Outcomes based commissioning

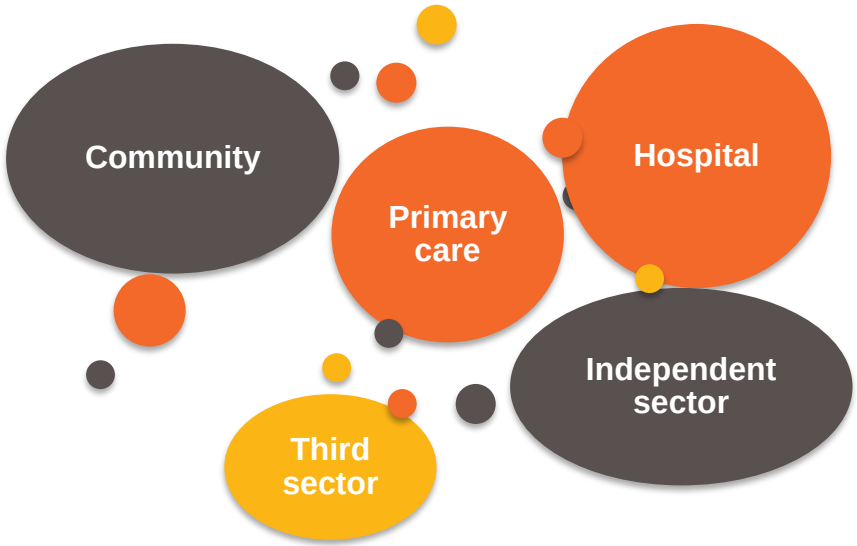
The ‘why’ and ‘how’

DR DIANE BELL, DIRECTOR OF INSIGHT

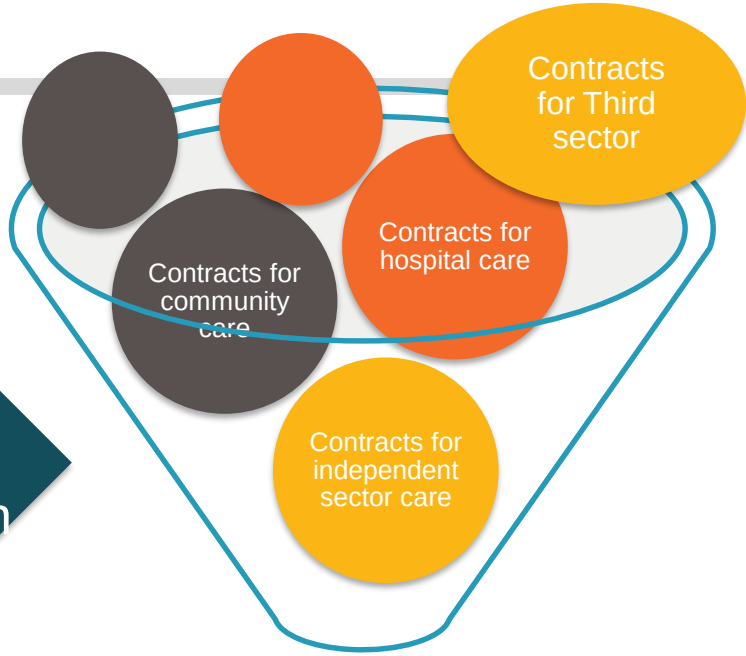
Challenges for payers

- Patients' challenge:
  - Too fragmented, 'ping ponged', 'sausage machine'
- Population challenge:
  - Inequitable care, hospital-centric system, too little focus on self-care or shared decision making
  - System needs transformation, a catalyst to change
- Accountants' challenge:
  - Poor control through multiple contracts and micro-commissioning
  - No more money!

What if we did it a different way?



Co-ordination

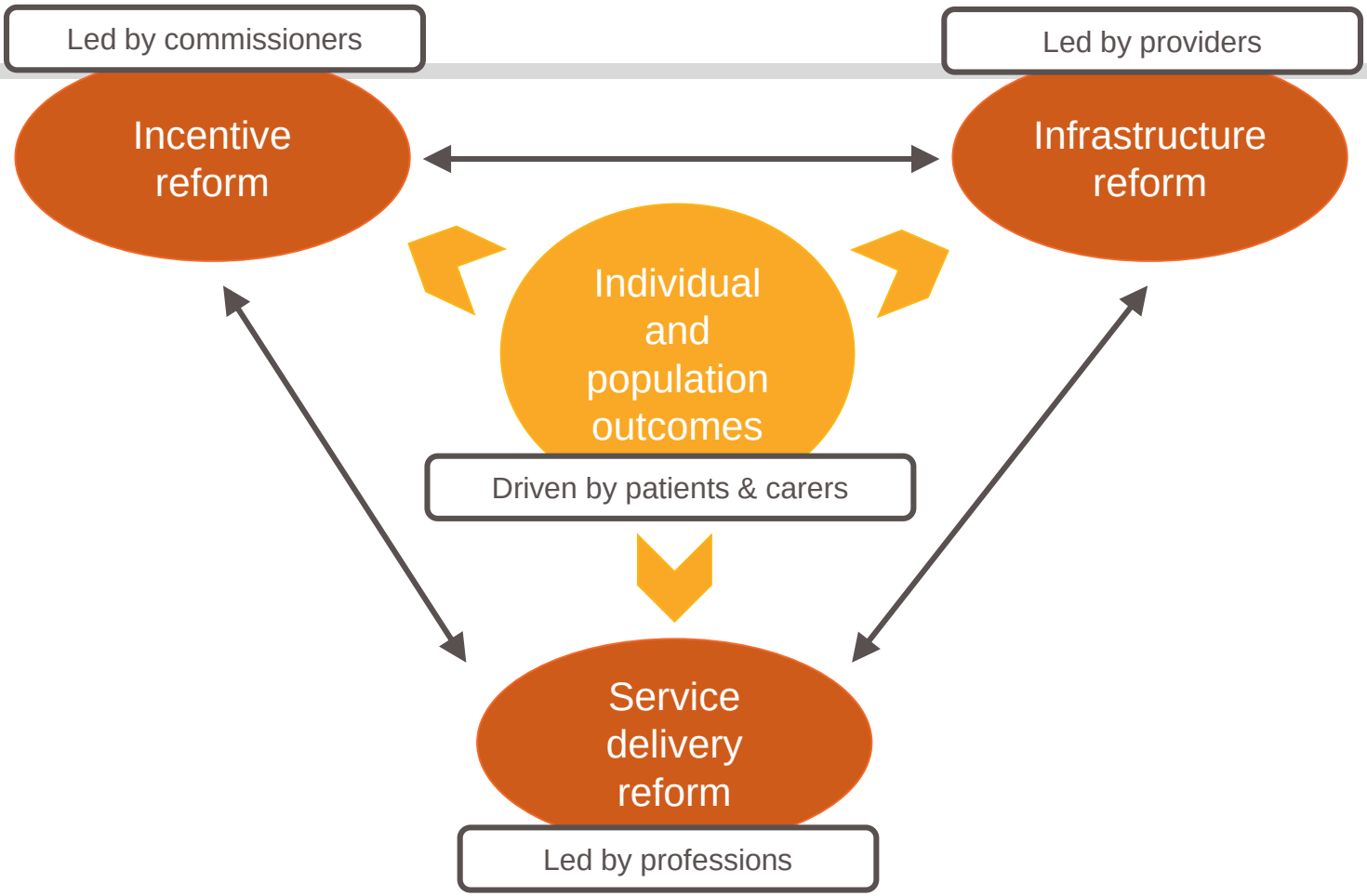


Capitated Outcomes-Based Incentivised Care

Multiple payer and provider relationships

Simpler relationships

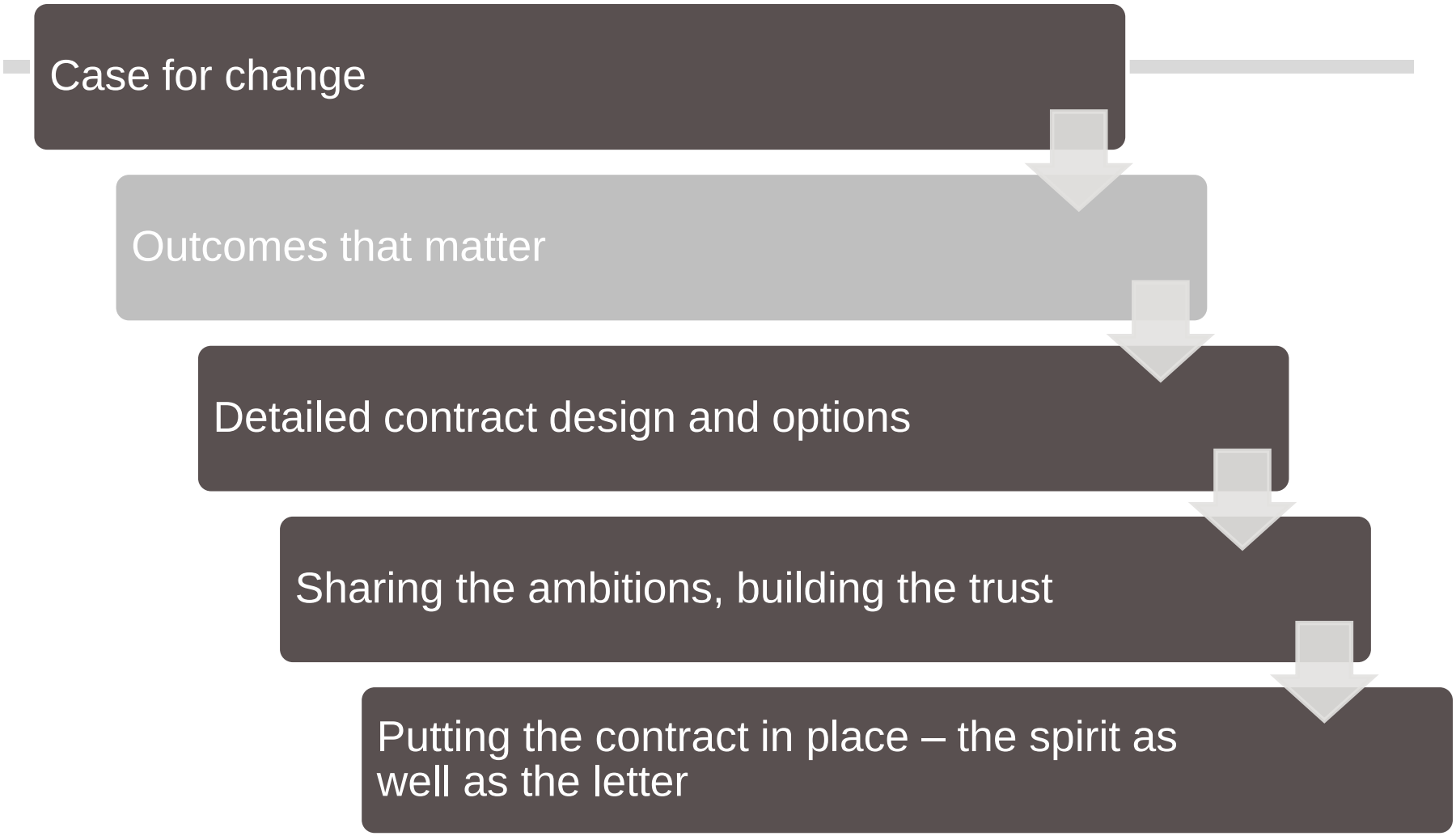
Outcomes central to service change



English national policy agrees

- A new relationship with patients and communities
- Promoting wellbeing and independence need to be the key outcomes of care
- We need to manage systems not just organisations
- ‘payment-for-outcomes’

Part of a broader change in approach



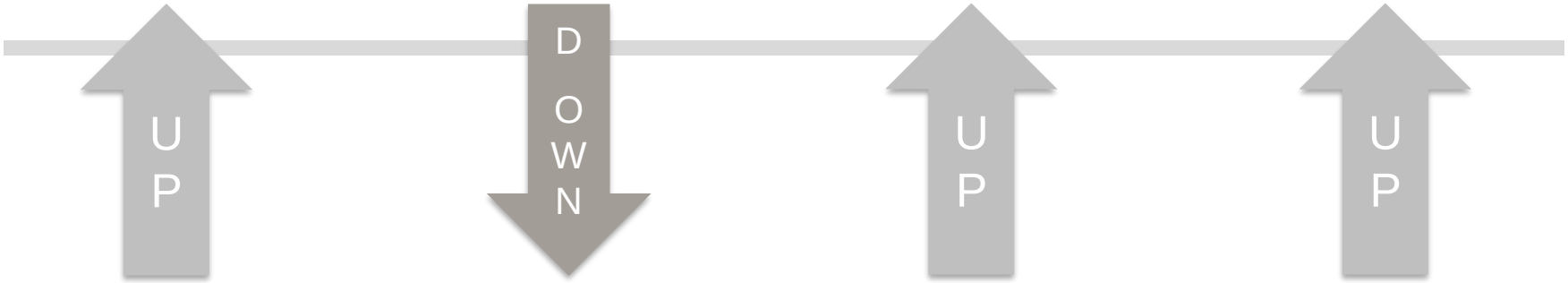
Whose outcomes are they?

- Dialogue with patients and the public
- Incorporation of ‘best practice’ outcome measures
  - ICHOM: MSK, mental health, cancer…..
  - Activation and goal attainment (PAM, GAS)
- Population outcomes: life expectancy, inequalities
- Feedback from staff: how was it for you?

Bedfordshire's MSK project

- Aim: To ensure delivery of high quality MSK care and experience to patients and improve outcomes within available resources
- Single budget (c. £26m pa), prime contract for 5 years
- Four main 'stages' of care:
  - Patient support and empowerment
  - Support, education and advice for primary care
  - Community-based MSK service
  - Use of hospital facilities only when those facilities are needed
- Incentivised 'game-changing' outcome measures

Impact already being seen



Shared Decision Making	Referrals to hospital care	Patient Outcomes	Community-based care
35% of patients having a dedicated discussion choose alternatives to surgery	24% reduction in referrals to hospital-based care	Tracked across whole pathway 7,700 measures collected 84% positive health gain (from 70% in 1yr.)	From 32% of total spend in 2012 to 48% now. On track for 52% by 2018

Data from Bedfordshire MSK, courtesy of Circle, Jan 2016

Lessons from early adopters

1. Remember the voice of patients, carers, communities
    - Don’t allow cost-savings to dominate
2. Focus on how to get best outcomes, not keeping current service patterns
3. It’s about more than the money – but you’ve got to get the money right!
4. Replace control with trust
5. Respect and free up front line staff from across organisations to learn together, innovate, test and improve

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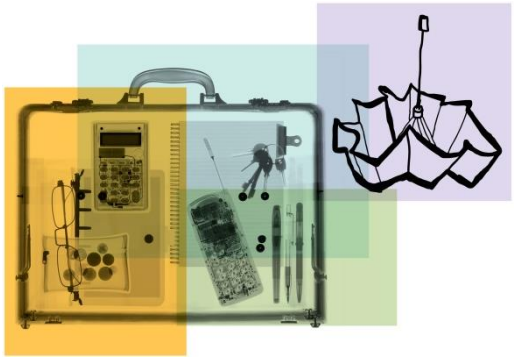


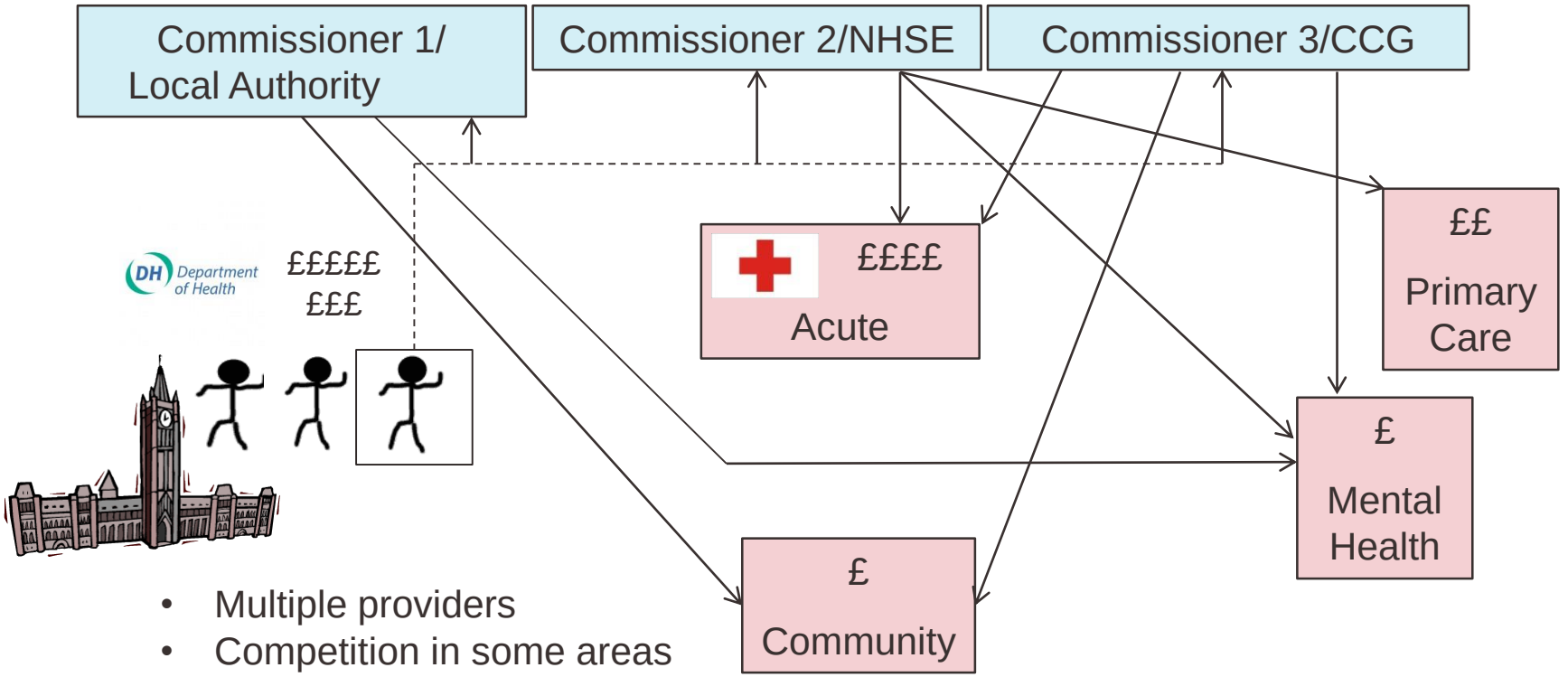
Outcomes based commissioning: The English legal experience

Robert McGough – Partner, Capsticks

May 2016

@capstickslip

The English NHS
A complex contracting system …



- Multiple providers
- Competition in some areas
- Fee for services (or block)
- Volume based

Structural change required?

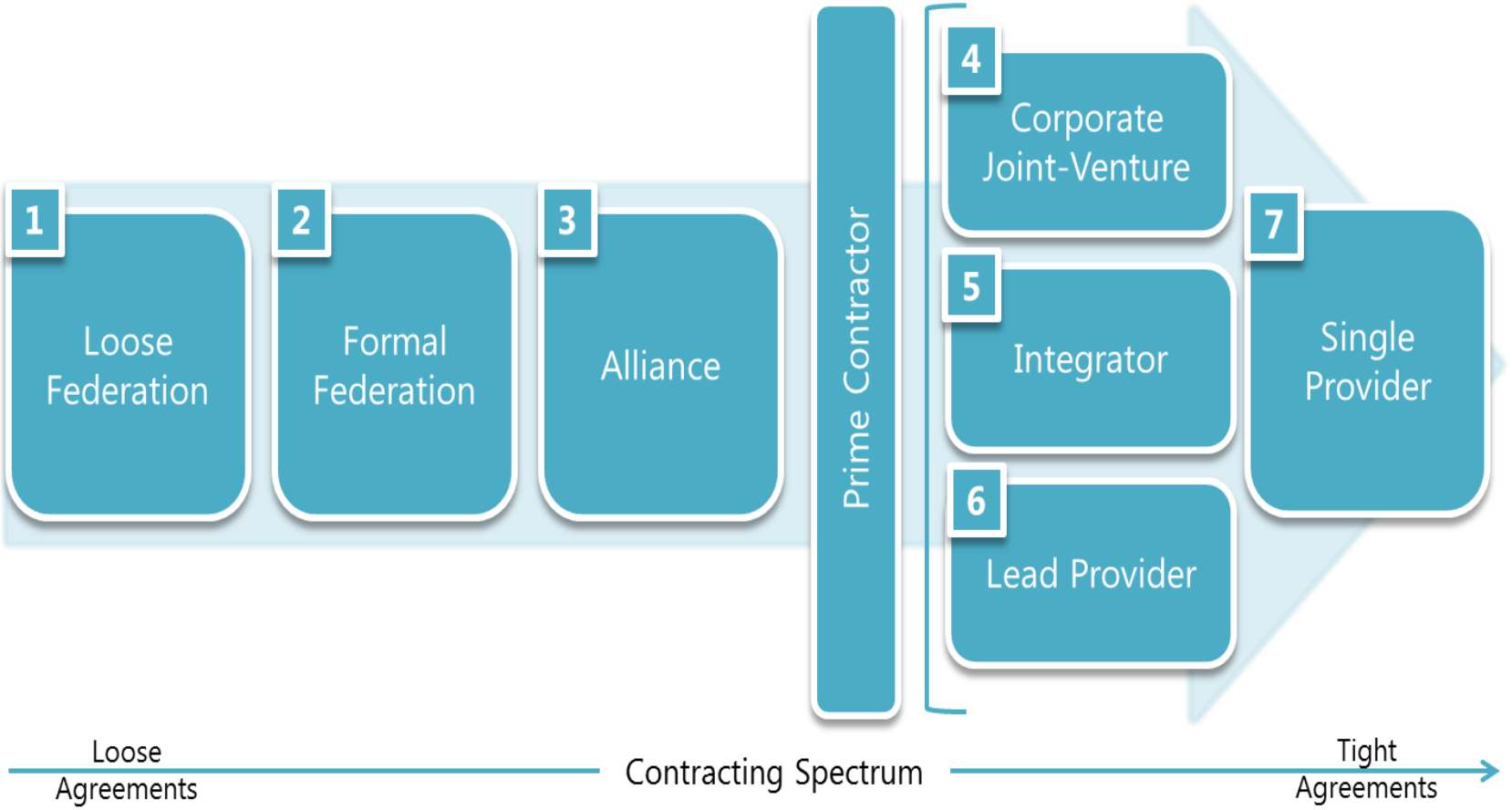
- NHS England – Five Year Forward View
- Looking more towards system/population based solutions and less towards organisational contractual models
- Commissioner/Providers are split in England so Commissioners' strategy plays a key role
  - how many contracts? If one, who holds it and will there be sub-contracting?
  - If more than one, how will providers be made to work together?

Moving towards “Bundled Contracts” for care pathways and populations with outcomes

Bundled Contracts:

- Differ from previous fee-for-service/tariff, block payments
- Encompasses a single payment for a full cycle of care, with mandatory outcome reporting
- Involve multiple providers working together - incentivise to improve outcomes and lower costs across full care cycle
- Underpinned by contracts which allow for shared incentives between providers on achievement of agreed outcomes
- Contract examples – Lead Accountable/Prime Provider- Cambridge & Peterborough and Bedford MSK - Alliance contracts – Lambeth, Leicester …

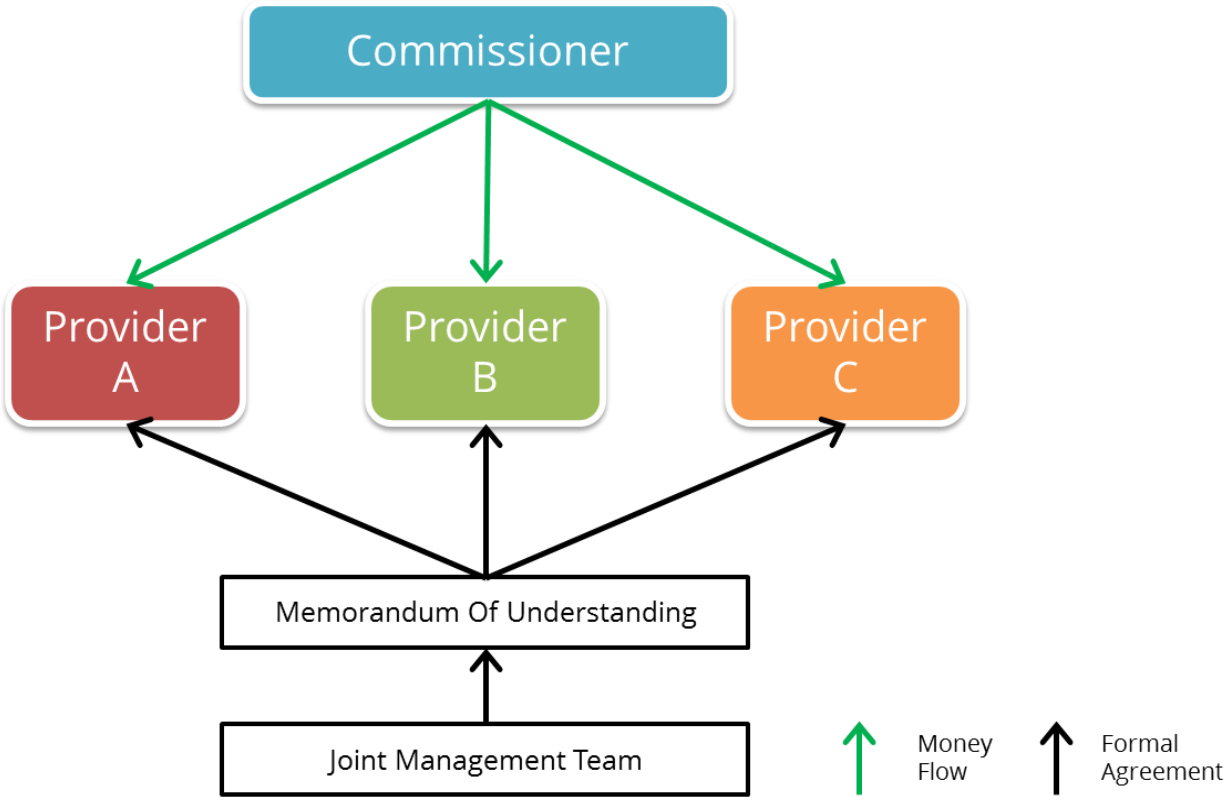
Contracting Structures



Source: 'Contracting for Outcomes', Outcomes Based Healthcare and Capsticks, 2014

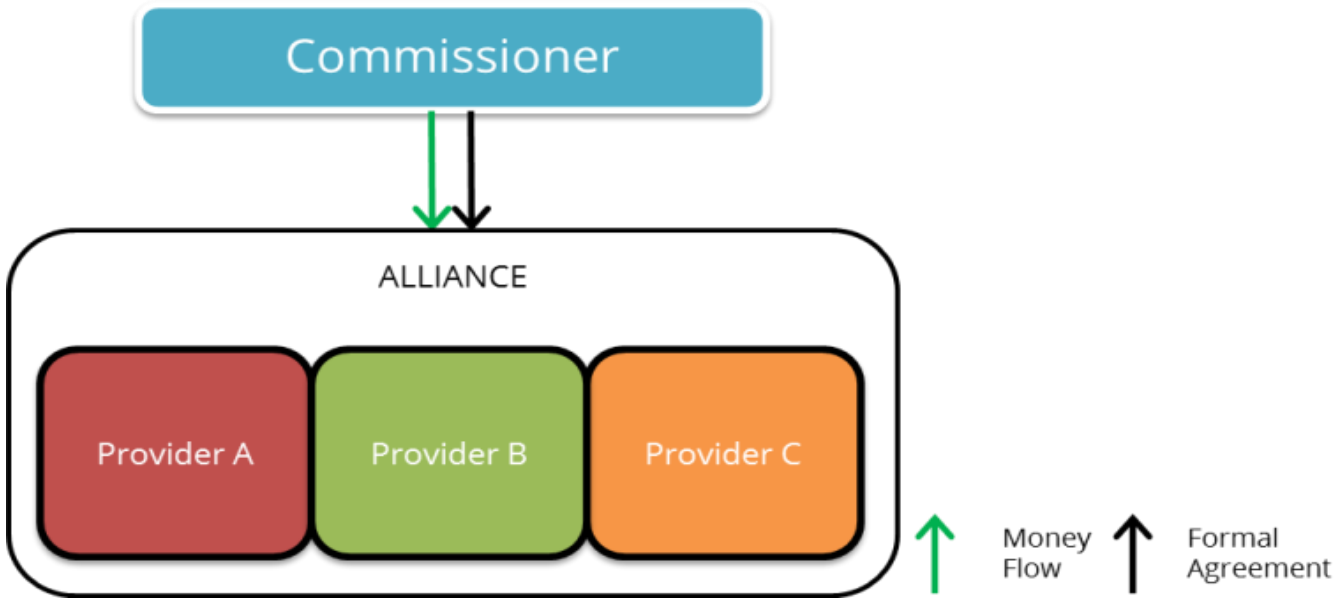
Federated Providers (closer working)

- What is it?



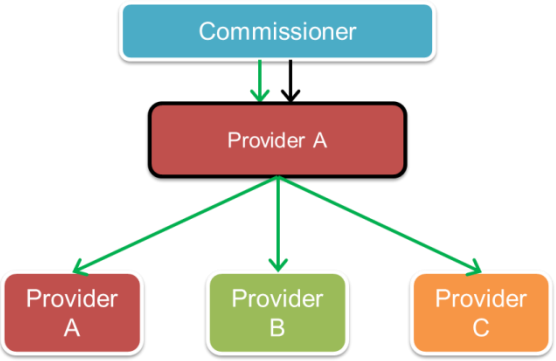
Alliance Contracting

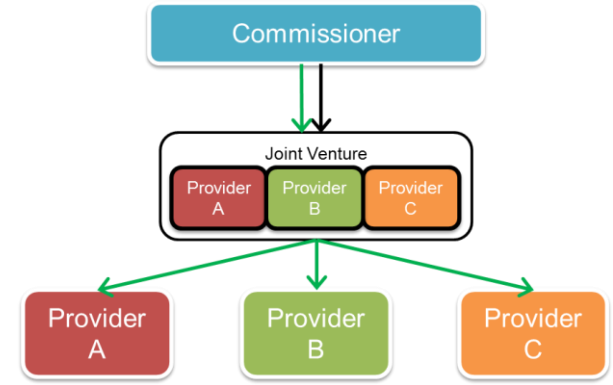
- What is it?
- How does an Alliance operate?
- Where has it been used before?

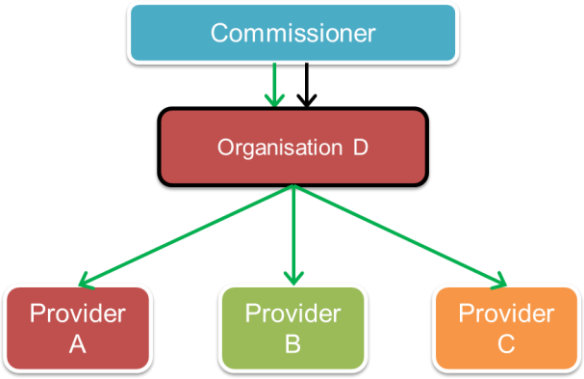


Prime Contractor

- Also called Prime/Lead Provider or Integrated Pathway Hub.
- What is it?
- Who are the parties?







Considerations – moving to outcomes based contracting (1)

- Existing contractual restrictions
- Accurate budget data (getting the price right)
- Double Counting of Services
- How many outcomes?
- Flow down to sub-contractors
- “Double Jeopardy” under contractual remedies

Considerations – moving to outcomes based contracting (2)

- Procurement of the new model or variations – considerations
  - New procurement regulations
  - Contract variations – materiality, length of contract term, risk
- Governance across Commissioners and Providers (decision making)
- Managing increased Council involvement in Health – Section 75's, pooled budget and Better Care Fund
- Data – information governance across organisations
- Regulatory/contractual restraints – GMS/PMS/APMS and NHSSC
- Workforce issues and models – where do the staff go/flexibility of terms and workforce models
- Competition concerns – creating a dominant provider…
- Consultation

Contact details

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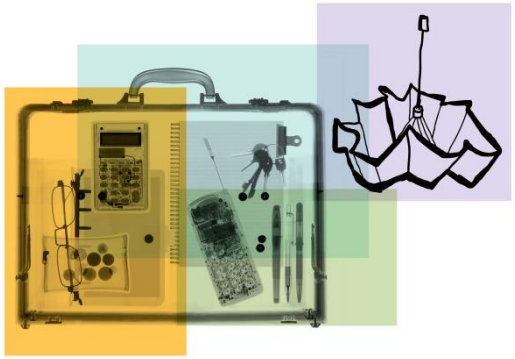

Outcomes-based Contracting in the US: a unicorn without a backbone?

ICHOM International Summit

2016

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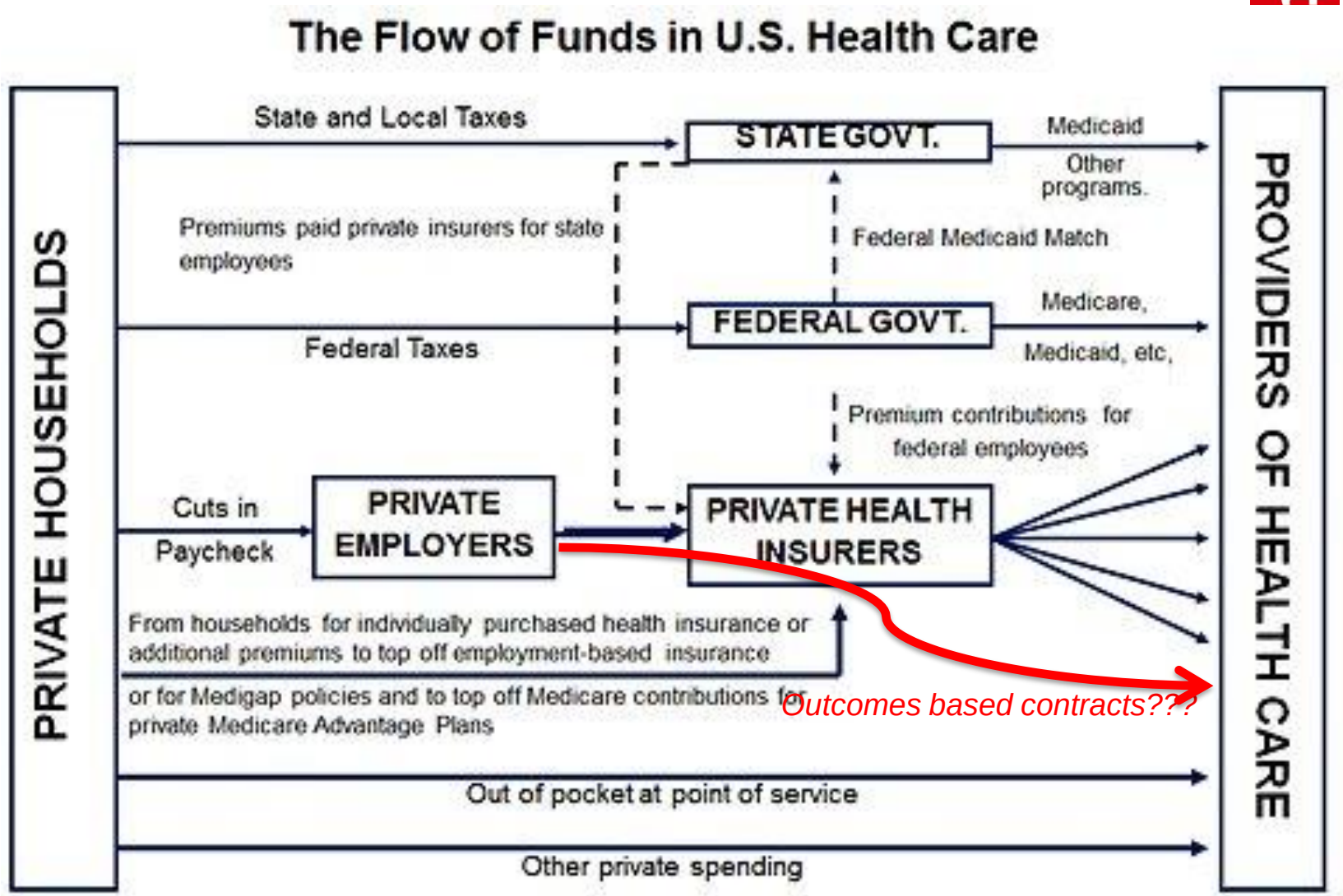
The US Contracting Maze, Oversimplified



Uwe Reinhardt, NY Times Blog, 9/30/2011

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Strategies to Accelerate Value

1. Competing providers gain market share based on outcomes
   - Today – benefit design that "steers" patients to higher performing providers, currently using price or composite "quality" scores based on process measures
   - Example: *Employers Centers of Excellence Network*
2. Payment larger or smaller based on outcomes
   - Today – two-party contracts with performance based payments, currently using process measures and slowly shifting to outcomes
   - Examples: *State of Washington, Intel ACO contracts*

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The Employers' Centers of Excellence Network

- Developed by employers for employers
- Addresses conditions with high cost and quality variation
- Directly contracts with the very best providers across the country
- Employs a travel surgery model
- Utilizes prospective episode-based bundled payments

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Program Value for All Stakeholders

PURCHASERS

- Competitive bundled rates
- ***Savings from better outcomes***
- Avoidance of inappropriate care
- Recruitment and retention advantage

PATIENTS

- Access to highest quality providers
- Savings from ***waived cost sharing***
- Concierge high touch experience

PROVIDERS

- Volume from outside typical service area
- Recognition of exceptional quality
- Collaboration on patient care and value based purchasing

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nter Evaluation Criteria

Employer Needs	Quality of Care	Patient Experience
➢ Location ➢ Bundled payment design ➢ Commitment to value ➢ Travel surgery experience ➢ Reporting on CoE performance	➢ Outcomes data and rankings ➢ Volume, training and experience ➢ Patient safety and experience scores ➢ Application of evidence-based medicine ➢ Registry participation	➢ Shared decision making ➢ Supportive resources ➢ Cultural competency ➢ Patient Reported Outcomes (PROs) collection ➢ Attention to the patient experience across the complete care continuum

Lowe's 2014 Outcomes and

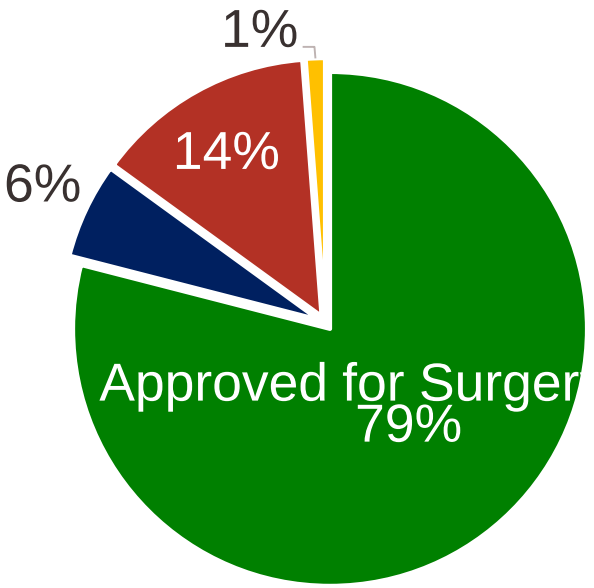
Quality Metric	Carrier	ECEN
Discharge to Skilled Nursing Facility	9.1%	0.0%
Readmissions < 30 Days	6.6%	0.4%
Revisions within 6 months	1.1%	0.0%

Pending

- Need to reduce BMI
- Need to stop nicotine use

Not Appropriate (Avoided)

- Most followed CoE recommendation
- Needed to attempt conservative therapy
- Previous misdiagnosis



Not Appropriate (had surgery outside ECEN)

- Subset had surgery against CoE recommendation of the CoE
- Patients paid cost-share under traditional benefit

Saved ***Lowe's nearly $1M from avoided, inappropriate care***

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Washington State ACO Contract

HCA Contract Number: **K1471**

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3. Overall Quality Improvement Score Calculation

3.1. Table I below lists the Weights w(i) and Target T(i) and Mean u(i) values used to calculate the overall Quality Improvement Score QIS used for the calculation of the Savings Share for Net Savings payable to the ACP or the Deficit Share for Net Deficit due from the ACP pursuant to Exhibit 3.1.

Table I.

Quality Measure	Quality Measure Description	Weight	Target	Mean
NQF 0059	1-Diabetes patients with A1C>9.0%	[redacted]%	[redacted]%	[redacted]%
NQF 0061	Diabetes patients with BP>140/90	[redacted]%	[redacted]%	[redacted]%
NQF 0055	Diabetes patients with eye exam	[redacted]%	[redacted]%	[redacted]%
NQF 0018	HTN patients with BP>140/90	[redacted]%	[redacted]%	[redacted]%
American College of Cardiology/AHA guidelines	CAD Statin prescribed	[redacted]%	[redacted]%	[redacted]%
NQF 0541	CAD Statin adherence	[redacted]%	[redacted]%	[redacted]%
NQF 0105	Depression Medication Management (12 Weeks)	[redacted]%	[redacted]%	[redacted]%
NQF 0105	Depression Medication Management (6 Months)	[redacted]%	[redacted]%	[redacted]%

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Intel ACO Contract Performance

REQUIREMENT	SCORE	PERFORMANCE	OUTCOME SUMMARY
Member Experience • Provider quality of care • Satisfaction with experience, likelihood of recommending	Quality **98%** Experience **94%**	EXCEEDED	Member experience metrics exceeded target and showed an overall positive trend throughout the year. Patients were happy with their provider and their experience with the healthcare system. They were likely to recommend their provider and/or PCMH to peers.
Evidence-Based Medicine • Diabetes (D3) bundle (Minnesota Criteria) • Depression screening	Diabetes **39%** Depression **93%**	EXCEEDED	Outcomes for the diabetes (D3) bundle exceeded the target, showing statistically significant improvement in the percent of "good control" of their es facilitated by clinical etter patient awareness
Right Time, Right Service • Nurse call response time • Time to 3rd next available PCP appointment • Initial engagement with PCMH	Response **94%** PCP Appt **65%** Engagement **68%**	EXCEEDED	ients had timely access to to their PCMH provider ded the target for 2013. The nts in their care, offering ensuring appropriate ogram members.
Cost • Medical and prescription costs	**3.6%** higher than projected	DID NOT MEET	Costs were higher in Year 1 due to increased member engagement, proactive primary care, and more pregnancies than predicted. Overall PMPM exceeded target. Presbyterian has actively looked for ways to reduce costs in subsequent years. Projections are becoming more specific each year.
Function-Learning Measure • Short-term disability	N/A	N/A	The population size was too low to draw conclusions about any impacts the program may have had. It was recognized that plan design was the most significant driver of disability metrics. Moving forward, more population-focused metrics will be added.

All of:

- HbA1c < 8%
- LDL < 100 mg/dL
- BP < 140/90

PHQ-2 depression screen

PHQ-9 follow-up

PCP: Primary Care Provider **PCMH:** Patient-Centered Medical Home **PMPM:** Costs Per Member Per Month

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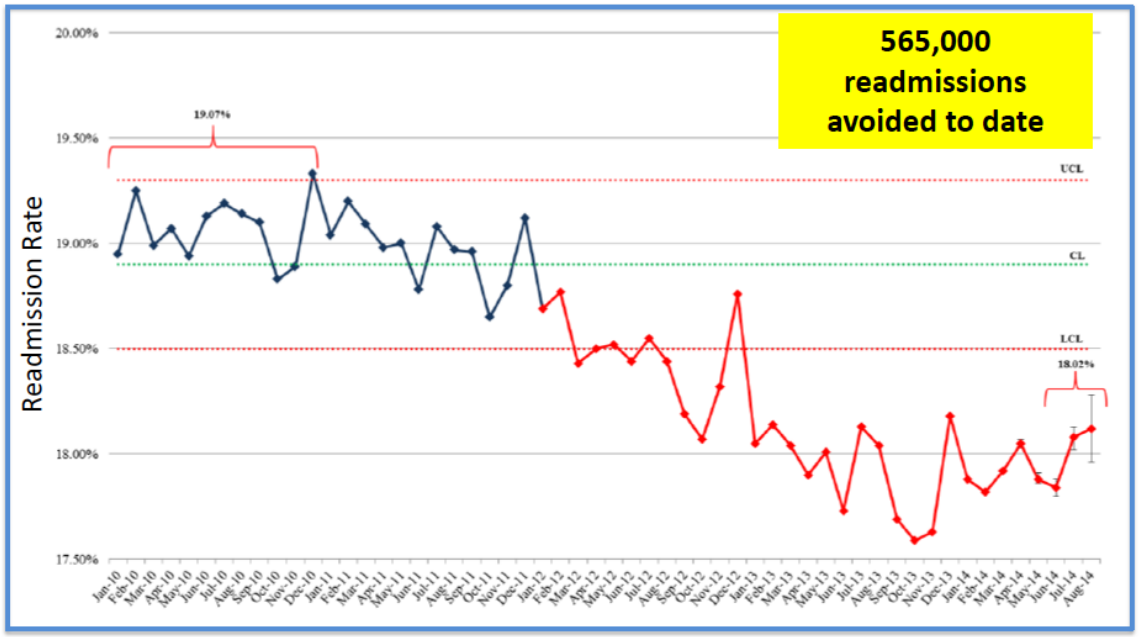
Use of Outcome Measures to Accelerate Value

- Simplest and most effective:
  - CMS readmission penalties
- Crude but feasib
  - Bree Collaborat
  - Geisinger patie
- Requirement to
  - Employers Cen
  - CMS Oncology
  - CMS Comprehe (voluntary)
  - Massachusetts
- Requirement to
- Payment tied to

Medicare all-cause, 30-day hospital readmission rate is declining



Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. April 2014 – August 2014 readmissions rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.

Legend: CL: control limit; UCL: upper control limit; LCL: lower control limit

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Challenges to Outcomes Based Contracting in the US

- Slow penetration of value based payment
- Provider *fee-for-service* culture
- Data infrastructure to capture PROs
- Methodological consensus
- Patient engagement
- Purchaser and payer alignment

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