



CIRCULAR

Reference: Definition and clarification of Managed Healthcare Services
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CIRCULAR 50 OF 2013: MANAGED CARE ACCREDITATION - DRAFT MANAGED HEALTHCARE SERVICES PUBLISHED FOR COMMENTS

The managed care accreditation, draft on managed healthcare services is hereby published for general comments by all relevant stakeholders.

In order to define and clarify managed care services, and to standardise the naming conventions used by the Council for Medical Schemes, medical schemes, managed health care organisations (MCOs), third party administrators and other stakeholders in the industry, it was decided to draft a document setting out the “accreditable” managed care services.

Kindly submit any comments or suggested changes you may have in writing to Ms Hannelie Cornelius, Accreditation Manager: Administrator and MCO's at h.cornelius@medicalschemes.com by close of business, Friday, 20 December 2013. The document is also available from the Council for Medical Schemes website in a format which can be edited and commented for your convenience (Click the link to open the document

<http://www.medicalschemes.com/files/Managed%20Care%20Organisations/MCOservices2013.docx>).

A handwritten signature in black ink, appearing to read 'Paresh Prema', is written over a horizontal line.

Paresh Prema
Acting Head of Accreditation
Council for Medical Schemes



MANAGED HEALTH CARE SERVICES

Introduction:

In order to define and clarify managed care services, and to standardise the naming conventions used by the Council, medical schemes, managed health care organisations (MCOs), administrators and other stakeholders in the industry, it was decided to draft a document setting out the “accreditable” managed care services. Whilst all managed health care services must meet the definition of a “relevant health service”, not all relevant health services will meet the definition of a “managed health care service”.

Some services which might have been perceived to be managed health care services as defined are in fact a health care service, administration services, or a complementary service to managed care. Such services would include preventative care (usually a health care service and scheme benefit), optical claims “washing” or “auditing” (usually part of the claims administration services and wellness type services (usually complementary to managed care but not a standalone managed care service in its own right).

Purpose:

The purpose of this document is to clearly define what is an accreditable managed health care service in its own right, i.e. it meets all the relevant criteria and the definition of “managed health care”; and to standardise the naming conventions used on managed care accreditation certificates, managed care agreements, statutory returns (annual and quarterly) and other reporting methods.

A. Notable definitions and concepts:

1. Managed care is defined in Regulation 15 of the Medical Scheme Acts 131 of 1998 –
 - “Managed health care - means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost effectiveness of relevant

health services within the constraints of what is affordable, through the use of rules-based and clinical management based programmes”

2. “Relevant health service” is defined in Section 1 of the Act –

- “Relevant health service” means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object –
 - (a) the physical or mental examination of that person,
 - (b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
 - (c) the giving of advice in relation to any such defect, illness or deficiency;
 - (d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
 - (e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
 - (f) nursing or midwifery,

and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy”

3. Medically / clinically necessary - Services or supplies which meet the following criteria: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good clinical practice within the medical community in the service area; they are not primarily for the convenience of the scheme member or a medical scheme; and they are the most appropriate level or supply of service which can safely be provided.

4. Protocol is defined in Regulation 15 to the Act –

- “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.

4.1. Components of a Protocol:

- Goals and Objectives of the program
- Applicable scheme rules
- Clinical Coding

- ICD 10
 - CPT
 - Tariff (RPL) / UPFS codes
 - NAPPI codes (medicines and or materials used during procedures etc.)
 - National stock number (NSN) for medicines and/or materials used in the public sector
 - Designated service provider (DSP) arrangements if any
 - Clinical Entry Requirements
 - Clinical Pathways
 - Provider type/s
 - Investigations / Procedures included
 - Frequency of events
 - Limitations (Both Scheme and managed care)
 - Severity
 - Formularies
 - Managed Care Exclusions
 - Funding Guidelines (risk / savings / out of pocket)
 - PMB entitlement (if applicable)
 - Costing Analysis
 - References to evidence based medicine on which the protocol is based on.
 - Appeal process mechanism
 - Outcomes measured.
 - Reporting on both financial and clinical measures
 - Date reviewed
5. Risk transfer arrangements – Depending on the nature of a managed health care service offered by a MCO and the remuneration arrangement in respect thereof, managed health care services may be classified as “risk transfer arrangements”. A typical example would be where beneficiaries with diabetes are enrolled onto a diabetes benefit management programme, where the MCO would receive a fixed fee per beneficiary enrolled per month and would then be responsible for the total treatment and management of the disease.

B. Accreditable managed care services

The following categories of services (1 to 7) are to be used uniformly for the purpose of classifying managed care services in respect of managed health care accreditation certificates, managed health care agreements and for scheme reporting:

1. Hospital Benefit Management Services

Hospital Benefit management aims to identify, track and optimise benefits within a hospital setting or in the management of high risk / cost events. Funding in general is made from a “risk pool”.

Management is based on protocols and formularies developed on the basis of cost effectiveness evidence based medicine. Protocols address the entry requirements, clinical pathways and outcomes achievable.

Management of hospital benefits may include one or more of the following;

a) Pre-authorisation services

A method of monitoring and controlling utilisation by evaluating the clinical appropriateness of a proposed medical service prior to it being performed by taking the following into consideration:

- Scheme rules
- Managed care protocols and formularies (incorporating clinical appropriateness based on evidence based medicine, cost effectiveness and affordability)
- Managed health care funding guidelines and or negotiated rates
- Provider networks
- Best clinical practice / Quality
- Appropriate clinical coding is applied i.e. ICD10 codes, CPT, tariff (RPL) / UPFS codes, NAPPI codes, NSN codes, etc.

b) Case Management

The monitoring and co-ordination of medical services rendered to patients whilst in-hospital with a specific diagnosis or requiring high-cost or extensive services.

Management may include one or more of the following:

- Adherence to scheme rules, protocols and formularies;
- Evaluation of the clinical and economic status;
- Allocation of the appropriate Length of Stay;
- Assessment and recommendation of the correct level of care;
- Monitoring of resource utilisation;
- Co-ordination and continuity of care; and/or
- Discharge planning.

c) Clinical Audit

Clinical Audit is described as the method by which provider claims are adjudicated prior to reimbursement.

Claim adjudication must take into account:

- Clinical appropriateness and accuracy of coding; and
- Financial accountability

Please Note:

- Protocol and formulary developments are the cornerstones in providing the before-mentioned services and therefore are not billed separately or considered as stand-alone managed health care services.
- Likewise, support services in determining benefit allocation, are included within the services rendered by managed care organisations, i.e. medical advisory services, actuarial services, rule based development, reimbursement models etc.
- Claims adjudication and payment based solely on claim rules, falls in the ambit of administration accreditation.
- Authorisation may not necessarily be a guarantee of payment, but is a decision based on clinical assessment and is subject to the scheme's benefit rules.
- Under certain circumstances the authorisation process used for Hospital Benefit Management may also be used for high cost out of hospital procedures.
- A claim that is pended during the clinical audit phase due to a clinical dispute will only be considered stale if the claim was not submitted in accordance with the timelines provided for in Regulation 6 to the Act.

2. Pharmacy Benefit Management Services

Pharmacy Benefit Management Services is described as the processing and funding of prescribed and/or dispensed medicine items.

Management may include one or more of the following:

- Application of scheme rules, protocols and formularies;
- Trend analysis on the prescribing and dispensing providers;
- Feedback mechanism to both members and providers on various aspects, i.e. generic substitutions, formulary inclusion and or exclusions, limitations, drug interactions etc,;
- Evaluation of clinical necessity in terms of age, gender, diagnosis, drug to drug interactions, etc,; and/or
- Compliance monitoring and education of members.

a) Pre-authorisation

Depending on the plan or option design, dispensed or prescribed medications may require pre-certification or pre-authorisation to determine a member's eligibility for coverage. Pre-certification criteria should be documented within the written protocols and formularies and should be made available to members and or beneficiaries of the scheme, treating providers and or general members of the public on request.

b) Drug Utilisation Review (DUR)

Prospective, concurrent or retrospective DUR ensures that an appropriate decision is made with regards to medication which in turn leads to positive patient outcomes.

c) Pharmacy Benefit Management: Disease management support services

Certain Chronic Disease List (CDL) and Prescribed Minimum Benefit (PMB) Diagnosis and Treatment Pairs (DTPs) where chronic treatment modalities are indicated may require additional management and/or allocation of additional benefits depending on the scheme rules and/or managed health care protocols and formularies.

Management tools include:

- Treatment baskets detailing clinical pathways, limitation of coverage etc., such as:
 - Consultations and type of service providers;
 - Procedures and investigations;
 - Pathology ;
 - Radiology;
 - Medication; and
 - Appeal processes

Please Note:

- Protocol and formulary developments are the cornerstones in providing the before-mentioned services and therefore are not billed separately or considered stand-alone services.
- Likewise support services in determining benefit allocation is included within the services rendered by Managed care organisations i.e. Medical advisory services, actuarial services, rule based development, reimbursement models etc
- Claims adjudication and payment, based solely on claim rules engine, falls in the ambit of administration accreditation.
- The type of DUR is dependent on the business model implemented by the individual managed health care organisation.
- Medicine claim switching, electronic data interface (EDI), etc. do not constitute managed health care services in their own right.

3. Active Disease Benefit Management Services

A co-ordinated system where health care interventions are aimed at chronic diseases with the emphasis placed on the prevention of exacerbations and or complications utilising evidence based protocols and formularies.

In the management of these diseases the managed care organisation may require the member to register on a disease management programme, adhere to protocols and formularies, measure and monitor compliance, educate the individual member and record and report clinical information in determining the quality of care and outcomes achieved.

The essential components to be considered when determining the diseases managed by a managed health care organisation include:

- Application of scheme rules;
- Identification of high risk diseases or prevalent diseases;
- Implementation of protocols and formularies based on evidence based medicine, affordability and cost effectiveness;
- Co-ordination of care, services and interventions;
- Member education on prevention of complication, behaviour modification, compliance etc.;
- Implementation, evaluation and recording of processes and outcomes such as:
 - Clinical Outcomes
 - Financial outcomes measures
 - Quality
- Compliance with the Regulations; and
- Reporting mechanisms

Chronic diseases:

- Asthma / COPD / Bronchiectasis
- Cardiac Failure / Cardiomyopathy / Dysrhythmias / Coronary Artery Disease
- Diabetes (Type 1 and 2)
- Hyperlipidaemia
- Hypertension
- Depression / Bipolar
- Oncology
- HIV
- Chronic Renal Disease
- Epilepsy
- Hypothyroidism
- Muscular-skeletal program

- Maternity Program

4. Disease Management Support Services

Where the full disease management programme is not actively followed for a disease, a managed health care organisation may make use of support services as documented within their protocols.

Management tools include:

- Treatment baskets detailing clinical pathways, limitation of coverage etc. such as:
 - Consultations and type of service providers;
 - Procedures and investigations;
 - Pathology;
 - Radiology;
 - Medication; and
 - Appeal processes

Please Note:

- Not all diseases are actively managed via a disease management programme, but are rather reliant on programmes and protocols; and hence they are excluded from the diseases listed above.
- Other diseases may be managed entirely via Pharmacy Benefit Management.
- Likewise a PMB DTP with a chronic element may only require baskets of care and may not be actively managed by a disease management department. See other service categories.
- Wellness, screening and education of members not yet diagnosed fall outside the ambit of this managed health care service.
- Management of any health care services that do not meet the requirements of managed care as defined shall not be included in the group of services.

5. Dental Benefit Management Services

a) Basic Dentistry

To comply with the core principles of managed health care:

- Application of scheme rules, protocols and formularies;
- Identification of high risk individuals;

- Co-ordination of care, services and interventions;
- Implementation, evaluation and recording of processes and outcomes such as:
 - Clinical Outcomes
 - Financial outcomes measures
 - Quality
- Compliance with the Regulations; and
- Reporting mechanisms.

b) Specialised Dentistry

- Pre-authorisation
Depending on the plan or option design, a member may require pre-authorisation to determine the eligibility for coverage. Pre-authorisation criteria should be documented within the written protocols and must be supplied to members, beneficiaries, providers and members of the general public on request.

Please Note:

- If claims are adjudicated via a rules-based claims engine with no active clinical management and do not meet the requirements of managed health care, the service may be deemed as an administrative function.

6. Managed Care Network Management Services

Once providers are included in a network, they agree to follow a scheme's rules, protocols and formularies. Providers of health care will be monitored and profiled against benchmarks related to good clinical practice, compliance to protocols and formularies, quality of care and outcomes achieved.

A network may consist of one or more of the following:

- General Practitioner Network;
- Specialist Network;
- Hospital Network;
- Pharmacy Network
- Dental Network; and/or
- Auxiliary Network

Please Note:

- A once off or annual fee negotiation or reimbursement arrangement per provider group may not meet the definition of managed health care services.

- Open networks are generally not included as any compliance to protocols or formularies are not monitored or reported on.

7. Primary Health Care Services (Risk Transfer)

The provision of basic or primary care to members within a capitation environment:

- Out-of Hospital Services
- In-Hospital Services (Limited services in accordance with the scheme benefit rules)

Please Note:

- Services rendered in respect of benefits are restricted and limitations are well documented and in line with scheme benefit option rules.

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