3. THE PRINCIPLES OF MANAGED CARE

A working definition of "managed care" is "the processes and techniques utilized by an entity that delivers, administers and/or assumes risk for health care services in order to control or influence the access, quality, utilization, prices or outcomes of such services provided to a defined population."

This definition of managed care may need to be revised in the future in view of the evolving trends in health care.

The following Principles have been developed to provide guidelines for policy makers, employers and payers, medical practitioners and other groups that set standards for health care. Although directed to managed care, the Principles describe obligations shared among all health care providers.

ACCESS TO HEALTH CARE SERVICES

1. Managed care organizations, whether they serve a broad based population or a specialty focus, shall ensure timely access to quality health care and appropriate health care services.

2. Managed care organizations shall not discriminate in enrollment with regard to age, gender, pre-existing medical conditions, health history or health status.

3. Managed care organizations shall have explicit criteria for access to specialty care and for the patient's role in decisions regarding specialty services.

CONSUMER INFORMATION & CHOICE

1. Managed care organizations have a responsibility to inform and educate consumers. This applies both to the information needed to select an appropriate health scheme and to the knowledge required to make effective use of the health care services and options offered by a health scheme.

2. Managed care organizations shall use marketing and public information materials that are accurate and understandable.

3. Managed care organizations shall make available information for selecting a health scheme, including:
   a. premium rates, out of pocket expenses and other obligations of enrollees
   b. access to and location of primary and specialty providers
   c. financial incentives to participating providers
   d. coverage of out-of-scheme care including policies on using specialist medical practitioners and facilities that are not within the health scheme
   e. any health care services that are excluded
   f. any limitations on the use of health care services

g. appeals and grievance policies when there is disagreement with decisions made by the managed care organizations
h. data on the quality of care provided e.g. consumer satisfaction, health status measures, disenrollment rates
i. percentage of the premium that is spent on provision of health care.

4. Managed care organizations shall make available to enrollees, information on:
   a. current list of providers
   b. availability access to specialty services
   c. how to obtain referrals
   d. complaint, grievance and appeals mechanism
   e. financial incentives to providers
   f. how to change providers
   g. ownership of the managed care organization
   h. possible conflict of interest situations

5. Managed care organizations shall ensure there is no limitation of discussions of clinical issues between patient and provider for financial reasons.

6. Managed care organizations shall provide enrollees opportunities to select and change primary care providers.

7. Managed care organizations shall ensure patient confidentiality.

DISCLOSURE PROVISIONS

1. All managed care organizations shall state clearly to enrollees and prospective enrollees, the health care services that they will and will not cover, and the extent of that coverage. The information disclosed should include the proportion of income devoted to administration, utilization review / management, financial arrangements or other restrictions that may limit the health care services, referral or treatment options.

2. It is the responsibility of the patient and his/her managed care organization to inform the registered medical practitioner providing treatment, of any restrictions of coverage imposed by the managed care organization.

3. Registered medical practitioners shall inform their patients of the medically appropriate treatment options regardless of their cost or the extent of their coverage.

4. There shall be no provisions that prohibit registered medical practitioners from discussing any issue with patients or other health professionals that may have a bearing on the patients health, including the consequences of payment decisions by a third party payer.

5. Managed care organizations that use criteria to determine the number, geographic distribution and specialties of registered medical practitioners should make a public report, on a regular basis, the impact that the use of such criteria has on the access, quality, cost and choice of health care services provided to their patients.

6. Registered medical practitioners shall have the right to apply to any managed care organization in which they desire to participate. Such applications shall be approved if they meet professionally approved criteria based on professional qualifications, competence and quality of care and which are available to both applicants and enrollees.

7. Managed care organizations shall disclose to registered medical practitioners applying to them the selection criteria used to select, retain or exclude a registered medical practitioner from contract or arrangement with a managed care organization. These include criteria used to determine the number, geographic distribution and specialties needed.

8. Selective contracting decisions by managed care organizations shall be based on an evaluation of multiple criteria related to professional competency, quality of care and appropriateness by which the health care services are provided. In general, no single criterion should provide the basis for selecting, retaining or excluding a registered medical practitioner from a managed care organization.

9. Managed care organizations that contract or have arrangement with selected providers shall have an appeals mechanism by which any provider willing to abide by the terms of the managed care organization's contract or arrangement could challenge a decision to deny the provider's application to participate.

10. All managed care contracts or arrangements shall expressly require the managed care organization to provide due process protections, in order to prevent wrongful and arbitrary termination of contracts or arrangements that leave the registered medical practitioner without means of redress.

11. Prior to the initiation of actions leading to termination or non-renewal of a registered medical practitioner's participation contract or arrangement for any reason, the registered medical practitioner shall be given notice specifying the grounds for termination or non-renewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except where the Malaysian Medical Council suspends or deregisters the medical practitioner.

12. Registered medical practitioners should seek advice from medical defence organization(s) or their lawyers prior to agreeing to any contract or arrangement with managed care organizations that contain disclosure provisions.

13. All contracts or arrangements of managed care organizations shall comply with Malaysian law.

FINANCIAL INCENTIVES TO PROVIDERS

1. The doctor's duty to his/her patient shall not be altered by the health care system in which (s)he practises or by the methods by which (s)he is compensated.

2. Registered medical practitioners should have the right to enter into whatever contractual arrangements which they deem desirable and necessary provided such arrangements are within the legal and ethical framework of medical practice in our country.

3. Registered medical practitioners should be aware of the potential for some types of arrangements to create conflicts of interest due to the use of financial incentives or disincentives in the management of patient care.

4. Financial incentives should enhance the provision of high quality, cost-effective patient care.

5. Financial incentives should not result in the denial of patient access to health care services or the withholding of such services.

6. Any financial incentives that may induce a limitation of the health care services available to patients, as well as treatment or referral options, shall be fully disclosed by managed care organizations to enrollees and prospective enrollees

7. Registered medical practitioners shall disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives available to patients or which restrict treatment or referral options. Registered medical practitioners may satisfy their disclosure obligations by assuring that the managed care organization(s), with which they contract or have arrangement with, have provided such disclosure to enrollees and prospective enrollees.

8. Financial incentives should not be based on the performance of registered medical practitioners over short periods of time nor should they be based on individual medical decisions over periods of time insufficient to identify patterns of care.

9. Registered medical practitioners should seek advice from medical defence organization(s) or their lawyers prior to agreeing to any contract or arrangement with managed care organization(s) that contain financial incentives to assure that such incentives will not inappropriately influence their clinical judgement.

10. Registered medical practitioners agreeing to contracts or arrangements with managed care organization(s) should seek the inclusion of provisions that allow an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract or arrangement.

11. Registered medical practitioners. other health care professionals and third party payers should, through their payment policies. encourage the use of the most cost-effective care setting in which patient care services can be provided safely without any detriment to quality.

UTILIZATION REVIEW / MANAGEMENT

1. Utilization review / management refers to the process of evaluating / managing the necessity, appropriateness and efficiency of the health care services provided. The information gathered from both the patient and provider is reviewed / managed for appropriateness and to determine whether it meets professionally established medical protocols and criteria. The health care services are reviewed / managed through prospective, concurrent and retrospective methods.

2. The medical protocols and review criteria used by managed care organizationss in any utilization review or management programme shall be developed by registered medical

practitioners.

3. The managed care organizations shall disclose to registered medical practitioners on request the screening and review criteria, the weighting elements and the algorithms used in the review / management process and the processes of their development.

4. Any managed care organization that utilizes a prior authorization programme shall act within two working days on a request by any patient or registered medical practitioner for prior authorization and respond within one working day to any other questions regarding the medical necessity of health care services.

5. The enrollee shall be provided by the managed care organization with consent forms for the release of medical information for utilization review / management purposes to be executed at the time the health care services requiring prior authorization are recommended by the registered medical practitioner.

6. Any decision by a utilization review / management programme to deny or reduce coverage for health care services based on the question of medical necessity shall be made by a registered medical practitioner of the same specialty.

7. Any registered medical practitioner who makes recommendations or judgements about the necessity, appropriateness. or site of provision of the health care services should be in active practice in the same state as the registered medical practitioner proposing or providing the reviewed health care service. Such registered medical practitioner shall be individually and professionally responsible for his or her decisions.

8. The managed care organization shall be responsible for certifying that its reviewers are registered medical practitioners and have the required experience to carry out the reviews.

9. The managed care organization shall provide the identity and credentials of the reviewing medical practitioner to the medical practitioner whose health care services are being reviewed for medical necessity.

10. The managed care organization shall be prohibited from having compensation arrangements for utilization review / management services that contain incentives for making adverse review decisions.

11. Any managed care organization that implements utilization review / management programmes shall establish an appeals process whereby patients, registered medical practitioners and other health care providers may appeal against policies that restrict access to health care services and decisions that deny coverage for health care services.

12. The appeals process shall have the right to and provide for the review of any denial of coverage based on medical necessity by a registered medical practitioner of the same specialty with appropriate expertise and experience.

13. Any managed care organization that compiles information on the performance of registered medical practitioners shall inform the registered medical practitioners involved a month prior to any public release.

14. Managed care organizations that use any techniques of utilization review / management shall be liable to legal action for any harm suffered by the patient resulting from the application of such techniques.

15. Managed care organizations shall also be liable to legal action for any harm suffered by enrollees resulting from failure to disclose coverage provisions prior to enrollment, financial arrangements, review / management requirements, or any other restrictions that limit referral for services, options for treatment or which affect negatively the responsibility of the registered medical practitioner to his or her patients.

QUALITY ASSURANCE

1. Quality assurance refers to a formal set of activities designed to review and affect the quality of services provided. These programmes are critical to ensure standards and to maintain public confidence.

2. Although quality assurance and utilization review / management are closely associated, there are distinct differences which must be understood by patients, medical practitioners and regulatory agencies. The focus of utilization review / management is on the appropriate and controlled utilization of medical resources whereas the focus of quality assurance is to ensure that the quality of care delivered is high. If utilization management is too stringent the quality of care may suffer.

3. Managed care organizations that have utilization review / management programmes shall have comprehensive quality assurance programmes in order to prevent deterioration in quality.

4. The managed care organization shall use professionally recognized standards of quality and appropriateness which meet professionally recognized certification or accreditation standards.

5. The managed care organization shall ensure that its registered medical practitioners and other health professionals providing health care services are competent and have the appropriate training, experience and credentialling.

6. The managed care organization shall provide professional autonomy for registered medical practitioners and other licensed health care providers in decisions concerning coverage of health care services, quality assurance and other clinical decisions.

7. The managed care organization shall collect, analyze and disseminate information regarding patient care outcomes, patient satisfaction, outcomes of grievances and complaints.

8. The managed care organizations shall structure financial incentives for registered medical practitioners and other health care providers to support appropriate and high quality care.

9. National standards of quality assurance shall be non-duplicative and shall provide latitude in the specific methods and activities employed to meet the standards to reflect the differences in the health plan organization.

10. There shall be provision for external review of the quality of care, which shall be conducted by qualified health care professionals who are independent of the managed care organization

and who are accountable to the Ministry of Health.

THE MEDICAL PRACTITIONERS' ROLE

1. All managed care organizations shall ensure that their health delivery policies are developed and administered by registered medical practitioners.

2. The principles of self-governance for registered medical practitioners that have contract or arrangements with managed care organizations shall include but are not limited to:
   a. the development of registered medical practitioners' by laws which cannot be altered by the governing board of the managed care organization
   b. election by registered medical practitioners of representatives to the governing board of the managed care organization and other appropriate committees including quality assurance, utilization review / management and credentialling committees
   c. due process protection for registered medical practitioners credentialed by the managed care organization
   d. full indemnification by the managed care organization of registered medical practitioners who, in good faith, serve as members of the credentialling, quality assurance, utilization review / management committees of the managed care organization.

3. Registered medical practitioners participating in managed care health schemes must be able to comment on and present their positions regarding the managed care organizations' policies and procedures without any threat of punitive action.

4. Certain professional decisions which are critical to high quality patient care shall always be the ultimate responsibility of the registered medical practitioner practising in a managed health scheme, whether in primary care or another specialty, either unilaterally or in consultation with the managed care health scheme. They include but are not limited to:
   a. what diagnostic tests are appropriate
   b. when referral(s) to other registered medical practitioners is/are indicated
   c. when non-emergency hospitalization is indicated
   d. when hospitalization from the emergency department is indicated
   e. choice of service sites for specific health care services (office, out-patient department, home care etc)
   f. hospital length of stay
   g. frequency and duration of office or out-patient visits or care
   h. use of out-of-formulary medication(s)
   i. when and what surgical procedure is indicated
   j. when termination of extraordinary or heroic care is indicated
   k. recommendations to patients for other treatment options including non-covered care
   l. scheduling the on-call coverage of doctors
   m. termination of the patient-doctor relationship
   n. whether to work with, and what responsibilities should be delegated to, another medical practitioner or other health professional

GOVERNANCE OF MANAGED CARE ORGANIZATIONS

1. The governance and advisory structures of managed care organizations shall represent the community's interests. The participation by members of the community offers a mechanism for understanding and achieving the goals contained in these Principles. The involvement of the community can include board membership, advisory committees, community forums and other vehicles for gathering information from the community.

2. The governance of managed care organizations shall be clearly identifiable and accountable to the regulatory agencies and the community.

3. The governance of managed care organization shall provide a mechanism for involvement by employers and other purchasers, medical practitioners, other health professionals, and institutional health care providers.

4. The managed care organization shall publish a mission statement identifying the population served and the organization's commitment to respond to the health care needs in the community and to the enrolled population.

FINANCIAL RESPONSIBILITY OF MANAGED CARE ORGANIZATION

1. The need to conserve resources and make a profit must be balanced against the obligation to meet the health care needs of enrollees. By adopting appropriate financial standards and by committing adequate resources to implement these Principles, the managed care organizations can help ensure that the balance is achieved.

2. The managed care organization shall meet appropriate Governmental requirements related to capitalization, financial solvency, surplus, reserves, deposits and fiscal soundness.

3. The managed care organization shall comply with applicable prohibitions against private benefit, conflict of interest, self referral, abuse, and excessive compensation.

4. The managed care organization shall reinvest in services and management activities, including quality assurance and information services, which are designed to improve organizational effectiveness.

5. The managed care organization shall budget adequate resources to carry out the Principles described above relating to access, consumer choice, quality and governance.

References

1. Agreement on Managed Care Consumer Protections between Families USA, AARP, Group Health Cooperative of Puget Sound, HIP Health Insurance Plans and Kaiser Permanente, September 1997.
2. Principles for Accountable Managed Care prepared by the Coalition for Accountable Managed Care, April 1997
3. Principles of Managed Care - American Medical Association 1997

4. Statement before the House Ways and Means Subcommittee on Health by the American Academy of Family Physicians, March 1997
5. Introduction to Managed Health Care in South Africa, Medical Association of South Africa 1993