CIRCULAR

Reference:	2014 Healthcare Utilisation Annual Statutory Return
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Date:	28 July 2015

Circular 49 of 2015: General Concerns Noted During the Analysis of the Healthcare Utilisation Annual Statutory Returns for the financial year ended 31 December 2014

1. Introduction

1.1. Purpose

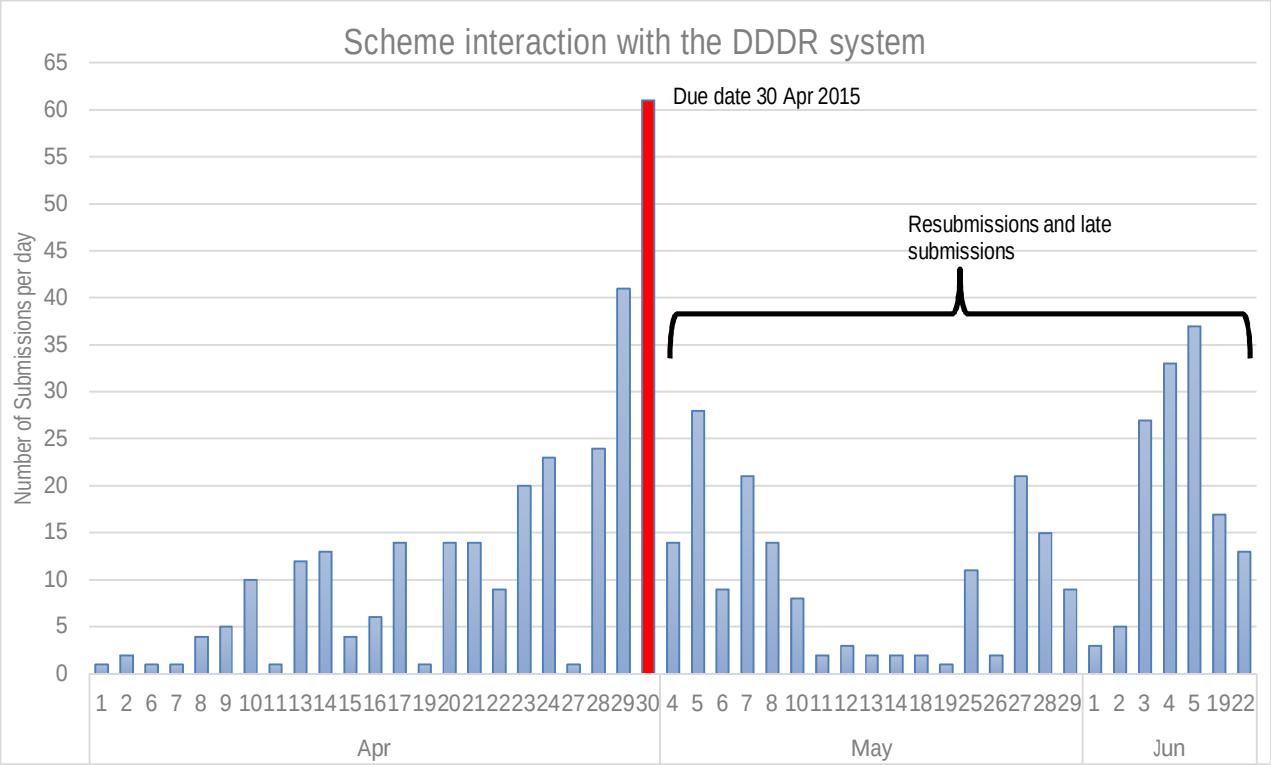
The Council for Medical Schemes (CMS) wishes to thank all medical schemes that submitted the 2014 Healthcare Utilisation Annual Statutory Return (ASR). The data submission process was completed successfully and CMS has finalised the data evaluation.

The purpose of this circular is to bring to your attention common problems and issues identified in the analysis of the ASR in order to:

- enhance the quality of data submitted in the ASR
- ensure consistent data from all registered medical schemes.
- to improve the future submission process

1.2. Number of submissions

A total of 86 schemes submitted the Healthcare Utilisation ASR data for 2013, 2014 or both. Two (2) schemes did not submit the 2013 ASR data. The main reason for non-submission was due to the change of administrators during the data collection period. PMB exempt schemes were excused from completing parts that required PMB data. The graph below depicts the submission activity by schemes before and after the submission due date. A majority of submissions were received on the due date.



1.3. Key areas of concern

During the data submission process, the CMS identified the following errors that were common in a majority of the medical schemes.

1.3.1. Part A.1: Membership profile at the end of the financial year

A few instances were noted where medical schemes reported beneficiaries with a year of birth greater than the Financial Year. This has an impact on the analysis of the age profile of medical scheme beneficiaries. Schemes must always ensure that the Year-of-Birth is always less than or equal to the Financial Year.

1.3.2. Part A.2: Number of registered members and dependants at the end of each month

Membership data for Part A.2 was of acceptable quality for most medical schemes.

1.3.3. Part A.3: Age analysis of member movement for the financial year

Schemes must ensure that the number of beneficiaries joining or leaving schemes is consistent with the beneficiary enrolment period reported in Part A.1. The CMS noted this was not the case in a few instances.

1.3.4. Part A.4: Waiting periods, pre-existing condition exclusions and late joiner penalties

Schemes must ensure that the number of beneficiaries for which waiting periods, pre-existing conditions or late joiner penalties are imposed is consistent with the beneficiary enrolment period reported in Part A.1.

1.3.5. Part A.5: Distribution of beneficiaries and benefits paid by province

The CMS noted that some schemes reported the number of active claiming beneficiaries instead of total active beneficiaries at the end of the Financial Year. The requirement is that medical schemes must report the number of beneficiaries by beneficiary type, irrespective of whether they have made a claim in December of the Financial Year or not.

Total benefits reported in Part A.5 did not agree with total benefits reported in Parts B.1 + B.2 + B.3 + B.11 for a number of schemes. The total amount claimed by provider, amount paid from risk and amount paid from savings must represent the schemes experience for the whole year and should not be limited to beneficiaries active in December only.

1.3.6. Part A.6: Managed Healthcare Indicators

A significant number of schemes reported more utilising beneficiaries than the number registered on a scheme's chronic disease program for CDL conditions. Part A.6 requires that medical schemes report a number of unique beneficiaries receiving or utilising managed care interventions. This number cannot be greater than the number of beneficiaries registered on a scheme's chronic disease program for CDL conditions.

1.3.7. Part A.7: Scheme Risk Measurement

The CMS noted the poor application of the Entry and Verification Criteria Guidelines for the Identification of Beneficiaries with CDL conditions. When correctly applied, the number of beneficiaries reported for the "Prevalence" table will always be greater or equal to those reported for the "Count" table. The number of beneficiaries without a CDL condition must always be the same for the "Prevalence" and "Count" tables.

1.3.8. Part B.1: Analysis of healthcare providers (GP's, Specialists, etc.)

The CMS noted that claims may have been duplicated in Parts B.1, B.2, B.3 and B.11. Claims data reported in Part B.1 cannot be duplicated in Parts B.2, B.3 and B.11.

1.3.9. Part B.2: Utilisation of medicines & consumables

Claims data reported in Part B.2 cannot be duplicated in Parts B.1, B.3 and B.11. Schemes must ensure that claims for medicines or consumables can only be reported in Part B.2. Non-product pharmacy claims must be reported in Part B.1.

1.3.10. Part B.3: Hospital utilisation

Claims data reported in Part B.3 cannot be duplicated in Parts B.1, B.2 and B.11.

Schemes must ensure that the reported number of unique beneficiaries admitted to hospitals is consistent across all the parts where such information is reported.

1.3.11. Part B.4: Analysis of the total benefits paid in respect of selected principal diagnosis types per ICD 10 codes

Schemes must ensure that the reported number of unique beneficiaries admitted to hospitals is consistent across all the parts where such information is reported.

1.3.12. Part B.5: Hospital admissions relating to beneficiaries with chronic diseases

The CMS noted that in a few instances schemes limited beneficiaries on a chronic disease management programme to the number admitted in hospital. All beneficiaries registered on a chronic disease management programme must be reported. Beneficiaries with multiple CDL conditions must be reported for each of the CDL conditions they are registered for. It is therefore possible to have multiple records for such beneficiaries. Table B.5 should contain data for all-cause admissions for beneficiaries registered on the scheme's chronic disease management programme.

1.3.13. Part B.6: Analysis of hospital admissions

Schemes must ensure that the reported number of unique beneficiaries admitted to hospitals is consistent across all the parts where such information is reported.

1.3.14. Part B.7, B8 & B9: Total PMB (CDL & DTP) expenditure

The CMS noted that the reported PMB Cost in Part B.7 was significantly different from the estimated PMB Cost (Scheme Risk Measurement 2013: Average) in a number of schemes. Schemes must always check the accuracy of the submitted PMB data.

1.3.15. Part B.10: Other hospital benefits

Schemes must ensure that the reported claims for beneficiaries admitted to hospitals is consistent across all the parts where such information is reported.

1.3.16. Part B.11: Other benefits

Claims data reported in Part B.11 cannot be duplicated in Parts B.1, B.2 and B.3.

1.3.17. Part C.1: Other benefits

The CMS noted that a number of utilisation statistics reported in Part C.1 was not consistent with the data reported in other parts. For example, the number of beneficiaries visiting a GP must be consistent in Parts A.1 and C.1. Schemes must always check the accuracy and reasonableness of the submitted utilisation statistics data.

1.3.18. Validation between Healthcare Utilisation Annual Statutory Return & Annual Financial Statements and Statutory Returns (AFS)

The CMS noted differences in the number of beneficiaries reported in the Healthcare Utilisation ASR Part A2 & Financial ASR. Schemes must ensure that there is no difference between the numbers of beneficiaries reported in the two systems.

The CMS noted that the total benefits paid (sum of B.1, B.2, B.3 and B.11) as reported in the ASR where significantly different from the total benefits paid reported in the AFS in a number of schemes. The differences between the two systems are likely to be due to the handling of claim reversals, timing of the data extractions, double or inconsistent counting of claims, or a different interpretation of the payment date.

The above listed errors resulted in the CMS requesting some medical schemes to resubmit the data. The CMS therefore wishes to alert the data officers to note these errors for future submissions.

In general, the 2014 Healthcare Utilisation Annual Statutory Return process ran smoothly and the CMS wishes to thank all the medical schemes that cooperated in the process.

The CMS is looking forward to improved Healthcare Utilisation Annual Statutory Return submissions in future and highly appreciates your cooperation.

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