PMB Task Team Workshop
11 May 2010
Dr Jonathan Broomberg

Presentation has formal mandate from following schemes and administrators

Medical Schemes

- AECI Medical Aid Society
- Altron Medical Aid Scheme
- Anglovaal Group Medical Scheme
- Bepmeds Medical Scheme
- Bestmed Medical Scheme
- Cape Medical Plan
- Chartered Accountants (SA) Medical Aid Fund
- Community Medical Aid Scheme
- Discovery Health Medical Scheme
- Hosmed Medical Aid Scheme
- Keyhealth Medical Scheme
- LA Health
- Libcare Medical Scheme
- Liberty Health Medical Scheme
- Massmart Health Plan
- MEDIHELP
- Momentum Health Medical Scheme
- Moto Health Care Medical Fund
- Nampak SA Medical Scheme
- Naspers Medical Fund
- National Independent Medical Aid Society
- PG Group Medical Scheme
- Pharos Medical Plan
- PROFMED
- Quantum Medical Aid Society
- Spectramed
- Tsogo Sun Group Medical Scheme
- UMED Medical Scheme
- Xstrata Medical Aid Scheme
- Remedi Medical Aid Scheme
- Afrisam Medical Scheme
- Edcon Medical Aid
- IBM South Africa Medical Scheme
- Retail Medical Scheme
- University of KZN Medical Scheme

Administrators / Managed Care companies

- Allcare Administrators
- Discovery Health (Pty) Ltd
- Momentum Medical Scheme Administrators
- Professional Medical Scheme Administrators
- Providence Healthcare Risk Managers
- Sanlam Healthcare Management
- Universal Healthcare (Pty) Ltd

Agenda

The principle of PMBs

Key issues regarding current implementation of PMBs:

The Principle of Prescribed Minimum Benefits

We fully support the concept of a set of well defined PMBs which define the minimum entitlement of medical scheme members

A number of systemic issues have prevented consistent and sustainable implementation of PMB requirements

These problems are impacting on all stakeholders, including members, schemes, providers and administrators

We strongly support the initiative of CMS and DoH to develop a jointly agreed, collaborative approach to addressing these problems.

Agenda

The principle of PMBs:

Key issues regarding current implementation of PMBs:

1. The concept of payment of PMBs at “cost”
2. The challenge of accurate identification of PMB claims
3. The definition of PMB entitlements

Key Issues: 1 Payment of PMBs at Full Cost Charged by Providers

1. Schemes face fundamental contradiction

Constrained premium increases

Key Issues: 1 Payment of PMBs at Full Cost Charged by Providers

2. Industry confused by varying legal interpretations of PMB obligations

Original intention of PMBs:

Ensure that PMBs were paid in full at scheme tariff or to pay in full at whatever provider chooses to charge with no limit?

Regulations promulgated prior to effective collapse of RPL system - no longer any std. tariff

Consistency between regulations regarding payment at cost and the broader requirements of the Act

Key Issues: 1 Payment of PMBs at Full Cost Charged by Providers

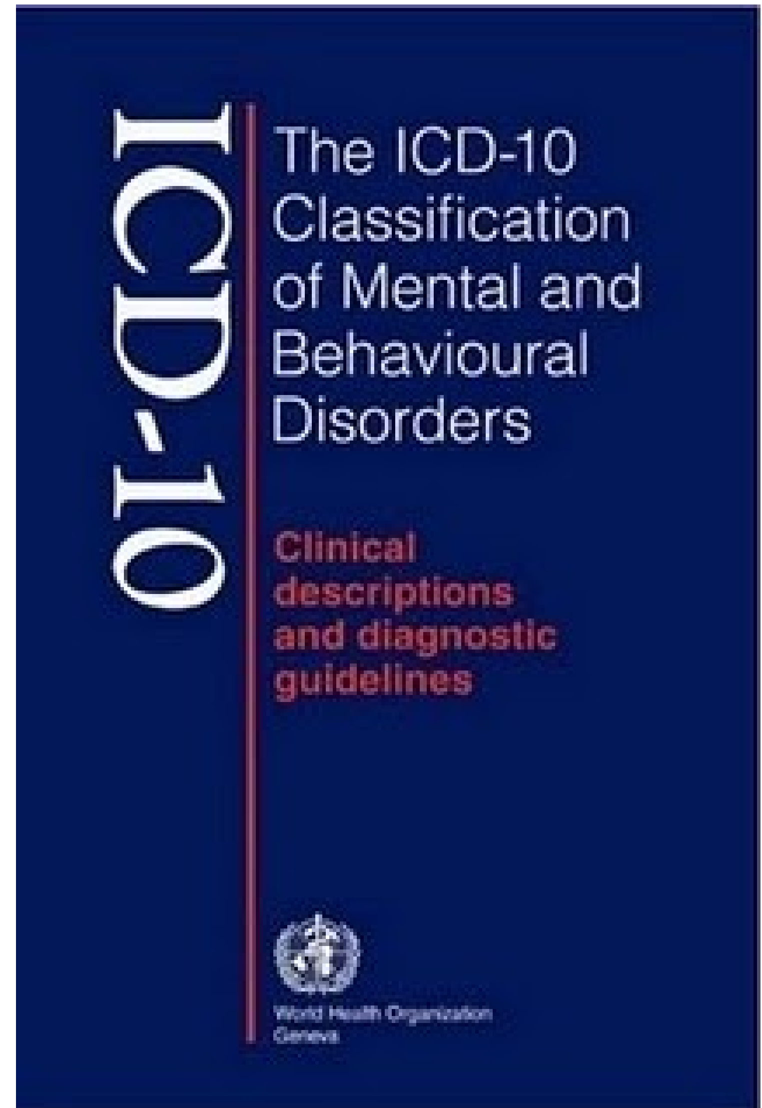
2. **Designated Service Provider arrangements provide theoretical protection BUT many schemes unable to negotiate DSPs arrangements at affordable tariffs due to scarcity of doctors and small scale of schemes**

3. **Forcing schemes to pay full cost without limits has several negative consequences for schemes and members**
   - Further weaken ability of schemes to negotiate prices
   - Incentivize inefficient billing behaviour: tariffmanship, upcoding; increased charges
   - Undermine ability to negotiate DSPs

Key Issues: 2 The challenge of accurate identification of PMB claims

Schemes cannot accurately identify PMB conditions only from ICD10 codes on claims for two main reasons:

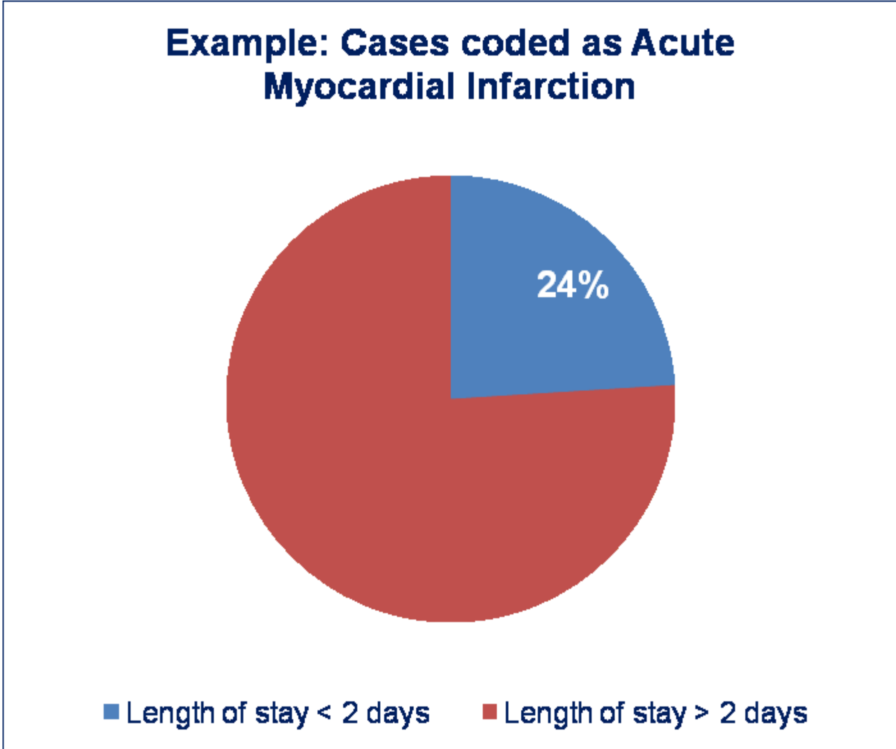
- Very serious problems with accuracy of ICD10 coding
- In many cases, additional information beyond ICD10 codes required to evaluate whether or nor a claim qualifies as a PMB event



Accuracy of ICD10 codes

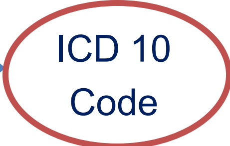
Discovery and other data confirm following problems

- *Poor correlation between coding submitted and actual treatment provided*



- *Poor correlation in coding between two different input sources:*

Only 42% correlation between hospital codes from treating doctor and provided at pre auth by hospital using least stringent coding level



Multiple factors undermine accuracy of ICD10 codes

- Some software vendors **systems non-compliant** with ICD-10 claim coding legislation
- **Lack of coding trainers**
- **Lack of consultants** in provider organizations that are medically trained
- **Lack of tools** that assist accurate coding by non-experts
- Widespread use of "**cheat sheets**" by practices, hospitals and billing bureaus that do not reflect true diagnoses and are simply a means to assure payment from funders

- **Incentives exist for providers to code "wrongly," whether intentionally or not:**
  - Up-coding can increase the monetary value of reimbursement for services
  - "Disguised" coding can bypass reimbursement limitations for non-covered benefits
  - "Default" codes or cheat sheets speed up operational/systems processes but undermine accuracy

Additional clinical information often required to evaluate a PMB claim

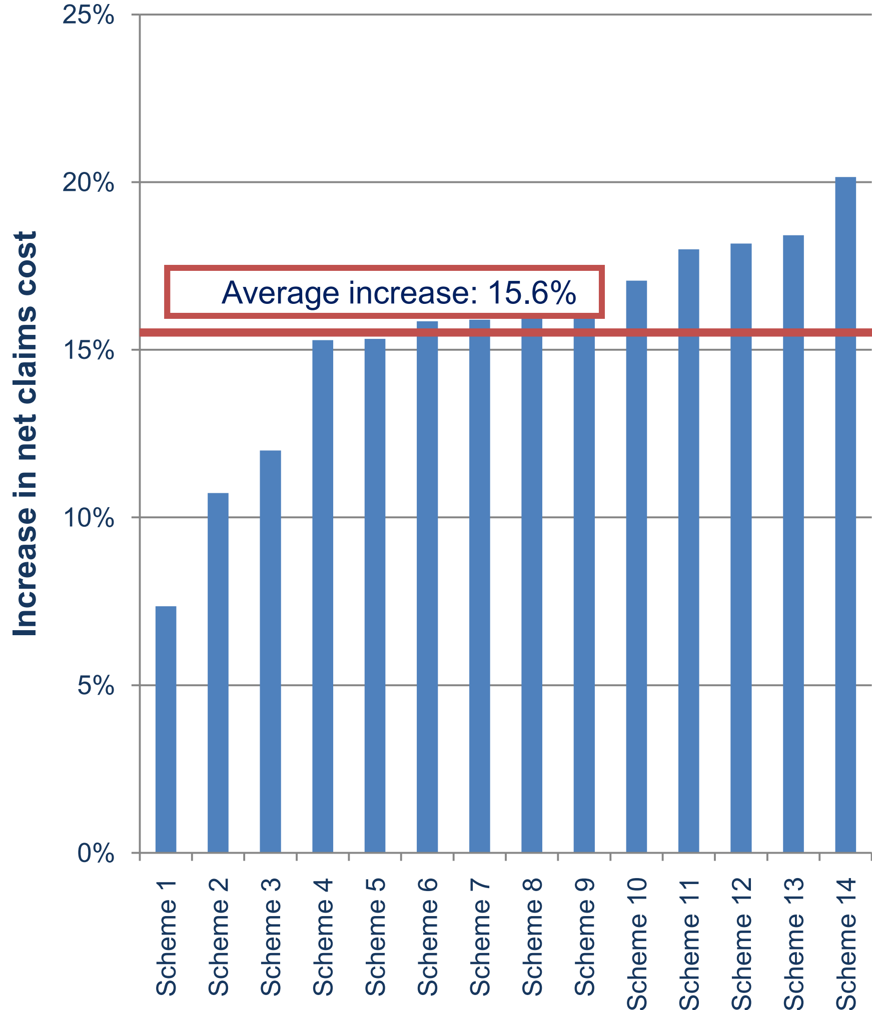
Implementation of clinical protocols and algorithms to manage PMB risk usually requires clinical information not provided by ICD10 codes alone. For these reasons, automated payment of PMB claims only possible based on either prior registration/ notification using complete information

- CDL conditions
- Some DTPMBs with chronic element

Other claims require adjudication and, most times, additional information

- ICD10 code for Hyperlipidemia: PMB management requires additional data including lipogram results, family history, blood pressure etc
- The PMB for gastric ulcer specifies perforated and/or haemorraging ulcer – this information not provided in ICD10 code alone.

Auto Payment of PMB claims based on ICD10 codes would create major risk for schemes



Conclusions

- Schemes not able to autopay on ICD10 claims due to inability to accurately identify PMBs
- Autopayment represents two significant risks to schemes:

  1. Significant financial impact which would require large premium increases and / or a significant drain on scheme reserves
  2. Significant fiduciary risk – to the extent that trustees may be paying claims in a manner inconsistent with the rules of the schemes

*14 schemes supplied an analysis of the expected increase in risk claims as a result of "autopayment" from risk benefits at full cost

Key Issues: 3 The definition of PMB entitlements

Schemes are struggling to manage PMB risk for most DTPMBs due to:

- Lack of clarity regarding treatments must be funded for each DTPMB
- Lack of defined baskets of care and algorithms
- lack of clear and consistent information on the “prevailing practice*” in state facilities

Lack of clarity creates several major problems for schemes and members:

- Inability to quantify and manage PMB risk
- Lack of clarity for members and providers regarding what is covered as PMB

- Incentives for providers to deem a wide range of interventions as PMB treatments, even where clinical and cost effectiveness evidence is poor

Current situation is “worst of all worlds’ for schemes – unlimited liability for wide range of PMB/DTPMB treatments, with no control on costs, and no specificity on actual PMB entitlements

Way Forward

We strongly support the CMS proposal for a collaborative Task Team approach and development of a “Code of Conduct’ governing billing and reimbursement for PMB conditions

The Code of Conduct should achieve clarity and consensus on following key issues:

- Scheme obligations regarding payment at cost
- Scheme obligations regarding specific and detailed entitlements in regard to every CDL and DTPMB
- Provider obligations and guidelines for coding and billing of PMB treatments
- Level of information required to evaluate and pay PMB claims

Way Forward

Actions to improve identification of PMBs

- Industry wide audit of ICD10 coding quality in collaboration with CMS

- Joint CMS/Industry/provider strategy to improve quality of coding

- Clarify rules regarding acceptable approaches to payment of PMBs with respect to
  - CDL conditions where member registered on basis of defined criteria and information
  - Those DTPMB conditions where member can be identified in advance
  - All other PMB claims where only information is on the claim itself

Actions to clarify PMB entitlements

- Use consultative process developed for PMB review to develop detailed DTPMB baskets of care and treatment algorithms

- Explicit guidance on definition of 'treatment available in state facilities' to underpin PMB definitions

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