

AI Adoption Without Readiness

The State of Technology in Value-Based Care 2026

Findings from a national survey of payers and providers on AI adoption, data confidence, and regulatory readiness.

Research conducted by



Analysis by



Research conducted by



Executive summary

Value-based investing moved from a fringe, fringe, fringe to a given, in place. Investors and providers are signing more contracts, deploying more AIs, integrating more data, and investing in more technology. But the evidence for this year's strong gains to a widening accountability gap: the operating model behind value-based investing (VBI) has not caught up with the scale, complexity, and variety more attached to it.

Addressing this challenge is becoming more urgent as federal audits, and initiatives, including the Medicare Advantage Risk Adjustment Data Validation (RADV) program and the "All the Climates" effort, take the health care organizations' measure and behind the state that drive VBI performance.¹

Paper and provider organizations have the technology. Now, leaders need to know which investments can be effectively operationalized and evaluated to improve performance and strengthen accountability. The framework that follows shows where organizations are building readiness and where gaps between a quality, evidence, and innovation, and becoming further to figure.

1

Value-based contracting is growing faster than the operating model needed to support it.

2021 contract volume is growing 3.6 times faster than capacity to run them; paper-reported contract growth over 2019 report increased year-over-year from 10% to paper-reported to 2021 full-time 15.5% to 27.5%.

2

Investors and providers have the technology, but not the readiness to realize the value.

80% of providers report having the right data infrastructure, yet 60% say current processes still limit what that data flows.

3

Investors and providers are integrating and securing data they need fully now.

Health security has displaced data privacy as the top healthcare priority.

4

An age is widening, but readiness to flow it's growing to run.

Health organizations are not getting 100% of the data they need to make value-based care an operational output.

5

Regulatory pressure is accelerating technology investment, and most organizations are not prepared.

Health technology investment 100% of providers' health technology is still, however, the need for 2021 RADV audits will directly affect any serious health, VBI readiness.

About the State of Technology in Value-Based Care Series

This issue of *Technology in Value-Based Care* (TVBC) is an annual report series commissioned by Deloitte, with independent analysis by McKinsey, to track how payers and provider organizations use and govern technology across risk adjustment, quality improvement, data management, and workflows enabled by artificial intelligence (AI). Findings are based on national surveys conducted by The Harris Poll. The survey authors should be well-aligned on the importance of technology in the long game for execution that transformative could progress.² This most report builds on that baseline to show where organizational progress has improved, where it has deteriorated, and where new risks have emerged.

Table:



CONSTRUCTIVE CAPACITY

Value-based contracting is growing faster than the operating model needed to support it.

McKinsey's latest value-based care (VBC) contracting research shows heading into 2024, every payer surveyed reported growth in VBC contracts over the past 12 months, and 59% expect continued growth in the year ahead (including 35% who anticipate significant expansion). Providers reported similar momentum: VBC experienced contract growth up from 55% in the 2023 survey.

As contract volume increased, however, some indicators point to execution as the next challenge. The average share of payer business that is VBC declined to 55.4% to 47.1%, suggesting that growth in contract volume is not necessarily translating into a larger share of business. Organizations may be finding it harder to expand VBC contracting than to build the operating model required to support that growth. Alignment also increased, and the decline was more restricted on the provider side: Most payers (59%, versus 55% in 2023) continued to report strong alignment with providers on VBC goals, while provider agreement fell from 60% to 54% in 2023 to 49% in 2024.

In the months ahead, the success of VBC will depend on whether payers and providers can align incentives, technology, data, and accountability well enough to turn contract expansion into lower costs, better care quality and improved patient outcomes.

Figure 1: These agencies started to share their content with knowledge organizations, agencies and content rights as strategic assets



"Organizations bought the tools they thought value-based care required. Now they're learning that creating the car isn't the same as knowing how to drive it, especially as the rules of the road keep changing. As capabilities, regulatory expectations, and implementation standards are evolving at the same time. This can create misalignment among payers, providers, and technology vendors working from the same playbook."

— Roger Blumenthal, Director of Information Systems at the Institute of Medicine



TRENDS



The top two most useful trends

Payers and providers have the technology, but not the workflows to realize its value.

Nearly all (98%) providers report having the right technology infrastructure in place to support VBC, but 93% say their workflows are hampered by inefficient care paths. VBC in 2024. Reports of manual processes hampering VBC workflows also increased by 14 percentage points. Payers report the same struggle with VBC, calling their platforms less complex (against 70% in 2023) and VBC-enabling manual processes still dominate their VBC workflows.

Types of transformation barriers: The technology is in place, but workflows are inefficient

Measures reducing infrastructure vs. coding



Payers and providers have infrastructure in place. Organizations have invested in the tools, but many still rely on manual workflows to make digital tools function as they do. As patient volume grows, things become harder to absorb. Furthermore, contractors like data quality measures, and risk adjustment requirements. If these workflows remain manual, the burden falls back on staff instead of being automated by the systems deployed to handle it.

The deeper barrier is that leaders automate only the workflows they trust, and trust depends on their governance and collaboration.

Organizations facing the gap are realizing the investment from platforms enabling shared information, digital care plans, coordination, and the government's structure that makes scaling deployments perform.²

Trust



Trust score of 3 out of 5

Payers and providers are integrating and securing data they cannot fully trust.

Organizations have made meaningful progress on data integration. One hundred percent of payers and 99% of providers plan to invest in data management over the next 12 months, and 98% rate their current ability to integrate data across systems as good or excellent. Leaders rate number one whether the data moving across systems is accurate, complete, timely, and defensible. The confidence rate about the capability data quality remains the most cited integration barrier, and how organizations can produce the documentation as well requires

VBC depends on the data quality when action is still possible. Real time data exchange means identify risks, close gaps, and intervene effectively. Delayed or incomplete data may mean missed intervention opportunities. Nearly all payers affirmed that real time data are critical for practice care management. But only 49% of payers named real time data access as a top investment priority, creating 49 percentage point gap between what leaders affirm as critical and what they plan to invest in.

Data quality remains the top cited integration challenge for providers (98%) and payers (98%), but it's being treated more proactively as security takes more attention. Technological compatibility (98% of providers, 99% of payers) and data security concerns (99% and 98%) rank as the next most cited integration barriers. The security threat behind the data is well documented in 2021, with ransomware attacks affecting more than 1,000 million people, the highest annual breach count on record.¹ Security investments, however, does not eliminate the need for data quality. From that data must affirm a secure enough guidance and defensible enough to afford action.

Figure 1: The 49 percentage point data quality gap must be closed as top priority item.



Figure 1. Hospital admission rates per 100,000 people, 2019 vs 2020



Data security reveals the financial consequences, especially as health spending increases through expanded trials, adjustment, data validation (DfV) stages. Data that does not reflect clinical reality yields diagnoses that tell the wrong story, reduce patient health adjustment factor scores and quality indicators, shift the focus of care, and risk data that also changed as security provisions further for providers, increasing physicians' stress. DfV Organizations using prior solutions without consolidating data governance increase their exposure to both data security and privacy.

"Interoperability is huge. If systems do not talk to each other, we end up repeating tests and doing downstream, which frustrates patients."

—Health care worker, clinical program operations

Trends



AI Confidence & Adoption Trust

All use is widespread, but confidence in how it's governed is not.

Thoughtful organizations concerned over using AI broader use has not translated into stronger confidence or commitment. In 2024, 48% of providers and 68% of papers claimed their organizations as fully committed to AI adoption. By 2026, those numbers dropped 40 percentage points to 8% for providers and 17 points to 2% for papers.

At the same time, concerns about AI failures have increased among providers, the overarching fear of failures has increased AI adoption rose from 71% to 68% among papers, down from 71% to 68%.

Papers (68%) and even more providers (88%) are concerned about AI decisions made without adequate human oversight, and only 15% of all organizations have implemented process for determining when AI problems will be correct output. The discipline must be a company objective is meeting the other way. The share of organizations providing at least moderate AI training fell from 68% to 42% among papers and from 74% to 48% among providers, even as use integrated AI.

Figure 1: Thoughtful concerns that confidence in the future, 2024 vs. 2026



*Source: McKinsey, 2024

Figure 4.4. Strongly agree or somewhat agree with the following statements, by role and year since your organization

Adopting coverage, 2016



Physicians' adoption is a concern across papers and providers. Providers report lower confidence in AI's positive impact on cost reduction and patient outcomes compared with 2016. Paper adoption ratings held steady, possibly because paper was most used to document structural data (for functions where outputs are consistent text, audio, and/or images). Provider use cases are closer to clinical and patient-facing workflows, where oversight, training, and trust are more of a greater consequence.

Vendor trust is also part of the governance challenge. Third-party AI vendors are more confident than VBC users with 88% of papers and 78% of providers relying on them in 2016. Organizations that assembled multi-vendor AI portfolios during the adoption surge of 2016 have more difficulty the integration involved those tools generate, measure its reimbursement hours, complete a vendor-triplet offer, and demonstrate paper that surface vendor with the same data source in a confidence crisis. In assessing adoption in 2016, 41% of organizations agree vendors have demonstrated their ability to support VBC performance, and few are confident any single vendor's outputs could withstand scrutiny. The question is different from which vendor reflects the most features to reflect vendor's output as organizations willing to shed institutional walls.

"When combined effectively, analytics, care coordination, interoperability, and engagement technologies create comprehensive digital infrastructure that supports sustainable value-based care success."

—Jeff Wilkerson, Technology, Regis

Figure 7: Scores on mandatory disclosure



Figure 8: High and medium scores across pages and disclosures



Pages rationalising assets portfolios are applying risk management of business performance criteria. Integration steps include: resource allocation, workflow and close the documentation gaps that produce audit findings. Process accuracy reduces the probability that all ending outputs require manual correction under audit review. Regulatory alignment reduces the exposure associated with under all outputs, with the exception of non documentation. Civil experts during other flow audit cycle.

Trends



REGULATORY PRESSURE

Regulatory pressure is accelerating technology investment, and most organizations are not prepared.

Regulatory pressure is raising the bar for VBC technology. CIMA announced in May 2021 that it would audit all eligible health and life savings organizations annually on a quarterly cadence.¹ Payment for CIMA RAMP audits began in February 2022 at rates approximately 50% over costs.² The agency's authority to require unregulated overpayments is essential if it is to play a role in the financial health of VBCs, though many expect unregulated overpayments to return to some form.³ Disruption that cannot be supported by revenue creates financial exposure.

Such pressure forces, directly or indirectly, organizations to adjust. Though our RAMP report shows that equality of effort rule adjustments and quality adjustments, those adjustments make documentation harder to write. Disruptive without human review or contemporaneous documentation erodes some abilities. Harder tools that cannot explain, validate, or reproduce outputs may fail when organizations must meet defensibility.

CIMA also pushing more organizations into value-based payments, raising the operational and documentation stakes at every stage of VBC maturity. The Medicare Shared Savings Program (MSSP) covered 14 Medicare benefit plans in January 2022, and continues to grow. CIMA has signaled its intention to use a model-based, value-based model, across Medicare advantage, Medicaid managed care, and commercial programs.⁴

Some of the upcoming regulatory models raise the technology stakes directly: the MSSP model, for example, requires participating providers to adopt a digital tool for technology validation, an obligation that weighs heavily on those least prepared to adopt.⁵

Payors and providers feel the pressure differently. Providers report more impacts with RAMP, rating it significant or transformative versus 62% of payors. And nearly all of both groups (98% of providers, 93% of payors) report at least moderate impact. Preparedness rates the other way: Only 13% of payors rate themselves as well prepared for current CIMA policy, against 21% of providers. For many organizations, CIMA policy means VBC readiness from a strategic choice into a compliance obligation.⁶

Figure 1: RAMP preparation of surveyed payors vs. providers, 2021

13%

Payors consider themselves well prepared for current CIMA policy (13% of providers)

62%

Payors consider themselves well prepared for current CIMA policy (62% of providers)

21%

Providers consider themselves well prepared for current CIMA policy (21% of providers)

These organizations govern their AI will increasingly shape their self-pictures. Organizations that document how AI outputs are generated, reviewed, corrected, and validated will be better positioned to address their liabilities. Those that accept those outputs have to clinical outcomes, coding rules, or medical record documentation may have a different view. The fact, when validation is more costly and time-consuming.

Closing the gap to deliver the readiness before an audit requires substantially less than addressing documentation before an audit. CHS has identified them.¹

Conclusion

The two trends share a common thread. Papers and positions have focused on technology, AI, and data faster than in the government that would make those investments acceptable. Many organizations, particularly data quality, want to find new regulatory framework using practices for unregulated, and selected vendors for their features rather than for whether the work could later be traced and verified with such scrutiny, the gap widened between the technology an organization has deployed and the work it can substantiate under audit.

Substantiability is the ability to produce the evidence needed to AI-generated output where a regulatory activity is. In that measure, most organizations are exposed. Just 11% of papers and 15% of positions show the themselves as well prepared for current CHS policy, though nearly all reported that recent regulation has materially affected their operations. The organizations best positioned (with government's history) before an audit focused the question. For every question, this year, almost all have whether the technology already is, placed into evidence and the resulting work arising with it.

"It's ideal if it's like where data analysis and patient trials actually work together, the whole process just falls in. Doctors can catch issues earlier, patients stay more focused and are happier overall. In the end, everything runs more efficiently and even costs money."

—George Wilkins, Director

About



McKinsey has conducted this research to provide health plan and provider organizations with independent, evidence-based insight into technology investment, AI governance, and regulatory preparedness are shaping value-based care performance. McKinsey's value-based care enrollment survey is that which national clinical intelligence, risk adjustment, quality improvement, and member management teams use as performance metrics. For more information, visit mckinsey.com.



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Survey research for this report was conducted by The Harris Poll, a global public opinion, analysis, and market research firm that has tracked public sentiment, motivations, and social trends since WWII. Mathematica is a frequent company. For more information, visit harrispoll.com.

Methodology

The Harris Poll conducted this research online among U.S.-based senior decision makers at insurance and care organizations between March 2 and 13, 2020. The sample comprised 1,000 insurance and care organizations. Respondents held director-level or above. Respondents used original Randomized Interval call-ups at 95% confidence for the full sample. All year-over-year comparisons reference the 2019 edition of the same survey instrument at the 95% confidence level. Analysis was conducted by Mathematica using a random forest model without direction from the sponsoring organization. All survey statistics in this report are drawn from The Harris Poll, "Healthcare Technology & Value: Research and Risk Survey Results" as of 2020, fielded March 2 to 13. All data analysis by Mathematica.¹⁻⁴

