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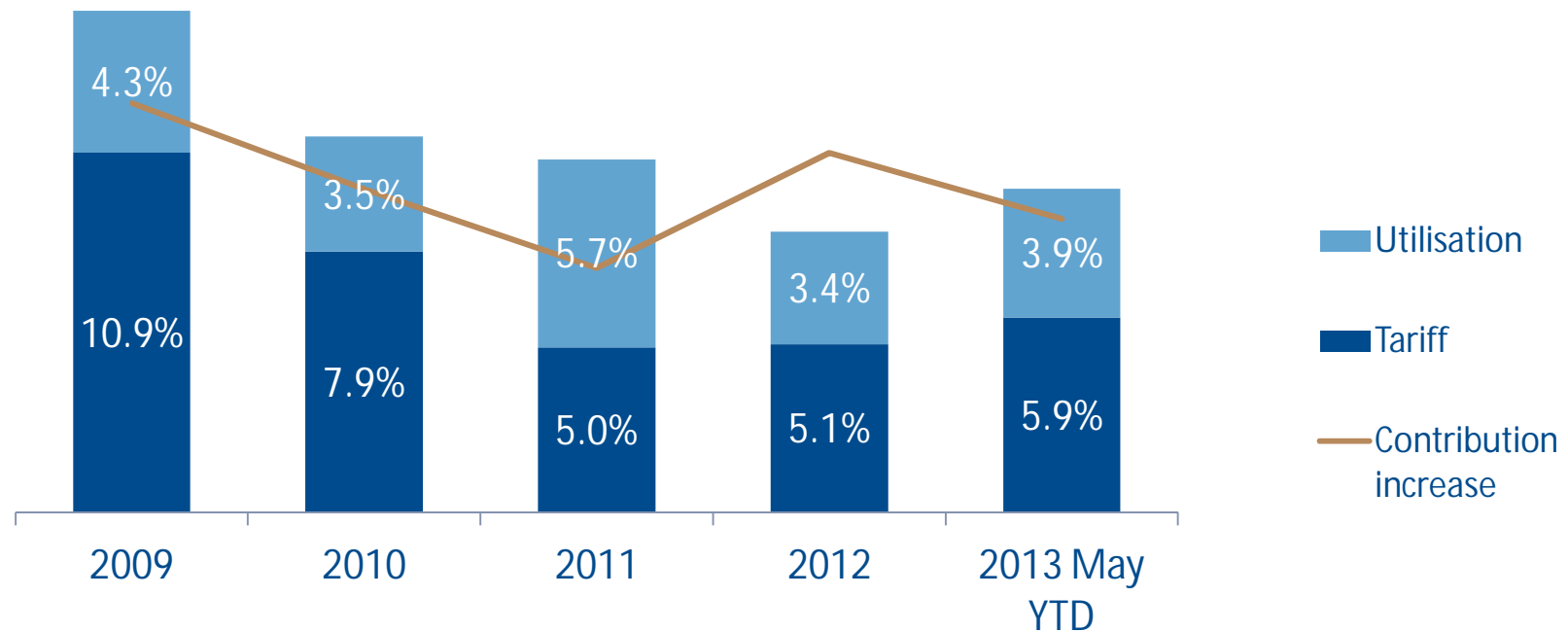
CMS Indaba, 27th November 2013

Coding, Pricing and Value in SA Healthcare

Dr Jonathan Broomberg, CEO, Discovery Health

What drives medical inflation in South Africa?

Medical Inflation: 2009 – 2013 May YTD



Drivers of utilisation:

Demand-side drivers :

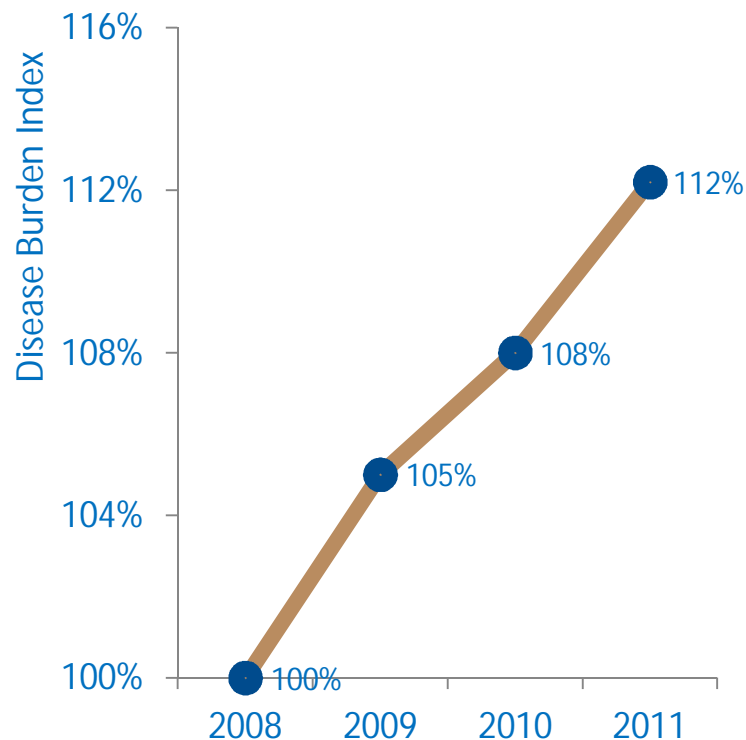
- ⊕ Adverse selection
- ⊕ Increased disease burden
- ⊕ Ageing

Supply-side drivers:

- ⊕ Fee for service system
- ⊕ Undersupply of doctors
- ⊕ New technology and procedures
- ⊕ New hospitals

Examples of demand-side and supply side inflationary drivers

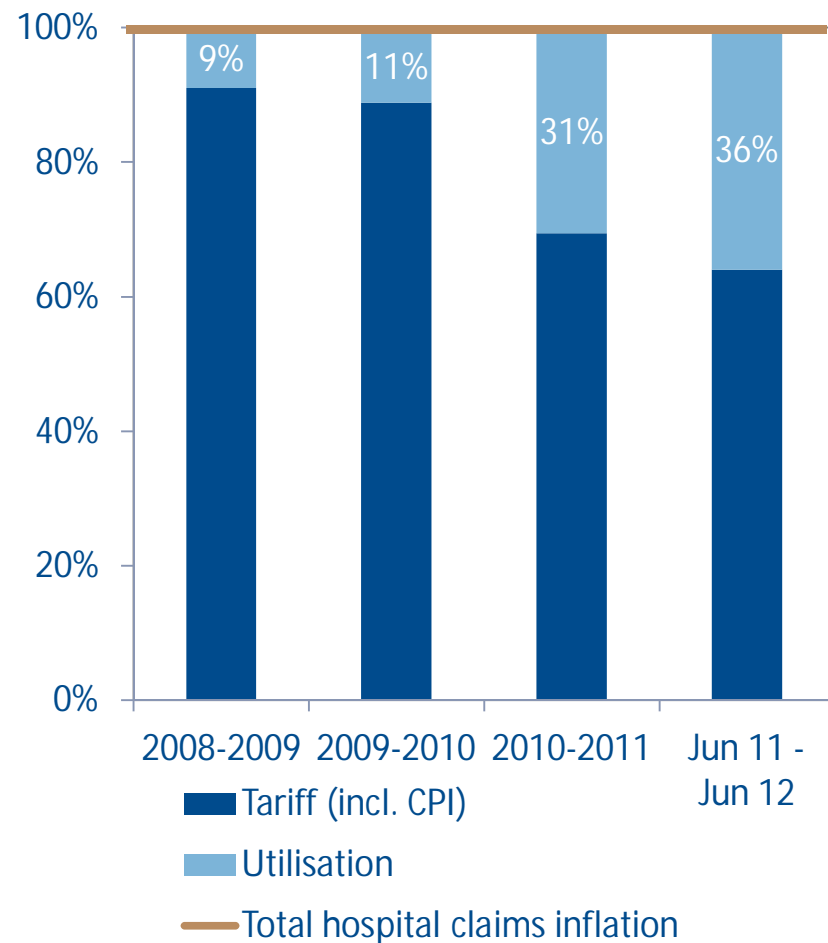
Demand-side: Increasing disease burden in medical schemes



- Chronic prevalence has increased by 60% over the last 4 years
- Chronic patients cost 4 x non-chronic

Hospital claims inflation driven by utilisation and price

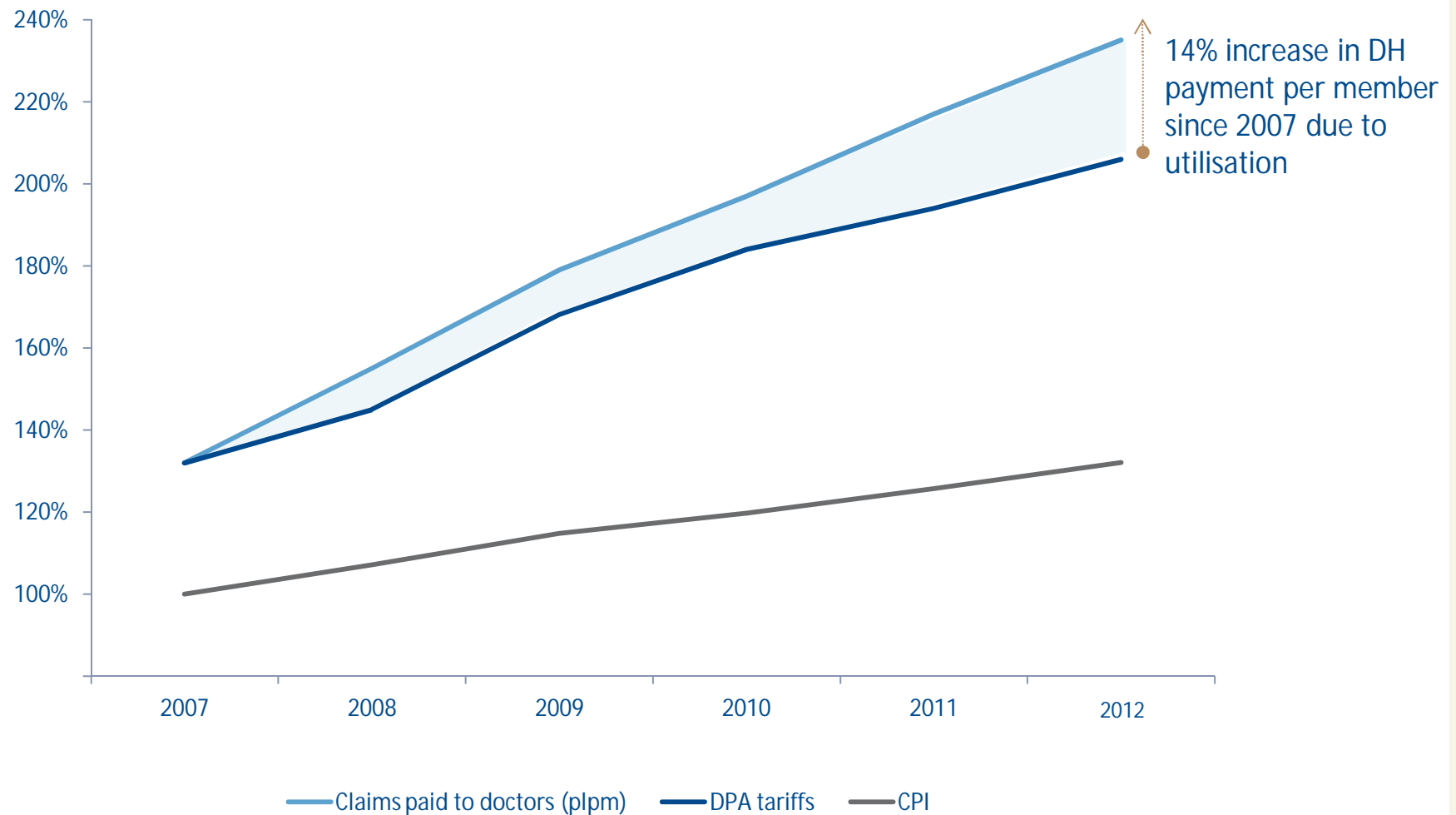
Utilisation leads to an average annualised increase in hospital claims of 2% p.a.



Utilisation also contributes to higher payments to health professionals



Increase in specialist payment rates



Coding plays a critical strategic role in sustainable healthcare funding

ICD - 10

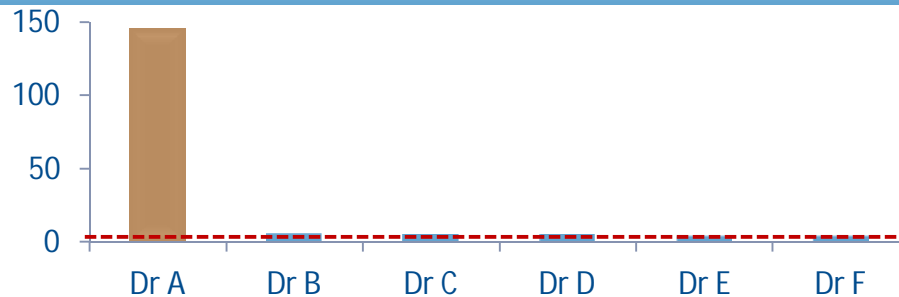


Enables

- Fair reimbursement for healthcare services
- Monitoring quality of care and outcomes
- Understanding the burden of disease
- Keeping current with new technologies and techniques
- Move to ARMs and effective risk management
- Planning of healthcare needs
- Reliable communication of healthcare data
- Facility management
- Research
- NHI – Public sector

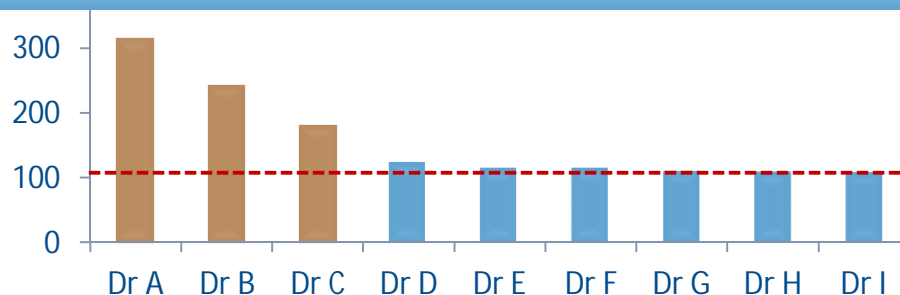
Coding helps to detect fraud and waste

Gentamycin: For middle ear infections, rarely used



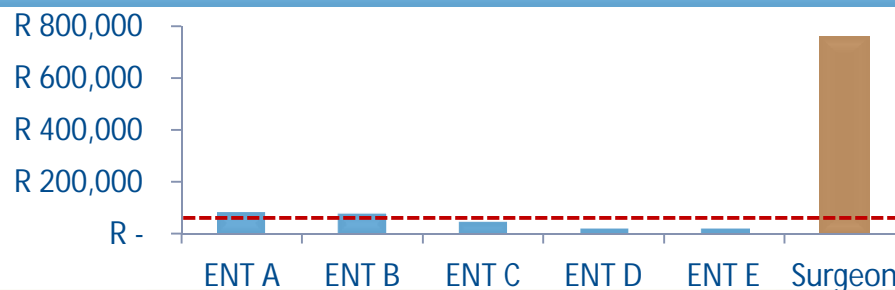
- Dr A bills code 3266, 100% of the time
- Peers bill 5% and less

Removal of tonsils



- Multiple providers bill code 1039, 100% of the time
- Peers bill 40% and less

Laryngeal stroboscopy with video capture: code 1118



- Surgeon used code 1118 (Laryngeal stroboscopy) which is used by ENTs
- Estimated savings from one surgeon: ~R1.2m

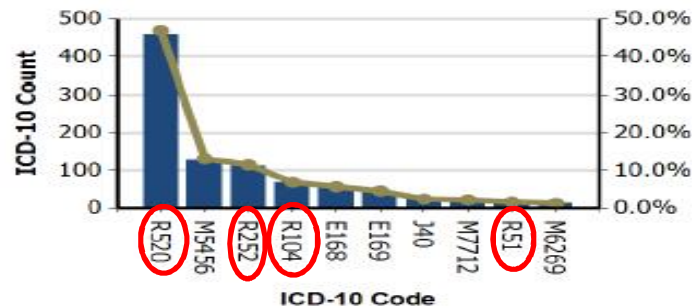
However there are several challenges in the current coding environment

- ④ Coding not updated since 2006 to reflect new technologies and practices
- ④ Inappropriate clinical use of coding
- ④ Poor discipline of coding, leading to inaccuracies
- ④ Fraud and code pairing
- ④ Abuse of Rule C workaround

Fee For Service system predisposes to poor coding and misinterpretation of guidelines

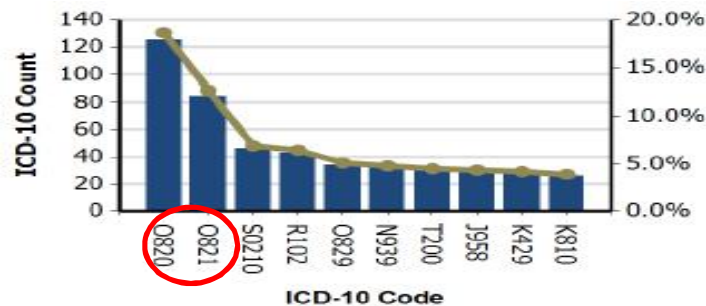
Examples of poor quality coding

Top 10 Primary ICD-10 code usage



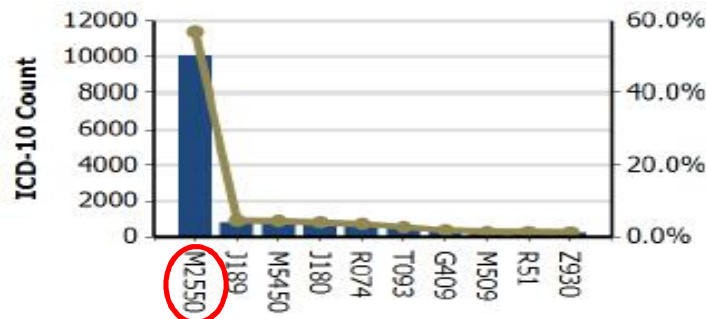
- Frequent use of sign/symptom codes instead of confirmed diagnosis codes

Top 10 Primary ICD-10 code usage



- Main conditions treated by an 'allied' health professional coded as Caesarean Section deliveries

Top 10 Primary ICD-10 code usage



- 50% (10 000 claims) from one doctor coded to same code: M2550 (Pain in joint, multiple sites)

Inappropriate clinical use of coding

Pr type description	ICD-10	Description
Dietician A	J069	Acute upper respiratory infection, unspecified
Dietician B	E282	Polycystic ovarian syndrome
Gynaecologist A	J069	Acute upper respiratory infection, unspecified
Gynaecologist B	A000	Cholera due to vibrio cholerae 01, biovar cholerae
Occupational Therapist	S818	Open wound of other parts of lower leg
Podiatrist	S101	Other and unspecified superficial injuries of throat
Social Worker A	L600	Ingrown nail
Social Worker B	L84	Corns and callosities
Speech Therapist/Audiologist	Z500	Cardiac rehabilitation
Surgeon	J029	Acute pharyngitis, unspecified

Critical to establish organised forum for schemes and providers to negotiate codes and tariffs

Objectives

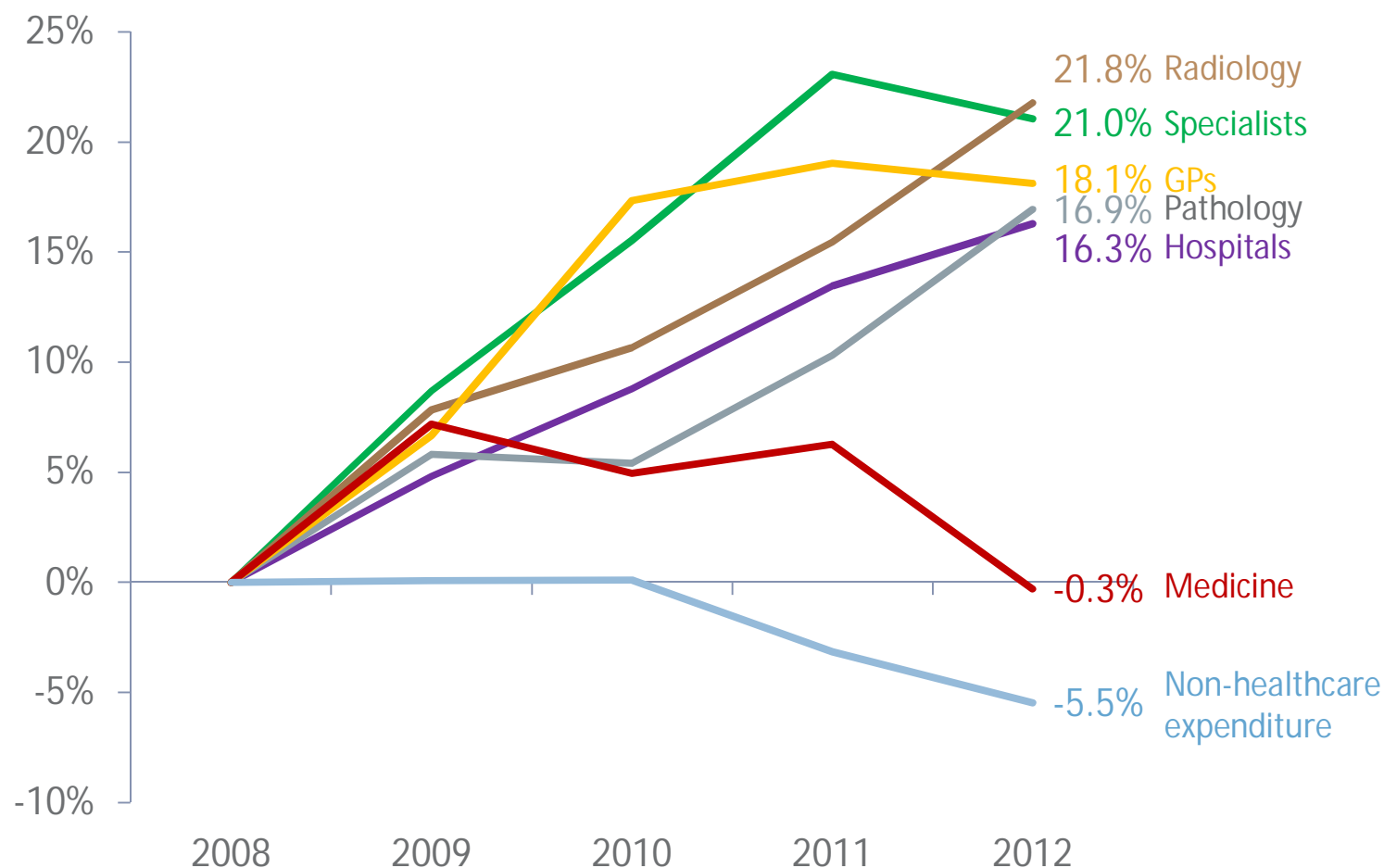
- ④ Appropriate remuneration for professionals
- ④ Manageable cost impact of changes for schemes and members – no “shocks” to system
- ④ Keep up with appropriate advances in medical practice
- ④ Ensure consistency and accuracy of coding

Key elements of a coding/tariff forum

- ④ Shared leadership and governance
- ④ Agreed, structured process
- ④ Focus on managing:
 - Codes
 - Tariffs
 - Utilisation

Tariff setting must take Scheme affordability and quality into account

Real increases in DHMS expenditure (2008-2012)



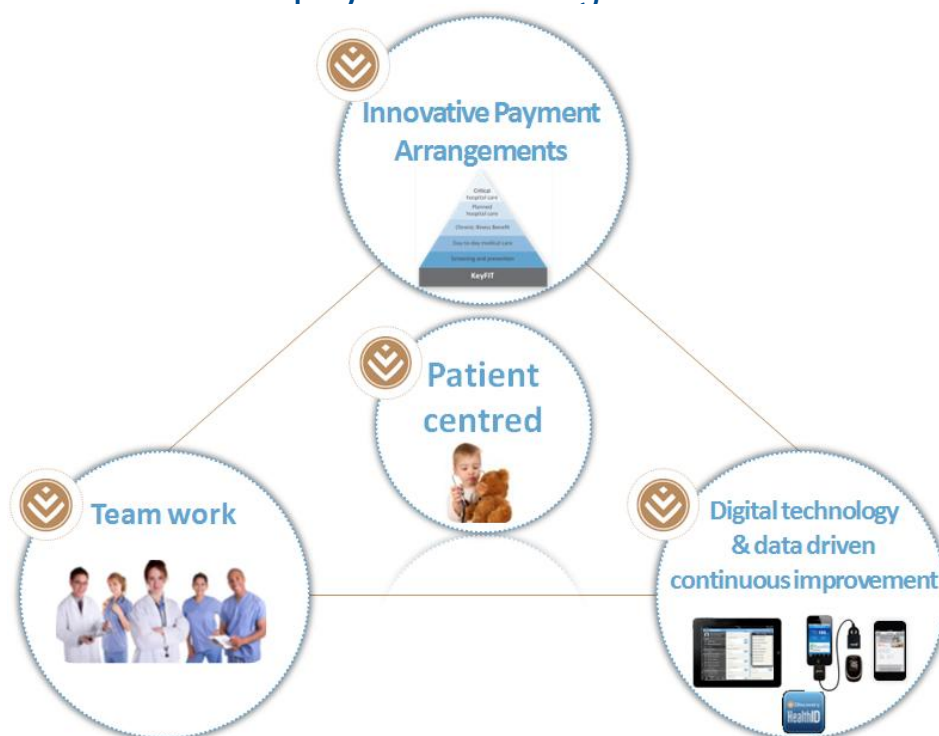
CMS data

2008 baseline based on PLPM costs

SA Health Improvement Triangle

Achieving quality of care, affordability and access

- Reduce waste
- Value based payments & innovative payment arrangements



- Wellness programmes
- Integrated patient-centred care and teamwork
- Quality improvement processes
- Embrace technology to improve access
- Electronic health records
- Transparent data on quality of care

There is a global movement away from FFS, towards value-based payments



Payment system reform for health care providers in Korea

SOONMAN KWON
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Since its introduction in 1977, the national health insurance programme in Korea has paid health care providers on a fee-for-service basis. Regulated fee-for-service payment has resulted in an increased volume and intensity of medical care. It has also distorted the input mix of treatment because physicians have substituted more profitable and uninsured (no coverage) medical services for those with lower margins, as is evidenced by the sharp increase in the caesarean delivery rate. This paper examines two recent supply-side reforms in Korea: Diagnosis Related Group (DRG) and Resource-based Relative Value (RBRV). Since 1997, through a pilot programme covering a selected group of diseases for voluntarily participating health care institutions, the DRG-based prospective payment system has proven to be effective in containing cost with little negative effect on quality. RBRV-based payment was implemented in 2001, but led to an almost uniform increase in fees for physician services without a mechanism to control the volume and expenditure. Challenges and future issues in the reform of the payment system in Korea include the expansion of benefit coverage, quality monitoring and improvement, strategic plans to overcome the strong opposition of providers and the introduction of global budgeting.

Key words: health insurance, provider payment, DRG, RBRV, Korea

Introduction

The national health insurance programme in Korea relies on a fee schedule for reimbursing health care providers, and the government regulates the fee. Fee regulation has been the source of recurrent complaints by providers in Korea. They maintain that the government regulates the fees so tightly that they at best barely cover the cost of providing medical care. A tension between the insurer and the provider over the adequacy of the fee level has existed since the introduction of the national health insurance programme and is likely to continue. In addition, fee-for-service payment leads to over-provision and distortion in the mix of medical care because physicians have an incentive to provide more of those services with a greater margin. For example, a physician in Korea usually recommends that a patient visit the office every 2 days for a minor case. An office visit consists of several tests at the initial visit and a very short physician consultation that lasts for only 2 or 3 minutes (KHCIM 1999).

For the purchaser – insurer or government – the payment compensates providers for their cost of providing medical care, and at the same time it should encourage them to be

as the Diagnosis Related Group (DRG) based reimbursement that provides them with stronger incentives to control costs.

The cost-sharing fees that patients pay at the point of service amount to about 50% of total medical expenses in Korea and hence impose a substantial burden on patients (NIHC 1999). Without a stop-loss mechanism for catastrophic expenses, the high co-payment (or excessive demand-side cost sharing) imposes a huge economic burden on the unhealthy and the poor because it does not take into account patients' varying need for health care and their differing ability to pay. A supply-side cost-sharing payment system would give strong incentives to providers to contain medical expenses by making them take on the economic consequences of health care utilization by patients (Ellis and McGuire 1993). Providers also have better knowledge and information about patients' health care needs (than patients themselves). Therefore a payment system with a supply-side incentive scheme can encourage providers to tailor medical care provision to the need of individual patients. In contrast, the patient co-payment often reduces both necessary and unnecessary health care utilization (Rice 1998).



Perspective
SEPTEMBER 18, 2008

Beyond Pay for Performance — Emerging Models of Provider-Payment Reform

Meredith B. Rosenthal, Ph.D.

Escalating costs and the growing imbalance between primary and specialty care have increased the urgency of calls for fundamental reform of the health care payment system. At the

core of the problem is the fact that the dominant fee-for-service model rewards volume and intensity rather than value. But although the faults in the way we currently pay for health care are obvious, it is much less clear what feasible approach would yield better results.

Earlier this decade, new for-

mers is enhancement of existing pay-for-performance programs through changes in scope, performance measures, and magnitude of funding. The changes appear to be focused on two perceived shortcomings of earlier efforts: too little impact on provider behavior and not enough focus on demonstrable benefits — including both health outcomes and spending — as opposed to process-of-care measures. At the same time, nonpayment for treatment of preventable complications has emerged as the mirror im-

age of the current reimbursement models — either unduly perverse incentives

PAYMENT & PRACTICE

By Paul B. Ginsburg

ANALYSIS & COMMENTARY

Achieving Health Care Cost Containment Through Provider Payment Reform That Engages Patients And Providers

ABSTRACT The best opportunity to pursue cost containment in the next five to ten years is through reforming provider payment to gradually diminish the role of fee-for-service reimbursement. Public and private payers have launched many promising payment reform pilots aimed at blending fee-for-service with payment approaches based on broader units of care, such as an episode or patients' total needs over a period of time, a crucial first step. But meaningful cost containment from payment reform will not be achieved until Medicare and Medicaid establish stronger incentives for providers to contract in this way, with discouragement of nonparticipation increasing over time. In addition, the models need to evolve to engage beneficiaries, perhaps through incentives for patients to enroll in an accountable care organization and to seek care within that organization's network of providers.

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For many years the US approach to controlling health care costs has centered on public payers lowering providers' payment rates, while private payers increased patients' cost sharing and required prior authorization for hospitalizations and some tests and procedures. However, provider and consumer push back, the latter fostered in part by continued large tax subsidies for those who obtain comprehensive health insurance through their employers, have limited the success of these approaches.

Yet as cost containment becomes increasingly urgent, these tools are being used more often. Under the Affordable Care Act, for instance, reimbursement pressure on providers has increased. And employers who provide health insurance are imposing larger increases in deductibles and co-payments, which in turn are

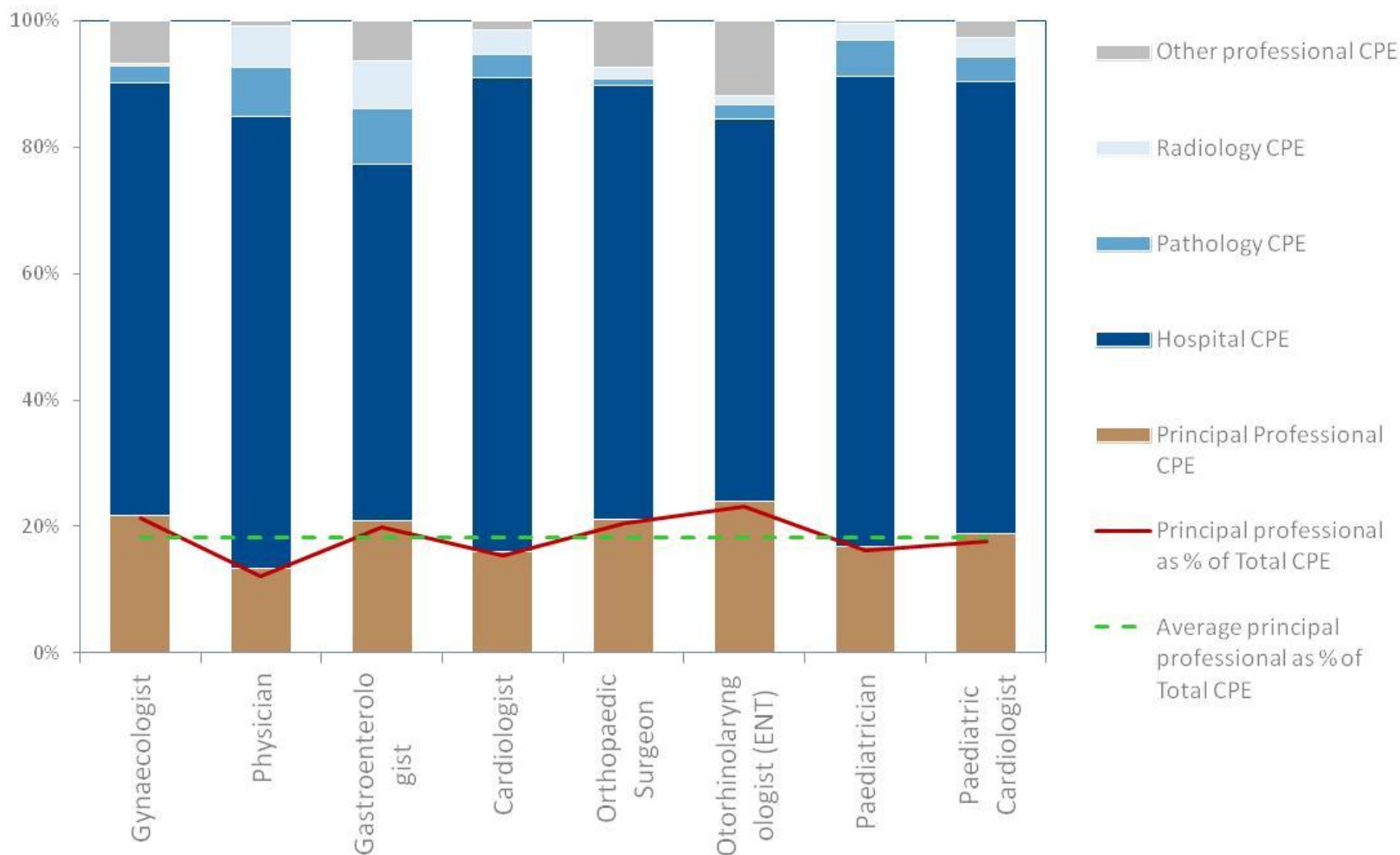
spending trends are unsustainable and traditional cost-control approaches are reaching the limits of acceptability. Health care spending continues to consume a growing share of the gross domestic product—almost doubling in the past three decades, from 9.2 percent in 1980 to 17.9 percent in 2003. An increasing number of Americans cannot afford health insurance because increases in premiums are outpacing income growth.

Meanwhile greater portions of federal and state budgets are needed to support health coverage for elderly, disabled, and lower-income Americans. In addition, spending on Medicaid expansions and insurance premium credits under the Affordable Care Act will leave federal and state budgets even more vulnerable to health care cost trends than in the past.

Reprinted with permission from the New England Journal of Medicine, September 18, 2008.

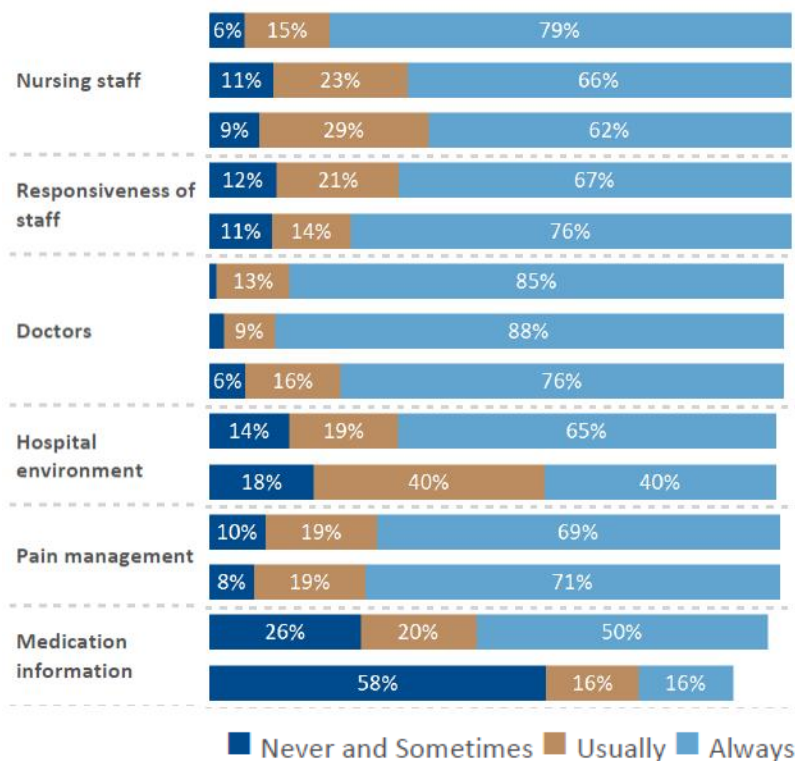
Significant opportunities to increase doctor remuneration by reducing waste and improving quality

Principal Professional Fee as a proportion of Total Procedure Cost



Collaborate on quality of healthcare

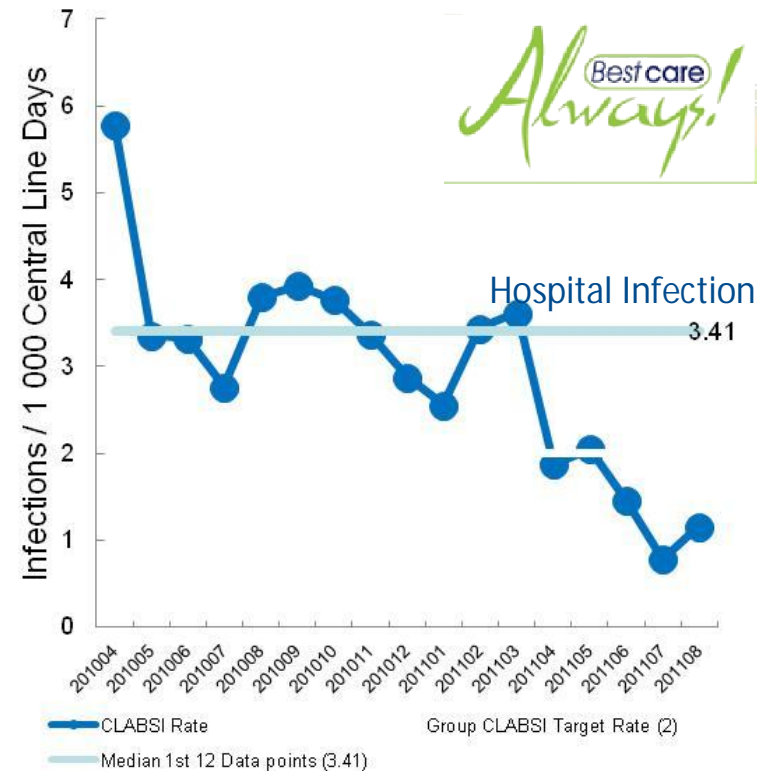
Patient Hospital Experience Survey



Since May 2010:

- >150 000 responses
- ~27% response rate

Best Care Always



- CLABSI doubles the hospital cost and has 12-25% mortality rate*
- BCA prevented ~1 200 infections per year and saved 150 - 300 lives per year

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