

Healthcare Systems and Services

The Trillion Dollar Prize

Using outcomes-based payment to address
the US healthcare financing crisis



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Introduction



Executive summary: There is growing consensus that transitioning to outcomes-based payment is fundamental to driving cost-reducing innovation among healthcare providers and achieving a financially sustainable healthcare system. We believe that successful implementation of outcomes-based payment could lead to a trillion dollars of cumulative savings in the United States over the next decade. The challenge is how to ensure that implementation succeeds. Our research indicates that there are eight fundamental requirements that payors must meet as they transition to outcomes-based payment, starting with a redefinition of what they expect from 21st-century care providers and implementation at a scale large enough (in terms of money at stake, support given, breadth of providers involved, etc.) to achieve impact. Although many useful payment initiatives are currently underway, few of them meet all, or even most, of these tests. To remedy the situation, we suggest that payors consider setting even bolder aspirations for their payment initiatives, find ways to collaborate with other payors, and expand the resources dedicated to the task.

Consensus is emerging that the long-term healthcare financing challenge facing the United States can be addressed only by changing the way we pay for healthcare. Most everyone agrees that we must migrate from a largely fee-for-service (FFS) system that pays for activity to one focused on delivering the best patient outcomes at the lowest possible cost (an approach herein referred to as outcomes-based payment). Policymakers across political parties, most health economists, and most other stakeholders agree, at least conceptually, that paying for outcomes can play a foundational role in reducing low- or no-value care while improving care quality.

We concur and believe that a compelling economic case exists to aggressively transitioning to outcomes-based payment. The financial and human capital that is now being poorly utilized for healthcare could be used to meet other important societal or individual needs. Furthermore, FFS payment often makes it more difficult for healthcare workers to fulfill their mission, because it often rewards failure while failing to reward healing. For example, many hospitals earn additional income from preventable readmissions. Physicians are typically given the same reimbursement for a failed procedure as for a successful one.

Our analyses suggest that aggressively migrating to outcomes-based payment has the potential to reduce healthcare spending in the United States by a trillion dollars over the next decade while improving patient well-being. This estimate relies on two key assumptions. First, we believe that as much as 50% of healthcare payments could be outcomes-based by 2018. Second, our research and experience indicate that if implemented thoughtfully, outcomes-based payment can reduce known sources of waste and inefficiency (redundant care, misuse, etc.), resulting in 10% or greater decrease in targeted spending. Over time, outcomes-based payment also has the potential to mitigate several core drivers of excessive medical cost inflation (e.g., it discourages low-value, expensive technologies and encourages primary/secondary prevention).

The crucial issue, therefore, is how to make outcomes-based payment a reality in the next three to five years. To this end, both private- and public-sector payors are exploring a range of strategies, including patient-centered medical homes, episode-based payments, global

payments, shared savings programs, stronger pay-for-performance schemes, value-based contracting, and dozens of permutations of accountable care organizations. We applaud this trend.

However, new approaches to payment will help address our healthcare cost crisis only to the extent that they generate true cost-reducing innovations—they must change how providers¹ and consumers behave and save money as a result. If the payment innovations do not alter how physicians practice, hospitals deploy capital, and pharmaceutical and medical device companies approach R&D, if they do not modify how patients make decisions and care for themselves, and if they do not stimulate considerably greater efficiency across the entire healthcare industry, they are unlikely to have much effect.

In this paper, therefore, we examine what it will take for payment innovations to substantially slow the growth in US healthcare costs over the next few years without adversely affecting patient outcomes. In the first chapter, we outline the types of innovations that will be needed now and in the future and how mind-sets, behaviors, and industry structure must evolve if those innovations are to succeed. It is difficult to overestimate the level of change required. The transformation must alter practice patterns that have been established over decades, as well as medical school curriculums, the corporate strategies of numerous companies, and multiple other things. Many of the changes require stakeholders to risk historical sources of competitive advantage. Thus, no one should expect the emergence of silver bullets or easy solutions.

In the second and third chapters, we describe eight traits that, our research indicates, must be present if new payment initiatives are to drive significant cost-reducing innovations. These “eight S’s” of payment innovation are:

re-Set expectations and align payment. Before introducing new payment methodologies, payors should define and set expectations for the three primary roles that 21st-century providers should take on in the future: Component Providers, Healers, and Partners.² Payors should align their payment approaches to encourage and reward all providers for delivering against these expectations. In the ideal end-state, Component Providers would receive FFS payments tied to performance/quality, Healers would receive episode-based payments, and Partners would receive population-based payments correlated with total costs over time.

As we explain later in this paper, many payors may find that retrospective episode-based payment is a highly attractive approach that can help them begin to align reimbursement with outcomes. It offers the potential to capture near-term cost reductions while giving population-based approaches time to take hold, mature, and generate value.

Significant. To motivate providers to change, a minimum of 30% to 50% of each provider’s total revenue—and at least 30% of its compensation or operating profit—should be tied to outcomes or value.

1 In this paper, the term *provider* covers any individual or institution that delivers healthcare services to patients or produces a device or drug used to treat patients; thus, it includes hospitals, physicians, pharmacies, medical device companies, pharmaceutical companies, skilled nursing facilities, and other organizations.

2 These three groups, and their roles and responsibilities, are discussed more extensively in chapter 2.

Scope. Many, if not most, cost-reducing innovations will arise only after a critical mass of providers (within a local market or nationally) make the transition to outcomes-based payment.

Stable. Given the long-term nature of many cost-reducing innovations and their high perceived risks and costs, providers must be confident that incentives will remain consistent over time.

Sustainable. The economic consequences of outcomes-based payment should be manageable for all providers willing to change and should offer most providers the potential to benefit financially.

Striving but practical. To achieve adequate scale, outcomes-based payment must initially work within the industry's existing structure. However, payment innovations, if effective, will encourage favorable changes in the industry's structure over time.

Supportive. Payors should champion innovation by giving providers extensive, direct support (for example, by sharing best practices; disseminating timely, actionable performance information; and offering training, capability building, and administrative assistance).

Synch with consumers. Payors should fully align payment approaches with network design, benefit design, and other forms of consumer engagement. Setting clearer expectations for providers, measuring and sharing their performance, and rewarding outcomes should help patients become better, more value-conscious healthcare consumers and assume greater responsibility for their health. Said differently, payment innovations should put consumers and providers “on the same side of the table.”

In the final chapter of this paper, we explore the implications of our findings for payors. Although most current payment initiatives have created a solid foundation and momentum, stronger action is needed, because few of the current initiatives meet all—or even most—of our eight requirements. We therefore encourage all public and private payors to consider taking four complementary actions: (i) compare your current portfolio of payment initiatives against the eight requirements outlined in this paper; (ii) set bolder, clearer, more public aspirations; (iii) collaborate more closely with other payors to establish and implement new approaches to payment; and (iv) increase the resources allocated to implementing outcomes-based payment at scale.

CHAPTER 1

**Challenges to driving
cost-reducing innovation**



The United States spends far more on healthcare than other wealthy countries do. McKinsey's 2011 report, *Accounting for the Cost of US Healthcare*, found that even when healthcare expenditures were adjusted to reflect national wealth levels, the United States outspends other developed countries by \$572 billion annually. For the most part, our higher healthcare spending does not deliver demonstrably better outcomes. Furthermore, growth in per-person US healthcare spending (medical cost inflation) is increasing at a substantially higher rate than general cost inflation.

As Exhibit 1 shows, three types of cost-reducing innovation are needed to slow the rise in our country's healthcare spending. Each of these types is discussed below.

Low-hanging fruit: scale existing best practices

The most straightforward cost-reducing innovations include minimizing unjustified clinical variability (i.e., by adopting clinical best practices) and improving operations. These innovations have clear evidence of efficacy and examples to draw on. They simply need to be adopted at scale.

Exhibit 1

Three types of innovation are needed to slow the rise in healthcare spending

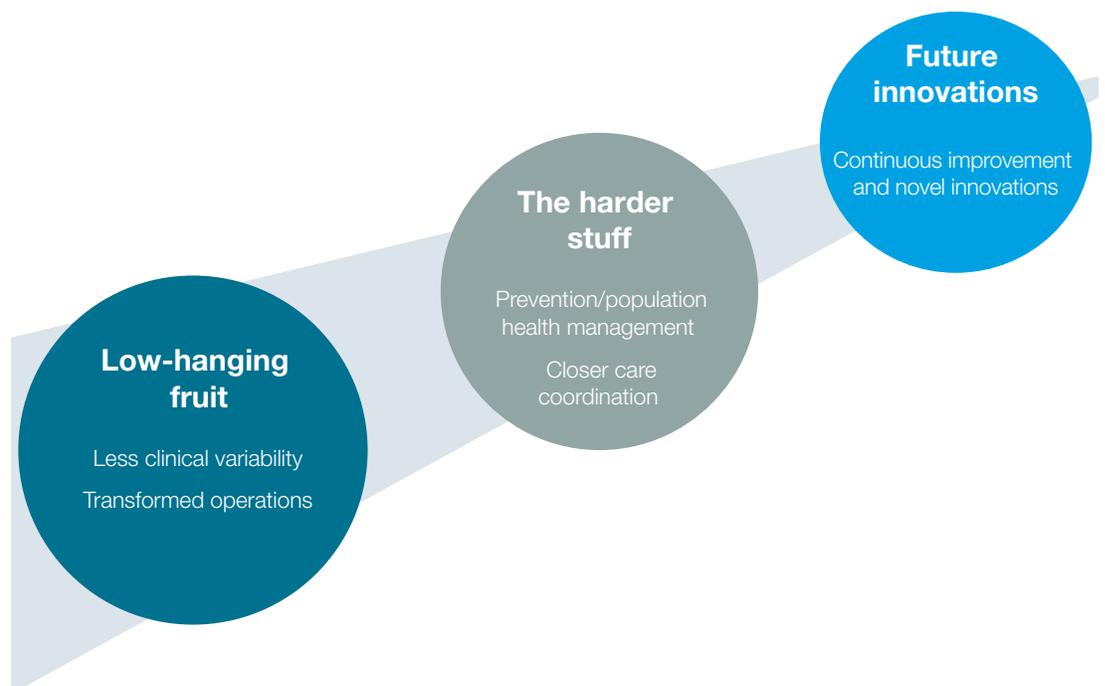


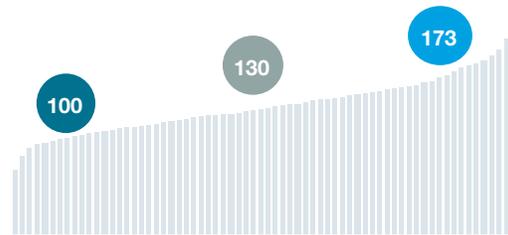
Exhibit 2

Average cost per episode varies widely among providers

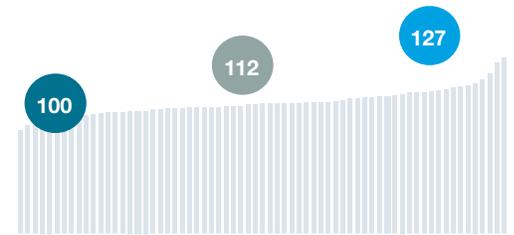
Costs indexed to the 10th percentile provider, by episode

- 10th percentile
- Median
- 90th percentile

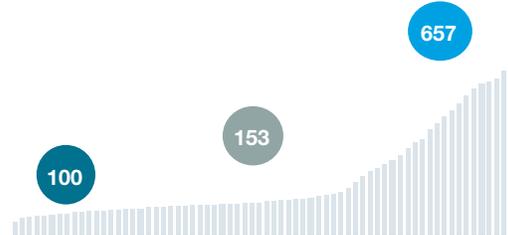
Simple upper respiratory infection



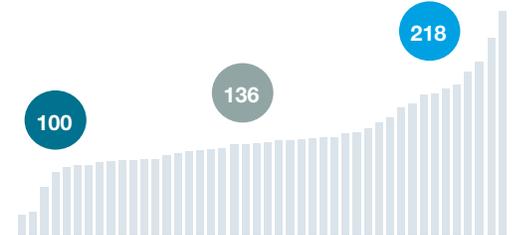
Pregnancy



Attention deficit hyperactivity disorder



Total hip replacement



Each bar represents total average costs per episode, post-risk adjustment by accountable provider, from 2008-2010. For upper respiratory infection, episode costs for children younger than age 10 were risk-adjusted by a historically derived multiplier. For pregnancy, individual episode costs were risk-adjusted for clinical drivers of severity based on historically derived multipliers. Attention deficit hyperactivity disorder (ADHD) episodes are for patients between ages 6 and 17 without comorbidities. Hospital costs are normalized.

The most straightforward evidence to support the existence of these opportunities is the fact that some providers deliver the same or better outcomes at dramatically lower costs than other providers in the same markets do. Exhibit 2 illustrates variations within a single state in the average total per-patient costs for four different episodes of care: upper respiratory infection, pregnancy, attention deficit hyperactivity disorder (ADHD), and total hip replacement. In the exhibit, each bar represents a different provider's average cost per episode. Even after we adjusted the costs for patient severity and normalized hospital unit-cost differences, the average cost per episode varied 30% to 600%. We were unable to identify any quality or outcomes advantages that explained why some providers had considerably higher average costs.

Reducing such unjustified variation would result in substantial value creation. For example, if the average cost of a total hip replacement was shifted to the 25th percentile of performance,

the cost of all hip replacements would be lowered by about 12%. This change could happen if higher-cost orthopedic surgeons followed the example of their lower-cost colleagues, who focus on procedures for which they have a meaningful base of experience; avoid redundant or low-value diagnostics; more appropriately weigh alternative treatment options (keeping in mind the trade-offs between patient need, product type, and product cost); and ensure that patients receive effective post-procedure care. These best practices are all feasible actions that any surgeon could take.

Hospital performance is similarly variable. Multiple studies and our work with clients have revealed substantial differences in hospitals' cost structures and efficiency. Differences in per-discharge operating costs can exceed 100%, even after adjustment for case-mix severity. Hospitals with lower cost structures typically achieve greater clinical productivity, are more effective at purchasing, and have shorter average lengths of stay and higher capacity utilization.

Migrating to best practices is largely do-able for both physicians and hospitals, even in the current environment. Nevertheless, we estimate that less than 20% of this low-hanging fruit has been captured in the past few years.

The harder stuff: treat chronic illness, coordinate care

Across the United States, more than 100 million people live with one or more chronic illnesses. Over the course of a year, many of these people consult dozens of different providers, make multiple emergency room visits, and require hospitalization. In most of these cases, no single provider is responsible—or reimbursed—for ensuring that the patients receive coordinated care and appropriate primary and secondary prevention services, or for making a serious attempt to engage them in managing their own illness. The result is often inefficient, overly expensive, and ineffective care.

If healthcare costs are to be reduced, a large-scale transformation of how primary care is delivered and chronic illness is treated is required. There must be substantially greater primary prevention, stronger care coordination among providers, more emphasis on patient education and engagement, and greater accountability for each patient's holistic health needs over multiple years.

Future innovations

“Bending” the long-term trajectory of medical costs (as opposed to making one-time improvements) will require the creation of an environment that encourages significantly greater continuous improvement and new cost-reducing innovations—be they clinical, operational, or structural. Incentives within the healthcare system should encourage providers, entrepreneurs, and other stakeholders to dramatically increase the resources dedicated to identifying, introducing, and scaling new cost-reducing innovations.

Consider what would happen if, for example, someone invented and commercialized a hip implant that was as or more effective than current models but cost only 20% as much, a way could be found to perform total hip replacement safely on an outpatient basis, and improvements in postoperative care reduced readmission rates to less than 0.1%. Spending on hip replacements could plummet.

Spending could also decrease significantly if the United States more regularly adopted delivery system innovations that have emerged in other parts of the world. An increasing array of services, for example, could be delivered through telemedicine or franchising arrangements.³ Hospitals could make much greater use of nurses and other non-physician staff to deliver a high volume of standardized services (e.g., maternity or eye care).

Why cost-reducing innovation is so difficult

Using outcomes-based payment to drive cost-reducing innovations in healthcare is exceptionally difficult, in large part due to the challenges described below.

Sheer magnitude. If cost-reducing innovations are to be implemented successfully at scale, the mind-sets and behaviors of around one million physicians and millions of other clinicians and supporting caregivers across the country must change. More than 5,000 hospitals will have to modify their operations, incentive systems, and cultures. Myriad other stakeholders, including drug and device manufacturers, pharmacies, other ancillary providers, and private equity firms, will have to alter their thinking and practices. As Exhibit 3 demonstrates, many of the changes required are far from trivial.

Increased risk. Often, the needed changes run contrary to strategies providers have long used successfully. In some cases, the changes demand that institutions risk historical sources of competitive advantage. In other cases, they require individuals to alter behaviors they have employed effectively throughout their careers.

Inertia. Attitudinal inertia may be particularly strong in the healthcare industry. Not only do many stakeholders benefit from the current system, but also their resistance to change is often buttressed by the belief that altering existing practices could harm patient care.

Technical know-how. At present, many, if not most, providers do not have the capabilities or know-how to improve their performance in any significant way.

Structural barriers. A variety of regulatory and legal issues (e.g., licensing requirements and any-willing-provider laws) increase the difficulty of implementing change, especially since most of them give advantage to incumbents.⁴ The US's medical liability system encourages defensive medicine and discourages discussion of honest mistakes (transparency about such mistakes could help drive continuous improvement over time). The absence of interoperable IT systems or other effective ways to share large amounts of data also challenges coordination among caregivers.

3 Ehrbeck T et al. Unlocking productivity through healthcare delivery innovations: Lessons from entrepreneurs around the world. McKinsey white paper. January 2010.

4 Kachalia A, Mello MM. New directions in medical liability reform. *N Engl J Med* 2011;364:1564-1572. Fuchs VR. Health reform: Getting the essentials right. *Health Affairs*. 2009;28:w180-w183.

Exhibit 3

Provider mind-sets and behaviors must shift to drive cost-reducing innovation

	Mind-set/strategy shift	More of	Less of
Hospitals	Embrace full accountability for clinical performance of employed and affiliated clinicians, as well as post-discharge care related to an inpatient stay	10-30% improvement in productivity and operational efficiency (e.g., through higher capacity utilization, higher labor productivity, better purchasing)	Building capacity to stimulate demand (and, potentially, reducing capacity in some markets)
Primary care providers	Embrace accountability for the quality and cost of care their patients receive over time, including care from other providers	Practicing at top of scope; maximizing the use of extenders and alternative caregivers for most routine care	Advocating for rules and regulations that prevent lower-cost clinical resources from being utilized
Chronic care providers	More providers specialize in providing chronic care for highly prevalent conditions and embrace accountability for progression of those conditions and their costs	More cognitive time to manage/refine therapy, identify issues, educate patients, reinforce treatment adherence, etc.	Referrals to specialists when unnecessary
Specialists	Embrace role as “quarterback” for an entire episode of care, with accountability for quality and cost	Using cost as a primary factor in the selection of devices and facilities	Use of expensive interventions when clinical rationale is unclear
Drug and device manufacturers	Believe that cost-reducing innovations are a legitimate and attractive source of differentiation and value creation	Focus R&D on identifying least costly therapies and finding strategies to increase patient adherence	Developing drugs and devices with marginal efficacy
Ancillary providers (e.g., pharmacies, labs)	Shift from using scale to increase unit prices to using scale to remove cost	Relentless focus on reducing unit costs while achieving zero defects via economies of scale, lean operations	High-cost clinicians performing lower-value activities
Entrepreneurs/private equity	Believe that disruptive cost-reducing innovations will be financially attractive investments	Investments in business model innovations that lower total cost of care	Investments in ventures that rely primarily on economic or regulatory distortions (e.g., government pricing, regulatory protection)

CHAPTER 2

The first step: re-Set expectations and align payment



There is wide consensus that our current FFS system encourages over-utilization, discourages primary and secondary prevention, and fails to promote integrated, coordinated care. There is also wide consensus that migrating to a payment system that directly rewards outcomes is fundamental to encouraging delivery innovations and waste/cost reduction. However, the best path to migrate to outcomes-based payment remains unclear.

Our experience indicates that new payment models must meet eight requirements if they are to lead to significant cost-reducing innovations (Exhibit 4). In this chapter, we discuss the first and most critical of these requirements: re-setting expectations for three types of providers and then aligning payment for each group against those expectations.

Expecting more from providers

Historically, neither payors—nor patients, for that matter—have clarified precisely what they expect from providers beyond meeting minimum credentialing requirements, following standard procedures for claims submissions, and agreeing to a schedule of prices for discrete

Exhibit 4

New payment models must meet 8 requirements to drive cost-reducing innovations

Requirement	Description
re-Set expectations and align payment	Create clear roles for Component Providers, Healers, and Partners; pay through a mix of enhanced fee-for-service, episode-based, and population-based payments
Significant	Maximize the proportion of provider revenue and earnings that are subject to outcomes-based payment
Scope	Ensure that a critical mass of providers transition to outcomes-based payment
Stable	Clarify long-term vision and make a long-term commitment to providers
Striving but practical	Design the new approach so that it is effective in current regulatory, legal, and industry structures
Sustainable	Ensure that providers that adapt thrive financially
Supportive	Champion innovation with information, insights, and infrastructure
Synch with consumers	Align payment with benefits, network design, and consumer engagement

services directly delivered. In today's highly complex, fragmented, and specialized healthcare system, this lack of expectations partially explains why “everyone and no one” is accountable for achieving specific patient outcomes and/or managing chronic illnesses.

Thus, before introducing new payment methodologies, payors should define and set expectations for the three primary roles that providers could play in the future: Component Providers, Healers, and Partners.

Component Providers

Payors should expect Component Providers to deliver discrete, high-quality products or services at the lowest possible cost. This expectation is appropriate when a provider has limited influence on upstream or downstream costs or on the desired outcome. Most diagnostic services (e.g., imaging scans, lab tests, health risk assessments), ancillary providers (e.g., pharmacies), medical device companies, and pharmaceutical manufacturers fall into this category. In many situations, healthcare facilities should also be considered Component Providers (especially when they have limited influence over the clinical decision makers who use their services).

Component Providers should seek to build and realize economies of scale to deliver the products/services in question with world-class efficiency and zero-defect quality. Component Providers should also invest in innovations that deliver either demonstrably higher efficacy or substantially lower costs.

Healers

When patients have acute health problems, payors should expect Healers to deliver a specific outcome at the highest level of quality and the lowest possible total cost. Healers are needed for all conditions, or “episodes of care,” that have both a relatively clear desired outcome and predictable start and end points (pregnancies, broken bones, strokes, etc.). Episodes of care would therefore include most procedures, hospitalizations, and acute outpatient care, as well as some forms of treatment for cancer and behavioral health conditions. This is a straightforward concept. When something happens to a patient, a single, specific person and/or institution should be equipped and accountable to ensure that the problem is addressed or the patient is healed.

To deliver against this expectation, Healers typically must lead, influence, select, and/or coordinate care from a group of Component Providers. Healers must therefore understand and be able to actively manage the relationship among all resources during the course of treatment, paying particular attention to the relationship between upstream services and downstream costs. In most cases, however, Healers need not have direct managerial, legal, or financial control over Component Providers.

In most clinical situations, a Healer would be a physician (or physician practice) or hospital, but it could also be an urgent care facility or mental health professional—whichever person or institution is in the best position to influence the overall cost and quality of care

delivered during the episode. To understand how payors might identify a Healer, consider these examples:

- Interventional cardiologists are in the best position to assume accountability for the quality and cost of coronary artery stenting (even though their fees account for a minority of that procedure's total cost), because they make or strongly influence every key clinical and economic decision during that episode of care.
- In contrast, hospitals are typically in the best position to influence the quality and total cost of care for most non-elective inpatient admissions (e.g., heart attacks and strokes), because they can influence and/or manage care during the hospitalization and ensure appropriate post-acute care to minimize the risk of readmission.

Partners

Payors should expect some providers to take on the role of Partner and support patients to maintain or improve their health over many years. Partners should encourage and offer appropriate preventive services, deliver holistic, effective care for chronic illnesses, and help patients make value-conscious treatment and provider choices (including which Healers are best suited to help address acute issues). A Partner's performance should therefore be measured by the patients' health status, quality of life, and total healthcare costs over time.

It should be noted that the same provider could play all three roles, depending on the context. The sidebar, "How payment models can come together: An illustration," on p. 20, provides more details about the roles each of these three groups would play and how they would interact.

Comparison with today

Today, few providers have the training, capabilities, mind-set, or incentives to meet the expectations described above for Healers or Partners. Instead, most of them currently function as Component Providers. Furthermore, payors today rarely expect or reward providers for playing a role beyond that of a Component Provider.

In the ideal end-state, however, every US resident would receive healthcare services under the direction of—but not always directly from—a Partner who shares some form of accountability for 100% of the cost of those services. The treatment of a specific episode of care would be under the direction of a Healer, who works in close collaboration with the patient's Partner. (For example, if the Partner accountable for the care of a patient needing cataract surgery was a geriatrician, the patient would be referred to an ophthalmologist, who would then become accountable for the costs associated with that surgery.) Our analysis of data from private insurers, Medicaid, and Medicare suggests that Healers would be accountable for between 50% and 70% of healthcare spending (Exhibit 5).

Exhibit 5

Partners and/or Healers should direct the majority of healthcare delivery and costs

ROUGH ESTIMATES

Expectation	Category	Examples	Percentage of total spending		
			Private	Medicaid	Medicare
Partner <i>Supports patients over time to maintain or improve health</i>	Prevention	Routine health screenings	~5	~5	~3-5
	Chronic care management¹	Diabetes, chronic CHF, CAD	~15-25	~10-15	~20-30
	Acute outpatient medical	Ambulatory URI, sprained ankle	~5-10	~5-10	~5-10
	Acute inpatient medical	CHF, pneumonia, AMI, stroke	~20-25	~5-15	~20-30
Healer <i>Leads team of providers to deliver specific outcome at lowest cost for an episode of care</i>	Acute procedural	Hip/knee, CABG, PCI, pregnancy	~25-35	~15-25	~20-25
	Cancer	Breast cancer	~10	<5	~10
	Behavioral health	ADHD, depression	~5	~15-20	~5
	Supportive care	Develop. disability, long-term care	n/a	~20-30	n/a

¹ Chronic care management includes the costs associated with the ongoing care required for a long-term condition, such as the charges for office visits, medications, care coordination, and patient education. It does not include the cost of procedures, hospitalizations, or other acute events that may occur in patients with chronic illness. Acronyms include: ADHD, attention deficit hyperactivity disorder; AMI, acute myocardial infarction; CABG, coronary artery bypass grafting; CAD, coronary artery disease; CHF, congestive heart failure; PCI, percutaneous coronary intervention; URI, upper respiratory infection.

Aligning payment with expectations

Payers should align their payment approaches to encourage and reward providers for delivering against the expectations outlined above. In the ideal end-state, Component Providers would receive FFS payments tied to performance/quality, Healers would receive episode-based payments, and Partners would receive population-based payments correlated with total costs over time (Exhibit 6).

Fee-for-service payments

In the ideal end-state, Component Providers would continue to receive FFS payments for products or services delivered. Even in these cases, however, payors would strive to link reimbursement to the value delivered by a product or service through bonus payments or other forms of pay-for-performance.

Exhibit 6

Re-Setting expectations for providers helps determine appropriate payment approaches

Expectation	Most applicable	Ideal payment types
<p>Partner Supports patients over time to help them maintain or improve their health</p>	<ul style="list-style-type: none"> • Primary prevention for healthy patients • Care for chronically ill patients (e.g., management of obesity, CHF) 	<p>Population-based payments</p> <ul style="list-style-type: none"> • Partial and full capitation • Medical homes • Accountable care organizations • Health homes • Other global payments <p>Episode-based payments</p> <ul style="list-style-type: none"> • Prospective bundled payments • Retrospective episode-based payments • Condition-specific accountable care organizations <p>Fee-for-service payments (including pay-for-performance)</p> <ul style="list-style-type: none"> • Bonus payments tied to quality • Bonus payments tied to efficiency
<p>Healer Leads team of providers to deliver a specific outcome at the lowest possible cost</p>	<ul style="list-style-type: none"> • Acute procedures (e.g., CABG, hip replacement, perinatal) • Most inpatient stays, including post-acute care and readmissions • Acute outpatient care (e.g., broken arm, URI, some cancers, some behavioral health issues) 	
<p>Component Provider Delivers a high-quality product or service at the lowest possible cost</p>	<ul style="list-style-type: none"> • Discrete services provided by an entity with limited influence on upstream or downstream costs and outcomes (e.g., imaging, drugs and devices, health risk assessments) 	

CABG, coronary artery bypass grafting; CHF, congestive heart failure; URI, upper respiratory infection.

In regions where most Component Providers have similar levels of efficacy, payors would work to drive down their unit prices (as is done in every other industry).

Episode-based payments

Episode-based payments should be used to reward a Healer for efficiently and successfully achieving a specific patient outcome. There are two primary types of episode-based payments: prospective bundled payments and retrospective episode-based payments (REBPs). A prospective bundled payment is a lump-sum payment made to a single Healer that is fully responsible for all care delivered during the episode; the Healer then distributes funds to all Component Providers involved in that episode. In our view, prospective bundled payments are likely to be relatively uncommon in most parts of the United States, given the administrative, legal, and financial challenges required for providers to accept them.

How payment models can come together: An illustration

To illustrate how the different payment models could work together in the future, let's assume that the Jones Clinic, a primary care practice, has become a patient-centered medical home and is the partner accountable for the health and total cost of care for Janice, a 54-year-old patient with congestive heart failure. The Jones Clinic is given financial incentives and support to help Janice adhere to a care plan that helps her maintain her health and prevent acute exacerbations (especially those requiring hospital stays). The Jones Clinic is also responsible for helping Janice decide if and when to engage specialists and if she would benefit from a medical device, such as a pacemaker or stent. In these cases, the care team helps Janice identify appropriate high-quality, cost-effective providers.

Janice and the care team eventually decide that a stent would help her. Dr. Smith, a local

cardiac surgeon, performs the procedure and is considered to be the Healer for that episode of care. He assumes responsibility for the quality and cost of all care associated with the stent implantation, including prescription medications, facility charges, associated readmissions, diagnostics, and the device itself. Because he is able to provide an excellent outcome at a below-average total cost, he receives a bonus payment.

In addition, one of the physicians at the Jones Clinic prescribes a generic ACE inhibitor for Janice to take daily. As a Component Provider, the pharmacy where she fills the prescription is paid on an FFS basis for the drug. However, it will be eligible for a bonus payment if Janice adheres to her treatment regimen for 12 months, because pharmacists can play an important role in encouraging compliance.

REBPs, on the other hand, rely on the current FFS claims system but apply both gain- and risk-sharing calculations retrospectively, based on the total cost and quality of an episode of care. In an REBP model, all providers are paid separately for the services they deliver, filing claims as they do today. However, at regular intervals (e.g., quarterly), the average cost per episode is calculated for the Healer and compared with pre-determined thresholds. (All costs are adjusted for patient risk and in some cases for other factors, such as setting of care, quality, and unique circumstances.) The savings or excess costs are then divided between the payor/patient and the Healer.

We should note that reimbursement for most inpatient admissions is currently based primarily on diagnosis-related groups (DRGs), a form of episode-based payment. Today, however, DRG payments do not cover post-acute care, some professional fees, or readmission costs, and are thus incomplete.

Population-based payment

Population-based payment models hold a Partner accountable for the cost and effectiveness of all care provided to a group of patients over time. Examples of such models include accountable care organizations, patient-centered medical homes, health homes, capitation, and global payments.

Episode-based performance management for providers

Because episodes of care are an ideal unit for assessing performance, we expect that many providers—especially hospitals—that agree to assume risk for populations will adopt clinical performance systems based on episodes of care. At a minimum, hospital administrators and department heads could use episodes

to better understand clinical and operational performance and thereby identify their greatest opportunities for improvement. In addition, they could more strongly link compensation for clinical decision makers to episode-specific performance.

Population-based payments should be designed to ensure that a sufficiently capable Partner assumes significant accountability for the long-term health status of a group of patients and the total cost of care required by them. This approach aligns the interests of providers and patients, because it gives providers an incentive to deliver primary and secondary prevention services, oversee the appropriate utilization of procedures (for which consumers typically have significant cost sharing), and ensure that patients with chronic illness receive holistic management and coordinated care. In short, population-based payments reward providers for improving people's health.

Why the emphasis on retrospective episode-based payment?

A great deal of attention has been placed recently on population-based models because of their focus on the total cost of care, primary and secondary prevention, and effective chronic disease management. We encourage payors to proceed with their current efforts to explore these models, given their long-term promise.

Nevertheless, we believe that REBPs offer greater potential for cost reduction in the near-to-medium term. Based on recent client experience, we believe it is possible for most US payors to transition about half of their spending to an REBP model within three to five years. Our calculations suggest that by doing so, they could save 5% to 10% of that spending or more.

REBPs offer the following advantages:

Direct connection between incentives and improvement

REBPs directly encourage and reward specific cost-reducing changes in provider behavior while establishing long-term pricing signals to encourage future innovations. For example, if a provider knew that, for the next five years, it would have a target of \$10,000 as the average cost for “procedure X” and would be able to keep 50% of any savings it achieved below that target, the provider would have a strong incentive to invest to identify new efficiency opportunities that go beyond today's best practices.

In addition, because REBPs are anchored in defined outcomes, they enable performance dialogues with a level of specificity that is managerially relevant to decision makers.

Disaggregating and reporting total cost and quality shines a bright light on specific sources of waste and on opportunities to improve quality. For example, it is much more tangible to discuss the appropriateness of an expensive diagnostic test, the performance of a downstream provider, or the efficacy of a particular drug in the context of a specific patient and specific desired outcome than in the abstract.

An episode of care is also the ideal unit for providers that want to assess performance and optimize resource utilization. If performance is evaluated at a unit narrower than an episode, the connection between upstream and downstream care and costs can be missed. (For example, strategies that focus exclusively on shortening inpatient length of stay could inadvertently increase the risk of expensive readmissions.) If performance is evaluated at a unit of care larger than an episode, discussions can become so abstract that providers have difficulty deciding where to focus.

Provider empowerment

Assigning and then incentivizing Healers through REBPs relieves payors of the need to micro-manage clinical decision making. For example, there is no reason to require pre-authorization of a diagnostic test if a Healer is being held financially accountable for the value that test delivers.

By calculating incentives based on the *average* cost for a particular episode (adjusted for patient risk), REBPs recognize that not all care can—or should—be uniform. Some patients will always need somewhat different care than others. Healers, not payors, are in the best position to make these judgments, and REBPs empower them to make those decisions without undue administrative burden.

Administratively feasible, even in fragmented delivery systems

REBPs can be implemented at scale even in the fragmented delivery systems present in most US markets, because they take advantage of existing FFS claims systems. As described previously, all providers are paid separately for the care they deliver, submitting claims as they do today. As claims are filed, they are attributed to one or more episodes of care and one or more Healer. Periodically, the average cost per episode is calculated for each Healer and compared with predetermined thresholds; savings or excess costs are then allocated. This approach encourages Healers to manage care across the episode, without requiring them to develop new contractual relationships with one another (as would be needed with prospective bundled payments).

The State of Arkansas has proved the administrative feasibility of REBPs. In less than nine months, it was able to design and implement all of the infrastructure required to track, measure, administer, and support this payment model for six distinct episodes of care across 3,000 providers.

Strategic flexibility for payors

REBPs offer payors much greater flexibility in setting risk and reward thresholds than bundled payments or even total-cost-of-care rewards do. Payors can use an array of detailed design choices to adapt the REBPs to specific contextual needs. Examples include risk adjustment methods, regional adjustments, outlier provisions, setting of care adjustments, quality measures, and minimum thresholds. (Although not the focus of this paper, calibration of these variables is a critical part of the use of REBPs; the choices made will vary considerably based on payor position, market dynamics, and other factors.)

CHAPTER 3

Ensuring that outcomes-based payment delivers



Re-setting expectations and aligning payment is critical but insufficient for driving significant cost-reducing innovations. In this chapter, we describe the other seven requirements for effective payment innovations.

Significant

To help providers overcome inertia, payors should commit to—and communicate—their intention to migrate most or all of their payments to outcomes-based payment over the next several years. Admittedly, there is no empirically defensible threshold for how much money is sufficient to overcome inertia. However, considerable anecdotal evidence suggests that something approaching a majority of revenue and/or operating income is probably required to encourage providers to consider the full scope of desired operational and clinical changes.

The reason is simple: Most physicians and hospitals perceive the cost of change to be high in terms of the time, capital, and risk required to implement cost-reducing innovations. They also expect that their likely return from outcomes-based payment will be low or nonexistent, a reasonable belief given our multi-payor system. Consider, for example, a physician who derives 25% of her income from a single payor. If that payor implemented a new reimbursement system that put 10% of its payments to the physician at risk, the change would affect only 2.5% of her revenue. From the physician's perspective, the payor is asking for a major investment in performance improvement yet is offering only a very modest incentive.

Scope

Having a significant amount of money at stake is necessary but may not be enough to overcome providers' resistance to change. Many, if not most, cost-reducing innovations are likely to be implemented only after a critical mass of providers (within a local market or at the national level) are transitioned to outcomes-based payment. At the local level, more conservative capital deployment decisions, increasing value-consciousness in physician culture, and significantly closer collaboration/coordination among providers are unlikely to occur until a critical mass of the providers in that market has made the transition to outcomes-based payment. Institutions that operate at a national level (e.g., medical device and drug manufacturers, pharmacy chains, and laboratory companies) are unlikely to change their R&D strategies to focus on lowering costs until they realize that a critical mass of clinical decision makers are now sharing financial accountability. For example, outcomes-based payments could prompt manufacturers to ensure that their innovations reflect the full complement of needs (features, quality, and cost).

Exhibit 7 highlights the types of cost-reducing innovations that require a critical mass of providers at a regional or national level.

Exhibit 7

A critical mass of outcomes-based payment is required to drive cost-reducing innovation

Focus of innovations	Directional critical-mass requirement	
<ul style="list-style-type: none"> • Some practice patterns (treatment selection, referral patterns, care coordination, etc.) • Operational inefficiency improvements 		<p>Individual providers</p> <p>30-50% of an <i>individual provider's</i> total revenue at stake; at least 30% of compensation or operating profit at risk</p>
<ul style="list-style-type: none"> • Delivery system structure (e.g., level of consolidation, capital deployment/new capacity) • Practice patterns rooted in culture of medical community • Holistic collaboration, supported by interoperable HIT/EHR • Bottom-up pressure on regulatory environment 		<p>Local market</p> <p>~30% of providers in a <i>market or region</i> have made the transition to outcomes-based reimbursement</p>
<ul style="list-style-type: none"> • Focus of R&D at drug and device companies • Medical school curriculum 		<p>National</p> <p>~30% of regions in the <i>United States</i> have a critical mass of providers who have transitioned to outcomes-based reimbursement</p>

EHR, electronic health records; HIT, health information technology; R&D, research and development.

Stable

It is hard to overstate how important it is that payors set long-term payment policies and communicate those policies clearly to providers. Given the long-term nature of many cost-reducing innovations and the high perceived risks and costs associated with them, providers must be confident that the new payment approaches will be stable enough to reward those that invest in the required changes. Therefore, even if migration to outcomes-based payment occurs in waves, payors should define and share their end-state vision and timeline with as much specificity as possible.

In addition, payors should consider how best to make significant, long-term commitments to individual providers and the broader provider community. In some cases, the commitments will be contractual; in other cases, they could be good-faith, public declarations (e.g., “we intended to maintain this price level for two or three years at a minimum”).

Striving but practical

Full implementation of many cost-reducing innovations will require multiple structural changes to our health system, including the adoption of interoperable IT systems to permit shared medical records, improvements in the medical liability system, modification of some labor regulations, greater consolidation in some sectors, and greater competition in other sectors. However, few of the changes will be fully realized in the next three to five years.

Unfortunately, many new payment models are unlikely to succeed in our current reality. Some of them, for example, are designed to work exclusively for large, fully integrated health systems. Others rely on (rather than encourage) interoperable electronic medical records, sophisticated disease registries, or other large IT investments. Some of the models employ full capitation and thus require provider scale, financial sophistication, and integration. In other cases, the models demand the creation of new, formal legal or financial relationships among providers.

Payors that want to drive cost-reducing innovations at scale in the near term must develop payment approaches that will work in the absence of structural change. Instead, the approaches should accept the current reality: a highly fragmented US health system comprised of sub-scale hospitals, small physician practices, and low levels of clinical or economic integration. The good news is that multiple approaches meet this requirement.

Sustainable

Paying for outcomes at scale will significantly increase performance pressure on providers. Three hard truths therefore deserve to be acknowledged. First, if providers are to bear some financial accountability for the cost and quality of the care they deliver, they must face a meaningful level of downside risk. Sharing upside potential only is unlikely to motivate some providers sufficiently to improve performance. Second, full implementation of cost-reducing innovations at scale is likely to result in “creative destruction”—institutions that fail to adapt will exit the market, shrink, or be acquired. Third, reducing or limiting the rate of growth in payors’ costs requires that some other entities lose revenue (or face lower revenue growth).

Nevertheless, if outcomes-based payment is to succeed over the long term, it should offer sustainable economics for most providers. Performance pressure should thus be carefully calibrated to give sufficient time and positive encouragement to providers willing to adapt. At a minimum, payors should avoid constructs that could lead these providers (especially hospitals with large fixed-cost bases) to fail financially in the short or medium term while working to adapt. Over the long term, providers that successfully adapt should thrive financially.

Sustainability is crucial for several reasons. In many markets, providers are powerful stakeholders that can prevent, or at least delay, change for long periods of time. Furthermore, it is extremely difficult to motivate people or institutions with “sticks” alone. Providers that perceive only downside risk are likely to spend as many or more resources fighting the change (including through regulation) than attempting to make improvements.

Below, we outline several practical suggestions for payors seeking to develop sustainable payment models.

- The new payment approaches should ensure that providers who make the necessary changes and lose revenue as a result have the potential to expand margins or return on invested capital. This is especially applicable for hospitals.
- Payors should migrate away from cost-plus pricing constructs that seek to optimize a provider's operating margin. Cost-plus pricing discourages cost-reducing innovations, especially among the more standardized services that will continue to be paid primarily on an FFS basis (e.g., imaging, generic drugs, durable medical equipment). Providers that develop high-quality approaches to deliver these services at lower cost (whether through economies of scale or other innovations) should be rewarded financially rather than penalized through lower unit profitability.
- The new payment approaches should ensure that pharmaceutical, device, and equipment manufacturers continue to have incentives to develop innovations that improve patient care.
- In many cases, more effective payment approaches could increase net physician (even specialist) take-home compensation, because physicians remain the major decision makers within our healthcare ecosystem. They are in the best position to champion many cost-reducing innovations, including greater value consciousness in treatment selection and referrals, and more effective patient education. Physicians are also well positioned to apply healthy performance pressure on the facilities with which they are affiliated. Moreover, their total take-home compensation represents only about 9% of all healthcare costs.⁵ Thus, payors can afford to reward physicians generously for total cost and outcome improvements. For example, if increasing physicians' take-home compensation by 20% led to a 5% reduction in total costs, a payor would still save over 3%.
- Furthermore, our research indicates that most US physicians have relatively low expectations for future compensation increases (Exhibit 8). Payors could capitalize on this reality, possibly by tying all payment increases to total cost or outcome improvements.

Supportive

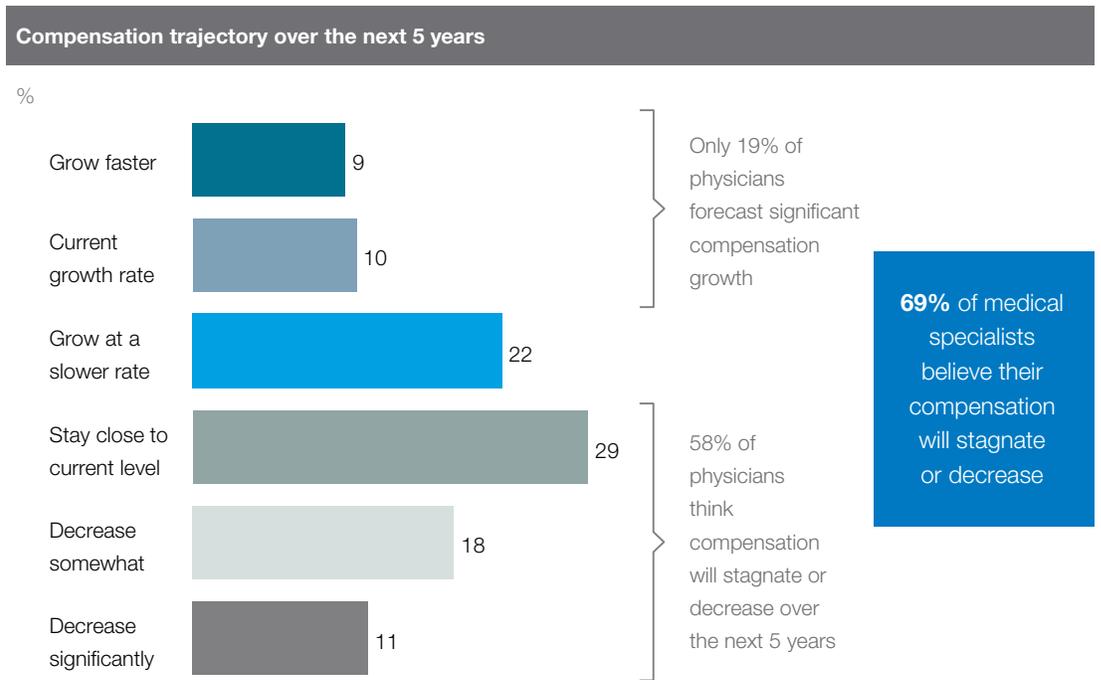
Shifting performance risk to providers without giving them meaningful support is likely to lead to less-than-anticipated results. It could also bring about widespread provider failure (as was seen in some markets that experimented with capitation in the 1990s).

To avoid these risks, payors (along with hospitals and physician organizations that assume population risk) should offer extensive, direct support to providers, especially physicians. Individual physicians, even more so than institutional providers, frequently lack the know-how, infrastructure, and resources to make the required changes and need help to do so.

⁵ Estimate is based on a detailed diagnostic of all healthcare spending in two different large states.

Exhibit 8

Most US physicians believe their compensation will stagnate or decrease



Source: 2011 McKinsey Physician Survey

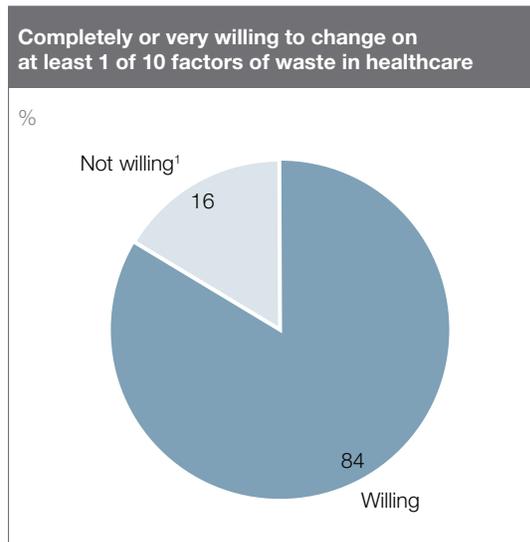
In many cases, payors are in the best position to provide the necessary assistance. This is especially true in highly fragmented markets.

As they offer support, payors should remember that most physicians are well intended and—in theory—fairly willing to change their behavior. McKinsey surveyed more than 1,400 US physicians (both primary care providers and specialists); over 80% of them said that they were willing to change their own decision making and actions, or would collaborate to change other physicians’ practices, if doing so would reduce healthcare waste and inefficiency (Exhibit 9).

We also asked the physicians to weight the various strategies payors could use to encourage them to adapt their practices to reduce waste. As Exhibit 10 shows, payment was given less than 30% of the total weight. Collectively, nonfinancial support strategies were more critical.

Exhibit 9

US physicians express a surprisingly high willingness to change



¹ Those categorized as not willing responded 4 or lower on 6-point scale for all 10 factors

Source: 2011 McKinsey Physician Survey

and economic drivers of performance (role of treatment selection, resource utilization, etc.). Ideally, this information should be shared rapidly—as close to real time as possible. Moreover, those providers that accept accountability should be able to view cost and quality performance data for upstream and downstream providers. Payors cannot expect them to make value-conscious referral decisions or to coordinate care effectively without this information.

Decision support and prioritization

Payors should help identify the biggest opportunities providers have to improve clinical and economic performance and then communicate this information, along with specific advice on how the opportunities can be captured. Too often, payors today either encourage evidence-based medicine but only in a general way, or they put incredible focus on a small number of very specific and easily measurable process metrics. In many cases, these metrics have little real impact on outcomes or costs, and thus collecting and analyzing data about them is merely an administrative burden for both providers and payors. Instead, payors should focus on specific practice pattern changes that, when implemented, would have the largest effect on cost and/or quality. Payors should therefore seek to understand the “top 10” highest return-on-investment decisions/actions for each patient, condition, and episode of care. Payors should also help

In our experience, providing direct support to physicians can lead to an order-of-magnitude greater decrease in costs than changing payment alone can achieve. Payors should focus their support in the following areas:

Performance measurement

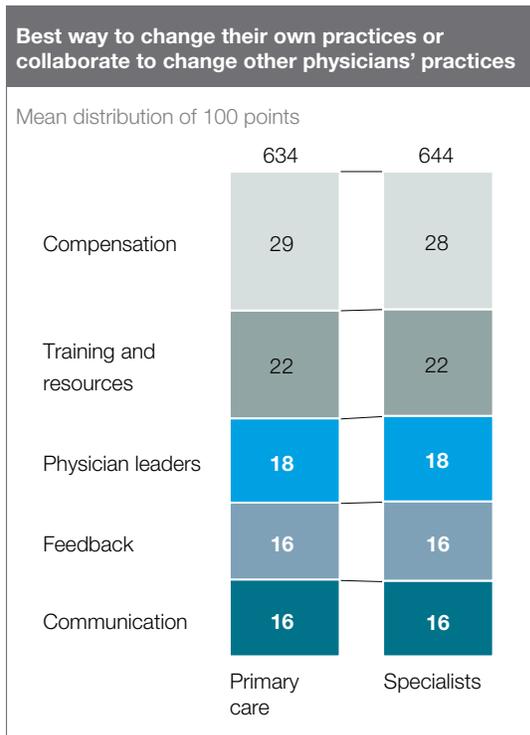
A fundamental part of any attempt to pay for value is to define, as specifically as possible, the targets providers are expected to meet and then to measure performance against those targets accurately and systematically. Ideally, payors should focus their attention on clinical outcomes and other measures that are important to patients.

End-to-end performance transparency

If providers are to accept accountability for outcomes and costs, they must be given robust cost and outcomes data, along with insights about the key clinical

Exhibit 10

Strategies beyond payment are required to change physician practices



Source: 2011 McKinsey Physician Survey

identify and promulgate specific best and worst practices at the market level for a particular situation or episode of care.

Mind-sets/culture

Most physicians have deep-seated assumptions or mind-sets about healthcare economics, their role in society, and what is in the best interest of patients. Unless payors are able to understand and, ultimately, influence those mind-sets, their attempts to change physicians' behavior are unlikely to be successful. Addressing physicians' mind-sets will require payors to partner with the broader provider community and to make significant investments in education and awareness building.

A wide array of other enablers, including training, capability building, and administrative assistance, can also be offered to providers to help them implement cost-reducing innovations (Exhibit 11). Payors should consider what role they, potentially in collaboration with other stakeholders, can play to ensure these enablers are available to clinical decision makers.

Synch with consumers

Strategies to control healthcare costs are often divided into those that are supply-oriented (they focus on the structure and behavior of providers) and those that are demand-oriented (they emphasize patient decision making). Unfortunately, some payors make the mistake of viewing outcomes-based payment exclusively as a supply-oriented strategy; they overlook the fact that most patients would also prefer to pay for value, not activity.

Instead, payors should fully align their consumer-oriented strategies with their approach to outcomes-based payment. As a first step, payors should give consumers greater transparency into the clinical and economic performance of different providers. Patients deserve to know that they are likely to pay more out of pocket if they go to a higher-cost, lower-value provider. They also deserve to know which providers are willing to be held accountable for their performance and which are not.

Exhibit 11

The right types of support can enable provider adaptation

System infrastructure	<ul style="list-style-type: none"> • Patient registry (including multi-payor portal, if needed) • Provider performance transparent to other providers • Cross-provider information exchange
Clinical support	<ul style="list-style-type: none"> • Evidence-based medicine (e.g., clinical pathways) • Workforce training and licensing • Changes to medical school curriculum
Practice transformation	<ul style="list-style-type: none"> • Methodology/approach to organize smaller practices • Governance and leadership to manage practice transformation • Clinical leadership/governance
Medical home infrastructure	<ul style="list-style-type: none"> • Care planning tools (e.g., risk stratification, care plans, clinical protocols) • Practice workflows and processes (e.g., case conferences, expanded hours) • Personnel (e.g., care coordinators, medical home point person)
Other stakeholder initiatives	<ul style="list-style-type: none"> • Employer wellness efforts • School prevention programs • Public health programs and policies (e.g., awareness campaigns, support systems)
Patient engagement	<ul style="list-style-type: none"> • Patient education/information • Tools for management (e.g., phone apps) • Transparent provider performance data

In addition, payors should align their network and benefit designs with outcomes-based payment. For example, they should base their network configurations on providers' willingness to accept outcomes-based payment and their overall performance. Payors could also lower co-payments or deductibles when patients seek care from providers with superior performance, and they could make sure that their patient engagement efforts (e.g., navigation tools, health coaching, and wellness programs) direct patients to such providers.

CHAPTER 4

Immediate actions



We encourage all public and private payors in the United States to consider taking four complementary actions: (i) compare your current portfolio of payment initiatives against the eight requirements outlined in this paper; (ii) set bolder, clearer, more public aspirations for your payment initiatives; (iii) collaborate more closely with other payors to establish and implement new approaches to payment; and (iv) increase the resources allocated to implementing outcomes-based payment at scale.

First, we suggest that payors examine their current payment initiatives to determine how many of the eight requirements the initiatives actually meet. By using the tests listed in Exhibit 12, payors can predict whether their initiatives are likely to have a substantive impact on costs. Payors should strongly consider redesigning any initiatives that meet few of these requirements.

Exhibit 12

Will your payment approach drive meaningful cost reductions?

Requirement	Test	Yes	No
re-Set expectations and align payment	<ul style="list-style-type: none"> • Clear, tangible expectations have been set for Healers and Partners • The majority of spending under management will be in robust population-based payment models within 3–5 years to reward Partners • Episode-based payment is major part of the strategy to reward Healers 	<input type="checkbox"/>	<input type="checkbox"/>
Significant	<ul style="list-style-type: none"> • 50% or more of each provider’s revenue will be outcomes-based and hence at risk 	<input type="checkbox"/>	<input type="checkbox"/>
Scope	<ul style="list-style-type: none"> • >30% of providers in the market will transition to outcomes-based payments that meet the “significance” test within the next 3 years 	<input type="checkbox"/>	<input type="checkbox"/>
Stable	<ul style="list-style-type: none"> • Full scale-up strategy and timing is transparent and understood by providers—they know how they will “win” in 5 years 	<input type="checkbox"/>	<input type="checkbox"/>
Striving but practical	<ul style="list-style-type: none"> • Approach does not require major changes in the regulatory/legal environment, alterations to the provider system structure, or the widespread adoption of interoperable IT 	<input type="checkbox"/>	<input type="checkbox"/>
Sustainable	<ul style="list-style-type: none"> • Most physicians and hospitals that transition to the new model will see their compensation/operating income remain steady or grow over the next 5 years 	<input type="checkbox"/>	<input type="checkbox"/>
Supportive	<ul style="list-style-type: none"> • Approach explicitly addresses system infrastructure and other enablers • Providers think that the data shared with them is valuable and actionable • Significant clinical resources are being deployed to train/coach providers 	<input type="checkbox"/>	<input type="checkbox"/>
Synch with consumers	<ul style="list-style-type: none"> • Approach is fully integrated with consumer incentives, network design, and other forms of patient engagement • Providers’ performance and outcomes achieved are transparent to consumers 	<input type="checkbox"/>	<input type="checkbox"/>

Second, payors should consider setting bolder, clearer aspirations for their payment initiatives and then publicize those aspirations both internally and externally. Doing so will help galvanize support within their organizations, send favorable signals to local providers, and give local leaders a mandate to drive change within their own organizations. As a result, many payors may realize some of the benefits of their payment initiatives even before significant risk sharing is put in place.

Third, payors should consider collaborating with other payors to help overcome common challenges to migrating to outcomes-based payment. As discussed previously, when new payment approaches achieve greater scale in a local market, it is easier for providers to embrace them and modify their behavior. By collaborating to introduce new payment approaches, payors could better achieve that scale, and potentially share investments in infrastructure and the other fixed costs associated with large-scale payment changes, such as provider education, new forms of data exchange, and support for practice transformation. For example, if several payors in a region were each planning to introduce medical homes, they would increase the odds of attaining the scale needed to persuade providers to set up such homes if they reached alignment on such common issues as the requirements to qualify as a medical home, care coordination expectations, quality metrics, and the timing of the new approach's introduction.

Two national initiatives, in particular, hold promise as frameworks to encourage multi-payor collaboration: the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care Program and State Innovation Model.

Understandably, many payors are concerned that stronger collaboration with other payors could undermine current or future competitive advantages and/or create legal or regulatory challenges. However, with the proper protections in place to avoid illegal activity, collaboration would allow payors to achieve these goals. We highlight below several examples in which industry participants successfully collaborated with each other and other stakeholders to better meet customer needs:

- *Visa* was established in the 1970s by several leading financial institutions to promote the use and acceptance of credit cards. Today, Visa is an association of thousands of banks and other financial institutions worldwide that helps authorize and settle electronic payments over a central system quickly and securely. Currently the largest payment network in the world, Visa processes several trillion dollars of transactions annually.
- *Blu-ray*: Nine major electronics companies joined together in 2002 to finalize technical details and develop a joint commercialization approach for this new technology. Over time, the founding group formed the Blu-ray Disc Association, which grew to include dozens of other manufacturers, studios, retailers, and other industry stakeholders. Blu-ray is currently the most commonly accepted standard for high-definition movies, and its development has benefited consumers as well as the stakeholders involved.

- *Orbitz* was founded and initially controlled by five major US airlines to access the rapidly growing online travel industry; give consumers an unbiased, comprehensive display of fares in a single location; and establish a lower-cost distribution channel. At one point, Orbitz was the third-most-visited travel site on the Internet and was eventually sold at a significant profit by the founding airlines.

Lastly, public and private payors (as well as providers that decide to assume the role of Partner or Healer) should consider increasing—perhaps by an order of magnitude—their financial and human capital investments in the migration to outcomes-based payment. As highlighted in Chapter 1, driving cost-reducing innovations in the healthcare industry is a monumental challenge. It will take substantial effort to develop the clinical and economic expertise, data infrastructure, and clinical support systems required.



Addressing the healthcare cost crisis in the United States is a daunting challenge but also a noble and necessary one. By ensuring that current and future payment initiatives meet the eight requirements described in this paper, we will increase the odds of our collective success.

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