THE SOUTH AFRICAN MEDICAL ASSOCIATION SUBMISSION TO:

THE COUNCIL FOR MEDICAL SCHEMES

In respect of

Call for Public Comments on the Draft PMB Code of Conduct (Circular 74 of 2017, 28 November 2017)

31 January 2018

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EXECUTIVE SUMMARY

The South African Medical Association (SAMA) thanks the Council for Medical Schemes (CMS) for the opportunity to comment on the Draft PMB Code of Conduct in respect of the Prescribed Minimum Benefits (PMBs).

SAMA also notes the comments by Dr Sipho Kabane on 23 January 2018 that this Code of Conduct, once finalised, will also be carried through into the deliberations of the current Prescribed Minimum Benefit Review process. We hope that this may mean that some of the requirements of the Code of Conduct will be considered for inclusion in the provisions of the Medical Schemes Act when regulatory changes of this nature are considered as part of the PMB Review.

We hope that the inputs to the document will assist the CMS in its further development.

- *SAMA recognises and appreciates the efforts which the Council has made with the second incarnation of the PMB Code of Conduct, to ensure a multi-stakeholder and representative Code of Conduct Task Team.*
- *SAMA remains concerned about the fact that the Code of Conduct is not a legally enforceable document. Our experience is that schemes do not apply even the regulations correctly – they are unlikely to apply to guidance of the Code of Conduct without some legal mandate*
- *We recognize the intention of the PMB Review process to consider the contents of the Code of Conduct once it is finalized – we believe this to be the best way to ensure the requirements of the Code of Conduct are actually adhered to.*
- *SAMA has provided detailed comments in respect of various aspects of the draft, which we hope the PMB Code of Conduct Task team will consider in finalising the document.*

1. COMMENTS ON BACKGROUND

Although we recognise that the Terms of Reference: Code of Conduct Task Team (Annexure 1), were meant to guide the task team itself and lay down the principles for the team to follow, we feel that these should also be made public as part of the Code of Conduct Documentation. This in the interest of transparency.

SAMA recommends: *The Terms of Reference of the PMB Code of Conduct Task team should also be made public, even if not for public comment…*

2. COMMENTS ON SCOPE AND PURPOSE

SAMA is concerned that the Code of Conduct still does not have any legal enforceability in terms of the Medical Schemes Act and its regulations. While we appreciate that the document aims to ensure that legislative requirements are practically achieved, medical schemes are not bound by the contents of the document, by any legal statute.

SAMA recommends: *Efforts should be made to ensure that the contents of the Code of Conduct become legally enforceable. We welcome the fact that the PMB Review Process will consider the final PMB Code of Conduct and hope that the contents of this document will serve to inform necessary amendments and additions to the current regulations.*

3. COMMENTS ON DEFINITIONS AND ABBREVIATIONS

3.9 SAMA applauds the clarity of this definition as to the interpretation of “pay in full”, as per the regulations and now case law in the country. We are, however, aware of many instances where the “pay in full” provision is still not being applied, and do recognise the potential for medical scheme abuse through this mechanism.

3.5 Prescribed Minimum Benefits – “emergency conditions”. The definition of what constitutes an emergency continues to be a bone of contention between clinicians and medical schemes. Clinically, In many cases, it is impossible to know if a patient presenting with a symptom is indeed in need of emergency care, or not, until procedures and interventions are instituted to diagnose the

nature of the presenting symptom. For example, severe chest pain, may be indicatory of a myocardial infarction (an emergency), pulmonary embolism (an emergency) or severe reflux – potentially not an emergency. Until proven otherwise, this presentation would be handled as an emergency by any responsible healthcare provider. The patient should not be punished by incurring costs if the symptom is diagnosed to be not immediately life-threatening.

3.16 "Unprofessional Conduct". SAMA finds that medical schemes frequently attempt to be the judge and jury of health professional unprofessional conduct. This judgement can only be made by the regulatory body concerned, which has the mandate to judge such cases. We would like this Code of Conduct to specifically address that medical Schemes do not have the mandate nor the legal standing to make this judgement of healthcare providers.

SAMA recommends:

- *The disputed "pay in full" regulation should be addressed as part of the PMB Review process*

- *The definition of "Emergency Medical Condition" needs to be further developed, or the regulations further developed to ensure that patients presenting with a potential emergency, found to be non-emergency through diagnostic processes and testing, are not economically disadvantaged as a result of the necessary investigations to make the diagnosis.*

- *Judgement of unprofessional Conduct of a healthcare professional can only be made by that health professional's regulatory body. This cannot be for medical schemes to determine.*

4. COMMENTS ON DEFINITIONS AND ABBREVIATIONS

SAMA welcomes the insertion of the relevant legislative provisions at this point in the document.

5. CODE OF CONDUCT

SAMA appreciates the detail provided on the drafting and the amendment processes for the PMB Code of Conduct.

SAMA recommends:

- *Annexure 2 should also be made public.*

6. CODE OF CONDUCT

A. Communication

SAMA is supportive of the principles and the objectives of the Communication Guidelines of 2014, and believe these should serve to improve the communication of patient PMB Entitlements.

SAMA has noted an improvement in the communication of benefit entitlements by certain medical schemes – the Government Employees Medical Scheme being one of these. While it is difficult to determine what patients really understand in terms of their PMB entitlements, based on communications from the scheme, which include clinical codes, medical procedures and qualifying clinical criteria, the provision of these details by the scheme on registration for a PMB condition does significantly clarify issues for the treating physician.

DSPs: The location and contact details of DSPs continue to be a challenge, and SAMA is gratified that this requirement is within the Code of Conduct. In our submission to the CMS on undesirable business practices (July 2017) relating to the appointment and maintenance of DSPs and networks, SAMA highlighted that DSPs are changed with little notification, and little choice is afforded to patients. We also appreciate the inclusion of arrangements specifically for patients who do not have internet or electronic access to such information. We would, however, like to add that this information should not only be provided during authorisation, but must be provided on member registrations of the scheme, annually and whenever there are changes. This assists members in making informed choices when selecting a health professional or hospital. Providing this information at authorisation is frustrating and potentially exploitative to vulnerable and sick members.

Alternatives to DSPs: Again, SAMA highlighted in our submission on undesirable business practices (July 2017) that in some instances, particularly in more outlying areas, there is only one doctor in an entire town who is a DSP for a particular medical aid – it is not possible for this practitioner to be available 24/7. Ideally, in such a situation, the DSP network should not be so severely limited. However, we deeply appreciate the inclusion of requirements for medical schemes to ensure that members are assisted with alternatives in such situations.

We would also like to bring to the attention accessibility of DSP's. When preferential networks are not inclusive or decided on arbitrary grounds (e.g. number of patients with a certain condition treated (e.g. Diabetes), this may push doctors from underserved areas out of business and perpetuate inequities between rural underserved areas and urban affluent areas.

Therefore, SAMA pledges that, when involuntary use of non-DSP is considered, the Council takes CMS into consideration mileage between facilities as well as access using public transportation. Transportation is a well-known barrier to healthcare access (1). It can wrongly be assumed that having a medical aid correlates with owning a car, however, we know that the vulnerable medical scheme population is likely not to own a car. For example, whilst SAMA, in Erasmuskloof, is only 16 km from CMS and about 15 minutes' drive, to travel between two points using taxi's will require one to go through Pretoria Central Business District first then to CMS, which can take anything up to an hour or more. Therefore, in this instance the CBD hospital may serve as a practical DSP location for the residents of Erasmuskloof due to accessibility and not necessary distance.

Members' responsibility to obtain details with regards to the PMB level of care: It must be acknowledged that it is difficult for members/patients to navigate these complicated components of PMB care. While SAMA practitioners agree there is a responsibility for the patient and their scheme to liaise on the scheme-specific baskets and establish what a specific patient's benefit entitlements are, we believe the onus should be on the scheme to provide the patient with the information without the patient having to actively seek it out.

Schemes continue to fund for potential PMB's from a Medical Savings Account. The fact that it is a requirement for schemes to pay valid claims, we find it disturbing that

the schemes do not identify PMB benefits that are not being funded from risk pools. There is an incentive for schemes for funding PMB's from MSA and we believe that putting onus on the scheme to identify PMB's when approving claims and through regular audits will go a long way in addressing the non-compliance by schemes.

We also believe that it is the responsibility of Council to routinely audit scheme claims to ensure that PMB's are reimbursed appropriately.

We believe that the clinicians, other healthcare professionals, laboratories and hospitals have a responsibility to provide correct diagnostic and treatment codes to assist the schemes in identifying potential PMB's.

SAMA recommends:

- *Council must also routinely audit scheme data to identify where PMB claims are being paid from MSA or from day-to-day benefits.*
- *Where coding us correctly submitted by healthcare professionals so as to allow for identification of PMB conditions, the council should take this issue up with the medical scheme involved..*

The process of lodging a clinical appeal: In addition to joining and in the annual benefits guide, the process to lodge a clinical appeal must be explained to the patient and provider at the time that a treatment request is declined.

The process must also have a pre-determined timeframe, relevant to the nature of the clinical appeal. SAMA membership complains about clinical appeal cases, which linger for months at medical schemes, despite the patient being in urgent need of treatment. Schemes must be required to provide specified timeframes relevant to the nature of the appeal. For example in life-threatening cases, clinical appeal outcomes should be possible within 24 hours, whereas for chronic treatment cases, acceptable turn-around times may be within a week. Unfortunately, there are no "set" timeframes for what is acceptable, but the clinical urgency of cases needs to be considered.

SAMA recommends:

- *DSP networks should not be so severely limited that patients find themselves in the position of needing to seek care from a non-DSP, except in exceptional circumstances. An alternative DSP should always be available and*

accessible. We recommend using the WHO radius of 5 km's for General Practitioner services and ***ease of accessibility*** *by public transport as considerations.*

- *If this is not possible, we support that schemes have the responsibility to advise and direct patients to acceptable alternatives.*
- *The onus should be on the medical scheme to automatically provide information such as PMB level of care, baskets of care and medicine formulary to the patient when dealing with a patient with a PMB condition. Giving the responsibility to the patient to ask for all these things is unreasonable.*
- *Clinical appeal processes need to be explained to the patient and the treating provider at the time of a decline.*
- *Clinical appeal processes need to be subjected to defined and publicly available timeframes, dependent on the urgency of the appeal…*

B. Application of Managed Care Interventions

i. Designated services providers

SAMA noted a number of challenges in the appointment and maintenance of DSP arrangements in our submission to the Council in response to Circular 39 of 2017 (Undesirable Business Practices).

The challenges we highlighted were:

- Criteria for selection to DSP status are frequently opaque and exclusionary.
- The same situation applies to managed care determination of doctor networks, which are not only set up to serve as vehicles for PMB
- General practitioners in small, rural or underserved areas are excluded from DSP arrangements and networks on the basis that the volumes of patients which they see are "too low."
- Practitioners are excluded from "closed" DSP and network arrangements, which are deemed "full" by schemes – thus even a practitioner willing to join the network or DSP arrangement is excluded.

- Practitioners are excluded from participation in networks or DSP arrangements on the basis of “claims histories”, which are not explained nor are the criteria for qualification for networks or DSP arrangements made transparent to them.
- DSP practitioner or network practitioner appointment takes place by “exclusive invitation” only and willing practitioners cannot participate.
- Doctors who do not wish to participate as DSPs are selected as DSPs without their knowledge and are then unable to change their status.
- Referral requirements imposed by DSP status see practitioners being forced to refer patients to specialists other than those they would recommend in all other circumstances.
- Unilateral decisions are taken by schemes at the beginning of new benefit years to change DSP providers, impacting hundreds of patients who are forced to leave their existing practitioner who was a DSP the previous year and seek treatment with the new DSP.
- Often this results in supersession without the necessary inter-professional communication, which is in contravention of the Health Professions Council’s Ethical Rules.

SAMA recommends:

- *The criteria for DSP and Network selection should be made clearly and transparently available to both patients and healthcare providers.*
- *DSP networks should not be a closed arrangement. They should be open to any practitioner willing to meet the funder requirements and criteria. Closed DSP networks stifle competition and choice for members.*
- *DSP arrangements should also involve voluntary participation by clinicians involved*
- *Changes to DSP arrangements, removal of providers from networks must be communicated to the patients and providers affected.*

ii. **Medicine Formularies**

SAMA supports the additions to the requirements for the communication and entitlements managements of medicines formularies.

iii. **Discharge Reports**

SAMA is comfortable with the requirements for the provision of discharge reports in keeping with the National Health Act No. 61 of 2003.

Since this is a statutory report requirement, the scheme should reimburse for writing a discharge report when they receive it, especially in the Fees for Service environment.

In the absence of Discharge report code we recommend charging code

iv. **Determination of a "reasonable" co-payment**

SAMA greatly appreciates that the CMS is looking at co-payments and the prevailing practices of medical schemes in terms of undesirable business practices.

IN our submission in response to Circular 39 of 2017, we highlighted:

- Network and DSP tariff arrangements are designed in such a way as to reward practitioners joining the network with higher than scheme rate tariffs. Non-network or non-DSP practitioners are "punished" through a variety of mechanisms.
- These include: lower reimbursement rates than what is paid to DSP practitioners, lower than inflation tariff increases following benefit year and letters directly to patients from schemes "advising" them to change their treating practitioner.
- Non-network and non-DSP practitioners are paid at the scheme rate, while DSP practitioners will be reimbursed at a higher than scheme rate, with the result that patients may face co-payments higher than the difference between the DSP tariff and the non-DSP tariff.

SAMA recommends:

- *The co-payment imposed on patients for the use of non-DSPs or the use of non-formulary medicines BY CHOICE should not exceed the difference between the scheme DSP tariff or medicine reference price, and the tariff charged by the non-DSP or the cost of the chosen medicine.*
- *Co-payments should not be used as a punitive measure – punishing scheme members for choosing a non-DSP or a non-formulary medicine.*

- *That the Council finalise its undesirable business practice project with urgency.*
- *If the intention of schemes is to lower costs of health care, refusing to reimburse health care professionals who charge lower than agreed DSP tariffs would be uncompetitive if the purpose of contracting DSP's is for cost containment.*

v. **Implementation of Regulations 15H and 15I**

SAMA agrees with the clauses in this statement, although we feel that the regulations are sufficiently clear in this regard, and that proper regulatory monitoring of scheme processes would negate the need to include these aspects in the Code of Conduct.

Nonetheless, our experience is that Schemes do not appropriately apply the provisions of Regulations 15I and H.

Where a patient willingly chooses a non-formulary item or non-preferred medicine, the co-payment the scheme applies on the medicine should not be more than the difference between the Single Exit Prices of the most expensive formulary item or preferred option and the chosen medication. The scheme should still pay up to the PMB Level of care.

The onus is on the providers to supply the medical schemes with relevant clinical information: This is a sound requirement, provided schemes also have the responsibility to advise the practitioner on what information is required. E.g. SAMA has received complaints from treating doctors who are advised that patients do "not meet clinical entry criteria" or "insufficient information has been provided" – but the scheme is not willing to advise on what the qualifying criteria are, or what additional information is required.

Secondly, scheme request motivations and are not willing to reimburse this. In the email interaction between Dr Kabane (CMS) and Dr Mametja (SAMA), CMS confirmed that the codes below are reimbursable for PMB conditions provided the schemes requested:

0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent

SAMA recommends:

- *Co-pays where non-formulary items are used by choice should not be punitive i.e. the quantity of the co-payment on the medicine should not be greater than the difference between the SEP of the most expensive formulary item and the chosen medication.*
- *As much as the onus rests with the doctor to provide the scheme with the relevant information to make a decision as to reimbursement, the onus must rest on the scheme to advise the doctor what information is required.*

C. Identification of PMBs and Defining PMB Level of Care

i. Valid PMB Cases

We thank the CMS for including the statement regarding the PMB Coded list from 2013 to be interpreted only as a guidelines, and not a legislated document for interpretation of PMB Conditions.

ii. Pre-registration, application and authorisation for PMBs

“Members may be requested to provide clinical updates…”

Doctors complete and submit chronic forms and schemes refuse to reimburse doctors for services rendered. We believe this is an opportune moment to address this in the code of conduct.

SAMA recommends:

- *The costs of the necessary information to be supplied in these clinical updates should be carried as part of the cost of the PMB condition, and covered in full by the scheme requesting the information.*
- *If more regular clinical check-ups are necessary than are provided for in the scheme protocol, because the patient is a more complicated case than the*

norm, or there is difficulty in stabilising the patient – these too must be paid for from PMB Benefits, upon necessary justification by the treating provider

- *As per 2006, NHRPL code doctors should be reimbursed for completing the chronic application forms. Procedure Code 0133.*

"Medical Schemes must reimburse healthcare providers for writing clinical motivations where such motivation is requested by the medical scheme or managed care company"

Treating clinicians face a substantial additional administration and cost burden as a result of requests to complete documentation from medical schemes.

Refusal to reimburse doctors for services requested by the medical scheme, and for which patients are not able to pay for themselves amounts to discriminatory practice.

SAMA recommends:

- *Where such documents are required by Medical Schemes, the medical schemes must reimburse healthcare providers appropriately for the following:*
  - *Disease management programme registration forms*
  - *Prescribed minimum benefit application form*
  - *Chronic medication application forms*
  - *Clinical appeal motivations*
  - *PMB Specialist referral forms*

iii. PMB Level of care

ii) "The prevailing/standard care in state sector facilities as is available in at least 3 public sector hospitals across 3 different provinces."

In PMB Benefit Definition discussions during 2017, the prevailing standard of care in the public sector has been difficult to determine and frequently, a technology or intervention is only not available in the public sector because of systemic limitations, or limitations in skills availability.

We do appreciate the allowance made for highly specialised care, which may only be available in a single centre of excellence in the public sector.

"It is important to note that not all PMB Level of care should be benchmarked against public sector healthcare provision. Where the private sector provides more efficient and clinical best practice care, specifically cost-effective and affordable interventions, such level of care should be recognised as PMB Level of care."

This statement seems to contradict the statement about state level of care. These criteria of clinical best practice and efficiency require different assessment and investigation to those of assessing state standard of care. This is the argument that commonly arises at medical scheme level currently with regard to care. Whose efficiency and affordability is being referred to – many technologies may make hospital procedures more efficient for hospitals, but may prove unaffordable to patients or medical schemes. There is currently no industry-wide process for assessment of cost-effectiveness – how will this be determined?

Cost-effectiveness: "At the reasonable discretion of the scheme such evaluations must be made available to relevant parties or individuals on request."

Patients may be denied effective treatments as PMB level of cover as a result of the scheme concluding that they are not cost-effective. If this claim is made, it should be an absolute requirement that the scheme share this analysis with requesting patients, providers, and technology and pharmaceutical companies.

iv. Diagnostic and Procedure Coding

"The National Health Reference Price List 2006 is the only legal procedure coding system in South Africa".

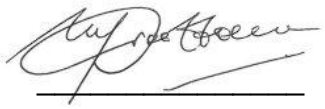
The 2006 NHRPL is highly outdated and no longer useful for claims coding on its own. This is an industry-wide problem that must be addressed. Since 2006, SAMA has identified many clinical codes that the schemes are funding.

SAMA appreciates that it is still considered a 'go to' for doctors in terms of clarity on codes as provided for in NRPL code Rule C and clearly outlined here in the Code of Conduct document.

CONCLUSION

SAMA is pleased to be in the position to contribute to the process of updating the PMB Code of Conduct.

We hope that our comments with regard to the current challenges, proposed processes and benefits will contribute substantively to the process and look forward to ongoing engagement with the Council and other impacted stakeholders.



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Chairperson: SAMA

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