STRATEGIC RESPONSE TO THE COVID-19 PANDEMIC FOR PRIVATE MEDICAL PRACTICES

THIS MEMORANDUM HAS BEEN PREPARED FOR THE

PROGRESSIVE HEALTH FORUM

This memorandum reflects the outcome of discussions amongst civil society, private medical practitioners and medical scheme representatives

20 JUNE 2020

1. PURPOSE

This memorandum has been drafted to communicate a holistic response to the COVID-19 pandemic for private medical practices in South Africa as an outcome of civil society engagement through the Progressive Health Forum (PHF) with segments of the health industry.

2. THIS MEMORANDUM

The outcomes of various deliberations concerning the COVID-19 pandemic and its implications for private medical practices are reflected in this memorandum.

These deliberations had as their origin the recognition that complex problems had arisen within the health sector as a consequence of the pandemic which required careful technical deliberation to produce a holistic response.

It is hoped that this memorandum can form the basis of an agreement between medical schemes and medical practices to maintain the resilience of the private health system during a period of great uncertainty due to the COVID-19 pandemic. It is expected that this uncertainty will continue from 2020 well into 2021.

This memorandum reflects a non-binding framework proposal developed as a potential technical proposal by the PHF to support stability in the country and the health system during the COVID-19 pandemic.

The contents of the memorandum have been extensively discussed and evaluated with a wide range of stakeholders with a substantial presence in the health system to assess the framework's feasibility and likely acceptance as a structural solution to an extended period of crisis faced by private practices.

The stakeholders include:

- First, the associations representing the bulk of medical practitioners in South Africa.
- Second, the three major medical scheme administrators.
- Third, selected corporate banks.

While not constitutive of all elements of the private health system, these stakeholders were able to comment with authority on the technical features of the proposals developed.

Ultimately, the usefulness of this proposed framework will depend on the value individual medical practices and medical schemes recognize in practice. Realising this value will be up to the various parties themselves, and reflected finally in negotiated contracts.

3. CONTEXT

The COVID-19 pandemic has both direct and indirect effects on the health system as a whole, as well as the rest of society. When considering the health system only, COVID-19 has caused a simultaneous increase and decrease in demand for health services. The former arises where the disease results in severe morbidity. The latter, where patients are too fearful to come to health services for normal treatment due to the fear of infection from SARS-COV-2 and/or where health services are closed due to COVID-19 infections.

The public sector demand increase for COVID-19 also runs up against the reduced availability for critical care beds, while the private sector has significant available capacity. The reduced demand for important treatments for non-communicable diseases in the public sector together with breaks in treatment for HIV and TB also raise serious concerns about the indirect implications for the burden of disease for households who depend on the public sector for key services.

In the private sector the reduced demand for services also raise concerns about the deferred treatment for non-communicable diseases. However, unlike the public sector, which is tax-funded, private medical practices face significantly reduced revenue due to the decline in demand. As many medical practices have staff and overhead costs, this drop in demand could result in the closure of practices that would otherwise have remained viable.

The public sector response has also been compromised by the implementation of the lockdown in March 2020, which indirectly undermined government tax revenues through closing down much of the economy. This has reduced the financial capability of government to properly finance a response that fully engages both the public and private health systems.

4. UNDERSTANDING THE PROBLEM

Focusing on the role of private medical practices, concerns for the health system can be summarized into four inter-dependencies:

First, reduced public sector finances affect the ability of the public sector to contract for private sector COVID-related services – undermining a unified response.

Second, increased financial distress of private medical practices impacts on their ability to support public sector patients while the maintenance of these practices remain precarious.

Third, the deferment of normal healthcare treatment will require a restored healthcare system as the COVID crisis tapers off, creating a medium-term problem that must be addressed with a functioning and resilient health system.

Fourth, the expected demand for critical care services for public and private COVID patients is immediate, urgent and cannot be postponed, but is compromised by the distressed position of the public and private health systems.

As an outcome of deliberations, it appears that the most effective holistic response requires that the first, second and third concern be addressed simultaneously as part of a holistic response. Adopting this approach will ensure that the health system remains sufficiently intact to address the third consideration, which is the deferred burden of disease which is likely to impact mainly in 2021.

5. DE-STRESSING PRIVATE MEDICAL PRACTICES

5.1 Contractual rigidities

Private medical practices are presently in a state of distress largely due to a technical anomaly in how they are funded. While the budget for medical practices is effectively allocated to medical schemes (ex ante), the funding is only triggered when a service is rendered (ex post). Essentially this is a contractual rigidity which has unforeseen and undesirable consequences within the current exceptional set of circumstances.

It is worth noting that medical schemes also face considerable uncertainty over the period 2020 and 2021. While they may accrue initial surpluses due to the

reduced demand, it is not unreasonable to expect resurgent demand to run down these surpluses in due course. When this resurgence is combined with private demand for COVID-19 treatment, much of which will involve critical care, surpluses may become deficits.

Addressing a *contractual rigidity* requires little more than the mutually agreed introduction of *flexibility*. If achieved, medical practices would be in a strong position to support public sector efforts to manage the COVID-19 crisis. No financing is required from the public sector as the funds already reside in the private funding pools – which if not spent, will accrue as temporary surpluses – which may however translate ultimately into underwriting losses.

The framework proposed here involves converting pure fee-for-service contracts into a partial capitation arrangement combined with a fee-for-service element. Through this restructuring part of the contract will involve a combination of prospective[1] and retrospective payments related to medical scheme benefits.

5.2 Proposed de-stressing arrangement for 2020 and 2021

To address the contractual rigidities it is proposed that a framework comprising ten features be considered to smooth the financing of medical practices and medical schemes until such time as normality is restored to the country. However, the period of disruption is expected to be quite protracted and likely to take upward of two years to realise.

First, it is proposed that the reimbursement of medical practices be converted from full fee-for-service into a combination of capitation fee component (i.e. a negotiated fixed fee) offset against actual claims, (referred to as the capitation fee), equivalent to 70% of historical experience, and fee-for-service for the remaining 30% of historical claims (referred to as the risk fee).

- The 70% is seen as a measure to core fund the basic overhead costs of practices. The percentage is chosen at a level that seems reasonable to accommodate a wide range of practice types and sizes.

[1] The prospective nature of the payment regime may nevertheless deviate little from existing fee-for-service arrangements.

- The value of 30% is regarded as sufficient to accommodate variable costs associated with patient activities where these activities exceed 70% of historical claims experience.

Second, overall reimbursement would be capped (referred to as the global cap) at 100% of the 2019 activity experience (referred to as the base year), made up of benefit claims from both risk and savings benefits, by medical practice, multiplied by the relevant tariff agreements reached for 2020 and 2021. The global cap could be adjusted for declines in beneficiaries covered (due to the COVID-19 economic decline). For any within-year reconciliation, this adjustment should be applied to the risk fee portion rather than the cap fee. The cap fee would logically be adjusted if the contribution revenue[2] decline exceeds 30% on an annualised basis.

Third, the global cap would apply to the full year (i.e. it would not be applied on a month-by-month basis). In 2020 the cap can be designed to apply to the period from 1 April to 31 December as the first three months could be considered normal. For 2021 the global cap would logically apply to the full twelve months.

Fourth, capitation payment, equivalent to 70% of demand in the base year, would be allocated as a fixed fee advance payment in anticipation of the delivery of benefits to medical scheme members. This is consistent with the definition of a capitation agreement contained in **regulation 15** to the Medical Schemes Act.

Fifth, the risk fee (i.e. the residual 30%) would be paid out for all claims in excess of the capitation fee. Medical practices would continue to submit claims as with normal fee-for-service. These claims would be offset against the capitation fees paid, with any residual claims paid out until the annual global cap is reached.

Sixth, while the arrangement works best with risk benefits, it is envisaged that medical, dental and related practices that derive their revenue substantially from medical savings accounts, would also be supported through this

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[2] Contribution revenue is a more appropriate measure as membership or beneficiary declines may not be proportional to revenue declines.

framework. Where appropriate, the capitation fee will be recouped from a member's medical savings account when a claim is submitted.

Seventh, medical practices must continue to provide services to members despite the capitation fee. Service level agreements need to be considered by medical schemes to address this requirement.

Eighth, as a measure to protect the public, balance billing arrangements should not be adjusted by medical practices to offset the global cap.

Ninth, it would make sense for the annual tariff increases into 2021 to involve a neutral adjustment, and be fixed at the consumer price index. This would minimize any need for real medical scheme contribution increases into 2021 due to the condition of the economy. While a conservative increase, it is suggested as a measure to manage uncertainty for members, funders and medical practices. It is expected that this approach also be reflected in medical scheme contribution increases.

Tenth, for the framework to work for all, participation should be near universal for all medical practices. As all medical practices achieve a high degree of financial certainty out of this framework it is hoped that near complete participation will occur. It is unlikely that medical schemes will support the framework if there is a significant opt out of the agreement.

5.3 Effects of the framework

The de-stressing framework has as its foremost outcome the achievement of *certainty* for medical practitioners and medical schemes. The framework however *does not underwrite losses* associated with any implied contingency.

Instead it smooths medical practice revenues over part (2020) or all (2021) of a year on the reasonable assumption that demand reductions in some months will be offset by demand increases in subsequent months.

Were a practice to cease operating for any reason during the relevant years, the capitation fee would end for that practice.

The smoothing occurs only through the 70% capitation fee, and is set at a level sufficiently close to average minimum fee-for-service billing (during COVID-19) so as to ensure that the payment does not take the form of a grant.

The agreement also involves important managed care risk-transfers.

- First, medical practices accept the risk: that they will not be reimbursed for any activities that exceed their 2019 experience and that where required, services continue regardless; that they will be required to provide services sufficient to justify the 70% capitation fee; and that they will face reduced payments where there is a reduction in medical scheme membership.
- Second, medical schemes carry the risk of all payments up to the 100% global cap and any activity shortfalls in respect of the 70% capitation fee.

The contingencies implicitly protected through this framework are:

First, medical practitioners are guaranteed minimum revenue for 2020 and 2021, with the opportunity to earn at least to levels consistent with 2019. The following contingencies are therefore implicitly covered through this approach:

- *Temporary demand reductions due to lockdowns*.
- *Temporary demand reductions due to* patients fearful of approaching medical practices or facilities.
- *Temporary practice closures due to COVID-19 infections* of practice members and/or staff.
- *Periods of temporary service stoppage* due to the closure of any facility or facilities associated with the medical practice due to COVID-19 infections.

Second, medical schemes are insulated against any deferred demand surge in 2020 and 2021 and any COVID-related demand surge affecting medical scheme beneficiaries in 2020.

Third, medical schemes are insulated against contribution revenue declines.

Fourth, the de-stressed private health system is in a position to support and even cross-subsidise public COVID-19 patients when and where required. Noting that it will be the medical practices themselves that cross-subsidise the public sector and not medical schemes.

Fifth, no exemptions are required in terms of the Medical Schemes Act as all arrangements fall within the discretion of the contracting parties.

The above provides an over-arching framework which would require direct negotiations between the parties to resolve finer details. These would include:

- Administrative considerations;

- Resolving discrepancies that may arise between practice sizes and types; and
- Resolving discrepancies between pre-existing contractual arrangements and the framework.

6. ARE THERE REQUIREMENTS FOR GOVERNMENT APPROVAL?

The proposed framework involves a standard re-negotiation of existing fee-for-service payments. The introduction of the 70% capitation fee is consistent with the provisions of the Medical Schemes Act in terms of the following sections:

First, it falls within the definition of the "business of a medical scheme" (section 1) as it involves making provision for the rendering of a relevant health service (as defined).

> "…*rendering a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme*."

Second, the proposed "advance" payment is in respect of services to be rendered over an extended period - nine months for 2020 and 12 months for 2021. This is consistent with section 24(4) which requires that:

> "*No amount shall be debited to the account contemplated in subsection 1(c) other than-*
>
> *(a) payments by a medical scheme of any benefit, payable under the rules of a medical scheme;*
>
> *(b) costs incurred by the medical scheme in the carrying on of the business as a medical scheme; or*
>
> *(c) amounts invested by the board of trustees in accordance with section 35 (7).*"

The capitation fee falls within both (a) and (b) above, as these payments are in respect of benefits payable in terms of scheme rules and are costs incurred in carrying out the business of a medical scheme.

A capitation fee, which is paid prospectively to medical providers is defined in regulation 15 to the Medical Schemes Act and states:

““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…”

A capitation fee is a pre-negotiated fee paid out as a fixed amount without regard to the actual number or nature of services provided to each payment. Such agreements are used to share demand-related risks between health insurers and medical providers. Internationally many agreements mix capitation, fee-for-service and global caps, as proposed in this framework.

As there is a risk of under-servicing with capitation agreements, it makes sense for medical schemes to include caveats in their contracts to address this contingency. This is also well-understood internationally.

7. CONCLUSION

The framework discussed in this memorandum is aimed principally at a particular inter-related set of proposals that are technical in nature. It is well understood that there are many important COVID-related considerations that are not raised in this memorandum. The narrow emphasis should be seen as focused on resolving a particular set of problems holistically that make it easier to address wider concerns.

If this framework is adopted, the private health system will retain a degree of resilience that will enable it to support government in addressing the COVID-related crises. Members, schemes and medical practices will face reduced uncertainty over the periods of greatest risk. A platform will also have been established that will enable productive engagements on the future of the health system and agreements into 2022.