مجلس الضمان الصحي
Council of Health Insurance

CHI's Payers'

Qualification and Classification Program

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Introduction

This program is an extension of the current qualification requirements. It is designed by the Council of Cooperative Health Insurance (CHI) to assess the performance of the organization (Insurance Company or Third Party Administrator, TPA) against a set of standards that are organized in 8 operational chapters. The 8th chapter, governmental requirements, encompasses the current qualification requirements.

The objectives of the program are as follows

1) Align the medical insurance market with the CHI's mission and vision and strategic directions.

2) Protect the beneficiary' rights and enhance their experience.

3) Provide an evidence-based model for the Payers' (Insurance companies and TPA's) operational excellence.

4) Provide the employers (policy holder) with quality information on payers.

5) Accelerate the delivery of Value Based Health Care and Population Health.

6) Introducing operational competition between payers.

7) Drives the basis for incentives and awards in the medical insurance market, sponsored by CHI.

CHI's mission

Improve the health of beneficiary through a regulatory environment that enables stakeholders to promote transparency and equity value-based care.

CHI's Vision

To be an international leader in improving value in healthcare for the beneficiary of cooperative health insurance.

CHI's strategic objectives (2020 – 2024)

- Enable target population segments to be fully covered and protected.
- Enable payers and providers to improve their services to beneficiary with progressive policies.
- Improve the sustainability and innovation in the sector.
- Operate as a reliable, lean, and learning regulator.
- Catalyze the digital transformation of the sector.

Standards' interpretation

The standards are organized in the following fashion:

- Each standard is designated an acronym that reflects the name of the chapter followed by the standard number in sequence.
- The standard statement: reflecting the quality dimension to be achieved from implementing the standard.
- The sub-standard: each standard is followed by a number of sub-standards. The cumulative compliance with the sub-standards reflects the overall compliance with the standard.
- The standard's intent: that explains why we need the standard and how the organization can comply with the standard.
- Evidence of compliance: the set of documents required from the organization that reflects their compliance with the intent statement and sub-standards.
- Some standards may not be applicable to the organization, for example standard BR.10 does not apply to TPA's.

Chapter I

Governance and Leadership

(9 Standards, 37 Sub-standards)

This chapter focuses on the Governance and leadership structure of the organization and their roles and responsibilities in setting up the strategic directions of the organization.

- Governance
- Leadership
- Organizational structure
- Strategic plan
    - Mission, vision, values
    - 3 years' business plan
    - Marketing
- Medical department
    - Manpower requirements
    - Staff retention

GL.1. The organization's Governance is presented in a document

GL.1.1. The document highlights the governance structure.

GL.1.2. The document describes the governance rules and responsibilities.

GL.1.3. The document states any conflict of interest from governance members.

GL.1.4. Meetings of the governing body are documented reflecting compliance with regulators and evidence of improvement projects.

Intent

The board of directors in the organization is its governing body. As such, it is ultimately responsible for the quality and safety of services rendered to the beneficiary. The board is also responsible for the organization's compliance with governmental insurance rules and regulations Strategic decisions affecting the organization's direction are also made by the board. Board members should not be shareholders of any healthcare provider organization, to avoid any conflict of interest.

Evidence of Compliance

1) Document describing Governance structure and its rules and responsibilities.

2) Terms of reference of the governance' meetings.

3) Evidence of meeting minutes reflecting discussions on compliance with regulators.

4) Evidence of meeting minutes reflecting discussions on overall performance and improvement projects.

5) Signed Conflict of interest statement from all board members.

GL.2. Leaders are identified in an updated organizational chart

GL.2.1. The leaders are identified by name and designation in an organizational chart.

GL.2.2. The leaders are registered with the Council on Cooperative Health Insurance.

Intent

The organizational chart reflects the organizational behavior and how functions are distributed to its different units and departments. It also defines the reporting mechanism and the chain of command. The organizational chart highlights the accountability of its leaders and senior managers, which is important for internal and external business and communications. The organization notifies the CHI of the names of the following leaders:

- Chief Executive Officer.
- Chief Financial Officer.
- Chief Medical Officer.
- Chief Information or Data Officer.
- Compliance Officer.

Evidence of Compliance

1) Organizational chart graph presented by name and designation.

2) Evidence of leaders' registration with CHI.

GL.3. The organization shares its updated medical insurance strategy with CHI

GL.3.1. The organization shares its mission, vision and values.

GL.3.2. The organization shares its 3 - 5 years' strategic plan with performance indicators.

GL.3.3. The organization shares its marketing strategy with CHI.

Intent

The organizational strategy sets the direction for the organization and establishes priorities for its business and improvement initiatives. It highlights the organization's goals and objectives that drives the integration and cooperation of the departments. The overall strategy is further projected in the departmental goals and objectives. The marketing strategy should be designed to reflect health and quality of life benefits from enrollment with the organization.

Evidence of Compliance

1) Mission, vision and values' statement are visible to its employees.

2) The organization's 3 years' strategic plan is shared with its employees and CHI.

3) The strategic plan is controlled with key performance indicators reflecting the goals intended to achieve.

4) Marketing strategy is shared with CHI.

References

Implementing Regulations of the Cooperative Health Insurance Law, Chapter 6; article 46.

GL.4. The organization has a dedicated medical division

GL.4.1. The division is responsible for approving the beneficiary's request for treatment (Pre – authorization).

GL.4.2. The division follows up the management of complex and rare diagnoses to ensure the provision of appropriate care.

GL.4.3. The division reviews beneficiary claims to ensure conformity with evidence based patient care guidelines and protocols.

GL.4.4. The division collects information on beneficiary's pre-authorization approvals and rejections.

GL.4.5. The division continuously improves beneficiary's experience based on data collected.

GL.4.6. The division leads the organization's "Population Health" program initiative.

Intent

The medical division is a corner stone in any medical insurance company or third party provider. The division is responsible for the provision of the differentiated healthcare that the beneficiary need, from approvals to allocating the appropriate healthcare facility. The division follows up the treatment plans and reviews beneficiary claims to ensure the service providers 'compliance with evidence-based guidelines and protocols. The division is expected to enrich the beneficiary's experience. Segmenting its population and improving the health of chronic disease beneficiary is an integral part of the organization's mission towards implementing the population health program initiative.

Evidence of Compliance

1) Organizational chart for the medical division.

2) Scope of services document for the medical division.

3) Daily record of pre-authorization approvals and rejections.

4) Tracking document for complex and rare cases.

GL.5. The medical division has qualified staff to execute its functions

GL.5.1. The division is chaired by a qualified medical director.

GL.5.2. Service approvals and claims processing are managed by medical insurance officers.

GL.5.3. The organization contracts formally or informally with part time medical consultants in different specialties.

GL.5.4. The organization has full time population health care manager (s).

GL.5.5. The organization ensures the appropriate claims' review by clinical coders.

GL.5.6. The organization ensures the coders' no conflict of interest.

Intent

The medical division should have the appropriate staff to execute its intended scope of services. The skills and expertise of the medical director are required to lead the physicians and care managers. The full time medical claim officers are non-practicing healthcare providers. (They must be registered with CHI to ensure their appropriate qualifications and experience). The organization should contract with qualified part time consultants to support its decision making for approvals and revisions of claims, when needed. The organization has its own clinical coders or contracts with part time coders. The organization ensures that the part time coders have no conflict of interest (refrain from reviewing claims from other contracted parties).

Evidence of Compliance

1) Organizational chart for the medical division.

2) (Registration of Medical claim officers with CHI).

3) Contract with external consultants.

4) Clinical coders' status.

5) Staff acknowledgment of CHI's rules and regulations.

GL.6. The medical director is a qualified and practicing consultant physician

GL.6.1. The medical director is a registered consultant physician with SCFHS.

GL.6.2. The medical director has a minimum of 5 years' consultant experience in a tertiary care hospital.

GL.6.3. The medical director dedicates at least 20 hours every week for the divisional activities.

GL.6.4. The medical director has an updated confidentiality and conflict of interest signed statement.

GL.6.5. The medical director is registered with CHI.

Intent

The medical director should be qualified to achieve the goals of the leadership position. He / she should be a practicing consultant dedicating 20 hours weekly for his / her administrative work in the organization. The director should show evidence of unbiased decisions related to his private practice. The medical director is a focal communication officer for all medically and clinically related issues with CHI.

Evidence of compliance

1) Medical director's short biography highlighting qualification, training, experience and current medical practice.

2) Evidence of registration with SCFHS.

3) Job description as the medical director of the organization.

4) Evidence of physicians' registration with CHI.

5) Conflict of interest statement.

GL.7. The part time medical consultants are qualified practicing specialty physicians

GL.7.1. The consultants are Board certified or equivalent and registered with SCFHS.

GL.7.2. The consultants function as advisors to the organization in all disputes related to pre-authorization approvals and claims.

GL.7.3. The consultants have an updated confidentiality and conflict of interest signed statement.

Intent

The medical consultants provide support to the decision making process of the medical division and as such they need to have the appropriate credentials. The following specialties are the minimum requirement: General Surgery, Internal Medicine, Cardiology, Neurology, Obstetrics and Gynecology, Intensive care, Rheumatology, Neonatology, with access to other rare subspecialties, when needed.

Evidence of Compliance

1) Consultants' short biography highlighting qualification, training, experience and current medical practice.

2) Evidence of registration with SCFHS.

3) Job description.

4) Conflict of interest statement.

GL.8. The organization has full time Population Health care manager (s)

GL.8.1. The care manager is a healthcare provider by qualification, experience and training.

GL.8.2. The care manager has a minimum of 5 years' healthcare clinical experience.

GL.8.3. The care manager works with the service provider to identify and promote the health of high risk beneficiary, aiming at reducing preventable emergency room visits and hospital admissions.

Intent

The care managers' role in the medical division requires knowledge, experience and work flexibility with possible frequent visits to service providers. The care manager is a healthcare provider (physician, nurse, or allied healthcare practitioner) with at least 5 years' healthcare experience. The care manager is responsible for identifying the high risk and problem prone beneficiary. The care manager promotes the health of such patients by coordinating the patients' care with their primary physicians.

Evidence of Compliance

1) Care manager's short biography highlighting qualification, training and experience.

2) Job description.

3) Tracking document for high risk beneficiary.

4) Tracking document for discharged high risk beneficiary.

GL.9. The organization retains its human resource asset

GL.9.1. Staff are recruited as per manpower policy and recruitment plan.

GL.9.2. All staff categories have job descriptions.

GL.9.3. Staff evaluation are based on objective performance criteria.

GL.9.4. The organization has a tailored professional development program for its employees.

GL.9.5. The organization performs periodic employee satisfaction surveys, with projects targeting improvements in outcomes.

Intent

The human resources are the non-tangible assets in the organization and their retention is critical to its success and sustainability. Having the right manpower and recruitment plan ensures the availability of the right number of competent staff. Maintaining the professional development of employees and ensuring an objective evaluation of their performance enhances the organization's overall performance. Unsatisfied employees at work are a source of non-compliance and hidden rejection to work ethics and rules and regulations, thus adversely affecting organizational performance. The organization should perform improvement projects targeting non-satisfactory survey results.

Evidence of Compliance

1) Manpower and recruitment plans for medical insurance staff.

2) Job description for medical insurance staff categories.

3) Employees' performance evaluation based on productivity, professional development and compliance with the organization's mission, vision and values.

4) Professional development program.

5) Annual standardized employee satisfaction survey and outcomes.

6) Evidence of improvement projects based on survey outcomes.

Chapter II

Beneficiary Rights (BR)

(10 Standards, 43 Sub-standards)

This chapter focuses on the payers' role in seeding and promoting the beneficiary' rights.

- Beneficiary' rights policies and procedures.
- Digitization of beneficiary' services.
- Portfolio of insurance services and service providers.
- TPA contract oversight.

BR.1. The organization acknowledges the beneficiary' rights in having an unprecedented healthcare experience

BR.1.1. Policies and procedures guide the policy holder initial enrollment and renewal of insurance contracts.

BR.1.2 Policies and procedures guide the beneficiary' pre-authorization approval process for outpatient and inpatient encounters.

BR.1.3. Policies and procedures guide the beneficiary' complaint process.

BR.1.4. Policies and procedures guide the oversight of TPA's contracts.

Intent

The organization must prove its customers' centric focus by developing and implementing a set of policies and procedures regulating its services. Policies targeting the beneficiary must include those dealing with approval of outpatient and inpatient services and any additional requested services and beneficiary's complaint policy. The organization must have a policy on claims processing and payment to providers. If the organization elects to outsource its claims management to a TPA, this should be controlled with an oversight policy. All policies should be monitored for compliance with process key performance indicators.

Evidence of compliance

1) Policy and procedure on service approvals.

2) Policy and procedure on claims management.

3) Policy and procedure on beneficiary's complaints.

4) TPA contract oversight policy.

References

Implementing Regulations of the Cooperative Health Insurance Law, Chapter 7; article 81.

BR.2. The beneficiaries are well informed of their rights at initial enrollment

BR.2.1. Beneficiaries are informed of their policy coverage, benefits and deductible payments in an understandable process and language.

BR.2.2. Beneficiaries are informed of the hospitals and clinics network serving their healthcare needs.

BR.2.3. Beneficiaries are aware of the pre-authorization approval process and its exceptions and time frame regulated by CHI.

BR.2.4. Beneficiaries are fully informed of the generic medication prescription and dispensing policy endorsed by CHI.

BR.2.5. Beneficiaries are aware of the complaint process against services provided by the organization.

Intent

A major cause for beneficiary's dissatisfaction and further complaints is the unawareness of their rights and benefits and the limits of their insurance policy. The insurance company, directly or through the employers, should ensure that the beneficiary is aware of the policy's inclusion and exclusion criteria, amount of deductibles to be paid in the outpatient setting, prior approval process for medical services, the healthcare network providing their health insurance services, the dispensing of generic medications and the need to pay for non-generic medications and finally how to raise a concern, suggestion or complaint.

Evidence of compliance

1) Awareness statement of the beneficiary at enrollment.

References

- Unified health insurance contract, chapter 3, Technical obligations.
- Unified health insurance contract, chapter 8, Beneficiary rights.
- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8; article 86.

BR.3. The policy on service approval complies with CHI rules and regulations

BR.3.1. The organizations' approval department is operational 24 hours a day, year round.

BR.3.2. The organization utilizes an evidence based medicine approach for approving medical requests, that is shared with providers.

BR.3.3. The process complies with the 60 minutes' approval timeframe rule.

BR.3.4. Beneficiaries are informed of the reason (s) for disapproval of services.

BR.3.5. Rejections are reported as per the CHI coding for rejected services.

Intent

Being customer centric, the organization develops a policy and procedure for the approval of beneficiary's medical services. The policy expedites the approval process, thus reducing unnecessary delays in treatment. The policy ensures conformity with evidence based clinical practices aiming to provide effective care and reducing service rejections.

Evidence of compliance

1) Tracking document for approvals with reasons for rejections.

2) Average turnaround time for approvals.

3) Approvals' tracking document sent to CHI, quarterly

References

- Unified health insurance contract, chapter 3, Technical obligations.
- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8; article 90.

BR.4. The organization continuously improves its pre-authorization approval process

BR.4.1. The organization collaborates with the service providers to reduce the beneficiary's waiting time for pre-authorization approvals.

BR.4.2. The organization measures and improves its average pre-authorization approval time rate.

BR.4.3. The organization measures and improves its pre-authorization approval rejection rate.

BR.4.4. Quarterly pre-authorization approval improvement report is shared with CHI.

Intent

The pre-authorization approval process and its timing is crucial for beneficiary safety and satisfaction. The organization is expected to measure and analyze a set of indicators governing its approval process and work with the providers to improve approvals. Utilizing the data collected on rejections, the organization should develop pro-active approaches to reduce its rate. The organization should show continuous improvements in its approval processes.

Evidence of compliance

1) Monthly collection of above KPI's

2) Evidence of analysis and suggested improvements.

References

- Unified health insurance contract, chapter 3, Technical obligations.
- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8; article 90.

BR.5. The beneficiary's complaint policy complies with CHI rules and regulations

BR.5.1. The beneficiary's complaint department manages all their complaints.

BR.5.2. The organization documents and tracks all complaints to ensure its resolution within the specified time frames.

BR.5.3. The organization measures and improves the beneficiary satisfaction of its complaint handling process.

BR.5.4. Quarterly complaint process satisfaction report is shared with CHI.

Intent

It is not uncommon that the beneficiary complain from services rendered by insurance companies. Organizations must have a dedicated beneficiary complaint department to handle beneficiary's complaints. The department should follow a clear policy on complaint handling that includes the approved communication process and the time frame for resolving the complaint. The payer should acknowledge receiving the beneficiary's complaint within 24 hours and advise submitting any missing or relevant documents. The beneficiary should receive a reply for the complaint within one working day for urgent complaints and 3 working days for routine ones. Beneficiaries are well informed of the complaint process and its time frames. A dedicated log book tracks all complaints to ensure resolving it within the approved time frame. Measuring beneficiary's satisfaction to the complaint process, using an evidence based method, is periodically analyzed and the complaint process improved accordingly.

Evidence of compliance

1) Organizational chart of the beneficiary's complaint department.

2) Complaint policy highlighting the time frame for resolving complaints and the complaints tracking process.

3) Satisfaction survey targeting the complaint process.

4) Quarterly complaint report.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 7; article 81.
- Regulations Governing the Protection of Health Insurance Beneficiary, chapter 6; article 12.

BR.6. The organization continuously improves its beneficiary's complaint rate and response time

BR.6.1. The organization measures and improves its complaint rate.

BR.6.2. The organization measures and improves its average complaint response time rate.

BR.6.3. The organization measures and improves its outstanding (Non-actioned) complaint rate.

BR.6.4. Quarterly complaint improvement report is shared with CHI.

Intent

Beneficiary's complaints are common. Organizations are required to show evidence of service improvement through reducing the number of complaints and improving its response time. Beneficiaries are also expected to receive satisfying results from complaints' handling. The above self-explanatory rates are the minimum expected to be collected monthly.

Evidence of compliance

1) Monthly collection of above KPI's

2) Evidence of analysis and suggested improvements.

BR.7. The organization provides the beneficiary with a complete online business solution

BR.7.1. Customers are granted access to online renewal of existing contracts.

BR.7.2. The solution provides beneficiary the access to their rights.

BR.7.3. The solution displays the beneficiary's specific network of providers and its differentiation into primary, secondary and tertiary care facilities.

BR.7.4. The solution provides the beneficiary with on time pre-authorization approvals or rejections.

BR.7.5. Beneficiaries can raise and receive responses on their complaints, concerns or suggestions utilizing the solution.

Intent

Well informed beneficiary enhance insurance practices and benefits in the market. The beneficiary often require more information on insurance services and the network of providers available. Utilizing an electronic portal for the policy renewals, service approvals, and submitting complaints or suggestions expedites transactions and enhances beneficiary's experience.

Evidence of compliance

1) Online beneficiary portal for inquiries.

2) The portal offers online contracting and renewal of contracts.

3) Specific beneficiary service providers are displayed in the portal.

4) The beneficiary receive pre-authorization approvals by SMS and emails.

5) Complaints and suggestions are handled through the portal.

BR.8. The organization has a portfolio of medical insurance products

BR.8.1. The portfolio covers corporate plans and complies with the requirements of CHI's unified contract.

BR.8.2. All products cover health promotion and disease prevention, curative, rehabilitative and palliative services.

BR.8.3. The portfolio respects beneficiary' wishes for involvement in deductible pays.

BR.8.4. The portfolio respects beneficiary' wishes for additional benefits on top of the unified contract.

Intent

The organization should have a variety of insurance schemes that suit the needs of the public. Some beneficiaries prefer to pay less premium and more co-pays, while other prefer higher premium and no co-pay (deductible). Some beneficiaries prefer VIP services, while others do not mind sharing a room with another beneficiary. Regardless of the beneficiary's wishes, the organization portfolio should cover the CHI's essential benefit package.

Evidence of compliance

1) The company caters for group and individual insurance.

2) The insurance covers the essential benefit package at a minimum

3) The company provides a variety of customer differentiated services.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8, articles 101, 102.

BR.9. The organization has a portfolio of providers

BR.9.1. The portfolio covers the beneficiary' healthcare service needs, covering at least the minimum network requirements and complies with the requirements of CHI's unified contract.

BR.9.2. The portfolio ensures an even distribution of services in major cities according to the minimum network requirements.

BR.9.3. The portfolio ensures the availability of high risk services in more than one location in major cities.

BR.9.4. The portfolio ensures the compliance with the beneficiary personalized services.

Intent

The organization must ensure providing its beneficiary with a safe and personalized services. The organization endeavors to ensure an even medical services coverage in the cities by contracting

with different service providers. The organization must contract with several providers of tertiary care services to ensure availability of high risk services in more than one location in any given city.

Evidence of compliance

1) The organization complies with the CHI's minimum network requirements.

2) The providers' portfolio covers personalized and high risk servicers in different locations.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 6, articles 59.

BR.10. The TPA's contract oversight policy complies with CHI healthcare insurance policy

BR.10.1. The organization contracts with a qualified TPA after notifying CHI's.

BR.10.2. The policy identifies the responsible staff for ensuring compliance with the TPA to CHI's rules and regulations.

BR.10.3. The organization develops a set of process and outcome key indicators targeting the performance of TPA.

BR.10.4. Decisions for renewal or termination of contracts with the TPA are influenced by the key indicators.

Intent

An organization may outsource its pre-authorization approval and claim processing tasks to a TPA. The organization needs to ensure that the TPA complies with CHI's regulations, including notifying CHI before contracting (article 119). The TPA shall follow the CHI regulations, being monitored by a responsible person from the organization. Monitoring includes the development of process and outcome indicators which are collectively used also for the purpose of discontinuing or renewing the TPA contract.

Evidence of compliance

1) Notification of CHI concerning the contract with qualified TPA.

2) TPA management oversight policy highlighting job responsibilities of contract handler.

3) Description of the key performance indicators in the contract.

4) Evidence of reviewing key performance indicators before contract renewal (or termination).

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8; article 119.

Chapter III

Providers Relationship (PR)

(3 Standards, 12 Sub-standards)

This chapter highlights the efforts exerted by the payers to streamline and strengthen the relationship with the service providers, in compliance with the CHI's rules and regulations for medical and clinical service pre-authorization, claims processing and final payments.

PR.1. The insurance company strengthens its relationship with the providers

PR.1.1. The insurance company contracts with the providers using the CHI unified contract template.

PR.1.2. The insurance company enhances the pre authorization process by appointing qualified physicians at the level of a specialist or higher.

PR.1.3. The insurance company uploads new and updated beneficiary' policies within 48 hours from paying the premium by the employer.

Intent

Payers and providers share the responsibility of delivering a safe, affordable and satisfying healthcare services to the beneficiary. CHI, as the health insurance sector regulator, issued the payers / providers unified contract, highlighting both parties' obligations. The contract is an obligatory template to be used for all contracts between payers and providers. Payers should ensure hiring qualified specialty physicians to streamline the pre-authorization communication. Payers should upload new and revised beneficiary' policies, in a timely manner, to ensure the un-interruption of beneficiary' health insurance cover.

Evidence of compliance

1) Contracts sample with providers.

2) Staff count and qualifications of pre-authorization staff.

3) Report on delayed policies uploading (verified from HIDP as well).

References

1) The Unified Contract between Insurance Company and Health Service Provider in Private Sector.

2) Regulations Governing the Protection of Health Insurance Beneficiary, Chapter 4; article 7

PR.2. The policy on claims' processing and payment complies with CHI rules and regulations

PR.2.1. The organization has a valid medical coding license from Saudi Health Council.

PR.2.2. Claims are classified according to the CHI approved Saudi billing system.

PR.2.3. The organization utilizes a "DRG Grouper" software to classify and process beneficiary claims.

PR.2.4. Claims are processed and payments paid to the provider within 30 days from receiving it.

PR.2.5. Disputed claims between payer and provider are referred to CHI's committee on disputed claims.

Intent

To ensure a smooth and productive relationship between payers and providers, CHI included the rules and regulations governing the processing and payments of claims in its unified contract policy document. Compliance of the payers with the policy offers a fair revenue cycle to the providers and ensures a financially sustainable business. The organization must utilize a DRG grouper software to classify claims according to Saudi Billing Codes System. CHI's medical department is contracted with eminent consultants to ensure a fair decision making in disputed medical cases. Therefore, it is anticipated that payers shall respect the CHI's opinion in such cases.

Evidence of compliance

1) The organization has a valid coding certificate from the "Saudi Health Council"

2) Classification of claims by CHI approved Saudi billing system.

3) Turnaround time document for providers' payments.

4) Statistics on settled medical claims versus total.

5) Quarterly report of disputed claims highlighting percentage of unsettled claims referred to CHI's relevant committee.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8; article 90.
- Unified health insurance contract, chapter 3, Technical obligations.
- Unified health insurance contract, chapter 4, Financial obligations.

PR.3. The organization is electronically connected with service providers through a two-way complete online business solution.

PR.3.1. The solution displays its network of providers and its differentiation into primary, secondary and tertiary care facilities.

PR.3.2. The organization facilitates the access of service providers to beneficiary insurance policies including inclusion and exclusion criteria and deductibles.

PR.3.3. Pre-authorization approvals and rejections are handled by the business solution.

PR.3.4. The solution provides access for claim submission by the providers.

Intent

Having an online communication platform with service providers expedites beneficiary registration, pre-authorization approvals, and claim processing. It also facilitates the recognition of other participating service providers in the company's network in case of referrals or for continuity of care purposes. Claims are shared by the provider through this solution following the "Saudi Billing system" requirements. Ultimately, all claims shall be submitted through NPHIES platform.

Evidence of compliance

1) Network of service providers displayed in the company's electronic platform (complying with the minimum network requirement of CHI).

2) Company policies are displayed in the company's electronic platform.

3) The platform facilitates the pre-authorization approvals and claim processing with service providers.

Chapter IV

Population Health and Innovative Products (PI)

(2 standards, 9 Sub-Standards)

This chapter differentiates companies by the ability of their products to create value and contribute to population health program.

PI.1. The organization has an active Population Health Program initiative

PI.1.1. The organization registers its beneficiaries with their preferred primary care physician.

PI.1.2. The organization provides ongoing disease segmentation of its beneficiaries.

PI.1.3. The care managers work with the service providers to promote the health of identified high risk beneficiary.

PI.1.4. The medical team work with the service providers to set short term and long term healthcare goals for the high risk beneficiary.

PI.1.5. The organization is active in educating its beneficiary on health promotion and disease prevention.

PI.1.6. The program is monitored by key performance indicators.

Intent

Population health is a major pillar for achieving the CHI's mission. Healthcare goals and objectives of "Population Health" can only be achieved by collaboration from public and private healthcare payers and providers. The organization should aim at promoting the health of its beneficiary, as part of its services portfolio. This should start by registering the beneficiaries with their preferred primary care physician. It may be difficult to satisfy all beneficiaries, due to operational issues. Segmenting its population helps in providing targeted health promotion and disease prevention programs to its high risk population, thus reducing their hospital visits and admission rates. The care manager promotes the health of high risk population by coordinating the patients' care with their primary physicians and jointly developing short term and long term preventive goals. The care manager is also responsible for following up the goals' achievement. Reaching out to the community is very important to deliver mass health promotion and disease prevention information. The Medical director is responsible for the program implementation. Key performance indicators are essential to monitor the success of the program, for example:

- Average HbA1c for the segmented diabetic population.
- ER attendance rate for the segmented chronic disease beneficiaries.
- Rate of emergency hospitalization of segmented chronic disease beneficiaries.
- Compliance with clinical pathways for managing chronic disease patients.

Evidence of compliance

1) Written population health program with objectives and delineated staff responsibilities.

2) Evidence of beneficiaries' segmentation.

2) Program's key performance indicators.

PI.2. The organization innovates to enhance its products and operations based on population health needs

PI.2.1. The organization includes telehealth and tele-monitoring in its insurance products.

PI.2.2. The organization provides the beneficiary with physical and mental health promotion and disease prevention applications.

PI.2.3. The organization utilizes analytics to predict fraud, waste and abuse from the claims transactions.

Intent

The organization should constantly utilize technology and innovation to enhance and reduce the cost of its services. The organization should utilize its information on claims and fraud, waste and abuse to formulate an analytical model to predict and prevent fraud, waste and abuse.

Evidence of compliance

1) Telehealth and tele-monitoring included in the insurance portfolio.

2) Mobile applications targeting health promotion and disease prevention.

3) Analytical program for prediction and prevention of fraud, waste and abuse.

Chapter V

Value Based Healthcare (VH)

(6 Standards, 23 Sub-standard)

This chapter focuses on the payers' initiatives to reduce waste and improve the value and outcome of healthcare services.

- Compliance with medical practice guidelines.
- Fraud, waste and abuse prevention.

VH.1. The organization monitors the providers' implementation of CHI practice guidelines

VH.1.1. The medical director is responsible for the regular auditing of the providers' compliance with CHI's practice guidelines.

VH.1.2. Quarterly compliance reports are issued by the organization, highlighting variation from evidence based practice and its justification.

Intent

To ensure the delivery of standardized and evidence based healthcare services, the CHI developed a set of practice guidelines targeting the most common and problem prone diseases. The compliance with the practice guidelines helps to eradicate service and claim rejections, and unifies the standards of clinical care, thus enhancing the beneficiary experience and reducing cost. The organization is required to monitor and track the providers' implementation of evidence based practice guidelines through the submitted claims. The CHI suggests that the organization starts with regularly reviewing the claims of the top 5 costly diagnoses and the top 5 costly procedures against practice guidelines.

Evidence of compliance

1) Quarterly audit reports on providers' compliance with practice guidelines.

VH.2. The organization supports safe and efficient medication utilization

VH.2.1. Medication contracts with providers conforms to CHI's insurance drug formulary policy (IDF).

VH.2.2. Contracts with community Pharmacies conforms to CHI's IDF policy.

Intent

The insurance drug formulary program issued by the Council aims at maximizing drug safety while reducing its cost. The medication contract between payers and providers must be based on the IDF generic medications. Similarly, contracts between community pharmacies and payers.

Evidence of compliance

1) Sample provider's contract, highlighting IDF formulary compliance.

2) Sample community pharmacy contract.

VH.3. The organization has a pharmacy benefit management program (PBM), in compliance with CHI's Insurance Drug Formulary (IDF) program

VH.3.1. A policy and procedure guides the program's implementation.

VH.3.2. The program is coordinated by a qualified and licensed pharmacist.

VH.3.3. The program is executed by evidence-based and updated software.

VH.3.4. Prescriptions are reviewed to ensure appropriateness of indications.

VH.3.5. Prescriptions are reviewed to avoid medication duplication.

VH.3.6. The program allows the dispensing of only generic medications or substitutes.

Intent

On average, medications contribute at least 20% of the cost of medical claims. In line with CHI's strategy to enhance beneficiary safety and adopt value-based health care, an IDF program has been developed by a group of National experts in the pharmaceutical industry. The objectives of the program are to enhance medication safety, reduce unnecessary medication cost, eliminate medication fraud and reduce claims' rejections. Payers should comply with the IDF program and institute their own PBM program under the stewardship of a senior qualified and licensed pharmacist. The organization must have a policy and procedure for the PBM program with clear tasks and accountability. All prescriptions sent for pre-authorization must be reviewed for appropriateness, generic substitution and possible duplication. The organization must have its own drug formulary, that is based on CHI's IDF, and shared with service providers and retail pharmacies.

Evidence of compliance

1) Pharmacy benefit management program.

VH.4. The organization is pro-active in preventing fraud, waste and abuse

VH.4.1. The organization develops and implements a strategic plan for the prevention, early detection and reporting of fraud, waste and abuse.

VH.4.2. Creating an internal unit for managing fraud, waste and abuse.

VH.4.3. Escalating cases of suspected fraud, waste or abuse is guided by an organizational policy and procedure.

VH.4.4. Payers, TPA's and providers are actively and transparently exchanging information on fraud, waste and abuse.

VH.4.5. The organization retains indefinitely detailed files on fraud, waste and abuse by beneficiary

Intent

Fraud, waste and abuse are ethical dilemmas that may reach a criminal act in some cases. They are considered as one of the road blocks for achieving value based healthcare. The organization should fight fraud, waste and abuse by developing a pro-active strategic plan. An internal unit should be created to handle manage the plan. The unit should escalate all cases to the CHI and relevant governmental entities as per a clear plan of action. The organization is expected to exchange fraud, waste and abuse cases and information with service providers in complete transparency. All fraud, waste and abuse cases are classified and kept in secure files indefinitely.

Evidence of compliance

1) Fraud, waste and abuse strategic prevention plan.

2) Organizational chart for the fraud, waste and abuse prevention unit or department.

3) Organizational policy on reporting of fraud, abuse and waste.

4) MOU with service providers on reporting and the exchange of information on fraud, waste and abuse.

5) Evidence of archived cases.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 7; article 77.
- سياسة سلوكيات سوق التأمين الصحي الخاص الباب الثالث, البند الخامس.

VH.5. The fraud, waste and abuse strategic plan actively involves all stakeholders

VH.5.1. The organization develops an ongoing educational program, for its clinical and non-clinical staff, on the risks of fraud, waste, and abuse.

VH.5.2. Fraud, waste and abuse prevention and management is included in the "onboarding" of new employees.

VH.5.3. Beneficiaries are well informed of the risks of fraud and how they could be involved in fraud cases.

VH.5.4. Beneficiaries acknowledge receiving and comprehending the delivered information on fraud at enrollment.

Intent

Payers' employees and beneficiary may not be aware of what actions are considered as fraud, waste or abuse. It is the organizational responsibility to continuously educate all stakeholders on what constitutes and the risks of fraud, waste and abuse and their further consequences on the individual, organization and the community at large. Beneficiaries must acknowledge their awareness in writing at enrollment and further renewal.

Evidence of compliance

1) Ongoing educational program on Fraud, waste and abuse prevention

2) Staff orientation program content.

3) Beneficiary's educational material on fraud, waste and abuse.

4) Sample, beneficiary enrollment form showing statement acknowledging receiving information on fraud, waste and abuse and taking full responsibilities for any breaches.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 7; article 77.
- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8; article 91.
- سياسة سلوكيات سوق التأمين الصحي الخاص الباب الثالث, البند الخامس.

VH.6. The organization complies with CHI's rules for fraud prevention

VH.6.1. The organization ensures the correct identification of the beneficiary using the full name and identification number as in the National ID or IQAMA documents.

VH.6.2. The organization complies with the quarterly reporting to CHI of any group policy (s) not subject to claims for a period of 3 months from issuance.

VH.6.3. The organization immediately informs CHI of cancelled policies due to employer non-payment.

VH.6.4. Suspected or actual frauds are immediately reported to CHI as highly confidential information.

Intent

Fraudulent practices range from individual beneficiary practices up to organizational behaviors. CHI is determined to eliminate all types of insurance fraud through the implementation of essential regulatory steps, as described in the sub-standards VH.6.1 through 6.4. This also enhances the compliance with the Ministry of Interior regulations for residents, tourists and visitors to the Holy Mosques.

Evidence of compliance

1) Compliance with MDS requirements and directive to service providers.

2) Notification to CHI related to group policy 3 months' compliance with claims.

3) Immediate notification of new beneficiary registration process.

4) Immediate notification of cancelled beneficiary.

5) Fraud notification process.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 6; article 48.
- سياسة سلوكيات سوق التأمين الصحي الخاص الباب الثالث, البند الخامس.

Chapter VI

Healthcare Information Management (HI)

(10 Standards, 46 Sub-standards)

This chapter focuses on how the organization utilize and manage its data to achieve its business goals. The following is covered in this chapter:

- Information system requirements.
- Data management strategy.
- Data governance framework.
- Protection of personal data.
- Cybersecurity requirements.
- Data protection.
- Ensuring data integrity.
- Data retention and final disposition.
- Data business continuity plan.
- Compliance with CHI digitization requirements.

HI.1. The organization utilizes an information system software that supports health information exchange

HI.1.1. The software language used is HL-7, preferably FHIR - R4 version.

HI.1.2. The software supports Public Key Infrastructure (PKI) integration capability.

Intent

The organization must have an information system that supports inter-operability and health information exchange with healthcare providers and the national health exchange platform, NPHIES. The software language preferred is HL-7 FHIR version R4. The software should support Public Key Infrastructure integration capability.

Evidence of compliance

1) Evidence of software language compliance.

2) Evidence of Public Key Infrastructure support.

References

- NPHIES RCM Systems Minimum Requirements, V.1.

HI.2. TThe organization efficiently and effectively manage its data

HI.2.1. The leaders design a data strategy managing its life cycle.

HI.2.2. The leaders design a data governance framework in compliance with the National "Data

Management and Personal Data Protection Standards".

HI.2.3. The leaders assign a data management officer responsible for implementing the governance framework.

HI.2.4. The data governance activities are audited yearly to ensure organizational compliance and provide transparency to stakeholders.

Intent

Data is an invaluable resource. Although its value is well-understood, unlocking that value is often a challenge due to the high volume of data and the challenges associated with its collection, classification, safe storage, protection and ensuring its reliability and availability to stakeholders at the required time. The organization should develop a data strategy that is aligned with its information technology in order to achieve its business objectives. A chief data officer is expected to be responsible for developing a data governance framework and accountable for its implementation. The data governance framework should follow a recognized methodology such as the National "Data Management and Personal Data Protection Standards". The chief data officer is also responsible for the yearly auditing of the data governance activities and providing a compliance report to stakeholders.

Evidence of compliance

1) Data strategy.

2) Data Governance framework.

3) Data stewardship.

4) Data Governance activity audit.

References

- https://sdaia.gov.sa/ndmo/Files/Policies001.pdf
- https://sdaia.gov.sa/ndmo/Files/PoliciesAr.pdf

HI.3. The organization protects all types of personal data in compliance with local rules and regulations

HI.3.1. The organization establishes policies and procedures to guide the protection of personal data from inception to final disposition, including third parties' sharing.

HI.3.2. A data officer is responsible for ensuring the organization's compliance with the personal data protection policies and procedures.

HI.3.3. The data officer continuously assess the risks from handling personal data within and outside the organization and develops protection plans in compliance with local rules and regulations.

HI.3.4. The organization documents the ongoing process for auditing the compliance with personal data protection policies.

HI.3.5. Organization staff are educated on the principles of personal data protection at initial

enrollment and yearly thereafter.

HI.3.6. Staff acknowledge their awareness of the confidentiality and sensitivity of personal data, and the legal consequences of its breaches.

HI.3.7. The organization reports personal data breaches to local authorities as per rules and regulations.

Intent

The National Data Management Office defines personal data as "any element of data, alone or in connection with other available data that would enable the identification of a person". Thus, all beneficiary related documents are considered personal data deserving the utmost attention to its protection and privacy. According to the Royal Decree published in 9/2/ 1443, the organization must protect all personal data in its possession and ensure the owner's rights for managing their data. Sub-standards HI.3.1 to 3.7 are self-explanatory and represent the minimum requirements for compliance with the Royal Decree.

Evidence of compliance

1) Policies and policies on the protection of personal data.

2) Evidence of staff education on personal data protection (probation / yearly).

3) Sample of staff consent to personal data protection.

References

- نظام حماية البيانات الشخصية الصادر بمرسوم ملكى رقم (م/19) فى 1443/2/9

HI.4. The organization protects the rights of data owners

HI.4.1. The organization establishes policies and procedures to protect the rights of data owners.

HI.4.2. The organization informs data owners of their right to obtain information related to the collection, storage and usage of their personal data.

HI.4.3. The organization informs data owners of their right to obtain an identical copy of their stored personal data.

HI.4.4. The organization informs data owners of their right to update or destroy their personal data unless it conflicts with local rules and regulations.

HI.4.5. The organization obtains the consent of data owners before using their personal data for the non-intended reason for collection.

Intent

The Royal Decree further explains the data owner's rights which are described in the sub-standards HI.4.2 through HI.4.5. The organization must develop policies and procedures to protect the rights of data owners

Evidence of compliance

1) Policies and procedures on the protection of data owner's rights.

2) Sample, data owner's consent for using their data for the un-intended reason.

References

- نظام حماية البيانات الشخصية الصادر بمرسوم ملكى رقم (م/19) فى 1443/2/9

HI.5. The organization ensures the security of its data

HI.5.1. The organization develops a policy and procedure on protecting its data from cybersecurity attacks.

HI.5.2. The policy is developed in accordance with the applicable relevant legislative and regulatory requirements such as the controls issued by thy the National Security Authority.

HI.5.3. Staff receive cybersecurity education relevant to their job functions.

HI.5.4. The organization periodically conduct a cybersecurity compliance assessment in accordance with the National regulatory requirements.

HI.5.5. The findings of the cybersecurity compliance assessment drives further cybersecurity improvements.

Intent

The organization should protect its information from internal and external threats in accordance with the applicable relevant legislative and regulatory requirements such as the controls issued by the National Security Authority. A policy and procedure should be developed to highlight the security controls and staff responsibility. All staff should receive education on how to prevent cybersecurity attacks. The effectiveness of the controls should be assesses periodically to identify areas of improvement and plan for its execution.

Evidence of compliance

1) Cybersecurity policy and procedure.

2) Evidence of staff education.

3) Cybersecurity compliance assessment reports.

References

- https://www.nca.gov.sa/pages/legislation.html.

HI.6. The organization protects its Data

HI.6.1. The organization develops a policy and procedure on data protection.

HI.6.2. The policy includes the data classification according to the National "Data Management and Personal Data Protection Standards".

HI.6.3. The policy describes how to prevent the un-authorized access to data.

HI.6.4. The policy outlines how data is protected from loss or theft.

HI.6.5. The policy describes the recovery process for lost data.

HI.6.6. The organization has a remote (offsite) data disaster recovery system in place.

HI.6.7. The organization audits the compliance with the policy at least yearly.

Intent

Data should be protected from un-authorized access, theft or loss. Data should be classified to differentiate between sensitive and non-sensitive ones and its degree of sensitivity. Beneficiary data must not be shared with un-authorized person or handled outside KSA. The organization should develop a policy and procedure on how to protect data from un-authorized access, loss or theft. Data should be stored securely with regular backups and the ability to recover any loss data with a time frame that is acceptable by the business. The organization should have a remote (offsite) backup storage to restore any lost data in disaster situations. The organization should audit its data protection policy for its effectiveness, at least yearly.

Evidence of compliance

1) Data protection policy and procedure.

2) Information on remote disaster recovery site.

References

- https://sdaia.gov.sa/ndmo/Files/Policies001.pdf
- https://sdaia.gov.sa/ndmo/Files/PoliciesAr.pdf

HI.7. The organization ensures the integrity of its data

HI.7.1. The organization performs regular audits for its medical records to ensure the completeness, accuracy, the timely provision, and the authenticity of its data.

HI.7.2. The organization performs regular audits on the data required by regulators to ensure its reliability.

HI.7.3. The organization performs regular audits on the data required by its governance to ensure its reliability.

HI.7.4. The organization performs regular audits on the data required by its staff to ensure its reliability.

Intent

Unreliable data defeats its business values. The organization must ensure the authenticity, accuracy, completeness and the timely provision of data required by stakeholders. The organization performs regular audits on its data to ensure its reliability.

Evidence of compliance

1) Audit reports on medical records data integrity.
2) Audit reports on data required by regulators.
3) Audit reports on data required by organization governance.
4) Audit reports on data required by staff.

References

- https://sdaia.gov.sa/ndmo/Files/Policies001.pdf
- https://sdaia.gov.sa/ndmo/Files/PoliciesAr.pdf

HI.8. Data retention and final disposition are controlled by a policy and procedure

HI.8.1. Data retention and final disposition considers the local regulations.

HI.8.2. Data retention and final disposition considers its business value.

HI.8.3. Data retention and final disposition considers its historical value.

HI.8.4. Data retention and final disposition considers its risks.

Intent

Storing large volumes of data un-necessarily is costly and may expose the data to possible breaches. Therefore, the organization should classify its data and its retention time according to local rules and regulations, its business value, benefits from its history and any risks involved in its premature deletion or destruction. The organization utilizes a robust system for data deletion to prevent any possible recovery by hackers. Data may be finally disposed of to a 3rd party inside KSA as required by local regulation.

Evidence of compliance

1) Policy and procedure on data retention and final disposition.

References

- https://sdaia.gov.sa/ndmo/Files/Policies001.pdf
- https://sdaia.gov.sa/ndmo/Files/PoliciesAr.pdf

HI.9. The organization ensures the un-interruption of its services during scheduled or unscheduled breakdown of its information technology platform (business continuity plan)

HI.9.1. The organization has a manual process to follow during scheduled or unscheduled downtime.

HI.9.2. End users are trained and tested competent on the process.

HI.9.3. Manually processed information are uploaded in the system after it retains its function.

HI.9.4. Un-scheduled interruptions are analyzed to ensure its non-recurrence.

Intent

Failure of the information technology platform is not uncommon. It can be caused by power outage or system issues related to planned system maintenance or upgrades. It can also occur due to hardware or software malfunction. The impact of the interruption can be higher if it involves more than one provider location. It can also be critical if due to cybersecurity breaches. In all cases, it results in interruption of services that can be critical to patient care, especially those waiting for approvals or its renewal. Therefore, the organization must mitigate this risk by shifting to a manual process that is well known to all its staff.

Evidence of compliance

1) All patient related technical approval processes have a manual backup process.

2) Staff are trained and tested competent on the manual process.

3) All manual transactions are uploaded in the system after it resumes its activity.

4) All unscheduled interruptions are analyzed by the risk management team to avoid its recurrence.

5) The effectiveness of the manual process is tested annually and improvements made as needed.

References

- SAUDI ARABIAN CENTRAL BANK (SAMA), Business Continuity Management Framework February, 2017 Version 1.0.

HI.10. The organization complies with CHI information management integration and the use of its empowerment platforms

HI.10.1. The organization utilizes CHI Customer Relation Management (CRM) application for reporting its activates with CHI.

HI.10.2. The organization integrates with the HIDP system for uploading employers and beneficiaries.

HI.10.3. The organization integrates (or ready to integrate) with the National Platform for Health Information Exchange System (NPHIES).

HI.10.4 The organization approves its documents integrity through CHI's minimum data set (MDS) platform and the data quality maturity index (DQMI).

Intent

Accurate insurance information and its placement in the designated system allows its integration with other inter-related governmental entities and ensures the rights of all parties. Conforming to KSA e-Government requirements, Insurance companies and TPA's must integrate its information management platforms with the HIDP. This allows the automatic transfer of accurate information on employers and their beneficiary as well as individual voluntary beneficiary, tourists and visitors of the 2 holy mosques. Hence the need to use the CHI applications and document quality control MDS and DQMI platform. CHI's CRM is the current e- communication platform with its customers. Qualification and re-qualification of payers takes place through this system. Beneficiary's complaints are responded to through the CRM. This accelerates the implementation of regulatory governmental processes. NPHIES is the state of the art information management platform intended to integrate the providers and payers and shall produce a wealth of information amenable to business and artificial intelligence. NPHIES shall provide the medical insurance market with medical records inter-operability. The connectivity and utilization of CHI's applications is crucial for achieving CHI's regulatory strategies.

Evidence of compliance

1) Evidence of communication through CRM.

2) Evidence of registration of employers and beneficiary in the HIDP.

3) Integration with NPHIES.

4) Evidence of monthly upload of MDS and DQMI of encounters, claims, diagnoses, procedures, services and pharmaceuticals.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8; article 99, 121, Annex (8)

Chapter VII

Quality and Risk Management (QR)

(6 standards, 28 sub-standards)

This chapter highlights the efforts exerted by the payers to continuously improve its services and mitigate its risk.

- Measuring operational performance.
- Continuously improving performance.
- Risk management program.

QM.1. The organization monitors its operational performance

QM.1.1. The organization develops and tracks a set of KPI's for its insurance policies turnover.

QM.1.2. The organization develops and tracks a set of KPI's for its pre-authorization process.

QM.1.3. The organization develops and tracks a set of KPI's for its "Claims".

QM.1.4. The organization develops and tracks a set of KPI's for its beneficiary's complaints.

QM.1.5. The organization compares its KPI's internally over time and externally with peers.

QM.1.6. CHI receives analyzed KPI's summary reports quarterly.

Intent

Organizational performance can only be measured with key performance indicators (KPI's) targeting its managerial (and financial) processes. The organization compares its performance over time with its own data and externally by benchmarking with other insurance organizations.

Evidence of compliance

1) The KPI's target the sales of policies.

2) The KPI's target the pre-authorization process.

3) The KPI's target the claims process.

4) The KPI's target the beneficiary's complaints.

5) Evidence of comparative benchmarking.

6) Quarterly reports received by CHI.

QM.2. The organization continuously improves its beneficiary's experience

QM.2.1. The organization collects information on its beneficiary's perception of enrollment and renewal process.

QM.2.2. The organization collects information on the beneficiary's pre-authorization period experience.

QM.2.3. The organization collects information on inpatient's admission period experience.

QM.2.4. The organization provides CHI with quarterly reports of beneficiary's experience.

QM.2.5. The quarterly reports show evidence of beneficiary's experience improvement.

Intent

The access to medical care starts at its approval process from the insurance company. The organization's role is to strengthen the beneficiary's trust in the provider, expedite the approval process and thus enhancing the beneficiary's experience. The organization is also responsible for ensuring that the beneficiary is getting the right care at both outpatient and inpatient levels. The organization is expected to collect information on the beneficiary's experience from the time of accessing the service until discharge and further follow up. It is expected that such responsibility carries with it a sense of being pro-active.

Evidence of compliance

1) The organization conducts satisfaction survey for its enrollment process (for group or private insurance).

2) The organization conducts a dedicated beneficiary's survey on the pre-authorization process.

3) The organization conducts a dedicated survey on the beneficiary's admission experience.

QM.3. The organization tracks its insurance policies turnover activities

QM.3.1. The organization measures its "Quote Rate".

QM.3.2. The organization measures its "Contract rate".

QM.3.3. The organization measures its "Sales Growth Rate".

Intent

The pattern of insurance sales reflects the organization's business stability and expansion. It reflects the organizational compliance of CHI's program for increasing the number of voluntary beneficiaries. It also reflects public trust in its services. A set of universally accepted KPI's must be collected and analyzed monthly representing the following:

- Quote rate: number of quotations out of business leads.
- Contract rate: number of contracts out of quotations.
- Sales growth rate: percentage increase (or decrease) of total policy sales from previous month.

Evidence of compliance

1) Monthly collection of above KPI's

2) Evidence of analysis and suggested improvements.

QM.4. The organization tracks the performance of its claims process

QM.4.1. The organization measures "claim rejection rate".

QM.4.2. The organization measures "Average Claim Cost".

QM.4.3. The organization measures "Claims Frequency".

QM.4.4. The organization measures "Average Claim Settlement Time".

QM.4.5. The organization measures "Claim Expense Ratio".

QM.4.6. The organization measures "Medical Loss Ratio".

Intent

The processing of claims is essential for the revenue cycle continuity and sustainability of the healthcare service provision. It also reflects the cost of healthcare in the private sector in the kingdom and the payers' contribution to healthcare. Claim KPI's are collected monthly and include at a minimum:

1) Claim rejection: claims rejected / total number of claims.

2) Average claim cost: Cost of all claims / number of claims.

3) Frequency of claims: number of claims / number of beneficiary.

4) Average claim settlement time: total time / number of claims.

5) Claim expense ratio: cost of all claims / total premiums.

6) Medical loss ratio: cost of all claims / total premium – (fixed cost + projected profit).

Evidence of compliance

1) Monthly collection of above KPI's

2) Evidence of analysis and suggested improvements.

QM.5. The organization continuously improves its services

QM.5.1. The organization utilizes an evidence based performance improvement tool.

QM.5.2. Improvement projects are based on the collected performance indicators.

QM.5.3. The organization conducts at least 2 improvement projects every year.

Intent

The organization should upgrade its services and processes through the concept of continuous quality improvement. The organization should adopt an evidence-based performance improvement tool such as PDCA or similar. Improvement projects are based on the collected information including the key performance indicators. The organization should perform at least 2 performance projects per year based on prioritization criteria.

Evidence of compliance

1) Quality improvement program with evidence of quality tool and prioritization matrix.
2) Improvement projects.

QM.6. The organization mitigates its risks through an enterprise risk management program.

QM.6.1. The organization identifies its clinical, financial and managerial risks.

QM.6.2. The organization has a robust process in place for reporting risks by its employees.

QM.6.3. The organization uses a unified risk scoring matrix for grading its risks.

QM.6.4. The organization has a process for risks' analysis and mitigation.

QM.6.5. The organization submits quarterly risk reports to CHI with action plans for improvements.

Intent

Insurance companies and TPA's are bound to clinical and managerial risks. The clinical risk arises from faulty rejection of needed services or the wrong disposition of a high risk patient. Managerial risk arises from fraudulent practices, wrong actuarial studies, and the inability to maintain its knowledgeable staff and customers. Therefore, the organization must have a risk management program to enable it to identify its risks and mitigate them proactively. Risky encounters should be reported by the staff as it occurs and graded according to a risk grading matrix. The organization must have a process for analyzing the "never events" to find its root cause and prevent them from recurring. Risk management reporting to CHI helps knowledge sharing and risk mitigation in the market.

Evidence of compliance

1) Risk registry highlighting possible risk encounters in the organization.
2) Risk reporting process.
3) Risk scoring matrix.
4) Minutes of risk management meetings highlighting analysis and mitigation solutions.
5) Evidence of quarterly reports to CHI.

Chapter VIII

Governmental Requirements (GR)

(3 Standards, 9 sub-standards)

The standards in this chapter are the pre-requisites for the payers' qualification / certification and include mandatory governmental regulatory documents.

The standards in this chapter require 100% compliance from the insurance companies. Any requests for initial or renewal of qualification / certification shall be denied if the compliance is below 100%.

GR.1. The organization is licensed to operate in KSA by the Saudi Central Bank "SAMA".

Intent

Licensing with SAMA is the entry point for providing medical insurance in KSA.

Evidence of compliance

1) Valid SAMA license.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 6; article 42.

GR.2. The organization submits a complete set of Governmental requirements

GR.2.1. The organization submits a request for qualification endorsed from the Chamber of Commerce.

GR.2.2. The organization submits a current and valid commercial register.

GR.2.3. The organization submits a current income and zakat certificate.

Intent

Compliance with Governmental requirements is a must. The documents in the sub-standards GR.2.1. through 2.3. are crucial for the certification process.

Evidence of compliance

1) Request for qualification endorsed from the Chamber of Commerce.

2) Current and valid commercial register (CR).

3) Current income and zakat certificate.

GR.3. The organization complies with the CHI's Bylaws

GR.3.1. The organization signs a compliance statement for the CHI's "Unified Contract".

GR.3.2. The organization signs a compliance statement for the CHI's "Regulations of the Cooperative Health Insurance Law".

GR.3.3. The organization signs a compliance statement for the CHI "Rules for Collection of Financial Consideration against Supervision of Implementation of the Health Insurance Regulation".

GR.3.4. The organization signs a compliance statement for the CHI's supportive statements for the above documents.

Intent

The organization must comply with all regulatory documents from CHI including the "Unified Contract" and rules and "Regulations of the Cooperative Health Insurance Law" and any supplemental directives related to both documents. The organization must endorse both documents, and any related supplements, by signing a compliance statement at registration.

Evidence of compliance

1) Signed compliance statement for the CHI's "Unified Contract" العقد الموحد.

2) Signed a compliance statement for the CHI's "Regulations of the Cooperative Health Insurance Law".

3) Signed compliance statement for the CHI "Rules for Collection of Financial Consideration against Supervision of Implementation of the Health Insurance Regulation".

4) Signed compliance statement for the CHI "Clinical Guide and Terminology" document.

5) Signed statements for individual regulation supplements.

The Survey Process

- The survey process depends on the organizations' self-assessment against the evidence of compliance.
- At lest a month before the qualification expiry date, the organization submits the required evidence of compliance electronically (process details shall be shared with the organizations).
- The submission process is designed in a simple format that allows the sequential submission of information by the organization.
- Once all the evidence of compliance are submitted, the CHI's surveyors are notified of the submission completions.
- The surveyors objectively assess the evidence of compliance to reflect the requirements from the sub-standards. The following are the scores to be assigned according to the degree of compliance to the evidence:
    - Fully compliant sub-standard is scored 10.
    - Partially compliant sub-standard is scored 5.

- Non-compliant standard is scored 0.
- Non-applicable standards are not scored.

- The scores are distributed over a score card with 4 quadrants, representing Governmental Regulations, Internal Business, Learning and sustainability and Quality and Customer care:

Glossary

• Beneficiary: an individual receiving benefits from a healthcare insurance plan or policy.

• Classification: the process by which the payers are operationally ranked in the insurance market.

• Clinical coder: is a health information professional who analyzes clinical statements from patient medical records and converts documented diagnoses, procedures and resources into codes according to a classification system.

• Customer: defined as all entities in direct business relationship to an organization.

• External customer: entities and stakeholders in direct relationship with payers such as service providers, employers, beneficiary, and regulatory bodies.

• Internal customer: employees, shareholders, and contracted services staff.

• Leaders: are the organization's senior executives, and include:

- Chief Executive Officer
- Chief Financial Officer.
- Chief Medical Officer.
- Chief Information or Data Officer.
- Compliance Officer.

• Organization: refers to the insurance company or TPA.

• Payers: insurance companies and third-party administrators (TPA's).

• Population Health: refers to the health status and health outcomes within a group of people rather than considering the health of one person at a time.

• Providers: healthcare facilities, healthcare support services, community pharmacies, and optical shops.

• Qualification: the process by which the payers are granted permission to provide insurance cover to beneficiary by the CHI.

• Value based healthcare: is the equitable, sustainable and transparent use of the available healthcare resources to achieve better outcomes and experiences for every person.

ضمان

مجلس الضمان الصحي

Council of Health Insurance