Discovery

PHARMACY NETWORK GUIDE

DISCOVERY HEALTH

2022

Contents

Overview

The medical scheme's challenge

Rising healthcare costs place severe pressure on healthcare systems and governments globally. In South Africa, medical schemes rely on the surpluses generated by healthy scheme members to fund the cost of treatment for unhealthy scheme members. These cross-subsidies must be managed and balanced carefully to ensure all medical scheme members enjoy cover when they need it most, while ensuring that medical scheme contributions remain affordable.

The current medical scheme regulatory environment is based on open enrolment and community rating, which means that medical schemes must accept all applicants regardless of age and health status. South Africa is unique in that medical scheme membership is voluntary, resulting in adverse selection where people join a medical scheme when they believe they will need it, or they join lower-cost options and 'buy up' to more comprehensive options when they get sick.

Medicine inflation together with demographic trends, such as an ageing insured population and a rapidly increasing chronic, cancer and lifestyle disease burden, drive increased demand for healthcare services. For Discovery Health, as an administrator of medical schemes, managing these cost drivers is vitally important to maintain the balance between quality, access and affordability of healthcare and requires rigorous efforts and collaboration between all stakeholders.

With this in mind, we continually develop initiatives to manage medicine cost to ensure it remains affordable for our members and the schemes, and to ensure the sustainability of the healthcare industry. Performance Based Remuneration and MedXpress, including MedXpress network pharmacies, are two such initiatives.

About some of the terms we use in this document

There may be some terms we refer to in the document that you may not be familiar with. Here are the meanings of these terms.

TERMINOLOGY	DESCRIPTION
Chronic Illness Benefit (CIB) claim	The Chronic Illness Benefit (CIB) covers members for a defined list of chronic conditions. Discovery Health Medical Scheme covers claims for treatment, including medicine for conditions on the Chronic Disease List (CDL) according to the Prescribed Minimum Benefit (PMB) treatment algorithms for all plans. It excludes claims paid from other benefit limits, such as oncology, although these conditions form part of chronic illnesses.
Chronic formulary (medicine list)	A list of medicines covered in full in accordance with the Council for Medical Schemes Prescribed Minimum Benefit (PMB) treatment guidelines pertaining to the Chronic Disease List for the treatment of approved chronic conditions. The formularies differ between the different Discovery Health Medical Scheme plans: - Comprehensive formulary for Executive and Comprehensive plans - Core formulary for Core, Priority and Saver plans - KeyCare formulary for KeyCare plans
Performance Based Remuneration (PBR) formulary	A subset of preferentially priced, generic medicine that is on the chronic formulary. Performance Based Remuneration incentivises compliance to the best-priced formulary generics. It integrates inflationary dispensing fee income with optimised performance.
PBR formulary item	The trade name of the formulary-listed medicine which includes the product name, strength and dosage formulation where listed on the formulary. The formulary item is linked to the approved Chronic Illness Benefit (CIB) condition. PBR formulary items attract the higher PBR dispensing fee.
PBR benchmark item	Any generic equivalent with the same active ingredient, strength, dosage formulation and the same clinical indication as the formulary product where the unit single exit price (SEP) is equal to or lower than the benchmark unit price. These are flagged along with formulary items for easy identification on dispensing. Benchmark items attract the higher PBR dispensing fee.
Benchmark price	The selected unit price published in the PBR formulary and benchmark document, to which the single exit price (SEP) of all generic equivalent items on the formulary are compared. Generic equivalents are required to be lower or equal to the PBR-benchmark unit price. The latest list is available on our website at www.discovery.co.za.
Non-benchmark item	Any generic equivalent to a formulary product with the same active ingredients, strength and dosage formulation and the same clinical indication as the formulary medicine, where the unit single exit price (SEP) exceeds the formulary benchmark unit price. Non-benchmark items attract the lower PBR dispensing fee.

TERMINOLOGY	DESCRIPTION
Non-formulary items	Products that treat the same chronic conditions (listed on the PMB Chronic Disease List) than the formulary item and are paid from Chronic Illness Benefits but have different active ingredients (molecules) to the formulary medicine. The monthly Chronic Drug Amount (CDA) applies to these therapeutic equivalents. Members will have a co-payment where the price of their prescribed non-formulary item exceeds the monthly CDA applied per medicine class and plan type. This group of therapeutic equivalents can be divided into two groups. If: - No generically substitutable items are available – the standard dispensing fee will apply as these items are excluded from Performance Based Remuneration (PBR). - Generically substitutable items are available – the lowest-priced generic equivalents will continue to attract the standard Discovery Health dispensing fee, as these are excluded from PBR. Higher priced items, attract the lower PBR dispensing fee.
Chronic formulary compliance	A pharmacy's performance is measured as a percentage of formulary items and formulary benchmark price compliant items dispensed out of all the generically substitutable claims paid from chronic benefits for applicable plans. For MedXpress DSP network participation, we measure and report performance monthly by looking at chronic medicine claims for all Discovery Health Medical Scheme plans (excluding KeyCare) paid over a rolling six-month period.
Generic equivalent	Medicine that is registered with the South African Health Products Regulatory Authority based on bioequivalence, safety, efficacy and quality. Generic equivalents contain the same active ingredient, with the same strength and the same formulation as the original brand product. The recommendation to use best-priced generics is a safe, and affordable recommendation aimed to assist consumers.
Compliance with the HIV ARV formulary	The percentage of ARV formulary items and ARV benchmark items that were dispensed out of all generically substitutable ARV claims paid from HIV benefits for the various schemes as communicated on the monthly report. We measure and report performance monthly by looking at ARV claims paid over a rolling six-month period.
Oncology preferred product list compliance	The percentage of oncology supportive preferred products and their benchmark items that were dispensed out of all generically substitutable claims paid from oncology benefits for members of Discovery Health Medical Scheme. We measure and report performance monthly by looking at oncology claims paid over a rolling six-month period.
Performance Based Remuneration (PBR)	A voluntarily programme designed to provide additional remuneration to pharmacists for adhering to Discovery Health Medical Scheme formularies. Performance Based Remuneration (PBR) only applies to claims paid from the Chronic Illness Benefit. Chronic Illness Benefit claims have been pre-authorised according to the Prescribed Minimum Benefit (PMB) treatment guidelines for conditions on the Chronic Disease List (CDL), taking PBR exclusions into consideration. PBR exclusions are claims paid from: - Plan types: KeyCare and Delta plans - Benefit pools other than those for chronic medicine claims, such as oncology, HIV and acute benefits - Non-SEP (single exit price) claims – surgical unregistered and schedule 0 items - MedXpress direct orders and courier pharmacies
Compliance with the oncology preferred product list	The percentage of oncology-support preferred products and their benchmark items that were dispensed out of all generically substitutable claims paid from oncology benefits for members of Discovery Health Medical Scheme. We measure and report performance monthly by looking back at oncology claims paid over a rolling six-month period.

Discovery Health pharmacy networks

The Medical Schemes Act governs our professional practice and allows for the use of designated service providers (DSPs) to ensure that quality healthcare is accessible and affordable for members of medical schemes in South Africa.

Members have a choice in how they want to receive their medicine

Discovery MedXpress facilitates digital orders has two available options for members to order their chronic medicine:

Discovery MedXpress digital order and delivery service

Discovery MedXpress is a convenient, online ordering, tracking and delivery service available to all Discovery Health Medical Scheme members with a valid prescription. Through Discovery MedXpress, members can re-order chronic medicine through several self-service methods, including on the Discovery website and the Discovery app as well as through SMS.

Discovery MedXpress is administered by Discovery Health and services a small subset of the total chronic illness member base. Discovery MedXpress routes orders to a MedXpress partner pharmacy. These independently owned, registered pharmacies assume all the clinical responsibility in dispensing and handling the prescriptions.

Discovery MedXpress, a cost centre operated and managed by Discovery Health, facilitates order requests from members through to system integrated MedXpress partner pharmacies. Members can also choose to pick up a ready-to-collect parcel at a MedXpress partner pharmacy, or have medicine delivered to them anywhere in South Africa at no cost to them. MedXpress partner pharmacies are required to meet all professional and legal requirements as well as meet the formulary-compliance benchmarks and targets.

MedXpress network pharmacies

To afford retail and community pharmacies equal opportunities, we created the MedXpress Pharmacy Network.

MedXpress network pharmacies are the designated service provider (DSP) for all approved, chronic medicine for Discovery Health Medical Scheme members on the Delta, Priority, Saver and Core plans. This means that members on one of these plans must use a MedXpress network pharmacy, to avoid a 20% co-payment on their approved, chronic medicine. Pharmacies can participate in the network by reaching MedXpress formulary compliance criteria.

This means that the pharmacy will not attract a 20% non-DSP co-payment on chronic medicines for members who use MedXpress as their designated service provider. Only contracted Discovery Health network pharmacies, charging the agreed Discovery Health tariffs and who meet the MedXpress formulary-compliance criteria, are eligible to participate in the MedXpress Pharmacy Network. Pharmacy contracts that charge rates over and above the agreed Discovery Health Rate will be terminated.

How members benefit from using network pharmacies

MedXpress benefits members by reducing co-payments and benefits the schemes through additional savings afforded by a high generic substitution rate. If a Discovery Health Medical Scheme member chooses to use a pharmacy outside of the MedXpress Pharmacy Network, they may be liable for a 20% co-payment on their chronic medicine. If a Discovery Health Medical Scheme member chooses to use a pharmacy outside of the HIV DSP pharmacy network, they may be liable for a 20% co-payment on their non-formulary ARV medicine. The levying of such a co-payment in these circumstances is set out in Regulation 8(2) issued in terms of the Medical Schemes Act.

MedXpress Pharmacy Network

Participation in the MedXpress Pharmacy Network is open to all contracted network pharmacies that meet the participation criteria. The participation criteria are based on pharmacies' compliance with Discovery Health Medical Scheme's formulary. We monitor and report back monthly to pharmacies on their formulary compliance. We review pharmacies' performance on a four-monthly basis for network participation. Pharmacies without a signed and valid contract for the standard network rate with us cannot participate in the MedXpress DSP network.

To be eligible for inclusion in the MedXpress DSP pharmacy network, we require compliance with the Discovery Health Chronic Illness Benefit (CIB) formulary and oncology preferred formulary. The formulary adheres to legal requirements as set out in the Prescribed Minimum Benefit (PMB) legislation and treatment algorithms for specific conditions on the Chronic Disease List (CDL).

Discovery MedXpress and MedXpress network pharmacies will remain the designated service providers (DSPs) for Core, Priority, Saver, Smart and Delta plans.

BENEFIT	CRITERIA
Chronic Illness Benefit	We require a minimum compliance to the chronic medicine formulary *over a rolling six-month* period of ≥77% (*measuring HIV and oncology separately).*
Oncology Benefit	In addition to the above, where there have been more than 180 claims over a six-month period, we also require compliance of ≥90% with the oncology preferred product list.

Please refer to the terminology table for a better understanding of how we measure chronic-formulary compliance and oncology compliance. These definitions are also included in your monthly report.

HIV Pharmacy Network

Discovery Health network pharmacies are eligible to participate in the HIV Pharmacy Network if they meet the criteria of ARV-formulary compliance. Any contracted, qualifying pharmacy will automatically be included in the HIV Pharmacy Network when meeting or exceeding the compliance criteria for the HIV ARV formulary.

Pharmacies without a signed and valid Standard Network Rate Agreement with us cannot participate in the HIV Pharmacy Network.

BENEFIT	CRITERIA
HIV Benefit	We require a minimum compliance to the HIV ART formulary over a rolling six-month period of ≥95% for participation and a minimum of 90% to retain participation.

Please note

- In future the pharmacy will not attract a 20% non-DSP co-payment on any ARV medicines whether the pharmacy is participating in the DSP network or not.
- Non-DSP pharmacies will attract a co-payment only on non-formulary items.

The HIV Pharmacy Network will be the designated service provider for all Discovery Health Medical Scheme plans, except KeyCare Start. The HIV Pharmacy Network will also be the designated service provider for the following additional schemes administered by Discovery Health:

- LA Health KeyPlus
- TFG Medical Aid Scheme MMED Option of Naspers Medical Fund
- Tsogo Sun Group Medical Scheme
- University of KwaZulu-Natal Medical Scheme

Please refer to the definitions table on page 2 for a better understanding of how we measure ARV-formulary compliance. These definitions are also included in your monthly report.

How we support you in reaching HIV-formulary compliance

- We measure your compliance with the HIV ARV formulary and your claims volumes monthly and send this report to the email address that we have on system for the practice. It is, therefore, important to ensure we have up-to-date email addresses. If your email address has changed, please send your new contact details along with your BHF number and pharmacy name to provider_administration@discovery.co.za.
- We arrange with numerous software venders to flag formulary items for easy identification on pharmacy screens while dispensing. Please request your software vendor to activate this functionality if you do not already use it.
- We publish the latest updated Discovery Health formulary (inclusive of chronic, oncology and HIV items) on the Discovery ProPBM webpage at www.discovery.co.za to assist you with stock management and ordering.

Creating a stable pharmacy network

It is important for us to ensure the stability of the MedXpress Pharmacy Network as well as the HIV Pharmacy Network so that our members can avoid out-of-network co-payments on their medicines.

If your pharmacy has less than 30 oncology claims per month (or 180 claims over a rolling six-month period), the compliance rate with the oncology preferred-medicine list will not be taken into consideration and you will not be affected by the small claims volume.

Our DSP network review process

MedXpress network pharmacies and HIV network pharmacies are reviewed for inclusion and ongoing participation in the network on a four-monthly basis.

- Inclusion: Once a practice meets the participation criteria, the practice is automatically enrolled in the network for the next four months. The practice will need to maintain formulary compliance to remain in the network. The practice will receive notice of inclusion in the monthly compliance report.
- Termination: Participating pharmacies that do not meet the criteria during review, as measured over the previous six-month period, will be removed from the network for the next four-month cycle. The practice will receive notice of termination by email. The pharmacy will then attract a 20% non-DSP co-payment until they meet the entry criteria during future reviews. Members will also be informed that the pharmacy is no longer a participating network pharmacy.

Performance Based Remuneration (PBR)

What is the objective of Performance Based Remuneration (PBR)?

Performance Based Remuneration (PBR) is a voluntarily incentive designed to provide an additional dispensing fee to pharmacists for adhering to the Scheme's chronic medicine formulary. The PBR model aims to create additional remuneration for pharmacies through improved prescription price efficiency.

Pharmacies without a signed and valid standard network rate contract with us cannot participate in the PBR network.

Performance Based Remuneration (PBR) model

The model, currently offered only by Discovery Health Medical Scheme, ensures an increase in revenue for pharmacists, lower out-of-pocket expenses for medical scheme members, and the ongoing sustainability of the Scheme.

The benefits of the PBR model include that it:

- Attracts a much higher PBR dispensing fee for formulary items and their generic replacement equivalents within the formulary price benchmark (benchmark items)
- Attracts a higher PBR dispensing fee penalty for non-preferentially priced generic medicines (non-benchmark items)
- Excludes medicines where the pharmacist cannot intervene with substitution to preferentially priced generic alternatives as these are not available.
- Allows for the highest percentage income incentive to be paid for dispensing the lowest-priced item. This allows PBR reference pricing to the best priced formulary equivalent generic medicine in the medicine class.
- Has a 100% PBR-compliance target which is easier to interpret and to communicate.

How does PBR work?

The model only applies to generically substitutable medicine claims paid from the Chronic Illness Benefit, subject to specific inclusion and exclusion criteria. The PBR model allows for a differential dispensing fee to be retrospectively applied once the PBR qualifying participation criteria has been reached. This comprises a differential PBR dispensing fee for:

Formulary molecules:

- A higher PBR dispensing fee applies to PBR claim lines based on formulary listed items and benchmark items (generic equivalent replacement items within benchmark pricing per plan type).
- A lower PBR dispensing fee applies to PBR claim lines where the generic replacement items fall outside benchmark pricing (non-benchmark items).

Methodology:
We use a reference price which is based on the best priced generic formulary item in the medicine class (generic grouper).
The SEP of each Chronic Illness Benefit claim in these generic groupers is retrospectively re-calculated using the reference price and the quantity claimed.
The PBR higher and lower dispensing fees are then applied to this adjusted SEP as applicable:

- *Formulary and benchmark items:* *Dispensing fee amount = Higher dispensing fee based on (Ref price X Quantity)*
- *Non-benchmark items:* *Dispensing fee amount = Lower dispensing fee based on (Ref price X Quantity)*

For the value, please see the website formulary document which is published on our website at www.discovery.co.za

Non-formulary molecules:

- The lower PBR dispensing fee applies to Chronic Benefit Illness claim lines (SEP) that are not listed on the formulary.

Methodology:

- *The best priced generic of the non-formulary item is exempt from the lower PBR dispensing fee, which means the standard dispensing fee will continue to apply.*
- *Other genericised non-formulary molecules:* *Dispensing fee amount = Lower dispensing fee based on (SEP X Quantity)*

Standard Discovery Health dispensing fee

This is the contracted dispensing fee structure that apply during dispensing and claims process. Independent pharmacies have a choice to participate in one of two Discovery Health standard DSP networks, attracting the specified standard dispensing fees for all medicines (whether paid from chronic or acute benefit payment pools).

Community network	36.32% capped at R59.92 (15% including VAT)
OR	
Corporate network rate	32.50% capped R32.50 (15% including VAT)

To be eligible for the PBR network, pharmacies need to participate as a contracted Discovery Health standard DSP network pharmacy in either the community or corporate Discovery Health Pharmacy Network. PBR does not apply to courier pharmacies while corporate hospital pharmacies need co-contract on corporate rates to be eligible for PBR.

What are the new PBR differential dispensing fees?

Rate (including VAT)	Corporate pharmacies	Community pharmacies
Higher PBR fee	56.74% capped at R58.01	58% capped at R113.80
Lower PBR fee	23.61% capped at R23.61	27.23% capped at R40.85
Standard Discovery Health Rate	32.50% capped at R32.50	36.32% capped at R59.92

Compliance measures for Performance Based Remuneration (PBR)

PBR compliance is measured and communicated to pharmacies on a monthly basis.

- PBR compliance means the pharmacy's performance measured as a percentage of PBR formulary and benchmark items dispensed out of all generically substitutable chronic medicine claims paid for the report period, taking into consideration the PBR exclusion rules.
- Benchmark items are generic equivalents of listed formulary items which fall within the same price bands as formulary products. These items are flagged along with formulary items for easy identification on dispensing screens. These items fall within the benchmark unit price as published in the latest PBR formulary and benchmark document, which is available on the Discovery website under Information > DiscoveryProPBM > Communiques.

What is the PBR threshold?

The pharmacy is protected by a threshold which acts as a safety net and ensures that the pharmacy will never earn lower dispensing fees than before joining the network. The threshold is one of two points where the PBR differential dispensing fee starts.

CRITERIA

For PBR dispensing fees to apply, pharmacies need to reach or exceed either of the two qualifying criteria (thresholds).

Value-based threshold

Qualification by claims value when reaching or exceeding 65%, calculated as follows:

- Determine the total value of PBR formulary items and their generic replacement equivalents in month one = R100 000
- Total value spent on formulary generic substitutable medicines in month one = R64 300
- Total value spent on items within the formulary price benchmark in month one = R700
- Formulary compliance (value) = 65%

OR

Volume-based threshold

Qualification by claims volume when reaching or exceeding 70%, calculated as follows:

- Determine the total claims volume of PBR formulary items and their generic replacement equivalents in month one = 1 000 claims
- Total formulary claims dispensed during month one = 630
- Total items within the formulary price benchmark dispensed in month one = 140
- Formulary compliance (volume) = 77%

Which claims are excluded from PBR?

Claims listed below do not qualify for PBR and continue to be paid at the appropriate chosen standard network rates. These are represented by:

- KeyCare and Delta plan options
- Non-SEP items including unregistered medicine, schedule 0 medicines and surgical consumable items
- Medicine not paid as pre-approved Chronic Illness Benefit conditions. Thus where paid from other benefits, such as HIV, Oncology, Acute, SMTB and Over-the-counter benefits
- Pharmacies that are not contracted by Discovery Health
- Medicine orders facilitated by Discovery MedXpress

- Medicine dispensed by courier pharmacies.

How to participate in the PBR network

- PBR participation is based on a willing provider network with a termination period of one calendar month. If not already participating, your pharmacy needs to submit two signed contracts for both the following:
  - Discovery Health standard DSP network agreement
  - Performance Based Remuneration (PBR) agreement for independently owned pharmacies
  - To apply, you will need to sign the latest standard DSP network agreement available at www.discovery.co.za and email it back to us at provider_administration@discovery.co.za

You can also request a copy of the agreement by emailing us at HealthPartnerInfo@discovery.co.za or call us on 0860 44 55 66. Once you have submitted a signed agreement, you will receive email confirmation of your participation in the network.

Achieving the compliance criteria

It remains the best option to keep to dispensing formulary items. Dispensing formulary items will increase both PBR-compliance and additional PBR dispensing fees while also increasing MedXpress DSP compliance.

If you need more support to reach the compliance criteria, you can request a top-ranking item report from Provider_administration@discovery.co.za. This identifies the top-ranking formulary items that improve your pharmacy's compliance as well as the top-ranking substitutable non-formulary items that bring down your pharmacy's compliance. Report examples can be seen below.

Do I need to amend my pharmacy's rate setting?

No amendments to scheme submission codes or the standard network rates as per Discovery Health standard DSP network agreement are required for PBR. The current rates and codes remain unchanged as the adjustments will be applied retrospectively per report.
Once your pharmacy opts in for PBR, the differential PBR dispensing fee will automatically apply once your pharmacy qualifies and reaches the PBR-compliance criteria. Additional fees are calculated and paid retrospectively.

The PBR criteria acts as a safety net to ensure that your pharmacy will never be financially worse off with the lower PBR differential dispensing fee. Thus, with Performance Based Remuneration, you have a chance to earn more than what you are currently earning on the standard network fee, without any risk.

How does payment of additional PBR dispensing fees work?

- Payment takes place quarterly and the cycle dates are displayed in your monthly report.
- We apply the PBR differential dispensing fee structure retrospectively to all the chronic claim lines paid from Chronic Illness benefit in the PBR-line level report that covers the three-month report period starting the month when the pharmacy has qualified by reaching or exceeding the PBR criteria. The difference in the standard and newly applied PBR differential fee is calculated.
- If you want to verify the additional PBR dispensing fee paid on chronic claim lines paid from Chronic Illness benefit, please email us at provider_administration@discovery.co.za and provide your pharmacy name and practice number to request the payment report on PBR-line level. The report contains all the affected CIB claim lines where the differential PBR dispensing fee have been re-applied as well as the settlement amount.
- The additional PBR amount due to you will be paid at the end of the payment cycle for the preceding three months.
- Look out for your payments on your statement which will show as PBR additional fees – paid in a lump sum with the rest of the payments that may be due.

What happens if your pharmacy again falls below the PBR-qualifying participation criteria?

If your pharmacy subsequently falls below the PBR criteria, you will no longer qualify for the PBR differential dispensing fee, nor will you receive the payment report on PBR-line level for payment due. Your pharmacy will revert to the standard network dispensing fee as per your signed Discovery Health standard DSP network agreement.

How do you identify the PBR formulary and benchmark items when dispensing?

We have worked with the pharmacy system vendors to highlight the PBR-formulary and benchmark items on your pharmacy screens so that these items are easily identifiable at the time of dispensing. All you need to do is to enrol by sending us a signed contract and send a copy of the signed PBR agreement to your vendor to ask them to highlight these items for you.

Technical questions and frequently asked questions

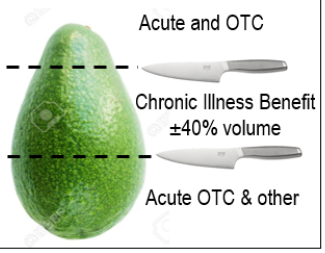
What is the difference between MedXpress and Performance Based Remuneration and how do we measure it?

To illustrate the difference between the ways we measure PBR compliance and MedXpress compliance, we use the avocado analogue.

PBR financial model - If an avocado pear represents last month's medicine claims …

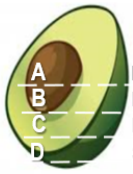
1. Last month's claims

Cutting off other claims than chronic - DHMS



2. Chronic Illness Benefit claims

Generic equivalents



Pip: Formulary (brand) items
Membrane: Equivalents ≤ BMK price
Flesh: Equivalents > BMK price
Skin: Non-formulary molecules divided into items where:
(i) generic equivalents are available
(ii) generic equivalents are not available - excluded

3. Exclusions

Only Chronic Illness Benefit claims

Excluding claims:
- KeyCare & Delta
- Oncology & HIV
- Non-SEP items
- Courier

4. Example

PMB CDL condition: Hypercholesterolemia
Formulary: atorvastatin & simvastatin
- Formulary: atorvastatin (10, 20 & 40 mg)
- Benchmark (BMK) R1.05 per SEP unit
- Benchmark (BMK) only applies for chronic

	Trade name	Unit price
A	Adco-atorvastatin 10mg	R1. 05
B	Alipto, Cholmin	R1.03, R1.05
C	Lipitor	R14.66
D	Crestor	Non-formulary

5. How PBR compliance is measured

Cross-subsidisation makes PBR affordable

PBR applies to all generically substitutable CIB claims:

A: Formulary item	↑PBR fee on Ref price
B: Equivalents ≤ BMK price	↑PBR fee on Ref price
C: Equivalents > BMK price	↓PBR fee on Ref price
D: Non-formulary (i)	
- More expensive generics	↓PBR fee on SEP
- Best priced generics	=Std fee on SEP

$$\% \text{ Compliance} = \frac{A+B}{A+B+C} \times 100\%$$

6. Threshold & dispensing fees

- PBR payment starts at Threshold, either
  Value of dispensed lines: $\frac{A+B}{A+B+C}$ % ≥ **65%**
- Volume of dispensed lines: ≥ **70%**

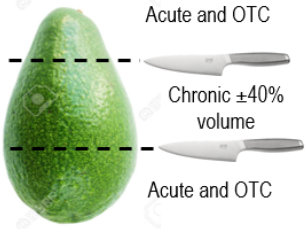
	Independent fees	Corporate fees:
1. Std fee	= 36.32% cap R59.32	32.50% cap R32.50
2.↑PBR fee	= 58% cap R113.80	56.74% cap R58.01
3.↓PBR fee	= 27.23% cap R40.85	23.61% cap R23.61

*The retrospectively, re-applied PBR variable dispensing fee is based on the **reference price** of the best priced formulary generic equivalent in the medicine class for CIB claims .*

DSPs: If an avocado pear represents last month's medicine claims …

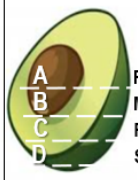
1. Last month's claims

Cutting off other claims than chronic



2. Chronic Illness Benefit claims

Generic equivalents



Pip: Formulary (brand) items
Membrane: Equivalents ≤ BMK price
Flesh: Equivalents > BMK price
Skin: Non-formulary items divided into items where:
(i) generic equivalents are available
(ii) generic equivalents are not available.

3. Last month's PBR claims

- Looking back on past 6 months' claims
- Measure compliance on *generically substitutable* items only, (contrary to PBR)
- Measure following separately:

  - Chronic Illness benefit (Chronic claims)
  - Oncology benefit claims (support)
  - HIV ARV benefit claims

4. Example

ARV formulary

Emtricitabine, tenofovir disoproxil and efavirenz
- No benchmark applicable to ARV formulary
- *Benchmark applies for ARVs and oncology.*

	Trade name	Unit price
A	Trenvir /Rizene	R8.18 / R7.93 /R8.18
B	*Benchmark (BMK)*	Atenef at R7.93
C	Atripla /Trivenz, etc	R23.85 / R10.21, etc.
D	*Not applicable*	

5. How compliance is measured

Only generically substitutable claims

1. Chronic formulary compliance
   % Compliance = $\frac{A+B}{A+B+C}$ X 100%
2. Oncology support list compliance
   % Compliance = $\frac{A+B}{A+B+C}$ X 100%

MedXpress DSP

3. HIV ARV and oncology compliance
   % Compliance = $\frac{A+B}{A+B+C}$ X 100%

HIV DSP

6. DSP qualifying criteria

1. **MedXpress DSP** network compliance:
   - **Chronic claims**
     Chronic compliance = 77% and
     oncology support claims >180/6mths
   - **Oncology claims**
     Oncology support item compliance = 90%

2. **HIV DSP** network compliance
   - **HIV claims**
     ARV formulary compliance =95%

How does a change in chronic formulary influence PBR?

Discovery Health Medical Scheme reviews the Chronic Disease List (CDL) formulary and Chronic Drug Amounts (CDAs) twice a year. This is done to make sure that the way medicine is paid for through the Chronic Illness Benefit, accurately reflects preferentially priced, accessible medicine as well as relevant new medicine in this dynamic market.

Any newly added formulary items will immediately improve the pharmacy's compliance figures from the implementation date onward. However, this is not due to the pharmacy's performance, but to the change in formulary. The opposite is also true – any formulary deletions may immediately lower a pharmacy's compliance figures.

To moderate this impact, we monitor and measure the effect of the formulary change over the three months directly following the update. During this period, we run compliance reports against both the old and new formulary to quantify the portion of the pharmacy's increased or decreased compliance rate that is due to the change in formulary. Taking the effect into consideration, we may adjust the qualifying participation criteria.

How does Discovery Health currently pay from chronic benefits?

The Discovery Health Medical Scheme Chronic Illness Benefit (CIB) formulary covers the medicine requirement for Prescribed Minimum Benefit (PMB) treatment algorithms for specific conditions on the Chronic Disease List (CDL) and is published on our website at www.discovery.co.za.

For all plans (except KeyCare where the formulary is NAPPI specific), we pay non-formulary items (which include generic and therapeutic items that fall within the same medicine class as treatment for the same condition) up to the monthly Chronic Drug Amount (CDA). Whenever the monthly CDA for the condition for the month is exceeded, the member will have a co-payment.

When you see 'Prescribed Minimum Benefits', it has been paid from chronic benefits. When you see 479 'Non-formulary item. Please substitute, kindly note 'Prescribed Minimum Benefits', which means that although this is not a formulary item for the patient's specific condition, the item has been paid from chronic benefits due to a special clinical appeal authorisation.

What is the difference between a formulary item and a benchmark item?

Regardless of price increases, we continue to cover **formulary items** as published on our website **in full** when approved for an authorised chronic condition. The Chronic Drug Amount (CDA) does not apply to formulary items.

When the pharmacy has reached the compliance criteria, formulary items always attract the higher dispensing fee for PBR participating pharmacies regardless of price increases. Please note that the excel version of the Discovery Health PBR formulary with the benchmark pricing is published on our website at www.discovery.co.za under **Communiqués**.

PBR benchmark items are not on the formulary, these are generic equivalents of formulary items that fall at or below the PBR-benchmark unit price at any given time. SEP increases, however, may cause these items to fall outside the PBR-benchmark unit price at which point the lower dispensing fee applies as soon as the price has been updated. Both PBR-formulary and benchmark items will be highlighted on the pharmacy screen for easy identification while dispensing. The Chronic Drug Amount applies to formulary items. *Therefore, although the item may count as a benchmark item when dispensed, the Chronic Drug Amount may attract a co-payment for the member*.

What happens if the price of the formulary item has increased and the unit price is now higher than the PBR-benchmark unit price?

The formulary list of items is published on www.discovery.co.za. Regardless of price increases, we cover formulary items in full when authorised. When the pharmacy reaches the compliance criteria, these authorised items attract the higher dispensing fee for PBR participating pharmacies even though the SEP unit price may be higher than the PBR-benchmark unit price after the increase.

What about non-formulary items, for example, rosuvastatin for hypercholesterolemia?

We pay non-formulary items (which include generic and therapeutic items that fall within the same medicine class as treatment for the same condition) up to the monthly Chronic Drug Amount (CDA) depending on your client's plan type. Whenever the monthly CDA is exceeded, the member will have a co-payment.

Dispensing non-formulary items may influence your compliance rate negatively where:

- The molecule is on the formulary (such as atorvastatin and simvastatin), but the SEP unit price of the particular generic product exceeds the PBR-benchmark unit price
- The ingredient or molecule is not on the formulary (such as rosuvastatin).

For PBR, Discovery Health does not expect the pharmacy to achieve a 100% compliance rate. We understand that certain members and certain healthcare professionals may choose non–formulary items that do not comply and may attract the lower dispensing fee. The PBR dispensing fee is paid in addition to the existing standard network dispensing fee, while the criteria act as a safety net to ensure that your pharmacy is never worse off as a result of your client's choices.

While prescriber preferences may vary from time to time and compromise adherence to the medicine list, this is adequately compensated for in the PBR model by lower compliance criteria. Please note that depending on the availability of preferentially priced generics, there may not always be a generic replacement item on the PBR medicine list.

What happens if I dispense a more expensive item that exceeds the PBR-benchmark unit price, but sacrifice part of the dispensing fee to fall within the PBR-benchmark unit price?

Dispensing a non-formulary item and charging less so that the unit price falls within the PBR-benchmark unit price will not affect your compliance positively as the compliance report is drawn on NAPPI codes and the SEP value that we have on our file.

Therapeutic replacements where there are no generic items available for substitution?

PBR is about cost-efficient *generic substitution*. Once the pharmacy has reached the compliance criteria, the lower dispensing fee applies for non-formulary items. The higher dispensing fee applies only to formulary items that either are on the formulary list or fall below the PBR-benchmark unit price.

However, whenever your client is not satisfied with a co-payment and the prescribed ingredient is not listed on the formulary (for products such as Crestor or Eltroxin), choosing the best-priced generic will avoid the lower PBR dispensing fee.

You will receive the higher dispensing fee when you dispense a formulary item or one that falls below the PBR-benchmark unit price.

It is important to note that it always has to be in the best interest of the patient and, therefore, it will always remain the decision of the pharmacist, patient and treating healthcare professional whether to make a (therapeutic) substitution or not. Discovery Health will in no way interfere with this decision.

We do not expect the pharmacy to achieve a 100% compliance rate. We understand that certain patients and healthcare professionals will choose not to fully comply. It is important to understand that:

- While prescriber preferences may compromise formulary compliance from time to time, this is adequately compensated for by lower compliance criteria
- We continue to promote access to affordable medicine and, therefore, affordable pricing remains a key consideration in inclusion of the CIB formulary. Depending on the availability of preferentially priced generics, there may not always be a generic replacement item on the formulary.

What are the principles that Discovery Health considers for substitution and formulary inclusion?

- Affordable pricing remains a key consideration in medicine benefit design. We continue to promote access to affordable medicine.
- Discovery Health Medical Scheme's chronic-formulary benefits are compliant with the Council for Medical Scheme's treatment algorithms for Chronic Disease List (CDL) Prescribed Minimum Benefits (PMBs).
- Medicines registered with the Medicine Control Council (MCC) are treated as compliant with registration requirements of safety, efficacy and quality until deemed otherwise by the MCC.
- Items not suitable for generic substitution will be strictly aligned with guidance from the MCC as applicable to all in South Africa.
- Clinical guidance from external independent clinical consultants will be considered in conjunction with prevailing regulations and legislation pertaining to medicine in SA.

What if I offer generic replacement items, however, the patient or doctor does not agree to generic replacement?

You need to dispense the item on the prescription according to the patient or doctor's decision and you will be paid the lower fee. You always have to adhere to legislation. While prescriber preferences may compromise formulary compliance from time to time, this is adequately compensated for by lower compliance criteria. We do not expect 100% PBR compliance.

Why do certain items not attract a co-payment for the member, yet it attracts the lower dispensing fee?

We pay up to the overarching monthly Chronic Drug Amount (CDA) for non-formulary medicines, for each medicine class, for a condition, each month. For example, we cover a few atorvastatin and simvastatin products on the formulary and if the products for hypercholesterolemia (even rosuvastatin) fall within the CDA, your client will have no co-payment. The patient needs to pay the balance when the monthly amount for hypercholesterolemia is exceeded.

The CDA has, however, no bearing on the PBR-benchmark unit price (unit price), which determines whether the pharmacy will earn the:

- Lower dispensing fee, such as when a non-formulary item is dispensed (such as rosuvastatin) or the SEP unit price of the dispensed atorvastatin item 20 mg exceeds the PBR-benchmark unit price of atorvastatin 20 mg for the plan (such as R1.14c per unit for both the Core formulary and the Comprehensive formulary).
- Higher dispensing fee for an atorvastatin 20 mg item on the formulary (such as Adco atorvastatin 20 mg, Aspavor 20 mg, Atorvastatin Unicorn 20 mg and Lestavor 20 mg) OR for any other product where the SEP unit price of the dispensed atorvastatin item falls within the PBR-benchmark unit price of R1.14c for both the particular plans.

What happens when a formulary item is dispensed, but it has not been authorised for funding from the Chronic Illness Benefit?

Prescribed Minimum Benefits (PMBs) only apply to medicine where the treatment has been pre-authorised, and payment has been made from the chronic benefit. Prescribed Minimum Benefit (PMB) regulations allow for the use of formularies for specific PMB conditions on the Chronic Disease List (CDL) according to the PMB algorithms. This means that treatment is approved for funding on the Chronic Illness Benefit according to:

- Medical scheme plan type (the formulary for the Core plans differs from the formulary for Executive plans)
- Condition according to CDL
- Formulary item
- Only when the medical scheme member qualifies according to certain clinical entry criteria.

Claims paid from other benefits, such as but not limited to oncology, HIV and acute benefits, fall outside PBR. These claims will continue to be paid according to the chosen network dispensing fees.

You also need to keep in mind that an item that forms part of a treatment guideline for a particular condition (such as bisoprolol for congestive heart failure), may not form part of the treatment guidelines of another condition (such as bisoprolol for hypertension) in which case it may not be authorised for a patient for hypertension.

When an item has not been clinically authorised for a member with a condition, the item is funded from the day-to-day benefits (Medical Savings Account) and the standard network dispensing fee is paid, even if the item is on the formulary for that condition or for a different condition. When an item has been clinically pre-authorised for a patient with a condition, the item is funded from the chronic illness benefits and the claim qualifies for PBR dispensing fees even though it may have been authorised for a different condition. (For example bisoprolol authorised for some patients for hypertension on a clinical appeal authorisation where it is normally only authorised for congestive heart failure).

PBR only applies to claims of pre-approved chronic medicine paid from the Chronic Illness Benefit. You also need to keep in mind that there are various types of authorisations. Where we may have granted a patient a 'special authorisation', we pay from the Chronic Illness Benefit up to the monthly CDA and the patient will be liable for a co-payment when exceeding the CDA.

The higher dispensing fee applies to authorised chronic medicine claims if the SEP unit price of the dispensed item is lower or equal to the PBR-benchmark unit price for the active ingredient. For instance, bisoprolol is on the formulary for cardiac failure in which case, when authorised, the patient will have a 'chronic authorisation'. Where bisoprolol has been authorised for hypertension as a 'special authorisation', it will pay from the Chronic Illness Benefit up to the CDA and the patient will be liable for a co-payment when exceeding the CDA. The higher dispensing fee applies when the SEP unit price of the dispensed item falls within the bisoprolol PBR-benchmark unit price. Please note that in these 'special authorisation' cases, the system responds with reason code 479: 'Non-formulary item. Please substitute'. This happens because the authorisation has not, in this case, followed normal protocols.

Patients sometimes have been granted a 'special appeal authorisation' that is specific to the NAPPI code. Medical scheme members with a 'special appeal authorisation' will not automatically have access to a generic substitution, unless Discovery Health changes the appeal to a standard authorisation. Pharmacies need to call 0860 44 55 66 for the change in authorisation.

What happens if I do not receive PBR-compliance or payment reports?

Ensure that your pharmacy participates in the PBR network and that Discovery Health is in possession of a signed PBR contract.

Call 0860 44 55 66 or send an email to provider_administration@discovery.co.za and ask to check your pharmacy's dispensing email address on the system. You will be responsible to ensure that the dispensing email address on our system remains updated. You can also ask the call centre to request your compliance figures.

How do I know I have been paid accordingly?

Your PBR payment is a line item on your statement. It will be flagged as 'PBR independent'. The PBR payment amount will be included and the total claims amount will appear in your bank account as a single payment.

What happens when there are items out of stock?

When an item is out of stock:

- Report out-of-stock items by sending an email to CIBAPPFORMS@discovery.co.za or call 0860 44 55 66. Alerting us will assist us to follow up with the company.
- Please substitute with alternative PBR formulary or benchmark items as, due to over-coding, most items do not need re-authorisation.
- Where necessary, please obtain authorisation for alternative items:
  - By following the normal application process by sending an email to CIBAPPFORMS@discovery.co.za.
  - By obtaining telephonic authorisation for a replacement item by calling 0860 44 55 66 if it is urgent and the client is waiting at the dispensary.

Please note: Depending on the availability of preferentially priced generics, there may not always be a new generic replacement item added to the formulary.

Contact us

Please send your enquiries to the correct email address listed below. We keep all past communiques on our website at www.discovery.co.za.

Real-time medicine claims queries • Claims transmission queries • Price differences • Reason code 98 where a paper claim is requested	ProPBM call centre	0860 77 67 26 (immediate resolution) or ProPBM_QUERIES@discovery.co.za. (48 hour resolution) Please have the following information ready for positive identification of the claim: • Pharmacy name and BHF number • Scheme • Member number • Date of claim • Item and • Reason code.
Remittance advices and payment run • Reconciliations • Remittances • PBR and MedXpress participation	Health provider call centre	0860 44 55 66 or healthpartnerinfo@discovery.co.za
Payment for clinical exceptions		ruleexceptionpayment@discovery.co.za
Chronic medicine • Add-A-line (telephonic authorisations) • Extended supply of medicine • Chronic Illness Benefit (CIB) application forms or prescription updates	Health partner call centre	0860 44 55 66 or 011 539 7000 (fax) or healthpartnerinfo@discovery.co.za
Out-of-stock chronic formulary items • Substitute with alternative formulary items (formulary document on the website) as these do not need re-authorisation • Alternatively obtain authorisation by email a list of your patients per item providing: membership number, patient information and details of the item that is out of stock • Where necessary, obtain telephonic authorisation for a replacement item • Where stock shortages impact your Discovery Health formulary compliance performance, we will retrospectively adjustments compliance figures to factor-in an allowance for the period where the applicable formulary item has been out of stock. This process will takes place retrospectively,	Health partner call centre • Chronic re-authorisations	0860 44 55 66 or CIBAPPFORMS@discovery.co.za
Report out of stock formulary products at	Health partner call centre Chronic re-authorisations	PRICE_AND_PRODUCT_FILE@discovery.co.za
Oncology and HIV • Oncology ICD-10 diagnosis codes	Health partner call centre	0860 44 55 66 or Provider_administration@discovery.co.za
Pharmacy Management Administrators • System and integration enquiries • (Pharmacy software vendors)	• Electronic Transmission Management	ETM_OPERATIONS@discovery.co.za
Preferred pharmacy networks • Joining network or altering of rates • PBR and MedXpress participation • PBR report: Top ranking items that affect compliance • Update contact details	• Provider Administration	Provider_administration@discovery.co.za
Discovery Wellness Network • Joining the Wellness or HIV network • Ongoing operational matters	Vitality call centre	011 529 8898 or vitalitypartnerrelations@discovery.co.za

Discovery fraud hotline	Fraud hotline	0800 004 500 or 0800 007 788 (fax) or discovery@tip-offs.com
Communications • Network arrangements • PBR information • General claims information	Website	ProPBM communiques
Registering a pharmacy and formularies • CIB formulary/ KeyCare information • Registration forms for a new pharmacy	Website	Pharmacy overview