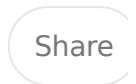
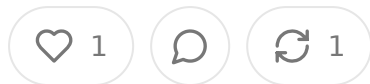


Beyond Value-Based Care: Empowering Healthcare's Inherent Goodwill

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The debate over healthcare payment models has dominated policy discussions for decades, with value-based care (VBC) positioned as the remedy to our fragmented and costly system. The prevailing narrative suggests that shifting financial incentives from volume to outcomes will fundamentally transform healthcare delivery. Yet what premise misunderstands healthcare's fundamental nature? What if the solution doesn't lie in restructuring payment systems but in empowering the intrinsic motivation that already exists among healthcare professionals?

The recently published Avalere Health analysis for the Healthcare Leadership Council offers an illuminating window into this question. After examining 18 models tested by the Center for Medicare and Medicaid Innovation (CMMI), the data reveals a striking pattern: despite billions invested, these payment innovations have yielded mixed results at best. This should prompt us to reconsider our assumptions about what truly drives healthcare improvement.

Healthcare providers overwhelmingly enter their professions with profound commitments to healing, not profit maximization. The notion that physicians, nurses, and other clinicians require financial engineering to deliver optimal care fundamentally misunderstands the professional ethos that guides medical practice. While payment reforms might reshape organizational behavior at the margins, they cannot substitute for the deeply personal commitment to excellence that characterizes healthcare at its best.

Rather than continuing down the path of increasingly complex payment models, we should redirect our innovation energy toward technologies and business models

enhance practitioners' existing capabilities. Today's entrepreneurs have unprecedented opportunities to develop solutions that work within—rather than attempt to replace—our current systems while dramatically improving outcomes, efficiency, and patient experiences.

This essay explores how entrepreneurs can leverage technological innovation to unlock healthcare's inherent value, not by replacing fee-for-service models but by making them work better for everyone involved. By augmenting rather than restructuring, we can achieve the quality and cost goals that have proven elusive through payment reform alone.

The Revelation in CMMI's Mixed Results

The Avalere Health analysis commissioned by the Healthcare Leadership Council reveals that after examining 18 CMMI models across their financial impacts, effect on care quality, and transparency in design and implementation, the results are decidedly mixed. Of these models, one-third generated substantial savings, one-third produced substantial losses, and one-third had nominal financial impacts. More tellingly, only four models demonstrated clear quality improvements, with the remainder showing nominal improvements, no impact, or mixed results.

These findings echo the Congressional Budget Office's 2023 assessment that CMMI activities have increased direct federal spending by \$5.4 billion between 2011 and 2020. The agency's efforts to transform healthcare delivery through payment innovation have not consistently delivered their promised value—either in cost reduction or quality improvement.

What makes these findings particularly significant is that they represent the most sophisticated, well-funded attempts to engineer better healthcare outcomes through payment reform. CMMI was established with extraordinary authority and resources to test new payment approaches outside the constraints of budget neutrality. Its mixed track record suggests fundamental limitations in the approach itself, not merely implementation challenges.

Consider the experience of the Medicare Advantage Value-Based Insurance Design (MA VBID) model. Despite improving beneficiary access to reduced cost-sharing supplemental benefits like medical transportation and grocery assistance, it generated \$4.5 billion in net losses for CMS. The improvements in quality were real but came at an unsustainable cost, leading CMMI to terminate the model five years early.

Similarly, the Primary Care First model, intended to strengthen primary care delivery, has thus far generated \$846.9 million in net losses. Even the Oncology Care Model, focused on cancer care improvements, resulted in \$639 million in net losses despite modest decreases in emergency department visits leading to inpatient stays.

These examples illustrate a critical insight: even well-designed payment innovations often fail to generate their intended systemic effects. The difficulty in calibrating financial incentives to produce consistent improvements across diverse practice settings suggests we may be focusing on the wrong lever for change.

The Healthcare Professional's True Motivation

Healthcare professionals overwhelmingly enter their fields driven by a desire to help, to serve, and to make a difference in patients' lives. This intrinsic motivation forms the foundation of medical practice and has sustained the profession through centuries of scientific advancement and organizational change.

Dr. Rachel Naomi Remen, clinical professor at UCSF School of Medicine, captured this ethos: "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet." Healthcare professionals don't merely perform technical tasks; they participate in healing relationships that engage their full humanity.

This commitment to patient wellbeing manifests even in settings with misaligned financial incentives. Physicians regularly make decisions that financially disadvantage their practices because they believe those choices serve their patients' best interests. They stay late to console grieving families, spend extra time researching treatments,

options, and advocate for patients navigating complex systems—none of which are adequately compensated in fee-for-service models.

Research in behavioral economics and psychology consistently shows that financial incentives often fail to improve performance on complex cognitive tasks requiring creativity and judgment—precisely the kind of work healthcare demands. In some cases, external incentives can actually reduce intrinsic motivation, a phenomenon known as the "crowding out" effect.

Daniel Pink, in his book "Drive," synthesizes decades of motivation research with a straightforward conclusion: "The best use of money as a motivator is to pay people enough to take the issue of money off the table." Beyond that threshold, what drives performance is autonomy, mastery, and purpose—all factors deeply embedded in healthcare's professional culture.

This isn't to suggest that financial considerations are irrelevant. Healthcare organizations must remain financially viable, and practitioners deserve fair compensation for their expertise and dedication. But the notion that practitioners only deliver optimal care when financially incentivized to do so fundamentally misunderstands what drives clinical excellence.

The Avalere analysis indirectly supports this understanding. If payment reform were truly the key driver of improved care, we would expect to see consistent patterns of quality improvement across CMMI models. Instead, we see varied and often mixed impacts, suggesting that other factors—including providers' existing commitment to excellence—play a more significant role in determining care quality.

The Hidden Costs of Value-Based Payment Systems

While value-based care models aim to align financial incentives with patient outcomes, their implementation often creates unintended consequences that can actually impede care quality. These hidden costs deserve serious consideration as we evaluate healthcare innovation strategies.

Administrative complexity represents perhaps the most significant hidden cost. The new payment model introduces unique quality metrics, reporting requirements, financial arrangements that providers must track, interpret, and operationalize. Complexity doesn't just consume resources—it diverts attention from patient care.

The Avalere report notes that operational costs for implementing and evaluating 18 CMMI models totaled \$1.3 billion. These costs represent just the government administrative expenses, not the substantial compliance costs borne by participating providers. Each model requires dedicated staff time for documentation, reporting, and adapting workflows to new incentive structures—all resources that might otherwise support direct patient care.

Beyond administrative burden, constant payment model changes create planning uncertainty that discourages long-term investments in care improvement. As the report observes, "Under different administrations, CMMI evolved its priorities and frequently amended model activities," creating an unstable environment for healthcare organizations trying to make strategic decisions.

Consider the difficulty providers face when attempting to invest in care coordination infrastructure that might become obsolete with the next payment model iteration. This uncertainty creates a "wait and see" approach that slows the adoption of beneficial innovations.

Value-based models can also inadvertently exacerbate healthcare disparities through risk adjustment mechanisms that often inadequately account for social determinants of health. Providers serving disadvantaged populations may find themselves financially penalized for circumstances beyond their control, creating disincentives to care for the most vulnerable patients.

The Avalere analysis found mixed results in addressing outcomes based on patient demographics across the 14 CMMI models that had relevant objectives. Only two models demonstrated clear improvement in patient demographic objectives, with others showing nominal improvement, mixed results, or no significant change.

Perhaps most concerning is the potential for value-based models to erode the professional autonomy and intrinsic motivation that drive clinical excellence. When every decision becomes framed through financial incentives, the patient-provider relationship can become instrumentalized, shifting focus from individualized care to metric optimization.

As one physician quoted in a 2023 JAMA study on clinician burnout explained: "I didn't go to medical school to check boxes. I went to help people. But now, I spend more time documenting that I provided good care than actually providing it." This sentiment captures the fundamental tension between metric-driven payment systems and the professional ethos that animates healthcare at its best.

Technology as the True Catalyst for Healthcare Transformation

If payment reform alone cannot transform healthcare delivery, what can? The answer increasingly lies in technologies that enhance providers' existing capabilities rather than attempting to reshape their motivations. These technologies can work with current payment structures while dramatically improving outcomes, efficiency, and patient experiences.

Artificial intelligence and machine learning offer perhaps the most transformative potential. These technologies can analyze vast datasets to identify patterns invisible to human observation, supporting clinical decision-making without replacing physician judgment. They can predict which patients are likely to deteriorate, recommend evidence-based interventions, and continuously learn from outcomes to improve future recommendations.

Consider how Jvion, a healthcare AI company, uses machine learning to identify patients at risk for preventable harm events. Their system analyzes thousands of clinical, social, and behavioral variables to predict adverse outcomes and recommend personalized interventions—all without requiring payment reform to generate value. Hospitals using this technology have reported 30% reductions in preventable harm events and significant decreases in readmissions.

Remote patient monitoring technologies similarly extend providers' capabilities working within existing payment structures. Devices that continuously track vital signs, activity levels, medication adherence, and other health indicators allow clinicians to intervene before deterioration requires costly emergency care. Companies like Biofourmis and Vivify Health have developed platforms that not only collect patient data but intelligently analyze trends to predict exacerbations of chronic conditions.

A 2024 study published in JAMA Network Open found that patients with congestive heart failure monitored through such platforms experienced 39% fewer hospitalizations than comparable patients receiving traditional care—all without changing the underlying payment model. The technology simply enhanced providers' ability to deliver proactive care within existing structures.

Data integration and interoperability solutions address another critical healthcare challenge that payment reform alone cannot solve. When patient information flows seamlessly across care settings, providers can make better-informed decisions regardless of financial incentives. Companies like Health Gorilla and Particle Health have created FHIR-based APIs that enable secure data exchange across previously siloed systems.

As one physician using Health Gorilla's platform explained: "Having complete medication lists and prior diagnoses at my fingertips doesn't just save time—it fundamentally improves the quality of my assessments and recommendations. No payment incentive could substitute for having the right information at the right time."

Patient engagement technologies represent another innovation category that enables care delivery without requiring payment reform. Digital platforms that educate, remind, and connect patients with providers between visits extend the therapeutic relationship beyond episodic encounters. Companies like Xealth and Welldoc have created solutions that allow clinicians to "prescribe" digital health tools tailored to individual patient needs.

Operational efficiency technologies perhaps best exemplify how innovation can work within existing systems to improve value. Automated scheduling, intake, documentation, and billing processes reduce administrative overhead, allowing providers to focus more attention on patient care. Companies like Notable Health and Olive AI use robotic process automation and natural language processing to automate routine administrative tasks, recapturing time for meaningful patient interaction.

What distinguishes these technological approaches from payment reform is their direct enhancement of clinical capabilities rather than attempts to reshape provider motivations. They assume—correctly—that healthcare professionals already want to deliver excellent care and focus on removing the barriers that impede that natural inclination.

Entrepreneurial Opportunities to Augment—Not Replace—Fee-for-Service

The mixed results of value-based care initiatives create remarkable opportunities for entrepreneurs who understand how to enhance rather than replace existing payment systems. By focusing on solutions that work within fee-for-service frameworks while addressing its known limitations, innovators can deliver immediate value without waiting for system-wide payment reform.

The first major opportunity area lies in technology that reduces administrative friction while preserving or enhancing reimbursement. Administrative costs constitute between 15-30% of healthcare spending, according to various estimates. Solutions that streamline documentation, coding, and billing processes can simultaneously reduce overhead and improve revenue capture.

Consider companies like Fathom, which uses AI to automate medical coding based on provider documentation. Their technology ensures accurate coding that maximizes appropriate reimbursement while reducing the administrative burden on clinicians. This approach doesn't require changing how providers are paid—it simply makes the existing system work more efficiently.

Similarly, entrepreneurs are finding success with solutions that support appropriate risk adjustment in fee-for-service models. Companies like Clarify Health and Apptify use machine learning to identify undocumented conditions and ensure that providers receive fair compensation for caring for complex patients. These technologies help address a key criticism of fee-for-service—that it inadequately accounts for patient complexity—without requiring wholesale payment reform.

Another rich opportunity area involves technologies that enable service expansion within existing reimbursement frameworks. Telehealth platforms that extend specialist access to underserved areas, remote monitoring systems that qualify for RPM billing codes, and digital therapeutics that complement reimbursable services all represent ways to deliver more comprehensive care while maintaining fee-for-service viability.

Consider how Omada Health initially positioned its digital diabetes prevention program. Rather than advocating for new payment models, they worked within existing structures by demonstrating how their solution could reduce costly complications reimbursed under fee-for-service. This approach allowed them to build a viable business while payment policies gradually evolved to better support digital interventions.

Some entrepreneurs are developing "hybrid" models that combine fee-for-service with targeted value components. These approaches maintain the predictability of fee-for-service while addressing specific quality concerns. Companies like Pearl Health provide technology that helps primary care physicians manage referrals and ED utilization within fee-for-service arrangements, creating shared savings opportunities without full-risk contracts.

Perhaps the most promising entrepreneurial approach involves technologies that enhance clinical decision-making at the point of care. These solutions recognize that providers want to deliver optimal care but often lack real-time access to comprehensive data and evidence-based guidelines. Companies like Aidoc and Veeva use AI to analyze imaging studies and highlight potential findings, helping

radiologists and emergency physicians deliver more accurate interpretations without changing how they're paid.

The Avalere report offers valuable guidance for entrepreneurs navigating these opportunities. Its finding that state and community-based models generated \$2.1 billion in net savings suggests potential for solutions tailored to specific regional needs rather than one-size-fits-all approaches. Additionally, the report's observation that several models achieved utilization reductions (particularly ED visits and hospitalizations) indicates market demand for technologies that help providers identify and intervene with high-risk patients.

Real-World Case Studies: Building Value Within Existing Systems

Entrepreneurs who understand how to enhance healthcare value without requiring payment reform are already building successful businesses. Their experiences offer valuable insights for innovators looking to make a meaningful impact while working within existing constraints.

Consider Stellar Health, founded in 2018 with a provocative premise: quality improvement doesn't require complex payment reform, just clearer guidance and modest incentives for completing specific evidence-based actions. Their platform integrates with EHRs to identify gaps in recommended care and provides micro-incentives to clinicians and staff for closing those gaps.

Critically, Stellar works alongside fee-for-service reimbursement rather than replacing it. The company's CEO, Michael Meng, explains: "We're not asking providers to fundamentally change how they're paid. We're simply making it easier for them to deliver the care they already want to provide and recognizing them for what they do."

This approach has yielded impressive results. A 2023 study found that primary care practices using Stellar's platform increased annual wellness visits by 22% and improved diabetic eye exam completion rates by 18% compared to non-participating

practices. These improvements came not through payment reform but by enhancing providers' awareness of care gaps and supporting workflow optimization.

Another instructive example comes from Agilon Health, which partners with primary care physicians to improve care coordination and quality without requiring them to abandon fee-for-service. Rather than imposing full-risk payment models, Agilon provides technology, analytics, and operational support that enables practices to deliver more comprehensive care while maintaining their existing payment arrangements.

As Agilon's founder, Ron Kuerbitz, notes: "Most primary care physicians want to provide comprehensive, coordinated care for their patients. The barrier isn't the willingness—it's having the tools, data, and support to do so effectively within their practices." By providing those enablers rather than focusing on payment restructuring, Agilon has grown to support over 2,500 physicians caring for more than 600,000 patients across multiple states.

Dispatch Health offers another compelling example of enhancing rather than replacing fee-for-service models. The company provides urgent care services in patients' homes, treating conditions that would otherwise require emergency department visits. Rather than creating new payment models, Dispatch bills standard fee-for-service codes for the care they provide while demonstrating value through reduced total cost of care.

This approach has proven remarkably effective. A peer-reviewed study published in the *American Journal of Accountable Care* found that Dispatch Health's model reduced costs by an average of \$1,800 per patient episode compared to similar conditions treated in emergency departments—all while working within traditional reimbursement structures.

Perhaps most instructive is the experience of Oak Street Health, which has built a thriving primary care model for Medicare beneficiaries. While the company participates in some value-based arrangements, its success stems primarily from optimizing care delivery within existing payment frameworks. By focusing inten-

on accessibility, preventive services, and chronic disease management, Oak Street demonstrates how better care organization—not payment reform—drives improved outcomes.

Oak Street's model yields 51% reductions in hospital admissions and 42% reduction in 30-day readmissions compared to regional averages. These improvements come through novel payment approaches but through technological and operational innovations that enhance providers' ability to deliver comprehensive care.

These case studies illustrate a powerful truth: healthcare innovators can drive meaningful improvements by working with, rather than against, existing payment structures. By focusing on enhancing provider capabilities rather than restructuring financial incentives, these companies have achieved what many payment reforms not—better outcomes at lower total costs.

Reimagining Quality Measurement for Entrepreneurial Success

The Avalere analysis highlights a critical issue in value-based care implementation: quality measurement remains challenging, inconsistent, and often disconnected from patients' priorities. This challenge creates opportunities for entrepreneurs who develop more meaningful, actionable approaches to measuring and improving care quality.

Traditional quality metrics often fail to capture what matters most to patients and providers. They tend to focus on processes (did the patient receive a particular treatment) rather than outcomes (did the patient's health improve?), and rarely account for patients' individual goals and preferences. This misalignment explains why many CMMI models showed mixed results on quality measures despite substantial investments.

Forward-thinking entrepreneurs are developing technologies that measure quality differently—focusing on patient-reported outcomes, functional status, and quality of life. Companies like Outcomes Based Electronic Research Database (OBERD) and

PatientIQ have created platforms that efficiently collect patient-reported outcomes measures and integrate them into clinical workflows, enabling providers to track meaningful improvements without burdensome documentation.

These solutions work within fee-for-service environments by making quality improvement simpler and more aligned with clinicians' intrinsic motivation to help patients. As one orthopedic surgeon using OBERD explained: "Seeing my patient functional improvement scores gives me much more meaningful feedback than checking boxes for quality programs. It reminds me why I went into medicine."

Another entrepreneurial approach involves technologies that provide real-time clinical insights during patient encounters. Rather than retrospective reports that arrive months after care delivery, these solutions guide clinical decisions when interventions can still make a difference. Companies like Navina and Abridge use AI to analyze patient information during visits and highlight potential quality gaps and evidence-based recommendations.

The Avalere report found that models showed success in "reducing utilization" for ED visits and hospitalizations but had "mixed results or no impact" on many traditional quality measures. This suggests opportunity for technologies that help providers identify and address the underlying drivers of avoidable utilization while working within fee-for-service arrangements.

Companies like Prealize Health and Jvion are seizing this opportunity by developing predictive analytics that identify patients at risk for preventable hospitalizations. Their technologies don't require payment reform to generate value—they simply provide providers actionable insights that enable more targeted interventions within existing payment structures.

Quality measurement approaches that account for social determinants of health represent another entrepreneurial frontier. The Avalere report noted that only two CMMI models demonstrated clear improvement in patient demographic objectives, highlighting the difficulty of addressing health disparities through payment reform alone.

Companies like UniteUs and NowPow are addressing this gap by creating platforms that connect clinical care with community resources addressing social needs. These solutions don't require new payment models—they simply make it easier for providers to deliver more holistic care by connecting patients with resources that address housing, food insecurity, transportation, and other social factors affecting health outcomes.

Perhaps most promising are entrepreneurial approaches that make quality improvement intrinsically rewarding for clinicians. Rather than administratively burdensome reporting requirements, these solutions provide meaningful feedback that enhances professional satisfaction. Companies like Embold Health and Qualtrics provide clinicians with intuitive dashboards showing how their care patterns compare to peers and evidence-based guidelines, tapping into professionals' natural desire for mastery and improvement.

Leveraging Technology to Address the Transparency Gap

The Avalere analysis identified another critical shortcoming in CMMI's approach: limited transparency and public input during model design and implementation. Of the 18 models analyzed, only half solicited comments on model development or refinement, and just one held a public listening session. This lack of stakeholder engagement likely contributed to models' mixed results and challenges in implementation.

Innovative entrepreneurs can address this transparency gap by developing technologies that facilitate better communication, feedback, and collaboration among healthcare stakeholders. These solutions can create value within existing payment structures by ensuring that quality initiatives align with the real-world constraints and priorities of patients, providers, and payers.

Platforms that enable more efficient stakeholder engagement in program design represent one promising approach. Companies like Qventus have created digital collaboration tools that facilitate rapid feedback cycles during healthcare

improvement initiatives. Rather than annual comment periods or occasional list sessions, these technologies enable continuous dialogue that helps organizations refine interventions based on front-line experience.

As Qventus founder Mudit Garg explains: "The people closest to care delivery—clinicians, staff, and patients—have invaluable insights about what works and what doesn't. Our platform makes it easy to capture those insights and use them to improve programs in real-time, rather than waiting for formal evaluation results months or years later."

Another entrepreneurial opportunity involves technologies that enhance transparency around outcomes and costs. The Avalere report found that only four of the 18 CMMI models published participant-level financial performance results, and only seven published quality performance results. This opacity makes it difficult for providers to understand what drives success in these programs and for patients to make informed choices about where to seek care.

Companies like Turquoise Health and Healthcare Bluebook are addressing this transparency gap by making cost and quality information more accessible to providers and patients alike. Their platforms don't require payment reform—they simply make existing systems more transparent, enabling market forces to drive improvement in value.

Technologies that improve patient understanding of healthcare decisions represent another important transparency innovation. Companies like Abridge and Upfront Healthcare have developed solutions that help patients better comprehend their conditions, treatment options, and care plans. By fostering more informed shared decision-making, these technologies can improve care alignment with patient preferences without requiring payment reform.

The Avalere report's finding that "no model received an endorsement from the Physician-Focused Payment Model Technical Advisory Committee" suggests a disconnect between CMMI initiatives and physician perspectives. This creates

opportunity for technologies that better incorporate clinician input into quality improvement efforts.

Companies like Clinician Experience Project and Martti have developed platforms that capture and amplify clinician voices in healthcare improvement initiatives. Ensuring that quality efforts align with front-line realities, these solutions can enhance program effectiveness without requiring complex payment changes.

Building for Healthcare's Future While Working in Today's Reality

The healthcare landscape will continue to evolve, with payment models likely becoming more sophisticated over time. However, the mixed results of CMMI's experiments suggest that waiting for payment reform to drive transformation may mean missing immediate opportunities to improve care. Successful healthcare entrepreneurs must therefore develop solutions that create value in today's predominant fee-for-service environment while positioning themselves for future payment evolutions.

This dual focus—improving current systems while preparing for future ones—requires particular strategic clarity. Companies must identify specific pain points within existing payment structures that their technologies can address while building capabilities that will remain valuable as payment models evolve.

Consider how Clarify Health has executed this strategy. Their analytics platform helps providers understand variation in care patterns and outcomes within fee-for-service environments, enabling improvement without payment reform. Simultaneously, the company has developed capabilities to support risk contract management, positioning them for value as payment models evolve.

Similarly, Transcarent has built a navigation platform that helps patients make better healthcare decisions regardless of payment model. Their solution creates immediate value by reducing unnecessary utilization and steering patients toward high-value

providers. As payment models increasingly reward outcomes, Transcarent's ability to influence care pathways becomes even more valuable.

The Avalere report offers guidance for entrepreneurs pursuing this dual strategy, finding that "the potential cost savings from elements of these models being adopted into permanent programs such as the MSSP or influencing spillover effects such as greater adoption of value-based care in the private sector were beyond the scope of this analysis" highlights how innovations originally developed for specific models can find broader application.

Entrepreneurs should therefore design solutions with modularity that allows components to be adapted across different payment environments. Technologies that improve care coordination, for example, create value in fee-for-service through increased efficiency and in value-based models through reduced complications and hospital readmissions.

The report's observation that "changes in administration have coincided with changes in model design" underscores the importance of building solutions that don't depend on specific policy frameworks. Technologies that enhance intrinsic elements of healthcare delivery—clinical decision-making, patient engagement, care coordination—remain valuable regardless of payment model fluctuations.

Perhaps most importantly, entrepreneurs should recognize that the healthcare professionals who will use their solutions are motivated primarily by improving patient outcomes, not optimizing for payment models. Technologies that align with this intrinsic motivation will find more ready adoption and sustainable success than those focused narrowly on financial optimization.

As one primary care physician quoted in a recent Health Affairs study noted: "I don't care what payment model you put me in—I care whether your technology helps me take better care of my patients. If it does that, I'll use it. If it just helps me document better for billing, I'm not interested."

Conclusion: Empowering Healthcare's Better Angels

The Avalere report's mixed assessment of CMMI models offers a profound lesson for healthcare innovators: payment reform alone cannot transform healthcare delivery. Despite billions invested and extraordinary authority granted, CMMI's experiments have yielded inconsistent improvements in cost and quality. This suggests we need a fundamentally different approach to healthcare innovation—one that works with, rather than attempts to reshape, healthcare professionals' existing motivation and delivery structures.

The alternative path forward lies in technologies that enhance providers' capabilities rather than restructuring their incentives. By developing solutions that address specific pain points within existing payment frameworks, entrepreneurs can deliver immediate value while positioning themselves for long-term success as payment models gradually evolve.

This approach recognizes what the architects of value-based care sometimes overlook: healthcare professionals overwhelmingly enter their fields driven by a desire to heal and serve. They don't need financial engineering to motivate quality care—they need tools, information, and support systems that enable them to act on their existing motivation more effectively.

The remarkable success stories of companies like Stellar Health, Agilon, Dispatch Health, and Oak Street demonstrate how this approach can yield dramatic improvements in outcomes and efficiency without requiring wholesale payment reform. By focusing on enhancing rather than replacing existing systems, these innovators have achieved what many CMMI models have not—better care at low total costs.

For entrepreneurs entering the healthcare space, this insight offers both liberation and direction. Liberation from waiting for payment reform to create opportunities and direction toward specific pain points within existing structures that technology can address today.

The most promising areas for innovation include reducing administrative friction while preserving appropriate reimbursement, enabling service expansion within existing payment frameworks, enhancing clinical decision-making at the point of care, improving quality measurement through patient-reported outcomes, and increasing transparency to facilitate better collaboration among stakeholders.

Ultimately, the path to better healthcare doesn't run primarily through payment reform but through innovations that empower healthcare's better angels—the commitment to healing, scientific curiosity, and professional excellence that have always driven medical progress. By developing technologies that enhance these intrinsic motivations rather than attempting to engineer new extrinsic ones, entrepreneurs can help fulfill healthcare's highest purpose: improving and extending human lives.

The Avalere report, with its sobering assessment of payment reform's limitations, doesn't counsel despair about healthcare improvement. Rather, it redirects our attention to the underlying human dynamics that have always driven care quality. It suggests that our innovation energies are better spent augmenting those dynamics than attempting to restructure them through payment incentives.

As we look toward healthcare's future, we would do well to remember that its greatest resource has always been the dedication of those who provide care. Our most valuable innovations will be those that honor and enhance that dedication rather than attempting to redirect it through financial engineering. In doing so, we may finally achieve the improvements in value that have proven elusive through payment reform alone.



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