nexera

Contracting

A BEST PRACTICE GUIDE

Contracting

A BEST PRACTICE GUIDE

Contracting is the process in which a provider signs an agreement with a vendor for a service or an item at a particular price, usually for a fixed time period. While pricing for food, fuel, and other commodities may vary as often as daily, purchasing items from fixed-price contracts helps hospitals better anticipate costs (and budgets) by ensuring that the pricing terms negotiated with approved vendors are stable over the course of the agreement. Contracts also provide conditions of product quality and warranties—among other conditions—that both parties agree to over the life of the purchasing agreement. Value-added discounts and rebates that the purchaser receives if certain conditions are met—as well as potential vendor penalties for failure to provide goods or services, or for failure to meet the delivery, quality, or availability requirements outlined in the terms and conditions—may also be included in a contract. In light of real-world incidents, any cybersecurity-related concerns should also be addressed in a contract.

Using comprehensive, efficient contract management for all regularly purchased stock products and services is important to providing quality care at an affordable cost. While price is always a critical factor (and the basic reason for a contract), a product's ability to affect patient outcomes positively—such as shortening the length of stay, reducing or eliminating the likelihood of hospital-acquired conditions, or minimizing the potential of a post-discharge illness that necessitates readmission—is an important consideration. While these clinical benefits are worth considering in and of themselves, providers must factor the financial implications of such outcomes into the total delivered cost of an episode of care.

An organization operating at the intersection of CQO (all costs associated with care, quality of care delivered, and financial outcomes driven by exceptional patient outcomes) uses value analysis to determine which item to purchase based on evidence that demonstrates that item's impact on the clinical and financial outcomes of the procedure for which it is used. The organization then uses an outcomes-based contracting approach to create an implicit relationship between the hospital and the product vendor to manage patient care jointly.

Outcomes-based contracting looks at the total cost of a product (from sourcing to reimbursement) and requires that the vendor play a role in supporting the provider's transition to value-based reimbursement by agreeing to share either savings or risk based on the ability of its product to improve patient outcomes. In this sense, outcomes-based contracting is by definition risk-based contracting.

Both hospitals and vendors have reason to align: hospitals want to treat patients successfully in a financially viable manner; vendors want to grow business with hospitals. Vendors are eager to provide value beyond price, assuming there is a good match between their product and a significantly beneficial outcome. Put a different way, as hospitals are reimbursed based on outcomes, they look to work with vendors with whom they can ensure those outcomes and share risk.

There are, however, many barriers to overcome when introducing a progressive outcomes-based contracting approach, such as an entrenched culture, offering transparency to an outside party (the vendor), dependence on effective data reporting, collaboration between clinicians and non-clinicians making an investment in quality, and developing new contract language. Outcomes-based contracting necessitates a significant culture change and requires accurate quality and outcome reporting—which is still evolving. However, when conducted properly, this kind of agreement can provide long-term quality and financial benefits to an organization.

As this is a much more time- and labor-intensive approach than traditional bid-and-award sourcing, it should be reserved for specific products that promise significantly improved outcomes and not be used for routine purchases. Medical devices, for example, are particularly relevant to this approach. The traditional method of looking at total delivered cost is usually applied to capital equipment, such as intravenous pumps, with long-term amortization, maintenance, and utilization schedules. However, the supply chain must begin to apply a total delivered cost approach to other items (such as single-use medical devices) in order to understand the effect these items have on patient outcomes and build a risk/reward relationship with vendors. This advanced approach represents the culmination of the supply chain's transformation from transactional to strategic. To conduct outcomes-based contracting, supply chain professionals must be prepared to do the following:

- Identify all components of an item or procedure that might impact outcomes
- Identify internal quality reporting metrics (e.g., length of stay, infection rates) that would help demonstrate that an item is improving care or meeting a predetermined outcome
- Isolate the outcome in a way that demonstrates that the product change was the cause (or contributed to the cause)
- Negotiate with vendors and hospital leadership to accept this model
  - As part of this discussion, receive authorization from both internal and vendor leadership that they will be held accountable for changes in the predetermined outcome and the subsequent risk payments or shared rewards
- Confirm that the agreed-upon metric determines the outcome
- Apply the rate of performance to the risk/reward benefit in a way that can demonstrate the product is responsible for the benefit
- Periodically measure outcomes and compare them to

Outcomes-Based Contracting in Practice

Silver-coated urinary (Foley) catheter manufacturers provided an early (mid-1990s) example of outcomes-based contracting. Because of the antimicrobial properties of silver, it can potentially reduce the rate of urinary tract and bloodstream infections. These hospital-acquired infections have a financial impact. They require expensive inpatient care over a longer time, the use of antibiotics, and they can potentially result in litigation. But adding a precious metal to a urinary catheter raises its price significantly.

The coated catheter vendors paid for studies that quantified the cost per incident of these negative outcomes. To encourage hospitals to invest in the new, far more expensive catheters, vendors allowed hospitals to purchase the silver-coated catheters at the then-current price of uncoated catheters for a period of time if the hospital would share its baseline infection rate statistics with them. If the number of urinary or bloodstream infections decreased over the agreed trial period—therefore lowering the total cost of care for catheterized patients—the hospital would begin to pay the higher price for the silver-coated catheters. This is an example of a supplier investing in quality that results in a shared reward.

baseline to ensure that benefits continue to be demonstrated
- Ensure that this reporting can be replicated

BEST PRACTICE

Improve fundamental operations before exploring outcomes-based methods

The supply chain's contracting process must be buttoned up before it can take on more strategic endeavors. To this end, hospitals should first assess current supply chain contracting performance before considering outcomes-based opportunities. The following parameters are good indicators of a supply chain's readiness:

- At least 75% of the hospital's predictable purchase expenses are on fixed-price contracts
- Contracts are centralized in a single electronic requisitioning program across the enterprise (individual departments should not be contracting independently)
- The hospital maintains a database of prices and use that can be reported by specific end user (cost center)
- The hospital's GPO is used for a majority of its product purchases
- Contract pricing is regularly validated to ensure that the provider is getting the agreed-upon price
- Hospital collects and maintains all state and federally required quality metrics
- Contracts are electronically activated, validated, and maintained
- There is a mandate to ensure that those contracts in GPO categories that must be negotiated locally are executed using GPO-vendor reporting
- Value-added services—such as analytics support—from the hospital's primary GPO are used broadly

Culture and governance are also critical to outcomes-based contracting. Leadership should assess if the hospital environment is suitable for this progressive approach. The following steps should be taken to ready your organization:

- Starting with the chief executive officer and the C-suite, create a

corporate culture that is dedicated to continuous improvement. Underscore the importance of multidisciplinary collaboration to achieve improved healthcare quality and outcomes; focus on processes, not people, when an adverse event occurs.

- Instill a team approach to purchasing that incorporates the C-suite, engaged clinicians (physicians, nurses, pharmacists), reimbursement managers, risk/quality managers, and clinical data managers. Like value analysis, outcomes-based contracting should involve all stakeholders and subject matter experts who can provide insight into metrics and other factors.
- Because outcomes-based contracting is a longer, more complicated process, key stakeholders should determine which product groups to target and then assign an individual to report on the short- and long-term results. In traditional contracting, purchasing decisions are the purview of the supply chain because price is the main factor. But with so many departments involved in outcomes-based contracting, it can be hard to determine who owns the process. The chief financial officer or the chief risk/quality officer may be in the best position to take on this role, as there may be hospital-wide implications.
- Work with the chief financial officer or the individual who is responsible for the initiative to help them understand the long-term benefit of this new approach and to ensure that the right resources are dedicated to it.

BEST PRACTICE

Establish a test model

Implementing outcomes-based contracting is best accomplished using several easily quantifiable achievements to build momentum toward a full value-based approach. Start small, with one product and one measurement, both of which pertain to one clinical outcome. The team can begin by identifying a single product—perhaps a device that supports a procedure that is expected to generate a good outcome and margin or a product that has a track record of positive clinical outcomes.

Not all products are appropriate. The best products and services are specific enough to determine a particular outcome. For example, a good choice might be an implantable pressure sensor that can remotely signal the onset of congestive heart failure. The implant—which is inserted into the pulmonary artery and sends a radio frequency signal to the physician that a patient is going into congestive heart failure—provides an opportunity for the hospital to intervene (prescribe a change in diet, medication, etc.) before a readmission becomes necessary. Since readmissions within 30 days of discharge for the same diagnosis are not reimbursed, there is a clear cost avoidance for monitoring patients in a congestive heart failure program. This can include measuring readmissions without the sensor against those who receive the sensor. While an implantable pressure sensor is expensive, it is significantly less expensive than the cost of care for a full readmission with no reimbursement.

Chosen carefully, some medical products can help shorten lengths of stay, minimize readmissions, and avoid a never event. These positive outcomes not only benefit the patient, they also help hospitals avoid unnecessary costs or they increase the contribution margin (amount of reimbursement the hospital receives above the cost of care) associated with an inpatient procedure or hospital stay.

It is important to ask the following questions before considering an outcomes-based contract engagement:

- Does the product have the potential to improve

an outcome, prevent a longer hospital stay, avoid a readmission, enable a treatment to be administered or a procedure to be performed on an outpatient basis, or avoid a common inpatient pitfall or adverse event?
- If so, can any of the benefits, penalties, or increased costs associated with these outcomes be quantified through in-house verifiable reporting?
- Does the clinical "owner" or risk manager in the hospital agree that there is a definite correlation between the product and the beneficial outcome?

Once the contracting team has determined the acquisition strategy and risk versus reward, it's time to approach the vendor.

BEST PRACTICE

Change the conversation to improve the provider-vendor relationship

The supply chain-vendor relationship can be contentious. Vendors hold out for the highest price, while supply chain executives try to drive as much margin out of the transaction as possible. Entering into a risk-based purchasing relationship requires a change in this dynamic. Both parties must be transparent about their expectations and willing to commit to making good on the outcome, whether it's the hospital sharing a benefit with a vendor or the vendor sharing the cost of an adverse outcome. While almost every vendor will publically market its product as the very best for patient care, it becomes a more serious matter when they stake their profit margin on it. Just because vendors like to push bottom-line cost to the periphery of the negotiation, it doesn't necessarily mean they are prepared to live with (or sell to their management) a transaction based on risk that has the potential for zero profit, or worse, a loss.

The hospital supply chain must be able to convince its financial and clinical leadership that the risk of increased cost, potentially without a demonstrable improved outcome, is a risk worth taking. A contracting team will likely be skeptical about a vendor's product assertions. This is where trusted subject matter experts can be brought in to validate vendor claims of efficacy. When it comes to evaluating an item before engaging a vendor, clinical peers are ideal. For example, if a hospital is considering an outcomes-based contract for equipment that reinfuses a patient's own blood perioperatively—thus reducing the hospital's dependence on expensive third-party transfusions—the supply chain executive should meet with surgeons and perfusionists who have experience and positive outcomes using cell saver equipment during cardiac, orthopedic, or other blood-dependent surgeries.

To make outcomes-based contracting work, both parties must invest in the relationship. Providers must be willing to take a leap of faith, and vendors must be willing to have skin in the game.

BEST PRACTICE

Involve a GPO

A new paradigm for many supply chain professionals—involving the hospital's GPO—can help kick-start discussions, build confidence, and potentially bring both parties to the table. The GPO often has the resources (time, analytics, access to data, references) to identify viable product choices for an outcomes-based arrangement as well as the capacity to perform due diligence and test risk-based models with national representatives from the vendor community. A GPO

may also know if there is already a working model in another part of the country.

Because GPOs are advocates for their members, a hospital is more likely to trust its relationship with its GPO than with a vendor. That relationship can be leveraged to support value-based contracting initiatives. The GPO's purchasing and analytics experts can provide direction for narrowing down product choices, provide examples of successful risk-based contracting models, and bridge the gap between the provider and the vendor to initiate value-based negotiations.

GPOs or third-party consultants, such as Nexera, can also help hospitals develop the value analysis infrastructure necessary to connect the supply chain with clinical leadership and risk managers so that they can properly assess and validate the right approach for the hospital. Enlisting a multidisciplinary team within the institution is critical to the success of outcomes-based contracting.

BEST PRACTICE

Select metrics to negotiate the contract carefully

Risk-sharing or shared-savings agreements between a hospital and a vendor rely on data (accurate data is essential for measuring whether an item is meeting the performance goal). As state and federal regulations and reimbursement methods continue to generate more outcomes-based reporting, the metrics necessary for outcomes-based contracts become more widely available.

Hospitals and vendors must carefully negotiate a shared-savings or risk-sharing agreement that includes descriptions of the following:

- The metric that will be used to measure performance
- The quantifiable cost of that outcome or penalty avoidance
- A mutually agreed-upon baseline
- The time period that will influence a change in the baseline
- An acceptable performance goal
- An agreed-upon reporting mechanism
- The penalty or benefit that the vendor will incur based on performance
  - Will the vendor share the savings?
  - Will the vendor pay a penalty?
  - Will the vendor accept the result?

Developing this kind of contract also means sharing data (good or bad) with the vendor. This is another new concept for hospitals, and it represents a change in culture. Sharing data becomes more palatable if the outcome is already publically reported. All outcomes reporting must be patient-blinded and free of any HIPAA privacy violations.

KEY PERFORMANCE INDICATORS

The following can be used to measure supply chain performance in contracting:

- On-contract PO spend (%)
- Supply spend as a percentage of net operating revenue (%)
  - Supply spend ÷ net operating revenue

Nexera, Inc. | 555 West 57th St. | New York, NY 10019 | nexerainc.com