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Surgicom News

THE SURGICOM-DISCOVERY HEALTH GOVERNANCE PILOT PROJECT TAKES SHAPE

Surgicom plans to launch this pilot project in the first quarter of 2016. Surgicom members who choose to participate will earn a great deal of money as well as being able to participate in a process designed to reduce managed health care hassle and introduce some additional alternative reimbursement strategies.

The Burden of MHC

Managed health care (and complex pre-authorisation procedures in particular) are expensive to run and a pain-in-the-neck for healthcare providers. Most surgeons do the right thing and believe that cost-efficient practice is part of best medical care. Most surgeons would like to know how their clinical outcomes and cost-efficiencies compare to their peers. It is easy to identify outliers so exception management is the way to go rather than trying to micro-manage every clinical event.

Exception management means intervening only when certain agreed performance standards are not met. Funders should be concentrating on outliers and leaving the majority of surgeons alone. This is the basis for the pilot. Surgeons generate R10 in downstream costs for every R1 of professional fees. A 10% reduction in downstream costs is equivalent to the entire spend on surgeons fees.

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The PMG Model

Surgicom's inspiration has been the Paediatric Management Group's model. Initiating a pilot with Discovery Health in 2006 led to a massive increase in PMG membership. Participants agree to certain pathways of care and to a peer review process. Admission rates for respiratory and GI infections are monitored and participating members rewarded with increased remuneration for certain codes. A sustained reduction in admission rates has been observed and an additional R100 million paid to participating doctors during the last 5 years. Participants receive regular feed-back on their performance but persistent outliers are asked to meet with PMG and DHMS to determine what it is about their practice that justifies the high utilizations.

This Pilot

We have selected five procedures to study: Appendicectomy, laparoscopic cholecystectomy, anal procedures, groin hernia repair and selected vascular procedures. Pathways of care will be agreed on but these will reflect standard practice and not be restrictive of new technologies. Various metrics will be studied including length of stay, theatre times, ICU stay and various immediate and down-stream costs including re-admissions, surgical site infections and significant complications. A performance profile for each participating surgeon will be constructed and this information confidentially fed back to the surgeon. A peer-review committee will anonymously analyze outlier profiles.

Participation

Participation is voluntary and limited to members of Surgicom. Participants are requested to log on to Health ID (either Ipad or web-based version) in order to generate a one-button authorisation before proceeding with any intervention. Thereafter participants will complete an on-line discharge summary with pre-populated fields and drop-down menus detailing the final diagnosis and outcomes. This will be designed to be particularly quick and easy.

Financial Reward

Throughout the project, surgeons will be paid R75 for logging on to Health ID every time they see a Discovery patient. Each discharge summary will generate an additional payment of R380. This will apply to all *events* (not consultations) including all admissions, scopes (in or out of hospital) and procedures. This applies to every Discovery event and not just the 5 procedures being studied.

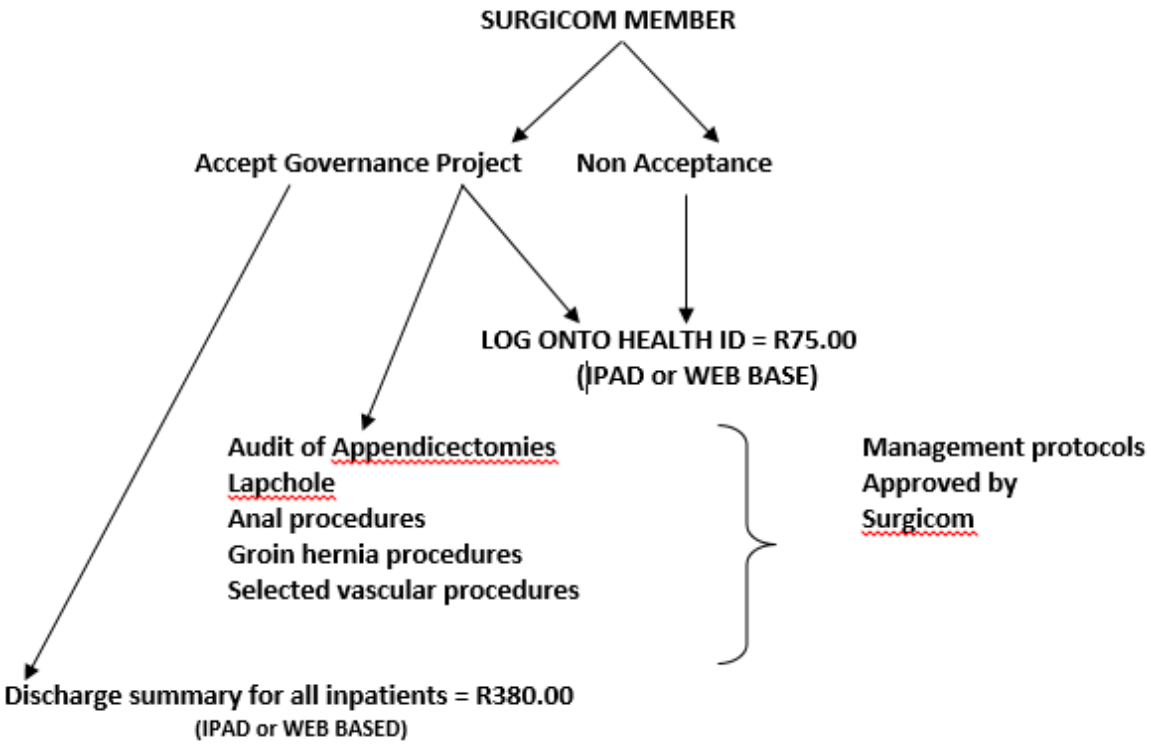
A surgeon who sees 50 DHMS patients a month, 10 of whom are admitted or have a procedure will generate an additional R95 000 per annum. A large practice seeing 140 DHMS patients a month with 45 events would be expected to earn an additional R340 000 per annum. We believe that these levels of remuneration are significant enough to encourage widespread participation and be a significant incentive for non-members to join Surgicom. In phase two when sufficient data has been collected, surgeons will in addition participate in a share of savings arrangement by an agreed and transparent process.

Time-Lines

The pathways of care are nearing completion. The actuaries at DHMS are preparing the profile structure and we aim to roll out the pilot with a marketing and information campaign at the beginning of 2016

The Bigger Picture

Surgicom is the private practice arm of ASSA and the management group for private surgical practice. In this we are hugely limited by the fact that of 537 general surgeons who render accounts to medical aids little over 200 are members. All surgeons currently benefit from Surgicom's engagement with regulatory authorities and funders but less than half contribute to the costs. The various legal challenges we are involved in including opposing both Genesis Medical Scheme and the Department of Health's initiatives to limit PMB reimbursements to scheme rates or the 2006 NHRPL rate (adjusted for cpix), respectively, are proving to be very expensive. We view these initiatives as crucial to the future of private practice but need to at least double Surgicom's membership in order to be a credible voice for the profession and be financially empowered to carry out our mandate. We view the pilot project with DHMS as a key move in increasing our membership base.



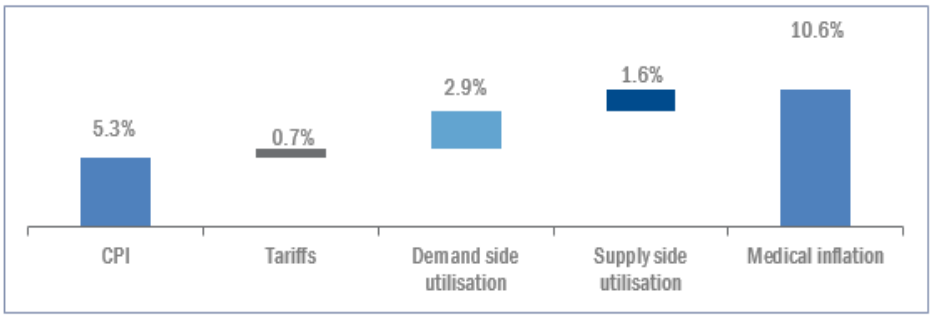
WHAT IS DRIVING MEDICAL INFLATION?

Shirley Collie, Actuary at DHMS addressing delegates at the recent Surgicom Private Practice session at the ASSA/SAGES meeting stated that the medical inflation rate over the past 5 years has been a consistent 10.6% versus a CPIX of 5.3%. What are the reasons for this 5.3% discrepancy?

Demand side drivers make up 2.9% comprising an increase in disease burden, adverse selection (for example healthy individuals leaving schemes and chronically ill individuals joining or remaining) and the increasing age of the population.

Supply side drivers are the fee for service system, fragmentation of care and the costs associated with new technologies, new drugs and new hospitals. These account for 1.6%. New drugs include Sovaldi for Hepatitis C at R1 million for a 12 week course and Yervoy for stage IV melanoma at R1-2 million per course. The use of ultra-high-cost medicines has increased ten-fold since 2008.

5 Year Average Annualised Inflation Rates (2010-2014)



1 **Tariffs**
- Hospital tariffs
- Doctor tariffs

2 **Demand-side drivers:**
- Increased disease burden
- Adverse selection
- Ageing

Supply-side drivers:
- Fee for service system
- Fragmentation of care
- New technology & procedures

Increased tariffs of both private hospitals and medical professionals account for only 0.7%. It is clear that this is not where the problem lies and efforts to target this area are unlikely to solve anything.

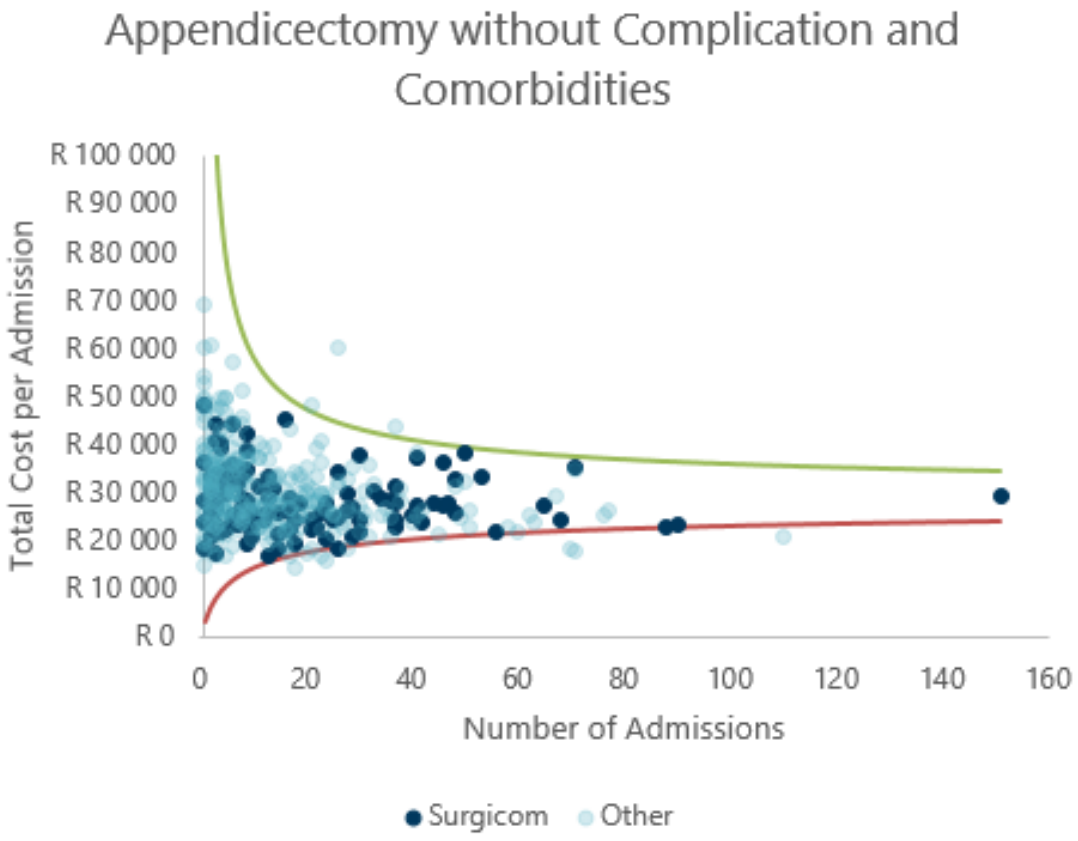
SURGICOM AND INSIGHT ACTUARIES EXAMINE BENCHMARKING

Surgicom has been collaborating with Barry Childs of Insight Actuaries to establish benchmarking and peer-review mechanisms. We provide the clinical input, the funders provide the data and Insight the technical expertise. We recognise that private health care is complex, expensive, fragmented and sometimes inefficient. Surgeons play a central role in directing patients but have been largely marginalized by managed health care. Benchmarking and peer review aims to improve the quality of care whilst containing the costs and empowering surgeons to secure fair remuneration. Reducing downstream costs should be rewarded by an improvement in remuneration for surgeons.

Peer Review is the process whereby surgeons can engage with their peers on how to improve the quality of care whilst containing the cost of care. Benchmark reports are independently produced on behalf of the surgeons for the betterment of the profession, bypassing any mistrust between doctors and funders. Benchmarking and Peer Review will help to identify and to unpack variations in clinical and billing practices. These can be considerable as depicted in Fig 2 which analyses the total costs of uncomplicated appendicectomy between members of Surgicom and non-members. The average total cost per admission is R29 291 but 5% of surgeons have an average cost above R46 592 and 5% of surgeons come in at consistently less than R19000. Overall Surgicom members out-perform non-members for this and most of the procedures studied.

Surgeons need to take the lead in this, for the betterment of the profession rather than being dictated to by funders. We are empowering ourselves to better understand and develop the methodologies.

The best way to predict the future is to create it!



RISK ADJUSTMENT AND PROFILING

At the Surgicom Private Practice session at the recent ASSA/SAGES conference, Shirley Collie (Actuary at DHMS Risk Intelligence) explained that considerable variability exists in healthcare utilization, largely because of three factors:

The composition of the demand and its preferences (the population)

The organization of the health system (fee for service, contractual, teams, strong primary care)

The way professionals go about their everyday practice

Two different professionals may understand the same health problem and its treatment in a different way, by making a different interpretation of the "right" approach and the intensity of the resource use to deal with it.

Profiling enables doctors to assess themselves by comparison with their peers as well as facilitating greater awareness, shared learning and opportunities for quality and cost improvement. To formulate a comparison, the outcomes of treatment for the same type of patient across providers need to be compared. The process of adjusting for the differences between patients to enable a like-for-like comparison between providers is called risk adjustment.

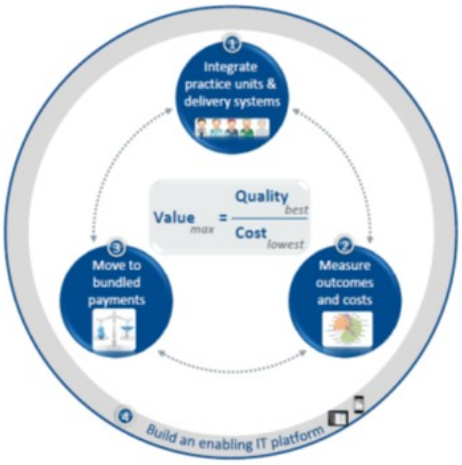
Factors considered need to adjust for underlying patient demand: A range of healthcare risk adjustment factors can be used reflecting demographic, clinical, socio-economic or health related behavior characteristics. These factors need to be available, clinically meaningful, statistically valid and parsimonious. Surgeon A with a higher average cost for a particular patient than Surgeon B may nevertheless have a better cost efficiency index because of the particular rick stratification of the patient population he is dealing with.

THE INTEGRATED PRACTICE MODEL

Speaking at the Surgicom Private Practice Session at the recent ASSA/SAGES meeting, Deputy CEO of DHMS, Ryan Noach emphasised the fact that fragmented care with a lack of coordination, quality and efficiency is resulting in poor outcomes. Overall 7% of DHMS patients develop a severe postoperative complication which increases the overall cost by 70% and doubles the length of stay. 6% of surgical cases are re-admitted within 30 days. They have observed huge variation in the quality of care delivered by various private hospitals. Although the average mortality rate for acute myocardial infarction in 111 hospitals studied was 7.4%, the range was from less than 2.5% in come centres to well over 20% in others. An international study published in Disease of Colon and Rectum in 2013 demonstrated that ERAS programmes utilising multi-disciplinary teams have reduced overall complications in colorectal surgery by 30% with an average reduction in hospital stay of 2.4 days.

The value-based healthcare agenda involves the formation of integrated multi-disciplinary practice units and delivery systems where outcomes and costs are carefully measured with a move to bundled payments. A well-defined IT platform is essential to enable this. This model has been very effectively developed by the Cleveland Clinic. Dr Marc Harrison of Cleveland Clinic, Dubai visited several centres in South Africa in June 2015 and sees considerable potential for this model in this country.

The value-based healthcare agenda



FORENSIC AUDITS: WHY DO WE NEED THEM?

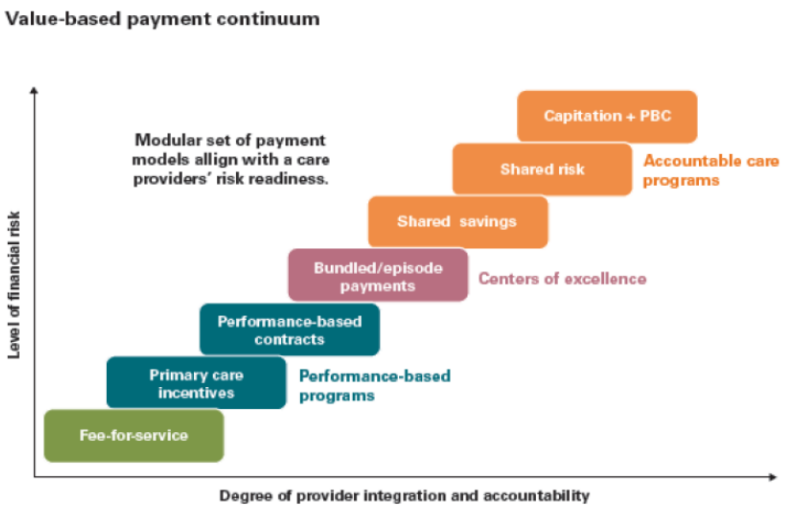
"International studies suggest that fraud and error costs the healthcare system between 3% and 15%" said Marius Smit, head of Discovery Health Forensic Services at the recent Surgicom Private Practice Session at the ASSA/SAGES congress. This was thought to amount to somewhere between R8 billion and R45 billion in South Africa in 2012. The DHMS forensic unit saved the scheme R893 million rand between 2012 and 2014 (approx. 1% of claims paid) but this is probably only the tip of the iceberg. Valid Investigations against 4.3% of individual practices, half of which involved amounts more than R5000, recovered R98 million (0.23% of total amount paid to individual practices). 9.3% of General Surgeons were audited recovering R3 million (0.48% of total amount paid to General Surgeons).

The unit aims to engage with individual healthcare providers rather than immediately institute punitive measures. Immediate behavior changes have been observed in more than 90% of practices after intervention. Repeat offenders are monitored closely.

Category A cases (Fraud) require a legal approach through an established panel, aiming for a signed mediation agreement following a mediation meeting. Category B Matters (Coding and billing errors) require a different approach including engagement with professional bodies, IPA`s and SAMA. The issues are identified and the financial impact is then communicated to the Healthcare Professional. No recoveries are made on losses suffered by the Scheme on condition that the Healthcare Professional acknowledges the irregularities identified and undertake to correct their billing going forward. Should the billing not be corrected going forward, or they identify a clear pattern of new billing irregularities, DHMS recover all losses suffered by the Scheme/s, including the amounts previously waived.

IS IT TIME FOR AN ALTERNATIVE REIMBURSEMENT MODEL?

At the Surgicom Private Practice Session at the ASSA/SAGES meeting, Mike Marshall of Medscheme outlined some of the drawbacks of the fee-for-service system. The system is volume-driven and not dependent on quality or potentially wasteful downstream costs. It facilitates fragmented care. Whereas some form of fee-for-service will remain it is likely that it will increasingly co-exist with other models such as capitation, payment for performance, bundled payments and global fees.



Medscheme is involved in a global fee pilot for hip and knee arthroplasty with a group of orthopaedic surgeons, anaesthesiologists and physiotherapists using agreed pathways of care and rapid recovery protocols. The global fee includes the hospital costs and prosthesis as well as the various professional fees. A considerable cost saving has enabled the healthcare professionals to significantly enhance their reimbursement.

Surgicom Fees 2015

The Surgicom membership fees will be R610 per month for members in full-time private practice and R245 per month for those in limited private practice.

Summary

Surgicom is rising to the challenge of a number of potential changes in private health care and reimbursement. We are taking the lead in this and engaging with funders, managed care organisations and actuaries to better understand and control this process. The proposed governance project will enable all interested surgeons to participate. The recent Private Practice Session at ASSA/SAGES was well attended and extremely well received and resulted in approximately 20 additional surgeons joining Surgicom.
These are interesting times.

Philip Matley
Chairman: Surgicom