مجلس الضمان الصحي
Council of Health Insurance

CHI Providers

Accreditation and Classification Program

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Introduction

This program is an extension of the current accreditation requirements. It is designed by the Council of Health Insurance (CHI) to assess the performance of the healthcare providers against a set of standards that are organized in 4 operational chapters. The 4th chapter, Governmental Requirements, encompasses the current accreditation 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's rights and enhance their experience.

3) Provide an evidence-based model for the Healthcare providers' operational excellence.

4) Provide Payers (Insurance companies and TPA's) Beneficiary, and Employers with quality information on healthcare providers.

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

6) Introducing operational competition between healthcare providers.

7) Classify the healthcare providers in preparation for the "Pay for performance".

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

Approvals and Revenue Cycle Management

(12 Standards, 46 sub-standards)

This chapter focuses on the beneficiary centric functions of the organization and its medical insurance department.

AR.1. The organization has a dedicated Medical insurance liaison department

AR.1.1. The department ensures the timely uploading of beneficiary policies.

AR.1.2. The department is responsible for the on time sending (within 15 minutes from submittal by the physician) of the medical insurance forms and other documents necessary for the insurance company's approval.

AR.1.3 The department ensures the on time sending (within 30 minutes) of additional information required from payers for service approvals.

AR.1.4. The department is responsible for following up and expediting the approvals from payers.

AR.1.5. The department maintains its full functions during the working hours of the organization.

Intent

A dedicated insurance department ensures the timely uploading of beneficiary policies to avoid registration delays. The department expedites sending the approvals thus reducing beneficiary's waiting time. The department should offer its services 24/7. The department should ensure the timely sending of the approval requests and any required follow ups, following the CHI's rules and regulations.

Evidence of Compliance

1) Turnaround time for sending and receiving of approvals.

2) Insurance department organization chart.

3) Policies and procedures of the insurance department.

References

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

AR.2. Qualified staff manage the daily activities of the Medical insurance liaison department

AR.2.1. The department is chaired by a qualified physician with a minimum of 5 years' experience in medical insurance.

AR.2.2. Medical insurance officers operate the daily activities of the department.

AR.2.3. The department has qualified care manager (s) overseeing and coordinating the patient care activities.

AR.2.4. Administrative activities of the department are run by health insurance clerks.

Intent

In order to provide efficient and timely services, the insurance department should have the appropriate qualified insurance officers and support staff. A qualified physician with a minimum of 5 years' experience in medical insurance chairs the department. The department has a sufficient number of medical insurance physician officers to handle the daily activities. The department also should have care managers to coordinate the care of high risk patients. The administrative activities of the department are coordinated by clerks with insurance experience.

Evidence of Compliance

1) Job descriptions of the insurance department staff.

AR.3. The organization ensures the beneficiary centricity of its employees

AR.3.1. The organization conducts a customer focus educational program for all its employees, at least yearly.

AR.3.2. Employees receive "on boarding" beneficiary focused education relevant to their job function.

AR.3.3. Front line staff are tested competent on handling registration and approvals of beneficiary.

AR.3.4. Beneficiary centricity is included in the employees' probationary and yearly evaluations.

Intent

The organization's business should be focused on the beneficiary. The organization should ensure its employees' understanding of beneficiary's centricity. Therefore, the organization should conduct a yearly customer focus program for all its employee. The organization should educate the frontline staff on registration and approval requirements (eligibility queries, inclusion and exclusion criteria, deductibles, policy limits) and any additional operational mandates. Staff should be tested competent on this education, initially and yearly thereafter. Customer centricity is included in the employee's probationary and yearly evaluation.

Evidence of Compliance

1) The center's educational program on beneficiary centricity.

2) Competency assessment of frontline staff.

3) Sample of probationary and yearly employee evaluation showing the beneficiary centricity evaluation.

AR.4. The organization supports the beneficiary's rights.

AR.4.1. The organization develops and ensures the implementation of patients and families bill of rights policy.

AR.4.2. Staff receive formal education on the policy.

AR.4.3. Staff maintain beneficiary's respect, privacy and dignity at all times.

AR.4.4. The beneficiary is involved in and fully aware of the care plan.

AR.4.5. The beneficiary is granted a free of charge room upgrade in the event of non-availability of insurance policy assigned room.

Intent

In compliance with MOH and CBAHI requirements, the organization should have a patients and family bill of rights that is accessible to patients and their families. A policy should be available highlighting the staff roles and responsibilities in ensuring the delivery of the rights. Staff should be educated on the policy. Staff should always respect beneficiary's privacy and treat them with respect and dignity. The beneficiary should be involved in the care plan, and all related concerns are answered in an understandable language. In the event of non-availability of an inpatient room complying with the beneficiary's policy, the beneficiary is granted an upgrade to its room class free of charge.

Evidence of Compliance

1) Patient and family bill of rights.

2) Patient and family bill of rights policy.

3) Evidence of staff education on the policy.

4) The policy highlights patients and families' involvement in the care plan.

5) The policy highlights the free upgrade of accommodation in the absence of the assigned class.

References

- Unified health insurance contract, Chapter 8, The insured.
- Unified health insurance contract, Chapter 3, Technical obligations.

AR.5. The beneficiary acknowledge any additional financial requirements

AR.5.1. Staff explain the deductible pay, and any additional payments to the beneficiary, before receiving the service.

AR.5.2. The beneficiary signs an agreement for paying additional services, outside the scope of their insurance policy, before receiving the service.

AR.5.3. The beneficiary is provided with an itemized service bill for additional services when requested.

Intent

It is not uncommon that beneficiary ask for additional services such as requesting a specific consultant or upgrading the inpatient room status. The staff should clearly explain the deductible payments in the outpatients and seek the written approval of the beneficiary for additional inpatient services. The beneficiary have the right to ask for the services' prices and an itemized bill.

Evidence of Compliance

- Unified health insurance contract, Chapter 8, The insured.
- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8, article 28.

References

1) Bill of rights policy.

AR.6. Care Managers coordinate the healthcare provision for the insured

AR.6.1. The care manager has a minimum of 5 years' healthcare clinical experience.

AR.6.2. The care manager is responsible for coordinating the access and continuity of care for high risk patients and those requiring complex treatments.

AR.6.3. The care manager is responsible for ensuring the implementation of evidence based practice guidelines.

AR.6.4. The care manager coordinates the approvals of inpatients' additional services and treatment extensions.

Intent

Care managers play a very important role in enhancing the beneficiary's health and experience. He / she is expected to coordinate the access to care and continuity of care of high risk patients. The care manager should monitor the implementation of practice guidelines. The care manager manages additional service approvals and treatment extensions for inpatients. The care manager post requires a healthcare worker with 5 years' experience.

Evidence of compliance

- Care manager's job description.

AR.7. The organization provides its patients and families with a complete online customer focused solution

AR.7.1. The online solution provides patients and families with information on available medical services and physicians.

AR.7.2. The online solution provides booking for clinical appointments.

AR.7.3. The online solution enables the patients and families to view medical reports and investigation results.

AR.7.4. The online solution provides reminders for appointments.

AR.7.5. The solution provides the beneficiary with health promotion and disease prevention information as well as specific beneficiary health education.

Intent

The organization facilitates communication and education with its beneficiary through a mobile application. The application facilitates the requirements of the sub-standards AR.7.1 to 7.5.

Evidence of Compliance

1) Online mobile application fulfilling the requirements of the sub-standards.

AR.8. The organization continuously improves the patients' reported experience measures

AR.8.1. The organization manages all its patients concerns through a patient relation office.

AR.8.2. The organization collects patients' experience utilizing an evidence based questionnaire such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) or similar surveys.

AR.8.3. The organization benchmarks its survey findings internally and with peers.

AR.8.4. The organization conducts performance improvement projects utilizing findings from survey data.

Intent

The organization should continuously strive to improve the beneficiary's experience. A dedicated patient relations office should continuously measure the beneficiary experience utilizing an evidence based tool such as "CAHPS" or similar. Survey findings should be compared internally and externally with peer organizations.

Evidence of Compliance

1) Organizational chart of patients' relations office.

2) Beneficiary's experience results with bench marking.

AR.9. The beneficiary is empowered to complain against services rendered by the provider

AR.9.1. The organization provides the beneficiary with a variety of transparent complaint processes including, online, manual and verbal.

AR.9.2. CHI's logo and its complaint hotline are visibly displayed in the organization.

Intent

The beneficiary may opt not to complain about the providers' services for fear of possible retaliation. The organization should ensure the beneficiary's right to complain. Possible ways of filing complaints or suggestions are clearly displayed in the organization. Also, CHI logo with its communication hotline and other means of submitting complaints are clearly displayed at front desks and waiting areas.

Evidence of Compliance

- This requires a physical or virtual organizational tour.

References

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

AR.10. The organization complies with CHI rules for claim submission to insurance companies and TPA's

AR.10.1. Claims are organized following the Saudi Billing System (SBS) and conforming to the minimum data set (MDS) requirements.

AR.10.2. Claims are submitted within 30 calendar days from the end of the patient's episode.

AR.10.3. Re-submission of rejected claims should not exceed 30 calendar days from receiving the rejection notification from the insurance company or TPA.

Intent

CHI has unified the process of claims submissions to the insurance companies and TPA's, including contents and time frames. The Saudi Billing System (SBS) should be followed. The quality of submitted documents is also controlled by CHI minimum data set (MDS). All claims are submitted within 30 calendar days from closing the patient's episode. Resubmission for rejected claims should be within 30 calendar days of receiving the notification from the insurance company or TPA.

Evidence of Compliance

1) Average claims' submission and resubmission rates within the specified 30 days period.

2) Claims format conforming to MDS and Saudi Billing System.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8, article 90.
- CHI Unified Contract, Chapter 4, Financial obligations.

AR.11. The provider is connected with the payers electronically

AR.11.1. The connectivity allows bilateral exchange of information.

AR.11.2. Providers can access approved beneficiary's list with policy validity, financial limits, and inclusion and exclusion criteria.

AR.11.3. Providers utilize the link for medical approval requests and claims submission.

AR.11.4. Providers receive approvals and claims' responses via the link.

Intent

To facilitate the beneficiary's service accessibility and further transactions with the payers, the service provider should be electronically connected with the payer. The connectivity allows the execution of the requirements in sub-standards AR.11.2 to 11.4.

Evidence of Compliance

- Evidence of connectivity with payers verifying the elements of sub-standards AR.2.2 to 2.4.

AR.12. The organization has a contract oversight process for ensuring the quality and integrity of services delivered by revenue cycle management (RCM) companies

AR.12.1. The organization assigns a responsible officer to manage the contract.

AR.12.2. The organization audits the performance of the RCM company utilizing a set of key performance indicators.

AR.12.3. The decision to discontinue or renew the contract with the RCM company is based on the key performance indicators.

Intent

Service providers utilizing RCM's for facilitating beneficiary's rights and managing claims on their behalves, should ensure the compliance of the RCM with the CHI requirements and the related standards in this document. The service provider is responsible for the quality performance of the RCM. Therefore, the service provider should assign a responsible person (s) (liaison officer) to monitor the RCM performance. The RCM operation should be monitored by key performance indicators that helps in the re-contracting process.

Evidence of Compliance

1) Job description of RCM liaison officer.

2) Monitoring indicators for the RCM performance.

References

- Unified health insurance contract, Chapter 6, Revenue Cycle Management.

Chapter II

Operational Excellence

(15 Standards, 58 sub-standards)

This chapter highlights the Providers' operational excellence beyond the provision of routine healthcare services and in line with the MOH new model of care.

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

OX.1.1 The organization leaders design a process for implementing the program on the beneficiary, in collaboration with the payers.

OX.1.2. The program stewardship reports to the Senior leadership.

OX.1.3. The program is monitored by key performance indicators.

Intent

In line with the Kingdom's healthcare transformation, the organization leaders are required to design a population healthcare program. The program is led by a senior physician reporting to the senior leaders (CEO - Organization director). Program objectives should be monitored by performance indicators, 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 beneficiaries.

Evidence of compliance

1) Population health program and objectives.

2) Job description of population health program leader.

3) Program KPI's.

References

- Health Sector Transformation Strategy.
- https://www.moh.gov.sa/en/Ministry/vro/Documents/Healthcare-Transformation-Strategy.pdf

OX.2. The Population Health Program initiative objective is to improve beneficiary's health and lower healthcare cost

OX.2.1. The organization provides ongoing disease segmentation of its beneficiaries.

OX.2.2. The organization works with the payers' care managers to promote the health of identified

high risk beneficiaries.

OX.2.3. The organization works with the payers' care managers to set short term and long term healthcare goals for high risk beneficiaries.

OX.2.4. The organization is active in educating the public on health promotion and disease prevention.

Intent

Segmenting the population helps in providing targeted health promotion and disease prevention programs to the organization's high risk population, thus reducing their organization visits and admission rates. This is achievable by first creating lists of payers' beneficiaries. Each payer's list is further segregated into chronic and non-chronic disease specific. The organization should work closely with payers' care managers to set short term and long term health promotion and disease prevention goals for the chronic disease beneficiary. The organization should also have community meetings and outreach programs aiming at mass health promotion and disease prevention and highlighting the importance of the population health program.

Evidence of compliance

1) Population segmentation document (Payers lists of chronic disease patients).

2) Examples of beneficiaries' short term and long term goals.

3) Community outreach program.

OX.3. The organization provides innovative products

OX.3.1. The organization provides the beneficiary with telehealth consultations and tele-monitoring capabilities.

OX.3.2. The organization provides the beneficiary with physical and mental health promotion and disease prevention mobile applications.

OX.3.3. The organization utilizes analytics to predict fraud, waste and abuse from the claims transactions.

Intent

Bringing healthcare nearer to home is one of the key elements of a successful population health program. Telehealth and tele monitoring are cost effective ways of providing beneficiary with convenient healthcare at an affordable cost. Evidence based physical and mental health mobile applications are widely used and of proven benefit when usage instructions are given by a medical professional. Fraud, waste, and abuse prevention can be predicted by auditing claims or using artificial intelligence to analyze it.

Evidence of compliance

1) Telehealth and tele-monitoring available services.

2) Mobile application for physical and mental health promotion.

3) Analytical reports on fraud, waste, and abuse (Manual auditing or electronic).

OX.4. The organization is active in adopting Value Based Healthcare

OX.4.1. The organization monitors the implantation of evidence based practice guidelines for its top 5 diagnoses and top 5 procedures (high volume and high cost).

OX.4.2. The procurement of medications, consumables, medical devices and equipment follows an approved value based procurement plan.

OX.4.3. The organization compares the cost of treating a segment of its population before and after introducing an intervention to improve its health, and shares it with CHI.

OX.4.4. Physicians' incentives are based on service quality and professional development.

Intent

The organization should focus on improving the quality of its services while reducing its cost. Unifying care by using evidence based practice guidelines and pathways reduces care variations, ensures favorable quality outcomes and reduces healthcare cost. The organization should design a procurement plan for medications, medical devices and equipment that reduces waste and enhances product availability. It is crucial that the organization tests the cost of its population health interventions to ensure its value. Physicians should be rewarded for their performance rather than for the revenue generated only.

Evidence of compliance

1) Compliance with clinical practice guidelines and pathways policy.

2) Value based procurement plan.

3) Comparing the cost of treating a population segment before and after introducing an intervention to improve its health.

4) Physicians' rewards, incentives and merit increase policy.

OX.5. The organization supports safe and efficient medication utilization

OX.5.1. The organization adopts the CHI insurance drug formulary program (IDF).

OX.5.2. Medication ordering complies with CBAHI's safe prescribing standards.

OX.5.3. Electronic prescriptions are augmented with an updated decision support system.

OX.5.4. The organization provides community pharmacies with a unified contact information for professional prescription inquiries.

Intent

In compliance with its strategy to achieve value based healthcare, CHI issued the insurance drug formulary that must be implemented by payers, providers and community pharmacies. Medications should be prescribed following the CBAHI medication standards. Electronic prescriptions should be supported by an updated clinical decision support with alerts for weight based medications, over dosage, over duration, medication duplications and interactions. To ensure dispensing rules, the organization provides their contracted pharmacies with a contact phone number to call for any prescription queries.

Evidence of compliance

1) Drug formulary with IDF medication list.

2) CBAHI score on medication chapter.

3) License of updated prescription decision support system.

4) Contact information for prescription inquiries.

OX.6. The organization complies with CHI's clinical practice guidelines

OX.6.1. The organization assigns a responsible person to ensure healthcare givers' compliance with the practice guidelines.

OX.6.2. Compliance (process) key performance indicators are collected monthly.

OX.6.3. Clinical outcome key performance indicators are collected monthly.

OX.6.4. Indicators are benchmarked internally over time.

OX.6.5. The organization shows evidence of continuous improvement in compliance and outcomes.

Intent

The organization is required to monitor the implementation of the clinical practice guidelines and pathways with key performance indicators. The organization should also monitor the implementation outcomes. The organization should compare its indicators internally over time and be able to show evidence of continuous improvement in compliance.

Evidence of compliance

1) Process indicators for clinical practice guidelines.

2) Outcome indicators for clinical practice guidelines.

3) Evidence of benchmarking internally.

4) Evidence of performance improvement projects on compliance.

References

- Unified health insurance contract, chapter 3, Technical obligations.

OX.7. The organization is pro-active in preventing fraud, waste and abuse

OX.7.1. The organization has a unified process to verify the identity of the beneficiary before registration.

OX.7.2. The organization has an internal policy and procedure for the management of fraud, waste and abuse.

OX.7.3 The organization has a process to share its fraud, waste and abuse information with the payers and TPA's.

OX.7.4. The organization grants payers' the access to beneficiary's medical files and view evidence of services provided.

Intent

Fraud, waste and abuse drain the market resources and may lead to criminal prosecution in some cases. The organization should be proactive in its prevention. A policy and procedure on fraud, waste and abuse should be in place and followed by all staff. An important element in the prevention is to ensure the identity of the beneficiary before registration. Sharing suspected information with payers is a healthy practice. Providers therefore should allow a payers' medical representative to access patients' files whenever fraud or abuse is suspected. The payer shall follow the providers' process or policy for accessing the medical records before attempting reviewing any files.

Evidence of compliance

1) Unified patient identification process.

2) Fraud, waste and abuse management policy.

3) Medical records accessibility policy highlighting how payers' medical representative can access medical records.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 7, article 77.
- Insurance market ethical framework, Chapter 3, article 5.

OX.8. Medical, clinical and administrative staff are accountable for preventing fraud, waste and abuse

OX.8.1. The organization conducts a continuous educational program on fraud, waste and abuse prevention.

OX.8.2. Fraud, waste and abuse prevention and management is included in the "onboarding program" of new employee.

OX.8.3. Staff involved in proven fraud, abuse and waste are suspended and reported to MOH and CHI for punitive actions.

OX.8.4. Providers' Executive Director or CEO or a designee ensures his / her responsibility for the accuracy of all invoices submitted to payers by signing a compliance statement submitted to CHI.

Intent

It is important that all staff are aware of what constitutes fraud, waste and abuse. There should be a continuous program for educating staff starting from their "onboarding program". The providers' executive director or CEO or a designee reflects his /her accountability for preventing fraud and abuse by signing a compliance statement submitted to CHI at the time of renewing their license to provide care to the beneficiary.

Once confirmed, staff involved in such practices should be immediately reported to MOH and CHI.

Evidence of compliance

1) Educational program on fraud, waste and abuse.

2) Sample, "onboarding / orientation program".

3) Executive Director / CEO / designee compliance statement for accountability to all claims / invoices submitted to payers.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8, article 91.
- Insurance market ethical framework, Chapter 3, article 5.

OX.9. TThe organization is utilizing value based innovations in providing its medical / clinical services

OX.9.1. The organization utilizes telehealth services for patients' follow up appointments.

OX.9.2. The organization utilizes tele-sensors for monitoring its home health care patients.

OX.9.3. The organization utilizes analytics to reduce length of stay and readmissions of critical cases.

OX.9.4. The organization utilizes analytics in order to efficiently and effectively manage its medical / clinical human resources.

OX.9.5. The organization utilizes analytics to improve its medical / clinical supply chain management.

Intent

Technology and artificial intelligence have paved the way for many healthcare innovations. Telehealth and tele-monitoring are examples. Artificial intelligence can be utilized to reduce the length of stay, manage the manpower numbers and distribution and improve the supply chain management. Similarly, manually audited studies can be useful for the same purpose.

Evidence of compliance

1) Telehealth and tele-monitoring programs.
2) Analytic reports on length of stay and readmissions.
3) Analytic reports on the use of manpower.
4) Analytic reports on supply chain management.

OX.10. Physicians' evaluation determines their financial incentives

OX.10.1. The organization implements an evidence based physicians' evaluation policy and procedure.

OX.10.2. The evaluation is based on an ongoing assessment of the physician's quality of service provision, compliance with organizational values and the MOH ethics of healthcare practice, and the physician's professional development.

OX.10.3. Physicians with the least pre-authorization rejection rates are rewarded for their performance.

OX.10.4. The parameters drive an evaluation score that is utilized for the financial incentives and the annual merit increase.

Intent

In order to comply with the National healthcare transformation strategy from "pay for service" to "pay for performance", incentives to physicians should be based on their performance and should not utilize any information related to the number of patients seen or referred services. Physicians' evaluation is based on the ongoing evaluation of their medical and clinical performance, their compliance with MOH medical ethics and their own professional development. Pre-authorization rates for physicians may be considered in their ethical behavior evaluation.

Evidence of compliance

1) Physician evaluation policy.

2) Physician incentives policy.

OX.11. The organization continuously improves its patient's reported outcome measures (PROM's)

OX.11.1. The organization targets the PROM's of its common 5 diagnoses and top 5 procedures.

OX.11.2. The organization utilizes an evidence based questionnaire for measuring PROM's.

OX.11.3. The results of the questionnaire are analyzed monthly and the information is further used to improve its services.

Intent

Patient reported outcome measures are indicators of how efficient or effective the treatment or procedure was. It is different from what organizations or physicians collect as it is the beneficiary's word of mouth. PROM's take a while to report and collect. Organizations are expected to measure the PROM's of its top 5 diagnoses and procedures and use the information to improve the quality of its services.

Evidence of compliance

1) PROM's selection and reports.

2) Evidence of improvement projects based on PROM's findings.

OX.12. The organization is continuously reducing the rate of its rejected claims

OX.12.1. The organization ensures the provision of claims according to the Saudi Billing Code, complying with the minimum data set (MDS) and ensuring a satisfactory Data Quality Maturity Index (DQMI).

OX.12.2. The organization has a process for managing rejected claims.

OX.12.3. The organization classifies and tracks its claim rejection.

OX.12.4. The organization shows evidence of continuous reduction in claims rejection.

Intent

Rejected claims denotes non conformity with CHI's regulating policies, procedures and directives and is a venue for open disputes between payers and providers. it also reflects on the market's

smooth operation. The organization must comply with the regulating policies. Claims should be raised following the Saudi Billing Code. All claim information must follow the CHI's minimum data set with satisfactory Data Quality Maturity Index. The organization must show evidence of reduction of its rejected claims by continuous measurement and improvement.

Evidence of compliance

1) Process for managing claims.
2) DQMI scores.
3) Claim rejection indicators by category /code.
4) Evidence of benchmarking.
5) Evidence of improvement.

References

- Unified Health Insurance Contract, chapter 2, obligations.

OX.13. The organization is affiliated with Universities and Professional bodies

OX.13.1. The organization is a venue for training undergraduate healthcare students.

OX.13.2. The organization is a provider of Saudi Heart life support courses.

OX.13.3. The organization is recognized by the Saudi Commission for Healthcare Specialties (SCFHS) for residency training.

OX.13.4. The organization is recognized by the SCFHS for post graduate training of nurses.

OX.13.5. The organization is recognized by the SCFHS for post graduate training of Allied healthcare providers

Intent

Affiliation with universities and professional bodies ensures the continuous knowledge and experience enhancement of its staff. Sub-standards OX.18.1 - 18.5 are examples.

Evidence of compliance

- Affiliation program documentation and outcomes.

OX.14. The organization is active in research

OX.14.1. The organization has an active research committee.

OX.14.2 The organization publishes yearly at least 10 articles in peer reviewed journals.

OX.14.3 The organization utilizes its Publications to improve its services.

Intent

Research activity is a sign of organizational healthcare maturity and the seniority of its healthcare providers.

Evidence of compliance

1) Evidence of research publications.

2) Evidence of research implementation.

OX.15. The organization achieved voluntary accreditation / certification

OX.15.1. The organization is currently accredited by an International healthcare accreditor recognized by the International Society for Quality in Healthcare (ISQua).

OX.15.2. The organization certifies one or more of its healthcare services by an International healthcare accreditor recognized by the International Society for Quality in Healthcare.

OX.15.3. The organization has an Electronic Medical Record Adoption Score (EMRAM) of 4 or above.

Intent

Healthcare accreditation is a tool to improve the delivery of best practice quality services. Voluntary accreditation strengthens the organizations processes and its staff accountability.

Evidence of compliance

1) Evidence of voluntary accreditation / certification.

2) EMRAM electronic medical records certificate score of 4 or above.

Chapter III

Healthcare Information Management (HI)

(14 Standards, 65 Sub-standards)

This chapter focuses on the components of the organization's health information system (HIS) and its governance in order to achieve its business goals. The following is covered in this chapter:

- Health information system essential components to support the revenue cycle.
- Data management strategy.
- Data governance framework.
- Protection of personal data.
- Cybersecurity requirements.
- Data protection.
- Ensuring data integrity.
- Data retention and final disposition.
- HIS business continuity plan.
- Compliance with CHI digitization requirements.

HI.1. The organization utilizes a Health Information System (HIS) in managing beneficiary's data and information needs

HI.1.1. The HIS is modular, patient centered and integrated.

HI.1.2. The HIS has a module for beneficiary demographics and clinical information.

HI.1.3. The HIS has a module for practitioner's order entry (CPOE).

HI.1.4. Results of orders are received in the results management module.

HI.1.5. The HIS is equipped with a billing module.

HI.1.6. The HIS is integrated with the general ledger and accounting module.

Intent

In line with the health sector transformation digitalization strategy, the organization is required to implement a health information system that is modular, patient centered and with integration of all modules. HIS's markedly improves beneficiary's safety and experience and enhances the exchange of health data. The modules mentioned in the sub-standards HI.1.2, through HI.1.6 are the basic to ensure the business value of implementation.

Evidence of compliance

1) HIS architecture.

References

- NPHIES RCM Systems Minimum Requirements, V.1.

HI.2. The Health information system supports the beneficiary's eligibility and pre-authorization processes

HI.2.1. The organization registers the beneficiary's demographics in a Master patient index.

HI.2.2. The organization integrates the beneficiary's individual policies with the master index, appointment and scheduling, and online payment modules

HI.2.3. The HIS supports coding of outpatient episodes.

HI.2.4. The HIS supports the generation of an automated Universal Claim Application Form (UCAF), Dental Claim Application Form (DCAF) and ophthalmic Claim Application Form (OCAF), derived from legible clinical information.

Intent

For a seamless and speedy beneficiary's registration experience, patient demographics are registered in a permanent beneficiary master index. The master index must be integrated with the appointment and scheduling module, online payment module and the beneficiary repository of insurance policies. This facilitates the beneficiary's eligibility assignment and linking with insurance benefits. The clinical information module must allow the accurate documentation of the beneficiary's condition. The HIS should be equipped with an automated coding software to ensure coding of all outpatient visits, investigations, procedures and prescriptions. It is expected that the organization verifies the accuracy of its automated coding. The system automates the clinic episode and the coding into an electronic UCAF, DCAF or OCAF, that is transmittable to the payers electronically. All claim forms are verified before sending to the payers.

Evidence of compliance

1) HIS architecture.

2) Policy on coding.

3) Policy on UCAF, DCAF and OCAF verification.

References

- NPHIES RCM Systems Minimum Requirements, V.1.

HI.3. The health information system facilitates the claim processing

HI.3.1. The clinical information module supports the accurate documentation of the beneficiary's episode.

HI.3.2. The claim's clinical information is coded electronically for outpatient episodes.

HI.3.3. The HIS captures and synchronizes all beneficiary's financial charges related to the clinical

episode.

HI.3.4. The HIS retrieves all clinical and financial claim's related documents into one file for single or batch posting to the payers.

HI.3.5. The HIS facilitates the analysis of rejected claims.

Intent

Clinical information obtained from the beneficiary should be relevant and complete and coded as per Saudi Billing System requirements. The HIS should facilitate the coding of outpatient episodes. The HIS should facilitate the tracking of all financial transactions related to a beneficiary's episode. It should also facilitate the preparation of all clinical and financial documents comprising a claim. The HIS supports submitting claims either in batches or individually.

Evidence of compliance

1) HIS architecture.

2) Policy on claim preparation and submission.

References

- NPHIES RCM Systems Minimum Requirements, V.1.

HI.4. The organization ensures the accurate clinical coding of its medical records

HI.4.1. The organization maintains its coding certificate with the Saudi Health Council.

HI.4.2. Certified coders perform timely coding for all beneficiary's episodes.

HI.4.3. A senior coder conducts a monthly audit on the coding quality and the findings are included in the quarterly risk management report.

HI.4.4. Corrective actions are implemented by the senior coder.

HI.4.5. The organization implements a clinical documentation improvement program (CDI) by certified clinical documentation improvement specialists.

Intent

Accurate coding of medical records is pivotal for producing the correct medical claims and ensures the fair service payment. This requires recruiting well trained coders. Coding should be audited by senior coders, reviewing a sample of 5% of medical records. The organization should define its threshold of accepting its coding audit according to the level of experience and maturity of its coders. Ideally the audit threshold should be at 95%. Clinical documentation improvement program ensures the healthcare providers compliance with the documentation policies and procedures and continuously improves the quality of documentation.

Evidence of compliance

1) Valid coding certificate from Saudi Health Council.
2) Registration of coders.
3) Senior coder registration.
4) Evidence of the coding audits and corrective action plans.
5) Outcomes from the CDI program.

References

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8. Article 99.

HI.5. The Health information system software supports health information exchange

HI.5.1. The software language used is HL-7, preferably FHIR – R4 version.

HI.5.2. The software supports Public Key Infrastructure (PKI) integration capability.

Intent

The HIS must be chosen to support inter-operability and health information exchange with other organizations and national platforms such as 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

- Implementing Regulations of the Cooperative Health Insurance Law, Chapter 8. Article 99.

HI.6. The organization efficiently and effectively manage its data

HI.6.1. The leaders design a data strategy managing its life cycle.

HI.6.2. The leaders design a data governance framework in compliance with the National "Data

Management and Personal Data Protection Standards".

HI.6.3. The leaders assign a data management officer responsible for implementing the governance framework.

HI.6.4. 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.7. The organization protects all types of personal data in compliance with local rules and regulations

HI.7.1. The organization establishes policies and procedures to guide the protection of personal data from inception to final disposition, including third parties' sharing.

HI.7.2. A data officer is responsible for ensuring the organization's compliance with the personal data protection policies and procedures.

HI.7.3. 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.7.4. The organization documents the ongoing process for auditing the compliance with personal data protection policies.

HI.7.5. Organization staff are educated on the principles of personal data protection at initial enrollment and yearly thereafter.

HI.7.6. Staff acknowledge their awareness of the confidentiality and sensitivity of personal data, and the legal consequences of its breaches.

HI.7.7. 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.8. The organization protects the rights of data owners

HI.8.1. The organization establishes policies and procedures to protect the rights of data owners.

HI.8.2. The organization informs data owners of their right to obtain information related to the collection, storage and usage of their personal data.

HI.8.3. The organization informs data owners of their right to obtain an identical copy of their stored personal data.

HI.8.4. The organization informs data owners of their right to update or destroy their personal data unless it conflicts with local rules and regulations.

HI.8.5. 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.9. The organization ensures the security of its data

HI.7.1. The organization develops a policy and procedure on protecting its data from cybersecurity attacks.

HI.9.2. 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.9.3. Staff receive cybersecurity education relevant to their job functions.

HI.9.4. The organization periodically conduct a cybersecurity compliance assessment in accordance with the National regulatory requirements.

HI.9.5. 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.10. The organization protects its Data.

HI.10.1. The organization develops a policy and procedure on data protection.

HI.10.2. The policy includes the data classification according to the National "Data Management and Personal Data Protection Standards".

HI.10.3. The policy describes how to prevent the un-authorized access to data.

HI.10.4. The policy outlines how data is protected from loss or theft.

HI.10.5. The policy describes the recovery process for lost data.

HI.10.6. The organization has a remote (offsite) data disaster recovery system in place.

HI.10.7. 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's 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.11. The organization ensures the integrity of its data

HI.11.1. The organization performs regular audits for its medical records to ensure the completeness, accuracy, the timely provision, and the authenticity of its data.

HI.11.2. The organization performs regular audits on the data required by regulators to ensure its reliability.

HI.11.3. The organization performs regular audits on the data required by its governance to ensure its reliability.

HI.11.4. 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.12. Data retention and final disposition are controlled by a policy and procedure

HI.12.1. Data retention and final disposition considers the local regulations.

HI.12.2. Data retention and final disposition considers its business value.

HI.12.3. Data retention and final disposition considers its historical value.

HI.12.4. 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.13. The organization ensures the un-interruption of its services during scheduled or unscheduled breakdown of its information technology platform (business continuity plan)

HI.13.1. The organization has a manual process to follow during scheduled or unscheduled downtime.

HI.13.2. End users are trained and tested competent on the process.

HI.13.3. Manually processed information are uploaded in the system after it retains its function.

HI.13.4. 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.14. The organization complies with CHI information management integration and the use of its empowerment platforms

HI.14.1. The organization utilizes the CHI Customer Relations Management (CRM) application for reporting its activates with CHI.

HI.14.2. The organization integrates (or ready to integrate) with the National Platform for Health Information Exchange System (NPHIES).

HI.14.3 The organization approves its data integrity through CHI's minimum data set (MDS) and data quality maturity index (DQMI) portals.

Intent

Providers need to ensure their connectivity and full access to CHI's CRM application. This is the main portal connecting providers with CHI for information exchange including the classification process and receiving and replying to beneficiary complaints.

NPHIES is the state of the art information management platform intended to integrate the providers and payers with a 2-way communication and shall produce a wealth of information amenable to business and artificial intelligence. Confirming service eligibility, pre-authorization and claim management shall all take place through this unified medical insurance platform. 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.

Providers need to ensure the quality of their data and its compliance with the minimum data set requirements of CHI "MDS" and "DQMI"

Evidence of compliance

1) Evidence of communication through "CRM".

2) Integration with NPHIES.

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

4) Evidence of monthly uploads of data for DQMI.

References

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

Chapter IV

Governmental Requirements

(3 Standards, 12 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 Ministry of Health "MOH"

GR.1.1. The organization has a final MOH license to provide healthcare services in KSA.

GR.1.2. All Healthcare workers are licensed to operate in KSA by the MOH.

Intent

The organization is required to maintain its MOH license and similarly the licenses of all its healthcare providers.GR.1.2. All Healthcare workers are licensed to operate in KSA by the MOH.

Evidence of compliance

1) Valid MOH final license.

2) Valid Healthcare staff licenses.

References

- Implementing Regulations of the Cooperative Health Insurance Law, chapter 6, article 58.

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

GR.2.1. The organization submits a request for accreditation / classification 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.

GR.2.4. The organization submits a valid CBAHI accreditation certificate, latest ESR results (Aman program), or similar international accreditation.

Intent

Compliance with Governmental requirements is a must. The documents in the sub-standards GR.2.1. through 2.4. are crucial for the classification process.

Evidence of compliance

1) Request for endorsed accreditation / classification 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, Rules and Regulations

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 "Annual fee for service providers' accreditation".

GR.3.4. The organization signs a compliance statement for the CHI "Clinical Guide and Terminology" document.

GR.3.5. The organization signs a compliance statement for the CHI "Private Health Insurance Sector Conduct Policy".

GR.3.6. 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", rules and "Regulations of the Cooperative Health Insurance Law", "Annual fee for service providers' accreditation", "Private Health Insurance Sector Conduct Policy", "Clinical Guide and Terminology", and any supplemental directives related that are added at a later stage. The organization must endorse all 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 a compliance statement for the CHI's "Annual fee for service providers' accreditation".

4) Signed a compliance statement for the CHI's "Private Health Insurance Sector Conduct Policy".

4) Signed statements for individual regulation supplements.

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

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.

Glossary

- Beneficiary: an individual receiving benefits from a healthcare insurance plan or policy.
- Classification: the process by which the providers 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.
- Clinical documentation improvement specialist (CDI): is a health information professional that facilitates modifications to clinical documentation through concurrent interaction with providers and promote the capture of clinical documentation to capture clinical severity and support the level of service rendered.
- Customer: defined as all entities in direct business relationship to an organization.
- Leaders: are the organization's senior executives, and include:
    - Chief Executive Officer
    - Chief Financial Officer.
    - Chief Medical Officer.
    - Chief Nursing Officer.
    - Chief Information or Data Officer.
    - Compliance Officer.
- Organization: refers to the healthcare provider.
- 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.
- Value based healthcare: is the equitable, sustainable and transparent use of the available healthcare resources to achieve better outcomes and experiences for every person.

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