



Analysis

Hospitals Turn To Value-Based Care Amid Headwinds

By [Yeji Jesse Lee](#) · October 20, 2026, 7:24 PM EDT · [Listen to article](#)

More hospitals are starting to see the value in value-based care.

That's according to attorneys and consultants in the healthcare space, who say that as financial headwinds hit their industry, health systems are increasingly turning to doctor compensation systems that diverge from traditional models in an effort to improve their bottom lines and retain good talent.

Value-based care models, which tie payment to the quality and cost of care rather than volume of services, tend to be "non-sexy," said Nick Alarif, a partner at [McDermott Will & Schulte](#) focused on healthcare regulatory, fraud and abuse matters.

Adopting a value-based model isn't flashy like a blockbuster acquisition or a new hospital wing, and won't necessarily overhaul a balance sheet, he said. But when done right, such systems can have real meaningful impacts on overall performance and alignment with physicians.

Through these arrangements, health systems could receive performance payments or share in savings if they meet certain cost or quality goals. They could then share some of that with physicians through compensation arrangements.

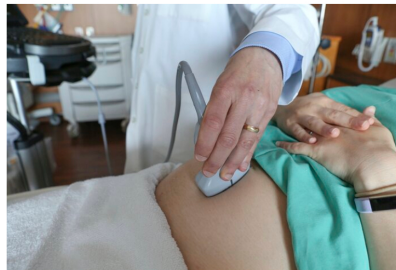
Structures can vary, and experts said that there's no one standard model for how these arrangements look. Proponents say they can help health systems' bottom lines while offering a way to incentivize physicians through compensation.

At one time, tying physician payments to the value or cost of care could have raised serious legal concerns under federal laws. But in 2021, the [Centers for Medicare and Medicaid Services](#) and the [Office of Inspector General](#) at the [U.S. Department of Health and Human Services](#) created new exceptions to the Stark Law and Anti-Kickback Statute safe harbors, effectively shifting the way that health systems could think about incorporating value-based care in their operations.

Together, these changes gave health systems more legal flexibility to incorporate value-based care models in their operations without running afoul of federal fraud and abuse laws, and encouraged them to explore solutions that went beyond traditional fee-for-service care. Instead of paying physicians based on the number of tests and services they provided patients, health systems could now structure arrangements that rewarded physicians for meeting certain quality or care goals.

Those changes were monumental because they offered more flexibility for incentivizing providers, Alarif said.

The uptake has been slow over the past few years as hospitals were still reeling from the COVID-19 pandemic and struggling with rising costs and other issues. But experts say that appears to be changing as health systems look at growing



As financial challenges pile up, health systems are adopting value-based care models, which link physician compensation to the quality and cost of care rather than volume of services. (AP Photo/Teresa Crawford, File)

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financial pressures on the horizon.

There's a "broader reckoning" happening among providers, which are facing [Medicaid cuts](#) and other challenges like the [expiration of tax credits that helped lower prices](#) for [Affordable Care Act](#) health plans, Alarif said. That's led to growing interest over the past few months in value-based care as health systems contend with these pressures, he added.

"Many are looking at these pathways as a way to do that non-sexy 'blocking and tackling' as a strategy, among others, to be ready for the next five to 10 years," Alarif said.

Jim Carr, co-founder and partner at InHealth Advisors, an advisory firm founded in 2021 that specializes in value-based care, said that five years into the new regulations, value-based care still feels like it's "in the infancy" of where it could be.

"Most people are taking a toe-in-the-water approach," he said.

But momentum is building. More federal programs are pushing health systems to adopt value-based care models, Carr said, and commercial payors will likely follow suit if they see these models are successful.

"The pressure is not going away on reimbursement," he said. "So folks are going to continue to be looking for ways to succeed in today's healthcare economic environment. I think the value-based arrangement can help them not only survive, but thrive. And so I just expect the uptake to continue to increase."

Despite the endless combination of arrangements, value-based care models are at their core meant to reward better outcomes instead of focusing on the number of services.

Carr said that one of the important shifts of the 2021 regulatory changes was in how hospitals could think about the economic value that doctors brought to them when calculating value-based payments.

Instead of structuring pay based on hours or number of services, according to Carr, health systems could now say: "If we are creating immense savings for the Medicare program, or if we're creating significantly better quality for Medicare beneficiaries, then whatever the value of that is, we can pay to the people that are performing that service."

"It kind of mirrors the economics of the rest of the world," he said.

There is also a slew of federal models pushing hospitals and other providers to adopt value-based arrangements for Medicare patients. Among them is the Transforming Episode Accountability Model, or TEAM, a five-year mandatory model launched by CMS for select hospitals focused on the cost and quality of care for certain surgical procedures.

The Comprehensive Care for Joint Replacement Expanded, or CJR-X, is another mandatory value-based care model. Scheduled to start nationwide in 2028, it holds hospitals responsible for the cost and quality of care for procedures like hip and knee replacements.

Jim [Burke](#), a partner at InHealth Advisors, said the concept of value-based care was already an "old topic" when he got into the healthcare industry decades ago.

Burke, who is also an attorney, was a principal adviser at healthcare law firm [Hall Render Killian Heath & Lyman PC](#) before joining InHealth this year. Before that, he worked in-house at several health systems.

While many systems have been slow to adopt such models and lacked the bandwidth to pay attention to the new regulations, that's shifting today, Burke said.

"They're now taking off," he said. "It is really a hot topic, and rightly so."

Christine Worthen, a healthcare attorney at [Epstein Becker Green](#), said CMS has been clear that it wants more providers in value-based care arrangements by 2030 and has pushed for more mandatory model participation to accomplish that goal.

Change is hard, but people are recognizing that traditional care delivery isn't working, Worthen said.

"I think everyone recognizes that value-based care is here, and it is a reality," she added. "I don't think that everyone's standing on the sidelines and saying that we want to just stay firmly within fee-for-service, because that's just not going to work."

Nesko Radovic, a partner at [Benesch Friedlander Coplan & Aronoff LLP](#) focused on value-based care, said that such arrangements are becoming so normalized that they're now coming up in employment agreement negotiations between physicians and hospitals, which never really happened before.

A change in attitude among doctors is also underway. Physicians used to be scared of value-based care because of its unfamiliarity, but now they're embracing it, he said.

"Now they're asking for it automatically. They know what's up, and they're always inquiring, 'What additional compensation am I going to be able to receive apart from my bonuses?'" he said.

"They already understand that the scope of their work. The scope of the job of being a physician has expanded," Radovic added. "The systems are already teaching the physicians that now we are transitioning into a total-cost-of-care environment."

InHealth's Burke said that when he was first starting out in the industry, a typical chief financial officer's response to the concept of value-based care would be an eye roll; the idea was perceived as a code word or proxy for risk without much payoff.

Now, many may still roll their eyes, but Burke said that "the typical response now is a healthy skepticism, but a willingness to listen."

"In the back of their mind, they know that there are some things happening that really are changing how we deliver care," he said. "I think the folks that are in these roles now realize that real change is happening."

But that change isn't evenly distributed, he noted. Some hospitals may have already done a dozen value-based enterprises and are looking to stand up a system-wide process and template, while others may be unfamiliar with such models altogether.

"I think we're going to end up with the haves and the have-nots," said Burke. "Folks that think about [value-based care] and do it well are going to thrive. The hospitals that won't think about it or can't implement it well are going to falter and maybe not be around."

--Editing by Alanna Weissman.

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