud investigations and subsequent payment pauses, enrollment freezes and audits created downstream effects for both provider networks and plan operations. This retrospective enforcement creates cash-flow disruptions for legitimate providers, access challenges for members, and reputational risk for plans operating in good faith.

California reflects a similar dynamic, but at a greater scale. Both federal and state scrutiny of Medicaid spending has elevated enforcement visibility, placing additional pressure on plans to demonstrate compliance and proactive oversight. Traditional FWA models that rely heavily on post-payment recovery risk put health plans in an untenable position between regulators demanding accountability and providers struggling to remain viable. We expect more states to be scrutinized by the federal government, so health plans must prepare for this change to ensure they meet rigorous government demands.

Prediction 9

Provider Enablement evolves into interoperability-driven performance management

Provider enablement is shifting from static, retrospective reporting toward closed-loop performance improvement—a transition accelerated by several CMS initiatives finalized or advanced in 2025. Through the **CMS Interoperability and Prior Authorization Final Rule**, CMS moved beyond aspirational data sharing and placed concrete expectations on plans to support real-time clinical decision-making—mandating faster prior authorization turnaround times, standardized APIs, and broader data exchange across payers and providers. These changes signal a clear regulatory shift.

At the same time, CMS continued to reinforce provider accountability through refinements to value-based programs, quality measurement alignment, and increased emphasis on equity and access. Collectively, these initiatives raise the bar for how plans support providers in value-based arrangements. It is no longer sufficient to deliver reports after the fact; plans must operationalize timely insights including quality gaps, risk indicators, utilization signals, and incentive mechanics directly within provider workflows. In 2026, enablement will increasingly be judged by demonstrable improvements in quality performance, reductions in avoidable utilization, and measurable decreases in administrative burden—not by the number of portals, dashboards, or tools deployed. Plans that fail to close the loop between data exchange, incentives, and action will struggle to convert regulatory compliance into value-based performance gains.

Prediction 10

CMMI's 2025 reset signals redesign and commitment to VBC

In 2025, CMMI advanced a more cohesive value-based strategy across primary, accountable, and specialty care, signaling where future models are headed. Initiatives like **Making Care Primary** shifted primary care away from upside-only incentives toward prospective, population-based payments supported by stronger care management infrastructure. Meanwhile, the launch of the **ACCESS Model** highlighted an increased emphasis on tech-enabled care in Medicare. CMMI also refined existing ACO models—prioritizing downside risk, attribution stability, and performance transparency over introducing new shared-savings constructs—indicating that sustained risk management, rather than episodic performance, will define successful accountable care participation. Finally, CMMI reset its specialty care approach through the **Transforming Episode Accountability Model (TEAM)** (set to begin in 2026) which reintroduces mandatory, episode-based accountability for high-cost service lines while placing clearer financial and quality-linked responsibility on hospitals, with a focus on improving outcomes and downstream utilization while protecting access.

Looking ahead to 2026, CMMI has made clear that future initiatives will favor models that are:

- **Operationally scalable** across geographies and provider types
- **Risk-bearing by design**, rather than optional or lightly governed
- **Data and measurement-forward**, with tighter attribution and performance timelines
- **Aligned with broader CMS priorities**, including equity, access, and total cost of care control

The net effect is not a slowdown in value-based care, but a higher bar for participation. This means that 2026 effectively becomes a readiness year in which payers and providers must prove they can manage multi-year risk and act on performance signals in near real time, while the government assess provider tolerance for sustained downside risk. Organizations that use this period to invest in measurement infrastructure, analytics, and execution discipline while preserving access and network stability will be best positioned to succeed as CMMI shifts from testing concepts to enforcing scale.