

# THE DEVIL IN THE DETAIL: A VALUE-BASED CONTRACTING CASE STUDY

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## ABSTRACT

Development of value-based contracting holds a multitude of philosophical, intellectual, pragmatic, relational and technical challenges. In this case study on value-based contracting for palliative care, we outline three key lessons learnt in relation to these challenges: that the process matters as much as the end-point; to constantly ask “What Would Porter Do?”; and the importance of maintaining “Beginner’s Mind”: the willingness to learn and re-create.

There are multiple challenges for end-of-life care in the South African private sector: limited time-based terminal benefits in the prescribed minimum benefits (PMBs), under-developed supply of palliative benefits, low impetus for value-based approaches and regulatory impediments to payment innovation. The process of designing a value-based contract required overcoming the trust deficit between funders and providers, which in turn required neutrality. The process and the end solution both required transparency, positive intent and a commitment to excellence.

The solution that was developed required multiple dimensions in order to satisfy the requirements of the Porter and Lee (2013) framework: a bundled professional fee for a multidisciplinary team, outcomes-based payment incentivising value and continuous improvement, a tiered-fee across care settings, an innovative remote-access solution and an enabling information technology platform.

## INTRODUCTION

The case study presented here reflects the personal experience of the three authors in developing a value-based contracting solution for the South African market. Through the lived experience of moving from a theoretical concept to a fully fledged offering, we have frequently encountered and continue to encounter the devil in the detail.

The title of the paper reflects the multitude of philosophical, intellectual, pragmatic, relational and technical challenges that lie under the hood of the deceptively simple concept of value-based contracting: a way for funders to purchase care from healthcare providers that incentivises and supports providers to deliver ‘good’ care, where good relates to health outcomes that matter to patients. The philosophical backbone of value-based approaches is that ‘the purpose of the healthcare system is not to minimise costs but to deliver value to patients, that is, better health per dollar spent’ (Porter and Teisberg, 2007).

The focus of the value-based contracting solution explored in this case study was on palliative care for patients with advanced or metastatic cancer at the end of life. Palliative care is not limited to end-of-life care but rather co-exists with curative or life-prolonging care in a wide range of clinical circumstances (Sepúlveda et al, 2002). It does, however, have particular resonance at the end of life when patients and their families are vulnerable and when paying close attention to the voice of the patient can be pivotal (Gawande, 2014).

Palliative care is in many ways an ideal candidate for value-based contracting: the focus on relief from the symptoms and stress associated with serious illness means that an orientation towards improving quality of life is in-built (Sepúlveda et al, 2002). Patient-centricity is also set in the bones of palliative care: it requires an exploration of personal goals and time spent listening to the patient and family (<https://getpalliativecare.org/whatis>).

The paper begins by outlining the South African context in terms of end-of-life palliative care and value-based contracting. It then presents the three key lessons that have been learnt through the process of developing the contracting solution.

## THE SOUTH AFRICAN CONTEXT

Privately funded end-of-life care in South Africa is expensive for funders, provides poor outcomes for many patients and does not support the development of palliative care services. Without meaningful palliative medical scheme benefits, patients are often forced to seek care in an acute setting, creating a perverse situation in which patients are dying in hospital when they would prefer to die at home, and where dying at home would have been cheaper for their medical scheme. As Sandy et al (2019) say: “The why is straightforward: no one is happy with the past or current state.”

The costs to medical schemes in the last year of life are more than three times higher than in the second-last year of life, and expenditure on decedents is more than twelve times the expenditure on survivors (Ranchod et al, 2015).

The structural factors affecting palliative care include a diminished role in the PMBs, despite one of the aims of the PMBs being adequate cover at the end of life (Ranchod et al, 2015). The PMBs allow for a terminal benefit in the last two weeks of life. A time-based benefit (as opposed to one that is clinically defined) requires the treating doctor to prognosticate and frequently means that benefits can only be accessed retrospectively. A benefit offered that close to the end-of-life does not empower patients or their families to consider their options for end-of-life care, undermining the efforts of managed care organisations to facilitate discharge or to halt non-beneficial care.

The financing of palliative care is also undermined by the lack of recognition by the Health Professions Council of South Africa (HPCSA) of palliative care as a sub-speciality, the absence of appropriate tariff codes and regulatory impediments for multidisciplinary teams. Standard consultation tariff codes do not capture the nature or value of palliative activities of care (inter-alia in-depth initial consultations, home visits, care-coordination and after-hours care). HPCSA regulations on fee-sharing and sub-contracting exacerbate this by discouraging multidisciplinary teams (Health Market Inquiry, 2018): a key feature of the way palliative care should be delivered. Medical scheme administrators have also not designed systems for making team-based payments (Health Market Inquiry, 2018).

The lack of an established way of paying palliative practitioners means they are not adequately reimbursed and often cannot afford to dedicate themselves to palliative practice full time, even though there is a shortage of trained staff. Most medical schemes operate nationally and require provider networks to have a national footprint (Health Market Inquiry, 2018), a challenge in an under-developed palliative care market. This poses somewhat of a chicken-and-egg problem where effective financing of palliative care is required to stimulate the supply of services, but adequate supply is required for medical schemes to agree to finance care.

The Health Market Inquiry notes that the South African market is characterised by ‘a general absence of value-based purchasing’ (Health Market Inquiry, 2018). It also notes ‘ineffective constraints on rising volumes of care’ (Health Market Inquiry, 2018) – not surprising in a market that largely pays for care on the basis of volume and not value. The responsibility for this is partly laid at the feet of schemes who do not hold their administrators and managed care organisations (MCOs) accountable in terms of purchasing care from healthcare providers on the basis of value, a situation exacerbated by insufficient competition in the administrator and MCO market (Health Market Inquiry, 2018). Medical scheme regulation incentivises competition between schemes on the basis of risk profile, providing a context that has slowed the market’s orientations towards strategic purchasing of care (McLeod and Ramjee, 2007). An effective value-based solution therefore requires paying close attention to the local context: addressing the limitations of current benefit design, being able to demonstrate meaningful financial benefit for medical schemes, ensuring regulatory compliance and finding innovative ways to address supply-side limitations.

## LESSON 1: THE PROCESS MATTERS AS MUCH AS THE END-POINT

Value-based approaches require the building of trust between stakeholders in order to align incentives across the health system (Sandy et al, 2019). Reaching congruence is therefore not just about the design of the contracting mechanism, but also about the process of getting there.

Porter and Teisberg (2007) argue that ‘improving the value of health care is something only medical teams can do’ hence value-based approaches require a seismic shift for funders away from micro-managing providers and throttling demand (the basis of much of managed care) towards the creation of a ‘shared covenant to patients and to system improvement’ (Sandy et al, 2019).

For providers, this requires understanding the ways in which fee-for-service arrangements are seemingly beneficial but are actually disempowering. This is hampered by a mistrust of alternative reimbursement mechanisms where these have not previously been part of the design process.

It was clear from the outset that for funders to be willing to engage in these contracts they would need to be assured that the risk of palliative benefits being misused for long-term frail care could be mitigated. This required the design of clinical entry criteria to inform eligibility for benefits and the design of a benefit that was sufficiently flexible to meet the wide variety of clinical needs at the end of life while still containing costs.

Sandy et al (2019) provide a model of trust relationships that encompasses competence, transparency and motive. Competence requires ensuring that all aspects of the process and end solution reflect best clinical practice, quality outcomes and a culture of continuous improvement. This requires clinical expertise within the team designing the solution, as well as close engagement with specialist providers – preferably those who represent a broader interest, and not just their individual perspective. In this case, there was a palliatively trained practitioner within the design team, and deep engagement with the leadership of PalPrac (<https://palprac.org/>), all of whom were able to move beyond their self-interest.

Transparency proved to be a critical part of the process. For example, in the costing of the global fee the details of all of the assumptions and technical workings to arrive at the fee were shared with the palliative practitioners. This allowed for the need for efficiency and cost-effectiveness to be explicitly communicated and understood.

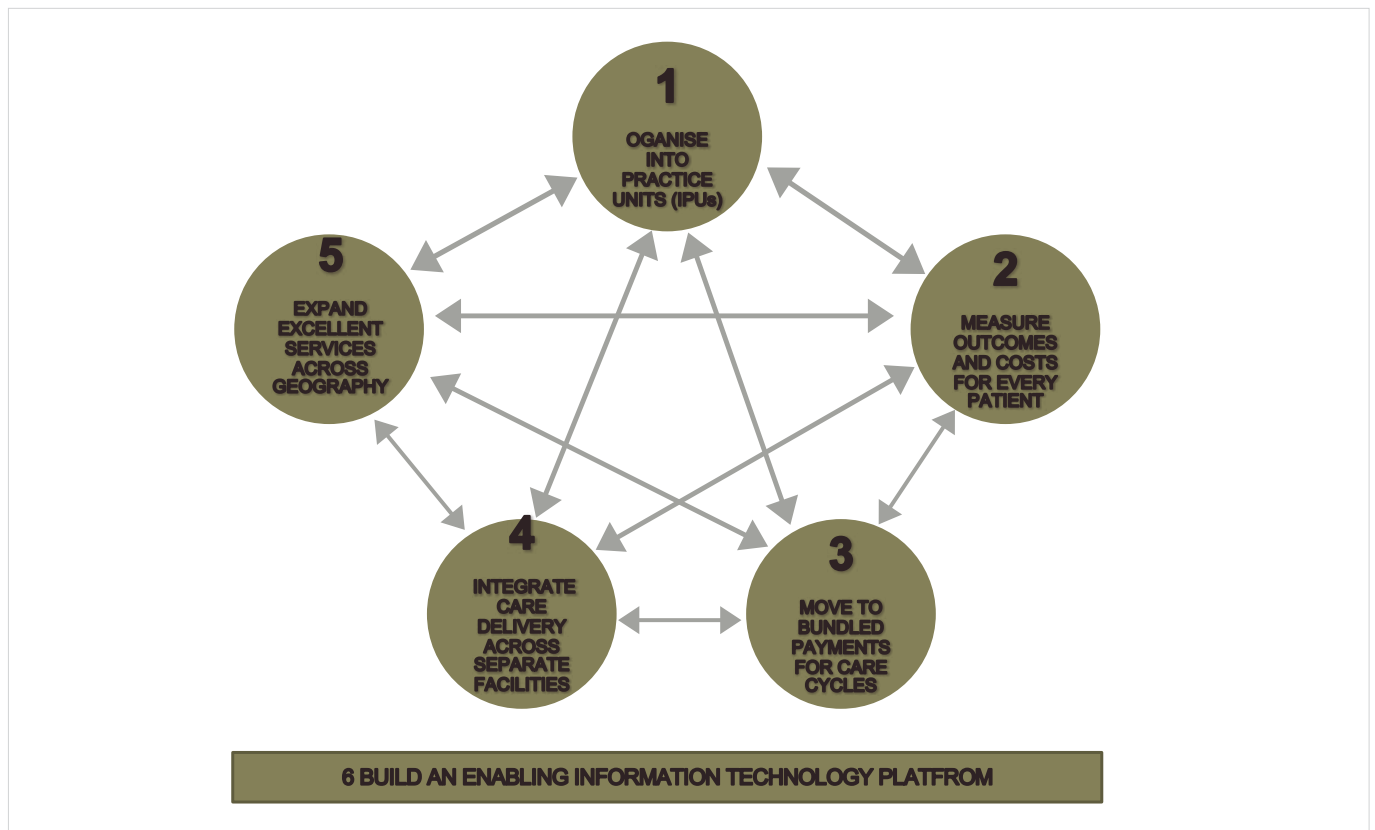
Trust was further deepened by making the design team’s own motives explicit in their contracts with funders. The design team’s remuneration is also outcome-based, where many of the outcomes mirror those of the healthcare providers, with a similar patient-centricity and commitment to delivering value. The assumption of positive intent when dealing with other stakeholders was also critical.

True alignment of incentives required that our role was neutral in that it did not represent a unitary perspective (of either the patient, the funder or the healthcare provider), but rather was explicitly working to balance those perspectives. This neutrality should not be mistaken for passivity: it required heart-felt engagement, true compassion for patients and a sensitivity to the challenges faced by funders and providers. It is not possible to align incentives without pushing back where one party’s interests would overwhelm the others. The designer of the value-based contract therefore requires a strong reflective practice to ensure the integrity of the solution.

## LESSON 2: WHAT WOULD PORTER DO?

Part of this reflective practice involved checking the design elements of the value-based contract against the Porter and Lee (2013) framework to ensure that the solution is sufficiently robust and encompassing. We explore each of the six elements of the framework (Figure 1).

Figure 1: The value agenda



**Organise into integrated practice units**

Palliative care is multidisciplinary in nature because it requires a holistic consideration of the patient’s physical, emotional and psychosocial needs (Sepúlveda et al, 2002). Palliative practitioners therefore require little convincing that they should be organised as such. However, the market is largely not organised into teams because of the HPCSA ethical rules and therefore requires HPCSA-compliant solutions and pragmatic support to transition. These support mechanisms include organisations such as PPOServe with their Integrated Clinical Consortium (ICC™) solution (Health Market Inquiry, 2018) and the use of the SignApps digital communication platform to facilitate communication between team members and transitional fee arrangements.

**Measure outcomes and costs for every patient**

The process of articulating outcomes and identifying key costs that could be influenced by the palliative team was informed by international literature (Bakitas et al, 2009, Hearn and Higginson, 1998, Holland et al, 2011, McCorry et al, 2019, Warrington et al, 2019) and refined through in-depth consultation with PalPrac. The process involved starting with outcomes, and then working out the metrics (as opposed to starting with the available data). The use of the SignApps communication platform allows for the collection of patient-reported outcomes (Warrington et al, 2019). This combined with advances in data science has enabled a more granular and nuanced view of outcomes.

Quality outcomes were built into the reimbursement of the palliative teams. The translation of these outcomes into metrics, and the attachment of targets to these metrics, is where the notion of continuous improvement is built into the contract design.

**Move to bundled payments for care cycles**

The payment mechanism has many dimensions: inter alia the extent to which the fee is bundled, what is in- and out-of-bundle and frequency of payment. The level of payment is also a key consideration. The start of the care cycle was determined by the clinical entry criteria for the benefit and the end of the cycle is the death of the patient. Only the professional fee was bundled, largely because it is too soon in the development of alternative reimbursement in South Africa to enable more substantial transfer of risks. There are some components of the solution which are still reimbursed on a fee-for-service basis – largely where the role of the palliative doctor does not encompass care co-ordination.

### **Integrate care delivery across separate facilities**

Palliative care is agnostic about setting. One of the objectives of the value-based contract was to ensure co-ordination of care across settings. This is particularly challenging when the patient is admitted to an acute facility as they would no longer be under the direct care of the palliative team. This is because palliative care is largely offered as primary care in South Africa with little integration into the hospital setting. The approach taken was to design a tiered fee where the palliative team receives a reduced fee while the patient is admitted. This ensures their continued involvement and the incentive to expedite discharge.

The solution is also designed to introduce the patient to palliative care early on in their care trajectory – this enables the co-existence of palliative and curative care and facilitates continuity of care between the treating oncologist and the palliative team.

### **Expand excellent services across geography**

Palliative care services are currently concentrated in metropolitan areas. In order to ensure national access, it was necessary to develop a remote-access solution. Due to the restrictive nature of regulations governing virtual consultations with patients, the solution takes the form of virtual peer-to-peer support. This requires the identification of a suitable provider in the patient's locale to co-ordinate care (with the preference being for hospice, a nurse able to offer home-based care or the patient's general practitioner).

### **Build an enabling information-technology platform**

Continuous improvement is enabled by having access to data that highlights the ways in which value can be enhanced. A data analytics platform, with a user-friendly interface, is therefore essential. Numerous alternative reimbursement mechanisms and doctor profiling solutions in South Africa have been ineffective because they do not use data to empower providers to better their clinical practice.

## **CONCLUSION AND LESSON 3:**

### **Beginner's Mind**

Beginner's Mind is a concept from Zen Buddhism: 'In the beginner's mind there are many possibilities, but in the expert's there are few' (Suzuki, 2010). It requires an openness, an enthusiasm and an absence of pre-conceptions that are difficult to achieved in a cynical industry.

From the outset, the process has required more flexibility and agility than anticipated. Part of building trust is listening and playing close attention to the input of other stakeholders. This requires the courage to make mistakes and the willingness to learn and re-create.

The commitment to continuous improvement does not apply only to the palliative care teams; it also applies to the design of the value-based contracting solution. Given the complexity of the design, the multiple interests to be balanced and the likelihood of unintended effects and gaming, it is essential that the contract design is considered to be a work in progress, subject to the same contractual incentives to improve and data analytics support.

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