IAA AAI SECTION COLLOQUIUM 2019

THE MODERN ACTUARY - CHALLENGE • INFLUENCE • LEAD

ASTIN • IAAHS • IAALS • IACA • PBSS

2 - 5 April
2019
Cape Town
South Africa
CTICC

www.colloquium2019.org.za

Hosted by
ACTUARIAL SOCIETY OF SOUTH AFRICA

ALIGNING INCENTIVES
Value-based purchasing

S Ranchod, K Chennells, Y Moodley
04 April 2019

Hosted by ACTUARIAL SOCIETY OF SOUTH AFRICA

SECTION COLLOQUIUM 2019

Outcomes

An improved understanding of:

1. The context and need for value-based purchasing

2. Technical and practical challenges in alternative reimbursement design

3. Emerging applications in the South African (SA) health system

Shivani Ranchod

- Health Actuary & Academic
- Co-founder and CEO of Percept, consulting firm
- Co-founder of Alignd, managed care company

Kelly Chennells

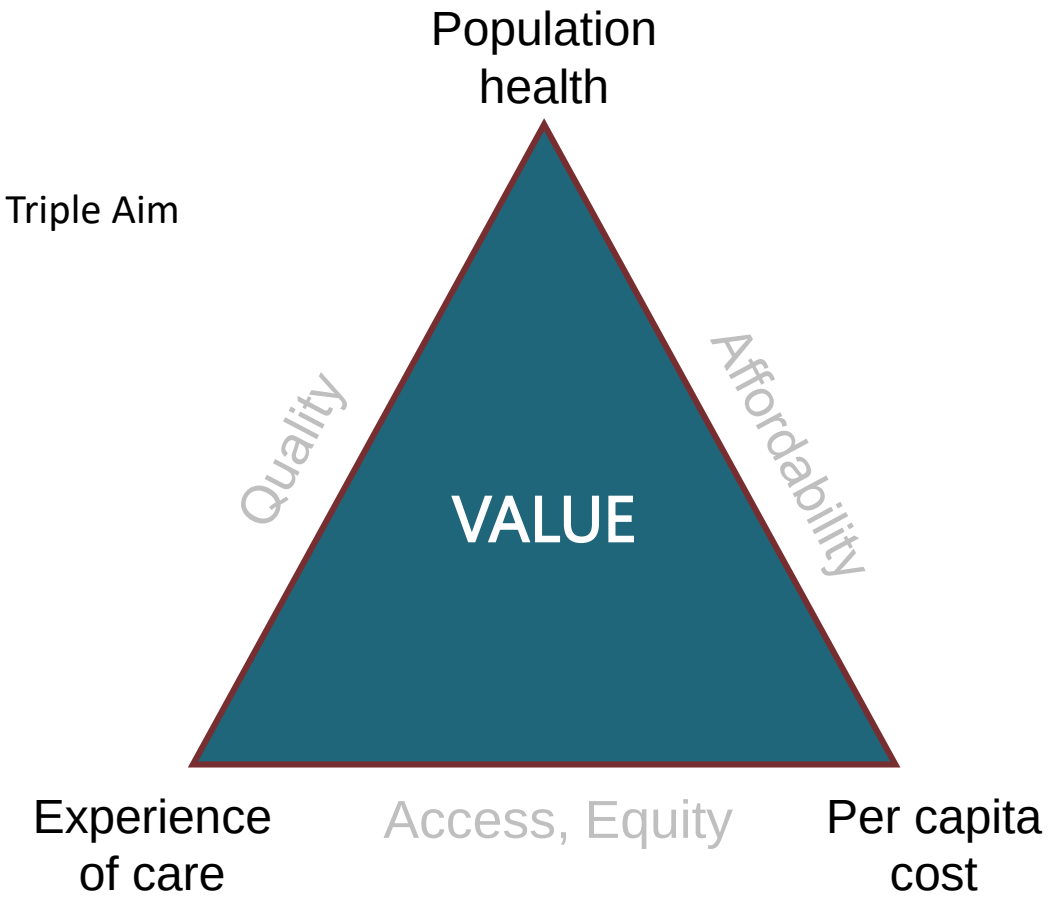
- Health & Reinsurance Actuary
- Expertise in doctor profiling and alternative reimbursement models

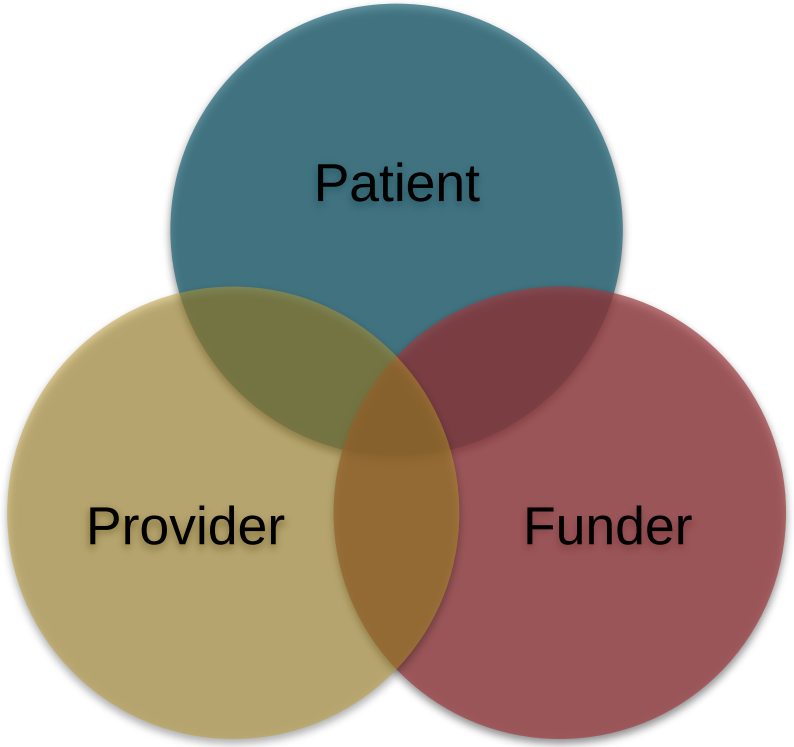
Yageshree Moodley

- Life & Health Actuary Operational strategy- IT system migration and user-centric design

The goal and the players

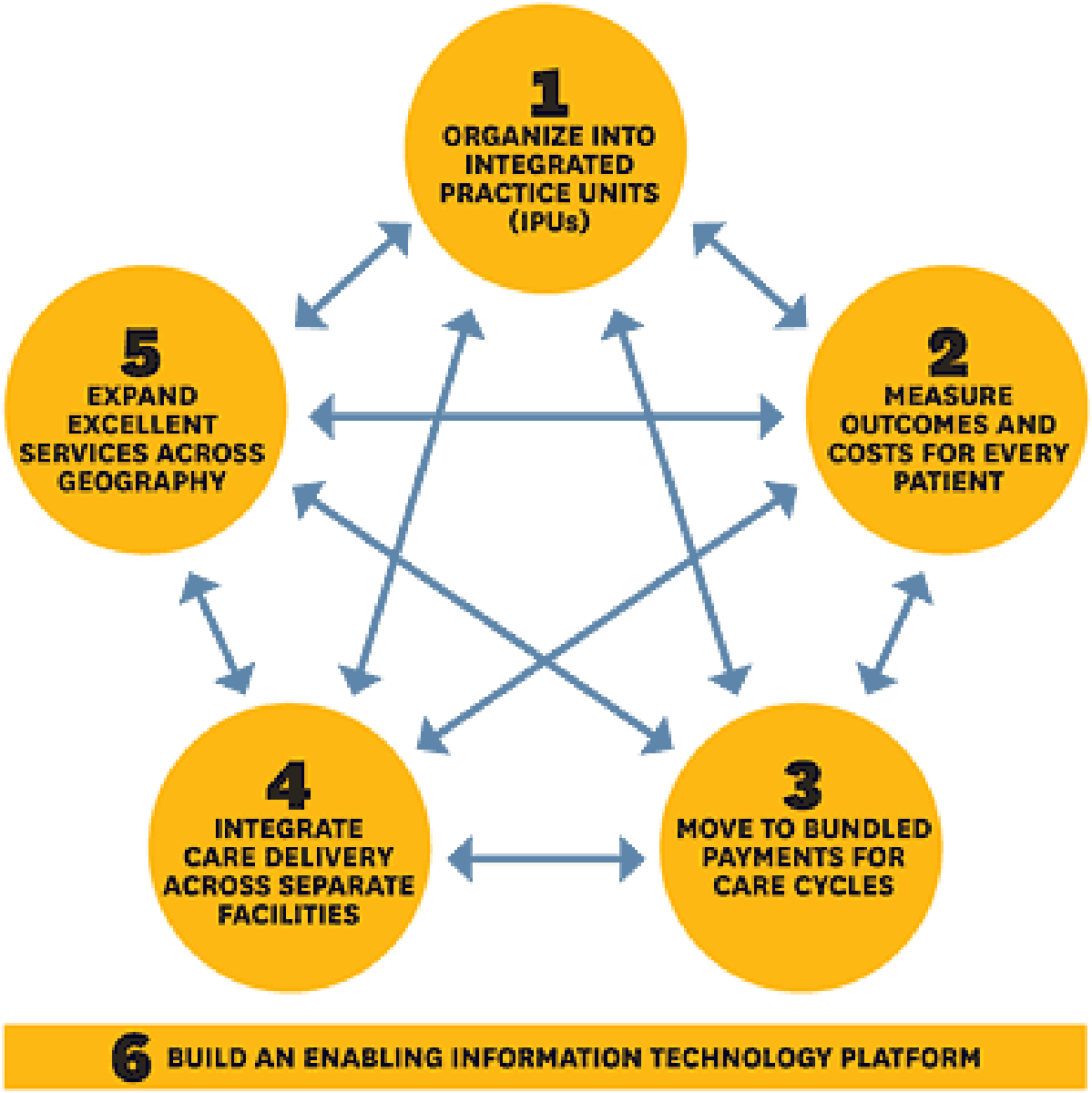
Source: IHI. The Triple Aim





The challenge

Move from	To
Supply-driven	Patient-centred
Services provided	Population health outcomes achieved
Fragmented delivery of services	Integrated practice units + gatekeeping



Source: Porter & Lee, 2013. The value agenda

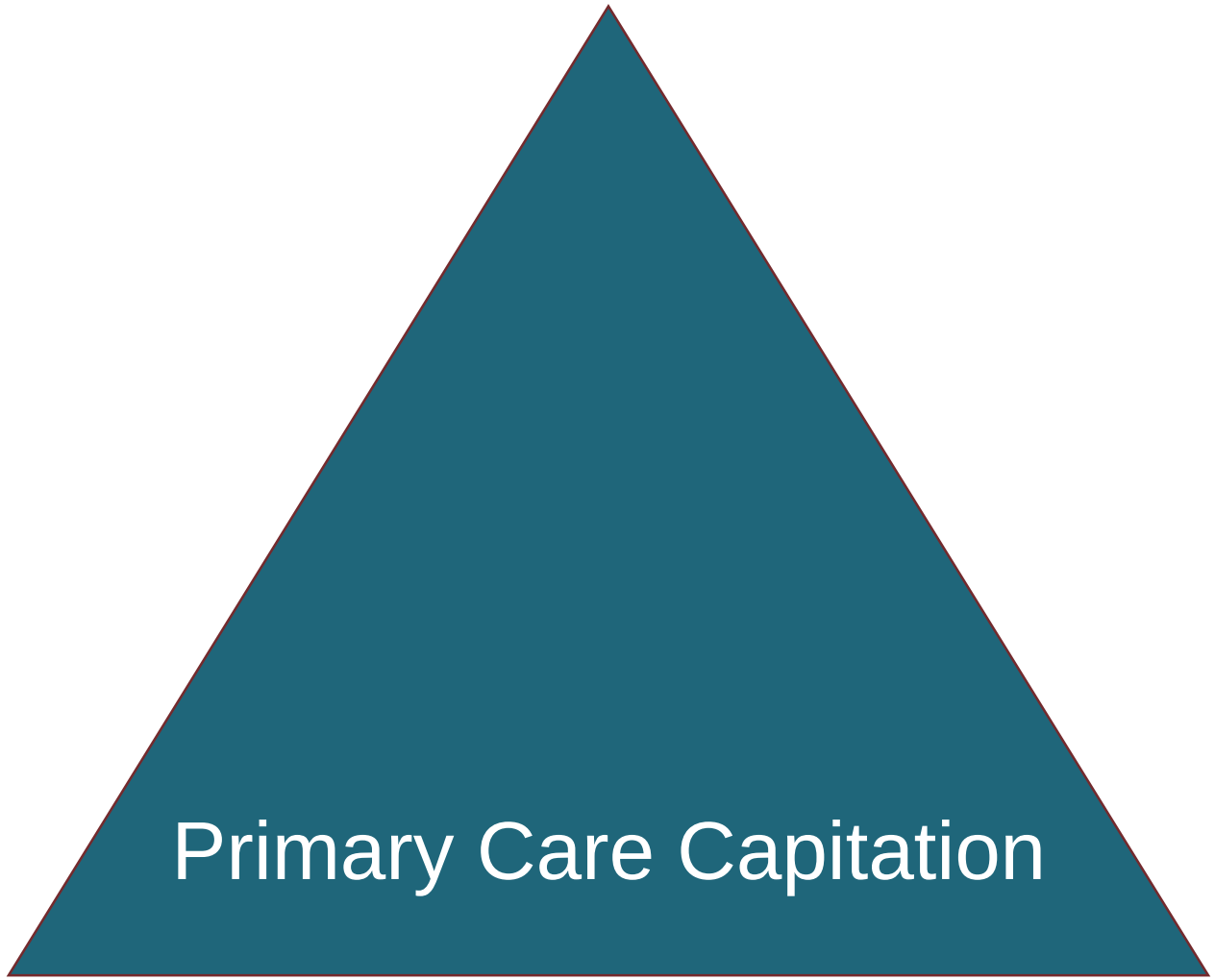
Let's focus on…

- "Move to bundled payments for care cycles"

- Work within existing market structures to align provider, purchaser/funder and patient interests and embed quality

- Practical challenges in implementing measures to:
  - Manage risks if rates are too high/low
  - Share and equalise risk
  - Collect and analyse data across the care cycle

- Let's look at two cases..


Primary Care Capitation

South African Primary Care Context

Public Sector

- Budgets
- No explicit attempt to control for utilisation
- Staff are salaried
- 48 million

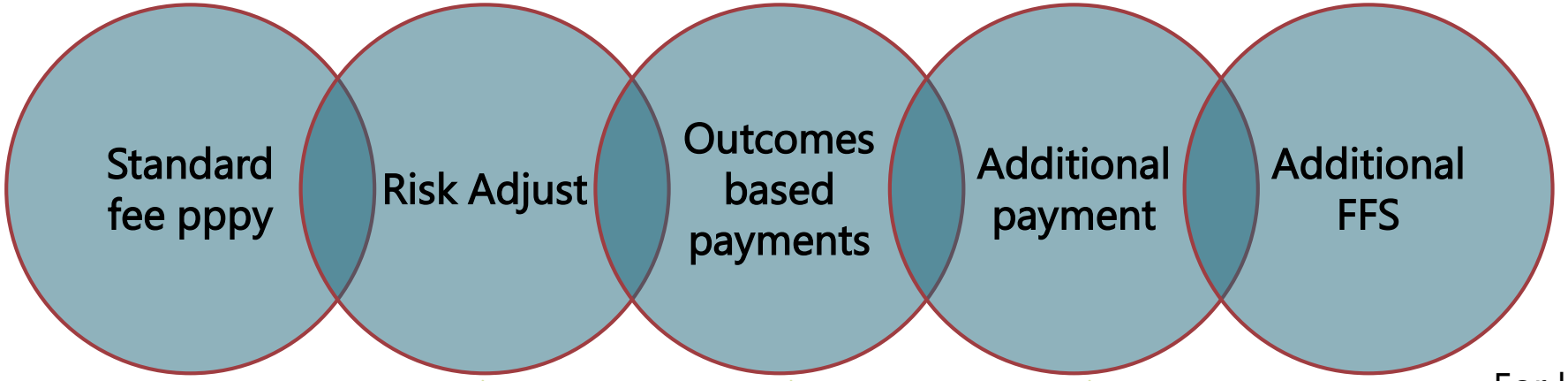
Private Sector

- FFS widely used
- GP driven service
- Poor gatekeeping

Framework

Design	Provider contracting	Value-based payment
• Patient base serviced • Benefit package • Best clinical practice	• Who does what? • How do clinicians work together?	• Global capitation fee • Additional outcomes based payments

Proposed reimbursement formula



Clearly define what is included
ex. consult only, consult + meds,
Consult + meds +path

ex. Age, Sex, Morbidity

Measurement proceeds payment

For incentivizing behavior

ex. Used of EHR, structural change including practicing in rural areas, quality data submissions

For less predictable services or to incentivize utilization

ex. to cover health checks and procedures

Costing approaches

Public Sector Costs

- PHC expenditure per person per year
- Strip out medicines and laboratory services
- Add staffing costs

Expenditure Forecasts

- Estimate the cost of running a community practice
- 8 assumed healthcare professionals per 10 000 patients

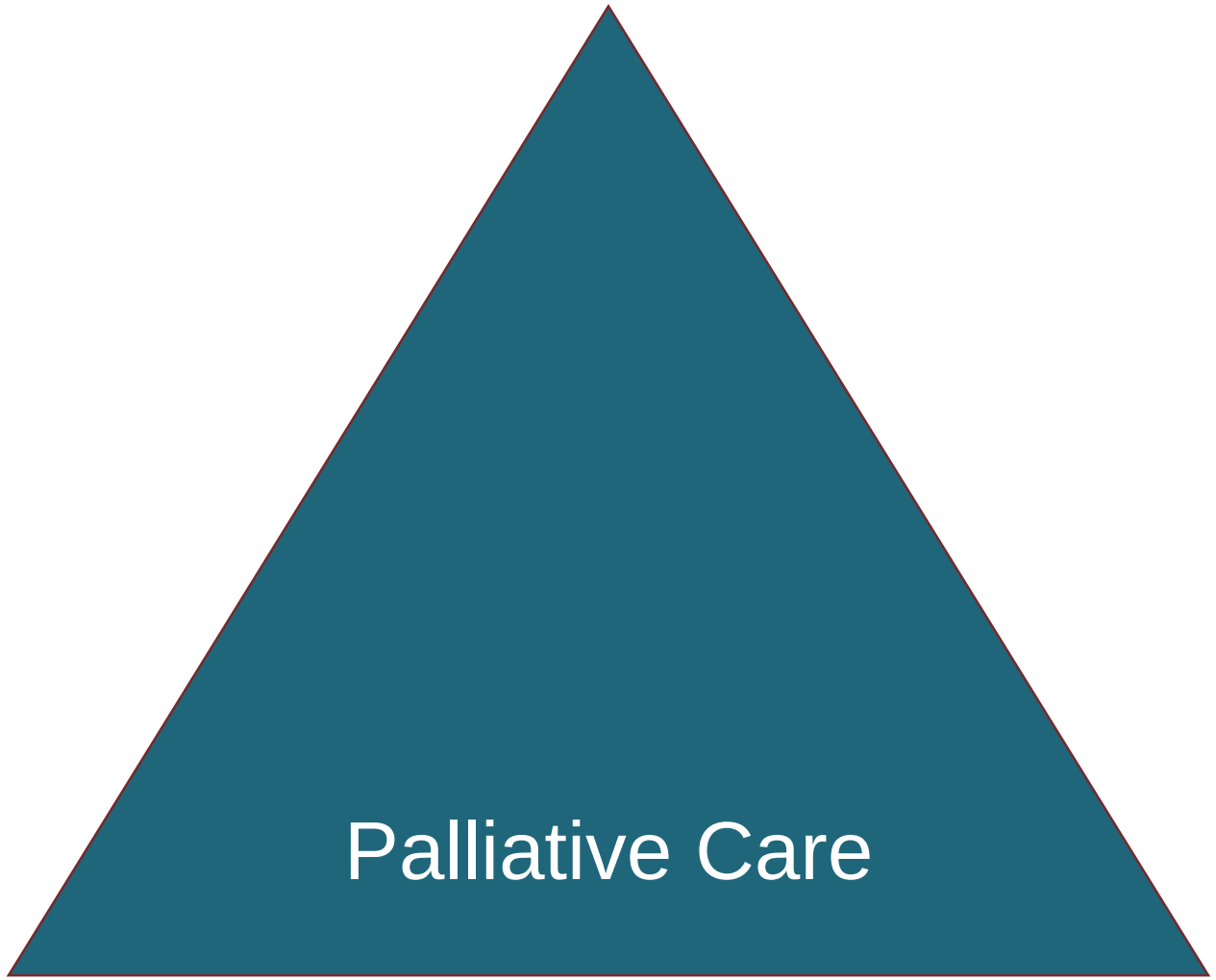
Historical GP Practice Costs

- Used the SAMA practice cost studies adjusted for inflation

Medical Scheme Expenditure

- Fee per visit
- Visits per person per annum

“actuarial mindlessness”


Palliative Care

What is palliative care?

What is palliative care?

- Palliative care is specialised medical care for people with serious illness, focused on providing relief from symptoms and stress. The goal is to improve quality of life for both the patient and the family.
- Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support.
- Palliative care, almost by definition, puts the patient at the centre of the care being delivered; it is essential to hear what the patient and their family really want and to attend to all of their needs as human beings (physical, emotional, spiritual).
- Palliative care doesn't stand in opposition to curative care; the two often co-exists side-by-side with the balance shifting over time.

A comprehensive approach

BENEFIT DESIGN

- Evidence-based clinical entry criteria.
- Specification of benefit package.
- Best practice clinical protocols.

PROVIDER CONTRACTING

- Provider network of PC multi-disciplinary teams.
- Doctor-to-doctor telephone peer support.
- Sub-acute facilities and hospice in-patient units.

PATIENT SUPPORT

- Notification of eligibility and unlocking benefits.
- Connecting patients with providers.
- Exception management.

VALUE BASED PAYMENT MODEL

- Global professional fee.
- Outcomes-based payment.
- Contract facilitation.

DATA ANALYTICS

- Pro-active identification of beneficiaries.
- Monitoring of cost and quality outcomes.
- Optimisation of product impact.

Costing for optimal care

Resource-based cost units
- Implicit in current tariff system
- Use these to consider what the new FFS components are

Who are the healthcare providers?
- Ideal MDT structure
- Time taken to co-ordinate MDT
- New activities!

What services are provided?
- Matrix of services and providers
- Need to consider balance of quality and cost-effectiveness

What does a typical care episode look like?
- Literature
- Local context

- Payment and incentivisation of multi-disciplinary teams (MDT)
- Working with doctors to facilitate change

- Process of articulating what “good” means
- Data analytics capability is key

- Global professional fee

- Tiered, continuous fee

- Remote care solution: doctor-to-doctor support
- Strengthening of supply-side

- To support working as an MDT; To enable data analytics; To facilitate patient engagement and business-to-business backend

QUESTIONS AND COMMENTS

Shivani Ranchod

shivani@alignd.co.za

Kelly Chennells

kelly@percept.co.za

Yageshree Moodley

yageshree@percept.co.za