# A Roadmap to Accelerate National Value-Based Payment Reform: Filling in the Missing Pieces

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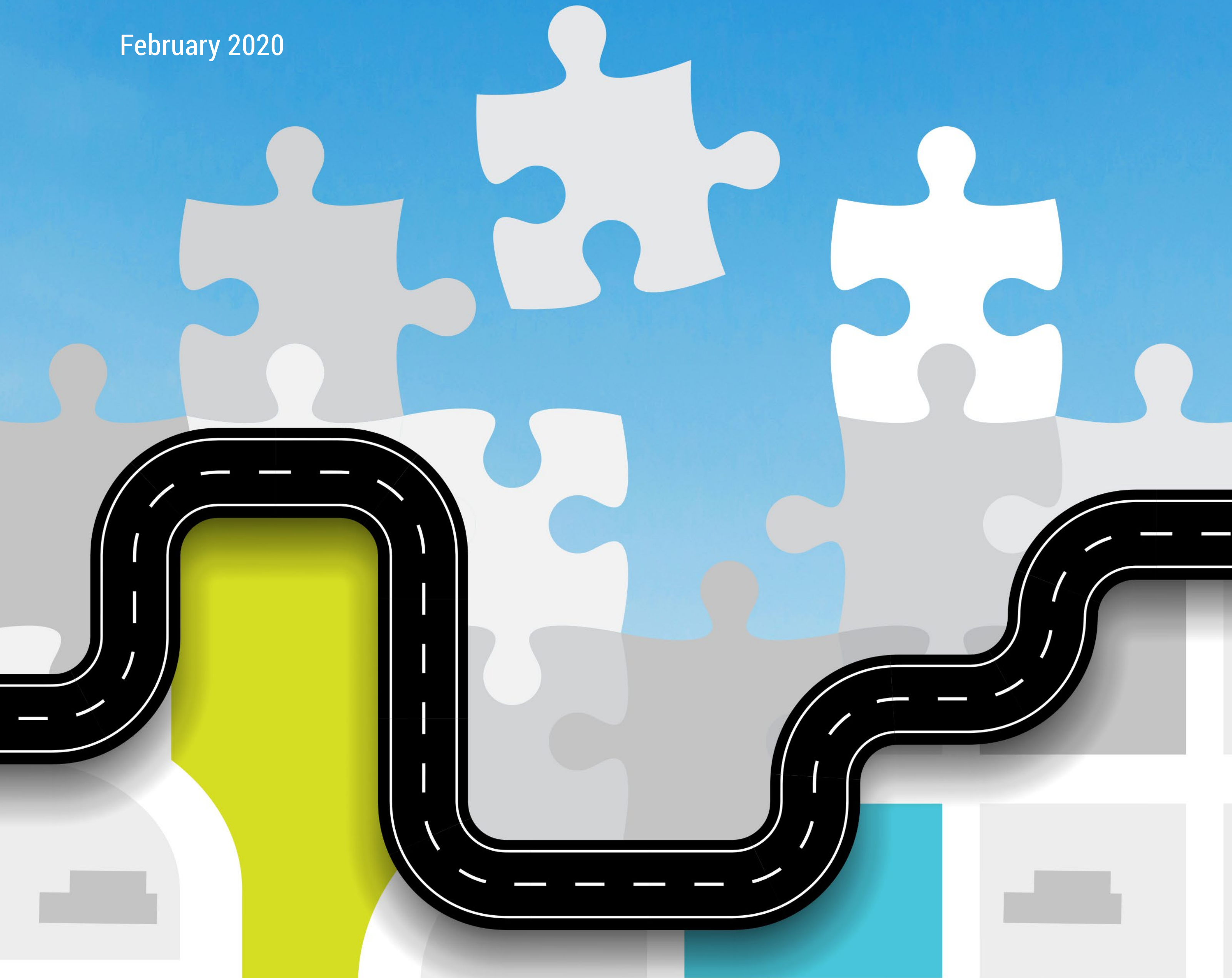

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## Key Takeaways and Recommendations

- Payment reforms are improving quality and lowering costs in primary care and for specific specialty surgeries, with critical opportunities across the health care landscape to foster new collaborations and develop innovative new payment and delivery models.
- A critical challenge in implementing new payment models is that the overall health care system has not moved far from fee-for-service payments, with most payment models still based on volume.
- To accelerate progress, we recommend action in four underdeveloped but promising areas:
    - Expanding opportunities for specialized care payment reform,
    - Improving serious illness care,
    - Reducing and eliminating low-value care, and
    - Engaging consumers and the public in payment reform.
- Along with more substantial payment reform, successful care redesign requires leadership in health care organizations to finance and develop key longitudinal data and analytics, and to build other needed infrastructure and capabilities for new care models.

## Landscape Analysis: Progress and Momentum

Value-based payment reform continues to expand, as efforts from federal and state governments, private payers, health systems, and provider groups affirm the role of payment reform as a key method of controlling costs and improving care. With more experience, increasing scale, and new collaborations, there is an opportunity to accelerate progress, with more advanced payment reforms helping health care organizations to make effective investments in new care delivery models.

So far, payment reforms like Accountable Care Organizations (ACOs) are improving quality and patient experience but have had only modest effects on cost. (Some studies suggest the ACO program is saving money beyond Centers for Medicare & Medicaid Services (CMS) calculations, depending on the methodology used.[1–4]) Specific subgroups of ACOs, specifically those led by physician groups and those that have moved from fee-for-service (FFS) to significant "downside risk," where organizations share in both savings and losses, have shown the most success.[5–7] Moreover, savings from ACOs have generally grown with time, with organizations saving more money the more experience they gain in an ACO program.[8] Bundled payments for major procedures and hospitalizations for acute medical events, often a complement to ACO payments, have shown reduced cost for common procedures such as joint replacement, but limited impact to date on reducing the cost of managing chronic conditions. While bundled payments provide an incentive for a more efficient surgery or acute interventions, they do not provide financial support for health care organizations to take "upstream" steps and invest in longitudinal models to avoid such procedures and hospitalizations in the first place.

While some analysts have reacted to the limited cost savings in value-based care with questions about the viability of value-based care initiatives, it is just as likely that the limited savings coincide with the fact that new models represent only a limited shift away from FFS and the care models FFS supports.[9] According to the Health Care Payment Learning and Action Network (LAN) national survey of payment reforms, 36% of total health care payments were in alternative payment models in 2018, with most of those in "shared savings" or "upside only" tracks.[10] Only around 15% of total payments were in "downside risk" models that align with non-incremental shifts away from fee-for-service based care.[10]

Right now, CMS, private payers, purchasers, and providers are all taking steps to encourage faster and more significant shifts, aiming for larger savings and supporting organizations as they gain the necessary experience. For example, Medicare initiatives in the past year have tightly limited the amount of time organizations can stay in "upside only" ACO models, where organizations share in savings but do not share in losses, and have offered greater proportions of savings in conjunction with taking on downside risk. CMS is also setting up new options intended to be more straightforward and predictable to physician groups and entities that support them, including a range of "direct contracting" models with established performance benchmarks and additional payments for reductions in hospital admission rates.[11]

Regional and state initiatives are also enabling larger-scale multipayer efforts, with the goal of reaching a critical mass of payment reform in particular health care markets.[12] When the incentives to focus on value match better across both public and private payers, health care organizations should have an easier time responding to payer initiatives for "buying health."[13]

While payment reform is necessary to develop new approaches to care, payment reform alone is not sufficient to improve outcomes and see significant cost savings. Reforms must go hand-in-hand with care redesign efforts that help build the care team and develop a robust data infrastructure to measure performance and streamline workflow, a tremendous undertaking for most. Comprehensive care redesign requires leadership, a cultural commitment to invest in new capabilities that support longitudinal team-based care, and a strong data analytics infrastructure, and many health care delivery organizations have struggled to find the resources needed for these investments. Care redesign challenges limit the pace of improvement, and some organizations are avoiding alternative payment models entirely because they do not have the resources or expertise to take on care transformation.[14,15]

Complementary initiatives aim to make it easier for organizations to develop the capabilities they need to improve outcomes and reduce costs, either on their own or through partnerships. Some Medicare and private-insurer reforms include up-front payments to support care redesign and improved care management.[16] Public and private learning networks, tools, and resources help organizations assess their needs and fill gaps in competencies.[17–19] Driven by growing payment reform opportunities and experience, third party organizations like Aledade, Agilon, and Caravan are examples of the many organizations whose business models are based on partnering with health care organizations to develop needed capabilities.

Taken together, these recent developments and continued bipartisan support for value-based care reforms suggest that the pace of change could move faster. However, it is not yet clear whether these steps will be sufficient to achieve sustainable health care spending growth—that is, health care spending growth in line with per capita growth in gross domestic product (GDP)—alongside continued improvement in outcomes and support for valuable health care innovations.

To accelerate the implementation of payment reforms that can help create a more sustainable and high-value health system, we identified four areas where evidence is promising but action has been limited:

## Box 1: Filling in the missing pieces to accelerate the implementation of payment reforms

- **Improving opportunities for specialized care payment reforms:** Accelerate specialized care transformation by creating new models that engage more specialists and allow for longitudinal care of high-cost conditions
- **Transforming serious illness care:** Facilitate serious illness care transformation to improve care for high-cost, high-need patients, reducing unnecessary hospitalizations and better aligning with patient and caregiver wishes
- **Reducing and eliminating low-value care:** Develop resources to reduce low-value care and make the right care choices easier
- **Engaging consumers in payment reform:** Improve consumer engagement by better understanding consumer perspectives and offering new opportunities to share in cost savings from value-based models

We outline some of the most feasible opportunities for improvement below, accompanied by recommendations for where and how a range of organizations should focus.

## Improving Opportunities for Specialized Care Payment Reforms

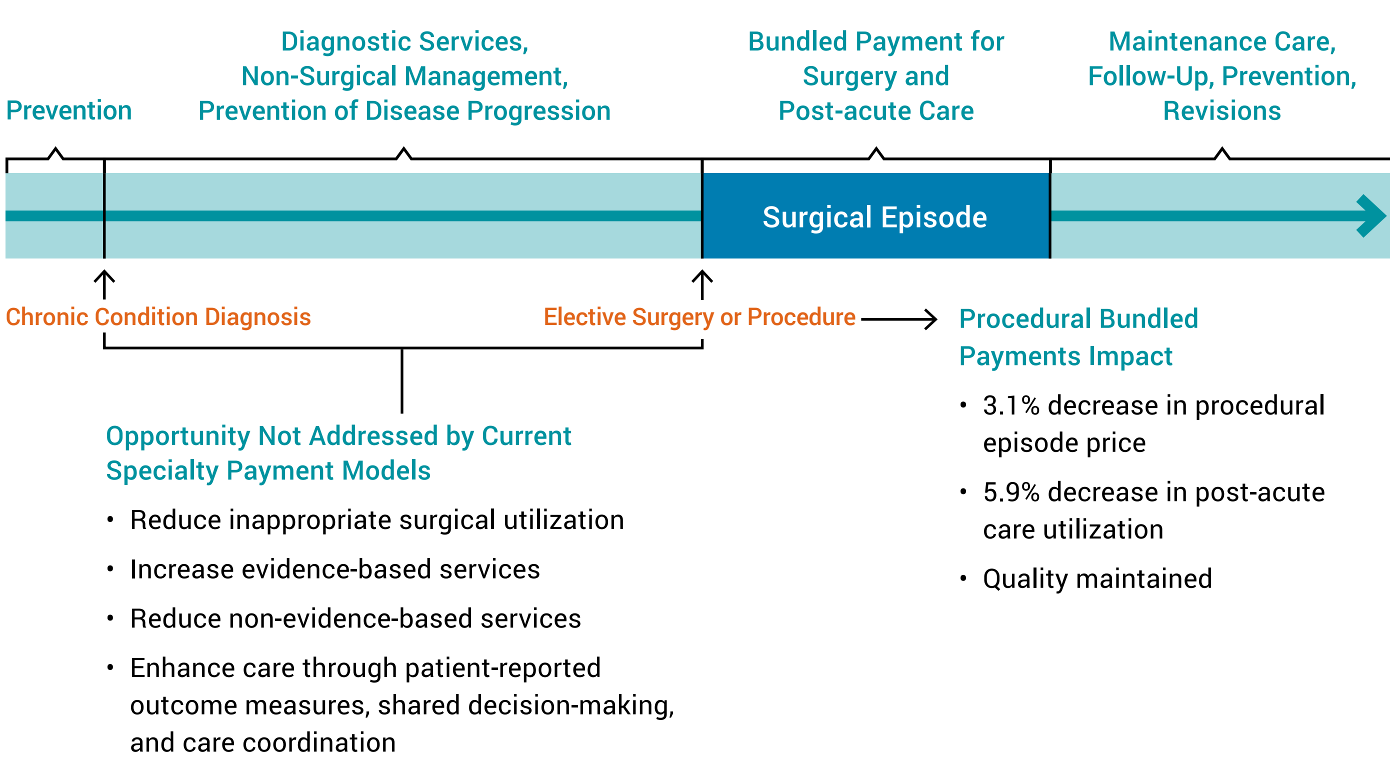
Specialized care—delivered with the involvement of medical specialists and often including intensive medical treatments—accounts for two-thirds of doctor visits and most health care spending, especially among seniors.[20,21] However, most alternative payment models to date have focused on primary care, specific acute interventions, or broad population health impact.

Bundled episode payments for certain procedures like joint replacement have shown some cost savings,[22–24] but have been less successful at lowering costs for acute medical events such as heart failure or stroke admissions.[25,26] Moreover, bundles do not provide support for avoiding costly procedures or admissions in the first place. Population-focused Alternative Payment Models (APMs) like ACOs often include specialty care physicians, but to date have mainly emphasized primary care reforms and care coordination, and have had limited activities to support specialized care. (Some exceptions include public and private oncology care models[27,28] and new CMS efforts to improve care for kidney disease.[29,30])

As a result, payment reforms are not substantively engaging most specialty physicians, who manage a substantial portion of care for many chronic conditions. Consequently, there is a need to increase the number of available models that encourage specialist engagement, generate more evidence on which models are working, offer greater opportunities for shared savings and shared risk, and develop more options to help specialty physicians succeed in a value-based world.[31–33]

Specifically, new person-focused, longitudinal payment reforms for specialized conditions could support more fundamental changes in specialized care that address the entire course of a disease, not just when a person's condition has progressed to the point that they need a major surgical procedure or hospitalization.[34] For example, interventions like physical therapy and better care management could help degenerative joint disease patients maintain mobility and reduce pain long before joint replacement becomes an option.[34] **Figure 1** shows how a longitudinal payment model for degenerative joint disease could dramatically expand opportunities for physicians to transform care and improve outcomes over the course of a disease.

## **Figure 1:** Opportunities for Longitudinal Payment Models to Expand Scope of Care



There are many other specialized care areas where new models could engage specialists in improving care, including:

- Management of back pain involving neurosurgeons and neurologists;
- Long-term management of cancer care, especially for cancer survivors;
- Heart disease care to reduce preventable hospitalizations from heart disease exacerbation;
- Pregnancy and maternity care to limit premature births, costly birth complications, and maternal morbidity and mortality;
- Chronic kidney disease to prevent progression to renal failure and dialysis; and
- Substance abuse disorders to improve ongoing care management.

Developing payment models for specialized care will require addressing a wide range of operational challenges, including identifying the optimal care pathway, building the ideal treatment team, establishing the role of specialty clinicians in managing the condition, and considering how to integrate and coordinate specialty and primary care. New models may also need supporting components to engage patients, address broader lifestyle and behavior change, and coordinate with the management of other conditions.

Common strategies can provide a foundation for engaging specialists in these new models. For example, longitudinal payment reforms generally shift from paying for procedure- or admission-based episodes to providing upfront per-member, per-month payments. These payments can help provide the upfront capital needed to build out capabilities in patient monitoring, team-based management, and other steps to avoid costly disease complications and procedures.

With new models available, organizations will need to determine how to redesign their specialty care pathways. A common way to do this is through the identification of clinical "trigger points" where specialist engagement is likely, and thus where payment reforms have the most potential for improving value. Alternatively, providing financial support for a "triage" process—in which specialized clinical assessment, shared decision-making, and timely referral to alternatives to surgery when clinically appropriate—can also have a similar impact. For example, orthopedists typically become involved in degenerative joint disease care when a patient has significant enough pain or other relevant symptoms to prompt a specialist referral. Therefore, an APM for degenerative joint disease might allow an earlier referral of patients with significant levels of functional impairment to a specialized joint care team.

Identifying these opportunities can help specialists better lead team-based approaches to comprehensively and longitudinally manage the full spectrum of care for a given condition, including prevention, diagnosis, non-surgical management, procedural shared decision-making, procedures, post-acute care, rehabilitation, and maintenance. Specialists need not undertake all of these treatment domains themselves. In some cases, primary care providers and other health professionals can handle fundamental elements and save specialist time and expense. However, as the decision-makers for the most expensive and riskiest interventions, specialists are in a unique position to guide the implementation of meaningful reforms to improve the patient journey.

Supporting these models will require a variety of actions from stakeholders across the health care system. Payers can further quality efforts by advancing new measures in a variety of areas to capture the range of specialist contributions. Measures should cover the use of appropriate services; functional status (using tools such as the Hip Disability and Osteoarthritis Outcome Score [HOOS] and the Knee Injury and Osteoarthritis Outcome Score [KOOS]); and patient-reported outcomes on quality of life, advanced care planning, and overall patient satisfaction. Aligned and relevant measures will not only focus attention on improving the patient experience and promoting shared decision-making, but can have a major impact on provider burnout and engagement by reducing administrative burden in new models.

As organizations gain experience in new payment models, specialized care learning networks can foster collaboration and share best practices to succeed. This is important because organizations otherwise interested in payment reforms are often uncertain about operational and financial issues, which keeps them from entering new models. While each organization's experience in payment models will be slightly different, the components and competencies necessary to succeed in new payment models are generally the same. Learning networks can have a national or local focus; the Health Care Payment Learning and Action Network provides a national forum for public and private payers, providers, and health systems to align on strategic directions and implementation steps to accelerate payment reform, and CMS' Transforming Clinical Practice Initiative has helped establish over 40 local learning networks to promote payment reform efforts across the country.[19,35]

Payers will also need to determine how different models can "nest," ensuring that shared savings and risk are distributed appropriately among providers. For example, a patient attributed to an ACO who undergoes a specific procedure by a specialist participating in the Bundled Payments for Care Improvement Advanced (BPCI-A) model would be potentially affected by two different payment models. Currently, CMS manages that overlap by adjusting payments to ensure the shared savings are not double-counted between the bundled payment participant and the ACO.[36] The current technical payment model considerations for precedence and exclusions threaten ongoing and future participation in advanced APMs, running the risk specialists will back out of programs in which they cannot capture value. It also creates significant administrative burden on practices that may have to track a variety of payment models from different payers to determine who is succeeding and why.[37]

One possible solution is to double-count benefits, allowing for cost savings but reducing administrative overhead and negative incentives for providers not recognized for their care redesign efforts. Any solution would need support from a coalition willing to pilot new approaches and develop provider education and engagement efforts. Solving this "nesting" problem is critical to ensure that physicians understand how they stand to benefit from new payment models and know clearly what they need to do to succeed in them.

**Figure 2** below outlines recommendations discussed throughout this section for multiple stakeholders to advance payment reform for specialized care.

## Figure 2: Recommendations to Advance Payment Reform for Specialized Care

### Payers

- Develop and pilot longitudinal specialized care models that can lower cost and improve care for high-opportunity conditions
- Include greater opportunities for shared savings and shared risk
- Provide support for organizations to develop new capabilities to support higher-value care pathways
- Further support new models by advancing a limited number of key performance measures
- Include patient-reported outcome measures for the conditions involved in specialized care models—these measures capture key specialist contributions toward improving outcomes and lowering costs
- Identify the best ways to "nest" specialized care models to complement population-based and primary care payment reform

### Health Care Organizations

- Identify "trigger points" where specialist engagement is likely and where payment reforms have the greatest chance of improving value
- Form specialized care learning networks to help providers and organizations identify key steps to succeed in Alternative Payment Models (APMs), reducing the uncertainty and time required to undertake successful reforms

## Transforming Serious Illness Care

People with serious illness deal with multiple chronic conditions, functional limitations, and unmet social needs.[38–40] This population has some of the highest utilization in the U.S. health care system and faces multiple challenges in their current care, such as:

- Wide variations in care quality;
- Silos in care delivery with poor care coordination;
- Lack of attention to patient goals of care or patient and caregiver education, with substantial unwanted care;
- Failure to address patient pain, symptoms, or social drivers of health; and
- Insufficient provider training and staffing, especially on primary palliative care skills.[38,39]

In short, there are substantial opportunities to improve serious illness care through value-based payment reform.[41,42] New reforms can support greater investments in care coordination, infrastructure, new workforce, and other capabilities, but few have been implemented so far. Recent research suggests that ACOs are well-suited to drive care transformation in this area given their incentives to improve care coordination and implement care reforms for high-need populations.[43] Still, most organizations have taken only limited steps to implement evidence-based serious illness care interventions like advanced care planning or home-based palliative care.[43] More broadly, most payment reforms to date in serious illness, ACOs or otherwise, represent only modest shifts from FFS payment and the challenges inherent in implementing such reforms effectively. But the payment reform context for serious illness care is changing. Recent reforms in the Medicare ACO program require participating organizations to shift further away from FFS into “downside risk” models. New CMS initiatives, such as the Serious Illness Population track of the Primary Care First model (PCF-SIP) and the Direct Contracting models, also provide new incentives for organizations to more rapidly progress in redesigning serious illness care and meet the needs of this complex population.[11,16] Given the high-need, high-cost characteristics of this population, public and private payers should continue making serious illness care a priority as they develop and implement new value-based arrangements. Concurrently, payers should ensure that these new programs are thoroughly evaluated to better understand where and how they improve care while reducing unnecessary care.

Even with the right supporting incentives from a payment model, health care organizations will need concurrent support in developing new competencies to successfully deliver care and implement new interventions.[43] Developing these competencies takes time, which can explain why the pace of serious illness care adoption remains slow even with supportive financial incentives in place. The competencies that health care organizations need to develop include:

- Obtaining buy-in from their clinicians and health care professionals;
- Identifying and raising the necessary capital to build infrastructure, as well as understanding the business case for redesigning care under new payment reforms;
- Expanding training and tools to encourage patient and caregiver engagement;
- Implementing needed data infrastructure and health IT for care coordination and care improvement; and
- Building an appropriate workforce.

Payers can help organizations as they develop or advance these competencies by providing additional data, especially data that will aid in understanding utilization outside of a system or in identifying patterns of care. Payers also can help design payment models that provide upfront capital, allowing smaller or less well-resourced organizations to invest in necessary infrastructure.

Public and private plans are not only assisting organizations, but also are driving multiple serious illness initiatives, especially in Medicare Advantage (MA). Several MA plans have worked with third-party firms

(such as Landmark Health, Turn-Key, and Aspire Health [which was acquired by Anthem in June 2018]) to provide certain services to high-need individuals.[44] These programs often include 24/7 call centers, home visitation, predictive models and care coordination, and home-based palliative care.

Recent policy shifts will continue plans' ability to offer additional serious illness services within MA. For example, they can now offer supplemental benefits such as in-home support services, home and bathroom safety devices, transportation, and caregiver support, and are allowed to target those benefits to their seriously ill beneficiaries.[45] Most plans have not yet taken advantage of these new flexibilities, but many express intent to do so in the coming years, a strong sign for progress in the near future.

For payers and policymakers, the successful implementation of payment and care reforms for serious illness presents several distinct technical challenges. For example, there are few widely used and accepted metrics that assess care quality for people with complex care needs.[46] These measures rarely capture quality of life or a person's functional status, or follow a person's goals for their care, including end-of-life care. An ideal measure set would include measures on symptom management and quality of life, as well as whether a care plan is in place and being followed. Additional measures could focus on key evidence-based structural capabilities, such as 24/7 access to clinicians familiar with patients' medical records and care plans, the use of advanced care planning, and access to palliative care services.

Risk adjustment issues create another barrier for value-based models focused on the seriously ill, as current methodologies often underestimate the care needs for this population. This creates financial uncertainty for practices, as they are unsure if they will be penalized for high utilization needed by a very complex and sick population. Some payment models like CMS' Programs of All-Inclusive Care for the Elderly (PACE) have introduced frailty adjustments or other adjustments for complex needs, while others like PCF-SIP simply increase reimbursement significantly for practices catering to patients with higher risk scores (paying more than four times the amount they would pay for lower risk categories).[16,47,48] The more risk adjustment methodologies can account for patients' health status, and the impact of social risk factors, the more providers will feel comfortable in new payment models for the seriously ill population.

**Figure 3** summarizes the recommendations for how to improve serious illness care, including developing new payment models, improving existing ones, and helping care organizations develop the competencies they need to improve care under these models.

## Figure 3: Recommendations for Improving Serious Illness Care

### Payers

- Develop and refine new models for serious illness care that move providers away from fee-for-service (FFS) payment and provide upfront support to develop competencies
- Track and analyze such models to ensure they are improving outcomes and lowering costs
- Incorporate frailty and functional limitations into risk adjustment methods OR undertake similar steps to improve the appropriateness of payments and incentives to improve care for seriously ill patients

### Health Care Organizations

- Obtain buy-in from physicians and other health care professionals
- Identify and provide necessary capital for infrastructure, as well as understand the business case
- Expand training and tools to encourage patient and caregiver engagement
- Implement needed data infrastructure and health IT
- Ensure the necessary workforce is available

### Measure Developers

- Accelerate development of measures that can show improvements in outcomes for serious illness populations
- Focus on quality of life and effective use of care plans in accordance with patient preferences

## Reducing and Eliminating Low-Value Care

Low-value care—services that provide little to no clinical benefit relative to their cost—accounts for an estimated 10% to 20% of annual health care spending in the U.S.[49–51] Despite well-funded, extensive national awareness campaigns and other education-oriented initiatives, including the identification of specific low-value and harmful services in many clinical practice areas, use of low-value care remains pervasive.[52] A wide range of financial, legal, social, and other non-financial barriers exist that make low-value care difficult to eliminate.

Value-based payment reforms provide a useful foundation for reducing low-value care, and new models are beginning to address the financial barriers to change. However, existing evidence suggests that these approaches alone are insufficient; most organizations that are solely adopting payment reforms have

made limited progress. In reviewing low-value care programs, we have found that organizations that take a multipronged approach have achieved greater success, employing strategies such as offering payment incentives, addressing delivery barriers and provider workflows, providing treatment decision supports, and improving patient engagement. It is imperative to underpin these efforts by building strong leadership, data and analytic capabilities, and involving other health care stakeholders—such as payers, employers, and policymakers—to maximize impact and sustainability.

Health systems and provider organizations serious about eliminating low-value care can begin by prioritizing specific services to address first, as part of a systematic and ongoing strategic focus on low-value care elimination. This prioritization is important as there are many areas of low-value care; changing clinical practice requires significant and focused effort and success will require that low-value care efforts are actionable. While organizations may find that initial costs exceed the savings of eliminating some procedures, improving provider engagement and developing the infrastructure to support low-value care elimination will make it easier to initiate and sustain these efforts. Simultaneously, this process will help create the culture change needed to make broader progress.

Building on existing work like the *Choosing Wisely* initiative,[53] there are numerous areas of waste in the system that organizations can use as a basis for their own elimination strategies. Identified opportunities for progress exist in oncology, orthopedics, cardiology, radiology, emergency medicine, and maternity care. Taking action on specific services in each care area requires engaging providers through a joint review of organizational data, capabilities, and resources to identify opportunities for improvement and developing a shared understanding of how these steps will contribute to success in reducing costs and improving patient outcomes.

Once these specific opportunities are identified, health care organizations should implement tools that support providers in making better decisions and redesigning care away from low-value services. For example, employing a system of measuring and reporting provider performance on low-value care can empower clinicians with the information needed to shift practice patterns toward more effective and evidence-based care. Further, some organizations have integrated clinical guidelines, quality measures, and other metrics into their electronic health records (EHRs) or added clinical algorithms, alerts, or reminders in computer-order entry systems to advise providers against unnecessary care and guide them toward more appropriate alternatives.

Health care organizations can also identify and support clinical champions or coaches to encourage buy-in from front-line providers on low-value care elimination goals. These leaders can work with providers to review performance reports, provide targeted education on low-value care, assess barriers to change, and identify strategies for steering treatment decisions away from inappropriate care. These leaders can also help design and implement alternative pathways that are easier to use. For example, in degenerative joint disease care, practices set up steps to discourage use of low-value procedures like joint injections, accompanied by rapid access to an evidence-based physical therapy program. The high-value alternative

pathway addresses pressure that physicians may feel from patients to "do something" in a timely way about their symptoms and their own concerns about providing the best possible care.

Organizations can further support low-value care elimination by coupling these strategies with resources to experiment with low-value care interventions and other financial and non-financial rewards for avoiding unnecessary care. For example, the University of Utah offered their internal medicine providers 50% of the cost-savings realized by reducing select low-value care services to support future quality improvement projects. Affording providers opportunities for enhanced patient referral streams or shared savings could also be used.

New West Physicians, a large, physician-led ACO in Colorado, provides a case example of a successful multipronged low-value care elimination strategy in action. After identifying which low-value care services to reduce, New West incorporated evidence-based guidelines in electronic order entry systems, targeted education for all new hires, developed clinical algorithms that show treatment alternatives, provided timely provider performance reports and peer comparisons, and offered opportunities for shared shavings and enhanced referral streams. The initiative reduced targeted low-value services by 29-94%, depending on the service, while maintaining high provider support.[54,55]

Payers, employers, and policymakers can also support low-value care elimination through complementary steps, ideally working in tandem with health systems and provider organizations. For example, development or adoption of "waste calculators" or low-value care "scorecards or dashboards" could provide a resource and necessary metrics to raise awareness, guide action, and assess progress within different systems.[56–58] If the right measures and metrics do not exist, these groups could work collaboratively with measure developers and IT vendors to identify better, more systematic methods for tracking progress in low-value care reduction.

In addition, stakeholders could align to further pilot low-value care interventions and, if promising, integrate them into new and existing value-based payment and delivery reform models. Furthermore, both payers and employers could support reductions in low-value care through coverage policies, preferred provider networks that offer lower co-pays for selecting providers with low unnecessary or inappropriate care use, and more transparent quality and cost reporting. Policymakers could also serve as key partners to disseminate best practices through regional, national, and global networks, in an effort to scale effective models.

Multipronged approaches to eliminate low-value care should also consider improving patient engagement. Potential supports include instruments to improve shared decision making, such as decision aids and transparency tools that help patients understand out-of-pocket costs, risks, and why low-value care reduction efforts will improve the quality of care and patient experience. These tools would need to be coupled with easier access to alternative, higher-value services. For example, decision aids and shared decision-making conversations for joint replacement could be coupled with easy, low-cost, and timely

access to physical and occupational therapy and behavioral health services. New value-based insurance designs could also be used by payers and employers to align lower payments with less costly, high-value care pathways.

Overall, low-value care elimination steps should be viewed as an integral part of broader value-based care reforms and cost-reduction efforts. As outlined in our recommendations in **Box 1**, the capabilities to support these reforms are similar to those used to increase the use of high-value services (**Figure 4**). Reducing low-value care not only has the potential to improve patient outcomes and reduce harms, it can also achieve short-and long-term cost reductions to avail resources for investments in high-value services or other important health care and other priorities.

## **Figure 4:** Recommendations for Reducing and Eliminating Low-Value Care

### Health Care Organizations

- Adopt an ongoing low-value care elimination strategy that includes a process to identify:
  - Which services should be prioritized for reduction;
  - Opportunities for clinician input and feedback;
  - A data infrastructure investment plan to track metrics, measure performance, analyze results, and provide feedback; and
  - Alternative care pathways that help avoid wasteful choices
- Cultivate a supportive culture for tackling low-value care by setting clear elimination goals, identifying clinical leaders to promote and oversee initiatives, securing required resources, and affording opportunities to experiment with new low-value care interventions
- Improve patient engagement efforts by utilizing shared decision-making tools and combining them with easy access to lower-cost and more effective care pathways

### Payers and Employers

- Develop or utilize tools (e.g., low-value care calculators) to help providers understand low-value care opportunities
- Reward providers for demonstrating progress

### Policymakers

- Support large-scale payment and delivery reform pilots that incorporate low-value care reduction goals and strategies
- Advance efforts to improve measurement and analytic capabilities

## Engaging Consumers in Payment Reform

While most value-based care reform activities have focused on providers, consumer engagement offers substantial opportunities to increase a reform's overall impact. Currently, consumers have limited opportunities to engage with their clinicians on care decisions and to understand value-based payment approaches. Consumers also receive few incentives to participate in value-based care or select high-value providers and rarely use tools and information to identify high-value clinicians and health care organizations.[59] Facilitating this activity is important, because while consumer attitudes show consistent concern about high and rising prices, surveys also reveal people are skeptical of claims that less costly care is often better.[60,61] There also remains significant disagreement between patients and physicians on what "value-based care" actually means.[62]

A concurrent challenge in doctor-patient engagement revolves around cost. Less than a third of doctor-patient conversations include a cost discussion, even though a much larger share of patients would like to have meaningful information about their out-of-pocket expenses and what they can do to lower those costs.[63,64] This can be addressed by payers and health care organizations providing tools for clinicians, such as cost transparency tools in the electronic health record, to support care discussions. Researchers can provide support by identifying productive approaches for providers and patients, along with assessing the impact of these approaches combined with other consumer engagement reforms.

Another challenge to engaging consumers in payment reform is the lack of incentives for them to select high-value clinicians, especially if they have met their insurance plan's deductible. Value-Based Insurance Design (VBID) has been expanding to offer consumers financial support that is better aligned with value-based care. Some health insurers like Blue Cross of Massachusetts have implemented VBID with lower co-pays for enrollees who see high-performing providers, in contrast to the FFS insurance practice of limiting networks based on negotiated charges. Walmart, the nation's largest private employer, is undertaking similar efforts through a partnership with the Nashville start-up Embold Health.[65-67] However, many VBID reforms have been limited; examples include incentives to choose generic drugs over brand name options or choose lower-cost providers for elective imaging services like MRIs. More substantial VBID reforms are vital to make payment reform more effective. For example, in a VBID model aligned with specialized care payment reforms, patients with substantial health needs (e.g., advanced heart failure, severe chronic kidney disease, or multiple chronic conditions) who choose a high-value care system could be rewarded with a significant share of the expected cost savings, regardless of whether they have met their out-of-pocket limit. Similar initiatives could focus on patient populations with other serious chronic illnesses, such as osteoarthritis or cancer.

To complement incentives and patient engagement, consumers will need more aligned, user-friendly price and quality information. Current price transparency initiatives are often unhelpful because consumers do not know the specific services they will use and can't easily determine what they would owe under their insurance benefit. More relevant pricing data would show patients how much they would pay under their

benefit design for alternative choices at key decision points in their care (e.g., which provider to choose for pregnancy and childbirth care, or for knee pain management), and some payers and organizations have started providing information this way. The Wear the Cost program in Maryland offers a key example for providing access to understandable information on some shoppable services, as it provides information on the breakdown of hospital costs for hip and knee replacement surgeries, hysterectomies, and vaginal births.[68] The more consumers and physicians can access episode-based, total cost, and quality information, the more informed decision-making will improve.

Another transparency challenge is that patients need access to better information about care quality that includes the outcomes and experiences that matter to them, and few current quality measures capture information meaningful to patients. Patient-reported outcome measures (PROMs) can fill critical gaps but are still nascent. Even when available, payers have not yet incorporated PROMs in payment models.[69,70] Medicare could drive the adoption of a limited set of key well-validated measures aligned with payment reform opportunities, like functional status for degenerative joint disease or depression. In addition, pilots could validate patient-generated health data derived from now widely-used mobile apps that track functional status and other symptoms, simultaneously reducing burden on providers.

As consumer technologies and value-based payment reforms progress, the potential benefits of engaging consumers will continue to rise. **Figure 5** summarizes recommendations that can address the challenges described in this section. The steps described here will help empower consumers to take better control of their health, identify the care that is best for them, and participate more meaningfully in that care, all of which will increase the impact of value-based care reforms.

## Figure 5: Recommendations to Engage Consumers in Value-Based Payment Reforms

### Researchers

- Identify methods to facilitate better conversations between clinicians and patients about value
- Identify ways to improve consumer-facing information about value and value-based care

### Providers

- Integrate available tools to improve shared decision-making with patients
- Help patients to identify higher-value care

### Payers

- Expand value-based insurance design for choosing high-value providers, such as by offering shared savings to high utilizers
- Create and share accessible, relevant information about total episode of care and quality information (with support from public and private stakeholders)

### Measure Developers

- Increase the number of measures that draw on patient-reported data, incorporate patient preferences and perspectives, and provide quality information that is meaningful to people

## Conclusion

The key to progress in payment reform is not one perfect model, but rather concurrent action in a variety of areas to help organizations build the capabilities they need to succeed. Improving opportunities for specialized care payment reforms, transforming serious illness care, reducing and eliminating low-value care, and engaging consumers in payment reform are some of the most important ways to address major gaps in advancing U.S. value-based payment reform to lower health care costs. To complement these strategies, which are largely focused on health care organizations and national policymakers, our companion report, "A Roadmap for Effective State Leadership in Value-Based Payment Reform," focuses on steps states are taking. Combined national and state efforts can help the U.S. health care system achieve a critical mass of meaningful value-based care reform.

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## Disclosures

Mark B. McClellan, MD, PhD, is an independent board member on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, Seer, the West Health Institute and the West Health Policy Center. He also co-chairs the Accountable Care Learning Collaborative and the Guiding Committee for the Health Care Payment Learning and Action Network; and receives fees for serving as an advisor for Cota and MITRE.

Robert Saunders has a consulting agreement with Yale-New Haven Health System for development of measures and quality measurement strategies for the Center for Medicare and Medicaid Innovation Alternative Payment Models under CMS Contract Number 75FCMC18D0042/Task Order Number 75FCMC19F0003, "Quality Measure Development and Analytic Support," Base Period.

## About Duke-Margolis Center for Health Policy

The Robert J. Margolis, MD, Center for Health Policy at Duke University is an academic research center and a policy laboratory, focusing on payment and delivery reform across the health care system. Its mission is to improve health and the value of health care through practical, innovative, and evidence-based policy solutions. To learn more, please visit healthpolicy.duke.edu or @DukeMargolis.

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