ACCREDITATION STANDARDS

FOR

MANAGED CARE ORGANISATIONS

Version 4

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REGULATORY PROVISIONS:

Section 67(1)(m) of the Medical Schemes Act, 1998 &

Chapter 5 of the Regulations

1. EXECUTIVE SUMMARY

This document sets out the accreditation standards for managed care organisations to be complied with, as required by the Medical Schemes Act, No 131 of 1998 and concomitant regulations (the Act).

The accreditation process involves a detailed evaluation of organisations, their facilities and infrastructure to determine whether they are fit and proper to provide managed care services to beneficiaries of medical schemes in accordance with the regulatory requirements.

Upon completion of the accreditation process, the Council may grant a bona fide managed care organisation accreditation, subject to conditions being met. It is at the discretion of Council to determine the accreditation status and the timeframes required for a managed care organisation to take corrective action if required. All accredited entities are furthermore required to comply with all standards for accreditation at all times and the office of the Registrar may at any time request information to establish such compliance.

It is important to note that this document is a living document which may be amended as and when required.

2. INTRODUCTION:

2.1 **Managed care**, within the South African context, is a term used to refer to a diverse range of healthcare organisational strategies aimed at controlling cost, improving access and assuring higher levels of quality of care provided to those covered by medical schemes.

2.2 The Council envisions managed health care service provision and financing which is optimally coordinated to ensure affordability, accessibility and quality of care, and which is focused on meeting physical, emotional, social, and spiritual needs of individuals while respecting their privacy and personal integrity.

2.3 **Regulation 15** defines the following managed care terms and concepts**:**

- "**managed health care"** means *"clinical and financial risk assessment and management of health care, with the view to facilitating appropriateness and cost-effectiveness of relevant health care services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes"*

- "**rules-based and clinical management-based programmes**" means a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of, health care services, procedures or settings, on the basis of which appropriate managed health care interventions are made.

- **"Evidence-based medicine"** means the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.

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

- **"Protocol"** means a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways.

- **"Managed health care organisation"** means a person who has contracted with a medical scheme in terms of regulation 15A to provide a managed health care service.

- **"participating health care provider"** means a health care provider who, by means of a contract directly between that provider and a medical scheme in terms of regulation 15A, or pursuant to an arrangement with a managed health care organisation which has contracted with a medical scheme in terms of regulation 15A, undertakes to provide a relevant health service to the beneficiaries of the medical scheme concerned.

2.4 The regulations further require any person entering into a managed care arrangement with a medical scheme to be **accredited** by the Council for Medical Schemes, hereinafter referred to as the "Council". The Council may request such information as it may deem necessary to satisfy itself that the managed care organisation meets the requirements for accreditation:

- It is fit and proper to provide managed health care services;

- It has the necessary resources, systems, skills and capacity to render the managed health care services which it wishes to provide; and
- It is financially sound.

2.5 It is important to note that accreditation as a managed care organisation is not an endorsement by the Council of the products or services offered by such organisations. The assurance provided to stakeholders does not relieve trustees of medical schemes from their fiduciary duty to exercise their powers to the benefit of the scheme, whilst displaying reasonable care and skills in this regard.

2.6 All managed care organisations should give due consideration to the application of the "Code of governance principles" as defined in the King Code of Corporate Governance insofar as the principles are applicable. Stakeholders interacting with such organisations are encouraged to monitor the application by these organisations of the principles set out in the Code. Organisations are required to measure the principles set out in the Code with other statutes and regulations and other authoritative directives regulating their conduct and operation with a view to applying not only the most applicable requirements, but also to seek to adhere to the best available practice that may be relevant to the organisation in its particular circumstances.

3. THE ACCREDITATION PROCESS:

3.1. Applying for accreditation

(a) Regulation 15B requires an entity to provide a written application to Council in the manner as prescribed. The prescribed application fee must also be paid to the Council.

(b) The application is reviewed by Council for completeness and validity and any additional information which may be required is obtained.

(c) Renewal of accreditation application – The organisation must submit its application for renewal of accreditation at least 3 months prior to the expiry of the current accreditation period. The same procedures as indicated in (a) and (b) above apply.

3.2. On-site evaluation of the organisation's compliance with the accreditation standards

(a) The evaluation team from Council will conduct a set-up meeting at the premises of the managed care organisation where the self-evaluation questionnaire (which contains the accreditation standards in questionnaire format) is provided to the organisation and the evaluation process is explained.

(b) The organisation is then afforded the opportunity to complete the questionnaire and evaluate its compliance with each of the accreditation standards. The completed questionnaire must be cross-referenced to supporting evidence of compliance which is evaluated by the evaluation team during the on-site evaluation.

(c) The on-site evaluation takes place at the premises of the organisation, during which the organisation's compliance with each of the accreditation standards is tested and verified. The following assessment is possible:

- Compliant: which means all criteria are met.

- Partially Compliant: which means the applicant met most of the criteria stipulated under the standard.

- Non-Compliant: which means the applicant did not meet the stipulated criteria.
- Not Applicable: which means the standard or part of the criteria is not relevant to the kind of services provided or activities conducted by the applicant.

(d) Upon completion of the on-site evaluation a "close-out" meeting is held with the senior management of the entity to discuss the evaluation findings. The organisation is then provided with a copy of the evaluation findings report and is afforded an opportunity to formally comment on the findings.

(e) The organisation's comments on the evaluation findings are incorporated into the findings report, which is then presented to an internal steering committee which consists of representatives from various units within Council.

(f) The final evaluation findings report and cover report (including recommendations) are presented to the Executive Committee of Council for consideration. Council will either grant accreditation (subject to any relevant conditions as may apply) where the organisation has met all the requirements for accreditation or request further information for consideration.

(g) An organisation is accredited for a period of twenty-four months, and is afforded a reasonable time period during which to comply with any accreditation conditions imposed.

(h) Conditions compliance evaluations (desk-based, and on-site where required) are performed to assess whether the organisation has complied with the accreditation conditions. Once all the conditions have been

complied with, a clear accreditation certificate is issued by the Accreditation Unit and the Council website updated accordingly.

(i) Renewal of accreditation – a full or partial, on-site re-evaluation of the organisation's compliance with the accreditation standards may be performed upon renewal of accreditation if there had been significant changes in the operating environment of the managed care organisation, e.g. a change in managed care systems employed, change in shareholding, change in services offered, etc. The same processes as described in (a) to (h) above will apply.

(j) Accreditation is done in respect of services specified on the accreditation certificate and applicants are not allowed to extend the scope of services without notifying this office and having obtained the necessary approval.

4. IMPLEMENTATION PROCESS

This document should be read in conjunction with the latest version of the policy document on managed care posted on the Council website at www.medicalschemes.com.

THE ACCREDITATION STANDARDS

SECTION 1 – GENERAL COMPLIANCE

Standard 1.1:

The current or proposed managed care organisation operates as a bona fide provider of managed care services, is based in South Africa, and has applied for accreditation in terms of regulation 15(B)(2) of the Act.

1.1.1 An application for accreditation has been made in terms of Regulation 15(B)(2) of the Act and is accompanied by all required supporting documentation.

1.1.2 The legal entity is registered in terms of South African law.

1.1.3 A copy of the relevant registration certificate or other supporting documentation is attached to the application.

1.1.4 The applicant's head office is based in South Africa.

1.1.5 Prescribed application fees have been paid.

1.1.6 A valid tax clearance certificate has been provided.

Standard 1.2:

The managed care organisation is financially sound (Regulation 15B(2)).

1.2.1 An auditor has been appointed to examine the accounting records and annual financial statements of the managed care organisation in accordance with the South African Auditing Standards and in compliance with International Financial Reporting Standards (IFRS).

1.2.2 The financial statements clearly confirm that the managed care organisation has assets which are at least sufficient to meet liabilities.

1.2.3 The financial statements clearly confirm that the managed care organisation's business is conducted in a manner to ensure that the business is at all times in a position to meet its liabilities.

1.2.4 The financial statements clearly confirm that the organisation's business is a going concern.

Standard 1.3:

Signed managed care agreements exist for all schemes.

1.3.1 Signed agreements exist for all medical schemes to which managed care services are provided.

1.3.2 The agreement clearly confirms the applicant and medical scheme as contracting parties.

1.3.3 The agreement confirms the scope and duties of the organisation for each specific scheme.

1.3.4 The agreement contains full details of fees payable by the medical scheme, including the basis on which fees are determined and manner of payment thereof.

1.3.5 Fees are specified per individual or group of related services provided.

1.3.6 The agreement provides for measures to ensure confidentiality of beneficiaries' information.

1.3.7 The agreement provides for the right of access by the medical scheme to any treatment record held by the managed care organisation or health care provider, and other information, data and records pertaining to the diagnosis, treatment and health status of the beneficiary in terms of the agreement subject to disclosure of such information in compliance with Regulation 15J(2)(c).

1.3.8 Provision is made in the agreement for the duration thereof.

1.3.9 Termination arrangements are clearly defined in the agreement.

1.3.10 The agreement provides for a formal mechanism which deals with disputes between the contracting parties.

1.3.11 The agreement provides for a formal mechanism which deals with complaints/disputes and appeals against the organisation which may be lodged with the scheme concerned and does not prevent the complainant from lodging complaints/disputes and appeals to the Council.

1.3.12 Provision is made in the agreement that if managed care services are sub-contracted by the organisation to another provider, no beneficiary may be held liable by the managed care organisation or any participating health care provider for any sums owed in terms of the agreement in compliance with Regulation 15E(b).

1.3.13 The agreement includes a detailed service level agreement which contains details of the services to be provided, agreed upon service levels, performance measures, and resulting penalties/remedies available to the parties in the case of partial or non-performance.

1.3.14 All amendments to the agreement, including annual fee adjustments are in writing and signed by the parties.

Standard 1.4:

Where applicable, capitation agreements entered into comply with Regulation 15F.

1.4.1 The agreement constitutes a bona fide transfer of risk from the medical scheme to the managed care organisation.

1.4.2 The agreement provides for a capitation based payment which is reasonably commensurate with the extent of the risk transferred.

Standard 1.5:

The organisation has in place policies and procedures to ensure that health care providers, beneficiaries of the relevant medical schemes and any other interested parties have reasonable access (on demand) to relevant information.

1.5.1 Policies and procedures include a clear and comprehensive description of the managed health care programmes and procedures in compliance with Regulation 15D(e).

1.5.2 Policies and procedures include the procedures and timeframes within which to appeal against utilisation review decisions adversely affecting the rights or entitlements of beneficiaries in compliance with Regulation 15D(e).

1.5.3 Policies and procedures include any limitations on rights or entitlements of beneficiaries including but not limited to restrictions on coverage of disease states, protocol requirements and formulary inclusions or exclusions.

1.5.4 Policies and procedures include details of designated service providers and/or preferred providers where applicable.

Standard 1.6:

Managed care policies and procedures.

1.6.1 Policies and procedures describe the manner of periodical assessment of managed care activities and reports to client schemes.

1.6.2 Policies and procedures exist that specify the staff positions functionally responsible for day-to-day management of the relevant managed care programme(s).

1.6.3 Policies and procedures exist that specify data collection processes and analytical methods used in assessing ultilisation and cost effectiveness of managed care services provided.

1.6.4 Policies and procedures exist that specify how confidentiality of clinical and proprietary information is to be maintained.

SECTION 2 – ORGANISATIONAL STRUCTURE AND INFORMATION MANAGEMENT

Standard 2.1:

Organisational structure and risk management.

2.1.1 The organisation is able to provide an up-to-date organogram aligned to its business process flow diagrams, which clearly indicates roles and responsibilities.

2.1.2 The organisation designates suitably qualified and skilled staff to perform clinical oversight in respect of services provided. In addition the appropriateness of such decisions are evaluated periodically by clinical peers in compliance with Regulation 15D(d).

2.1.3 Documented evidence exists that the organisation has verified that all relevant employees are registered with the relevant professional bodies.

2.1.4 The organisation has a documented risk register that identifies the risks, risk ratings and mitigating controls, including the ability of the system to deal with capacity, complexity and potential growth of the business.

Standard 2.2:

Detailed business process flow diagrams.

2.2.1 The organisation is able to provide detailed business process flow diagrams of all its current operational functions.

2.2.2 The business process flow diagrams clearly illustrate how the operational functions are integrated.

2.2.3 The business process flow diagrams identifies all out-sourced services.

2.2.4 The business process flow diagrams demonstrate the process adopted by the organisation to integrate out-sourced services.

Standard 2.3:

Systems diagram.

2.3.1 The organisation is able to provide a high level systems diagram of all systems employed.

2.3.2 The systems diagram clearly illustrates how integration with out-sourced services is achieved.

Standard 2.4:

Suitable corporate governance structures and policies are in place.

2.4.1 The governance structures and policies in place address all ethical issues pertaining to the organisation's functions.

2.4.2 The governance structures and policies in place ensure that staff members are trained on ethical issues which are relevant to their job descriptions.

2.4.3 The governance structures and policies in place ensure that the organistaion's reimbursement, bonus, or incentive systems in respect of staff or health care providers do not compromise members' best interests or the quality of care provided.

Standard 2.5:

The organisation is able to maintain confidentiality, security and integrity of data and information.

2.5.1 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained on the system.

2.5.2 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained by officers and staff of the organistation.

2.5.3 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.

2.5.4 The organisation has procedures to ensure that the system parameters are only capable of amendment by authorised senior management.

2.5.5 There is an audit trail of authorised individuals entering the system.

2.5.6 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 which is reviewed by senior management.

Standard 2.6:

The organisation has in place processes for the early detection and mitigation of irregularities and illegal acts by employees, members and providers.

2.6.1 Processes have been established to identify, record and resolve possible irregularities and illegal acts which may include mechanisms such as a fraud hotline, whistle blower processes, etc.

2.6.2 At a minimum, the applicant has in place a basic fraud detection system.

Standard 2.7:

Comprehensive back-up policies and disaster recovery processes exist in accordance with accepted industry norms and standards.

2.7.1 Data is successfully and completely backed up daily.

2.7.2 Daily backups are stored off the premises of the applicant in a secure and fire-proof environment on at least a weekly basis.

2.7.3 Comprehensive disaster recovery and business continuity plans are implemented to ensure complete data recovery.

2.7.4 Testing of the disaster recovery and business continuity plans is done periodically to ensure that it is fully functional.

2.7.5 Hardware redundancy (e.g. the provision of multiple interchangeable components to perform a single function in order to provide resilience (to cope with failures and errors)) exists and is built into the system.

SECTION 3 – CLINICAL OVERSIGHT

Standard 3.1:
Protocols utilised are in compliance with Regulations 15D, 15H and 15I.

Standard 3.1.1:
Documented protocols are in place in compliance with Regulations 15D, 15H and 15I.

3.1.1.1 The documented protocols are developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability.

3.1.1.2 The documented protocols are clear, comprehensive, include a description of the managed health care programmes and procedures, and are made available on request.

3.1.1.3 The documented protocols contain details of any limitations on rights or entitlements of beneficiaries, including but not limited to restrictions on coverage of disease states, protocol requirements and formulary inclusions and exclusions.

3.1.1.4 The documented protocols contain details of the clinical review criteria used in consideration of the cost effectiveness to ensure relevance of funding decisions in compliance with Regulation 15D(b).

3.1.1.5 The documented protocols incorporate procedures to evaluate clinical necessity, appropriateness, efficiency and affordability of services provided, to intervene where necessary and to inform beneficiaries, providers of care acting on their behalf, and medical schemes of the outcomes of such procedures.

3.1.1.6 The documented protocols describe mechanisms to ensure consistent application of clinical review criteria and compatible decisions.

3.1.1.7 The documented protocols provide for clinical pathways and appropriate exceptions where a protocol or specific treatment is or has been ineffective, or causes or would cause harm to a beneficiary, without penalty to such beneficiary.

3.1.1.8 The written protocols contain managed care programmes that are based on transparent and verifiable criteria for other relevant factors that affect funding decisions which are periodically evaluated in compliance with regulation 15D(c).

3.1.1.9 The documented protocols include procedures to be followed for beneficiaries and providers to appeal decisions made in accordance with the protocols.

Standard 3.1.2:

The documented protocols demonstrate appropriate clinical coding rules applied.

3.1.2.1 Clinical coding rules applied ensure proper identification and reconciliation of the application of the protocols.

3.1.2.2 Clinical coding rules are compliant with legislation regarding Prescribed Minimum Benefits (PMB's).

3.1.2.3 The organisation has procedures in place to ensure that the managed care systems maintain the most recent diagnostic, procedural, pharmaceutical classification system and other generic tariff codes.

Standard 3.2:
Clinical effectiveness and quality management.

Standard 3.2.1 – The organisation has in place a documented and well defined quality management programme to measure clinical outcomes.

3.2.1.1 The quality management programme is approved and supported (including commitment of the necessary resources) by senior management.

3.2.1.2 The quality management programme clearly defines the scope, objectives, structure and activities of the programme.

3.2.1.3 The quality management programme includes key quality indicators.

Standard 3.2.2:
Quality management function, reporting and outcomes.

3.2.2.1 The quality management function is mandated by senior management to oversee the quality management programme and to implement recommendations.

3.2.2.2 The quality management function guides the organisation on priorities and projects in terms of quality management.

3.2.2.3 The quality management function documents the processes followed in the implementation of the recommendations made and outcomes achieved.

3.2.2.4 The quality management function monitors and evaluates the progress made towards achieving the quality management programme goals.

3.2.2.5 The quality management function reports the quality management outcomes to the schemes in terms of the applicable agreements.

Standard 3.2.3:

Value added by the organisation.

3.2.3.1 The applicant has demonstrated the value added services to client schemes in accordance with the structured cost/benefit analysis (see attached as Annexure 1)

SECTION 4 – SCHEME MEMEBERSHIP MANAGEMENT

Standard 4.1:

The organisation maintains relevant membership information.

4.1.1 The organisation maintains up-to-date scheme membership records on its managed care system in accordance with the managed care agreement with the scheme concerned.

4.1.2 The member records indicate whether a member is active, or has been suspended or terminated.

4.1.3 The member record indicates waiting periods and exclusions relevant to the services provided by the organisation.

4.1.4 Member banking details are only updated by authorised staff. (Where applicable).

4.1.5 Audit trails exist of all changes made to member records.

SECTION 5 – CLAIMS MANAGEMENT

Standard 5.1:

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

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 with which the organisation has contracted to provide managed care services.

5.1.2 Marketing material issued by the organisation in respect of managed care services rendered to members is fully aligned with the registered rules (specifically with regards to benefits) of the scheme concerned.

5.1.3 The organisation has procedures to ensure that the system parameters are only capable of amendment by authorised senior management.

Standard 5.2:

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

5.2.1 All claims received should be date stamped with the applicable date on which the claim was first received, and this date is captured as the date received on the system.

5.2.2 A log (manual or electronic) is maintained to ensure that all claims received have been captured onto the system.

5.2.3 All legitimate claims are captured and assessed in line with the rules of the medical scheme and individual benefit option profiles, as well as the appropriate managed care protocols applied.

5.2.4 The date of service for each claim is recorded on the system.

5.2.5 The system automatically generates unique reference numbers for each claim captured.

5.2.6 Individual beneficiary details per claim are recorded on the member record.

5.2.7 The date of processing of each claim is recorded on the system.

5.2.8 Internal control processes are in place to check on the accuracy of claim recording.

5.2.9 The date of payment of each claim is recorded on the system.

5.2.10 The organisation has procedures in place to ensure that the claims management system maintains the most recent diagnostic, procedural, pharmaceutical classification system and other generic tariff codes.

5.2.11 Each claim in the system includes the diagnostic, procedural, pharmaceutical classification system or other generic codes per line item.

5.2.12 The claims management system has the capability of processing claims against valid ICD10 codes.

5.2.13 Each claim in the system includes the provider's name, practice number and partner number (where applicable).

5.2.14 Recovery of overpayment or unlawful payment of claims reversed to providers, occur monthly against the correct provider with specific details.

5.2.15 The organisation 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.

5.2.16 The system facilitates the distinction between prescribed minimum benefits and other benefits.

5.2.17 Claims are only approved for payment after first interrogating the individual member record to establish the member's entitlement to benefits, including available savings where appropriate.

Standard 5.3:

Valid claims payments are allocated to individual member level.

5.3.1 The organisation can provide a complete, reconciled claims payment schedule history per individual member.

5.3.2 The organisation has the ability to extract the required data, at beneficiary level, to complete the ICD10 compliance reports as required by Council.

5.3.3 The claims management system is integrated with all other sub-systems to ensure immediate and accurate processing of claims.

Standard 5.4:

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

5.4.1 The processing and payment of all claims are done strictly in accordance with the rules of the medical scheme and the benefit option selected by each individual member.

5.4.2 The allocation between risk claims and savings claims is performed correctly.

5.4.3 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.

5.4.4 The organisation'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.

5.4.5 The organisation demonstrates that adequate clinical audit procedures are in place to detect any potential non-disclosure based on sound data mining protocols.

5.4.6 All valid claims must be paid within 30 days of all information being provided to verify the validity of the claim.

5.4.7 The organisation 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.

5.4.8 The claims management system is able to accept claims in the majority of formats submitted (for example: electronically).

5.4.9 The claims management system prevents claims being paid in respect of members that are suspended or terminated.

5.4.10 The claims management system is able to identify and prevent payment of duplicate claims.

5.4.11 The claims management system is able to identify and prevent processing of claims with no membership number.

5.4.12 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.

5.4.13 Stale claims are not paid without an authorised mandate from an authorised officer of the medical scheme concerned.

5.4.14 The claims management system is able to identify and prevent processing of claims without a valid provider practice code number.

5.4.15 The claims management system is able to identify and prevent processing of claims that exceed the benefits for an individual member.

5.4.16 The claims management system prevents the processing and payment of claims outside the membership period.

5.4.17 The organisation has the ability to produce exception reports in respect of claims processed (e.g. force code reports) that log all verified manual changes, which must be authorised by senior management.

5.4.18 Contracted fees to providers are calculated and paid in terms of the applicable agreements.

5.4.19 The organisation is able to make payments to providers and members electronically.

5.4.20 Providers are appropriately informed of payments being made.

5.4.21 All discounts received from service providers are allocated to the scheme, and at member level where applicable.

5.4.22 The claims management system has the capability of processing legitimate adjustments to valid claims after an appropriate level of authorisation.

5.4.23 Audit trails exist for all transactions processed through the system.

5.4.24 The organisation demonstrates a procedure to effectively deal with resubmitted claims (amended or previously rejected claims) in line with the requirements of the Act and the rules of the scheme.

Standard 5.5:

Members receive regular, detailed and accurate claims statements.

5.5.1 Each month and in respect of valid claims that have been paid, the organisation dispatches to the affected member a statement detailing the benefits that the member received, where applicable and in accordance with the managed care agreement.

SECTION 6 – FINANCIAL MANAGEMENT

Standard 6.1:

The ability exists to produce all information required to enable schemes to complete the statutory returns in the format required by the Council.

6.1.1 The organisation is able to collect and collate financial management information as well as non-financial information to enable the schemes to compile the statutory returns as required by Council.

Standard 6.2:

The ability exists to record and reconcile all scheme financial information where applicable.

6.2.1 Age analyses at individual member or provider level are produced monthly (where applicable).

6.2.2 Monthly reconciliations between the sub-systems and the general ledger are completed by the end of the following month.

6.2.3 Reconciling items on the monthly general ledger reconciliations are cleared timeously.

6.2.4 All journal entries are adequately narrated and signed off by a senior level official.

6.2.5 All claim cheque payments that have not been presented to the bank for payment within 6 months from date of issue are identifiable in a separate general ledger control account for stale cheques.

6.2.6 All stale cheques are recorded as a liability for at least 3 years or until otherwise prescribed in law.

6.2.7 A valid methodology is utilised in the calculation of the IBNR (outstanding claims) provision and takes into account various factors, e.g: claims patterns, member demographics, changes in the nature and average cost of claims, etc.

6.2.8 Where applicable, provisions for long outstanding debtors are raised.

SECTION 7 – CUSTOMER SERVICES

Standard 7.1:

Customer services are provided to the scheme and its members in accordance with the managed care agreement

7.1.1 The organisation provides all customer services in the manner stipulated in the managed care agreement.

Annexure 1

COST/BENEFIT ANALYSIS (VALUE ADDED TEMPLATE)

- Standard 3.2.3.1

Component	Measure	Notes and differentiators
• Access	1. How has the provision of service/s by your organisation improved access to appropriate levels of healthcare services of beneficiaries	E.g. access to GP's, specialists, hospitalisation, etc. CMS report indicators: • Clearly demonstrate that access to healthcare is fair and equitable. Scheme rules that limit access should be quoted and explained. • Differentiate between fee for service contracted DSP's and Capitation (or other differentiated reimbursement models) service providers clearly demonstrating ease of access to members taking into consideration infrastructural limitations such as presence or absence of public transport in area of member concentration relative to DSP. • Explain member education processes and communication strategy in place. Is it clear, understandable and in plain language for members to comprehend?
	2. How has the provision of service/s by your organisation improved geographical access to healthcare of beneficiaries.	• Demonstrate that access to health care is fair and equitable. • New members should be accommodated across all geographical areas. Explain and indicate location of service provision in terms of the geographical spread of medical scheme beneficiaries covered by the contract. • Explain approach towards limiting access implicitly as well as explicitly and provide reasons for each limitation. • Highlight contractual obligations to support motivation

Component	Measure	Notes and differentiators
• Cost	1. Quantify the financial benefit/cost to medical schemes through utilising your organisation's services in terms of healthcare expenditure.	• Indicate in terms of quarterly and annual cost • Provide detailed analysis of the difference between contribution income to the scheme and capitation fees charged per member and dependants and in total. • Rand value and percentage of contributions. Due to the nature of capitation arrangements the net financial effect to each scheme should be positive.
	2. Explain your pricing model/strategy in respect of the services provided, i.e. how do you arrive at your price relevant to the capitation or contracted fee for the risk managed by your organisation.	• Price transparency • List assumptions made • Include assumptions made and rationale followed in building your pricing model. • Provide cost efficiency analysis and clearly indicate the sustainability of the capitation arrangement and cover revenue *vs.* expenditure and done per healthcare discipline. • Explain by way of cost efficiency analysis how your managed care /admin processes (output criteria) reduced the cost and maximised the clinical outcomes for client scheme's members. Supply comparative data quarter to quarter over a 12 month period.
	3. From the fees received, what co-admin fees are payable to other parties e.g. administrator, re-insurer etc.	• Provide details and breakdown of non-healthcare items. • Provide full details of re-insurance arrangements if any and indicate the nature and extent of the risk so re-insured.
• Reimbursement mechanism(s)	1. Provide details of the reimbursement mechanism(s) used	• E.g. negotiated fee, fee for service or capitation arrangements, etc. • Describe the reimbursement model and

Component	Measure	Notes and differentiators
	to reimburse healthcare providers where services are outsourced.	process to arrive at the respective fee determination • Clear indication that services are sustainable through reimbursement model and balanced with healthcare provision to beneficiaries
• Quality of Care	1. How has the provision of service/s by your organisation (input criteria) impacted on the quality of care received by medical scheme members?	• Explain how quality is measured and monitored. Compare these indicators to local and international standards quality of measure. • Demonstrate use of protocols and illustrate focus on health outcomes rather than denial of benefits. • Effect of interventions relative on e.g. % re-admissions during a particular period.
• Reporting	1. How and when are the above results reported to medical schemes?	• Frequency and details reported on to assist scheme management to evaluate performance. Attach copies of specimen reports. • Provide proof of health outcome measurements showing which clinical, direct and indirect cost outcomes are monitored.
• Innovation	1. What differentiates your services provided from those provided by similar managed care organisations and the services provided by medical schemes themselves?	• Provide detailed analysis of differentiating factors • Tabulate results of the comparison.