UPDATED ACCREDITED MANAGED HEALTH CARE SERVICES

Standardised classifications and naming conventions

Updated by:

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Background and introduction:

In order to define and clarify managed care health services, and to standardise the naming conventions used by all stakeholders in the industry in terms of managed care agreements, statutory return reporting, etc, a document setting out the "accreditable" managed care services was published with Circular 13 of 2014.

Whilst all managed health care services must meet the definition of a "relevant health service", not all relevant health services will meet the definition of a "managed health care service" as defined in Regulation 15.

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

This document represents the revised and update the Accredited Managed Health Care Services document which reflects relevant changes and/or updates in the managed health care service delivery since 2014.

Effective date of implementation:

The effective date of implementation of the updated managed care services document is 1 January 2023:

- All new managed care agreements must be prepared in accordance with the naming conventions and service classifications as contained in this document.
- All existing managed care documents must be updated by way of an addendum (where appropriate)

A. Notable definitions and concepts:

1. Managed care is defined in Regulation 15 of the Medical Scheme Act 131 of 1998 ('the Act") –

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

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

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

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

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

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

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

   Components of a managed care protocol would typically include the following (also refer to the latest Managed Care Protocol Guideline published on the CMS website in January 2022 with Circular 8 of 2022):

   - Goals and Objectives of the protocol
   - Applicable scheme rules and benefits
   - Clinical Coding
     - ICD 10
     - CPT
     - Tariff (RPL) / UPFS codes
     - NAPPI codes (medicines, materials and/or devices and technologies used during procedures etc.)
     - National stock number (NSN) for medicines and/or materials used in the public sector
   - Designated service provider (DSP) arrangements if any
   - Clinical Entry Requirements
   - Clinical Pathways
     - Provider type/s
     - Investigations / Procedures included
     - Frequency of events
     - Limitations (Both Scheme and managed care)
     - Severity
     - Formularies
   - Managed Care Exclusions
   - Funding Guidelines (risk / savings / out of pocket)

- PMB entitlement (if applicable)
- Costing Analysis (where applicable)
- References to evidence-based medicine on which the protocol is based on.
- Appeal process mechanism
- Outcomes measured (defined outcomes stated, methodology of measurement of effectiveness of intervention, etc.)
- Reporting on both financial and clinical measures
- Date reviewed

5. **Formulary –** A formulary is typically a restricted list of medicines, medical devices, etc. that is funded in part or in full by the medical scheme. Formularies used in managed care must comply with the requirements set out in Regulation 15I:
   - They must be developed on the basis of evidence-based medicine, taking into account cost-effectiveness and affordability;
   - They must be made available to health care providers, beneficiaries of medical schemes and the public on request; and
   - They must provide for appropriate substitution of drugs where a formulary drug is ineffective or causes or would cause adverse reaction in a beneficiary, without a penalty to that beneficiary.

6. **Risk transfer arrangements** – Depending on the nature of a managed health care service offered by an MCO and the remuneration arrangement in respect thereof, managed health care services may be classified as "risk transfer arrangements". A typical example would be where beneficiaries with diabetes are enrolled onto a diabetes disease risk management programme where the MCO would receive a fixed fee per beneficiary enrolled per month and would then be responsible for access to the total treatment and management of the disease (with reference to the relevant protocols and formularies, registered scheme rules, PMB provisions, etc.).

   - Definition regarding risk transfer arrangements:
     - Regulation 15 to the Act –

       "**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 or the medical scheme."
   - Provision specifically relating to managed care risk transfer arrangements / capitation agreements:
     - Regulation 15F to the Act –

       "**Capitation agreements** – a medical scheme shall not enter into a capitation agreement, unless –

(a) The agreement is in the interests of the member of the medical scheme;

(b) The agreement embodies a genuine transfer of risk from the medical scheme to the managed health care organisation;

(c) The capitated payment is reasonably commensurate with the extent of the risk transfer."

B. Accredited managed care services

- **Important:** It is important to note that an MCO must ensure that a particular managed care service has been accredited, i.e. it duly appears on its managed care accreditation certificate, before contracting with a medical scheme or commencing delivery of the said services to a medical scheme.

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

1. Hospital Benefit Management

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

Management is typically based on protocols and formularies developed on the basis of cost effectiveness and evidence-based medicine.

- Protocols usually indicate the entry requirements, clinical pathways and clinical outcomes to be achieved.

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

a) Pre-authorisation services

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

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

- Advising members upfront, and confirm in writing, of applicable Prescribed Minimum Benefit ("PMB") entitlements and limitations (e.g. PMB level of care, Designated Service Providers ("DSPs") to be utilised, etc.)

b) Case Management

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

Management may include one or more of the following:

- Adherence to scheme rules, protocols and formularies;
- Evaluation of the clinical and economic status of the particular case;
- Allocation of the appropriate Length of Stay;
- Assessment and recommendation of the appropriate Level of Care;
- Monitoring of resource utilisation;
- Identification of adverse incidents / events;
- Co-ordination and continuity of care; and/or
- Discharge planning.

c) Clinical Audit

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

Claim adjudication must take into account:

- Clinical appropriateness and accuracy of coding;
- Financial accountability;
- Pre-authorisation and case management policies and procedures;
- Pricing and tariff rules;
- Scheme rules and exclusions; and
- Possible fraud, waste and abuse.

Please Note:

- Protocol and/or formulary development and employment by MCOs are an intrinsic part of delivering managed health care services and therefore are not billed separately or considered as stand-alone managed health care services.

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

2. Pharmacy Benefit Management

Pharmacy Benefit Management ("PBM") services aim to ensure that the medicine benefit of a scheme is managed in accordance with the principles of clinical appropriateness, cost-effectiveness and affordability.

Pharmacy Benefit Management may include one or more of the following:

- Application of scheme rules, protocols and formularies;
- Feedback mechanism to both members and providers on various aspects of benefit management, i.e. generic substitution, formulary inclusions and/or exclusions, limitations, drug interactions etc.;
- Evaluation of clinical necessity and appropriateness of evidence-based treatment guidelines in terms of age, gender, diagnosis, drug to drug interactions, etc;
- Interventions with prescribers to ensure that clinically appropriate, cost-effective and affordable medicines are prescribed;
- Quality indicators, measurement and reporting of clinical outcomes; and
- Compliance monitoring and education of members.

a) Pre-authorisation

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

b) Drug Utilisation Review (DUR)

Drug Utilisation Review is a process which evaluates the clinical appropriateness, cost effectiveness and affordability of prescribed and dispensed medicines, taking into account application of the scheme rules and benefit limits. DUR is typically conducted prospectively (before the medicine is dispensed) or concurrently (at the time of dispensing). Retrospective DUR takes place after the medicine has been dispensed and takes the form of an analysis of the prescribing and utilisation trends in medicine usage.

c) Pharmacy Benefit Management: Disease Risk Management Support Services

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

Management tools may include treatment baskets detailing clinical pathways, limitation of coverage etc., such as:

- Consultations and type of service providers;
- Procedures and investigations;
- Pathology;
- Radiology;
- Medication;
- Appeal processes; and
- Utilisation review

Please Note:

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

3. Active Disease Risk Management Services

Active disease risk management services entail a co-ordinated system where health care interventions are aimed at chronic diseases and/or healthcare management programmes with the emphasis being placed on the prevention of exacerbations and/or complications utilising evidence-based protocols and formularies and minimising the risk of higher down-stream costs such as hospitalisation.

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

Involving the patient in the optimal and appropriate management of their condition is central to Disease Risk Management with the emphasis being placed on the prevention of exacerbations and or complications utilising evidence-based protocols and formularies.

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

- Application of scheme rules and benefit limitations;
- Identification of high risk or high prevalence diseases;
- Implementation of protocols and formularies based on evidence-based medicine, affordability and cost-effectiveness;
- Coordination of care, services and interventions;
- Ongoing member education, monitoring and counselling to encourage compliance with treatment plans and required behaviour modifications;
- Implementation, evaluation and recording of processes and outcomes including:
  - Clinical outcomes;
  - Financial outcomes; and
  - Quality outcomes
- Compliance with the Regulations to the Medical Schemes Act; and
- Reporting requirements and mechanisms.

The following chronic diseases and/or healthcare management programmes are typically considered to be amenable to active disease risk management:

- Asthma / COPD / Bronchiectasis
- Cardiac Failure / Cardiomyopathy / Dysrhythmias / Coronary Artery Disease

- Diabetes (Type 1 and 2)
- Hyperlipidaemia
- Hypertension
- Depression / Bipolar
- Oncology
- HIV
- Chronic Renal Disease
- Epilepsy
- Hypothyroidism
- Muscular-skeletal program
- Maternity Program (Improved access to healthcare benefits and providers and an improvement in quality and cost outcomes)

Please Note:

- The list of active diseases managed, be it chronic or acute, will differ per organisation and per the contractual agreements in place.
- Each specific disease actively managed will need to be accredited by the Council for Medical Schemes before the MCO may contract with a medical scheme for the particular service or commence delivering such services.

4. Disease Risk Management Support Services

Where the full disease risk management programme is not actively implemented for a specific disease or a disease is not able to be actively managed but is rather reliant on the implementation of a specific protocol and/or formulary or treatment algorithm, an MCO may make use of disease risk management support services (as documented within their protocols).

Management tools may include treatment baskets detailing clinical pathways, limitation of coverage etc., such as:

- Consultations and type of service providers;
- Procedures and investigations;
- Pathology;
- Radiology;
- Medication;
- Appeal processes;

- Member profiling / identification of members requiring managed care interventions; and
- Case management to drive member awareness and compliance.

Please Note:

- Not all diseases are actively managed via a disease management programme, but are rather reliant on programmes and protocols; and hence they are excluded from the diseases listed under Active Disease Risk Management.
- Other diseases may be managed entirely via Pharmacy Benefit Management.
- Likewise a PMB DTP with a chronic element may only require baskets of care and may not be actively managed through an active disease risk management programme.
- Wellness, screening and education of members not yet diagnosed fall outside the ambit of what is defined as managed health care service, e.g. wellness days.
- Management of any health care services that do not meet the requirements of managed care as defined shall not be included in the group of services.

5. Dental Benefit Management Services

If dental benefit management services are delivered through the adjudication of claims via a rules-based claims engine or with reference only to the medical scheme's specific dental benefits provided for with no active clinical management it will not be deemed to be managed care services as defined and would form part of claims administration services.

Where active clinical management of dental benefits is implemented, e.g. through the application of dental protocols and/or formularies and the use of dental provider networks, such dental benefit management services may well constitute managed care services as defined:

a) Basic Dentistry

To comply with the core principles of managed health care:

- Application of scheme rules, protocols and formularies;
- Identification of high risk individuals;
- Co-ordination of care, services and interventions;
- Implementation, evaluation and recording of processes and outcomes such as:
  - Clinical outcomes;
  - Financial outcomes; and
  - Quality outcomes
- Compliance with the Regulations to the Medical Schemes Act; and
- Reporting requirements and mechanisms.

b) Specialised Dentistry

- **Pre-authorisation**

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

6. Managed Care Network Management Services and Risk Management

Managed care network management should be distinguished from provider network management.

Typically, provider network management entails the management of a provider network established based on agreed/discounted tariffs for agreed services – providers are not bound to any managed care clinical protocols but scheme formularies may apply.

Managed care network management also entails the management of a provider network, but the providers are bound to implementing the relevant managed care protocols and formularies as developed by the MCO in question without compromising the patient's best interest or quality of care in addition to the agreed tariffs for the agreed services. Such network providers should be monitored and profiled against benchmarks related to good clinical practice, compliance to protocols and formularies, quality of care and clinical outcomes achieved.

A managed care network may be open or closed consist of one or more of the following:

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

Please Note:

- A once off or annual fee negotiation or reimbursement arrangement per provider group may not meet the definition of managed health care services.
- Networks must conform to the contractual arrangements with the managed care organisations / scheme and may include a specific type of healthcare provider, e.g. oncologists; or a specific provider grouping for a specific treatment or procedure, e.g. arthroplasty, which should then be indicated as such in the managed care agreement and on the managed care accreditation certificate.

- Clear, fair and transparent criteria for network participation should be developed and implemented by the MCO.
- Provider profiling, peer review, tariff negotiation and implementing alternative reimbursement models may be applied to providers contracting to a network.

7. Health Care Services – Managed Care Risk Management

This category of managed care service relates to the provision of the full range of health care services available to members in terms of the scheme's registered rules and particular benefit option and typically includes:

- All out-of-hospital, and in some instances in-hospital services (may be limited) as per the scheme's benefit rules for the particular benefit option.