



The Council for Medical Schemes

**Accreditation Standards
for Third Party Administrators
of Medical Schemes**

Standards and Measurement Criteria

Version 5

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SECTION 1: INTRODUCTION

1. Executive summary

This document sets out the accreditation standards for third party administrators of medical schemes as required by the Medical Schemes Act, No 131 of 1998 and concomitant regulations (the Act).

The document contains all standards and criteria that are included in a detailed questionnaire, to be completed by each administrator applying for accreditation. Once completed, an evaluation team will validate each administrator's questionnaire and test responses where required.

Upon completion of the accreditation exercise, the Council will award to an administrator an accreditation status of compliant, compliant subject to conditions being met, or non-compliant. It will be at the discretion of the Council to determine the accreditation status and the timeframes required for an administrator to take corrective action if required.

2. Background

In order for Third Party Medical Scheme Administrators (Administrators) to be measured in terms of the Act, an assessment and development project was undertaken to establish the accreditation criteria. The following Council objectives were set:

- To identify and define for administrators, the operational systems and processes necessary for compliance with the Act;
- To develop a set of minimum standards to measure these requirements;
- To develop an evaluation mechanism that allows the degree of compliance with the standards to be measured and identifies the reasons for non-compliance, thus enabling the administrator to make the necessary improvements to address deficiencies and ultimately achieve full compliance with the standards; and
- To develop an accreditation decision-making process that will allow administrators meeting the requirements for accreditation to be identified and accredited.

3. Accreditation methodology and supporting principles

3.1. Introduction

Using the Act, subsequent revisions and relevant regulations, the methodology identified systems and processes required by administrators to meet these requirements.

An advisory team was appointed to assist with the process of defining the functional elements, associated systems, processes and structures required by the administrators to function according to the requirements of the Act and to develop a full set of standards and accreditation criteria.

The advisory team developed a draft set of standards that was workshopped with the Council on a number of occasions, resulting in Version 1 of this document, and which contained the standards and their measurable elements (criteria). Versions 2 and 3 were developed after completion of the evaluation of the 3 pilot project administrators. This document represents Version 4 of the accreditation standards and criteria, which were updated to reflect recent changes in the medical schemes environment, e.g. the introduction of the Risk Equalisation Framework (REF) requirements.

The standards encompass the following services provided by administrators:

- General compliance
- System assessment
- Member record management
- Contribution management
- Claims management
- Financial management reporting
- Information management and data control
- Customer services

3.2. Severity

3.2.1. Rating

Each standard is defined by a set of criteria, each of which must be complied with if the standard is to be assessed as compliant. The criteria are the elements that are measured to show the degree of compliance with the standards.

The following assessments are possible:

- **Compliant (C)** means that the criterion requirement is met in full.
- **Partially compliant (PC)** means that the criterion requirement is not totally met but there is positive progress towards compliance and the deficiency does not seriously compromise the standard.
- **Non-compliant (NC)** means that there is no observable evidence of compliance with the criterion requirement.
- **Not Applicable (NA)** means that the criterion is not applicable because the organisation does not provide the service at all, or the organisation or department does not provide the service at the particular level the criterion is designed to measure.

The level of compliance of standards is calculated by aggregating and averaging criterion ratings, taking the severity of non- or partial compliance into consideration.

Where a critical criterion is failed it would result in automatic failure of a standard.

3.3. Applying for accreditation

1. An organisation that provides administration services to a medical scheme must be accredited in terms of section 58 of the Act, read together with Regulation 17.
2. Administrators are therefore obliged to apply for accreditation in writing to the Council for Medical Schemes in the manner determined by the Council. The full set of standards and measurement criteria is available on the Council's website at www.medicalschemes.com.
3. A Standard Assessment Questionnaire aligned directly to the standards and measurement criteria will be sent to each administrator for self-evaluation.
4. Each administrator will evaluate its performance against the standards and measurable elements.
5. The completed questionnaire must be filed with comprehensive cross referenced supporting documentation by the administrator to be made available to the Council evaluation team. The administrator will be required to make available space for the evaluation team to work and to prevent any documentation from being taken "off site".
6. The evaluation team will meet with the administrator management and staff to verify the self-evaluations. This process will include an element of system testing and review of operational functionality. The administrator will be required to make available space for the evaluation team to work.
7. On completion of the evaluation, the team will have a final meeting with the management of the administrator to discuss/confirm the evaluation findings. Thereafter, the team will analyse and report on the questionnaire to determine the degree to which the administrator complies with the accreditation standards and meets the requirements for accreditation.
8. The evaluation team will submit its findings report to the Council Accreditation Steering Committee. The Administrator will receive a copy of the final findings report for final comments direct to Council.
9. The evaluation reports, together with the administrator's response thereto, are then submitted to the Council Sub-Committee who will then consider the administrator's accreditation application for approval. The Council will grant the accreditation subject to any conditions that it may deem necessary, or refuse accreditation and provide reasons for such refusal.

SECTION 2: STANDARDS DOCUMENT

Introduction

The following sections set out the standards and measurement criteria required for accreditation as a third party administrator of Medical Schemes.

1. MEDICAL SCHEME ADMINISTRATORS

1.1. General compliance

Intent

In terms of the relevant legislation, all administrators are required to apply for accreditation and meet stipulated requirements. This section confirms that the administrator has adhered to the requirements of the Act.

1.1.1. The current or proposed administrator has applied for accreditation in terms of regulation 17 of the Medical Schemes Act, 1998.

1.1.1.1. An application for accreditation has been made and is accompanied by all required supporting documents as prescribed in regulation 17 of the Act.

1.1.2. The administrator has in place administration agreements, in compliance with the provisions of regulations 18 and 19 of the Act, for all schemes under its administration.

1.1.2.1. Signed administration and service level agreements are in place for all medical schemes for whom administration services are provided.

1.1.2.2. The agreements confirm the scope and duties of the administrator for each specific scheme.

1.1.2.3. The agreement contains full details of fees payable by the medical scheme, including basis of determination, reconciliation and payment.

1.1.2.4. Any amendments to the initial agreement are in writing and signed by the parties in terms of Regulation 18(3) of the Act.

1.1.2.5. The duration of the contract is provided for in the agreement.

1.1.2.6. The transfer of data procedures to be followed upon termination of the administration agreement must be clearly defined with particular regard to the timing, format and cost thereof.

1.1.2.7. The service level agreement (SLA) contains details of the service to be provided, the agreed upon service level, the performance measures, and relating penalties/remedies available to the parties in case of non-performance.

1.1.2.8. Where applicable, the admin agreement provides for the sub-contracting of admin functions by the administrator to another party.

1.1.2.9. The agreement provides that all registers, minute books, records and all other data pertaining to the medical scheme, must at all times remain the sole property of the medical scheme concerned, and that no lien may be held over them by the administrator.

- 1.1.2.10. The agreement contains details of how confidentiality of data is to be maintained.
- 1.1.2.11. The agreement contains details on procedures to be followed in instances of breach of contract.
- 1.1.2.12. The agreement confirms that the administrator will take out or has in place the required fidelity and indemnity insurance.

1.1.3. The administrator is in a financially sound position as prescribed.

- 1.1.3.1. An auditor has been appointed to examine the accounting records and annual financial statements of the administrator in accordance with International Auditing Standards and in compliance with International Financial Reporting Standards (IFRS).
- 1.1.3.2. The financial statements clearly confirm that the administrator's business has current assets which are at least sufficient to meet current liabilities.
- 1.1.3.3. The financial statements clearly confirm that the administrator's business is conducted in a manner to ensure that the business is at all times in a position to meet its liabilities.
- 1.1.3.4. The financial statements clearly confirm that the administrator's business is a going concern.
- 1.1.3.5. The applicant has in place fidelity and indemnity insurance as prescribed in the Act and Regulations, and written motivation is provided by the administrator for the selected level/value of cover.

1.2. System assessment

Intent

Good business practice requires that the administrator has a detailed process map of its operational functionality and relevant policies and procedures that define operational systems and processes.

1.2.1. Detailed business process flow diagrams, as well as application software logical designs, are available for each of the business processes.

- 1.2.1.1. The applicant is able to provide detailed business process flow diagrams (high level) of all its current operational functions.
- 1.2.1.2. The business process flow diagrams clearly illustrate how the operational functions are integrated to ensure the rapid reconciliation and utilisation of data.
- 1.2.1.3. The applicant is able to provide an up-to-date organogram aligned to its business process flow diagrams, which clearly indicates roles and responsibilities.

1.2.2. Detailed application software logical designs which support the business processes are available.

- 1.2.2.1. The applicant is able to provide detailed application software logical designs (high level), which support the business process flow diagrams.
- 1.2.2.2. The application software logical designs clearly illustrate any outsourced services and how integration is achieved.
- 1.2.2.3. The application software logical designs clearly illustrate how integration is achieved between the operational systems, as well as with the financial systems.

1.3. Member record management

Intent

An administrator must ensure that it has in place a proper and robust mechanism for the registration, maintenance and updating of member records.

All services offered to a scheme (whether contracted out or in-house) must form part of an integrated process which allows the member record to be fully utilised for contributions, claims and financial management.

In order to manage services appropriately on behalf of a medical scheme, member record management should be a core business process for any administrator. If an administrator is unable to organise and align member record management to other key operational processes, a medical scheme is likely to receive an inappropriate service.

1.3.1. The applicant has the ability to fully manage member/employer records to individual member level.

- 1.3.1.1. The applicant operates a system that maintains individual member records.
- 1.3.1.2. New members/dependants are registered in a timely manner within the prescripts set by the administration agreement with the medical scheme.
- 1.3.1.3. The applicant is able to respond to changes to membership /dependant details and update records prior to any claims being made against an adjusted benefit or contribution profile.
- 1.3.1.4. The member record includes the medical scheme membership number.
- 1.3.1.5. The member record includes the status of the member (i.e. ordinary or continuation membership).
- 1.3.1.6. The member record includes the full name (initials and surname), age and identity number of the principal member.
- 1.3.1.7. The member record includes the full name (initials and surname), age and identity numbers of each registered dependant.
- 1.3.1.8. The member record includes the member's physical and postal address.
- 1.3.1.9. The member record includes the contact details of the member.
- 1.3.1.10. The member record includes the date of birth of each member and dependant.
- 1.3.1.11. The member record includes the gender of each member and dependant.
- 1.3.1.12. The member record reflects the relationship between the member and dependants.
- 1.3.1.13. The member record retains a full history of all transactions for each member family.
- 1.3.1.14. The member record includes each beneficiary's REF number.
- 1.3.1.15. The member record reflects a member and dependant's date of admission to and exit from the scheme.
- 1.3.1.16. The member record identifies the benefit option pertaining to the member family and changes exercised.
- 1.3.1.17. The member record identifies special rules and benefit limitations relevant to the member family.
- 1.3.1.18. The member record contains details of salary and income bands for each member to allow for contribution calculation, where applicable.
- 1.3.1.19. The member record indicates the monthly contributions payable and the method of payment.
- 1.3.1.20. The member record indicates waiting periods and/or exclusions on entry to the scheme.

- 1.3.1.21. The member record indicates late joiner penalties and adjusts the monthly contribution accordingly.
- 1.3.1.22. The member record contains the medical scheme name and period of cover in respect of prior scheme membership.
- 1.3.1.23. The member employer details include the full name, address and contact details of the employer, where applicable.
- 1.3.1.24. The member's employee number is recorded where applicable.
- 1.3.1.25. Employer details include subsidiary codes for each employer group to identify associated members and continuation members.
- 1.3.1.26. The applicant has procedures in place, manual or system related, to ensure employee details are updated prior to an impact on claim payments and contribution collections.

1.3.2. The applicant has the required system and ability to maintain and operate an effective membership management system. This system is fully integrated, accurate and is real time compliant.

- 1.3.2.1. The individual member record system integrates with all other administration systems in use such as contribution management (including the billing run) and claims management.
- 1.3.2.2. Audit trails exist for all changes to member records.
- 1.3.2.3. The member management system is real time compliant.
- 1.3.2.4. The applicant has formal review procedures by senior personnel in place in respect of the processing of the member records.

1.4. Contribution management

Intent

In order to manage services appropriately on behalf of a medical scheme, contribution management is a core business process for any administrator. If an administrator is unable to organise and align contribution management to other key operational processes, a medical scheme is likely to receive an inappropriate service.

1.4.1. System parameters and marketing material embodying contribution tables, in full accordance with the registered rules of each scheme under administration, are established and maintained.

- 1.4.1.1. Contribution tables per benefit option are maintained on the system and are fully aligned to the registered rules of each scheme under administration.
- 1.4.1.2. The contributions marketing material is fully aligned to the registered rules of each scheme under administration, if this function is the responsibility of the administrator as specified in the administration agreement.
- 1.4.1.3. Amendments made to the registered rules that impact on contribution tables are effected timeously onto the system before any further billing runs are generated.
- 1.4.1.4. The applicant is able to provide evidence that amendments to the registered rules are submitted to the Office of the Registrar as determined by the Registrar, if this function is the responsibility of the administrator as per the administration agreement.

1.4.1.5. The applicant has policies and procedures to ensure that the system parameters are only capable of amendment by authorised senior management.

1.4.1.6. Any changes to standing data should be logged in an audit trail and reviewed monthly by senior management.

1.4.2. The ability exists to generate complete and accurate billing runs, and to supply members/employees with monthly accurate billing/contribution statements.

1.4.2.1. The contribution collection system interfaces with the individual membership record to ensure accuracy prior to generating a billing run.

1.4.2.2. The applicant manages and maintains the collection and receipt of contributions to individual member level.

1.4.2.3. The ability exists to generate contribution information for all member categories promptly and accurately (for example: Persal-like interfaces, cash payment, direct paying members, debit order).

1.4.2.4. The applicant provides all employer groups with monthly contribution schedules/billings/invoices, including refund and arrears lists in a form agreed by the scheme and the employer group concerned.

1.4.2.5. The applicant ensures that contribution schedules/billings/invoices are provided timeously to procure the collection of the contributions due in terms of the rules of each scheme.

1.4.2.6. The applicant has systems and procedures to advise employers/individuals of discrepancies between billings and contributions received by no later than 30 days after becoming due.

1.4.2.7. The applicant has systems to correct billing and contribution discrepancies by no later than the end of each month following the month to which the contributions apply.

1.4.2.8. The membership data management system and member billing system are integrated.

1.4.3. All contributions registered in terms of the rules of the scheme are collected, allocated and reconciled at individual member level.

1.4.3.1. The applicant ensures compliance with section 26(7) of the Act in that contributions are collected within 3 days of becoming due and payable to the medical scheme.

1.4.3.2. The applicant demonstrates that it deposits all medical scheme funds (i.e. cheques and cash received) directly into a bank account opened in the name of the medical scheme within one business day following the date of receipt thereof.

1.4.3.3. Where medical scheme funds, including contributions, are paid by means of electronic funds transfer, such funds are deposited directly into a bank account opened in the name of the medical scheme.

1.4.3.4. The applicant's system has the ability to collect member contributions by debit order and/or any other electronic means.

1.4.3.5. The applicant manages and maintains records of monthly deposits of members' contributions in the medical schemes' bank accounts.

1.4.3.6. The applicant manages and maintains at least monthly reconciliations of individual members' contributions to actual remittance advices.

1.4.3.7. The applicant allocates all contribution receipts to the individual member record at least monthly.

1.4.3.8. Audit trails exist for all transactions processed through the contributions system.

- 1.4.3.9. All unidentified deposits or receipts are recorded in a separately identifiable ledger account along with all known details for further investigation.
- 1.4.3.10. The applicant has policies and procedures in place to follow up all unidentified deposits or receipts by the end of the following month to which the contributions or other debt applies.
- 1.4.3.11. The applicant demonstrates a procedure in respect of any refunds to members on the basis set out in the rules of the scheme.

1.4.4. Appropriate and robust credit control measures are in place.

- 1.4.4.1. The applicant has systems to follow up non-payment of contributions or other amounts due to the medical scheme by members or employers by the end of the following month to which the contributions or other debt applies.
- 1.4.4.2. Follow up and enquiry is performed for unpaid or overpaid contributions by members and former members strictly in accordance with the rules of the medical scheme.

1.4.5. There is comprehensive application of scheme rules in terms of suspension and termination procedures.

- 1.4.5.1. All membership terminations are accepted onto the computer system promptly in accordance with the service level agreement, and ideally within 1 day of receipt of notice.
- 1.4.5.2. Membership is suspended / terminated in terms of the rules of the medical scheme where contributions are outstanding or on failure to repay debts owing to the scheme.
- 1.4.5.3. Reinstatement of membership is performed in accordance with the rules of the medical scheme.
- 1.4.5.4. Membership is suspended/terminated in accordance with the specific rules of a medical scheme on submission of fraudulent claims.
- 1.4.5.5. Membership is suspended/terminated in accordance with the specific rules of a medical scheme on committing a fraudulent act.
- 1.4.5.6. Membership is suspended/terminated in accordance with the specific rules of a medical scheme on non-disclosure of material information.
- 1.4.5.7. The member is advised timeously in writing of any action contemplated above.
- 1.4.5.8. The applicant has the ability to supply a certificate stating the period of cover and type of cover to the current or former member and their dependants when required.
- 1.4.5.9. Relevant Income Tax information, including savings refunds and interest on savings, is made available to members upon request or automatically at the end of the tax year.
- 1.4.5.10. The applicant has the ability to record the reversal of contributions for retrospective terminations correctly.

1.4.6. The ability exists to reconcile the debtor's age analysis (billings ledger) to the general ledger control account on a monthly basis.

- 1.4.6.1. An age analysis of debtors at individual member level is produced monthly.
- 1.4.6.2. For each category of debtor (group debtors, direct paying members, arrear contributions, etc), reconciliation is performed between the debtor's age analysis and the general ledger control account on a monthly basis.
- 1.4.6.3. Reconciling items are cleared and where not, reported to individual schemes at least monthly.

1.5. Claims management

Intent

As with contribution management, claims administration is a core role of an administrator and must be an integral part of overall operational functionality.

1.5.1. System parameters and marketing material are established and maintained in line with the registered benefit options as per scheme rules and the Act.

- 1.5.1.1. Benefit tables for each benefit option are maintained on the system and are fully aligned to the registered rules of each scheme under administration.
- 1.5.1.2. The benefits marketing material is fully aligned to the registered rules of each scheme under administration, if this function is the responsibility of the administrator as specified in the administration agreement.
- 1.5.1.3. The applicant has version control procedures in place to ensure that the system maintains the appropriate REF Entry and Verification criteria.
- 1.5.1.4. Amendments made to the registered rules that impact on benefit tables are effected timeously onto the system before any claims relating to that specific benefit year are paid.
- 1.5.1.5. The applicant is able to provide evidence that amendments to the registered rules are submitted to the Office of the Registrar as determined by the Registrar, if this function is the responsibility of the administrator as per the administration agreement.
- 1.5.1.6. The applicant has policies and procedures to ensure that the system parameters are only capable of amendment by authorised senior management.

1.5.2. All claims received are managed and verified in line with the registered benefit options of the scheme rules and the Act.

- 1.5.2.1. All claims received by the scheme should be date stamped with the applicable date on which the claim was received (i.e. only process paper claims with a date stamp) and ensure that this date is captured as the date received on the system.
- 1.5.2.2. A log (manual or electronic) is maintained to ensure that all claims received are captured onto the system.
- 1.5.2.3. All legitimate claims are captured and assessed in line with the rules of the medical scheme and individual benefit option profiles.
- 1.5.2.4. The applicant has procedures in place to process applications for chronic medication, and to inform members in writing of the outcome of chronic medication applications.
- 1.5.2.5. The date of service and date of receipt for each claim is recorded on the system.
- 1.5.2.6. The system automatically generates unique reference numbers for each claim captured.
- 1.5.2.7. Co-payments due by the member are correctly calculated, reconciled and recovered monthly from the member.
- 1.5.2.8. Individual beneficiary details per claim are recorded on the principal member record.
- 1.5.2.9. The date of processing of each claim is recorded on the system.
- 1.5.2.10. Internal control processes are in place to check on the accuracy of claim recording.
- 1.5.2.11. The date of payment of each claim is recorded on the system.
- 1.5.2.12. The applicant has procedures to ensure that the claims management system maintains the most recent diagnostic, procedural, pharmaceutical classification system and other generic tariff codes.

- 1.5.2.13. Each claim in the system includes the diagnostic, procedural, pharmaceutical classification system or other generic code per line item.
- 1.5.2.14. Each claim in the system includes the provider's name and practice number.
- 1.5.2.15. Recovery of overpayment or unlawful payment of claims reversed to providers, occur monthly against the correct provider with specific details.
- 1.5.2.16. The applicant has the ability to record the reversal of claims for retrospective terminations correctly.
- 1.5.2.17. The applicant has the ability to reconcile and manage third party claims (for example Road Accident Fund and compensation for occupational injuries and diseases) monthly and ensure any reconciling items are cleared timeously.
- 1.5.2.18. The system facilitates the distinction between prescribed minimum benefits and other benefits.
- 1.5.2.19. Claims are only approved for payment after first interrogating the individual member record to establish the member's entitlement to benefits.

1.5.3. Valid claims payments are allocated to individual member level.

- 1.5.3.1. The applicant can provide a complete, reconciled claims payment schedule history per individual member.
- 1.5.3.2. The applicant has the ability to assign REF risk factors to beneficiary level based on the claims and diagnosis information in accordance with the REF Entry and Verification criteria.
- 1.5.3.3. The applicant's system maintains each beneficiary's REF risk factor status history, including the claims history and diagnosis information on which the risk factor status is based, for at least 3 years.
- 1.5.3.4. The claims management system is integrated with all other sub-systems to ensure immediate and accurate processing of claims.
- 1.5.3.5. The applicant's system has the capability to extract the required data, at beneficiary level, to complete the REF returns.
- 1.5.3.6. The system ensures the allocation of claims to the correct accounting period based on the treatment date of the claims.

1.5.4. Claims payments are accurate and valid and in line with specific scheme rules and the Act.

- 1.5.4.1. The payment of all claims is made strictly in accordance with the rules of the medical scheme and the benefit option selected by each individual member.
- 1.5.4.2. The applicant's system is date sensitive and will prevent payment of any benefit after date of suspension/termination other than benefit entitlements prior to suspension/termination
- 1.5.4.3. The administrator demonstrates that adequate clinical audit procedures are in place to detect any potential non-disclosure based on sound data mining protocols.
- 1.5.4.4. All valid claims must be paid within 30 days of all information being provided to verify the validity of the claim.
- 1.5.4.5. The applicant has in place an effective procedure to inform members, within 30 days of receipt of a claim, that such claim is erroneous or unacceptable for payment and to provide reasons therefore (regulation 6(2) of the Act).
- 1.5.4.6. The claims management system is able to accept claims in the majority of formats submitted (for example: electronically).

- 1.5.4.7. The claims management system prevents claims being paid in respect of members that are suspended or terminated.
- 1.5.4.8. The claims management system is able to identify and prevent payment of duplicate claims.
- 1.5.4.9. The claims management system is able to identify and prevent processing of claims with no membership number.
- 1.5.4.10. The claims management system is able to identify and prevent processing of stale claims, i.e. claims received after the end of the fourth month following the end of the month of treatment.
- 1.5.4.11. Stale claims are not paid without an authorised mandate from an authorised officer of the medical scheme concerned.
- 1.5.4.12. The claims management system is able to identify and prevent processing of claims without a valid provider practice code number.
- 1.5.4.13. The claims management system is able to identify and prevent processing of claims that exceed the benefits for an individual member.
- 1.5.4.14. The system prevents the processing and payment of claims outside the membership period.
- 1.5.4.15. The applicant has the ability to produce exception reports (e.g. force code report) that logs all verified manual changes, which must be authorised by senior management.
- 1.5.4.16. Contracted fees to providers are calculated and paid in terms of the applicable agreements.
- 1.5.4.17. The applicant is able to make payments to providers electronically.
- 1.5.4.18. Providers are appropriately informed of payment being made.
- 1.5.4.19. All discounts received from service providers are allocated to the scheme, and at member level where applicable.
- 1.5.4.20. The claims management system has the capability of processing legitimate adjustments to valid claims after an appropriate level of authorisation.
- 1.5.4.21. The claims management system is checked to establish if the claim is a reinsurance or third party claim and to ensure that this can be substantiated.
- 1.5.4.22. Audit trails exist for all transactions processed through the claims management system.
- 1.5.4.23. The applicant demonstrates a procedure to effectively deal with resubmitted claims (adjusted or previously rejected claims) in line with the requirements of the Act and the rules of the scheme.

1.5.5. Medical savings accounts are administered and controlled according to the provisions of the Act and the rules of each medical scheme, with particular regard to the allocation of claims between the risk pool and savings accounts.

- 1.5.5.1. Medical savings accounts are treated according to the Act and the rules of the medical scheme.
- 1.5.5.2. The allocation between risk contributions/claims and savings contributions/claims is performed correctly.
- 1.5.5.3. The applicant is able to reconcile all medical savings accounts with the general ledger and to an individual member level at least monthly.
- 1.5.5.4. The applicant is able to generate at any time a detailed report reflecting each individual member's available savings account balance.
- 1.5.5.5. The applicant is able to generate at any time a detailed report reflecting the savings account liability owing to, or the overdrawn savings debtor owing by, each member.

- 1.5.5.6. The claims management system is checked prior to payment to establish that where a claim is made against the savings account there are sufficient funds available in the savings account to pay the claim.
- 1.5.5.7. Interest is calculated and allocated to individual member savings accounts on a monthly basis or in accordance with the rules of the scheme.
- 1.5.5.8. The system parameters are configured to ensure that no more than 25% of gross contributions (i.e. registered contributions) is allocated to savings accounts.
- 1.5.5.9. The applicant demonstrates a procedure to refund the balance of the savings account to the individual member on resignation or death, or to transfer savings balances to another scheme within 6 months of termination date.

1.5.6. Members receive regular, detailed and accurate claims statements.

- 1.5.6.1. Each month and in respect of valid claims that have been paid, the applicant dispatches to the affected member a statement detailing the benefits that the member received.
- 1.5.6.2. Member statements include the member's name and membership number.
- 1.5.6.3. The statement indicates to whom the service was provided.
- 1.5.6.4. The statement provides the name of the service provider.
- 1.5.6.5. The statement provides the date of service rendered.
- 1.5.6.6. The statement provides the total amount charged for the service supplied.
- 1.5.6.7. The statement provides the amount of benefit awarded for the service.
- 1.5.6.8. The statement indicates the amount payable by the scheme and the member's portion in accordance with the benefit option for that member.
- 1.5.6.9. The statement provides details of the member's available savings balance, and the information is available by telephone or electronic request.
- 1.5.6.10. The statement provides details of unused/available benefits, or the information is available by telephone or electronic request.

1.6. Financial management reporting

Intent

An administrator must comply with legislation and be in a position to provide the Principal Officer and the Board of Trustees of each medical scheme with up-to-date information on scheme performance.

1.6.1. The ability exists to produce all reports required for completion of the statutory returns in the format required by the Council.

- 1.6.1.1. The applicant is able to collect and collate financial management information as well as non-financial information to facilitate the compilation of the statutory returns in the required format and within the prescribed time.

1.6.2. The ability exists to produce, at least monthly, reconciliations between the operating and financial management systems, including but not limited to contributions, claims and savings accounts.

Intent

Where the administration system and the general ledger accounting system are not fully integrated into one system and a process of batch posting is relied upon to transfer data from one system to another, the process must be secure and free of error.

- 1.6.2.1. The applicant allocates, reconciles and maintains medical scheme accounts, as prescribed by the Act and/or medical scheme rules.
- 1.6.2.2. All journal entries are adequately narrated and signed off by a senior level official.
- 1.6.2.3. Reconciliations for all accounts are performed monthly between the sub-systems and the general ledger. These reconciliations are completed before the end of the following month end.
- 1.6.2.4. All major variances are explained at the time of completing all the reconciliations.
- 1.6.2.5. Action plans are instituted to prove that these reconciling items are completed systematically with named individuals being responsible.
- 1.6.2.6. Contribution income reflected in the income statement, cash received and outstanding contribution debtors are reconciled to the billing run, at least monthly.
- 1.6.2.7. The balance of outstanding contributions on the contribution management system or individual member records is reconciled to the general ledger control accounts at least monthly.
- 1.6.2.8. Reconciling items should be cleared at least monthly and, where not, reported to the specific medical scheme.
- 1.6.2.9. All major variances are explained at the time of completing the reconciliation.
- 1.6.2.10. The total of the individual savings accounts are reconciled to the general ledger at least monthly where the allocation to savings accounts from gross contributions, less claims paid from savings, plus interest accrued or paid (if applicable) equates to the balance available to the member or the amount owing to the member, as the case may be.
- 1.6.2.11. The cash book for each scheme under administration is reconciled monthly to the bank statement.
- 1.6.2.12. All reconciling items on the cash book reconciliation are cleared before the end of the month following the month in question and where they are not cleared, a full report and explanation is provided to the Principal Officer of the scheme concerned.
- 1.6.2.13. The claims payment run is reconciled to the general ledger control account and to individual member account level.
- 1.6.2.14. All claims payments that have not been cleared by the bank for payment after 6 months from date of issue are identifiable in a separate general ledger control account for stale cheques.
- 1.6.2.15. All stale cheques are recorded as a liability of the scheme for at least 3 years or until otherwise prescribed in law.
- 1.6.2.16. The age analyses of amounts owing to the scheme is produced at individual member level and reconciles to the general ledger control account at least monthly.
- 1.6.2.17. Amounts owing by the scheme to members are recorded and reflected in the general ledger and financial statements of the scheme separately from amounts owing to the scheme by members.
- 1.6.2.18. Contributions owing to the scheme are reflected separately from amounts owing by members in respect of overdrawn savings and/or co-payments.
- 1.6.2.19. Contributions or other amounts received in advance of due date are reflected as a creditor at period end.
- 1.6.2.20. The detailed contribution debtors' age analysis should be compared / reconciled to the data membership management system to ensure that the member did not resign or terminate his/her membership between the date of billing and the reconciliation date.

- 1.6.2.21. Administration fees paid and managed care expenses should reconcile to the billing run and/or contributions received in order to ensure payments are made in terms of applicable agreements.
 - 1.6.2.22. The individual commission schedules should be reconciled to the general ledger and the commission system.
 - 1.6.2.23. Payments should only occur to brokers accredited under the Medical Schemes Act.
 - 1.6.2.24. Investment schedules received from the investment managers should be reconciled to the general ledger.
 - 1.6.2.25. Any accrued interest on investments should be recorded as a debtor and any interest received in advance should be classified under creditors.
 - 1.6.2.26. The applicant provides reports on the status and performance of investments.
 - 1.6.2.27. All monthly reconciled control accounts should be signed off by the responsible person as having completed the task and the financial manager should review all reconciliations monthly.
 - 1.6.2.28. Debtors ageing – Outstanding amounts owing by members to the scheme must be aged correctly, and amounts received must be matched to the relating amount on the age analysis according to a remittance advice or confirmation from the debtor, and not against the oldest outstanding amount.
- 1.6.3. The ability exists to produce complete and accurate detailed operational documentation (monthly financial statements /management accounts, annual financial statements, and budgets or otherwise) for each scheme under administration as required by the Board of Trustees.**
- 1.6.3.1. The applicant is able to comply with section 37 of the Act with regard to the preparation of annual financial statements for each scheme under administration.
 - 1.6.3.2. The applicant is able to produce a monthly balancing trial balance.
 - 1.6.3.3. The annual financial statements are prepared in accordance with International Financial Reporting Standards (IFRS).
 - 1.6.3.4. The annual financial statements fairly present the state of affairs and the business of the scheme and the results thereof and the surplus or deficit for the year.
 - 1.6.3.5. A valid methodology exists in the calculation of the provision for outstanding claims (IBNR), which takes into account various factors e.g. claims patterns, member demographics and changes in the nature and average cost of claims, and is supported by appropriate working papers.
 - 1.6.3.6. The actual claims paid figure used in the calculation of IBNR should correspond with the claims figure accounted for in the general ledger.
 - 1.6.3.7. The applicant provides back-up information for all line items on the income statement.
 - 1.6.3.8. The applicant provides back-up schedules to validate all major balances on the balance sheet.
 - 1.6.3.9. The applicant provides accurate and valid monthly management reports in the format required by the Board of Trustees and /or Principal Officer.
 - 1.6.3.10. The applicant has procedures to ensure that provisions are raised for any long-outstanding contributions, if not recoverable in line with the rules of the scheme and the Board of Trustees policy decision.
 - 1.6.3.11. Any bad debt written off and all provision for bad debts is approved by the Board of Trustees of the medical scheme.
 - 1.6.3.12. The ability exists to produce accurate, valid and complete information per benefit option and on a consolidated basis as required by section 37(4)(d) of the Act.

- 1.6.3.13. Where appropriate or prescribed by law, including SAICA guidelines, separately discloseable items should be disclosed as such (for example: re-insurance, brokers commission, investment schedules of all categories of assets invested, etc).
- 1.6.3.14. Audit trails exist for all entries processed through the financial management system.
- 1.6.3.15. All realised surpluses and/or deficits are included in the Income Statement and all unrealised surpluses and deficits are treated as per the scheme's accounting policy.
- 1.6.3.16. Items of income and expenditure and assets and liabilities are classified correctly, and are not offset against each other.
- 1.6.3.17. The applicant has the ability to provide the scheme with monthly financial reports covering issues such as contribution schedules, credit control, claim settlement, payment of creditors, age analysis of debtors and creditors, lists of debtors, analysis of provider claims that have been reversed.
- 1.6.3.18. The applicant is able to provide the necessary financial information to enable the Principal Officer and Board of Trustees to develop budgets, to analyse budget variations to income and expenditure and provide reasons for variations.
- 1.6.3.19. The applicant is able to produce annual budgets (income statement and balance sheet) with detailed assumptions for the medical scheme for approval by the Board of Trustees.
- 1.6.3.20. The applicant develops and implements written policies and procedures for all accounting functions.
- 1.6.3.21. Financial managers make these policies and procedures available to guide staff and assist them in implementing them.

1.7. Information management and data control

Intent

To provide, co-ordinate and integrate services, administrators rely upon and require an array of information. Information must be managed in such a way that promotes integrity and protects the interests of schemes and their members.

1.7.1. A comprehensive off-site data storage, backup policy and disaster recovery process exists in compliance with accepted industry norms and standards.

- 1.7.1.1. Data is successfully and completely backed up daily.
- 1.7.1.2. Daily backups are stored off the premises of the applicant in a secure and fire-proof environment on at least a weekly basis.
- 1.7.1.3. Comprehensive disaster recovery systems and business continuity plans are implemented to ensure complete data recovery.
- 1.7.1.4. Hardware redundancy exists and is built into the system.

1.7.2. The administrator is able to maintain the confidentiality, security and integrity of data and information.

Intent

A comprehensive information security policy exists which will ensure the confidentiality, security, retention and integrity of data and information.

- 1.7.2.1. Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained on the system.
 - 1.7.2.2. Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained by officers and staff of the administrator.
 - 1.7.2.3. The policies and procedures identify those permitted access to each category of data and information and access controls are in place in order to enforce proper segregation of duties.
 - 1.7.2.4. A corporate/enterprise wide Anti-Virus solution exists and is implemented to secure data against malicious viruses, Trojans, worms, etc.
 - 1.7.2.5. A corporate/enterprise wide Anti-Virus solution is updated on a frequent basis to ensure adequate protection of data against malicious viruses, Trojans, worms, etc.
 - 1.7.2.6. System* level activities (e.g. changes to the system or parameters) are logged, reviewed and managed on a monthly basis.
 - 1.7.2.7. System* level exception reports are reviewed monthly.
 - 1.7.2.8. Each process is defined to ensure that only authorised individuals maintain member records.
 - 1.7.2.9. The applicant has procedures to ensure that the system parameters are only capable of amendment by authorised senior management.
 - 1.7.2.10. There is an 'audit trail' of authorised individuals entering the system.
 - 1.7.2.11. There is an audit trail of all attempts at unauthorised entry into the system or to certain sections that are unauthorised to the specific user, and is reviewed by senior management.
- 1.7.3. The administrator has in place processes for the early detection and mitigation of irregularities and illegal acts by employees, members and providers.**
- 1.7.3.1. Processes have been established to identify and record possible irregularities and illegal acts.
 - 1.7.3.2. At a minimum, the applicant has in place a basic fraud detection system.

1.8. Customer services

Intent

The applicant is in the business of providing services to a medical scheme and its members. In addition to having robust internal operating processes, the applicant must provide members with relevant and professional customer care services.

- 1.8.1. The applicant provides medical schemes and their members with the full range of services as stipulated in the contract/agreement between the scheme and administrator. Legislative requirements are also complied with at all times.**
- 1.8.1.1. The applicant ensures delivery against all customer services as stipulated in the contract/agreement between the medical scheme and applicant. These services might include operating a call centre/ information centre that effectively deals with enquiries.
 - 1.8.1.2. The applicant ensures delivery against all customer services as stipulated in the contract/agreement between the medical scheme and applicant. These services might include ensuring that robust communication processes exist for all medical scheme members in more than one language.

* System refers to both the application and operating systems.

- 1.8.1.3. The applicant ensures delivery against all customer services as stipulated in the contract/agreement between the medical scheme and applicant. These services might include having in place mechanisms to deal with written enquiries from members and providers.
- 1.8.1.4. Records are maintained of all enquiries made per specific scheme and the response of the applicant in dealing with them.

1.8.2. Where required, the applicant appropriately manages the payment of broker commissions in full compliance with the Act.

- 1.8.2.1. The applicant has in place a robust and transparent process that calculates and makes broker payments in full compliance with the Act.
- 1.8.2.2. The applicant is able to produce a fully detailed report of all broker commissions paid that confirms correct payment in terms of the Act.
- 1.8.2.3. The applicant has a process in place to ensure that commission is calculated and paid for member appointed brokers only, i.e. broker notes or appointment letters are in place.
- 1.8.2.4. The applicant has a process to ensure that the payment of commission is only made in terms of a prior written agreement with the medical scheme.
- 1.8.2.5. The applicant has a process in place to ensure that every broker in receipt of commission is accredited in terms of the Act, from the first time of calculating the commission.
- 1.8.2.6. Broker payment reports are available per individual broker and per scheme.