SAPPF
SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM

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Council for Medical Schemes

Senior Investigator: Compliance & Investigations

Thamsanqa Diniso

Dear Thamsanqa

SAPPF SUBMISSION REGARDING UNPAID PMBs BY GEMS, DISCOVERY HEALTH AND OTHER MEDICAL SCHEMES

1. The South African Private Practitioners' Forum (SAPPF) represents 3500 Specialist doctors, in consulting, surgical and other specialist disciplines. SAPPF became aware of the Council for Medical Scheme investigation into unpaid Prescribed Minimum Benefits (PMBs) by the Government Employees Medical Scheme (GEMS) and Discovery Health. In response to this investigation, SAPPF sent out a call to members to submit evidence of unpaid PMBs in their respective practices, mostly limited to these schemes.

2. SAPPF members submitted 21 000 unpaid or short paid PMB claim lines in the week since submissions were requested. This is not an exhaustive list and presents only a partial view of the total unpaid or short paid claims, merely reflecting the practices that have responded within the first week. There are still a large number of providers that have anecdotally indicated that they have numerous unpaid PMB claims that they would have wanted to submit as part of this investigation by the CMS, had time allowed this. The problem is therefore much wider than the large sample contained in the spreadsheet indicates.

3. The sheer quantum of the number of unpaid claims submitted is an indication that there is a pervasive element of non-payment of PMBs amongst funders, with GEMS and Discovery Health being very involved, with the problem certainly not being isolated to these two funders.

4. The magnitude of the problem is of great concern to SAPPF, as this impacts directly on our members and their ability to continue rendering services to Medical Scheme members and the ability of Medical Scheme members to access PMB services they are legally entitled to. SAPPF therefore implores the CMS to deal decisively with the Medical Schemes involved, so that the problem of continued unpaid and short-paid PMB claims can be addressed. SAPPF would also like to highlight some specific trends as observed in our data gathering process.

5. Discovery Related Issues:

a. Discovery Health does not have a Healthcare Professional Designated Service Provider network, but instead relies on Direct Payment Arrangements (DPAs) to try and deal with PMB cost liabilities. Professionals that do not participate in the DPAs are mostly not paid directly, but patients are rather paid, creating a large administrative burden for practices in trying to recover large amounts of money from their patients. The Discovery DPA is not considered a scheme DSP and as such, Discovery should be paying PMBs at cost when services are rendered by professionals not signed up to a DPA agreement. The evidence shows this does not appear to be the case, as PMBs are still regularly short paid, or paid from savings. Both the short payment of PMBs and the direct payment to patients are problematic.

b. The direct payment of patients is used a as a punitive mechanism by Discovery Health to further control their PMB costs by paying patients directly in cases where providers charge above medical scheme rate and don't belong to DPAs. There is an apparent reluctance of Discovery to take responsibility when patients do not pay healthcare professionals with the moneys received from the scheme for this purpose, which needs to be addressed by the CMS. Absconding patients who are paid for services rendered by professionals and then do not pay the professionals involved, are effectively committing theft and yet, Discovery Health has absolved itself from any responsibility for their involvement in the situation, based on a CMS circular from 2016. This situation leaves healthcare professionals out of pocket, both by having to pay VAT on the money invoiced, but also not actually receiving the money in question. There are also additional expenses incurred in having to recover the money from patients using civil means.

c. SAPPF implores the CMS to take steps against both the practice of short payment of PMBs and also the direct payment of patients in instances where providers are not signed up to Direct Payment Agreements with Discovery Health. Alternatively, the CMS must ensure that Discovery Health holds scheme members accountable for non-transfer of such payments to healthcare professionals, by instilling a requirement of both civil and criminal action by the scheme against its members for such transgressions. The healthcare professional renders services in good faith and yet, this arrangement of allowing schemes to pay patients directly (in cases where payment is not suspended due to forensic reasons), leaves the provider unpaid and saddled with additional legal costs to try and recover funds from the patient.

d. There is a specific concern raised regarding Cancer PMB treatment conducted by a super specialist surgeon in Cape Town. The practice in question is concerned with an "incoherent claims processing process" by Discovery Health:

i. The claims are very often not properly processed, at times the practice needs to resubmit the claims 3 x and each time it is assessed with a different rejection code, all of which do not make any sense to the practice.

ii. The code 3629 is used for skin-nipple-and-areola-sparing mastectomy with Sentinel node biopsy (SNB), as well as skin-sparing mastectomy with Sentinel Node Biopsy (SNB), which takes longer and is more complicated than a straight-forward mastectomy with SNB.

iii. The practice charge code 0014: Rule J for additional complexity, for the reason above or, for example if the patient has had prior chemotherapy, which makes a procedure more complex, even for an experienced surgeon.

iv. **Example:**

Service provider procedure code 0014; Rule J.

Discovery reason for non-payment: code **389**.

Code 389: Member not responsible for the amount on this line. ***Healthcare provider may not bill for this treatment under his/her practice type****.*

This is factually incorrect and defamatory towards the professionals involved. It also creates the impression amongst patients that providers are charging fraudulently and that patients are not liable for the unpaid items.

Code 0014; Rule J is a valid SAMA MDCM code, which is contained in the 2006 NHRPL and is charged for additional complexity due to prior chemo. The practice indicated that a motivation is sent to Discovery each and every time and the standard response is that they need more information to consider payment.

v. The motivation and information is, on occasion, re-sent up to 3 times, and the practice indicated that Discovery Health is non responsive and do not reimburse the valid accounts.

vi. **Another problematic Example:**

Service provider procedure code 0009.

Often the assistant fees are not reimbursed with Discovery's reason for non-payment being: code **285**.

Code 285: Procedure code not in use. ***Member is not responsible for payment.***

e. SAPPF requests the CMS to act on such administrative responses from Discovery Health, which creates the impression that payment of PMBs at cost is being circumvented. Modifier 0009 is in the SAMA MCDM, the 2006 NHRPL and is widely in use, along with being reimbursed by Discovery Health. It is concerning that in certain instances it is not recognised as a valid code. The

practice in question is on the spreadsheet: APFFELSTAEDT AND ASSOCIATES practice number 4207181.

f. SAPPF is also concerned with the perceived practice of initial short payment of PMBs by Discovery, which then get paid in full only once queried by professionals. With the sophistication of Discovery's administration systems, it is concerning that efforts to resolve this payment issue have not been successful up to this point. Once again, the CMS is requested to hold the administrator accountable for the additional administrative burden placed on our members by a lack of compliance with Regulation 8 of the Medical Schemes Act.

g. The final concern is that a large number of PMBs are funded using Medical Savings Accounts and not out of risk, as is the legal requirement. The CMS needs to investigate avenues of ensuring that PMBs are always paid out of Risk.

6. **GEMS Specific Issues**:

a. The administrative processes in GEMS are highly problematic as far as reimbursement of PMBs are concerned. With the state named as DSP, every case needs to be individually reviewed by a PMB review committee before being paid at cost. The committee responsible for this then has to determine whether the state is capable of rendering the service in question, or whether the PMB qualified as an emergency PMB. This PMB review process takes such an extended period of time, that many claims have to be referred for stale payment condonement from GEMS, as the process is not completed and claims are not paid within the stipulated four month period, then being considered stale. This stale claims process adds even further to the payment delay and as can be see from the spreadsheet, there are claims from 2017 that are still waiting on stale claim approval. This situation is caused by the Public Sector being named as default DSP for most GEMS cases, in the absence of specific professional DSP networks. This nomination of the State as DSP, occurs irrespective of whether the Public Sector has the capacity to deal with such PMB cases, and in the opinion of SAPPF, is negatively impacting on legitimate PMBs being reimbursed at cost price.

b. It is very concerning that the CMS allows GEMS to nominate the State Sector as DSP, as the whole premise of PMBs is to ensure equitable distribution of patients and resources amongst the public and private sector. By naming the State as DSP, GEMS is adding to the burden of the, already overburdened, public sector. While there are cost savings for GEMS in paying public sector rates for any treatment occurring in the state sector, GEMS members are utilising resources which should be allocated to public sector patients, who cannot afford medical schemes. Payments to the state for such treatments go into the general State fiscus. This creates the health economic

situation where resources in the public sector are consumed by private use, but are not replaced in the facility they are used, by payments ending in the general State fiscus. It is highly questionable whether naming the state complies with the spirit of PMB legislation, which in the Medical Schemes Act Regulations state that:

"The objective of specifying a set of Prescribed Minimum Benefits within these regulations is two-fold:

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.

(ii) To encourage improved efficiency in the allocation of Private and Public health care resources."

c. SAPPF therefore implores the CMS to review this arrangement of the State being contracted as DSP, as it is in our view, not in keeping with the spirit of the PMB Regulations and is creating an immense administrative burden which GEMS is struggling to address in a timely manner. It is also creating an impression that this DSP arrangement is not based on acquiring services from the state, but rather being used to circumvent paying for PMBs at cost. Most GEMS members are not willing to use public facilities, which are of substandard quality. The 2017 Office of Health Standards Compliance report indicated that only 6 out of 696 public facilities inspected during 2017, complied with the required quality norms and standards. It is concerning that the CMS allows such DSP contracting with the State to happen in the light of the apparent poor quality of the public sector facilities reflected by the OHSC. This DSP arrangement is exposing patients who are paying medical scheme premiums to ensure access to private facilities, to these poor quality state facilities. Alternatively, these poor quality state facilities are, in this arrangement, considered an acceptable alternative to private care, in order to circumvent payment of PMBs at cost. The allowance of such an arrangement needs to be reconsidered by the CMS.

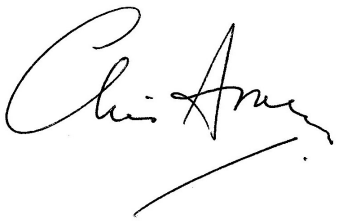
d. There is a concern raised amongst anaesthetists that the GEMS Anaesthetic DSP is not a practical arrangement, as DSP anaesthetists cannot be expected to travel between facilities for a single case at a facility they don't normally work at, to assist surgeons they do not normally operate with. This creates a further situation where the DSP is not capable of rending the services, but is used as an excuse not to pay PMBs at costs, due to the presence of a DSP. SAPPF would request the CMS to also address this situation.

e. The final concern that SAPPF has is that there are instances in the GEMS environment where PMBs are paid out of day-to-day benefits and only out of risk once day-to-day benefits have been exhausted. While this complies with the Regulations in not paying PMBs out of a Medical Savings Account, it creates a situation where day-to-day funds can become depleted by PMBs. This

situation then leaves the member unable to use these funds for normal day-to-day expenses, such as medication or Family practitioner visits. This benefit structure indirectly means that the patient is out of pocket as a result of PMB payments, even though there are no direct costs for the PMBs themselves. SAPPF would appreciate if the CMS can also relook at this benefit design issue.

SAPPF appreciates the opportunity to assist the CMS in this investigation and trust that the CMS will take note of the abundance of evidence of non-payment presented in the attached excel spreadsheet, as well as the general concerns contained in this written submission. The spreadsheet is only a sample of unpaid accounts, which raises the concern that this PMB payment problem is much larger than anticipated.

Kind regards



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