



Negotiations between hospitals and medical schemes and administrators to introduce other forms of billing have begun but have tended to exclude smaller schemes and low-cost options. Other billing methods under consideration are fixed fees, daily and capitation fees.

Ntsaluba praised the private sector's level of sophistication, saying that it would back up the government's intentions of attracting more foreign investment and tourists to South Africa.

BHF PROPOSES RARE DISEASE FUND

The Board of Healthcare Funders recently wrote to its members to suggest that medical schemes volunteer to initiate a separate, shared fund to cater for specific rare conditions that usually create significant financial risk.

Included on the proposed list of diseases are Gaucher disease, an inherited enzyme deficiency disorder, haemophilia, cystic fibrosis, cochlear implants, interferon-treated multiple sclerosis and chronic myeloid leukaemia. It would for instance cost between R600 000 and R700 000 to treat one individual with Gaucher disease, which has now been included as a prescribed minimum benefit.

Thiru Appasamy, BHF's Manager for Statistics and Informatics, said that the concept was still being developed and that it would only work with buy-in from most medical schemes. The list of conditions might include HIV/AIDS.

Shaun Matisonn, principal of Discovery Health, commented that such a fund might protect individual schemes from 'adverse selection fallout'. He said schemes are currently deterred from offering best practice care unless other schemes did so because if few schemes offered treatment for particular expensive conditions, then all the sufferers of those diseases flocked to that limited number of firms.

LEGISLATION

SUMMARISED HIGHLIGHTS OF THE LATEST AMENDMENTS TO THE REGULATIONS OF THE MEDICAL SCHEMES ACT: FINAL PART 3

By Elsabé Klinck

78 Regulation 15B & C: Accreditation of managed health care organisations (new)

A number of criteria must be fulfilled before an organisation can be accredited as a managed care organisation, such as having the necessary resources, systems and skills. Accreditation will be granted for a period of 24 months, but the Council will have the power to withdraw, amend or add to

such an accreditation after the organisation's submissions have been considered by the Council.

Regulation 15D: Standards for managed health care (new)

The medical scheme must ensure that a written protocol for managed care is in place as part of the managed care contract, that describes:

- procedures to evaluate the clinical necessity, appropriateness, efficiency and affordability of services
- procedures for interventions
- methods to inform beneficiaries and providers of the outcomes of these procedures
- data sources and clinical review criteria used in decisions
- an appeals procedure for decisions that adversely affect the entitlements of the beneficiary in terms of scheme rules
- mechanisms to ensure consistent application of clinical review data and decisions
- data collection and analytical methods used in assessing utilisation and price of services
- provisions of ensuring confidentiality of clinical and proprietary information
- the organisational structure that will assess managed care activities and report to the scheme (e.g. ethics committees or quality assurance committees)
- the staff position responsible for the day-to-day management of managed care programmes

The above types of information in managed care agreements will greatly assist doctors in challenging decisions or behaviour that may negatively affect on payment for services by a scheme.

All managed care programmes should be based on clinical review criteria for evidence-based medicine. Cost-effectiveness and affordability should also be taken into account. However, these programmes should:

- be evaluated periodically to ensure relevance
- use transparent and verifiable criteria in decision-making
- be administered by qualified health professionals whose decisions are subject to periodic peer review.

The beneficiary, provider or any member of the public is entitled to demand:

- a document that contains a clear description of the managed health care programmes
- the procedures and timing limitations for appeal against utilisation review decisions adversely affecting the beneficiary
- any limitations on rights or entitlements of beneficiaries, including, but not limited to, restrictions on coverage of disease states, protocol requirements and formulary exclusions/inclusions.



Regulation 15E: Provision of health services (changed old and added new)

Irrespective of the existence of a managed care agreement between a provider and a scheme, the scheme is not absolved of its responsibilities towards its members if any other party is in default. No beneficiary may be held liable for any amounts owed in terms of the agreement. If treatment, however, falls outside of the scope of the agreement, a doctor would be permitted to recover such amounts from the patient.

The provider may not be forbidden in any manner from informing patients of the care they require and of treatment options consistent with medical necessity and appropriateness. SAMA believes that doctors should discuss available treatment options with their patients, even when managed care agreements or scheme decisions prompt a change in, or review of treatment.

Doctors should also remember that the HPCSA ruled in 1999 that where a medical scheme decision is in conflict with that of the doctor, and the patient ultimately suffers due to that decision, the scheme could be held liable. It is advised that doctors register their dissent in writing with the decisions of a scheme. The managed care agreement may NOT be terminated on the grounds of the doctor expressing dissent or when the doctor assists the patient in seeking reconsideration of a decision made by the scheme.

Any party wishing to terminate a managed care agreement must serve a notice on the other party, and provide reasons for the proposed termination. It is submitted that doctors, when the original agreement is concluded, insist on provisions to be included in the agreements that provide for:

- proper notice of at least 90 days (see regulation 15j)
- an opportunity to appeal, and
- a process of mediation and arbitration.

In limiting the number of providers with whom they conclude managed care agreements, schemes:

- may not unfairly discriminate and
- must use a selection process based on a clearly defined and reasonable policy that furthers affordability, cost-effectiveness, quality care and member access to services.

Regulation 15F: Capitation agreements (new)

A scheme may enter into a capitation agreement if it is the interest of the scheme members; the agreement embodies a real transfer of risk to the managed care organisation, and the payment is commensurate with the extent of risk transfer.

Regulation 15G: Limitation on disease coverage (new)

Limitations and a restricted list of diseases must be developed on the basis of evidence-based medicine, cost-effectiveness and affordability. This list has to be provided to providers, beneficiaries and the public upon request.

Regulation 15H: Protocols (new)

Protocols should be based on evidence-based medicine and cost-effectiveness and affordability should be 'taken into account'. This means that doctors could challenge protocol-based decisions, or present new evidence on pharmacoeconomics to schemes, especially as the scheme has to provide the protocol to any requesting provider, beneficiary or member of the public.

A protocol should provide for appropriate exceptions where the protocol has been ineffective or causes/would cause harm to a beneficiary. If an exception is made, no penalty should affect the beneficiary.

Regulation 15I: Formularies (new)

A product gets included in a formulary or restricted list on the grounds of evidence-based medicine. This implies that inclusion on the basis of payment of any amount of money, i.e. buying the product onto a formulary, would contravene this regulation.

The formulary must provide for appropriate substitution of drugs where the formulary drugs have been ineffective or causes/would cause adverse reaction in a beneficiary without penalty to that beneficiary.

Regulation 15J: General provisions (changed and new)

Ninety days notice has to be given to terminate a managed care contract, unless:

- there has been a material breach of the contract (doctors may need legal advice in evaluating material breach) or
- where the availability or quality of health care rendered is likely to be compromised by continuation of the contract.

The second instance would provide an option for doctors who feel that patient care is being compromised. Doctors should however immediately inform patients of that fact and the implications, for example in terms of the beneficiaries having to claim from a scheme directly. The scheme should however continue to pay all claims that fell within the period when the contract was still in place.

SAMA particularly welcomes the addition of the sub-regulation that prohibits the use of any incentive that compensates or rewards a doctor for providing medically inappropriate services. SAMAs still has problems with cases where doctors for reasons of medical appropriateness do not or cannot conform to standards set by incentive schemes. Such doctors should be able to claim compensation similar to that of his/her colleagues, in cases where conforming to the incentivisation requirements would amount to inappropriate service provision.

This regulation also provides the scheme with access to any health information held by the practitioner party to a managed care agreement on a beneficiary, but prohibits the scheme from passing that information on to any third party.



Managed care agreement should also not be interpreted to restrict a beneficiary from complaining to his/her scheme, to lodge a complaint with the Council or to take legal action.

Remaining regulations

The remaining regulations deal with issues of the accreditation of administrators, brokers, assets of schemes and the amendments to the PMBs (of which the chronic conditions subregulation will only come into effect on 1 January 2004).

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PRACTICE MANAGEMENT

SETTING UP A PRACTICE, PART II: STANDARDISATION

By Jules and Tana Rivalland

When starting your practice, it is imperative that you bear in mind the numerous day-to-day obstacles.

It seems strange that there are many medical aids that seem to go out of their way to make life more difficult for GPs without realising that they are creating an administrative nightmare for themselves.

Take for instance, the medical aids that insist on original cheques when attempting to register with them for EFT. Can you imagine having to send an original cheque to over 150 medical aids in order to ensure payment? Some medical aids want only processed and not cancelled cheques and a certified photocopy is not good enough. After a day of telephone calls, faxes and letters, you end up putting your payment in the hands of the Post Office rather than wasting valuable time and money getting together the requested documentation.

I fully understand the question of fraud - however, if you are prepared to provide them with certificates, signed letterheads and certified copies, how much more certain does one need to be? It seems that more often than not, medical aids have been given a rule-book and if the words 'certified copy' are not printed in the book of rules, it is just not acceptable.

One of the most common shortfalls in any practice is the reconciliation and the follow-up of outstanding claims. Many medical aids are extremely helpful, allowing free and easy access to remittances on the Internet and willingly assisting with phone queries. However, there are others that insist on knowing your mother's maiden name or the name of your first

pet before allowing access to your own records. It is constantly baffling that some medical aids handle this as a waste of their time, considering that easy access to remittances would alleviate loss of remittances, resubmissions and unnecessary administrative work for all concerned.

The reasons for outstanding and/or unpaid claims are often based on reconciliation problems, but there are often times that medical aids will insist that the claims were never received. This results in time and money being, once again, wasted in supplying submission dates and registered post details or EDI batch numbers. I have yet to receive an apology from any medical aid for payment delays that are usually invalid.

My favourite excuse for non-payments are medical aids that tell you they have not received any medication on a claim, when in fact the consultation and procedure portion of the claim has been paid. How is this possible? I can understand that there is human error involved - but more often than not, these claims are resubmitted up to eight times and still the medication is ignored or not received? Such a problem can end up costing a practice the resubmission of this claim eight times, the telephone query, the refaxing and finally, the letter writing regarding the reason for delayed payment (which should not have to be done by the GP in the first place). The end result will often be a complete loss to the GP when the claim finally comes back rejected as limit exceeded because the patient has used up all benefits in the interim.

The biggest frustration is that medical aids do not honour the window of opportunity set for GP adherence, namely submission within three months of consultation date. However, medical aids certainly don't seem to honour the same. We have had cases where certain medical aids have reversed claims up to 18 months back, without having to answer to anyone at all. In some cases, the patient has been seen resulting in claims worth about R6 000 but they resigned 18 months prior to payment dates. Even the fact that the doctor has telephoned the medical aid upon each visit would not assist in this problem because the medical aid just hasn't updated their records in time and uses the excuse that it is in fact the patient's responsibility to let the doctor know. The problem with this excuse is that these are often illiterate patients who do not know the details of their medical aid scheme. The end result is that the GP must take the brunt of this inefficiency and write the money off as a bad debt. Surely medical aids should not be allowed to operate in this fashion - GPs should not have to pay for the mistakes of the medical aids.

The solution, yet again, would certainly be a set standard of rules and regulations for all medical aids and administrators and a watchdog body to monitor compliance and ensure that the GPs represented and treated fairly. While the controlling authorities are engaging in petty squabbles, matters pertaining to equitable health care are being neglected. There is adequate representation for patients and for medical aids, but more