



Using payments to drive cost-reducing innovations

When properly designed, outcomes-based payments can encourage innovations that improve care quality and reduce costs. How can you tell if your design is right?

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In countries around the world, many experts have come to believe that the health-care payment mechanisms in common use today fail to encourage the cost-efficient delivery of high-quality care. All too often, payment mechanisms reward failure or fail to reward healing. Consider, for example, that many hospitals earn additional income from preventable readmissions. Doctors typically receive the same reimbursement for a failed procedure as for a successful one.

Interest is therefore growing in new approaches to payment that promote the delivery of the best patient outcomes at the lowest possible cost. These approaches are often referred to collectively as outcomes-based payments. Most stakeholders agree, at least conceptually, that paying for outcomes can play a foundational role in reducing the use of low- or no-value care and improving care quality. However, what features the new payment approaches must have to ensure that they deliver optimal results has remained unclear.

To investigate this issue, we have conducted extensive research, interviewed numerous experts, undertaken detailed analyses, and reviewed our experience with clients. Our investigation was grounded in a simple idea—that new payment approaches will generate savings and improve care quality only to the extent that they generate real changes in how providers¹ and consumers behave. If outcomes-based payments 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.

Our investigation has enabled us to identify eight requirements that we believe outcomes-based payments must meet if they are going to produce meaningful cost-reducing innovations in care delivery. We have also developed a list of questions that health systems and payors can use to determine if their new payment approaches are meeting these requirements.

Why innovation in healthcare is so difficult

Migrating to outcomes-based reimbursement that drives cost-reducing innovation in health-care delivery is exceptionally challenging. In most countries, hundreds or thousands of institutions and, potentially, millions of caregivers will have to alter their mind-sets and behaviors (Exhibit 1). 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. Many if not most providers do not have the full capabilities or know-how to improve their performance in any significant way.

Furthermore, implementing change may be harder in healthcare than in other industries. Many stakeholders fear that altering existing practices could adversely affect patient care. Some of the regulations and laws that govern health-care delivery in many countries can increase the difficulty of implementing change. The absence of interoperable IT systems or other effective ways to share large amounts of data impedes care coordination.

The eight requirements for outcomes-based payments

New payment models can address these challenges, but only if they are carefully designed to make it worthwhile for providers

¹In 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 physicians, hospitals, skilled nursing facilities, pharmacies, medical device companies, pharmaceutical companies, and other organizations.

Exhibit 1

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

	Mind-set/strategy shift	Behavior 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)

Exhibit 2

Requirements for payment to drive cost-reducing innovations

Requirement	Innovation
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
at Scale	Ensure that a critical mass of providers transition to outcomes-based reimbursement
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

and other stakeholders to embrace real change. Our research suggests that eight criteria must be met if outcomes-based payments are to improve care delivery and reduce costs (Exhibit 2).

re-Set expectations and align payment

Historically, few health systems or payors have clarified precisely what they expect from providers beyond certain basics (for example, meeting minimum credentialing requirements and following standard reporting procedures to obtain payment). This lack of expectations partially explains why all too often “everyone and no one” is accountable for achieving specific patient outcomes and/or managing chronic illnesses. Thus, before they devise new payment methodologies, health

systems (or the payors within them) should set clear expectations for providers.

New roles and expectations

In our view, a high-performing 21st-century health system needs providers to fill three primary roles: Component Providers, Healers, and Partners.

Component Providers. Health systems (and the payors within them) 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 only limited influence on upstream or downstream costs and/or the desired outcome. One example is a pathologist who analyzes biopsy samples.

“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.”

Other examples include diagnostic imaging services, pharmacies and other ancillary providers, pharmaceutical companies, and medical device manufacturers. Component Providers should seek to build economies of scale to supply the good/service in question with world-class efficiency and near-zero-defect quality.

Healers. When a patient has an acute health issue, health systems and payors should expect Healers to deliver a specific patient



outcome at the highest level of quality and at the lowest possible total cost. Healers are needed for all conditions, or “episodes of care,” that have a relatively clear desired outcome and predictable start and end points. Examples of such conditions include pregnancy, repair of a broken bone, most procedures, hospitalizations, and acute outpatient care, as well as some forms of 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. Thus, Healers must understand and be able to actively manage the relationships among all resources during the course of treatment, paying particular attention to the relationship between upstream services and downstream costs. That said, in most cases Healers need not have direct managerial, legal, or financial control over the Component Providers.

In most situations, a Healer will be a physician, physician practice, or hospital. However, it could also be an urgent care facility or

How different provider groups would interact: an illustration

To illustrate how the different provider groups could work together in the future, let's assume that the Jones Clinic, a primary care practice, 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 community-based cardiac surgeon, performs the procedure and is consid-

ered 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. (Note: If Dr. Smith were an employee of a hospital, the hospital—not Dr. Smith—would be the Healer of record.)

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 a fee-for-service basis for the drug itself. 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.

mental health professional—whichever provider is in the best position to influence the overall cost and quality of care delivered during the specific episode.

Partners. Health systems and 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 must encourage appropriate preventive care, 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. Ideally, every person would have a specific provider—either an institution or human being—as their Partner.

Today, few health systems or payors reward providers for playing a role beyond that of a Component Provider. Furthermore, few providers currently have the skills, infrastructures, and other capabilities needed to serve as Healers or Partners. In the ideal end-state, however, every person would receive healthcare services under the direction of—but not always directly from—a Partner who is accountable for the total cost of those services. The treatment of most acute episodes would be under the direction of a Healer, who would work in close collaboration with the patient's Partner.

It should be noted that the same provider could play all three roles, depending on the context. The sidebar above provides more details about how these three groups would interact.

Exhibit 3

re-Setting expectations for providers and aligning payment

Expectation	Most applicable	Ideal payment types
Partner Supports patients over time to help them maintain or improve their health	<ul style="list-style-type: none"> • Primary prevention for healthy patients • Care for chronically ill patients (e.g., management of obesity, CHF) 	Population-based payments <ul style="list-style-type: none"> • Partial and full capitation • Medical homes • Accountable care organizations • Health homes • Other global payments
Healer Leads team of providers to deliver a specific outcome at the lowest possible cost	<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) 	Episode-based payments <ul style="list-style-type: none"> • Prospective bundled payments • Retrospective episode-based payments
Component Provider Delivers a high-quality product or service at the lowest possible cost	<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) 	Fee-for-service payments (including pay-for-performance) <ul style="list-style-type: none"> • Bonus payments tied to quality • Bonus payments tied to efficiency

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

Align payment to expectations

Payment methods would differ for the three groups but in all cases would reward providers that deliver against the expectations for the roles they play (Exhibit 3). In the ideal end-state, Component Providers would continue to receive fee-for-service payments. Even in these cases, however, payors should strive to link payment to the value delivered by the product or service through bonus payments or other forms of pay-for-performance.

Episode-based payments should be used to reward a Healer for efficiently and successfully achieving a specific patient outcome. There are two distinct types of episode-based payments: prospective bundled payments

and retrospective episode-based payments (REBPs). (For more information about episode-based payments, see the sidebar on p. 23).

Partners should be paid through population-based payment models that measure and hold providers accountable for the health and the total (or end-to-end) cost of care for a group of patients over time. Examples of such models include partial and full capitation, accountable care organizations, medical homes, health homes, and other global payments.

Significant

Outcomes-based payments are likely to influence providers' behavior only if the providers believe that real money is at stake. 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 therefore need a strong incentive to make the needed changes. Consider, for example,

a physician in a multi-payor health system who derives 25 percent of her income from a single plan. If that plan implemented a new reimbursement system that put 10 percent of its payments to the physician at risk, the change would affect only 2.5 percent of her

Paying for episodes of care

Episode-based payments can be grouped into two distinct types: 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 will be difficult for many health systems to implement (at least in the short term), given the administrative, legal, and financial challenges required for providers to accept them.

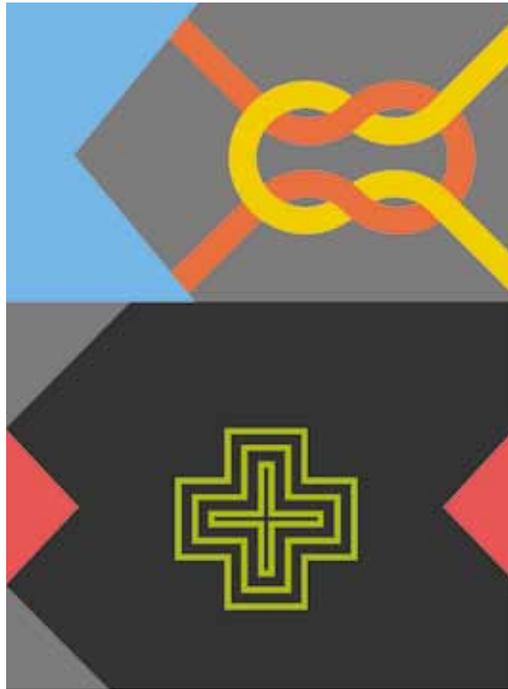
REBPs, on the other hand, can be built on the claims systems currently used in many countries. In brief, REBPs apply both gain- and risk-sharing calculations retrospectively, based on the total cost and quality of an episode of care. With this payment approach, all providers are paid as they currently are for the services they deliver during an episode of care. However, at regular intervals (perhaps quarterly), the average cost per episode is calculated for the providers designated as Healers. All costs are adjusted for patient risk and in some cases for other factors, such as setting of care, quality, and unique circumstances. Each Healer's average cost per episode is then compared with predetermined thresholds. Any savings or excess costs are divided between the Healer and payor.

We believe that in the short term (perhaps the next three to five years), REBPs may offer many countries a greater opportunity for cost reduction than other new payment approaches do, because they do not require major structural changes, yet they establish a direct

link between incentives and outcomes. REBPs encourage and reward immediate cost-reducing changes in provider behavior, and they create long-term pricing signals that can encourage future innovations in care delivery. Because they are anchored in defined outcomes, REBPs enable health systems and payors to evaluate provider performance with a high level of specificity. At the same time, they empower providers, because they eliminate the need for health systems or payors to micro-manage clinical decision making. (For example, there is no reason to require preauthorization of a diagnostic test if a Healer is being held financially accountable for the value that test delivers.) Thus, REBPs could be a pragmatic solution for many health systems looking to gain rapid impact from outcomes-based payments.

The State of Arkansas has proved the administrative feasibility of REBPs, even in a health system as fragmented as the one in the United States. 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. Arkansas will report its initial results with this new payment model next summer.

Over the long term, bundled payments (either REBPs or prospective payments) could be used as part of a defined suite of payment approaches, such as the one we discuss in the main article. The configuration of each health system will likely determine whether REBPs or prospective bundled payments are more appropriate for long-term use.



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.

To maximize the effectiveness of outcomes-based payments, health systems and payors should therefore commit to—and communicate—their intention to migrate most or all of their payments to the new approach within a few years. In multi-payor systems, health insurers might also consider collaborating on new approaches to achieve greater impact. Admittedly, there is no clear, empirically defensible threshold for how much money is sufficient to overcome resistance. 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.

at Scale

Having a significant amount of money at stake is necessary but may not be sufficient 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 are transitioned to outcomes-based payments. Physicians, for example, are unlikely to significantly increase their collaboration with peers until a large number of the providers in their market have transitioned to outcomes-based payments. Device manufacturers are unlikely to change their R&D strategies to lower production costs until they realize that numerous clinical decision makers throughout a country are now sharing financial accountability for device selection (and thus have a strong reason to select less expensive equipment when it is as appropriate as a more costly alternative).

Stable

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

In addition, health systems/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 (for example, “we intended to maintain this reimbursement level for two or three years at a minimum”).

Striving but practical

In most countries, full implementation of many cost-reducing innovations will require multiple structural changes, including the widespread adoption of interoperable IT systems to permit shared medical records, modification of labor regulations, greater consolidation in some sectors, and greater competition in other sectors. Although these structural changes are important, few of them are likely to be fully realized in the next few years.

Therefore, health systems and payors that want to drive cost-reducing innovations at scale in the near term must develop new payment approaches that will work in the absence of these structural changes. Instead, the approaches must accept the current reality, which in many countries will include multiple sub-scale hospitals, small primary care physician practices, and low levels of clinical or economic integration.

Sustainable

Because the widespread use of outcomes-based payments will significantly increase performance pressure on providers, three hard truths must be acknowledged. First, if providers are to bear financial accountability for the cost and quality of the care

“It is clear that if outcomes-based reimbursement is to succeed over the long term, the payments and incentives it offers should be sustainable for most providers.”

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 may have to exit the market, shrink, or be acquired. Third, reducing or limiting the rate of growth in health system or payor costs requires that other entities lose revenue or face slower revenue growth.

Nevertheless, it is clear that if outcomes-based reimbursement is to succeed over the long term, the payments and incentives it offers should be sustainable for most providers. Performance pressure should thus be carefully calibrated to give sufficient time



Practical suggestions for developing sustainable payment models

Health systems and payors that want to ensure that their new payment models are financially sustainable for most providers should bear the following suggestions in mind:

Payment approaches should ensure that providers that make the necessary changes and lose revenue as a result should have the potential to expand their margins or return on invested capital. (This is especially applicable for hospitals.)

Health systems and 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 a fee-for-service basis (for example, imaging, generic drugs, and durable medical equipment). Providers that find high-

quality ways 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 innovate.

The new payment approaches should, in most cases, increase net physician take-home compensation, because physicians remain the major decision makers within most health systems. They are in the best position to champion many cost-reducing innovations, including greater value consciousness in referrals and treatment selection, and more effective patient education. Physicians are also well-positioned to apply healthy performance pressure on the facilities with which they are affiliated.

and positive encouragement to providers willing to adapt. At a minimum, payors should avoid constructs that could lead some providers (especially hospitals with large fixed cost bases) to fail financially in the short or medium term. Over the long term, the payment systems should be structured so that providers willing to adapt have the potential to thrive financially.

Sustainability is crucial for several reasons. Most markets have insufficient excess capacity to allow volume simply to shift to the highest-performing providers; thus, cost-reducing innovations can be implemented only if most providers improve performance. Accomplishing this can be difficult, however, because in many markets, providers are powerful stakeholders that can prevent or 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 than attempting to make improvements.

Practical suggestions for health systems and payors that want to develop sustainable payment models are given in the sidebar above.

Supportive

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

To avoid these risks, health systems and payors should offer extensive, direct support to providers, especially physicians; specific examples of the types of support that can be given are listed in Exhibit 4. 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. As they offer support, health systems and payors should remember that most physicians are well intended and—in theory, at least—fairly willing to change their behavior if they believe that doing so would improve patient care. In our experience, offering direct support to physicians can lead to a decrease in costs that is an order-of-magnitude greater than can be achieved by changing payment alone.

In many countries (especially those with highly fragmented markets), payors are in a strong position to provide many elements of the needed support. Payors are particularly well positioned to offer help in four main areas:

Performance management. The targets providers are expected to meet should be defined as carefully as possible, and their performance against those targets should be measured accurately and systematically. Ideally, most of the targets should reflect 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

Exhibit 4

Examples of support that 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

about the key clinical and economic drivers of performance (for example, treatment selection and resource utilization). Moreover, those providers that accept accountability—that is, Partners and Healers—should be able to view cost and quality performance data for upstream and downstream providers. They cannot be expected to make value-conscious referral decisions or to coordinate care effectively without this information.

Decision support and prioritization. Payors can 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. Wherever possible, they should focus on specific practice pattern changes that, when implemented, would have a large effect on cost and/or quality. In addition, payors should help 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 about healthcare economics, their role in society, and what is in the best interest of patients. Unless payors (and health systems, more broadly) can influ-

ence these beliefs, their attempts to change physicians' behavior are unlikely to succeed. However, influencing physicians' mind-sets may require payors to partner with the broader provider community and to make significant investments in education and awareness building.

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 health systems and payors make the mistake of viewing outcomes-based payments exclusively as a supply-oriented strategy; they overlook the fact that most patients would also prefer to pay for value, not activity.

Instead, health systems and payors should fully align their new payment approaches with their consumer-oriented strategies. As a first step, they should give patients greater transparency into the clinical and economic performance of different providers. Patients deserve to know which providers are willing to be held accountable for their performance and which are not. And in systems that require copayments, they also deserve to know that they may have to pay more out of pocket if they go to a higher-cost, lower-value provider.

In multi-payor health systems, payors should also align their network and benefit designs with outcomes-based payments. For example, network configurations could be based on providers' overall performance and willingness to accept such payments. Payors could also make sure that their patient engagement efforts (for example, navigation tools, health



Exhibit 5

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"/>
at Scale	<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"/>

coaching, and wellness programs) direct patients to providers with superior performance.²



We believe that all health systems and payors should examine their current payment initiatives against the eight requirements outlined in this article. By asking the questions in Exhibit 5, they can predict whether those initiatives are likely to have a substantive impact on costs. Those that do should receive strong

support. Finding ways to provide better care at lower cost is extremely challenging, but it is also noble—and necessary. 

Tom Latkovic, a director in McKinsey's Cleveland office and a leader in its Healthcare Systems and Services Practice, has worked extensively on innovative approaches for healthcare payors. This article is an abridged version of a white paper that provides more details about healthcare payment innovations, especially retrospective episode-based payments; interested readers can contact him (tom_latkovic@mckinsey.com) for a copy of that paper.

²For more information about how to encourage patients to adopt healthier behaviors, see the article on p. 64.