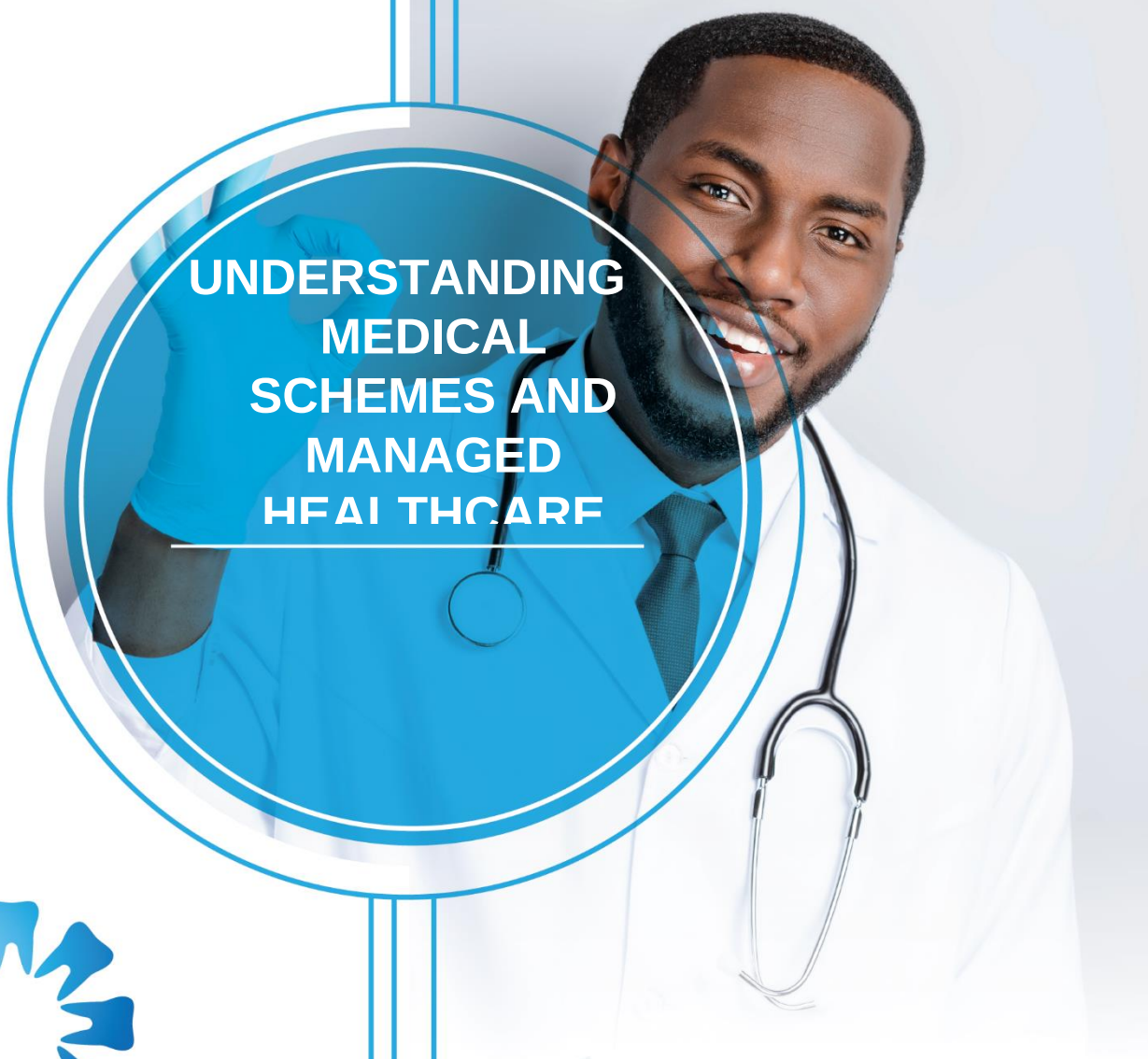

UNDERSTANDING MEDICAL SCHEMES AND MANAGED HEALTHCARE

SADA

The South African Dental Association **(SADA)** NPC

June 2022

Registration Number:
1935/0070/92/08

Content Page

MEDICAL SCHEMES ACT, 131 of 1998 ("MSA") AND DENTISTS 5
Introduction 5
Medical Schemes Act, 1998 5
Section 59 - Charges by suppliers of service. 6
Section 59 (1) 6
Section 59 (2) 6
Section 59 (3) (Claw backs) 10
The nature of the schemes' powers 11
Reasonableness 12
Procedural fairness 12
Adequate Notice 13
Reasonable opportunity to make representations 13
Right to request reasons 13
SUSPENDING DIRECT PAYMENT 14
Are schemes empowered to suspend direct payments? 14
Is there an implied power to suspend direct payments? 15
The Rules of the Scheme 17
The problem of confidential patient information 17
Legislative Context 17
Views of the Panel 19
CALCULATION OF CLAW BACK AMOUNTS 20
ACKNOWLEDGEMENT OF DEBT (AOD) 23
FRAUD, WASTE AND ABUSE (FWA) 24
Detection 25
Investigation 25
Probes / entrapment 26
Sanctions 27
REGULATIONS 30
Regulation 5 - Accounts by suppliers of services 30
Regulation 6 – Manner of payments of benefits 31
Regulation 8 – Prescribed Minimum Benefits (PMBs) 32
Regulation 15 – Provision of Managed Health Care 37
Introduction 37
Useful Definitions 37
Regulation 15A – Prerequisites for managerial health care arrangements 38
Regulation 15B – Accreditation of managed health care organisations 39

15C. Suspension or withdrawal of accreditation..... 40
15D. Standards for managed health care..... 40
15E. Provision of health services..... 42
15F. Capitation agreements..... 43
15G. Limitation on disease coverage..... 45
15H. Protocols..... 45
15I. Formularies..... 46
15J. General provisions..... 48

MEDICAL SCHEMES ACT, 131 OF 1998 ("MSA") AND DENTISTS

"Just like retirement reform regulations, the Medical Schemes Act pays more attention to actuarial models than human behaviour or unforeseen circumstances. Surely human behaviour is the point of insurance".

INTRODUCTION

In this booklet, we will try to unpack the various provisions of the MSA and its regulations that impact dentists and dental specialists. The MSA is a complex piece of legislation, the provisions are open to several interpretations and have been the subject of many court cases, rulings of the Council for Medical Schemes (CMS) and also subject to the Health Market Inquiry by the Competition Commission.

1. More recently the Council for Medical Schemes initiated an independent investigation known as the 's 59 Investigation" into allegations of racial discrimination by medical schemes and administrators' inquiry. This manual draws largely from the contents of the interim report.

2. The Medical Schemes Act (MSA) [1] governs private health care funding in South Africa. The Act has Regulations that guide medical schemes in their implementation of managed care.

3. The Medical Schemes Act (MSA), provides the legal framework for the governance of medical schemes. It states that the board of trustees and principal officer are the representatives of the medical scheme members and are legally responsible for the administration of the medical scheme on behalf of its members.[2]

4. The Act stipulates when and how schemes should pay beneficiaries / members of schemes and providers of healthcare services.

MEDICAL SCHEMES ACT, 1998

1. Section 59 of the Act regulates how suppliers charge for services (**subsection 1**); how and when schemes pay for such services (**subsection 2**); and the circumstances in which a scheme may deduct amounts owing to a provider or member from future benefits payable (**subsection 3**).

2. Before we discuss the provisions of section 59, it is to be noted that all these sections and the Regulations must be read in the context of the following provisions of the MSA Act:

3. **Section 26(1)(b)** of the Act, which provides that:
   "Any medical scheme registered under this Act shall—

[1] Medical Schemes Act no 131 of 1998
[2] Section 57 of the MSA.

(b) assume liability for and guarantee the benefits offered to its members and their dependants in terms of its rules"

4. **Section 1** of the Act, which provides that:
"business of a medical scheme" means the business of undertaking liability in return for a premium or contribution—
(a) to make provision for the obtaining of any relevant health service;
(b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; …"

5. Therefore, schemes take liability for issues such as obtaining health services, paying for health services or the rendering of health services.

SECTION 59 - CHARGES BY SUPPLIERS OF SERVICE.

1. Section 59 of the Act regulates how suppliers charge for services (**subsection 1**); how and when schemes pay for such services (**subsection 2**); and the circumstances in which a scheme may deduct amounts owing to a provider or member from future benefits payable (**subsection 3**).

2. The section makes provision for payments to be made:
(i) to a member who has paid the provider and is claiming the money back from the scheme; or
(ii) to the provider who invoices the scheme directly and is then paid by the scheme.

3. Either way, the scheme must pay the member or the provider within 30 days of receiving the account.

4. Section 59 of the Act goes on to provide for situations where, for a number of reasons, a member or provider should not have been paid. This is contained in section 59(3).

SECTION 59 (1)

(1) A supplier of a service who has rendered any service to a member or to a dependant of such a member in terms of which an account has been rendered, shall, notwithstanding the provisions of any other law, furnish to the member concerned an account or statement reflecting such particulars as may be prescribed.

Practitioners providing dental services to scheme members must provide an account that shall contain such particulars as stipulated in Regulation 5 (discussed in more detail below).

The HPCSA ethical rules also require a practitioner provide a patient with an account in respect of services rendered. If the practitioner is registered for VAT, there is an additional obligation to provide a Tax Invoice in terms of VAT Act.

SECTION 59 (2)

A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

1. The schemes and administrators generally argue that they have the choice of paying either the member or the provider. Where a provider is engaging in what is termed Fraud, Waste & Abuse (FWA), they would choose to pay the member rather than the provider.

2. Service providers have argued that the Medical Schemes Act , specifically section 59(2), creates a basis for direct payment by stating that a medical scheme may dispose of any benefit owing to a member – either to the service provider directly or to the member - within 30 days of the scheme receiving the claim.

3. The issue is whether section 59(2) of the Act merely allows medical schemes to pay service providers directly or whether it compels them to do so directly. This will have to be read in conjunction with a consideration of some cases.

4. The Council for Medical Schemes (CMS), a regulatory body supervising private health financing through medical schemes, has a dispute tribunal to which members may lodge complaints, which would initially be heard by the Appeal Committee, after which they may be referred to its Appeal Board.

5. In Alimag Pharmacy v Registrar for Medical Schemes, the question raised was whether a scheme could withhold payment from a service provider. In this case the scheme was withholding payment to a group of four pharmacies for services rendered owing to a fraudulent claims' investigation. The scheme alleged that the Act gave medical schemes the discretion to pay either the service provider or the scheme member. The Appeal Committee disagreed, stating that there was nothing in section 59(2) to suggest a scheme could pay a member directly for an account that had already been submitted by the service provider. The Appeal Committee took the same view.

6. In both cases the submission of an account by a service provider was considered sufficient to oblige the scheme to pay that provider directly, leaving the schemes with little recourse when they suspected fraudulent activity.

7. However, the Appeal Board differed when faced with the same question in Government Employees Medical Scheme (GEMS) v Omphemetse Pharmacy CC. GEMS had given notice to Omphemetse that it would no longer pay claims to it directly. Rather, GEMS would pay any benefit owing directly to its members, Omphemetse would need to recover payment directly from the members. Omphemetse subsequently lodged a complaint against GEMS alleging that GEMS had not paid moneys owed to it for services rendered to its members.

8. The Appeal Board found there was no automatic contractual relationship between a medical scheme and a service provider entitling the service provider to such payment. The Board noted that a medical scheme existed and was registered for the purpose of

assisting its members in defraying expenditure incurred in accordance with the rules of the scheme in return for contributions paid to it by the member.

9. Thus, a medical scheme may lawfully discharge its obligations owed to a member by paying the service provider directly. However, without a separate contract between the service provider and the medical scheme there exists no basis upon which a service provider may enforce direct payment from the medical scheme. The medical scheme has a duty to reimburse its members.

10. The Appeal Board explained that it was the member and not the medical scheme that was indebted to the service provider. The Board referred to the SCA judgment of Medscheme Holdings (Pty) Ltd and another v Bhamjee wherein it was found that Mr Bhamjee, a medical practitioner, had no basis upon which to demand that Medscheme pay him directly. The SCA appeared to recognise that although section 59(2) created a basis upon which medical schemes were allowed to discharge obligations owed to members by reimbursing service providers directly, the section did not oblige the medical scheme to do so where the provider had lodged an account with the medical scheme.

11. Hence, unlike the relationship between members and medical schemes, there was no contractual or other automatic relationship between medical schemes and service providers. Accordingly, for a service provider to hold a medical scheme liable to pay an account there would have to be an agreement between the scheme and the service provider.

12. A relevant case on section 59(2) is the 2015 decision of the Supreme Court of Appeal (SCA) in **Sechaba Medical Solutions Ltd v Sekete [3],** where claims were challenged by Sechaba on the basis that section 59 of the Act did not entitle a provider (Life Healthcare) to submit its account directly to the scheme (Gen-Health).

13. The key question decided by the SCA was whether, if a scheme gives a hospital pre-authorisation for treatment, this creates a contract between the scheme and the provider.

14. The SCA analysed the issue of pre-authorisation by stating,
"What the scheme undertakes to do as against the hospital is to comply with its contractual obligation as against its member... [and] to pay the hospital in accordance with the applicable tariff, provided it is bound to do so as against its member."[4]

15. The court stated the statutory obligation that the scheme owed to its member is that it will take responsibility for the member's debt, i.e. it will pay the healthcare provider,
"The undertaking given, and statutory obligation owed, to its member is that it will pay the healthcare provider itself, not that it will reimburse the member for what the member has paid. On that argument the 'benefit' referred to in s 26(1)(b) is the act of discharging the obligation incurred by the member to the healthcare provider when receiving medical treatment."[5]

[3] Sechaba Medical Solutions and Others v Sekete and Others [2015] ZASCA 8 (11 March 2015) ("Sechaba")
[4] Sechaba, para 14, citing Margate Clinic, para 642E.
[5] *Sechaba*, para 16.

16. The SCA held, therefore, that "a benefit conferred on a member under a medical scheme [is] primarily to pay the member's health service providers for their services." [6] This obligation entails both the liability for the benefit but also to "guarantee the benefit."[7]

17. The SCA when on explain this guarantee as follows:
"A guarantee is an obligation given by one party on behalf of another to discharge that other's liability to a third party. And that seems to me precisely what a medical scheme is obliged to do. It is obliged to guarantee to its members that it will discharge, to the extent of the benefits set out in the schedule of benefits, their liability to the healthcare providers who render services to the members."

18. The Court also recognised and noted that many providers in South Africa are dependent on direct payment from the schemes because their patients are not able to afford upfront payments:
"Construing the obligations of medical schemes in that way constrains them to function in a manner that is consonant with the social realities of this country. By far the majority of people are not in a position, after paying their medical aid subscriptions, to fund medical treatment from their other resources and seek reimbursement from their medical scheme. They are dependent for their ability to obtain such treatment on the fact that the cost will be borne by the medical scheme. And that is reinforced by the fact that the schemes enter into agreements with doctors, pharmacies, clinics and other healthcare providers to establish preferred provider networks and other systems for the provision of medical services."[8]

19. They are dependent for their ability to obtain such treatment on the fact that the cost will be borne by the medical scheme. This is reinforced by the fact that the schemes enter into agreements with doctors, pharmacies, clinics and other healthcare providers to establish preferred provider networks and other systems for the provision of medical services.

20. Finally, the SCA turned to Section 59(2) of the Act, noting the following relevant points:

(a) The Act "expressly recognises that the medical scheme may pay the service provider directly ... It is plain therefore that a benefit may be owing to the service provider…"; [9]and

(b) The language in sections 59(1), 59(2) and 26(1)(b) of the Act underscores this finding. The court approached the question of schemes' obligations to the provider by examining the text of section 59. It noted that section 59(1) refers to the provider's account; section 59(2) refers to benefit being payable, not the account.[10] That this was further reinforced by the language of 26(1)(b) of the Act, which provides that the scheme assumes liability for the benefit and guarantees the payment therefor.[11]

[6] *Sechaba*, para 18.
[7] *Ibid*.
[8] *Sechaba*, para 20.
[9] Sechaba, paras 23 - 24.
[10] Ibid
[11] Ibid

21. The Court's conclusion is that "if the benefit is owing to the service provider, which is what the section says, they failed to see on what basis it can be said that the medical scheme is not obliged to pay the service provider." [12]

22. It must be noted that the Sechaba case, however, only takes us so far.

23.1. First, it was driven by the specific facts of that case, where the provider had received pre-authorisation for the services rendered thereby resulting in a contract between the scheme and provider. Also, the scheme's schedule of benefits made it clear that the scheme was obliged to pay providers directly when contractual arrangements were in place. This limits the application of the findings of this case to those cases where there is a contract between the scheme and the provider.

Where there is no contractual relationship between the scheme and the provider then the Sechaba judgment is of limited use.

23.2. Secondly, the Sechaba judgment does not deal with instances when a scheme suspends direct payment to a provider because it suspects that such provider is engaging in FWA.

23. In summary, the case demonstrates that a scheme is required to pay a provider, rather than the member, where the provider has a contractual relationship with the scheme. This may arise out of a situation where a service has been pre-authorised by the scheme or where the scheme and provider have entered into any form of direct payment arrangements (the evidence indicated that this could be a preferred provider arrangement, a network arrangement or the designated service provider arrangement at the very least).

24. There may well be situations where a provider submits an invoice to a scheme for payment where such provider is not in a contractual relationship with the scheme but the cases referred to above make very little pronouncement on what section 59(2) of the Act means for this transaction.

26. How do these decisions impact industry stakeholders?
To be ensured payment, service providers must either claim payment directly from their patients, or ensure that they have contractual agreements with medical schemes, which will have to decide whether or not to enter into contractual relations with service providers, which service providers and how many.

It seems the only potential beneficiaries of these decisions are medical schemes, since they will have more control over the payment of benefits.

SECTION 59 (3) (CLAW BACKS)

[12] Sechaba, para 25

(3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of—
(a) any amount which has been paid bona fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or

(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme,

deduct such amount from any benefit payable to such a member or supplier of health service.

1. The key distinction between subsections (2) and (3) is that:
   - section 59(3) is concerned with **deductions of future benefits**; and
   - section 59(2) is concerned with the obligations to **pay current benefits**.

2. Section 59(3) gives the schemes significant power vis-à-vis providers and members – the power to deduct past payments made to providers or members from future benefits which are owed to providers or members.

3. Section 59(3) empowers the schemes to unilaterally make a decision regarding when and what amount is clawed back from future benefits owed to members or providers. This allows the schemes to 'take back' monies which they believe are rightfully owed to them – either they were paid when they should not have been or they were paid because the scheme sustained a loss as a result of fraud, negligence, theft or (professional) misconduct.

4. There are no Court judgments interpreting section 59(3) of the Act. One would therefore have to look at interpretation of statutes.

The nature of the schemes' powers

1. Section 59(3) gives significant powers on schemes.

1.1. Schemes unilaterally determine when and what amounts are clawed back from future benefits payable to providers or members. This allows the schemes to 'take back' monies which they believe are rightfully owed to them – either they were paid when they should not have been or they were paid because the scheme sustained a loss as a result of fraud, negligence, theft or (professional) misconduct.

1.2. It involves depriving a provider of an amount owed and it is coercive.

1.3. It is aimed at rectifying what is identified in the statute as a "wrong";

1.4. There is generally an imbalance of power between the scheme and provider. The scheme is generally better resourced than a provider, and the scheme exercises this power unilaterally;

1.5. It has an immediate effect on the provider (or member), although schemes are always at pains to emphasise, that it for the benefit of the whole membership of the scheme as the deduction benefits the pool of members' funds.

2. Where a scheme has a contract in place with a provider allowing for such a deduction then of course section 59(3) of the Act would not apply.

3. The consequence of a deduction made in relation to a future benefit is that current claims are not paid until the amounts owed are paid off by way of deductions. This means there is immediate non-payment of claims submitted by providers. The providers have no choice but to accept such non-payment and have no effective recourse in relation to non-payment.

4. The powers exercised by medical schemes in terms of section 59(3) of the Act are public powers and therefore subject to the principles of administrative review as provided for sections 1 and 33 of the Constitution and the provisions of the Promotion of Administrative Justice Act 3 of 2000 (PAJA).

5. The CMS Appeal Board ("the Appeal Board") has already acknowledged this and have stated that schemes should **not** claw back monies in terms of section 59(3) or place providers on indirect payment without first being notified of such proposal and being given an opportunity to comment.

6. Section 59(3) of the Act properly interpreted requires that the schemes act in a manner that is **procedurally fair and reasonable** before making a decision to deduct amounts from future benefits payable to providers (or members).

Reasonableness

1. Reasonableness rests on the pillars of rationality and proportionality.

2. The decision by the scheme must be supported by the evidence and information which it has and give reasons for it. There has to be a rational connection between the action taken and the reasons given for it.

3. There must also be a balance between effects of the decision and the benefits the scheme is seeking to achieve.

4. So what will constitute a reasonable decision will depend on the circumstances of each case.

Procedural fairness

1. Procedural fairness has two components:
a) a fair hearing ("audi alteram partem" or "audi")
b) by an impartial decision-marker ("nemo iudex in sua causa").

2. The audi component of procedural fairness is a flexible requirement in that its requirements are determined by the circumstances of the particular case.

3. Section 3 of Promotion of Administrative Justice Act (PAJA) governs procedures for a fair administrative action which affects persons.

4. The PAJA set out ways to effect procedural fairness. It requires a medical scheme to give:
4.1. adequate notice of the nature and the purpose of the proposed administrative action (practitioner must be informed of the issues at hand);
4.2. practitioner must be given a reasonable opportunity to make representations before a decision is made;
4.3. a clear statement of the administrative action i.e. the scheme must state what action it intends to take against the practitioner);
4.4. adequate notice of the right to request reasons i.e. the practitioner must be given the right to request reasons for the action by the scheme); and
4.5. the practitioner affected by the administrative action should, where a case is serious or complex, be able to seek assistance generally or seek the assistance of a legal representative, be able to present and dispute information or arguments.

Adequate Notice

1. In relation to the requirement of adequate notice of the nature and purpose of the proposed administrative action:
a) There must be sufficient information to enable a person to exercise their fair hearing rights when affected by the decision;
b) The charges must be formulated with sufficient accuracy so that the person affected by the decision understands the charge; and
c) There must be sufficient time for the person affected by the administrative action to prepare their case adequately. Whether the time period is sufficient will depend on the level of understanding of the person affected by the administrative action and on the consequences of the decision.

Reasonable opportunity to make representations

The persons affected by administrative action must be properly apprised of the information which underlies, and reasons for, the decision. If there is any incriminatory documentation or material, it would be unfair not to disclose it.

Right to request reasons

1. Practitioners as affected persons are entitled to request reasons and, at minimum, a decision-maker must provide adequate reasons for its decision.

2. When medical schemes exercise powers in terms of section 59(3) of the Act, whether it be vis-à-vis practitioners or members, they are therefore required to act reasonably and procedurally fairly in the ways described above.

3. The power to claw back must be exercised consistently with the rule of law principle.

4. Schemes cannot deduct amounts unilaterally and without a meaningful opportunity to make representations, as this amounts to a form of self-help that is contrary to the rule of law.

5. Similarly, where the liability is in dispute, if schemes continue to place providers on indirect payment without a meaningful opportunity to make representations, that would amount to self-help which is inconsistent with the principle of the rule of law. It follows that in order to uphold the rule of law in the Constitution section 59(3) of the Act must be interpreted to allow for procedural fairness. The powers in section 59(3) of the Act must be exercised reasonably.

6. Schemes will often argue that section 57(6)(a) imposes a duty on trustees of schemes to protect the interest of beneficiaries. The schemes have argued that by terminating direct payments and making deductions in terms of section 59(3), they are protecting beneficiaries. This may be true but it must be balanced with other beneficiary interests.

7. Clearly without a fair procedure, it is not possible to determine if a provider is unfairly being targeted, or there is in fact a legitimate concern about their conduct.

SUSPENDING DIRECT PAYMENT

Are schemes entitled to place practitioners on indirect payment? If so, what are they required to do before placing practitioners on indirect payment?

1. These questions demand consideration of both sections 59(2) and (3) of the Act and how they interact.

2. The reason is that section 59(2), embodies the obligation to pay current benefits (invoices) and placing a provider on indirect payment means that he or she is not paid his or her current invoices directly – rather the member (patient) is paid.

3. Section 59(3) is concerned with claw backs of future benefits.

4. The implementation of section 59(3) requires the scheme to deduct an amount from a benefit to be paid in the future. The net effect however is that a current benefit (invoice) is not paid as it is subject to a claw back of a past amount that should not have been paid by the scheme.

5. In order for the schemes to place providers on indirect payments they must either be entitled to do so as a result of their contracts with the providers or they must source their power to do so from section 59(2) and (3) of the Act.

6. The situation where a scheme may be in a contractual relationship with a provider and where the circumstances in which the provider may be placed on indirect payment are normally agreed in such contract.

Are schemes empowered to suspend direct payments?

Broadly speaking, most schemes argue that placing a provider on indirect payment, helps better manage further loss while an investigation is underway. That this management which flows from the Act and other legislation to safeguard members' funds. Furthermore, schemes

and administrators rely on the provisions of their Rules to justify placing providers on indirect payment.

Is there an implied power to suspend direct payments?

Sections 59(2) and 59(3)

Neither section 59(2) or 59(3) of the Act expressly empowers schemes to place practitioners on indirect payment.

The question is if there are any implied powers given to schemes in the Act or the regulations to suspend direct payment to providers.

As the action of suspending direct payments to the provider is drastic, coercive or oppressive with far reaching effect, such action would require express statutory power. It is not likely the courts will find support for implied powers.

The question therefore is whether the power to place providers on indirect payment is reasonably necessary for the exercise of either the powers in section 59(2) or 59(3) of the Act.

1. The question, therefore, is whether the power to place providers on indirect payment is reasonably necessary for the exercise of either the powers in section 59(2) or 59(3) of the Act.

2. In terms of duties imposed by **section 59(2),** it does not seem reasonably necessary that in order for schemes to pay providers, it must also be a power not to pay providers. There is nothing in section 59(2) powers that support this.

3. Again on reading **section 59(3)** which gives schemes powers to deduct an amount from a provider, there is nothing to indicate that it cannot be exercised without the power to suspend payments to providers.

4. In fact the opposite is true – the power to deduct amounts is given because it is assumed that providers will be paid and therefore there needs to be a mechanism to claw back monies that should not have been paid.

5. For these reasons it seems relatively clear that neither sections 59(2) nor 59(3) of the Act confer a power on the schemes to place providers on indirect payment.

6. Bearing in mind the coercive nature of the power to place a provider on indirect payment it also seems unlikely on this basis that an implied power can be read into section 59(2) or (3) of the Act.

7. There is no implied power in either section 59(2) or (3) of the Act that enables a scheme to suspend direct payment to providers.

8. However, section 57 of the Act which deals with the powers and duties of the schemes when managing their risk management functions and more particularly FWA systems.

9. Section 57(4)(c) of the Act provides that:
"(4) The duties of the board of trustees shall be to— (c) ensure that proper control systems are employed by or on behalf of the medical scheme".

10. A proper control system would include issues such as preventing payments to providers who are engaged in fraud, theft, professional misconduct or negligent behaviour which is causing the scheme loss.

11. Section 57(4)(c) of the Act requires a scheme to put proper control systems, including proper financial control systems, in place.

12. If neither section 59(2) nor (3) of the Act empower to scheme to place providers on indirect payment, schemes cannot argue that they can make Rules empowering themselves to place providers on indirect payment. This would be using the Rules to subvert a constraint in the Act.

Are the schemes also required to act reasonably and procedural fairly when suspending direct payments to providers?

1. Section 57(4)(c) of the Act requires the schemes to put in place a proper system of financial control and such system may provide for a provider to be placed on indirect payment. The Act therefore introduces the standard by which a scheme will be measured when developing and implementing such systems of financial control.

2. A proper system of financial control will at the very least include a system which:
a. treats providers procedurally fairly before they are placed on indirect payment; and
b. ensures that the decision to place a provider on indirect payment is reasonable.

3. As with the decision to claw back amounts which ought not to have to have been paid to the provider in terms of section 59(3) of the Act, the system of financial control that a scheme puts, or has, in place should ensure that the following, before the scheme places a provider on indirect payment, that:

a) the scheme notifies the provider in writing that the scheme is considering placing the provider on indirect payment. Such notice should give the provider an opportunity to meaningfully comment on the proposed decision. A meaningful comment would be enabled by giving the provider the information on which the scheme's proposed decision is based as well as a summary of the scheme's reasons for the proposed decision. Additionally, the time which a provider is given to comment will depend on the complexity of the allegations as well as the time a provider might require to consider the allegations;
b) the scheme should consider the providers' representations before making any final decision; and
c) if the scheme decides to place the provider on indirect payment despite the representations made by the provider, such a decision must be reasonable. In other words, it should be based on the facts and its impact on the provider should be considered, to ensure that the consequences of indirect payment are not disproportionate to the reasons the scheme believes indirect payment is necessary.

The Rules of the Scheme

1. A number of schemes and administrators will argue that their Rules allow them to place practitioners on indirect payment.

2. However, as stated above if neither section 59(2) nor (3) of the Act empower to scheme to place providers on indirect payment, schemes cannot argue or make Rules empowering themselves to place providers on indirect payment. This would be using the Rules to subvert a constraint in the Act.

The position of the Panel in relation to a scheme's decision to suspend direct payment to providers may be summarised as follows:

a) schemes are required to have a proper system of financial control in place as a result of section 57(4)(c) of the Act;
b) in order for such a system of financial control to be proper they must treat the provider procedurally fairly and any decision to place the provider on indirect payment must be reasonable; and
c) procedural fairness requires giving the provider a meaningful opportunity to comment on the proposed decision to place the provider on indirect payment. It further requires the schemes to ensure that the impact of the decision to place the provider on indirect payment is not disproportionate to the reasons for doing so.

THE PROBLEM OF CONFIDENTIAL PATIENT INFORMATION

1. One of the issues that arises repeatedly is whether schemes are entitled to insist that providers disclose confidential patient information in order to allow the scheme to verify their claims. This is a useful issue through which to consider whether the schemes implementation of section 59(3) of the Act is reasonable as well as whether it is reasonable to place a provider on indirect payment.

2. It appears that the schemes use the patient's clinical notes to:
a. determine if a service was provided at all;
b. determine if the length of the service was justified;
c. determine if a particular medicine was dispensed; and
d. determine if the diagnosis matches the treatment claimed.

Legislative Context

1. Section 14 of the **National Health Act 61 of 2003 ("NHA")** provides as follows:

"All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.

(2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless:

a) the user consents to that disclosure in writing;
b) a court order or any law requires that disclosure; or
c) nondisclosure of the information represents a serious threat to public health."

2. The Health Professions Act 56 of 1974 makes provision for the making of ethical rules governing health care providers.

3. The Ethical Rules of Conduct for Practitioners registered under the Health Professions Act were published (in GNR 717 of 4 August 2006) ("the Ethical Rules"). The obligation to protect patient confidentiality is contained in Rule 13, which provides as follows:
   "13(1) A practitioner shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only –
   (a) in terms of a statutory provision;
   (b) at the instruction of a court of law; or
   (c) where justified in the public interest.
   (2) Any information other than the information referred to in subrule (1) shall be divulged by a practitioner only –
   a. with the express consent of the patient;
   b. in the case of a minor under the age of 14 years, with the written consent of his or her parent or guardian; or
   c. in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate"

4. The question of patient confidentiality must of course be understood against the background of the right to privacy contained in section 14 of the Constitution. Health information, including diagnosis and treatment of a patient, epitomises the type of information which would fall within the scope of personal private information which is protected by the right to privacy entrenched in the Constitution.

5. In addition to the legislation and case law, there are various directives from the HPCSA and booklets published by the HPCSA, which address the issue of confidential patient information. The most relevant booklet appears to be Booklet 5 entitled "Confidentiality: Protecting and Providing Confidential Information" and updated in September 2016 ("Booklet 5").

6. Paragraph 3 of Booklet 5 reaffirms the patient's right to confidentiality. Paragraph 8 of Booklet 5 explains how health care providers should go about seeking express and informed consent from patients:
   "8.2.1 Seeking consent of patients to disclosure is part of good communication between healthcare practitioners and patients and is an essential part of respect for the autonomy and privacy of patients. The following principles should be applied:
   7.2.2 Obtaining consent where the disclosures will have personal consequences for patients:
   7.2.2.1 Healthcare practitioners must obtain express consent where patients may be personally affected by the disclosure, for example when disclosing personal information to a patient's employer or to a medical scheme for ICD-10 coding.
   7.2.2.2 When seeking express consent, health care practitioners must make sure that patients are given enough information on which to base their decision, the reasons for the disclosure and the likely consequences of the disclosure.
   7.2.2.3 Healthcare practitioners should also explain how much information will be disclosed and to whom it will be given.
   7.2.2.4 If the patient withholds consent the healthcare practitioner should first attempt to persuade the patient to consent.
   7.2.2.5 If the patient continues to refuse consent, or consent cannot be obtained, the consequences of disclosure and non-disclosure should be explained to the patient.

Disclosures may be made only where they can be justified in the public interest." (our emphasis)

7. The National Health Act (NHA, the Ethical Rules, the case law explaining the right to privacy in the context of personal health information and the HPCSA booklets) all emphasise:
a. The exceptionally sensitive nature of personal health information, particularly diagnoses of health conditions and treatments;
b. The general rule is that disclosure of personal health information is not allowed;
c. There is a high bar for justifying disclosure of health information:
d. it must be with the consent of the patient and such consent must be express and fully informed; alternatively
e. there must be an overriding public interest in a particular disclosure if express and fully informed consent is not obtained.

8. The question of patient confidentiality must of course be understood against the background of the right to privacy contained in section 14 of the Constitution. Health information, including diagnosis and treatment of a patient, epitomises the type of information which would fall within the scope of personal private information which is protected by the right to privacy entrenched in the Constitution.

Views of the Panel

1. In the face of demands from the schemes to provide patient files and patient notes, the providers rightly refused to disclose this confidential patient information.

2. Providers' concerns regarding the confidentiality of patient information are extremely important and it appears they are upholding the requirements of the NHA, the Ethical Rules and the right to privacy in the Constitution. If a provider is unable to obtain express and informed consent from the patient to disclose their file or the provider's clinical notes, then there is little more that the provider can be obliged to do.

3. The Panel considered the arguments put forward by GEMS that membership application form provides inter alia that the member authorises the provider "who has attended to me or my dependants in the past or who will attend to me or my dependants in the future, to provide GEMS and/or its agents with such information as it may require". The Panel were of the view this is an exceptionally wide consent, and it is doubtful whether when a member signs such consent, she will be aware that it may allow a provider to hand over her patient file or patient notes.

4. The clause does not appear to satisfy the requirements of being express and informed as:
a. there is a risk that many members will sign the application form without their attention being brought to the particular clause and in these circumstances the consent is not informed (and only arguably express);
b. prior consent to future disclosure of information does not cover the disclosure of information which may materialise after the consent is given and in these circumstances the consent is not informed nor is it express.

5. **Medscheme on the other hand argued that section 15(1) of the NHA and Regulation 15J(2)(c) of the Regulations entitled it to access patient files and notes from providers and the onus is on the provider to seek the necessary consent. The Panel found reliance on Regulation 15J(2)(c) of the Regulations is wrong – the regulation is designed to enable the managed healthcare function – a function with which an administrator conducting an FWA function should not be concerned. The regulation is therefore not relevant.**

6. The Panel stated in sum:
a. The schemes should be requesting non-confidential (redacted) versions of patient files and notes if this is what is required to verify a claim submitted by a provider;
b. Should the schemes demand confidential information from providers and the providers refuse to provide such confidential information the scheme cannot exercised powers in terms of section 59(3) of the Act. This is not a reasonable exercise of powers.

7. Similarly, a scheme cannot place a provider on indirect payment on the basis that a provider refuses to provide patient confidential information. This is improper and unreasonable.

CALCULATION OF CLAW BACK AMOUNTS

1. The process of clawback is initiated with a s 59(3) letter sent by the administrator of the scheme to the supplier stating that it has detected certain anomalies in relation to the claims submitted by the health practitioner.

2. The administrators of the schemes also rely on reg 15J(2)(c) of the Act, which entitles a medical scheme to access any treatment record held by a managed health care organisation or health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary.

3. Thus, the administrators rely on this regulation to conduct desktop audits on practices or to threaten these practices with the possibility of a full-scale audit.

4. The modus operandi of the administrator is to withhold payment of money owed to health practitioners for services rendered; then after the health practitioner has provided verification documents, the scheme nonetheless holds the withheld money owed to the health practitioner as a sword over the health practitioner's head.

5. Once the scheme has done their calculations (often using a flawed audit process), they quantify a substantial amount over an extended period, thus suffocating the health practitioner and often forcing them to agree to a settlement with the scheme that is detrimental to their practice.

6. Section 59(3) of the Act identifies the circumstances in which a scheme may claw back monies erroneously paid to a provider, from future benefits payable to members or providers. These circumstances are limited to where a member or provider was not entitled to payment and to where the scheme has experienced loss (as a result of the four forms of aforementioned conduct).

7. Therefore, the conditions that must exist prior to the exercise of the powers in section 59(3) are:
   i. an amount has been paid bona fide to which a provider is not entitled; or
   ii. loss has been sustained as a result of theft, fraud, negligence or any misconduct.

9. Both of these conditions indicate that the subsection envisages actual amounts, which can be calculated. It is only then that such an amount can be deducted from future benefits payable to the provider. The question which arises is how schemes calculate the amounts to repaid – and whether such amounts can be an estimate of loss.

10. The providers have generally argued that section 59(3) of the Act did not allow the schemes and administrators to use estimates. For example, Section 59(3)(a) speaks of "an amount" that has been paid bona fide. However the schemes through their desktop audits or other audit processes work on an average and convert that average to an amount.

11. Section 59(3)(a) does not make provision for aggregation of such amounts and the practice of aggregation thereof is a breach of this provision.

12. The schemes and administrators argue that it was permissible to make use of estimates to calculate their Acknowledgement of Debt (AOD) amounts or the calculation of the claw back amount in terms of section 59(3) of the Act, or both.

13. Some schemes such as Discovery estimates the quantum of FWA claims from a practice by analysing all claims submitted by the practice over the prior 3 years. It will apply a different methodology depending on the type of FWA (claims from pharmacies or dispensing GPs, claim submissions for non-scheme members, purchase record audits, and audits for time-based coding). Discovery usually makes an extrapolation, based on the information it has, to calculate the amount owed by the provider. There is significant variation in the methods used, where for example in an audit on time-based coding where a provider "cannot provide suitable verification'', the claims paid out are recovered in full.

14. GEMS, through its administrator (DENIS), negotiates amounts owed. The amounts are determined using the claims line data for the current year to date and the previous year. The practitioner is asked to submit corrected claims and the difference between the actual amounts claimed and the corrected claims are then quantified in order to reach the amount.

15. Medscheme does not appear to follow a particularly rigorous or explicit methodology for the calculation of the amounts owed. Medscheme in written submission to the Panel simply stated that "based on the findings of our investigations, we then quantify any financial loss suffered by medical schemes and notify the practices of our findings and quantification. They would suggest that it claims 5% of the provider's total claims during the investigation period".

16. The Panel accepted and understood some of the constraints under which the schemes operate. They accepted that neither the provider nor the schemes have the resources to consider every record in order estimate loss with perfect precision.

17. Section 59(3) refers to two amounts, one described as an amount "to which a member of a supplier of health services is no entitled to" and the other being a loss sustained by the scheme through theft, fraud, negligence of (professional) misconduct. Only "such amount[s]" may be deducted from future benefits.

18. The Panel were of the view that the exercise of power in terms of section 59(3) is probably a public power and if not, is constrained by the common law principles of administrative law. Therefore, when a scheme makes a decision to deduct an amount it must do so based on at the very least a rational method of calculation and probably on a reasonable method of calculation.

19. The method of calculation should therefore be justifiable, in that it should be based on the logic of mathematics and/or statistics. On this standard it seems that the methodologies put forward by GEMS and Discovery pass muster in that they are probably reasonable.

20. The methodology used to calculate losses should not have disproportionately harsh impacts on providers. It seems to us that the disproportionate impact on providers often arise out of the fact that an audit, and hence a calculation of loss, may go back as far as three years.

21. The Panel noted another difficulty that the schemes and administrators face when formulating a method of calculation which is reasonable is that a method of calculation may be fair for a provider who is guilty of FWA but unfair on a provider who is not guilty of FWA. By way of example, where an innocent provider cannot produce records to justify his services then he or she will be subject to the same method of quantification as a guilty provider unable to produce records to justify services. Both the innocent and the guilty party will be subject to the method of calculation.

22. This observation underscores two important points:

a) First, the Panel were of the view that schemes and administrators need to move away from the assumption of guilt in relation to their engagements with providers; and

b) Second, the importance of giving a proper hearing to providers will do much to improve the scheme's understanding of the provider's position and hence the proper method for calculating loss.

22. Although section 59(3) of the Act properly interpreted requires the schemes to adopt a reasonable method of calculating the losses which it proposes clawing back in terms of section 59(3), the evidence also suggested that this might not be enough to weaken the power imbalance between scheme and provider nor solve some of the difficulties of determining when an approach adopted by a scheme may result in a disproportionate impact on providers.

23. The Panel were of the view that there is value in recommending that an independent mediator assist a scheme and provider in reaching a reasonable determination of the losses experienced by the scheme which may be clawed back in terms of section 59(3).

24. Having an independent person in the room is likely to reduce actual duress as well as any duress. It is also likely to cast light on any racialised dynamics which might lead to unequal treatment and outcomes or the perception of unequal treatment and outcomes.

25. They suggested a warning that could read as follows: "Our regular run of our analytics system has identified behaviour on your part that could potentially constitute fraud, waste or abuse. This identification is not proof on any unethical behaviour on your part, nor is it an accusation that you have acted unethically. The aim of this notification is simply to alert you that we may at some future date need to review your documentation in order to satisfy ourselves that the scheme has not suffered any damage. Please retain all documentation related to the behaviour identified.".

26. Such a warning should also be followed by a detailed description of the behaviour identified by the system, which should be a statutory function of the CMS and therefore we recommend that the CMS appoints and remunerates the independent mediator.

27. The South African Society of Physiotherapy (SASP) is challenging Section 59 of the Medical Schemes Act. Their members were subject to an inordinate number of audits and SASP initiated legal action on behalf of its members.

28. As such, a comprehensive case was brought in the High Court of South Africa on 29 September 2021, challenging the constitutionality of Section 59 (3), the relevant clause of the Medical Schemes Act, the one-sided interpretation of which has provided the funder with the authority to conduct these forensic processes.

29. The legal action names all of the medical schemes and their administrators, the Council for Medical Schemes as well as the Minister of Health as respondents. The thrust of this action is to seek readdress on the application of Section 59 and to ensure that the funder or their representatives do not act as sole judge, jury and executioner on accused members. Currently no right of appeal or review exists other than a high court application, and such is well outside the financial ability of most physiotherapists.

30. SASP has asked the Gauteng High Court (Pretoria) to declare section 59 (3) of the Act unconstitutional and invalid, arguing it gives too much power to schemes and administrators because they both investigate and adjudicate claims suspected to be fraudulent or erroneous. One would have to await the outcome of the decision.

ACKNOWLEDGEMENT OF DEBT (AOD)

1. Providers are often intimidated and coerced into entering settlement agreements with the schemes to avoid being reported to the regulatory authority or the police or to offset potential financial harm of being put on indirect payment or blacklisted.

2. It is a well-established principle in our law that, where a party enters into a contract as a result of duress, the contract may be challenged on the basis of a lack of true consent.

The threat of economic duress has not been incorporated as a principle in South African law of contract

3. In the case of Medscheme Holdings (Pty) Ltd and another v Bhamjee[13] ("*Bhamjee*"), the SCA stated:
"it is not unlawful, in general, to cause economic harm, or even to cause economic ruin, to another, nor can it generally be unconscionable to do so in a competitive economy. In commercial bargaining the exercise of free will (if that can ever exist in any pure form of the term) is always fettered to some degree by the expectation of gain or the fear of loss."

3. There is a power imbalance in these negotiations, as Section 59(3) gives the schemes the power to claw back. This power imbalance does not operate in the abstract.

4. The schemes are entitled to place providers on indirect payment where the circumstances justify it. If an AOD is not agreed, the schemes will exercise one or both of these powers. This is not a situation of a person, who having incurred heavy debts, wants to sell their house; and a buyer exploits this situation by offering a cheeky purchase price. In that situation, the seller technically may be able to look for another buyer. In the case of claw backs and suspension of direct payment, the power lies with the schemes. This can hardly be said to be an equal relationship with sophisticated bargaining abilities on both sides of the negotiating table.

5. The schemes must be fair and reasonable and must take into account their disproportionate power relations in the negotiation of AODs.

5. The Panel recommended that an independent mediator is required to assist in the negotiation and conclusion of AODs. Having an independent person in the room is likely to reduce actual duress as well as allegations of duress. It is also likely to cast light on any racialised dynamics which might lead to unequal treatment and outcomes or the perception of unequal treatment and outcomes.

FRAUD, WASTE AND ABUSE (FWA)

1. FWA is not is not a statutory concept and is not defined anywhere in the Act.

2. Section 59(3) of the Act refers to "theft, fraud, negligence or any misconduct" and "bona fide payment" to which a provider or member is "not entitled". Regulation 6(2) of the Regulations made in terms of the Act ("the Regulations") uses the language of claims that are "erroneous or unacceptable for payment".

3. FWA manifests in a variety of ways. The scale and type of FWA practices vary. Some of the irregular claims were minor infractions or the result of an unknowing error. Others were organised and sophisticated fraudulent operations, usually involving a number of practices and service providers.

The examples of FWA include:

[13] [2005] 4 All SA 16 (SCA)

Inflating claims
A common form of fraud occurs where a provider prescribes a certain procedure but claims, for example, the cost of more than one procedure. The provider fraudulently inflates the claim it makes on the scheme. Another example is inflating the costs of direct materials by adding a mark-up on the price of the material which is unreasonable.

Card farming
Card farming occurs where several individuals use a single member's medical scheme card.

The provider will treat these patients, who are *not* members of the scheme and claim the cost from the scheme for the services provided to the cardholder or scheme member/dependant.

Claiming for services not rendered or goods not provided

Providers claiming for services that had not been rendered.

Coding Irregularities

1. Sometimes incorrect codes or misinformation about billing codes. The ICD10 Codes that signify the diagnosis do not correlate to clinical codes. Providers are sometimes were flagged, investigated, and sanctioned for FWA where they unintentionally or innocently used the incorrect code.

2. There could also be up-coding, which involves billing for a more expensive service than the one actually provided, and other forms of overcharging through code abuse or using codes that fall outside the scope of the provider's practice area or specialisation.

Detection

1. Each scheme has different mechanisms to detect cases that need to be investigated for FWA.

2. On the whole there are two ways in which providers are flagged as possible cases of FWA that should be investigated. The first is a system that allows for tip-offs, such as hotlines.

3. The second method is through the utilisation of algorithms or mechanised systems that detect possible FWA. These systems use statistical analyses to identify practices that, in comparison with other providers, fall outside the norm of comparable providers. Such providers are identified as outliers and may be subject to further investigation.

Investigation

1. The second phase is the actual investigation. Once a case has been flagged as possible FWA, the administrators tend to use a variety of methods to rank the risk and seriousness of the potential FWA.

2. The investigation usually begins with a letter to the provider who has been flagged, requesting information about the billing anomaly. Some administrators use "probes", or "moles" or investigators who go to the provider's practice under the guise of a patient to determine whether there is indeed FWA.

3. When a scheme engages the provider directly, it will usually request a series of documentary evidence from the provider to verify the provider's claims. The evidence will include, for example: diary entries, to prove that the provider had a consultation on a

particular date; consultation or diagnostic notes; or an explanation of the use of a particular code.

4. If the information is provided, the scheme will determine whether or not the requested information validates the anomalous billing. If it does not, the scheme will then move to the next stage, which, depending on the scheme's policy, may include meeting with the provider or presenting an acknowledgment of debt or sanctioning the provider by paying members directly.

5. Where a provider does not, is unable to, or refuses to provide the information requested by the scheme, the scheme may take the position that the claim is invalid. It will then move to the next stage, which, depending on the scheme's policy, may include sanctioning the provider.

6. Medscheme's practice is practitioners are identified by their practice numbers, which practice numbers Medscheme uses for the purposes of assisting in detecting or preventing fraud.

7. Discovery's standard approach is to pay claims based on automatic rules and then investigate potential FWA retrospectively.

8. Simply put the two methods that Discovery uses to detect FWA are tip-offs and using its statistical analytical tool called the RRT. The RRT is an algorithm (or algorithms), which Discovery developed and now owns.

9. Cases are allocated to individual investigators who will not always engage with practitioners during the investigation at the same stage of an investigation. Sometimes a practitioner may be engaged early on in the investigation to obtain specific information for verification purposes and in other instances the practitioner is engaged when the investigation has largely been completed.

10. Although Discovery states where there is an irregularity following from an investigation, it engages with the practitioner in order to reach an "agreed resolution of the issues at hand". That practitioners are given an opportunity to repay the number of irregular claims to which a practice was not entitled but had already paid out.

11. This was found to be inaccurate by the Panel as amounts it claims is based on an estimate of claims that may have amounted to similar FWA claims (making use of the practitioner's 3-year historic claim records). The settlement agreement is structured as an AOD where the practitioner pays back an agreed amount over a period of time without interest.

Probes / entrapment

1. Some schemes will send probes or undercover forensic agents into a provider's practice to determine whether there is FWA. Complainants provided evidence that in the cases concerning probes (i.e. agents of funders entering practices or facilities as fake patients), there was a tendency to entrap the provider, persisting until they are successful. The encounters would be recorded secretly.

2. Probes would, inter alia, ask providers to (a) write sick certificates, (b) dispense medication; or (c) allow a member's family to be treated on their medical scheme membership where the family were not members or dependents.

3. These probes are usually "quite skilled" in getting the providers to comply with their illicit requests. The result was that providers had a sense of being set up and then threatened with reporting to the relevant regulatory body.

Sanctions

1. There are several different sanctions that the schemes employ if there is a finding of FWA.

2. Very often, the scheme will place a hold on the claims of a provider under investigation. If the investigation results in a finding of FWA, the scheme will stipulate the amount that it has calculated as having been overpaid to the provider. In some instances, the scheme and the provider will enter into a settlement agreement, often in the form of an acknowledgement of debt ("AOD").

3. The scheme may also impose a "claw back" on the future amounts owed to the provider as a way of off-setting the amount owed. The quantum of the deduction is determined by the administrators in different ways.

4. The scheme may decide to blacklist the provider. This means that the administrator will no longer pay that provider, and will advise its members that such provider is blacklisted. Where providers are in direct payment arrangements with schemes, the administrator may suspend or end the direct payment relationship.

5. In some circumstances, the scheme or administrator reports the provider to one of the relevant regulatory bodies or the police.

6. Providers complained of a 'one size fits all' approach to addressing irregular claims and that there is limited differentiation in the way the FWA processes operate. On the whole, the process of addressing FWA is not concerned about the various ways a billing concern may arise. This may result in innocent cases being harnessed in the wide and uniform net cast by the schemes to hold providers accountable for FWA. This 'net' tends to assume that all cases flagged for FWA are fraudulent or intentional. A 'one size fits all' approach is used.

7. There is usually a combination of implicit threats and heavy-handedness leading to coercion, particularly in signing AODs. There is also intimidation with a threat of being reported to the provider's regulatory body.

8. Where a scheme is concerned about possible FWA, it may stop making direct payments to a provider pending the completion of an investigation.

9. The consequence is that the provider has to charge their patients directly. If the provider's patients are not accustomed to this or fall into a socio-economic bracket where they are unable to pay immediately, the provider is unlikely to be paid. If the provider insists on payment from the patient, which of course they are entitled to do, and the patient is unable to find the funds to pay upfront, the patient will forsake the service or go to another provider who is prepared to claim directly from the scheme. They are literally saying to the doctors that they must close their businesses.

10. Providers are often informed about the suspension of payments to them at the same time as they were told they were being investigated or audited. There was a sense of being found guilty and punished without an opportunity of being heard.

11. As part of the FWA audit, schemes often request confidential patient information about a in order to verify the provider's claims (discussed below).

12. Once a scheme like Discovery has decided if a practitioner is guilty of FWA then it proceeds to follow one or more of the following routes: administrative, professional, criminal or civil action:
    Administrative - a settlement is reached between Discovery and the practitioner.
    Professional route - where the matter gets reported to the relevant statutory body such as the HPCSA.
    Criminal action - a criminal case is opened with the South African Police Service ("SAPS"),
    Civil action - a civil case is opened in order to recovery losses (the latter route is uncommon as "civil action is generally quite expensive and likelihood or recovery should be considered carefully").

13. Discovery's approach is that "unless there is a legal obligation to do so it may not be appropriate to routinely report cases to the SAPS and/or a statutory body, and it might be more appropriate to deal with these cases on an administrative level.'' A meeting is convened with the practitioner.

14. It is clear that practitioners experience of such meetings is very different to the experience of Discovery.

15. Practitioners report that they are intimidated in such meetings as they are called into Discovery's offices and are outnumbered and ambushed with information about their billing practices which is difficult to address in the meeting.

16. In relation to settlement agreements, Discovery "estimates the quantum of fraudulent claims from a practice by analysing all claims submitted by the practice over the prior 3 years, thus using an extensive sample of claims to ensure an accurate and fair estimate of the quantum of claims inappropriately paid to the practice." The settlement agreement is usually structured as an AOD where the practitioner pays an agreed amount back to Discovery over a period of time, without interest.

17. The manner in which Discovery calculates the re-payment set out in the AOD has also been controversial. Practitioners and even the CMS have alleged that the amount is a "thumb suck".

18. Where a practitioner is not cooperating with the investigators and/or where ongoing payments to a practice are deemed to pose material risk to the schemes, Discovery will temporarily suspend payments to the practice until the matter is resolved.

19. In a small minority of cases payments to a provider or practice are permanently blocked.

20. GEMS's Sanctions Policy, provides for a range of possible sanctions which may be imposed on practitioners where evidence of FWA has been found. These sanctions include: reversal of all irregular claims, issuing a final warning, terminating direct payment, monitoring claim submission, imposing a longer claim payment cycle, reporting providers to the relevant regulatory body, and recovering losses through civil litigation or a negotiated settlement.

21. The policy provides the sanctions for three categories of transgressions: irregular behaviour (including unacceptable human error), abuse; and fraud.

22. For all categories of transgression GEMS provides an appropriate sanction would be to:
    a. "reverse the irregular claim";
    b. "quantify the financial loss suffered and recover such loss from provider through settlement"; and
    c. terminate direct payment in respect of any claims submitted from date of notice.

23. Medscheme has five mechanisms that are utilised for the purposes of detecting FWA cases, which include tip-off processes, healthcare provider vetting processes, analytical process, operational and financial controls, information sharing through industry initiatives and general media monitoring, which is discussed more fully hereunder.

24. Subsequent to investigation Medscheme enters into the settlement stage, which consists of quantification and sanctioning, recovery of payments and other sanctions.

25. Subsequent to having investigated complaints and having reached a finding, Medscheme will quantify the FWA claim and sanction the practitioner, thereafter seek to recover overpayments and will, where necessary, ensure other sanctions are also given effect.

26. These other sanctions include:
    (i) placing the practitioner on indirect payment;
    (ii) termination of membership;
    (iii) the cancellation of contractual relationship;
    (iv) referral of the matter to the HPCSA if the conduct is grossly unethical or dishonest; or
    (v) lodging a criminal case with the SAPS in the event that there is clear criminal intent

REGULATIONS

In this section we seek to identify those regulations that may affect private practitioners and those providing for managed healthcare.

One of the very first regulations that the profession needs to be aware of when submitting to medical schemes are Regulation 5

Regulation 5 - Accounts by suppliers of services

5. Accounts by suppliers of services.—The account or statement contemplated in section 59 (1) of the Act must contain the following—

(*a*) The surname and initials of the member;

(*b*) the surname, first name and other initials, if any, of the patient;

(*c*) the name of the medical scheme concerned;

(*d*) the membership number of the member;

(*e*) the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;

(*f*) the relevant diagnostic and such other item code numbers that relate to such relevant health service;

(*g*) the date on which each relevant health service was rendered;

(*h*) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine;

(*i*) where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;

(*j*) where mention is made in such account or statement of the use of a theatre—

(i) the name and relevant practice number and provider number contemplated in paragraph (*e*) of the medical practitioner or dentist who performed the operation;

(ii) the name or names and the relevant practice number and provider number contemplated in paragraph (*e*) of every medical practitioner or dentist who assisted in the performance of the operation; and

(iii) all procedures carried out together with the relevant item code number contemplated in paragraph (*f*); and

(*k*) in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating—

(i) the expected total amount in respect of the treatment;

(ii) the expected duration of the treatment;

(iii) the initial amount payable; and

the monthly amount payable.

1. It is to be noted paragraph (e) provides for the situation where there is more than one clinician in a practice whose HPCSA registration number must appear on the account of the owner practitioner, incorporated company or partnership or association. This will assist

with identifying who the service provider is in the event of an audit or benefits payable if the service provider employed is an oral hygienist, dental therapist or dentist.

2. The relevant ICD10 must also be reflected on the account.

3. The requirements in paragraph (k) specifically provides for the information that must appear on the account supplied by an orthodontist.

4. It must be remembered that even if the practitioner does not submit accounts to medical schemes and requires their patients to pay, compliance with these requirements is imperative for patients to obtain reimbursement from their schemes.

REGULATION 6 – MANNER OF PAYMENTS OF BENEFITS

6. Manner of payment of benefits.—

1) A medical scheme must not, in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month—

a) from the last date of the service rendered as stated on the account, statement or claim; or

b) during which such account, statement or claim was returned for correction.

2) If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant health care provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion.

3) After the member and the relevant health care provider have been informed as referred to in sub regulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned for correction.

4) If a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of sub regulation (2) or fails to provide an opportunity for correction and resubmission in terms of sub regulation (3), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute.

(5) If an account, statement, or claim is correct or where a corrected account, statement or claim is received, as the case may be, a medical scheme must, in addition to the payment contemplated in section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars—

a) the name and the membership number of the member;

b) the name of the supplier of service;

c) the final date of service rendered by the supplier of service on the account or statement which is covered by the payment;

d) the total amount charged for the service concerned; and

e) the amount of the benefit awarded for such service.

1. The far-reaching powers granted to medical schemes in terms of s 59 of the Act are counterbalanced by reg 6(2) – (4) of the Act.

2. Briefly set out, these regulations provide that if a medical scheme is of the opinion that a claim submitted is erroneous or unacceptable for payment, the scheme must notify the supplier within **30 days** and state the reasons for such an opinion; thereafter the supplier must be afforded an opportunity to correct and resubmit the claim within **60 days**. If this process is not followed, the medical scheme will bear the onus of proving that the claim is erroneous or unacceptable for payment.

3. All accounts will therefore become stale if an account is not submitted within four months after which time the scheme is not obliged to pay providers or sent to provider for correction and not resubmitted during this time.

4. These regulations and the procedure and time-periods set out therein are peremptory and cannot be disregarded by an administrator of a scheme.

5. The purpose of these regulations is to obligate a medical scheme to take prompt action within the time-periods stated in the regulations when it deems a claim to be 'erroneous or unacceptable' for payment. Instead many of the medical schemes embark on a large-scale retrospective audit, severely disrupting the practices of these health suppliers. Moreover, in many instances the administrators are simply using the provisions of the Act to conduct a nightmarish inquiry where providers are sometimes are crushed by nonsensical and blind authority without affording the health practitioner a fair opportunity to clarify any suspected irregularities.

6. Therefore, health practitioners should hold the administrators and medical schemes accountable and inform them that if they are of the opinion that a claim is erroneous or unacceptable for payment, the administrator or medical scheme must do the following in terms of reg 6(2) – (4) of the Act –
   - the medical scheme must notify the supplier within 30 days and state the reasons for such an opinion; and
   - thereafter the supplier must be afforded an opportunity to correct and resubmit the claim within 60 days.

REGULATION 8 – PRESCRIBED MINIMUM BENEFITS (PMBS)

8. Prescribed Minimum Benefits.—

1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.

2) Subject to section 29 (1) (p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that—

a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and

b) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

(3) For the purposes of sub regulation (2) (b), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if—

a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

(4) Subject to sub regulations (5) and (6) and to section 29 (1) (p) of the Act, these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies.

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.

(6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorization from the medical scheme or any other party, in respect of an emergency medical condition.

1. In terms of the Medical Schemes Act No. 131 of 1998, all registered medical schemes in South Africa have an obligation to cover Prescribed Minimum Benefits (PMBs) on all the plans they offer to their members.

2. PMBs are a set of defined, minimum health benefits that all scheme members have access to, irrespective of the scheme option or plan they have selected. Their aim is to ensure that all medical scheme members have access to continuous care for a defined list of conditions to improve their health and make healthcare more affordable. Therefore, medical aids have a duty to pay in full, without a co-payment or the use of deductibles, for the diagnosis, treatment, and care costs of the PMB conditions.

3. Of late, certain medical schemes and managed care companies have approached SADA in an effort to clarify to members which conditions are covered as PMBs as well as the guidelines on how to apply these conditions. Members are reminded that PMBs consist of:
   - any emergency medical condition;
   - a limited set of 271 medical conditions; and
   - 25 chronic conditions defined in the Chronic Diseases List (CDL)

4. There are certain requirements before a patient may benefit from PMBs. The requirements are:
   - The condition must qualify for cover and be on the list of defined Prescribed Minimum Benefit (PMB) conditions.
   - The treatment needed must match the treatments in the defined benefits on the Prescribed Minimum Benefit (PMB) list.
   - The patient must use the Scheme's designated service providers (DSPs) for full cover unless there is no DSP applicable to their plan.

5. As per the Council for Medical Schemes (CMS), an emergency medical condition refers to the ''sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.''

6. It is important to note that the 271 medical conditions that have been listed are defined in the form of Diagnosis Treatment pairs. This means that there are standard treatments, procedures, investigations, and consultations for each PMB condition on the list. These defined benefits are supported by thoroughly researched, evidence-based clinical protocols, medicine lists (formularies), and treatment guidelines. Therefore, any application for treatment that is not listed in the "treatment" provision for a condition, cannot be considered as a PMB as it does not form part of the prescribed treatment that forms part of the PMB level of care.

7. Below is an example of a PMB:

219C	Leukoplakia of oral mucosa, including tongue	incision/excision; medical management	K13.2	Leukoplakia and other disturbances of oral epithelium including tongue

8. The first column indicates the PMB code to be applied when submitting an application to the scheme for the PMB. The second column lists the diagnosis of the PMB condition that is covered and the third advises what treatment must match that particular diagnosis – these two columns are regarded as the previously mentioned Diagnosis Treatment Pairs. In this instance, the only treatment covered from the PMB benefit would include incision or excision of the leukoplakia lesion, as well as medical management which may refer to systemic medication. If a patient's condition does indeed qualify for cover as a PMB, it is essential that the correct ICD-10 code is supplied by the practitioner in order for the patient to benefit from the guaranteed cover of the condition. This is indicated above in the fourth column, with the specific description of that ICD-10 code listed in the last column.
9. For any PMB, it is therefore not only the treatment that must be funded, but also the "diagnosis" and "care":

10. The PMB law gives medical schemes two mechanisms to control the cost associated with the PMBs, namely

(a) appointing designated service providers (DSPs) and
(b) by the implementation of managed care, such as setting medicines lists.

11. However, neither of these strategies (i.e. DSPs and managed care), are without limitations, and medical schemes can only use these strategies insofar as it is permitted by law.

12. The use of DSPs to render health services must be done in line with the law. There should be a formal contract between the service provider and the scheme, which sets out how the services are to be rendered, and what the scheme will pay the DSP.

13. A scheme can, in its rules, say they will only fund a PMB condition or conditions in full, if the beneficiary obtains their healthcare from a DSP. If one freely chooses to not use the DSP, the scheme may impose a co-payment.

14. However, where one must go to the non-DSP, the scheme may not impose a co-payment.

15. This means that there are exceptions to DSPs. These exceptions are called "involuntary visits to non-DSPs":
    - If the DSP was not available (e.g. one battles to get an appointment) or the service would not be provided without unreasonable delay (e.g. one must join a waiting list).
    - If you required immediate treatment (e.g. in the event that the illness must be managed in hospital) and where the circumstances or the place where this happens means that one cannot get to the DSP.
    - If the DSPs that the scheme has appointed, are too far from your home or work (e.g. you must travel far, or it is expensive, to get to the DSP).

16. It may seem that, although schemes must fund "in full" the PMBs, they have the power to limit the options and choices that patients have. In this regard regulation 8(5) is important, as it allows patients freedom of choice. The same as a patient can, at the payment of a co-pay, access even a non-DSP and exercise a free choice of a service provider (doctor, hospital, etc.), patients can also exercise choices in terms of treatment.

17. This part of the law allows patient to choose a medicine that is not on a scheme list. This may be where the patient wants to experience fewer side effects; have a specific preference for a specific product that they were on in the past; have other objectives, such as weight loss; or want to do fewer injections of medicine because of work or school obligations, and so on.

18. This is a free choice, and is not necessitated by medical reasons.

19. In this case, the patient can decline the medicine that the scheme says it will fund in full, and fund an alternative medicine. So, the patient declines a medicine that they would have been okay on, in favour of something that satisfies other needs. In this case, the scheme may impose a co-payment on the patient.

20. This co-payment, as is the case with all co-payments, must be reasonable. This means it must be "reasonable", i.e. it cannot be exorbitant, and should be close to the real difference in cost.

21. The opposite of the above is also true: if the scheme medicine is inappropriate for the patient (e.g. the medicine on the list cannot be taken by the patient due to specific circumstances, e.g. pregnancy), the patient should not co-pay to access appropriate care.

For access to the complete list of PMB conditions with associated ICD-10 codes, kindly visit the following link: https://www.medicalschemes.co.za/resources/pmb/pmb-conditions/

For access to the list of chronic conditions covered, kindly visit: https://www.medicalschemes.co.za/resources/pmb/ and click on ''Chronic Disease List''.

REGULATION 15 – PROVISION OF MANAGED HEALTH CARE

Introduction

1. A new set of regulations governing managed health care activities in South Africa took effect on 1 January 2003, by way of amendment to the general regulations1 made in terms of the Medical Schemes Act, 1998.

2. Over the years, the dental profession is experiencing extreme challenges due to health management policies that they feel are impeding the doctor-patient relationship. These policies risk ruining clinical dentistry, diminishing clinical autonomy and compromising patients' well-being.

3. There is a general mistrust and hostility towards managed care policies.

4. Managed care, within the South African context, typically includes one or a combination of consumer cost-sharing arrangements, preferred provider arrangements, reimbursement mechanisms, monitoring service utilisation, and the specification of benefits covered and level of those benefits. Managed care mechanisms differ in their stringency and design. Combinations of these mechanisms change constantly over time and vary significantly between managed care organisations (MCOs).

5. MCOs provide clinical and financial risk management solutions to medical schemes. The medical scheme may decide to conduct these clinical and financial risk management solutions in-house or contract to a third-party administrator (accredited as an MCO) and/or an independent MCO.

6. Administrators providing managed care services must receive separate MCO accreditation even if the administrator and MCO is the same entity. Medical schemes can contract with medical scheme administrators for the entire administration and managed care service or only for a partial range of these services.

7. Managed care services include hospital benefit management services, pharmacy benefit management services, active disease risk management services, disease risk management support services, dental benefit management services, managed care network services, and health care services (risk transfer).

Useful Definitions

"capitation agreement" means an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme;

"evidence-based medicine" means the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research;
"managed health care" means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes;
"managed health care organisation" means a person who has contracted with a medical scheme in terms of regulation 15A to provide a managed health care service;
"participating health care provider" means a health care provider who, by means of a contract directly between that provider and a medical scheme in terms of regulation 15A, or pursuant to an arrangement with a managed health care organisation which has contracted with a medical scheme in terms of regulation 15A, undertakes to provide a relevant health service to the beneficiaries of the medical scheme concerned;
"Protocol" means a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways;
"rules-based and clinical management-based programmes" means a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of, health care services, procedures or settings, on the basis of which appropriate managed health care interventions are made.

REGULATION 15A – PREREQUISITES FOR MANAGERIAL HEALTH CARE ARRANGEMENTS

15A. Prerequisites for managerial health care arrangements.—

(1) If a medical scheme provides benefits to its beneficiaries by means of a managed health care arrangement with another person—

(a) the terms of that arrangement must be clearly set out in a written contract between the parties;

(b) with effect from 1 January 2004, such arrangement must be with a person who has been granted accreditation as a managed health care organisation by the Council; and

(c) such arrangement must not absolve a medical scheme from its responsibility towards its members if any other party to the arrangement is in default with regard to the provision of any service in terms of such arrangement.

(2) To the extent that managed health care undertaken by the medical scheme itself or by a managed health care organisation results in a limitation on the rights or entitlements of beneficiaries, the medical scheme must furnish the Registrar with a document clearly stating such limitations, which document must be resubmitted to the Registrar within 30 days of any amendment to such limitations taking effect, including the relevant amendments.

(3) Limitations referred to in sub regulation (2) include, but are not limited to, restrictions on coverage of disease states, protocol requirements, and formulary inclusions or exclusions.

1. Where medical schemes require managed care services from third-party providers, Regulation 15A of the MSA requires that they enter into a formal contract with the Managed Care Companies (MCOs).
2. These contracts must clearly stipulate the managed health care arrangement and that such arrangement must not absolve a medical scheme from its responsibility towards its members.
3. Managed care companies must also be accredited by the Council for Medical Schemes as set out in Regulation 15B below.

REGULATION 15B – ACCREDITATION OF MANAGED HEALTH CARE ORGANISATIONS

15B. Accreditation of managed health care organisations.—

(1) Any person desiring to be accredited as a managed health care organisation must apply in writing to the Council.

(2) An application for accreditation as a managed health care organisation must be accompanied by—

(a) the full name and curriculum vitae of the person who is the head of the managed health care organisation's business;

(b) the home and business address and telephone numbers of the person referred to in paragraph (a);

(c) a copy of the proposed managed health care agreement or agreements between the managed health care organisation and the medical scheme or medical schemes concerned; and

(d) such information as the Council may deem necessary to satisfy it that such person—

(i) is fit and proper to provide managed health care services;

(ii) has the necessary resources, systems, skills and capacity to render the managed health care services which it wishes to provide; and

(iii) is financially sound.

(3) In considering an application for accreditation in terms of this regulation, the Council may take into consideration any other information regarding the applicant, derived from whatever source, if such information is disclosed to the applicant and she or he is given a reasonable opportunity to respond thereto.

(4) The Council must, after consideration of an application—

(a) if satisfied that an applicant meets the criteria listed in items (i), (ii) and (iii) of subregulation (2) (d), grant the application subject to any conditions that it may deem necessary; or

(b) if not so satisfied, refuse the application and provide reasons to the applicant for such refusal.

(5) If accreditation is granted by the Council in terms of sub regulation (4) (a), it shall be granted for twenty-four months, and shall be accompanied by a certificate from the Registrar clearly specifying the expiry date of the accreditation and any conditions imposed by the Council in terms of sub regulation (4) (a).

(6) The Council may at any time after the issue of a certificate of accreditation, on application by a managed health care organisation or on own initiative add, withdraw or amend any condition or restriction in respect of the accreditation, after having given the relevant managed health care organisation a reasonable opportunity to make submissions on the proposed addition, withdrawal or amendment and having considered those submissions, if the Council is satisfied that any such addition, withdrawal or amendment is justified and will not unfairly prejudice the interests of the clients of the managed health care organisation, and must in every such case issue an appropriately amended certificate to the managed health care organisation.

(7) A person wishing to renew accreditation as a managed health care organisation shall apply to the Council for such renewal in such format as the Council may from time to time determine, provided that—

(a) such application for renewal shall be made at least three months prior to the date of expiry of the accreditation; and

(b) such person shall furnish the Council with any information that the Council may require.

(8) The provisions of sub regulations (4) to (6) shall apply mutatis mutandis to an application for renewal of accreditation in terms of sub regulation (7).

1. Regulation 15B of the MSA set out the accreditation criteria.

2. An organisation applying for accreditation must submit to the CMS copies of agreements between itself and the medical scheme.

3. It must also submit information that the CMS may require to satisfy itself that:
   - It is fit and proper- e.g. there must be no conflict of interest with regards to its shareholding or management structure, it must be a company registered within South Africa, it must provide a certificate of good standing from the South African Revenue Services, etc. and in general conduct its business in a professional and ethical manner;
   - It has resources, system skills and capacity to render the managed healthcare services

- The organisation must be financially sound- i.e. it must be profitable, and its assets must be sufficient to meet its liabilities at all times.

4. All managed care organisations' financial soundness is assessed every two years with the accreditation renewal application. In addition, the financial soundness of all MCOs that offer capitation services is assessed every six months.

5. A total of 47 managed care organisations were accredited subject to various conditions.

15C. SUSPENSION OR WITHDRAWAL OF ACCREDITATION

15C. Suspension or withdrawal of accreditation.

(1) The Council may, subject to sub regulation (2), at any time suspend or withdraw any accreditation granted in terms of regulation 15B if the Council is satisfied on the basis of available information, that the relevant managed health care organisation—

(a) no longer meets the criteria contemplated in regulation 15B (2) (d);

(b) did not, when applying for accreditation, make a full disclosure of all relevant information to the Council, or furnished false or misleading information;'

(c) has, since the granting of such accreditation, contravened or failed to comply with any provision of this Act;

(d) has, since the granting of such accreditation, conducted his or her business in a manner that is seriously prejudicial to clients or the public interest;

(e) is financially unsound; or

(f) is disqualified from providing managed health care services in terms of any law.

2) (a) Before suspending or withdrawing any accreditation, the Council must inform the managed health care organisation concerned of—

(i) the intention to suspend or withdraw the accreditation and the grounds therefor;

(ii) in the case of suspension, the intended period therefor; and

(iii) any terms attached to the suspension or withdrawal, including such measures as the Council may determine for the protection of the interests of the clients of the managed health care organisation, and must give the managed health care organisation a reasonable opportunity to make a submission in response thereto.

(b) The Council must consider any such response, and may thereafter decide to withdraw or suspend or not to withdraw or suspend the accreditation, and must notify the managed health care organisation of the decision.

(c) Where the accreditation is suspended or withdrawn, the Council must make known the terms of the suspension or withdrawal or subsequent lifting thereof, by means of any appropriate public media announcement.

(3) During the period that the accreditation of a managed health care organisation has been suspended, such person may not apply for renewal of the accreditation or reapply for accreditation.

(4) On withdrawal of the accreditation of a person as a managed health care organisation, the Council may determine a reasonable period within which such person may not reapply for accreditation as a managed health care organisation, taking into account the nature of the circumstances giving rise to such withdrawal.

Regulation 15C of the MSA sets out the criteria for suspension or withdrawal of the MCO. The Council may at any time suspend or withdraw the accreditation granted to an MCO.

15D. STANDARDS FOR MANAGED HEALTH CARE

15D. Standards for managed health care.—

If any managed health care is undertaken by the medical scheme itself or by a managed health care organisation, the medical scheme must ensure that—

(a) a written protocol is in place (which forms part of any contract with a managed health care organisation) that describes all utilisation review activities, including a description of the following:

(i) procedures to evaluate the clinical necessity, appropriateness, efficiency and affordability of relevant health services, and to intervene where necessary, as well as the methods to inform beneficiaries and health care providers acting on their behalf, as well as the medical scheme trustees, of the outcome of these procedures;

(ii) data sources and clinical review criteria used in decision-making;

(iii) the process for conducting appeals of any decision which may adversely affect the entitlements of a beneficiary in terms of the rules of the medical scheme concerned;

(iv) mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

(v) data collection processes and analytical methods used in assessing utilisation and price of health care services;

(vi) provisions for ensuring confidentiality of clinical and proprietary information;

(vii) the organisational structure (e.g. ethics committee, managed health care review committees, quality assurance or other committee) that periodically assesses managed health care activities and reports to the medical scheme; and the staff position functionally responsible for day-to-day management of the relevant managed health care programmes;

(b) the managed health care programmes use documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of cost-effectiveness and affordability, and are evaluated periodically to ensure relevance for funding decisions;

(c) the managed health care programmes use transparent and verifiable criteria for any other decision-making factor affecting funding decisions and are evaluated periodically to ensure relevance for funding decisions;

(d) qualified health care professionals administer the managed health care programmes and oversee funding decisions, and that the appropriateness of such decisions are evaluated periodically by clinical peers;

(e) health care providers, any beneficiary of the relevant medical scheme or any member of the public are provided on demand with a document setting out—

(i) a clear and comprehensive description of the managed health care programmes and procedures; and

(ii) the procedures and timing limitations for appeal against utilisation review decisions adversely affecting the rights or entitlements of a beneficiary; and

(iii) any limitations on rights or entitlements of beneficiaries, including but not limited to restrictions on coverage of disease states; protocol requirements and formulary inclusions or exclusions.

1. Regulation 15D sets out standards for managed care services.

2. It places an obligation on the medical scheme to ensure that the MCO meets these standards.

3. The regulation requires the medical scheme to ensure, amongst other things, that:
   - A written protocol is in place that describes all utilisation review activities. Procedures to evaluate the clinical necessity, and affordability of relevant health services, and to intervene where necessary.
   - The protocol must also describe an organisational structure that periodically assesses managed health care activities and reports to the medical scheme.
   - The managed health care programmes use documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of

cost-effectiveness and affordability, and are evaluated periodically to ensure relevance for funding decisions.

15E. PROVISION OF HEALTH SERVICES

15E. Provision of health services.—

(1) If managed health care entails an agreement between the medical scheme or a managed health care organisation, on the one hand, and one or more participating health care providers, on the other—

(a) the medical scheme is not absolved from its responsibility towards its members if any other party is in default to provide any service in terms of such contract;

(b) no beneficiary may be held liable by the managed health care organisation or any participating health care provider for any sums owed in terms of the agreement;

(c) a participating health care provider may not be forbidden in any manner from informing patients of the care they require, including various treatment options, and whether in the health care provider's view, such care is consistent with medical necessity and medical appropriateness;

(d) such agreement with a participating health care provider, may not be terminated as a result of a participating health care provider—

(i) expressing disagreement with a decision to deny or limit benefits to a beneficiary; or

(ii) assisting the beneficiary to seek reconsideration of any such decision;

(e) if the medical scheme or the managed health care organisation, as the case may be, proposes to terminate such an agreement with a participating health care provider, the notice of termination must include the reasons for the proposed termination.

(2) A managed health care organisation or a medical scheme, as the case may be, may place limits on the number or categories of health care providers with whom it may contract to provide relevant health services, provided that—

(a) there is no unfair discrimination against providers on the basis of one or more arbitrary grounds, including race, religion, gender, marital status, age, ethnic or social origin or sexual orientation; and

(b) selection of participating health care providers is based upon a clearly defined and reasonable policy which furthers the objectives of affordability, cost-effectiveness, quality of care and member access to health services.

1. Even if the medical scheme appoints an MCO, it still remains responsible to the members of the scheme.

2. Members are not to be held liable for any amounts in terms of provider contracts. However, some MCO contracts with providers do permit them to charge for non-covered services and in some cases balance bill.

3. It is important to note that in terms of sub- regulations (c) and (d, providers cannot be prevented from informing their patients about the care they require including providing all treatment options which are necessary or appropriate.

4. Any agreement with an MCO cannot be terminated simply because the service provider disagrees with their decision to deny or limit services or assist their patients is getting the MCO to reconsider their decision.

5. Any termination of the provider contract must be subject to a proper notice period including providing the practitioner with reasons for the termination.

6. Practitioners in a particular area or region sometimes complain that the MCO refuses to sign them on as a preferred provider. The regulation above gives them the right to do so provided it is not based on some arbitrary discrimination grounds and that there must a rational decision for example, there are more than sufficient contracted provided in an area to service their members.

15F. CAPITATION AGREEMENTS

15F. Capitation agreements.—
A medical scheme shall not enter into a capitation agreement, unless—
(a) the agreement is in the interests of the members of the medical scheme;
(b) the agreement embodies a genuine transfer of risk from the medical scheme to the managed health care organisation;
(c) the capitated payment is reasonably commensurate with the extent of the risk transfer.

1. The only risk transfer arrangement that is accommodated in the MSA is capitation.

2. The MSA defines a capitation agreement as "an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme". ".

3. It literally means "per head". Payment does not occur as the result of a service being rendered but rather, it is the prepayment for services usually on a per-member, per-month basis. A provider is therefore paid the same amount of money every month for a member regardless of whether that member receives services or not, and regardless of the cost of those services.

4. So, the scheme would pay an average amount per head, for all diabetic patients, irrespective of what that patient actually costs. So, if a patient has complex diabetes, the amount may be too little, but if the patient is easy to treat, the amount may be more than what is required to treat the patient.

5. If the cost of providing care exceeds the fixed payment, the provider makes a loss. The fixed payment thus creates an incentive for providers to take more efficient treatment decisions. Efficient treatment decisions are likely to result in lower cost which is the primary objective of managed care.

6. The MSA further states that a medical scheme shall not enter into a capitation agreement unless:
   a) the agreement is in the interests of the members of the medical scheme;

b) the agreement embodies a genuine transfer of risk from the medical scheme to the managed care organisation
c) the capitated payment is reasonably commensurate with the extent of the risk transfer.

7. The MSA does not explain what ought to be regarded as a genuine transfer of risk in a capitation agreement nor does it give guidance on how one should assess if a capitated payment is reasonably commensurate with the extent of the risk transfer.

8. Capitated budgets are usually awarded to primary care facilities that serve formally registered enrollees or residents in their geographical area. These facilities usually fulfil a gatekeeper function in the healthcare system. It is relatively data-intensive to calculate the capitation rate that these facilities receive. Capitation payments are output-based because the payment is not linked to the inputs used or the volume of services provided. Most of the risk is therefore shifted from the purchaser to the provider, since the provider is liable for costs that are greater than the per capita budget.

9. If there are efficiency gains are achieved and costs are lower than the capitation fee, the provider can keep and reinvest the surplus. Capitation therefore aims to increase coordination and decrease inefficiency in provision.

10. The risk-sharing arrangement is used to control costs, since providers become concerned with the coordination of dental services, providing care in the least costly manner, increasing doctor productivity, prescribing less costly drugs and being innovative in-service delivery. In practice however, capitation alone does not cause doctors to better coordinate care.

11. Unlike in a Fee for Service (FFS) model, preventative care is encouraged in capitation models to the extent that it can reduce future medical costs and there is a strong incentive to innovate to reduce costs, improve outcomes and increase patient satisfaction.

12. This is an important point since patients can usually move to, or register with, another doctor if they are unhappy – in such a case the capitation fee follows them by being allocated to the new doctor.

13. There is also a financial incentive to decrease patient access and to reduce the use of services or refer the patient to a specialist, since spending fewer resources means higher profits. Once a patient is registered at a facility, the marginal revenue for an additional service is zero, while marginal resource costs are positive.

14. Although capitation is one of the favoured future health reforms for SA at the PHC level, it is not widely used at present.

15. Such a model requires tight administrative control and in-depth data on patients' health profiles, as well as other demographic information. The administration of such a system could be overly burdensome for both the doctors and funders. Changes in choice of doctor, for instance, have to be carefully monitored and efficiently administered since

each doctor should receive the exact amount related to the number of patients registered with him/ her in advance of such treatment.

16. Capitation arrangements can also be especially problematic for solo dental practices by introducing major variability. For instance, a number of high-risk patients could visit the doctor so often that the capitation fee is not sufficient. Capitation payments also need to be risk-adjusted for different patient profiles (such as for older patients or those with chronic diseases who visit a doctor more often and need more medication – including monthly chronic medication) and geographical factors (such as for patients living in areas where specific diseases, deficiencies and other known factors are more prevalent than elsewhere).

17. The decisions on how to treat the range of patients, then is up to the doctor, who then undertakes the assessment as to what would be possible for each patient.

18. However, if this is done, regulation 15F sets the following criteria for these capitated contracts namely:
    - It must be in the interests of the members of the medical scheme;
    - There must be a "genuine transfer of risk" from the scheme to providers, which means they must truly empower the provider to make the decisions on appropriateness per patient and to take the risk of more complicated patients; and
    - The capitated payment must be "reasonably commensurate with the extent of the risk transfer", which means it must be certain that, overall, the doctor is able to appropriately treat all patients, even if s/he has more complicated patients than someone else to manage.

15G. LIMITATION ON DISEASE COVERAGE

15G. Limitation on disease coverage.—
If managed health care entails limiting coverage of specific diseases—
(a) such limitations or a restricted list of diseases must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
(b) the medical scheme and the managed health care organisation must provide such limitation or restricted list to health care providers, beneficiaries and members of the public, upon request.

Any restrictions imposed by MCOs on coverage must be evidence-based and take into account affordability.

15H. PROTOCOLS

15H. Protocols.—
If managed health care entails the use of a protocol—
(a) such protocol must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;

(b) the medical scheme and the managed health care organisation must provide such protocol to health care providers, beneficiaries and members of the public, upon request; and

(c) provision must be made for appropriate exceptions where a protocol has been ineffective or causes or would cause harm to a beneficiary, without penalty to that beneficiary

1. Treatment protocols are a set of guidelines in relation to the optimal sequence of diagnostic testing and treatment for specific conditions". Treatment protocols can therefore be seen as an addition to guidelines in which treatment methods can be stipulated. It is not a set of rules that dictate how treatment must be carried out but rather how it should not be carried out.

2. Most medical schemes provide services in the form of a basket of care that lists all the services included in the protocol, for example, the number of annual consultations allowed at a specialist.

3. It is important to be aware that the protocols are based on the services necessary to manage members with stable conditions.

4. The Council for Medical Schemes dictates that ''all managed care protocols be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability". This means that even if there is scientific evidence for the validity of a specific treatment, it may not be cost-effective, affordable or appropriate to prescribe in the South African environment. In addition, if a member voluntarily chooses to use a different treatment protocol the scheme may charge a co-payment.

5. Evidence-based medicine (EBM) is defined in the law as considering, in an honest and ethical way, what's the current best ways of treating patients with a certain condition.

6. It then also considers the individual circumstances of the patient and the doctor's experience in managing such diseases. Then one must also consider what research says, i.e. clinical research on patients, treatments and various products. This includes considerations that may come to light during a clinical trial, e.g. that patients with certain other conditions cannot take a specific medicine, or that in some groups, the medicine has a bad reaction.

15I. FORMULARIES

15I. Formularies.—

If managed health care entails the use of a formulary or restricted list of drugs—

(a) such formulary or restricted list must be developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability;

(b) the medical scheme and the managed health care organisation must provide such formulary or restricted list to health care providers, beneficiaries and members of the public, upon request; and

(c) provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary.

1. "Formulary" refers to a list of drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable medical practitioners, dentists and, as appropriate, other practitioners, to prescribe all medically appropriate treatment for all reasonably common illnesses. In some health plans, providers are limited to prescribing only drugs listed on the plan's formulary.

2. It is a means of restricting the dentists' choice of the drug they want to prescribe and rather forces them into prescribing cheaper alternative drugs and revising their prescription behaviour.

3. Drug formularies may also have the undesired consequence of resulting in poor health outcomes as drugs are excluded on the basis of cost and not effectiveness. Thus patients are not able to make an out-of-pocket purchase of the effective drug resulting in poorer health outcomes.

4. Schemes may have a formulary (i.e. a list of medicine they will pay for). Some schemes also have medicines exclusion lists in place, i.e. a list of medication they will not pay for at all. In other cases, limits are placed on the total cost of medicines that will be funded for certain types of illnesses. For example, acute medicine (i.e. medicine for day-to-day health needs that may occur such as flu or ointment for an eye infection), will be paid for, but only up to a limited amount.

5. The doctor should discuss various treatment options with a patient. The patient may then decide to opt for a medicine that is not on the formulary. If the patient would have done fine on the formulary medicine, the scheme must pay the amount that it would have paid for the medicine on the list. The patient has to co-pay approximately the difference in price between the list-medicine and the medicine of choice.

6. One would assume, because managed care is about managing cost, that the law would say these must be set on price. However, healthcare is more complex than just what is cheap or expensive. It is about:
   a) What is, in healthcare terms, appropriate for a patient; and
   b) To cater for cases where not all patients are equally well, or well at all, on the same medicine.

7. In terms of what is appropriate for a patient, the medical scheme must set its medicine lists and treatment protocols based on evidence-based medicine (EBM).

8. Medicines for PMB treatments on all options have to be funded in full, unless the scheme has a formulary in which case they will only pay for the medicine on the list / formulary.

9. What about "in the interest of the patient's health" so, to cater for the patients who are not well on the medicines on the list, the law, in Regulations 15H(1)(c) of the General Medical Schemes Regulations, states that the scheme must deviate from their medicine list, in the interest of the patient's health, under the following situations:

- Where the medication that the scheme is willing to pay for, did not work for the patient (this is called "treatment failure"). In diabetes, this can be proven by showing that the medicine is not bringing one's blood glucose levels within the right range.
- Where the scheme-recommended treatment causes, or would cause an adverse reaction. This means that the patient has experienced a side effect on the medicine on the list, or that we know, often from research and experience, that certain patients will experience a side effect.

10. If the above cases are proven, the scheme must, by law, fund an appropriate alternative medicine, even if that medicine is not on their list, without a co-payment.

11. The same principles that apply to medicines lists or formularies, also apply to treatment protocols (regulation 15H(1)(c)). Where the patient is not well on the treatment as set out step-by-step, the scheme must pay for a deviation from the protocol. This is also in cases where the step-by-step approach is not working for the patient and his/her condition is not getting better (i.e. "treatment failure") or where following those steps would cause, or have already caused, the patient to suffer harm.

15J. GENERAL PROVISIONS

15J. General provisions.—

(1) Any managed health care contract, contemplated in Regulation 15A, must require either party to give at least 90 days' notice before terminating the contract, except in cases of material breach of the provisions of the contract, or where the availability or quality of health care rendered to beneficiaries of a medical scheme is likely to be compromised by the continuation of the contract.

(2) Notwithstanding anything to the contrary in these regulations—

(a) a medical scheme and a managed health care organisation may not use any incentive that directly or indirectly compensates or rewards any person for ordering, providing, recommending or approving relevant health services that are medically inappropriate;

(b) any information pertaining to the diagnosis, treatment or health of any beneficiary of a medical scheme must be treated as confidential;

(c) subject to the provisions of any other legislation, a medical scheme is entitled to access any treatment record held by a managed health care organisation or health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but such information may not be disclosed to any other person without the express consent of the beneficiary;

(d) where provision is made by a managed care provider for complaints or appeals procedures or mechanisms, such provision shall in no way impact upon the entitlement of a beneficiary to—

(i) complain to, or lodge a dispute with, his or her medical scheme;

(ii) lodge a complaint with Council; or

(iii) take any other legal action to which he or she would ordinarily be entitled.

Managed Care Contracts

1. Medical scheme members may be restricted to obtain their healthcare services from a network of providers. In South Africa, these networks are referred to as Preferred Provider Networks (PPNs) or Designated Service Providers (DSPs) where PMBs are concerned (importantly, PPNs encompass DSPs).

2. A PPN is where the scheme contracts with different providers to obtain services for its members. Members are entitled to visit any provider within the network. If the member joins a benefit option that makes use of a PPN, a visit to a provider outside of the PPN may result in the member having to cover the cost of the service themselves or the scheme may only pay as much as it would have cost to make use of the PPN the member will have to pay the difference.

3. If the scheme expects the member or beneficiary to use a PPN, it must inform them, and the rules of the scheme must also state which service providers are the `preferred' ones, and what the scheme will or won't pay if they use a provider other than the `preferred' one.

4. PPNs were established with the aim of reducing the cost of healthcare, through negotiating volume discounts from the providers or by securing agreements with providers to practice cost-effective dentistry.

5. They will use various tools including Utilisation management involving pre-authorisation of non-emergency admissions, anticipated expensive treatment plans, expensive treatments and prolonged and or expensive admissions.

6. Schemes will sometimes rely on Regulation 15 (2)(c) for access to patient files and notes from providers and the onus is on the provider to seek the necessary consent. The Panel found that this was wrong. This regulation is designed for a managed healthcare function so that they may request these records subject to a PPN contract.

References:

Medical Schemes Act, 131 of 1998
Regulations under Medical Schemes Act, 1998
Section 59 Investigation – Interim Report - INQUIRY INTO ALLEGATIONS OF UNFAIR RACIAL DISCRIMINATION AND PROCEDURAL UNFAIRNESS BY MEDICAL SCHEMES, 19 January 2021