



Managed Care Organisations
Medical Schemes
Medical and Clinical advisors
Boards of Trustees
Auditors

Ref: Circular 27 of 2010
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CIRCULAR 27 OF 2010

REVISED STANDARDS (VERSION 2) FOR ACCREDITATION OF MANAGED CARE ORGANISATIONS

This office has concluded the process of soliciting views on the draft standards published for comment. The standards document attached hereto represents the final result and is published as Version 2. The revised documents take effect from date of publication hereof and apply to all applications for accreditation and renewal thereof.

It was also necessary to revise the application form and the latest version accompanies the standards and the self-evaluation questionnaire. The questionnaire is aligned with the standards and as before, applicants are required to perform a written self evaluation in terms of complying with the said standards to be provided with every application. The relevant documents are available in both PDF and Word format for ease of completion.

Your co-operation in this regard is valued.

Kind regards

Dr M Gantsho
REGISTRAR & CE



Application Form:

Accreditation and Renewal as a Managed Health Care Organisation

(For use by managed health care organisations in terms of Chapter 5 of the Regulations to the Medical Schemes Act.) **This form is also available on the Web Site of Council:** www.medicalschemes.com

Applicants are requested to furnish the required information by mail to:

Postal Address: The Registrar of Medical Schemes Private Bag X34 HATFIELD 0028	Delivery address: Hadefield Office Block Block E 1267 Pretorius Street HATFIELD, PRETORIA
Enquiries: Danie Kolver Tel: 012-431 0509/10 Fax: 012-431 0609/10 E-mail: d.kolver@medicalschemes.com	Enquiries: Ms Belinda van der Walt Tel: 012 431 0510 Fax: 012 431 0610 E-mail: b.vdwalt@medicalschemes.com

SECTION A: To be completed by all applicants

1. Full name of organisation/company/closed corporation: _____

2. Registration no of entity: _____

3. State the translated, abbreviated name, trading name or derivative, if any, of the name in question 1.

a) Translated:	b) Abbreviated:
c) Trading name:	d) Derivative:

4. Particulars of the head office of the applicant managed care organisation:

(a) Physical address:

(b) Postal address:

(c) E-mail: _____

(d) Website address: _____

(e) Telephone: _____ (f) Telefax: _____

5. Details of directors:

Name:

ID Number:

Nationality:

Name:	ID Number:	Nationality:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Questions 6 to 13 below refer to the person who is the head of the managed care organisation:
(Note that a curriculum vitae must be supplied for this person.)

6. Full name:	_____
7. Designation:	_____
8. Identity no:	_____
9. Home address :	_____
10. Postal address:	_____
11. Telephone no:	_____ (Office) _____ (Home)
12. Cell no:	_____ Fax no: _____
13. E- mail address:	_____

14. Financial year-end of the applicant managed care organisation: _____

15. Name of audit firm appointed by the applicant in terms of Regulation 20 in terms of the Act, and the responsible partner at the firm:

16. Provide a brief description of the managed health care service(s) provided:

17. Indicate whether services are provided in terms of: a capitation fee arrangement in respect of risk/risks transferred in terms of the contract; a fixed fee per member or beneficiary per month; a standard fee or a combination of any of the above:

18. Provide details of any re-insurance undertaken by the applicant:

18.1 Name of re-insurer: _____

18.2 The extent of cover re-insured: _____

18.3 Duration of agreement: _____

18.4 Copy of re-insurance agreement to be attached.

19. Supply the names of all medical schemes with whom the organisation has contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

20. Supply the names of all medical scheme administrators with whom the managed care organisation has contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

21. Supply the names of all other persons or entities with whom the applicant has contracted or sub-contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

22. Supply details of any financial interest by the applicant in :

- (a) an administrator of medical schemes;
 - (b) a broker organisation;
 - (c) another managed care organisation;
 - (d) a group of health care providers;
 - (e) any other organisation which provides health care services to medical schemes;
 - (f) a life office, a short term insurance company or a re-insurer.
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23. Provide full details of shareholding **in the applicant**:

Organisation/Individual (Any of the above)	% Shareholding

24. Provide a brief description of the main business of the persons / entities in question 23:

25. Provide full details of any shareholding **by the applicant** in any other entity:

Organisation/Individual (Any of the above)	% Shareholding

26. Provide a brief description of the main business of the persons/ entities in question 25:

SECTION B: To be completed by applicants applying for renewal of accreditation as a managed care organisation

The following information relates to the period from the previous accreditation evaluation up to the date of the renewal application:

27. Provide details of any changes in shareholding:

a) in applicant:

b) by applicant in other entities:

28. Provide details of any changes in the organisational structure of the applicant:

29. Provide details of any changes in senior management within the organisation and the impact of such changes on the applicant's business in terms of availability of skills and expertise :

30. Provide details of any changes in the nature and/or extent of managed care services provided:

31. Provide details of any changes in the outsourced services to other parties:

32. Indicate the ability of applicant's operational system and infrastructure to accommodate growth in existing business for which services are provided and/or to take on additional business:

33. I hereby enclose the following documents:

1. Attach a copy of the structural chart of the group to which the applicant belongs, showing the respective percentages of shareholding indicated in questions 21 and 23.
2. A *curriculum vitae* in respect of the person who is the head of the managed care organisation.
3. Latest signed copies of all managed care agreements or proposed agreements between the managed care organisation and medical schemes.
4. Latest signed copies of all agreements with medical scheme administrators and other entities to provide managed care services.
5. A copy of the latest audited annual financial statements with notes attached thereto for the financial year preceding the application.
6. Copy of the re-insurance agreement referred to in question 21.
7. The completed self-evaluating questionnaire, available on our web-site www.medicalschemes.com
8. Payment by cheque or proof of direct deposit/electronic transfer (banking details provided below) in favour of the Council for Medical Schemes, in respect of a **non-refundable application fee** as prescribed for accreditation as a managed care organisation. (Kindly refer to Regulation 31 of the Regulations to the Medical Schemes Act, 1998)

Declaration by head of the applicant organisation:

1. I declare that, to the best of my knowledge, the information herein supplied is complete, true and correct and not misleading in any respect.
2. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.
3. I undertake to supply any further information requested by the office of the Registrar, or Council for Medical Schemes, as and when required for purposes of carrying out the provisions of the Medical Schemes Act, 1998 and regulations published thereunder.

Signature

Date

Full names: (Please print)

Designation

COUNCIL FOR MEDICAL SCHEMES: BANKING DETAILS

Bank	:	ABSA
Branch	:	Vermeulen Street
Branch Code	:	517 245
Account number:	:	4051 163 394
Reference	:	Organisation name



Accreditation standards for managed care organisations

Standards and measurement criteria

Version 2
June 2010

A statutory body established in terms of the
Medical Schemes Act, 1998 (Act 131 of 1998)

Chairperson: Prof. W Pick Registrar & CE: Dr M Gantsho



**Regulatory provisions:
Section 67 (1)(m) of the Medical Schemes Act, 1998
Chapter 5 of Regulations promulgated in terms of
the Act**

1. Executive summary

This document sets out the accreditation standards for managed care organisations as required by the Medical Schemes Act, No 131 of 1998 and concomitant regulations (the Act). The 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 a manner which would not compromise health care provision.

The document contains all standards and criteria that are included in a detailed self-evaluating questionnaire, to be completed by each managed care organisation applying for accreditation or renewal of accreditation. Once completed, an evaluation team will validate each managed care organisation's questionnaire and test responses where required.

Upon completion of the accreditation exercise, the Council will award a managed care organisation an accreditation status of compliance, 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 a managed care organisation to take corrective action if required. 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 also important to mention that this document is a living document which may be amended as and when occasioned.

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 Regulations promulgated in terms of the Medical Schemes Act, 1998, Act No 131 of 1998, hereinafter referred to as the “Act” and the “Regulations” define **managed health care** as *“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 organization” 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 organization 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.

2.3. 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 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.

2.4. Accreditation is considered as a process by which the Council will review a managed care organization’s operations to ensure that the organization is conducting business in a manner consistent with defined standards. The accreditation process consists of:

- (a) A review of the application, contract(s), organizational structure, policies and procedures;
- (b) An onsite visit to the applicant organization to determine that it has in fact, the required skills, infrastructure and systems capable of providing managed care services in terms of the contract(s) entered into with medical schemes; and
- (c) A reporting system that enables the Council to monitor the performance of the organisation and eventually, the overall impact of managed care on the South African medical schemes industry. It is considered prudent to prepare guidelines over time or one or more standardised reporting mechanisms.

2.5. The foreseeable required core competencies for a managed care organization include the following:

- (a) Promote access to appropriate, efficient and effective health care services;
- (b) provide competent and customer focused services;
- (c) comply with all relevant Acts and regulations;
- (d) accommodate expanded accountability to the relevant stakeholders;
- (e) create a working environment that is conducive for staff development, motivation and innovation;
- (f) manage information and ensure confidentiality, both in terms of patient information and clinical proprietary information;
- (g) adequately addresses relevant ethical and clinical issues on an ongoing basis.



- 2.6.** The Council may request such information as it may deem necessary to satisfy it that the managed care organisation:
- (a) Is fit and proper to provide managed health care services;
 - (b) has the necessary resources, systems, skills and capacity to render the managed health care services which it wishes to provide; and
 - (c) is financially sound.
- 2.7.** All managed care organisations should give due consideration to the application of the “Code of corporate practices and conduct” 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.

Accreditation should, however not be equated with an endorsement by the Council of the products or services offered by those organizations who have successfully applied for accreditation. 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.

The Accreditation Process:

2.8. The application:

Managed care organisations are required to apply in writing to the Council for Medical Schemes. A set of documents including the application form, the accreditation standards, detailed policy document and self-evaluation checklist are available on Council’s website www.medicalschemes.com The applicant should then return the completed application form with accompanying documents and proof of payment of the prescribed statutory fee.



Upon submission of the completed application, the Accreditation Unit at the office of the Registrar of Medical Schemes will evaluate the content and perform an assessment of compliance with the standards. 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 are not relevant to the kind of services provided by the applicant.

Based on the outcome of the evaluation, additional information or clarity on aspects of the application may be required in order to complete the analysis for referral to Council for consideration of accreditation. The managed health care organisation would receive written feedback from the Council for Medical Schemes stating one of the following accreditation awards:

- Accreditation, without specific conditions;
- Accreditation subject to certain conditions; or
- Refusal of accreditation.

2.9. Verifying compliance with standards:

On-site visits to verify information in applications for accreditation will take place at the discretion of the Office.

2.10. The reporting system:

Managed care contracts should incorporate a clearly stipulated service level agreement with a defined reporting mechanism that enables the medical scheme to monitor the performance of the organisation. The service level agreement should at minimum, contain the following:

- (a) Reports on the cost effectiveness of the managed care interventions performed by the organisation; and



- (b) Sharing of claims information (data records) with the medical scheme to allow complete reporting in the financial statements of schemes and in terms of the SAICA guideline.

As a condition of accreditation, managed care organisations may be obliged to comply with all the reporting requirements as determined by the Registrar from time to time, and these may include *inter alia* documentation pertaining to:

- (c) continued financial soundness;
- (d) underwriting results in terms of the contract with regard to capitation or risk transfer arrangements;
- (e) the quality of the contracted services provided.
- (f) The method in which the risk taken over by the managed care organization is managed.

Non-compliance with these reporting requirements might lead to suspension or withdrawal of accreditation.

2.11. Implementation process

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

The implementation process has until now been conducted in a phased manner. The current process provides for a holistic approach which incorporates an assessment of the infrastructure, skills and ability of managed care organisations to comply with primarily legal as well as more advanced standards in relation to clinical performance.

The Accreditation Standards:

Section 1 – General Compliance

Objectives

Managed care organisations are required to apply for accreditation and meet specific criteria. This section is intended to promote adherence to these criteria and the application of best practices.



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.

Compliance:

- 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 applicant is registered in terms of any Act.
- 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 (office) is based in South Africa
- 1.1.5 Prescribed fees were paid.
- 1.1.6 A tax clearance certificate is provided.

Standard 1.2

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

Compliance:

- 1.2.1 Copies of the latest audited financial statements are attached to this application and are not older than 18 months from last year-end.
- 1.2.2 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).
- 1.2.3 The financial statements and notes thereto clearly confirm that the managed care organization:
 - (a) Has assets which are at least sufficient to meet current liabilities;
 - (b) provides for all liabilities;
 - (c) business is conducted in a manner to ensure that the business is at all times in a position to meet its liabilities;
 - (d) the method in which the liabilities are evaluated in the financial statements if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards); and



- (e) the provision in the financial statements in respect of services rendered by providers that have not been reimbursed if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards).

Standard 1.3

The managed care organisation has in place, signed agreements with medical schemes in compliance with Chapter 5 of the Regulations or, in the case of a newly established organization, has pro-forma agreements which adhere to the relevant provisions.

Compliance:

- 1.3.1 Signed agreements exist for all medical schemes to whom managed care services are provided.
- 1.3.2 The agreements clearly confirm the applicant and medical schemes 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 confirms that the organisation will provide the services in full compliance with the Act and the rules of the scheme.
- 1.3.5 The agreement contains full details of fees payable by the medical scheme including the basis of determination and payment thereof.
- 1.3.6 Fees are specified for individual services provided.
- 1.3.7 The agreement provides for measures to ensure confidentiality of beneficiary information.
- 1.3.8 The agreement provides for the right of access by the medical scheme to any treatment record held by a 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). The records of treatment are ultimately the property of the medical scheme.
- 1.3.9 Provision is made in the agreement for the duration thereof.
- 1.3.10 The agreement provides for termination of the agreement in accordance with Regulation 15J(1).
- 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, such other provider must be duly accredited as a managed care organization by the Council.
- 1.3.13 Provision is made in the agreement that if managed care services are sub-contracted by the organization to another provider, no beneficiary may be held liable by the managed care organization or any participating health care provider for any sums owed in terms of the agreement in compliance with Regulation 15E(b).
- 1.3.14 The agreement contains service levels for compliance by the organisation and penalties for failure to comply.

Standard 1.4

Capitation agreements (where applicable) entered into comply with Regulation 15F.

Compliance:

- 1.4.1 The agreement constitutes a bona fide transfer of risk from the medical scheme to the managed care organisation. The risks can be measured and reported to the medical scheme concerned as per the SLA.
- 1.4.2 The agreement provides for a capitation based payment which is reasonably commensurate with the extent of the risk transferred.
- 1.4.3 The risks being transferred can be adequately managed in the best interests of members and demonstrated to comply with Regulation 15F(a).

Standard 1.5

The organisation has in place, policies and procedures to ensure that health care providers, beneficiaries of the relevant medical scheme and any interested party have reasonable access (on demand) to:

- 1.5.1 A clear and comprehensive description of the managed health care programmes and procedures in compliance with Regulation 15D(e);
- 1.5.2 the procedures and timing limitations for appeal against utilization review decisions adversely affecting the rights or entitlements of a beneficiary in compliance with Regulation 15D(e);
- 1.5.3 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 protocols in full compliance with and in the manner prescribed by Regulation 15H;
- 1.5.5 drug formularies or restricted lists in compliance with Regulation 15I;and



1.5.6 details of designated service providers or preferred providers.

Compliance:

Submission of a policy document which confirms compliance with the above mentioned criteria and which include the process how exceptions created by Regulations 15H and 15I will be dealt with and disclosure thereof.

Section 2 – Clinical Oversight

Objective:

To promote clinical effectiveness, the organisation demonstrates that it has the requisite capacity, professional skills and infrastructure to render the services.

Standard 2.1

To the extent that services are rendered in accordance with a protocol and utilization review processes, a written protocol is in place in compliance with regulation 15D(a).

Compliance:

Evidence of the availability and application of such protocol.

Standard 2.2

The protocol complies with Regulations 15D and 15H to the extent that:

- 2.2.1 it is developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;
- 2.2.2 provision is made for clinical pathways and appropriate exceptions where a protocol or specific treatment is or has been ineffective or causes or would cause harm to treatment of a beneficiary without penalty to such beneficiary;
- 2.2.3 the protocol incorporates 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;
- 2.2.4 the protocol describes mechanisms to ensure consistent application of clinical review criteria and compatible decisions;



- 2.2.5 the protocol describes data collection processes and analytical methods used in assessing utilization and cost-effectiveness of health care services provided;
- 2.2.6 the protocol provides for ensuring confidentiality of clinical and proprietary information;
- 2.2.7 the protocol describes the organisational structure that periodically assesses managed care activities and reports to client schemes; and
- 2.2.8 details are available of the staff position functionally responsible for day-to-day management of the relevant programme/s.

Compliance:

Evidence of the availability and application of such protocol in compliance with the standards.

Provision is made for the duty to change such protocol and effective implementation and communication of any changes thereto should a ruling be made which requires a change in the content or application of such protocol.

Standard 2.3

The applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15D(b).

Compliance:

Evidence of the existence and evaluation process.

Standard 2.4

The managed care programmes are based on transparent and verifiable criteria for other decision-making factors that affect funding decisions which are periodically evaluated in compliance with regulation 15D(c).

Compliance:

Evidence of the use and evaluation processes in place.

Evidence that ICD 10 and other relevant coding practices are in use where applicable to ensure suitable identification of claims and proper reconciliation of data.



Standard 2.5

To the extent that services are rendered in accordance with a formulary or restricted lists of drugs, the applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15I.

Compliance:

Evidence of the availability and application of such protocol and proof of evaluation process in place.

Standard 2.6

Provision is made for appropriate substitution of drugs in exceptional circumstances where a formulary drug is ineffective or has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to such beneficiary.

Compliance:

Evidence of the availability and application of such protocol in compliance with the standard.

Section 3 – Organisational structure and information management

Objectives

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

Information management is viewed as a strategic enabler for achieving the organisation's objectives.

Information must be managed in such a way that promotes integrity and protects the interests of schemes and their members and to promote quality and cost reduction.

Standard 3.1

A detailed business system process map of all operational functions is available.

Compliance:

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



- 3.1.2 The applicant is able to provide detailed business process flow diagrams of all its current operational functions.
- 3.1.3 The business process flow diagrams clearly illustrate how the operational functions are integrated.
- 3.1.4 Full details in respect of outsourced services and entities involved are provided.
- 3.1.5 The process evaluation map demonstrates the ability to integrate any outsourced services.
- 3.1.6 The managed care organisation designates staff with appropriate qualifications and skills to perform clinical oversight for the services provided and the appropriateness of such decisions are evaluated periodically by clinical peers in compliance with Regulation 15D(d).

Compliance:

Evidence of the availability of documents and of such expertise to meet the above.

Standard 3.2

The organisation has a mechanism to identify, measure and manage potential business and other related risks.

Compliance:

Submission of documented proof outlining the organisation's risk management programme.

Emphasis is placed on the ability of the system to deal with the capacity, complexity and potential growth of the business.

Standard 3.3

The organisation has in place, suitable corporate governance structures and policy documents which deals with *inter alia*, the following:

- 3.3.1 All ethical issues pertaining to the organisation's functions.
- 3.3.2 Ensures that staff members are trained on ethical issues which are relevant to their job description.
- 3.3.3 Ensures that the organisation's reimbursement, bonuses, or incentives system to staff or health care providers/ suppliers does not compromise member's healthcare, best interests or quality of care.

Compliance:



Documented proof of composition of corporate governance structures and policy documents pertaining to the matters referred to herein.

Standard 3.4

The managed care organisation implements a written policy that verifies the current professional registration of personnel/consultants upon appointment and thereafter no less than annually. The organisation should also implement corrective action in response to adverse change in registration status.

Compliance:

- 3.4.1 The written policy is available.
- 3.4.2 Documented proof exists confirming that all the relevant employees are registered with the relevant professional body.

Standard 3.5

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

Compliance:

A comprehensive information security policy exists which will ensure the confidentiality, security, retention and integrity of data and information in accordance with applicable legislation..

- 3.5.1 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained on the system.
- 3.5.2 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained by officers and staff of the MCO.
- 3.5.3 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.
- 3.5.4 The applicant has procedures to ensure that the system parameters are only capable of amendment by authorised senior management.
- 3.5.5 There is an 'audit trail' of authorised individuals entering the system.
- 3.5.6 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 is reviewed by senior management.



Standard 3.6

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

- 3.6.1 Processes have been established to identify and record possible irregularities and illegal acts.
- 3.6.2 At a minimum, the applicant has in place a basic fraud detection system.
- 3.6.3 The applicant should have confidential internal fraud control mechanisms such as a “Fraudline” and “Whistleblower” process.

Compliance:

The written policy is available and applicant demonstrates compliance with the standard.

Standard 3.7

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

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

Section 4– Clinical effectiveness and quality management

Objective:

- To promote clinical effectiveness by utilising persons with relevant professional qualifications and skills.
- The Council for Medical Schemes puts great emphasis on ensuring the provision of quality-driven managed care services to the South African medical schemes industry. Through the accreditation process, managed care organisations are afforded the opportunity to demonstrate their commitment to quality services and ongoing self improvement.



- Value added services being provided to beneficiaries of medical schemes are essential to warrant ongoing consideration as a *bona fide* provider of managed care services.

Standard 4.1

The organisation has a written well defined quality management programme that:

- 4.1.1 Is approved and supported (including commitment of the necessary resources) by senior management;
- 4.1.2 clearly defines the scope, objectives, structure and activities of the programme;
- 4.1.3 provides for the establishment of a quality management committee as a custodian of the programme; and
- 4.1.4 includes and maintains at least two ongoing quality improvement projects, focusing on consumers and other key quality indicators.

Compliance:

The submission of documentation which clearly outlines the quality management programme including an outline of the aforementioned criteria.

Standard 4.2

The managed care organisation has in place, a quality management committee that:

- 4.2.1 Is mandated by senior management to oversee the quality management programme.
- 4.2.2 Meets regularly and maintains minutes of all meetings.
- 4.2.3 Guides the organisation on quality management priorities and projects.
- 4.2.4 Monitors and evaluates the progress made towards achieving the quality management programme goals.

Compliance:

Documented proof of the composition and functioning of the quality management committee.

Standard 4.3

The organization demonstrates the ability to render services to client schemes in accordance with a structured cost / benefit analysis in accordance with the following:



Component	Measure	Notes and differentiators
<ul style="list-style-type: none">Access	1. How has the provision of this service/s by your organisation improved access to appropriate levels of healthcare services of beneficiaries	<p>E.g. access to GP's, specialists, hospitalisation, etc.</p> <p>CMS report indicators:</p> <ul style="list-style-type: none">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 this service by your organisation improved geographical access to healthcare of medical scheme beneficiaries.	<ul style="list-style-type: none">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
<ul style="list-style-type: none">Cost	1. Quantify the financial benefit/cost to medical schemes through utilising your organisation's services in terms of healthcare expenditure.	<ul style="list-style-type: none">Indicate in terms of quarterly and annual costDetailed 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



Component	Measure	Notes and differentiators
		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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 to reimburse healthcare providers where services are outsourced.	<ul style="list-style-type: none"> • E.g. negotiated fee, fee for service or capitation arrangements, etc. • Describe the reimbursement model and 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 this service by your organisation(input criteria) impacted on the quality of care received by medical scheme members?	<ul style="list-style-type: none"> • 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.



Component	Measure	Notes and differentiators
		<ul style="list-style-type: none">Effect of interventions relative on e.g. % re-admissions during a particular period.
<ul style="list-style-type: none">Reporting	<ol style="list-style-type: none">How and when are the above results reported to medical schemes.	<ul style="list-style-type: none">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.
<ul style="list-style-type: none">Innovation	<ol style="list-style-type: none">What differentiates your services provided from those provided by similar managed care organisations and the services provided by medical schemes themselves.	<ul style="list-style-type: none">Provide detailed analysis of differentiating factorsTabulate results of the comparison.

Compliance:

The submission of documentation which clearly outlines the value added services in the interest of members of client scheme(s) in accordance with evidence based and cost effective principles.

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Accreditation of Managed Care Organisations

THE SELF-EVALUATION
CHECKLIST

Version 2
June 2010

A statutory body established in terms of the
Medical Schemes Act, 1998 (Act 131 of 1998)

Chairperson: Prof. W Pick Registrar & CE: Dr M Gantsho



Introduction:

The accreditation of managed care s process is self-directed with an inherent emphasis on self-evaluation and self-improvement. The purpose of this checklist is to assist applicants to determine readiness for accreditation and to facilitate the smooth conduct of the accreditation process itself. Responses to this questionnaire maybe utilized to be verified during an on-site visit to the applicant.

THE ACCREDITATION STANDARDS

Section 1 – General Compliance

Standard 1.1

The current or proposed managed care 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.

Nr	Requirements	Met	Not Met	N/a
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.2	The applicant is registered in terms of any Act.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.3	A copy of the relevant registration certificate or other supporting documentation is attached to the application.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.4	The applicant's head office (office) is based in South Africa.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.5	Prescribed fees were paid.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.6	A tax clearance certificate is provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 1.2

The managed care organization is in a financially sound position (Regulation 15B(2))

Nr	Requirements	Met	Not Met	N/a
1.2.1	Copies of the latest audited financial statements are attached to this application and are not older than 18 months from last year end.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.2	An auditor has been appointed to examine the accounting records and annual financial statements of the managed care organization in accordance with the South African Auditing Standards and in compliance with International Financial Reporting Standards IFRS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.3	The Financial statements and notes thereto clearly confirm that the managed care organization:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(a) Has assets which are at least sufficient to meet current liabilities;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Provides for all liabilities;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Business is conducted in a manner to ensure that the business is at all times in a position to meet its liabilities;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(d) The method in which the liabilities are evaluated in the financial statements if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards); and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(e) The provision in the financial statements in respect of services rendered by providers that have not been reimbursed if the financial statements are not prepared in accordance with IFRS ((International Financial Reporting Standards).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 1.3

The managed care organisation has in place, signed agreements with medical schemes in compliance with Chapter 5 of the Regulations or, in the case of a newly established organization, has pro-forma agreements which adhere to the relevant provisions.

Nr	Requirements	Met	Not Met	N/a
1.3.1	Signed agreements exist for all medical schemes for whom managed care services are provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.2	The agreements clearly confirm the applicant and medical schemes as contracting parties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.3	The agreement confirms the scope and duties of the organization for each specific scheme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.4	The agreement confirms that the organization will provide the services in full compliance with the Act and the rules of the scheme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.5	The agreement contains full details of fees payable by the medical scheme including the basis of determination and payment thereof.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.6	Fees are specified for individual services provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.7	The agreement provides for measures to ensure confidentiality of beneficiary information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.8	The agreement provides for the right of access by the medical schemes to any treatment record held by a managed care organization 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). the records of treatment are ultimately the property of the medical scheme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.9	Provision is made in the agreement for the duration thereof.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.10	The agreement provides for termination of the agreement in accordance with Regulation 15J(1).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	Council;			
1.3.12	Provision is made in the agreement that if managed care services are sub-contracted by the organisation to another provider, such other provider must be duly accredited as a managed care organization by the Council.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.13	Provision is made in the agreement that if managed care services are sub-contracted by the organization to another provider, no beneficiary may be held liable by the managed care organization or any participating health care provider for any sums owed in terms of the agreement in compliance with Regulation 15E(b).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.14	The agreement contains service levels for compliance by the organisation and penalties for failure to comply.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 1.4

Capitation agreements (where applicable) entered into comply with Regulation 15F.

Nr	Requirements	Met	Not Met	N/a
1.4.1	The agreement constitutes a bona fide transfer of risk from the	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	medical scheme to the managed care organization. The risks can be measured and reported to the medical scheme concerned as per the SLA.			
1.4.2	The agreement provides for a capitation based payment which is reasonably commensurate with the extent of the risk transferred.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4.3	The risks being transferred can be adequately managed in the best interests of members and demonstrated to comply with Regulation 15F(a).			

Comments:

Standard 1.5

The organisation has in place, policies and procedures to ensure that health care providers, beneficiaries of the relevant medical scheme and any interested party have reasonable access (on demand) to:

Nr	Requirements	Met	Not Met	N/a
1.5.1	A clear and comprehensive description of the managed health care programmes and procedures in compliance with Regulation 15D(e);	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.2	The procedures and timing limitations for appeal against utilization review decisions adversely affecting the rights or entitlements of a beneficiary in compliance with Regulation 15D(e);	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.3	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.4	Protocols in full compliance with and in the manner prescribed by Regulation 15H;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



1.5.5	Drug formularies or restricted lists in compliance with Regulation 15l; and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.6	Details of designated service providers or preferred providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Section 2 – Clinical Oversight

Standard 2.1

To the extent that services are rendered in accordance with a protocol and utilization review processes, a written protocol is in place in compliance with Regulation 15D(a).

Nr	Requirements	Met	Not Met	N/a
2.1.1	Evidence of the availability and application of such protocol.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 2.2

The protocol complies with Regulations 15D and 15H to the extent that:

Nr	Requirements	Met	Not Met	N/a
2.2.1	It is developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.2	Provision is made for clinical pathways and appropriate exceptions where a protocol or specific treatment is or has been ineffective or causes or would cause harm to treatment of a beneficiary without penalty to such beneficiary;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.3	The protocol incorporates procedures to evaluate clinical necessity, appropriateness, efficiency and affordability of services provide, to intervene where necessary and to inform beneficiaries, providers of care action on their behalf and medical schemes of the outcomes of such procedures;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.4	The protocol describes mechanisms to ensure consistent application of clinical review criteria and compatible decisions;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.5	The protocol describes data collection processes and analytical methods used in assessing utilization and cost-effectiveness of health care services provided;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.6	The protocol provides for ensuring confidentiality of clinical and proprietary information;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.7	The protocol describes the organizational structure that periodically assesses managed care activities and reports to client schemes; and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.8	Details are available of the staff position functionally responsible for day-to-day management of the relevant programme/s.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 2.3

The applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15D(b).

Nr	Requirements	Met	Not Met	N/a
2.3.1	Evidence of the existence and evaluation process exists.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 2.4

The managed care programmes are based on transparent and verifiable criteria for other decision-making factors that affect funding decisions which are periodically evaluated in compliance with Regulation 15D(c).

Nr	Requirements	Met	Not Met	N/a
2.4.1	Evidence of the existence and evaluation process exists. Evidence that ICD 10 and other relevant coding practices are in use where applicable to ensure suitable identification of claims and proper reconciliation of data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 2.5

To the extent that services are rendered in accordance with a formulary or restricted lists of drugs, the applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15l.

Nr	Requirements	Met	Not Met	N/a
2.5.1	Evidence of the availability and application of such protocol and proof of evaluation process is in place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 2.6

Provision is made for appropriate substitution of drugs in exceptional circumstances where a formulary drug is ineffective or has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to such beneficiary.

Nr	Requirements	Met	Not Met	N/a
2.6.1	Evidence of the availability and application of such protocol in compliance with the standard.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Section 3 – Organisational structure and information management

Standard 3.1

A detailed business system process map of all operational functions is available:

Nr	Requirements	Met	Not Met	N/a
3.1.1	The applicant is able to provide an up-to-date organogram aligned to its business process flow diagrams, which clearly indicates roles and responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.2	The applicant is able to provide detailed business process flow diagrams of all its current operational functions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.3	The business process flow diagrams clearly illustrate how the operational functions are integrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.4	Full details in respect of outsourced services and entities involved are provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.5	The process evaluation map demonstrates the ability to integrate any outsourced services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.6	The managed care organization designates staff with appropriate qualifications and skills to perform clinical oversight for the services provided and the appropriateness of such decisions are evaluated periodically by clinical peers in compliance with Regulation 15D(d)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.2

The organization has a mechanism to identify, measure and manage potential business and other related risks.

Nr	Requirements	Met	Not Met	N/a
3.2.1	Submission of documented proof outlining the organisation's risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	management programme. Emphasis is placed on the ability of the system to deal with the capacity, complexity and potential growth of the business.			
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Comments:

Standard 3.3

The organization has in place, suitable corporate governance structures and policy documents which deals with *inter alia*, the following:

Nr	Requirements	Met	Not Met	N/a
3.3.1	All ethical issues pertaining to the organisation's functions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.3.2	Ensures that staff members are trained on ethical issues which are relevant to their job description.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.3.3	Ensures that the organisation's reimbursement, bonuses, or incentives system to staff or health care providers/suppliers does not compromise member's healthcare, best interests or quality of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.4

The managed care organization implements a written policy that verifies the current professional registration of personnel/consultants upon appointment and thereafter no less than annually. The organization should also implement corrective action in response to adverse change in registration status.



Nr	Requirements	Met	Not Met	N/a
3.4.1	The written policy is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.4.2	Documented proof exists confirming that all the relevant employees are registered with the relevant professional body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.5

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

Nr	Requirements	Met	Not Met	N/a
3.5.1	Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained on the system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.2	Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained by officers and staff of the MCO.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.3	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.4	The applicant has procedures to ensure that the system parameters are only capable of amendment by authorized senior management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.5	There is an “audit trail” of authorized individuals entering the system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.6	There is an audit rail of all attempts at unauthorized enter into the system or to certain sections that are unauthorized to the specific user, and is reviewed by senior management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:**

Standard 3.6

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

Nr	Requirements	Met	Not Met	N/a
3.6.1	Processes have been established to identify and record possible irregularities and illegal acts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.6.2	At a minimum, the applicant has in place a basic fraud detection system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.6.3	The applicant should have confidential internal fraud control mechanisms such as a “Fraudline” and “Whistleblower” process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.7

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

Nr	Requirements	Met	Not Met	N/a
3.7.1	Data is successfully and completely backed up regularly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.7.2	Daily backups are stored off the premises of the applicant in a secure and fire-proof environment on at least a weekly basis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



3.7.3	Comprehensive disaster recovery systems and business continuity plans are implemented to ensure complete data recovery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.7.4	Hardware redundancy exists and is built into the system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Section 4 – Clinical effectiveness and quality management

Standard 4.1

The organization has a written well defined quality management programme that:

Nr	Requirements	Met	Not Met	N/a
4.1.1	Is approved and supported (including commitment of the necessary resources) by senior management;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.1.2	Clearly defines the scope, objectives, structure and activities of the programme;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.1.3	Provides for the establishment of a quality management committee as a custodian of the programme; and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.1.4	Includes and maintain at least two ongoing quality improvement projects, focusing on consumers and other key quality indicators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 4.2

The managed care organization has in place, a quality management committee that:

Nr	Requirements	Met	Not Met	N/a
4.2.1	Is mandated by senior management to oversee the quality management programme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2.2	Meets regularly and maintains minutes of all meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2.3	Guides the organization on quality management priorities and projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2.4	Monitors and evaluates the progress made towards achieving the quality management programme goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 4.3

The organization demonstrates the ability to render services to client schemes in accordance with a structured cost/benefit analysis in accordance with the following:

Component	Measure	Notes and differentiators
<ul style="list-style-type: none">Access	1. How has the provision of this 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: <ul style="list-style-type: none">Clearly demonstrate that access to healthcare is fair and equitable. Scheme rules that limit access should be quoted



Component	Measure	Notes and differentiators
		<p>and explained.</p> <ul style="list-style-type: none">• 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 this service by your organisation improved geographical access to healthcare of medical scheme beneficiaries.	<ul style="list-style-type: none">• 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
<ul style="list-style-type: none">• Cost	1. Quantify the financial benefit/cost to medical schemes through utilising your organisation's services in terms of healthcare expenditure.	<ul style="list-style-type: none">• Indicate in terms of quarterly and annual cost• 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.



Component	Measure	Notes and differentiators
	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.	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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.
<ul style="list-style-type: none">• Reimbursement mechanism(s)	1. Provide details of the reimbursement mechanism(s) used to reimburse healthcare providers where services are outsourced.	<ul style="list-style-type: none">• E.g. negotiated fee, fee for service or capitation arrangements, etc.• Describe the reimbursement model and process to arrive at the respective fee determination• Clear indication that services are sustainable through reimbursement model and balanced with healthcare provision to beneficiaries
<ul style="list-style-type: none">• Quality of Care	1. How has the provision of this service by your organisation(input criteria) impacted on the quality of care received by medical scheme members?	<ul style="list-style-type: none">• 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. %



Component	Measure	Notes and differentiators
		re-admissions during a particular period.
<ul style="list-style-type: none"> Reporting 	<ol style="list-style-type: none"> How and when are the above results reported to medical schemes. 	<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Innovation 	<ol style="list-style-type: none"> What differentiates your services provided from those provided by similar managed care organisations and the services provided by medical schemes themselves. 	<ul style="list-style-type: none"> Provide detailed analysis of differentiating factors Tabulate results of the comparison.

Nr	Requirements	Met	Not Met	N/a
4.3.1	Attached detailed written explanation as per 4.3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Managed Care Organisations
Medical Schemes
Medical and Clinical advisors
Boards of Trustees
Auditors

Ref: Circular 27 of 2010
Enq: Danie Kolver
t: 012-4310509/10
f: 012-4310609/10
e: d.kolver@medicalschemes.com
Date: 15 June 2010

CIRCULAR 27 OF 2010

REVISED STANDARDS (VERSION 2) FOR ACCREDITATION OF MANAGED CARE ORGANISATIONS

This office has concluded the process of soliciting views on the draft standards published for comment. The standards document attached hereto represents the final result and is published as Version 2. The revised documents take effect from date of publication hereof and apply to all applications for accreditation and renewal thereof.

It was also necessary to revise the application form and the latest version accompanies the standards and the self-evaluation questionnaire. The questionnaire is aligned with the standards and as before, applicants are required to perform a written self evaluation in terms of complying with the said standards to be provided with every application. The relevant documents are available in both PDF and Word format for ease of completion.

Your co-operation in this regard is valued.

Kind regards

Dr M Gantsho
REGISTRAR & CE



Application Form:

Accreditation and Renewal as a Managed Health Care Organisation

(For use by managed health care organisations in terms of Chapter 5 of the Regulations to the Medical Schemes Act.) **This form is also available on the Web Site of Council:** www.medicalschemes.com

Applicants are requested to furnish the required information by mail to:

Postal Address: The Registrar of Medical Schemes Private Bag X34 HATFIELD 0028	Delivery address: Hadefield Office Block Block E 1267 Pretorius Street HATFIELD, PRETORIA
Enquiries: Danie Kolver Tel: 012-431 0509/10 Fax: 012-431 0609/10 E-mail: d.kolver@medicalschemes.com	Enquiries: Ms Belinda van der Walt Tel: 012 431 0510 Fax: 012 431 0610 E-mail: b.vdwalt@medicalschemes.com

SECTION A: To be completed by all applicants

1. Full name of organisation/company/closed corporation: _____

2. Registration no of entity: _____

3. State the translated, abbreviated name, trading name or derivative, if any, of the name in question 1.

a) Translated:	b) Abbreviated:
c) Trading name:	d) Derivative:

4. Particulars of the head office of the applicant managed care organisation:

(a) Physical address:

(b) Postal address:

(c) E-mail: _____

(d) Website address: _____

(e) Telephone: _____ (f) Telefax: _____

5. Details of directors:

Name:

ID Number:

Nationality:

Name:	ID Number:	Nationality:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Questions 6 to 13 below refer to the person who is the head of the managed care organisation:
(Note that a curriculum vitae must be supplied for this person.)

6. Full name:	_____
7. Designation:	_____
8. Identity no:	_____
9. Home address :	_____
10. Postal address:	_____
11. Telephone no:	_____ (Office) _____ (Home)
12. Cell no:	_____ Fax no: _____
13. E- mail address:	_____

14. Financial year-end of the applicant managed care organisation: _____

15. Name of audit firm appointed by the applicant in terms of Regulation 20 in terms of the Act, and the responsible partner at the firm:

16. Provide a brief description of the managed health care service(s) provided:

17. Indicate whether services are provided in terms of: a capitation fee arrangement in respect of risk/risks transferred in terms of the contract; a fixed fee per member or beneficiary per month; a standard fee or a combination of any of the above:

18. Provide details of any re-insurance undertaken by the applicant:

18.1 Name of re-insurer: _____

18.2 The extent of cover re-insured: _____

18.3 Duration of agreement: _____

18.4 Copy of re-insurance agreement to be attached.

19. Supply the names of all medical schemes with whom the organisation has contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

20. Supply the names of all medical scheme administrators with whom the managed care organisation has contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

21. Supply the names of all other persons or entities with whom the applicant has contracted or sub-contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

22. Supply details of any financial interest by the applicant in :

- (a) an administrator of medical schemes;
 - (b) a broker organisation;
 - (c) another managed care organisation;
 - (d) a group of health care providers;
 - (e) any other organisation which provides health care services to medical schemes;
 - (f) a life office, a short term insurance company or a re-insurer.
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23. Provide full details of shareholding **in the applicant**:

Organisation/Individual (Any of the above)	% Shareholding

24. Provide a brief description of the main business of the persons / entities in question 23:

25. Provide full details of any shareholding **by the applicant** in any other entity:

Organisation/Individual (Any of the above)	% Shareholding

26. Provide a brief description of the main business of the persons/ entities in question 25:

SECTION B: To be completed by applicants applying for renewal of accreditation as a managed care organisation

The following information relates to the period from the previous accreditation evaluation up to the date of the renewal application:

27. Provide details of any changes in shareholding:

a) in applicant:

b) by applicant in other entities:

28. Provide details of any changes in the organisational structure of the applicant:

29. Provide details of any changes in senior management within the organisation and the impact of such changes on the applicant's business in terms of availability of skills and expertise :

30. Provide details of any changes in the nature and/or extent of managed care services provided:

31. Provide details of any changes in the outsourced services to other parties:

32. Indicate the ability of applicant's operational system and infrastructure to accommodate growth in existing business for which services are provided and/or to take on additional business:

33. I hereby enclose the following documents:

1. Attach a copy of the structural chart of the group to which the applicant belongs, showing the respective percentages of shareholding indicated in questions 21 and 23.
2. A *curriculum vitae* in respect of the person who is the head of the managed care organisation.
3. Latest signed copies of all managed care agreements or proposed agreements between the managed care organisation and medical schemes.
4. Latest signed copies of all agreements with medical scheme administrators and other entities to provide managed care services.
5. A copy of the latest audited annual financial statements with notes attached thereto for the financial year preceding the application.
6. Copy of the re-insurance agreement referred to in question 21.
7. The completed self-evaluating questionnaire, available on our web-site www.medicalschemes.com
8. Payment by cheque or proof of direct deposit/electronic transfer (banking details provided below) in favour of the Council for Medical Schemes, in respect of a **non-refundable application fee** as prescribed for accreditation as a managed care organisation. (Kindly refer to Regulation 31 of the Regulations to the Medical Schemes Act, 1998)

Declaration by head of the applicant organisation:

1. I declare that, to the best of my knowledge, the information herein supplied is complete, true and correct and not misleading in any respect.
2. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.
3. I undertake to supply any further information requested by the office of the Registrar, or Council for Medical Schemes, as and when required for purposes of carrying out the provisions of the Medical Schemes Act, 1998 and regulations published thereunder.

Signature

Date

Full names: (Please print)

Designation

COUNCIL FOR MEDICAL SCHEMES: BANKING DETAILS

Bank	:	ABSA
Branch	:	Vermeulen Street
Branch Code	:	517 245
Account number:	:	4051 163 394
Reference	:	Organisation name



Accreditation standards for managed care organisations

Standards and measurement criteria

Version 2
June 2010

A statutory body established in terms of the
Medical Schemes Act, 1998 (Act 131 of 1998)

Chairperson: Prof. W Pick Registrar & CE: Dr M Gantsho



**Regulatory provisions:
Section 67 (1)(m) of the Medical Schemes Act, 1998
Chapter 5 of Regulations promulgated in terms of
the Act**

1. Executive summary

This document sets out the accreditation standards for managed care organisations as required by the Medical Schemes Act, No 131 of 1998 and concomitant regulations (the Act). The 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 a manner which would not compromise health care provision.

The document contains all standards and criteria that are included in a detailed self-evaluating questionnaire, to be completed by each managed care organisation applying for accreditation or renewal of accreditation. Once completed, an evaluation team will validate each managed care organisation's questionnaire and test responses where required.

Upon completion of the accreditation exercise, the Council will award a managed care organisation an accreditation status of compliance, 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 a managed care organisation to take corrective action if required. 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 also important to mention that this document is a living document which may be amended as and when occasioned.

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 Regulations promulgated in terms of the Medical Schemes Act, 1998, Act No 131 of 1998, hereinafter referred to as the “Act” and the “Regulations” define **managed health care** as *“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 organization” 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 organization 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.

2.3. 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 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.

2.4. Accreditation is considered as a process by which the Council will review a managed care organization’s operations to ensure that the organization is conducting business in a manner consistent with defined standards. The accreditation process consists of:

- (a) A review of the application, contract(s), organizational structure, policies and procedures;
- (b) An onsite visit to the applicant organization to determine that it has in fact, the required skills, infrastructure and systems capable of providing managed care services in terms of the contract(s) entered into with medical schemes; and
- (c) A reporting system that enables the Council to monitor the performance of the organisation and eventually, the overall impact of managed care on the South African medical schemes industry. It is considered prudent to prepare guidelines over time or one or more standardised reporting mechanisms.

2.5. The foreseeable required core competencies for a managed care organization include the following:

- (a) Promote access to appropriate, efficient and effective health care services;
- (b) provide competent and customer focused services;
- (c) comply with all relevant Acts and regulations;
- (d) accommodate expanded accountability to the relevant stakeholders;
- (e) create a working environment that is conducive for staff development, motivation and innovation;
- (f) manage information and ensure confidentiality, both in terms of patient information and clinical proprietary information;
- (g) adequately addresses relevant ethical and clinical issues on an ongoing basis.



- 2.6.** The Council may request such information as it may deem necessary to satisfy it that the managed care organisation:
- (a) Is fit and proper to provide managed health care services;
 - (b) has the necessary resources, systems, skills and capacity to render the managed health care services which it wishes to provide; and
 - (c) is financially sound.
- 2.7.** All managed care organisations should give due consideration to the application of the “Code of corporate practices and conduct” 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.

Accreditation should, however not be equated with an endorsement by the Council of the products or services offered by those organizations who have successfully applied for accreditation. 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.

The Accreditation Process:

2.8. The application:

Managed care organisations are required to apply in writing to the Council for Medical Schemes. A set of documents including the application form, the accreditation standards, detailed policy document and self-evaluation checklist are available on Council’s website www.medicalschemes.com The applicant should then return the completed application form with accompanying documents and proof of payment of the prescribed statutory fee.



Upon submission of the completed application, the Accreditation Unit at the office of the Registrar of Medical Schemes will evaluate the content and perform an assessment of compliance with the standards. 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 are not relevant to the kind of services provided by the applicant.

Based on the outcome of the evaluation, additional information or clarity on aspects of the application may be required in order to complete the analysis for referral to Council for consideration of accreditation. The managed health care organisation would receive written feedback from the Council for Medical Schemes stating one of the following accreditation awards:

- Accreditation, without specific conditions;
- Accreditation subject to certain conditions; or
- Refusal of accreditation.

2.9. Verifying compliance with standards:

On-site visits to verify information in applications for accreditation will take place at the discretion of the Office.

2.10. The reporting system:

Managed care contracts should incorporate a clearly stipulated service level agreement with a defined reporting mechanism that enables the medical scheme to monitor the performance of the organisation. The service level agreement should at minimum, contain the following:

- (a) Reports on the cost effectiveness of the managed care interventions performed by the organisation; and



- (b) Sharing of claims information (data records) with the medical scheme to allow complete reporting in the financial statements of schemes and in terms of the SAICA guideline.

As a condition of accreditation, managed care organisations may be obliged to comply with all the reporting requirements as determined by the Registrar from time to time, and these may include *inter alia* documentation pertaining to:

- (c) continued financial soundness;
- (d) underwriting results in terms of the contract with regard to capitation or risk transfer arrangements;
- (e) the quality of the contracted services provided.
- (f) The method in which the risk taken over by the managed care organization is managed.

Non-compliance with these reporting requirements might lead to suspension or withdrawal of accreditation.

2.11. Implementation process

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

The implementation process has until now been conducted in a phased manner. The current process provides for a holistic approach which incorporates an assessment of the infrastructure, skills and ability of managed care organisations to comply with primarily legal as well as more advanced standards in relation to clinical performance.

The Accreditation Standards:

Section 1 – General Compliance

Objectives

Managed care organisations are required to apply for accreditation and meet specific criteria. This section is intended to promote adherence to these criteria and the application of best practices.



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.

Compliance:

- 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 applicant is registered in terms of any Act.
- 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 (office) is based in South Africa
- 1.1.5 Prescribed fees were paid.
- 1.1.6 A tax clearance certificate is provided.

Standard 1.2

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

Compliance:

- 1.2.1 Copies of the latest audited financial statements are attached to this application and are not older than 18 months from last year-end.
- 1.2.2 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).
- 1.2.3 The financial statements and notes thereto clearly confirm that the managed care organization:
 - (a) Has assets which are at least sufficient to meet current liabilities;
 - (b) provides for all liabilities;
 - (c) business is conducted in a manner to ensure that the business is at all times in a position to meet its liabilities;
 - (d) the method in which the liabilities are evaluated in the financial statements if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards); and



- (e) the provision in the financial statements in respect of services rendered by providers that have not been reimbursed if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards).

Standard 1.3

The managed care organisation has in place, signed agreements with medical schemes in compliance with Chapter 5 of the Regulations or, in the case of a newly established organization, has pro-forma agreements which adhere to the relevant provisions.

Compliance:

- 1.3.1 Signed agreements exist for all medical schemes to whom managed care services are provided.
- 1.3.2 The agreements clearly confirm the applicant and medical schemes 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 confirms that the organisation will provide the services in full compliance with the Act and the rules of the scheme.
- 1.3.5 The agreement contains full details of fees payable by the medical scheme including the basis of determination and payment thereof.
- 1.3.6 Fees are specified for individual services provided.
- 1.3.7 The agreement provides for measures to ensure confidentiality of beneficiary information.
- 1.3.8 The agreement provides for the right of access by the medical scheme to any treatment record held by a 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). The records of treatment are ultimately the property of the medical scheme.
- 1.3.9 Provision is made in the agreement for the duration thereof.
- 1.3.10 The agreement provides for termination of the agreement in accordance with Regulation 15J(1).
- 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, such other provider must be duly accredited as a managed care organization by the Council.
- 1.3.13 Provision is made in the agreement that if managed care services are sub-contracted by the organization to another provider, no beneficiary may be held liable by the managed care organization or any participating health care provider for any sums owed in terms of the agreement in compliance with Regulation 15E(b).
- 1.3.14 The agreement contains service levels for compliance by the organisation and penalties for failure to comply.

Standard 1.4

Capitation agreements (where applicable) entered into comply with Regulation 15F.

Compliance:

- 1.4.1 The agreement constitutes a bona fide transfer of risk from the medical scheme to the managed care organisation. The risks can be measured and reported to the medical scheme concerned as per the SLA.
- 1.4.2 The agreement provides for a capitation based payment which is reasonably commensurate with the extent of the risk transferred.
- 1.4.3 The risks being transferred can be adequately managed in the best interests of members and demonstrated to comply with Regulation 15F(a).

Standard 1.5

The organisation has in place, policies and procedures to ensure that health care providers, beneficiaries of the relevant medical scheme and any interested party have reasonable access (on demand) to:

- 1.5.1 A clear and comprehensive description of the managed health care programmes and procedures in compliance with Regulation 15D(e);
- 1.5.2 the procedures and timing limitations for appeal against utilization review decisions adversely affecting the rights or entitlements of a beneficiary in compliance with Regulation 15D(e);
- 1.5.3 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 protocols in full compliance with and in the manner prescribed by Regulation 15H;
- 1.5.5 drug formularies or restricted lists in compliance with Regulation 15I;and



1.5.6 details of designated service providers or preferred providers.

Compliance:

Submission of a policy document which confirms compliance with the above mentioned criteria and which include the process how exceptions created by Regulations 15H and 15I will be dealt with and disclosure thereof.

Section 2 – Clinical Oversight

Objective:

To promote clinical effectiveness, the organisation demonstrates that it has the requisite capacity, professional skills and infrastructure to render the services.

Standard 2.1

To the extent that services are rendered in accordance with a protocol and utilization review processes, a written protocol is in place in compliance with regulation 15D(a).

Compliance:

Evidence of the availability and application of such protocol.

Standard 2.2

The protocol complies with Regulations 15D and 15H to the extent that:

- 2.2.1 it is developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;
- 2.2.2 provision is made for clinical pathways and appropriate exceptions where a protocol or specific treatment is or has been ineffective or causes or would cause harm to treatment of a beneficiary without penalty to such beneficiary;
- 2.2.3 the protocol incorporates 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;
- 2.2.4 the protocol describes mechanisms to ensure consistent application of clinical review criteria and compatible decisions;



- 2.2.5 the protocol describes data collection processes and analytical methods used in assessing utilization and cost-effectiveness of health care services provided;
- 2.2.6 the protocol provides for ensuring confidentiality of clinical and proprietary information;
- 2.2.7 the protocol describes the organisational structure that periodically assesses managed care activities and reports to client schemes; and
- 2.2.8 details are available of the staff position functionally responsible for day-to-day management of the relevant programme/s.

Compliance:

Evidence of the availability and application of such protocol in compliance with the standards.

Provision is made for the duty to change such protocol and effective implementation and communication of any changes thereto should a ruling be made which requires a change in the content or application of such protocol.

Standard 2.3

The applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15D(b).

Compliance:

Evidence of the existence and evaluation process.

Standard 2.4

The managed care programmes are based on transparent and verifiable criteria for other decision-making factors that affect funding decisions which are periodically evaluated in compliance with regulation 15D(c).

Compliance:

Evidence of the use and evaluation processes in place.

Evidence that ICD 10 and other relevant coding practices are in use where applicable to ensure suitable identification of claims and proper reconciliation of data.



Standard 2.5

To the extent that services are rendered in accordance with a formulary or restricted lists of drugs, the applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15I.

Compliance:

Evidence of the availability and application of such protocol and proof of evaluation process in place.

Standard 2.6

Provision is made for appropriate substitution of drugs in exceptional circumstances where a formulary drug is ineffective or has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to such beneficiary.

Compliance:

Evidence of the availability and application of such protocol in compliance with the standard.

Section 3 – Organisational structure and information management

Objectives

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

Information management is viewed as a strategic enabler for achieving the organisation's objectives. Information must be managed in such a way that promotes integrity and protects the interests of schemes and their members and to promote quality and cost reduction.

Standard 3.1

A detailed business system process map of all operational functions is available.

Compliance:

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



- 3.1.2 The applicant is able to provide detailed business process flow diagrams of all its current operational functions.
- 3.1.3 The business process flow diagrams clearly illustrate how the operational functions are integrated.
- 3.1.4 Full details in respect of outsourced services and entities involved are provided.
- 3.1.5 The process evaluation map demonstrates the ability to integrate any outsourced services.
- 3.1.6 The managed care organisation designates staff with appropriate qualifications and skills to perform clinical oversight for the services provided and the appropriateness of such decisions are evaluated periodically by clinical peers in compliance with Regulation 15D(d).

Compliance:

Evidence of the availability of documents and of such expertise to meet the above.

Standard 3.2

The organisation has a mechanism to identify, measure and manage potential business and other related risks.

Compliance:

Submission of documented proof outlining the organisation's risk management programme.

Emphasis is placed on the ability of the system to deal with the capacity, complexity and potential growth of the business.

Standard 3.3

The organisation has in place, suitable corporate governance structures and policy documents which deals with *inter alia*, the following:

- 3.3.1 All ethical issues pertaining to the organisation's functions.
- 3.3.2 Ensures that staff members are trained on ethical issues which are relevant to their job description.
- 3.3.3 Ensures that the organisation's reimbursement, bonuses, or incentives system to staff or health care providers/ suppliers does not compromise member's healthcare, best interests or quality of care.

Compliance:



Documented proof of composition of corporate governance structures and policy documents pertaining to the matters referred to herein.

Standard 3.4

The managed care organisation implements a written policy that verifies the current professional registration of personnel/consultants upon appointment and thereafter no less than annually. The organisation should also implement corrective action in response to adverse change in registration status.

Compliance:

- 3.4.1 The written policy is available.
- 3.4.2 Documented proof exists confirming that all the relevant employees are registered with the relevant professional body.

Standard 3.5

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

Compliance:

A comprehensive information security policy exists which will ensure the confidentiality, security, retention and integrity of data and information in accordance with applicable legislation..

- 3.5.1 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained on the system.
- 3.5.2 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained by officers and staff of the MCO.
- 3.5.3 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.
- 3.5.4 The applicant has procedures to ensure that the system parameters are only capable of amendment by authorised senior management.
- 3.5.5 There is an 'audit trail' of authorised individuals entering the system.
- 3.5.6 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 is reviewed by senior management.



Standard 3.6

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

- 3.6.1 Processes have been established to identify and record possible irregularities and illegal acts.
- 3.6.2 At a minimum, the applicant has in place a basic fraud detection system.
- 3.6.3 The applicant should have confidential internal fraud control mechanisms such as a “Fraudline” and “Whistleblower” process.

Compliance:

The written policy is available and applicant demonstrates compliance with the standard.

Standard 3.7

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

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

Section 4– Clinical effectiveness and quality management

Objective:

- To promote clinical effectiveness by utilising persons with relevant professional qualifications and skills.
- The Council for Medical Schemes puts great emphasis on ensuring the provision of quality-driven managed care services to the South African medical schemes industry. Through the accreditation process, managed care organisations are afforded the opportunity to demonstrate their commitment to quality services and ongoing self improvement.



- Value added services being provided to beneficiaries of medical schemes are essential to warrant ongoing consideration as a *bona fide* provider of managed care services.

Standard 4.1

The organisation has a written well defined quality management programme that:

- 4.1.1 Is approved and supported (including commitment of the necessary resources) by senior management;
- 4.1.2 clearly defines the scope, objectives, structure and activities of the programme;
- 4.1.3 provides for the establishment of a quality management committee as a custodian of the programme; and
- 4.1.4 includes and maintains at least two ongoing quality improvement projects, focusing on consumers and other key quality indicators.

Compliance:

The submission of documentation which clearly outlines the quality management programme including an outline of the aforementioned criteria.

Standard 4.2

The managed care organisation has in place, a quality management committee that:

- 4.2.1 Is mandated by senior management to oversee the quality management programme.
- 4.2.2 Meets regularly and maintains minutes of all meetings.
- 4.2.3 Guides the organisation on quality management priorities and projects.
- 4.2.4 Monitors and evaluates the progress made towards achieving the quality management programme goals.

Compliance:

Documented proof of the composition and functioning of the quality management committee.

Standard 4.3

The organization demonstrates the ability to render services to client schemes in accordance with a structured cost / benefit analysis in accordance with the following:



Component	Measure	Notes and differentiators
<ul style="list-style-type: none">Access	1. How has the provision of this service/s by your organisation improved access to appropriate levels of healthcare services of beneficiaries	<p>E.g. access to GP's, specialists, hospitalisation, etc.</p> <p>CMS report indicators:</p> <ul style="list-style-type: none">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 this service by your organisation improved geographical access to healthcare of medical scheme beneficiaries.	<ul style="list-style-type: none">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
<ul style="list-style-type: none">Cost	1. Quantify the financial benefit/cost to medical schemes through utilising your organisation's services in terms of healthcare expenditure.	<ul style="list-style-type: none">Indicate in terms of quarterly and annual costDetailed 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



Component	Measure	Notes and differentiators
		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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 to reimburse healthcare providers where services are outsourced.	<ul style="list-style-type: none"> • E.g. negotiated fee, fee for service or capitation arrangements, etc. • Describe the reimbursement model and 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 this service by your organisation(input criteria) impacted on the quality of care received by medical scheme members?	<ul style="list-style-type: none"> • 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.



Component	Measure	Notes and differentiators
		<ul style="list-style-type: none">Effect of interventions relative on e.g. % re-admissions during a particular period.
<ul style="list-style-type: none">Reporting	<ol style="list-style-type: none">How and when are the above results reported to medical schemes.	<ul style="list-style-type: none">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.
<ul style="list-style-type: none">Innovation	<ol style="list-style-type: none">What differentiates your services provided from those provided by similar managed care organisations and the services provided by medical schemes themselves.	<ul style="list-style-type: none">Provide detailed analysis of differentiating factorsTabulate results of the comparison.

Compliance:

The submission of documentation which clearly outlines the value added services in the interest of members of client scheme(s) in accordance with evidence based and cost effective principles.

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Application Form:

Accreditation and Renewal as a Managed Health Care Organisation

(For use by managed health care organisations in terms of Chapter 5 of the Regulations to the Medical Schemes Act.) **This form is also available on the Web Site of Council:** www.medicalschemes.com

Applicants are requested to furnish the required information by mail to:

Postal Address: The Registrar of Medical Schemes Private Bag X34 HATFIELD 0028	Delivery address: Hadefield Office Block Block E 1267 Pretorius Street HATFIELD, PRETORIA
Enquiries: Danie Kolver Tel: 012-431 0509/10 Fax: 012-431 0609/10 E-mail: d.kolver@medicalschemes.com	Enquiries: Ms Belinda van der Walt Tel: 012 431 0510 Fax: 012 431 0610 E-mail: b.vdwalt@medicalschemes.com

SECTION A: To be completed by all applicants

1. Full name of organisation/company/closed corporation: _____

2. Registration no of entity: _____

3. State the translated, abbreviated name, trading name or derivative, if any, of the name in question 1.

a) Translated:	b) Abbreviated:
c) Trading name:	d) Derivative:

4. Particulars of the head office of the applicant managed care organisation:

(a) Physical address:

(b) Postal address:

(c) E-mail: _____

(d) Website address: _____

(e) Telephone: _____ (f) Telefax: _____

5. Details of directors:

Name:

ID Number:

Nationality:

Name:	ID Number:	Nationality:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Questions 6 to 13 below refer to the person who is the head of the managed care organisation:
(Note that a curriculum vitae must be supplied for this person.)

6. Full name:	_____
7. Designation:	_____
8. Identity no:	_____
9. Home address :	_____
10. Postal address:	_____
11. Telephone no:	_____ (Office) _____ (Home)
12. Cell no:	_____ Fax no: _____
13. E- mail address:	_____

14. Financial year-end of the applicant managed care organisation: _____

15. Name of audit firm appointed by the applicant in terms of Regulation 20 in terms of the Act, and the responsible partner at the firm:

16. Provide a brief description of the managed health care service(s) provided:

17. Indicate whether services are provided in terms of: a capitation fee arrangement in respect of risk/risks transferred in terms of the contract; a fixed fee per member or beneficiary per month; a standard fee or a combination of any of the above:

18. Provide details of any re-insurance undertaken by the applicant:

18.1 Name of re-insurer: _____

18.2 The extent of cover re-insured: _____

18.3 Duration of agreement: _____

18.4 Copy of re-insurance agreement to be attached.

19. Supply the names of all medical schemes with whom the organisation has contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

20. Supply the names of all medical scheme administrators with whom the managed care organisation has contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

21. Supply the names of all other persons or entities with whom the applicant has contracted or sub-contracted to provide managed care services (*note that copies of the latest signed agreement/s must be supplied*):

22. Supply details of any financial interest by the applicant in :

- (a) an administrator of medical schemes;
 - (b) a broker organisation;
 - (c) another managed care organisation;
 - (d) a group of health care providers;
 - (e) any other organisation which provides health care services to medical schemes;
 - (f) a life office, a short term insurance company or a re-insurer.
-
-
-

23. Provide full details of shareholding **in the applicant**:

Organisation/Individual (Any of the above)	% Shareholding

24. Provide a brief description of the main business of the persons / entities in question 23:

25. Provide full details of any shareholding **by the applicant** in any other entity:

Organisation/Individual (Any of the above)	% Shareholding

26. Provide a brief description of the main business of the persons/ entities in question 25:

SECTION B: To be completed by applicants applying for renewal of accreditation as a managed care organisation

The following information relates to the period from the previous accreditation evaluation up to the date of the renewal application:

27. Provide details of any changes in shareholding:

a) in applicant:

b) by applicant in other entities:

28. Provide details of any changes in the organisational structure of the applicant:

29. Provide details of any changes in senior management within the organisation and the impact of such changes on the applicant's business in terms of availability of skills and expertise :

30. Provide details of any changes in the nature and/or extent of managed care services provided:

31. Provide details of any changes in the outsourced services to other parties:

32. Indicate the ability of applicant's operational system and infrastructure to accommodate growth in existing business for which services are provided and/or to take on additional business:

33. I hereby enclose the following documents:

1. Attach a copy of the structural chart of the group to which the applicant belongs, showing the respective percentages of shareholding indicated in questions 21 and 23.
2. A *curriculum vitae* in respect of the person who is the head of the managed care organisation.
3. Latest signed copies of all managed care agreements or proposed agreements between the managed care organisation and medical schemes.
4. Latest signed copies of all agreements with medical scheme administrators and other entities to provide managed care services.
5. A copy of the latest audited annual financial statements with notes attached thereto for the financial year preceding the application.
6. Copy of the re-insurance agreement referred to in question 21.
7. The completed self-evaluating questionnaire, available on our web-site www.medicalschemes.com
8. Payment by cheque or proof of direct deposit/electronic transfer (banking details provided below) in favour of the Council for Medical Schemes, in respect of a **non-refundable application fee** as prescribed for accreditation as a managed care organisation. (Kindly refer to Regulation 31 of the Regulations to the Medical Schemes Act, 1998)

Declaration by head of the applicant organisation:

1. I declare that, to the best of my knowledge, the information herein supplied is complete, true and correct and not misleading in any respect.
2. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.
3. I undertake to supply any further information requested by the office of the Registrar, or Council for Medical Schemes, as and when required for purposes of carrying out the provisions of the Medical Schemes Act, 1998 and regulations published thereunder.

Signature

Date

Full names: (Please print)

Designation

COUNCIL FOR MEDICAL SCHEMES: BANKING DETAILS

Bank	:	ABSA
Branch	:	Vermeulen Street
Branch Code	:	517 245
Account number:	:	4051 163 394
Reference	:	Organisation name



Accreditation standards for managed care organisations

Standards and measurement criteria

Version 2
June 2010

A statutory body established in terms of the
Medical Schemes Act, 1998 (Act 131 of 1998)

Chairperson: Prof. W Pick Registrar & CE: Dr M Gantsho



**Regulatory provisions:
Section 67 (1)(m) of the Medical Schemes Act, 1998
Chapter 5 of Regulations promulgated in terms of
the Act**

1. Executive summary

This document sets out the accreditation standards for managed care organisations as required by the Medical Schemes Act, No 131 of 1998 and concomitant regulations (the Act). The 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 a manner which would not compromise health care provision.

The document contains all standards and criteria that are included in a detailed self-evaluating questionnaire, to be completed by each managed care organisation applying for accreditation or renewal of accreditation. Once completed, an evaluation team will validate each managed care organisation's questionnaire and test responses where required.

Upon completion of the accreditation exercise, the Council will award a managed care organisation an accreditation status of compliance, 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 a managed care organisation to take corrective action if required. 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 also important to mention that this document is a living document which may be amended as and when occasioned.

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 Regulations promulgated in terms of the Medical Schemes Act, 1998, Act No 131 of 1998, hereinafter referred to as the “Act” and the “Regulations” define **managed health care** as *“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 organization” 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 organization 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.

2.3. 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 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.

2.4. Accreditation is considered as a process by which the Council will review a managed care organization’s operations to ensure that the organization is conducting business in a manner consistent with defined standards. The accreditation process consists of:

- (a) A review of the application, contract(s), organizational structure, policies and procedures;
- (b) An onsite visit to the applicant organization to determine that it has in fact, the required skills, infrastructure and systems capable of providing managed care services in terms of the contract(s) entered into with medical schemes; and
- (c) A reporting system that enables the Council to monitor the performance of the organisation and eventually, the overall impact of managed care on the South African medical schemes industry. It is considered prudent to prepare guidelines over time or one or more standardised reporting mechanisms.

2.5. The foreseeable required core competencies for a managed care organization include the following:

- (a) Promote access to appropriate, efficient and effective health care services;
- (b) provide competent and customer focused services;
- (c) comply with all relevant Acts and regulations;
- (d) accommodate expanded accountability to the relevant stakeholders;
- (e) create a working environment that is conducive for staff development, motivation and innovation;
- (f) manage information and ensure confidentiality, both in terms of patient information and clinical proprietary information;
- (g) adequately addresses relevant ethical and clinical issues on an ongoing basis.



- 2.6.** The Council may request such information as it may deem necessary to satisfy it that the managed care organisation:
- (a) Is fit and proper to provide managed health care services;
 - (b) has the necessary resources, systems, skills and capacity to render the managed health care services which it wishes to provide; and
 - (c) is financially sound.
- 2.7.** All managed care organisations should give due consideration to the application of the “Code of corporate practices and conduct” 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.

Accreditation should, however not be equated with an endorsement by the Council of the products or services offered by those organizations who have successfully applied for accreditation. 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.

The Accreditation Process:

2.8. The application:

Managed care organisations are required to apply in writing to the Council for Medical Schemes. A set of documents including the application form, the accreditation standards, detailed policy document and self-evaluation checklist are available on Council’s website www.medicalschemes.com The applicant should then return the completed application form with accompanying documents and proof of payment of the prescribed statutory fee.



Upon submission of the completed application, the Accreditation Unit at the office of the Registrar of Medical Schemes will evaluate the content and perform an assessment of compliance with the standards. 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 are not relevant to the kind of services provided by the applicant.

Based on the outcome of the evaluation, additional information or clarity on aspects of the application may be required in order to complete the analysis for referral to Council for consideration of accreditation. The managed health care organisation would receive written feedback from the Council for Medical Schemes stating one of the following accreditation awards:

- Accreditation, without specific conditions;
- Accreditation subject to certain conditions; or
- Refusal of accreditation.

2.9. Verifying compliance with standards:

On-site visits to verify information in applications for accreditation will take place at the discretion of the Office.

2.10. The reporting system:

Managed care contracts should incorporate a clearly stipulated service level agreement with a defined reporting mechanism that enables the medical scheme to monitor the performance of the organisation. The service level agreement should at minimum, contain the following:

- (a) Reports on the cost effectiveness of the managed care interventions performed by the organisation; and



- (b) Sharing of claims information (data records) with the medical scheme to allow complete reporting in the financial statements of schemes and in terms of the SAICA guideline.

As a condition of accreditation, managed care organisations may be obliged to comply with all the reporting requirements as determined by the Registrar from time to time, and these may include *inter alia* documentation pertaining to:

- (c) continued financial soundness;
- (d) underwriting results in terms of the contract with regard to capitation or risk transfer arrangements;
- (e) the quality of the contracted services provided.
- (f) The method in which the risk taken over by the managed care organization is managed.

Non-compliance with these reporting requirements might lead to suspension or withdrawal of accreditation.

2.11. Implementation process

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

The implementation process has until now been conducted in a phased manner. The current process provides for a holistic approach which incorporates an assessment of the infrastructure, skills and ability of managed care organisations to comply with primarily legal as well as more advanced standards in relation to clinical performance.

The Accreditation Standards:

Section 1 – General Compliance

Objectives

Managed care organisations are required to apply for accreditation and meet specific criteria. This section is intended to promote adherence to these criteria and the application of best practices.



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.

Compliance:

- 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 applicant is registered in terms of any Act.
- 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 (office) is based in South Africa
- 1.1.5 Prescribed fees were paid.
- 1.1.6 A tax clearance certificate is provided.

Standard 1.2

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

Compliance:

- 1.2.1 Copies of the latest audited financial statements are attached to this application and are not older than 18 months from last year-end.
- 1.2.2 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).
- 1.2.3 The financial statements and notes thereto clearly confirm that the managed care organization:
 - (a) Has assets which are at least sufficient to meet current liabilities;
 - (b) provides for all liabilities;
 - (c) business is conducted in a manner to ensure that the business is at all times in a position to meet its liabilities;
 - (d) the method in which the liabilities are evaluated in the financial statements if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards); and



- (e) the provision in the financial statements in respect of services rendered by providers that have not been reimbursed if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards).

Standard 1.3

The managed care organisation has in place, signed agreements with medical schemes in compliance with Chapter 5 of the Regulations or, in the case of a newly established organization, has pro-forma agreements which adhere to the relevant provisions.

Compliance:

- 1.3.1 Signed agreements exist for all medical schemes to whom managed care services are provided.
- 1.3.2 The agreements clearly confirm the applicant and medical schemes 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 confirms that the organisation will provide the services in full compliance with the Act and the rules of the scheme.
- 1.3.5 The agreement contains full details of fees payable by the medical scheme including the basis of determination and payment thereof.
- 1.3.6 Fees are specified for individual services provided.
- 1.3.7 The agreement provides for measures to ensure confidentiality of beneficiary information.
- 1.3.8 The agreement provides for the right of access by the medical scheme to any treatment record held by a 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). The records of treatment are ultimately the property of the medical scheme.
- 1.3.9 Provision is made in the agreement for the duration thereof.
- 1.3.10 The agreement provides for termination of the agreement in accordance with Regulation 15J(1).
- 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, such other provider must be duly accredited as a managed care organization by the Council.
- 1.3.13 Provision is made in the agreement that if managed care services are sub-contracted by the organization to another provider, no beneficiary may be held liable by the managed care organization or any participating health care provider for any sums owed in terms of the agreement in compliance with Regulation 15E(b).
- 1.3.14 The agreement contains service levels for compliance by the organisation and penalties for failure to comply.

Standard 1.4

Capitation agreements (where applicable) entered into comply with Regulation 15F.

Compliance:

- 1.4.1 The agreement constitutes a bona fide transfer of risk from the medical scheme to the managed care organisation. The risks can be measured and reported to the medical scheme concerned as per the SLA.
- 1.4.2 The agreement provides for a capitation based payment which is reasonably commensurate with the extent of the risk transferred.
- 1.4.3 The risks being transferred can be adequately managed in the best interests of members and demonstrated to comply with Regulation 15F(a).

Standard 1.5

The organisation has in place, policies and procedures to ensure that health care providers, beneficiaries of the relevant medical scheme and any interested party have reasonable access (on demand) to:

- 1.5.1 A clear and comprehensive description of the managed health care programmes and procedures in compliance with Regulation 15D(e);
- 1.5.2 the procedures and timing limitations for appeal against utilization review decisions adversely affecting the rights or entitlements of a beneficiary in compliance with Regulation 15D(e);
- 1.5.3 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 protocols in full compliance with and in the manner prescribed by Regulation 15H;
- 1.5.5 drug formularies or restricted lists in compliance with Regulation 15I;and



1.5.6 details of designated service providers or preferred providers.

Compliance:

Submission of a policy document which confirms compliance with the above mentioned criteria and which include the process how exceptions created by Regulations 15H and 15I will be dealt with and disclosure thereof.

Section 2 – Clinical Oversight

Objective:

To promote clinical effectiveness, the organisation demonstrates that it has the requisite capacity, professional skills and infrastructure to render the services.

Standard 2.1

To the extent that services are rendered in accordance with a protocol and utilization review processes, a written protocol is in place in compliance with regulation 15D(a).

Compliance:

Evidence of the availability and application of such protocol.

Standard 2.2

The protocol complies with Regulations 15D and 15H to the extent that:

- 2.2.1 it is developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;
- 2.2.2 provision is made for clinical pathways and appropriate exceptions where a protocol or specific treatment is or has been ineffective or causes or would cause harm to treatment of a beneficiary without penalty to such beneficiary;
- 2.2.3 the protocol incorporates 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;
- 2.2.4 the protocol describes mechanisms to ensure consistent application of clinical review criteria and compatible decisions;



- 2.2.5 the protocol describes data collection processes and analytical methods used in assessing utilization and cost-effectiveness of health care services provided;
- 2.2.6 the protocol provides for ensuring confidentiality of clinical and proprietary information;
- 2.2.7 the protocol describes the organisational structure that periodically assesses managed care activities and reports to client schemes; and
- 2.2.8 details are available of the staff position functionally responsible for day-to-day management of the relevant programme/s.

Compliance:

Evidence of the availability and application of such protocol in compliance with the standards.

Provision is made for the duty to change such protocol and effective implementation and communication of any changes thereto should a ruling be made which requires a change in the content or application of such protocol.

Standard 2.3

The applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15D(b).

Compliance:

Evidence of the existence and evaluation process.

Standard 2.4

The managed care programmes are based on transparent and verifiable criteria for other decision-making factors that affect funding decisions which are periodically evaluated in compliance with regulation 15D(c).

Compliance:

Evidence of the use and evaluation processes in place.

Evidence that ICD 10 and other relevant coding practices are in use where applicable to ensure suitable identification of claims and proper reconciliation of data.



Standard 2.5

To the extent that services are rendered in accordance with a formulary or restricted lists of drugs, the applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15I.

Compliance:

Evidence of the availability and application of such protocol and proof of evaluation process in place.

Standard 2.6

Provision is made for appropriate substitution of drugs in exceptional circumstances where a formulary drug is ineffective or has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to such beneficiary.

Compliance:

Evidence of the availability and application of such protocol in compliance with the standard.

Section 3 – Organisational structure and information management

Objectives

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

Information management is viewed as a strategic enabler for achieving the organisation's objectives.

Information must be managed in such a way that promotes integrity and protects the interests of schemes and their members and to promote quality and cost reduction.

Standard 3.1

A detailed business system process map of all operational functions is available.

Compliance:

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



- 3.1.2 The applicant is able to provide detailed business process flow diagrams of all its current operational functions.
- 3.1.3 The business process flow diagrams clearly illustrate how the operational functions are integrated.
- 3.1.4 Full details in respect of outsourced services and entities involved are provided.
- 3.1.5 The process evaluation map demonstrates the ability to integrate any outsourced services.
- 3.1.6 The managed care organisation designates staff with appropriate qualifications and skills to perform clinical oversight for the services provided and the appropriateness of such decisions are evaluated periodically by clinical peers in compliance with Regulation 15D(d).

Compliance:

Evidence of the availability of documents and of such expertise to meet the above.

Standard 3.2

The organisation has a mechanism to identify, measure and manage potential business and other related risks.

Compliance:

Submission of documented proof outlining the organisation's risk management programme.

Emphasis is placed on the ability of the system to deal with the capacity, complexity and potential growth of the business.

Standard 3.3

The organisation has in place, suitable corporate governance structures and policy documents which deals with *inter alia*, the following:

- 3.3.1 All ethical issues pertaining to the organisation's functions.
- 3.3.2 Ensures that staff members are trained on ethical issues which are relevant to their job description.
- 3.3.3 Ensures that the organisation's reimbursement, bonuses, or incentives system to staff or health care providers/ suppliers does not compromise member's healthcare, best interests or quality of care.

Compliance:



Documented proof of composition of corporate governance structures and policy documents pertaining to the matters referred to herein.

Standard 3.4

The managed care organisation implements a written policy that verifies the current professional registration of personnel/consultants upon appointment and thereafter no less than annually. The organisation should also implement corrective action in response to adverse change in registration status.

Compliance:

- 3.4.1 The written policy is available.
- 3.4.2 Documented proof exists confirming that all the relevant employees are registered with the relevant professional body.

Standard 3.5

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

Compliance:

A comprehensive information security policy exists which will ensure the confidentiality, security, retention and integrity of data and information in accordance with applicable legislation..

- 3.5.1 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained on the system.
- 3.5.2 Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained by officers and staff of the MCO.
- 3.5.3 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.
- 3.5.4 The applicant has procedures to ensure that the system parameters are only capable of amendment by authorised senior management.
- 3.5.5 There is an 'audit trail' of authorised individuals entering the system.
- 3.5.6 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 is reviewed by senior management.



Standard 3.6

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

- 3.6.1 Processes have been established to identify and record possible irregularities and illegal acts.
- 3.6.2 At a minimum, the applicant has in place a basic fraud detection system.
- 3.6.3 The applicant should have confidential internal fraud control mechanisms such as a “Fraudline” and “Whistleblower” process.

Compliance:

The written policy is available and applicant demonstrates compliance with the standard.

Standard 3.7

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

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

Section 4– Clinical effectiveness and quality management

Objective:

- To promote clinical effectiveness by utilising persons with relevant professional qualifications and skills.
- The Council for Medical Schemes puts great emphasis on ensuring the provision of quality-driven managed care services to the South African medical schemes industry. Through the accreditation process, managed care organisations are afforded the opportunity to demonstrate their commitment to quality services and ongoing self improvement.



- Value added services being provided to beneficiaries of medical schemes are essential to warrant ongoing consideration as a *bona fide* provider of managed care services.

Standard 4.1

The organisation has a written well defined quality management programme that:

- 4.1.1 Is approved and supported (including commitment of the necessary resources) by senior management;
- 4.1.2 clearly defines the scope, objectives, structure and activities of the programme;
- 4.1.3 provides for the establishment of a quality management committee as a custodian of the programme; and
- 4.1.4 includes and maintains at least two ongoing quality improvement projects, focusing on consumers and other key quality indicators.

Compliance:

The submission of documentation which clearly outlines the quality management programme including an outline of the aforementioned criteria.

Standard 4.2

The managed care organisation has in place, a quality management committee that:

- 4.2.1 Is mandated by senior management to oversee the quality management programme.
- 4.2.2 Meets regularly and maintains minutes of all meetings.
- 4.2.3 Guides the organisation on quality management priorities and projects.
- 4.2.4 Monitors and evaluates the progress made towards achieving the quality management programme goals.

Compliance:

Documented proof of the composition and functioning of the quality management committee.

Standard 4.3

The organization demonstrates the ability to render services to client schemes in accordance with a structured cost / benefit analysis in accordance with the following:



Component	Measure	Notes and differentiators
<ul style="list-style-type: none">Access	1. How has the provision of this service/s by your organisation improved access to appropriate levels of healthcare services of beneficiaries	<p>E.g. access to GP's, specialists, hospitalisation, etc.</p> <p>CMS report indicators:</p> <ul style="list-style-type: none">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 this service by your organisation improved geographical access to healthcare of medical scheme beneficiaries.	<ul style="list-style-type: none">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
<ul style="list-style-type: none">Cost	1. Quantify the financial benefit/cost to medical schemes through utilising your organisation's services in terms of healthcare expenditure.	<ul style="list-style-type: none">Indicate in terms of quarterly and annual costDetailed 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



Component	Measure	Notes and differentiators
		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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 to reimburse healthcare providers where services are outsourced.	<ul style="list-style-type: none"> • E.g. negotiated fee, fee for service or capitation arrangements, etc. • Describe the reimbursement model and 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 this service by your organisation(input criteria) impacted on the quality of care received by medical scheme members?	<ul style="list-style-type: none"> • 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.



Component	Measure	Notes and differentiators
		<ul style="list-style-type: none">Effect of interventions relative on e.g. % re-admissions during a particular period.
<ul style="list-style-type: none">Reporting	<ol style="list-style-type: none">How and when are the above results reported to medical schemes.	<ul style="list-style-type: none">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.
<ul style="list-style-type: none">Innovation	<ol style="list-style-type: none">What differentiates your services provided from those provided by similar managed care organisations and the services provided by medical schemes themselves.	<ul style="list-style-type: none">Provide detailed analysis of differentiating factorsTabulate results of the comparison.

Compliance:

The submission of documentation which clearly outlines the value added services in the interest of members of client scheme(s) in accordance with evidence based and cost effective principles.

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Accreditation of Managed Care Organisations

THE SELF-EVALUATION
CHECKLIST

Version 2
June 2010



Introduction:

The accreditation of managed care s process is self-directed with an inherent emphasis on self-evaluation and self-improvement. The purpose of this checklist is to assist applicants to determine readiness for accreditation and to facilitate the smooth conduct of the accreditation process itself. Responses to this questionnaire maybe utilized to be verified during an on-site visit to the applicant.

THE ACCREDITATION STANDARDS

Section 1 – General Compliance

Standard 1.1

The current or proposed managed care 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.

Nr	Requirements	Met	Not Met	N/a
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.2	The applicant is registered in terms of any Act.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.3	A copy of the relevant registration certificate or other supporting documentation is attached to the application.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.4	The applicant's head office (office) is based in South Africa.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.5	Prescribed fees were paid.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.6	A tax clearance certificate is provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 1.2

The managed care organization is in a financially sound position (Regulation 15B(2))

Nr	Requirements	Met	Not Met	N/a
1.2.1	Copies of the latest audited financial statements are attached to this application and are not older than 18 months from last year end.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.2	An auditor has been appointed to examine the accounting records and annual financial statements of the managed care organization in accordance with the South African Auditing Standards and in compliance with International Financial Reporting Standards IFRS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.3	The Financial statements and notes thereto clearly confirm that the managed care organization:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(a) Has assets which are at least sufficient to meet current liabilities;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Provides for all liabilities;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Business is conducted in a manner to ensure that the business is at all times in a position to meet its liabilities;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(d) The method in which the liabilities are evaluated in the financial statements if the financial statements are not prepared in accordance with IFRS (International Financial Reporting Standards); and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(e) The provision in the financial statements in respect of services rendered by providers that have not been reimbursed if the financial statements are not prepared in accordance with IFRS ((International Financial Reporting Standards).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 1.3

The managed care organisation has in place, signed agreements with medical schemes in compliance with Chapter 5 of the Regulations or, in the case of a newly established organization, has pro-forma agreements which adhere to the relevant provisions.

Nr	Requirements	Met	Not Met	N/a
1.3.1	Signed agreements exist for all medical schemes for whom managed care services are provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.2	The agreements clearly confirm the applicant and medical schemes as contracting parties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.3	The agreement confirms the scope and duties of the organization for each specific scheme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.4	The agreement confirms that the organization will provide the services in full compliance with the Act and the rules of the scheme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.5	The agreement contains full details of fees payable by the medical scheme including the basis of determination and payment thereof.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.6	Fees are specified for individual services provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.7	The agreement provides for measures to ensure confidentiality of beneficiary information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.8	The agreement provides for the right of access by the medical schemes to any treatment record held by a managed care organization 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). the records of treatment are ultimately the property of the medical scheme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.9	Provision is made in the agreement for the duration thereof.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.10	The agreement provides for termination of the agreement in accordance with Regulation 15J(1).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	Council;			
1.3.12	Provision is made in the agreement that if managed care services are sub-contracted by the organisation to another provider, such other provider must be duly accredited as a managed care organization by the Council.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.13	Provision is made in the agreement that if managed care services are sub-contracted by the organization to another provider, no beneficiary may be held liable by the managed care organization or any participating health care provider for any sums owed in terms of the agreement in compliance with Regulation 15E(b).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3.14	The agreement contains service levels for compliance by the organisation and penalties for failure to comply.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 1.4

Capitation agreements (where applicable) entered into comply with Regulation 15F.

Nr	Requirements	Met	Not Met	N/a
1.4.1	The agreement constitutes a bona fide transfer of risk from the	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	medical scheme to the managed care organization. The risks can be measured and reported to the medical scheme concerned as per the SLA.			
1.4.2	The agreement provides for a capitation based payment which is reasonably commensurate with the extent of the risk transferred.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4.3	The risks being transferred can be adequately managed in the best interests of members and demonstrated to comply with Regulation 15F(a).			

Comments:

Standard 1.5

The organisation has in place, policies and procedures to ensure that health care providers, beneficiaries of the relevant medical scheme and any interested party have reasonable access (on demand) to:

Nr	Requirements	Met	Not Met	N/a
1.5.1	A clear and comprehensive description of the managed health care programmes and procedures in compliance with Regulation 15D(e);	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.2	The procedures and timing limitations for appeal against utilization review decisions adversely affecting the rights or entitlements of a beneficiary in compliance with Regulation 15D(e);	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.3	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.4	Protocols in full compliance with and in the manner prescribed by Regulation 15H;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



1.5.5	Drug formularies or restricted lists in compliance with Regulation 15l; and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5.6	Details of designated service providers or preferred providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Section 2 – Clinical Oversight

Standard 2.1

To the extent that services are rendered in accordance with a protocol and utilization review processes, a written protocol is in place in compliance with Regulation 15D(a).

Nr	Requirements	Met	Not Met	N/a
2.1.1	Evidence of the availability and application of such protocol.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 2.2

The protocol complies with Regulations 15D and 15H to the extent that:

Nr	Requirements	Met	Not Met	N/a
2.2.1	It is developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.2	Provision is made for clinical pathways and appropriate exceptions where a protocol or specific treatment is or has been ineffective or causes or would cause harm to treatment of a beneficiary without penalty to such beneficiary;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.3	The protocol incorporates procedures to evaluate clinical necessity, appropriateness, efficiency and affordability of services provide, to intervene where necessary and to inform beneficiaries, providers of care action on their behalf and medical schemes of the outcomes of such procedures;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.4	The protocol describes mechanisms to ensure consistent application of clinical review criteria and compatible decisions;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.5	The protocol describes data collection processes and analytical methods used in assessing utilization and cost-effectiveness of health care services provided;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.6	The protocol provides for ensuring confidentiality of clinical and proprietary information;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.7	The protocol describes the organizational structure that periodically assesses managed care activities and reports to client schemes; and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2.8	Details are available of the staff position functionally responsible for day-to-day management of the relevant programme/s.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 2.3

The applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15D(b).

Nr	Requirements	Met	Not Met	N/a
2.3.1	Evidence of the existence and evaluation process exists.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 2.4

The managed care programmes are based on transparent and verifiable criteria for other decision-making factors that affect funding decisions which are periodically evaluated in compliance with Regulation 15D(c).

Nr	Requirements	Met	Not Met	N/a
2..4.1	Evidence of the existence and evaluation process exists. Evidence that ICD 10 and other relevant coding practices are in use where applicable to ensure suitable identification of claims and proper reconciliation of data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 2.5

To the extent that services are rendered in accordance with a formulary or restricted lists of drugs, the applicant uses documented clinical review criteria that are based upon evidence-based medicine, taking into account, considerations of cost-effectiveness and affordability and are evaluated periodically to ensure relevance for funding decisions in compliance with Regulation 15l.

Nr	Requirements	Met	Not Met	N/a
2.5.1	Evidence of the availability and application of such protocol and proof of evaluation process is in place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 2.6

Provision is made for appropriate substitution of drugs in exceptional circumstances where a formulary drug is ineffective or has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to such beneficiary.

Nr	Requirements	Met	Not Met	N/a
2.6.1	Evidence of the availability and application of such protocol in compliance with the standard.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Section 3 – Organisational structure and information management

Standard 3.1

A detailed business system process map of all operational functions is available:

Nr	Requirements	Met	Not Met	N/a
3.1.1	The applicant is able to provide an up-to-date organogram aligned to its business process flow diagrams, which clearly indicates roles and responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.2	The applicant is able to provide detailed business process flow diagrams of all its current operational functions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.3	The business process flow diagrams clearly illustrate how the operational functions are integrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.4	Full details in respect of outsourced services and entities involved are provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.5	The process evaluation map demonstrates the ability to integrate any outsourced services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1.6	The managed care organization designates staff with appropriate qualifications and skills to perform clinical oversight for the services provided and the appropriateness of such decisions are evaluated periodically by clinical peers in compliance with Regulation 15D(d)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.2

The organization has a mechanism to identify, measure and manage potential business and other related risks.

Nr	Requirements	Met	Not Met	N/a
3.2.1	Submission of documented proof outlining the organisation's risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	management programme. Emphasis is placed on the ability of the system to deal with the capacity, complexity and potential growth of the business.			
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Comments:

Standard 3.3

The organization has in place, suitable corporate governance structures and policy documents which deals with *inter alia*, the following:

Nr	Requirements	Met	Not Met	N/a
3.3.1	All ethical issues pertaining to the organisation's functions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.3.2	Ensures that staff members are trained on ethical issues which are relevant to their job description.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.3.3	Ensures that the organisation's reimbursement, bonuses, or incentives system to staff or health care providers/suppliers does not compromise member's healthcare, best interests or quality of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.4

The managed care organization implements a written policy that verifies the current professional registration of personnel/consultants upon appointment and thereafter no less than annually. The organization should also implement corrective action in response to adverse change in registration status.



Nr	Requirements	Met	Not Met	N/a
3.4.1	The written policy is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.4.2	Documented proof exists confirming that all the relevant employees are registered with the relevant professional body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.5

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

Nr	Requirements	Met	Not Met	N/a
3.5.1	Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained on the system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.2	Information management policies and procedures exist that explain how confidentiality of data and information is to be maintained by officers and staff of the MCO.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.3	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.4	The applicant has procedures to ensure that the system parameters are only capable of amendment by authorized senior management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.5	There is an “audit trail” of authorized individuals entering the system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5.6	There is an audit rail of all attempts at unauthorized enter into the system or to certain sections that are unauthorized to the specific user, and is reviewed by senior management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:**

Standard 3.6

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

Nr	Requirements	Met	Not Met	N/a
3.6.1	Processes have been established to identify and record possible irregularities and illegal acts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.6.2	At a minimum, the applicant has in place a basic fraud detection system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.6.3	The applicant should have confidential internal fraud control mechanisms such as a “Fraudline” and “Whistleblower” process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 3.7

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

Nr	Requirements	Met	Not Met	N/a
3.7.1	Data is successfully and completely backed up regularly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.7.2	Daily backups are stored off the premises of the applicant in a secure and fire-proof environment on at least a weekly basis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



3.7.3	Comprehensive disaster recovery systems and business continuity plans are implemented to ensure complete data recovery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.7.4	Hardware redundancy exists and is built into the system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Section 4 – Clinical effectiveness and quality management

Standard 4.1

The organization has a written well defined quality management programme that:

Nr	Requirements	Met	Not Met	N/a
4.1.1	Is approved and supported (including commitment of the necessary resources) by senior management;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.1.2	Clearly defines the scope, objectives, structure and activities of the programme;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.1.3	Provides for the establishment of a quality management committee as a custodian of the programme; and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.1.4	Includes and maintain at least two ongoing quality improvement projects, focusing on consumers and other key quality indicators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Standard 4.2

The managed care organization has in place, a quality management committee that:

Nr	Requirements	Met	Not Met	N/a
4.2.1	Is mandated by senior management to oversee the quality management programme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2.2	Meets regularly and maintains minutes of all meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2.3	Guides the organization on quality management priorities and projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2.4	Monitors and evaluates the progress made towards achieving the quality management programme goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Standard 4.3

The organization demonstrates the ability to render services to client schemes in accordance with a structured cost/benefit analysis in accordance with the following:

Component	Measure	Notes and differentiators
<ul style="list-style-type: none">Access	1. How has the provision of this 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: <ul style="list-style-type: none">Clearly demonstrate that access to healthcare is fair and equitable. Scheme rules that limit access should be quoted



Component	Measure	Notes and differentiators
		<p>and explained.</p> <ul style="list-style-type: none">• 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 this service by your organisation improved geographical access to healthcare of medical scheme beneficiaries.	<ul style="list-style-type: none">• 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
<ul style="list-style-type: none">• Cost	1. Quantify the financial benefit/cost to medical schemes through utilising your organisation's services in terms of healthcare expenditure.	<ul style="list-style-type: none">• Indicate in terms of quarterly and annual cost• 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.



Component	Measure	Notes and differentiators
	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.	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Reimbursement mechanism(s) 	1. Provide details of the reimbursement mechanism(s) used to reimburse healthcare providers where services are outsourced.	<ul style="list-style-type: none"> E.g. negotiated fee, fee for service or capitation arrangements, etc. Describe the reimbursement model and process to arrive at the respective fee determination Clear indication that services are sustainable through reimbursement model and balanced with healthcare provision to beneficiaries
<ul style="list-style-type: none"> Quality of Care 	1. How has the provision of this service by your organisation(input criteria) impacted on the quality of care received by medical scheme members?	<ul style="list-style-type: none"> 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. %



Component	Measure	Notes and differentiators
		re-admissions during a particular period.
<ul style="list-style-type: none"> Reporting 	<ol style="list-style-type: none"> How and when are the above results reported to medical schemes. 	<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Innovation 	<ol style="list-style-type: none"> What differentiates your services provided from those provided by similar managed care organisations and the services provided by medical schemes themselves. 	<ul style="list-style-type: none"> Provide detailed analysis of differentiating factors Tabulate results of the comparison.

Nr	Requirements	Met	Not Met	N/a
4.3.1	Attached detailed written explanation as per 4.3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>