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?

Multiple payer and provider relationships

Simpler relationships

Community

Primary care

Independent sector

Hospital

Third sector

Contracts for community care

Contracts for hospital care

Contracts for independent sector care

Contracts for Third sector

Capitated Outcomes-Based Incentivised Care

Coordination
Outcomes central to service change

- Incentive reform: Led by commissioners
- Infrastructure reform: Led by providers
- Service delivery reform: Led by professions

Individual and population outcomes: Driven by patients & carers
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

- Case for change
- Outcomes that matter
- Detailed contract design and options
- Sharing the ambitions, building the trust
- Putting the contract in place – the spirit as well as the letter
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
35% of patients having a dedicated discussion choose alternatives to surgery

Referrals to hospital care
24% reduction in referrals to hospital-based care

Patient Outcomes
Tracked across whole pathway
7,700 measures collected
84% positive health gain (from 70% in 1yr.)

Community-based care
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
Outcomes based commissioning: The English legal experience

Robert McGough – Partner, Capsticks

May 2016
The English NHS
A complex contracting system …

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

Commissioner 1/Local Authority

Commissioner 2/NHSE

Commissioner 3/CCG

£££££

£££

Acute

££££

Primary Care

£

Mental Health

£

Community
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 …
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

Robert McGough
Partner, Capsticks
robert.mcgough@capsticks.com
@capsticksllp

www.capsticks.com
Outcomes-based Contracting in the US: a unicorn without a backbone?

ICHOM International Summit 2016
The US Contracting Maze, Oversimplified

The Flow of Funds in U.S. Health Care

PRIVATE HOUSEHOLDS

State and Local Taxes

Medicaid
Other programs.

Premiums paid private insurers for state employees

FEDERAL GOVT.

Federal Medicaid Match

Medicare,
Medicaid, etc.

PRIVATE EMPLOYERS

Other private spending

Out of pocket at point of service

PRIVATE HEALTH INSURERS

From households for individually purchased health insurance or additional premiums to top off employment-based insurance or for Medigap policies and to top off Medicare contributions for private Medicare Advantage Plans

Federal Taxes

Premium contributions for federal employees

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

Outcomes based contracts???
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
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
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
# Center Evaluation Criteria

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

- **Location**
- **Bundled payment design**
- **Commitment to value**
- **Travel surgery experience**
- **Reporting on CoE performance**
### Lowe’s 2014 Outcomes and

<table>
<thead>
<tr>
<th>Quality Metric</th>
<th>Carrier</th>
<th>ECEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge to Skilled Nursing Facility</td>
<td>9.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Readmissions &lt; 30 Days</td>
<td>6.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Revisions within 6 months</td>
<td>1.1%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

#### 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**
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>
<thead>
<tr>
<th>Quality Measure</th>
<th>Quality Measure Description</th>
<th>Weight</th>
<th>Target</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0059</td>
<td>1-Diabetes patients with A1C&gt;9.0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>NQF 0061</td>
<td>Diabetes patients with BP&gt;140/90</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>NQF 0055</td>
<td>Diabetes patients with eye exam</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>NQF 0018</td>
<td>HTN patients with BP&gt;140/90</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>American College of Cardiology/AHA guidelines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NQF 0541</td>
<td>CAD Statin prescribed</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>CAD Statin adherence</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>NQF 0105</td>
<td>Depression Medication Management (12 Weeks)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>NQF 0105</td>
<td>Depression Medication Management (6 Months)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
## Intel ACO Contract Performance

<table>
<thead>
<tr>
<th>REQUIREMENT</th>
<th>SCORE</th>
<th>PERFORMANCE</th>
<th>OUTCOME SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Experience</td>
<td>Quality 98%</td>
<td>EXCEEDED</td>
<td>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.</td>
</tr>
<tr>
<td>• Provider quality of care</td>
<td>Experience 94%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Satisfaction with experience, likelihood of recommending</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-Based Medicine</td>
<td>Diabetes 39%</td>
<td>EXCEEDED</td>
<td>Outcomes for the diabetes (D3) bundle exceeded the target, showing statistically significant improvement in the percent of patients with &quot;good control&quot; of their disease, facilitated by clinical care teams, better patient awareness and adherence to prescribed medications.</td>
</tr>
<tr>
<td>• Diabetes (D3) bundle (Minnesota Criteria)</td>
<td>Depression 93%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Depression screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Time, Right Service</td>
<td>Response 94%</td>
<td>EXCEEDED</td>
<td>Patients had timely access to care through their PCMH provider. The program exceeded the target for 2013. The PCMHs in their care, offering care that improves patient outcomes, is key to ensuring appropriate care for all program members.</td>
</tr>
<tr>
<td>• Nurse call response time</td>
<td>PCP Appt 65%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Time to 3rd next available PCP appointment</td>
<td>Engagement 68%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initial engagement with PCMH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>3.6% higher than projected</td>
<td>DID NOT MEET</td>
<td>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.</td>
</tr>
<tr>
<td>• Medical and prescription costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Function-Learning Measure</td>
<td>N/A</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>• Short-term disability</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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 feasible:
  - Bree Collaborative complications warranty
  - Geisinger patient experience guarantee
- Requirement to collect PRO data:
  - Employers Centers of Excellence Network
  - CMS Oncology Care Model bundle
  - CMS Comprehensive Joint Replacement bundle (voluntary)
  - Massachusetts Blue Cross Alternative Quality Contract
- Requirement to report to the public?? – not yet
- Payment tied to performance?? – not yet

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

565,000 readmissions avoided to date

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.
Challenges to Outcomes Based Contracting in the US

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