NEWS

NEW CAPITATION MODEL SUGGESTION FROM RESOLUTION HEALTH

If what Resolution Health Medical Scheme has in mind actually works, it may mean additional income for doctors, or at least more rapid recovery of capitation fees.

Capitation models currently in force work on the basis that medical schemes contract managed care or network organisations, who in turn contract general practitioners. The medical scheme pays a capitation fee to an organisation, and this organisation then charges a fee for its administrative functions before passing the fee on to the doctor who rendered the service. With this type of contract, the service fee and / or the money owing to the doctor is passed on to the third entity who passes it on to the doctor at its convenience.

Resolution Health enters into capitation contracts directly with the doctor, which allows for the doctor to 'slowly enter into the market of capitation'. The doctor will still be able to treat fee-for-service patients who are members of other medical schemes, while slowly increasing the number of patients seen on a capitation basis.

Other advantages, according to Resolution Health Medical Scheme, are that there is less administration in that the doctor's money is not channelled through other entities; there is a direct line and service level between the medical scheme and the doctor; and there is constant communication between the medical scheme and the doctor.

Jannie Kotze, Chairman of the Board of Resolution Health, says, 'Resolution Health Medical Scheme also works closely with independent practitioner organisations to assist in this process. These organisations are contracted to assist with aspects such as peer review. With a model like this, administrative hiccups are circumvented, and the GP's hard-earned fees flow directly from the medical scheme to the practitioner.'

EASTERN CAPE HEALTH DEPARTMENT WILL UNDERSPEND THIS YEAR

The Eastern Cape (EC) will underspend R121 million of its capital expenditure budget this financial year. Health MEC, Bevan Goqwana, announced this during his policy speech in the Legislature in March. The money was intended to purchase equipment for hospitals and clinics. About R46 million was intended for the new Nelson Mandela Hospital in Umtata, but the hospital has not yet been completed, so the equipment was not bought. Other provincial hospitals received about R65 million for maintenance and renovations, but these hospitals did not have the capacity to spend the money. The unspent balance was earmarked for building new hospital structures, said Goqwana.

Prior to Minister Goqwana's announcement, EC Finance Minister Enoch Godongwana revealed that almost two-thirds of the HIV / AIDS programme's budget was unspent. Goqwana said, however, that by the end of the financial year on 31 March, all the money allocated to HIV / AIDS would have been spent. He attributed the non-expenditure to funds which were not reflected by the Treasury Department. He continued, 'Funds for payment of community health workers, purchasing of antiretroviral drugs, and funds used for increasing prevention of mother-to-child transmission, were not being reflected when Godongwana made his speech. Goqwana's department would focus more on recruitment and retention of professional health staff, he said.

In terms of the Hospital Revitalisation and Rehabilitation Programme, Goqwana said that his department had embarked on 153 projects since 1997, at a cost of over R733 million, which placed the Eastern Cape second after Gauteng. During the current financial year, 24 projects were under way including upgrading of wards and casualty departments, and electrifying administration blocks. In addition, X-ray and anaesthetic equipment was installed in 40 hospitals and 21 health centres, and over 90% of equipment ordered for clinics and other rural hospitals had been delivered.

MANAGED CARE

UTILISATION MANAGEMENT

Introduction

Funders of health care are introducing systems aimed at managing costs by controlling utilisation (volume) of services delivered. This refers to the process of medical management that comprises three components:

- Demand management programmes aim to reduce the overall requirement for health services through for instance medical advice (nurse) lines, self-care and medical consumerism programmes.
- Disease management manages a specific disease across all encounter sites. It includes a comprehensive range of clinical and therapeutic services focused on a particular disease. The aim is to ensure prospective intervention and prevention to manage cost and improve outcomes.
- Utilisation management is a cost control mechanism used by managed care organisations to analyse medical treatment of enrollees in order to evaluate and control the use of resources. It generally consists of utilisation review, case management and provider risk or incentive arrangements.

Utilisation management programmes ensure significant cost savings through the use of facilities and methods of treatment that are less expensive and do not affect the quality of health care.

Examples are:

- outpatient and day care surgery
- same day admissions
- home health care
- drug formularies
- generic medicines.

Utilisation review programmes evaluate the necessity, appropriateness, efficiency and quality of services provided. Information gathered from both the patient and the provider is reviewed for appropriateness of care (especially for services such as specialist referrals and hospital care) and to determine whether it meets established guidelines and criteria. The appropriateness of services can be reviewed through prospective (before the service is rendered e.g. pre-certification), concurrent (while the service is rendered e.g. case management) or retrospective (after the service has been rendered e.g. claims review) methods.

Utilisation review often includes pre-admission certification (pre-authorisation.

PRE-AUTHORISATION

An important feature of prospective and concurrent utilisation review programmes is the use of an authorisation system. It could involve only pre-certification of elective hospitalisation or could involve mandatory authorisation for all referral services. The primary reasons for pre-certification are the following:

- Notification of the case to allow for preparation for discharge planning and concurrent review.
- To ensure care takes place in the most appropriate setting (centres of excellence).
- To capture data for financial accruals.

Pre-certification is not required for an emergency or urgent admission.

The following issues must be clearly defined:

- A clear definition of a list of services requiring authorisation.
- Special provision should be made for emergencies and other situations where pre-authorisation is not possible.
- Who is responsible for the authorisation of a specific service.
- Authorisations should be linked to claims payment by means of an authorisation number.
- A clear definition of the process and documents required, e.g. who should apply for authorisation (provider / patient).
- Quick authorisation.
- Appeals process when denied.

In South Africa pre-authorisation for elective hospitalisation is most commonly used. In this instance the provider or patient usually calls the funder before an elective hospitalisation and the funder reviews the case against defined criteria in order to determine appropriateness.

UTILISATION REVIEW POLICY

The methodology used in utilisation review programmes has raised certain concerns from the medical profession. The South African Medical Association has formulated a policy to guide the implementation of these programmes. It should however be recognised that the policy states the ideal situation which may not necessarily be practical or achievable.

Clinical guidelines and protocols

Clinical guidelines, protocols and review criteria, used in any utilisation review or utilisation management programme, must be developed by doctors. Funders should appoint an advisory committee to refine and assess whether the available guidelines are appropriate. Funders should disclose to doctors on request the screening and review criteria, weighting elements and algorithms used in the review process and how they were developed.

Clinical decision-making

A doctor of the same specialty (true peer) as the treating doctor, and with appropriate expertise and experience who is independent of the funder, must be involved in the decision-making process at funder level as whether to deny or reduce cover for services based on medical necessity.

Appeals process

All funders should establish an appeals process whereby doctors, other health care providers and patients may challenge policies restricting and denying access to certain services. Health care providers are entitled to have any of their clinical decisions reviewed by a true peer who is independent of the funder.

The reviewing doctor's identity should be disclosed on request to the doctor whose services are being reviewed. Any doctor who makes judgements or recommendations regarding the necessity or appropriateness of services or the location of services should be licensed to practise medicine and should be actively practising medicine in the same area (jurisdiction) as the practitioner who is being reviewed. The reviewing doctor should furthermore be professionally and individually accountable for his / her decisions.

Disclosure of benefits

Funders should inform members and prospective members clearly and distinctly of the services, the extent of cover and non-covered services in a standardised disclosure format.

This should include the proportion of funder income devoted to utilisation management, marketing and other administrative costs; the existence of review requirements; financial arrangements or other restrictions that may limit services; and referral or treatment options that may negatively affect the doctor's fiduciary responsibility to his/her patients. It is the duty of the patient and his/her funder to inform the treating doctor of any restriction on benefits.

Accountability

Funders using managed care techniques should be legally accountable for any harm caused to a patient as a result of the application of such techniques. Such funders should also be legally accountable to members for failure to disclose prior to enrolment their benefits, financial arrangements, or restrictions that may limit services, referrals or treatment options that may negatively affect the doctor's fiduciary responsibility to his/her patient

Providers should take note that notwithstanding any financial arrangements that may exist between the patient, the provider and the funder, a provider has a legal duty towards his/her patient to treat the patient with reasonable skill and care. It is the responsibility of the provider to inform the patient which treatment modalities are available and make recommendations as to the treatment regime to be followed.

Where pre-authorisation for a specific treatment and/or hospital admission is required, a provider should do what is necessary to obtain the authorisation from the funder for the treatment that is regarded necessary for the patient's wellbeing. If the funder is not willing or able to provide such authorisation for payment, the provider should communicate the funder's decision in writing to the patient and should clearly advise the patient of his/her recommendations in writing.

QUALITY ASSURANCE

Where there are restrictions on care, it must be ensured on a continuing basis that the care received by the member is of good quality. Quality assurance refers to a formal set of activities that review and influence the quality of services provided. The objective is to ensure that good quality of care is delivered. In this regard it differs from utilisation review programmes that ensure the appropriate and controlled utilisation of medical resources.

Various tools can be used to ensure continuous quality improvement:

Legislation
In the USA, State and Federal regulations specify minimum criteria for quality assurance against which managed care plans are annually evaluated. In SAthe first regulatory step in this regard is visible in the proposed regulations for managed care initiatives. Criteria for quality assurance programmes are recommended.

Credentialling
Providers are required to meet certain pre-determined criteria such as certain qualifications to participate in the delivering of health care services.

Clinical guidelines and therapeutic protocols
Conditions that occur frequently and where there is sufficient clinical agreement are usually selected for the purpose of drafting clinical treatment guidelines through a consensus process.

Outcomes measurement
Outcome studies are difficult to perform, but provide useful evidence of areas for improvement and benchmarks for future evaluation.

Peer review
Peer review is the evaluation of quality of the total care provided by health care professionals with equivalent training and from similar practice settings. To be effective and acceptable, true peers should perform the peer review.

Grievance procedures
Provision should be made for formal and informal grievance procedures for members and health care providers. There should be sufficient flexibility to change structures and systems when valid grievances arise.

Member satisfaction surveys
The main interaction members have with health plans is usually through providers. Member satisfaction surveys therefore generally focus on the doctor's manner and interpersonal skills, e.g. length of doctor-patient relationship, waiting periods, amount of time spent with the patient, efficiency and courtesy of office staff and the length of time to obtain an appointment.

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