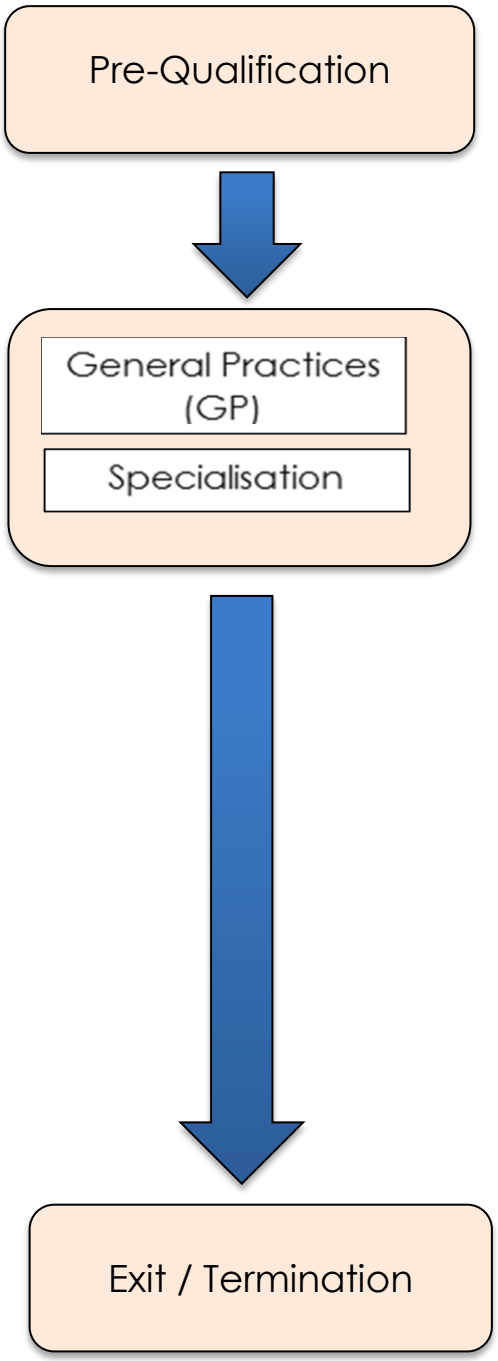
Chapter 6: Managed Care Organization (MCO)



1. Inadequate quality control of private colleges providing health sciences education
2. Supplies of clinical training for housemen and nursing graduates

2. Lack of Regulatory Framework for MCO Operation
   - Minimal fees paid to medical professionals
   - Intervention on clinics operation
   - Delayed and partial reimbursement
   - Selective Empanelling and Fee Splitting

3. Discrepancies between Personal Data Protection Act 2010 and PHFSA 1998
   - The Redundancy on Confidentiality
   - Difficulties to gain access of data of Information

6.0 Managed Care Organization (MCO)/ Third Party Administrator (TPA)

In *Private Healthcare Facilities and Services Act 1998 Part XV,* the Managed Care Organization (also known as Third Party Organization (TPA) and Health Maintenance Organization (HMO)) is defined as any organization or body, with which a private healthcare facility or service has a contract or an arrangement (or intends to have a contract or an arrangement) to provide specified types or quality or quantity of healthcare within a specified financing system through one or a combination of the following mechanisms:

a) delivering or giving healthcare to consumers through the organization or the body's own healthcare provider or a third party healthcare provider in accordance with the contract or arrangement between all parties concerned;

b) administering healthcare services to employees or enrollees on behalf of payers including individuals, employers or financiers in accordance with contractual agreements between all parties concerned

The United States National Library of Medicine defined Managed Care as programmes or organisations "intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programmes for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases.

The first MCO in Malaysia was established in 1995 which is Pantai Medical Care[1]. As at 2016, there are 29 registered MCOs in Malaysia (as per Table 6.1) with the intention to assist in reducing costs which include monitoring, receiving, auditing and consolidating all medical bills from panel clinics, specialist clinics, hospitals or insurance company prior to billing the company (payer). MCO will monitor medical benefits usage

[1] PM Care (2014) MCO in Malaysia; see: http://www.pmcare4u.com.my/html/whyus.htm

to ensure that employees receive the required medical service from their panel clinics and hospitals[2].

Table 6.1: MCOs in Malaysia

No	MCO	No	MCO
1	American International Assurance Bhd	16	Mediscreen Sdn. Bhd.
2	ASIA Assistance Network (M) Sdn Bhd	17	MiCare Sdn. Bhd.
3	ASP Medical Clinic Sdn Bhd	18	P.C.S. Rakyat Sdn. Bhd.
4	Cresent Solutions	19	PMCare Sdn. Bhd.
5	Compumed Services Sdn. Bhd.	20	PR Aassist Medical Network Sdn. Bhd.
6	Cynergy Care Sdn. Bhd.	21	Prudential Assurance Malaysia Berhad
7	Datalink Healthcard Network Sdn. Bhd.	22	Red Alert Online Sdn Bhd
8	Eximus Medical Administration Solutions (E-MAS)	23	Tele Assist Sdn. Bhd.
9	FWHS Medik Sdn Bhd	24	Tejani Emergency Assistance (M) Sdn. Bhd.
10	Great Eastern Life Assurance (Malaysia Berhad)	25	Mondial Assistance
11	Health Connect Sdn Bhd	26	IA Assistance
12	International Medicare Group Sdn. Bhd.	27	MCO Care
13	International SSOS (Malaysia) Sdn. Bhd.	28	FOMEMA (UNITAB MEDIC SDN BHD)

[2] National Human Resource Centre (NHRC) (2012), Health Maintenance Organisation (HMO) (Also known as Managed Care Organisation (MCO)/Third Party Administrator (TPA)), see: http://www.nhrc.com.my/health-maintenance-organisation-hmo-also-known-as-managed-care-organisation-mco-/third-party-administrator-tpa-)

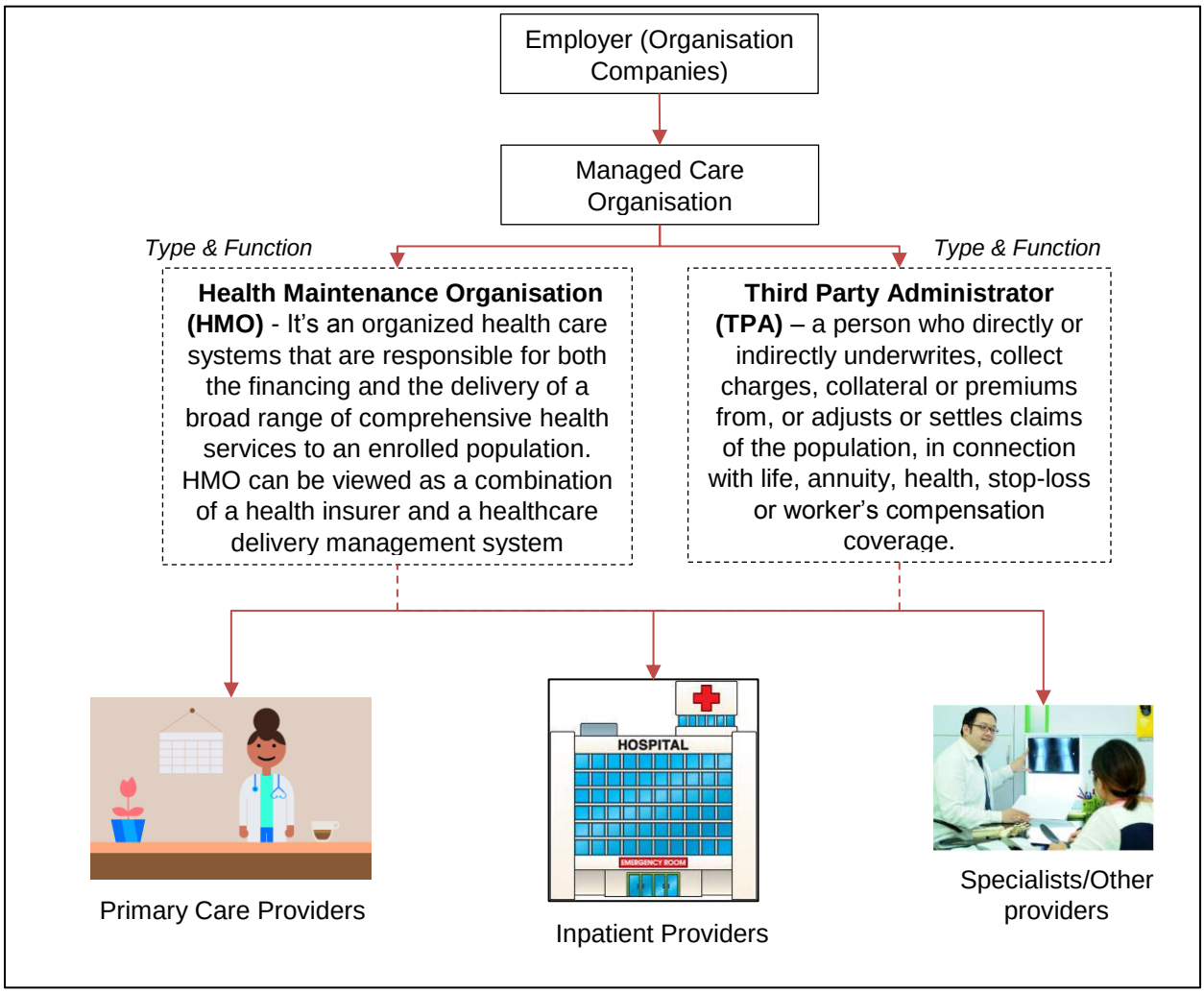
14	Integrated Healthcare Management (IHM)	29	E-Clinic Online Technology Sdn. Bhd. (Klinik Alam Medic)
15	MediExpress (M) Sdn. Bhd.		

Source: MOH, 2016

In 1997, Malaysian MCOs had a total enrolment of approximately 300,000 or about 1.5% of an estimated population of 20 million. These MCOs covered about 10% of the private labour force (Pilus, 1999) (Bakar, 1999). However by 2014, the number had increased significantly, marking an increasing role of MCOs in the country. It is estimated that over 16.36 million (2014) population are covered under MCOs operations (10% of private sector employees who are under the TPA and 15 million personal insurance policy subscribers[3] in 2014). Figure 6.1 summarizes the type and functions of MCOs in Malaysia.

[3] Star Online, Tan Kay How (2014) ,Malaysian Grossly Underinsured, see : http://www.thestar.com.my/news/community/2014/12/05/msians-grossly-underinsured-only-half-of-population-have-some-form-of-life-insurance/

Figure 6.1: Summary of the Type and Function of MCOs.



While the MCOs can be recognized under various forms (for example, the HMOs, TPAs, Preferred Provider Organisations, Exclusive Provider Organisations, Primary Care Preferred Provider Organisations), the HMOs and TPAs are the most common type of MCO in Malaysia positioning themselves as one of the notable players in healthcare industry.

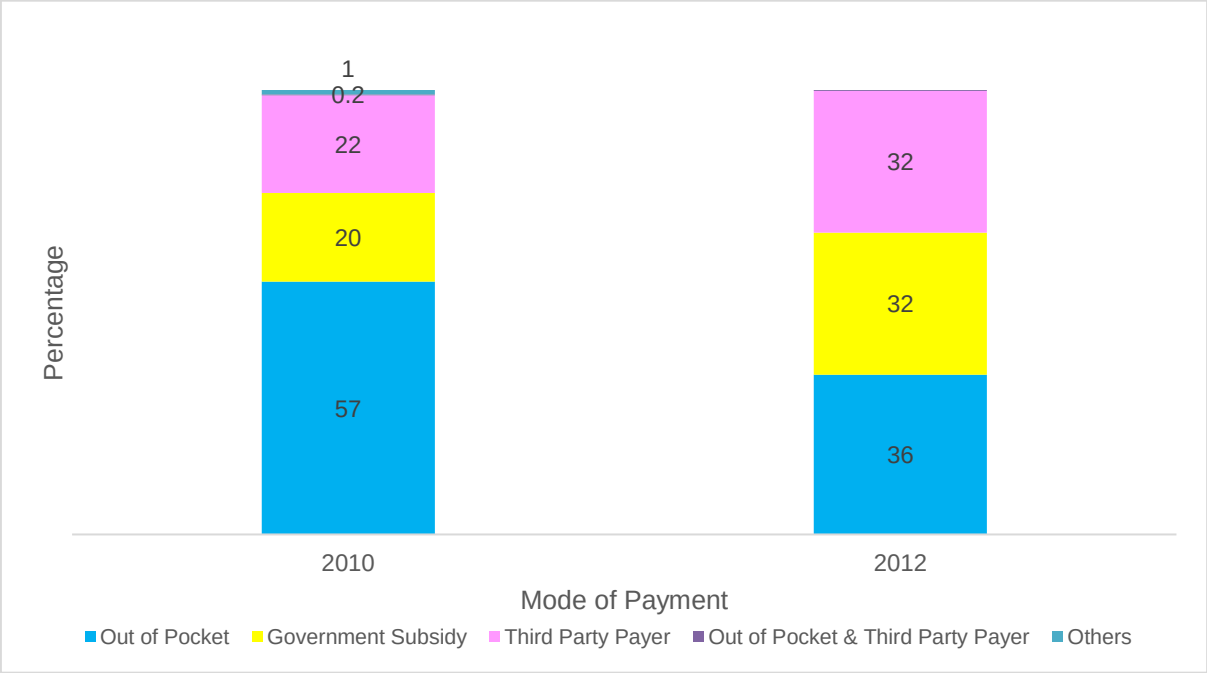
Subsequently in 2013[4], the Ministry of Health (MOH) identified four categories of MCOs in the Guidelines for MCOs and Private Healthcare Facilities and Services:-

i. Any organisation including insurance companies (via letter of guarantee) or their subsidiaries having a contract or an arrangement with any private healthcare facilities or services to provide healthcare services to enrollees or employees
ii. Any third party or agent for local or overseas-based insurance companies having a contract or an arrangement with any private healthcare facility or services to provide healthcare services to enrollees or employees
iii. Any third party administrator managing the medical benefits of personnel in a company and having contract or an arrangement with any private healthcare facility or services to provide healthcare services to the employees
iv. Any organisation selling membership for clients to take part in any wellness package and enters into a contract or makes an arrangement with selected PHFS to provide healthcare to these members.

The market segmentation of MCO is reflected below in Figure 6.2 which indicates the mode of payment used by the patients in primary care clinics. It can be seen from Figure 6.2, the percentage of Third Party Payers increases with the decrease of Out-of Pocket Payment mode which also indicates that the market segmentation for MCO is getting larger as the Insurance users increase over the years. As such, this chapter would highlights the regulatory concerns of the healthcare professionals concerning the Managed Care Organisations in the country.

[4] Ministry of Health (2013) The Guidelines for Managed Care Organisations and Private Healthcare Facilities and Services

Figure 6.2: Mode of payment in primary care clinics in 2010 and 2012



Source: Clinical Research Centre, MOH 2015[5]

Despite the information on various types of MCOs presented earlier, it is important to establish that this study focuses on the MCO operating on the TPA model. This is because insurance companies or the HMOs are governed by the Federal Bank Act, whilst this study pays a bigger emphasis on the medical and PHFSA Acts governing the practice of medical professionals.

6.1 Issue 6.1 - Minimal fees paid to medical professionals

The encumbrance of being a panel clinic for private organization under a third party administrator is significant and does impose burdens to Medical Professionals.

The operation of MCO is currently regulated under the *Private Healthcare Facilities and Services Act 1998.* Section *82 to 86* clearly address all relevant matters. *Section 83* of the Act addresses contracts between private healthcare facilities or services and managed care organisations and the penalties if either party commits an offence whilst

[5] Clinical Research Centre (2015) National Medical Care Statistics Primary Care, 2010 & 2012, Ministry of Health (MOH) see: http://www.crc.gov.my/nhsi/category/medical-care-statistics/

Sections 84 and 85 covers the need to furnish information to the Director General and penalties if either party fails to provide such information.

Deep diving into the regulation, the study discovers that there is no clear control over the practice of MCOs. Section 83 of the PHFSA only emphasizes on the accountability of RMPs to ensure that the contract they sign with MCOs does not interfere with their roles as imposed by the respective Board. In addition, Section 86 of the same Act, merely explained the contractual relationship between MCOs and registered medical professionals, without mentioning any specific responsibilities of MCOs in delivering services to the medical professionals, their focus on ethical conduct and the importance of safeguarding patients' interest. The MCO Guideline 2013 (Clause 5) again emphasizes on RMPs' responsibilities in ensuring that the contract they enter must safeguard their professional rights and is not conflicting with their Code of Professional Conduct.

It is only in Clause 6: Guidelines for MCOs that the responsibility of MCO is written in a bigger perspective. However, the Guideline has no legal influence over the subject, which is the MCO. Such situation results in a weak control over MCOs operations and their emphasis over cost savings and profits rather than looking after the welfare of the patients. This is supported by various statements which raised their concerns over the regulatory arrangements of MCOs[6]. Many believe that the regulatory framework on MCO practice in Malaysia is weak and does not impose adequate control over its implementation.

[6]1- Dr. Steven Chow, the President of the Federation of Private Medical Practitioners' Associations, Malaysia ,2013 in a statement (http://fpmpam.org/p_007.html)
2- See the PPS Column by the Malaysian Medical Association (MMA) in March, 2011 (http://www.mma.org.my/Portals/0/March-pps.pdf)
3- See the slides presentation on Investments in Healthcare – Insurance Implications by Frost & Sullivan in June 2010

6.1.1 Minimal fees paid to medical professionals

The biggest effects of weak regulation over MCO is the fee structure imposed by MCOs to medical professionals especially private panel clinic doctors. Consultation and medication fees are capped at RM30 although medical providers are eligible to charge more based on the Seventh Fee Schedule of the *Private Healthcare Facilities and Services Act 1998,* which is the fee structure established for private clinic. A newspaper report indicated that an average allowable consultation fee paid by MCOs to Registered Medical Practitioners (RMPs) in private clinics is only RM15, which is 50% less than the maximum consultation fee in schedule Seventh. The same report further stated that there are MCOs which impose a service fee of 10% from each patient's treatment charged by RMPs[7].

Box 6.1 : Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulation 2006

Seventh Schedule
A. Consultation Fees
1. General Practitioners (Non specialists)
(a) Clinic with pharmaceutical services

Item	Fee (RM)
Consultation only	10 - 35
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

b) Clinic without pharmaceutical services

Item	Fee (RM)
Consultation only	30 - 65
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

2) Specialist Fees
a) First Visit/ Initial Consultation

Item	Fee (RM)
Consultation only	60 - 180
Consultation with examination	
Consultation with examination and treatment plan	

[7] Utusan Malaysia, 22 September 2015

Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

b) Follow-up visit/follow-up consultation

Item	Fee (RM)
Consultation only	35 - 90
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

Despite the issue faces by private clinics operator, there is no evidence of minimum fee structure imposed upon private hospital panel doctors and specialists. For the record, private hospital fee are regulated by Thirteenth Schedule of the PHFSA 1998. The schedule as below:

Box 6.2: Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013

Thirteenth Schedule

A. Consultation Fees

1. General Practitioners (Non specialists)

(a) First Visit /Initial consultation

Item	Fee (RM)
Consultation only	30 - 125
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

b) Clinic without pharmaceutical services

Item	Fee (RM)
Consultation only	35 - 145
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

2) Specialist Fees

a) First Visit/ Initial Consultation

Item	Fee (RM)
Consultation only	80 - 235
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

b) Follow-up visit/follow-up consultation

Item	Fee (RM)
Consultation only	40 - 105
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	Up to 50% above the usual rate
House call or home visit	Up to 100% above the usual rate

As seen in both schedules there is big difference between the allowable fees for RMP in clinics compares to RMP in private hospitals. Interview with CKPAS of the MOH on 26 April 2016, revealed that the difference occur because of Seventh fee schedule was not revised when Schedule Thirteenth was revised in 2013. Medical professionals have raised that the current Seventh fee schedule is too low and does not meet the industry standard. The fact of the matter is that doctors' professional fees are capped and this has only been increased by 14.4% since the year 2000 working out to be a mere 1% per annum. RMPs have been quietly absorbing the yearly increase in cost of running a clinic[8].

Over the years, the situation is worsened as the number of cash paying patient decreases as almost 15 million or 50% of Malaysian population become insurance

[8] Federation of Private Medical Practitioner's Associations, Malaysia (FPMPAM) (2014) Message from President: Doctors' Fees and Fee-Splitting, Suara FPMPAM, see: http://fpmpam.org/newsletter/SUARA_FPMPAM_Issue%201_2014.pdf

policy subscribers[9]. Whilst over 1 million others are private sector employees covered under the TPA facility. In order for RMPs to obtain patient flow and sustain their clinic set ups, they have to enter into agreement with MCO. However, this leads to MCOs high bargaining power and results in low fee structure imposes upon the RMPs which is between RM10 - RM15. Based on Seventh Schedule, the MCOs have not violated the Act. However, the fee is far too low compared to the maximum of RM35 and RM65 allowable as consultation fees (refer to Box 6.1).

The low fee structure imposes upon the RMPs by the MCOs could be driven by the promise to provide a more efficient medical fees management and reduced cost to their clients (payors). Despite the positive intention, study and interviews with owners of panel clinics disclosed that this is done at the expense of the RMPs, which has led to inefficient patient's services including the practice of treatment unbundling, prescription of generic / low cost medicine and prescription of medicine in reduced quantity which in the end would discriminate the patient's rights to the most fitting medical services.

The ripple effect of MCO's cost cutting measure could be the nonconformity of Section 12 of the *Consumer Act 1999*, as recorded in Box 6.3. Nevertheless, despite the cost cutting promised by the MCOs as the value proposition of their service, there has been no study conducted on the actual savings by businesses after the existence of MCO.

[9] Star Online, Tan Kay How (2014) ,Malaysian Grossly Underinsured, see : http://www.thestar.com.my/news/community/2014/12/05/msians-grossly-underinsured-only-half-of-population-have-some-form-of-life-insurance/

2) *Consumer Protection Act 1999*

Box 6.3: Under the *Consumer Protection Act 1999*

Section 12 : Misleading indication as to price

(1) A person commits an offence –

(a) if he gives to a consumer an indication which is misleading as to the price at which any goods or services are available; or

(b) if an indication given by him to a consumer as to the price at which any goods or services are available becomes misleading and he fails to take reasonable steps to prevent the consumer from relying on the indication

Looking at this issue, it is believed that there is an opportunity for the revision of the fee Schedules and regulation over MCOs' practice. The fee schedule could be revised by increasing the minimum fee and reducing the range between minimum and the ceiling fee. Such a revision could provide a more competitive fee for RMPs. This could help the RMPs to better manage their clinical operations as well as reduce/eliminate the practice of treatment unbundling, prescription of generic / low cost medicine and prescription of medicine in reduced quantity.

6.1.2 Delayed and partial reimbursement

On top of the minimum pay structure, MCOs have also reportedly delayed payment reimbursement to panel hospitals and clinics. On average, a report has cited that this delay has ranged from 90 days to 365 days from the date of invoice from RMP. In addition to that, payments are also made partially (piecemeal) not as per total invoice amount. A report has cited that MCO being a third party administrator for healthcare currently owes 35 doctors in Malaysia an amount of over RM1,000,000 for the medical services rendered to patients registered under their medical panel. Interviews with medical professionals further confirms this and unpublished report also stated that the amount due may have reached a few millions. RMPs are also exposed to the risk of non-payment as there have been cases where MCOs revoked their operations or involved in merger and acquisition process without transferring their liabilities (money owed to RMPs) to the new establishments. For the record the number of MCOs has reduced from 49 in 2000 to 29 in 2016, source by MOH information.

Under the *Private Healthcare Facilities & Services Act 1998* (Part XV: Managed Care Organisation), Section 82 to 86 do not mention MCO's responsibilities with regards to their financial commitments, obligations and reimbursement timeframe to their panels. The only indication to this commitment is mentioned in the Guidelines for Managed Care Organisations and Private Healthcare Facilities and Services (2013) (sections 5.1(vii) and 6.11) where both the RMPs and MCOs are eligible to establish a grievance mechanism plan and grievance procedure for addressing any grievance on monetary arrangement or payment or reimbursement of professional or healthcare facility or services' charges in the contract or arrangement. However, the guideline has no legal influence on the subject as discussed above.

Current practice indicates that the MCO guidelines has not been implemented effectively by the industry players, nor has it been regulated efficiently by the Regulators concerned. RMPs are still operating under the domineering administrative structure of MCOs especially on fee and reimbursement. RMPs find it challenging to negotiate on new terms with MCOs due to MCOs position within the healthcare industry where a large number of patients (estimated at 16.36 million in 2014)[10] are the enrollees of MCOs. This indicates that the MCO controls a large market share of patients in a monopoly structure. The event suggests that the MCOs have an unjust position of market monopoly that is significantly preventing, restricting and distorting competition for goods or services, as stated in Chapter 1 of the *Competition Act 2010* illustrated in Box 6.4.

[10] Calculated based on article from Star Online, Tan Kay How (2014) ,Malaysian Grossly Underinsured, see :
http://www.thestar.com.my/news/community/2014/12/05/msians-grossly-underinsured-only-half-of-population-have-some-form-of-life-insurance/ (50% of total population) and
Daniel Simonet (2009), Managed Care Expansion to Asia :A Critical Review (10% of subsribers from private company)
MCO enrollees : 10% from total EPF subsribers + total population

Box 6.4 : Competition Act 2010

Chapter 1: Anti-competitive agreement

4. Prohibited horizontal and vertical agreement

(1) A horizontal or vertical agreement between enterprises is prohibited insofar as the agreement has the object or effect of significantly preventing, restricting or distorting competition in any market for goods or services.

Chapter 2: Abuse of dominant position

10. Abuse of dominant position is prohibited

(1) An enterprise is prohibited from engaging, whether independently or collectively, in any conduct which amounts to an abuse of a dominant position in any market for goods or services.

The position enables the MCOs to impose biased terms on the RMPs and leave the RMP with a limited opportunity to negotiate. Many RMPs operating small clinics highlighted that their protest against the low fee structure and reimbursement delay has resulted in losing of a large market share of patients. This is an indication of a noncompliance to Clause 6.2 of MCO guideline where *all MCOs shall not remove any RMP from the "cashless" benefits without establishing and adhering to an orderly and adequate procedure that is applicable uniformly in all cases which shall include reminder and opportunity for his defence.*

6.1.3 Intervention on clinics operation

MCOs have also reportedly tried to intervene into patients' confidential information, determining the type of medicines and degree of treatment to patients. It is doubtful that this practice would provide adequate service for patients. That is because MCOs usually hire nurses and medical assistant to make final decision regarding patient's treatment. In this case, the public who expects that an RMP will provide and maintain a good standard of medical care maybe misled by decision made often remotely by the MCO representatives. This could lead to a breach of Section 83 of PHFSA (Contracts between Private Healthcare Facility or Service and managed care organization). The section specifically stated that:-

(1) The licensee of a private healthcare facility or service or the holder of a certificate of registration shall not enter into a contract or make any arrangement with any managed care organization that results in -

(a) a change in the powers of the registered medical practitioner or dental practitioner over the medical or dental management of patients as vested in paragraph 78*(a)*, and a change in the powers of the registered medical practitioner or visiting registered medical practitioner over the medical care management of patients as vested in paragraphs 79*(a)* and 80*(a)*;

(d) the contravention of the code of ethics of any professional regulatory body of the medical, dental, nursing or midwifery profession or any other healthcare professional regulatory body; as shown below:-

Box 6.5: Code of Professionals Conduct

1.1. Responsibility for Standards of Medical Care to Patients

In pursuance of its primary duty to protect the public, the Council may institute disciplinary proceedings when a practitioner appears seriously to have disregarded or neglected his professional duties to his patients. The public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care. This includes:-

a. conscientious assessment of the history, symptoms and signs of a patient's condition;
b. sufficiently thorough professional attention, examination and where necessary, diagnostic investigation;
c. competent and considerate professional management;
d. appropriate and prompt action upon evidence suggesting the existence of condition requiring urgent medical intervention; and
e. readiness, where the circumstances so warrant, to consult appropriate professional colleagues

Similarly, such a breach is also prohibited under the Guidelines for Managed Care Organisations and Private Healthcare Facilities and Services, as mentioned in clause 5.2 (d): RMP shall:

(i) not participate in schemes that encourage or require him to practice below his professional standards or beyond his competence;

(vi) at all times, in any contract or arrangement with MCOs, comply with the MMC's Code of Professional Conduct, its guidelines "Good Medical Practice" and "Confidentiality" and other directives or guidelines issued out by MMC.

6.1.4 Selective Empaneling and Fee Splitting

The monopoly position of MCO also enables them to practice selective empanelling of hospitals and clinics. This possesses the following effects:

(1) may limit the access of enrollees or policy holders to seek treatment from preferred or more reputable RMPs and

(2) fee-splitting[11]

In Malaysia, it is estimated that over 16.36 million (2014) or 50% population are covered under MCOs operations. 10% of this is private sector employees who are under the TPA and the remaining 90% or 14.7 million are personal insurance policy subscribers[12]. These enrollees or policy holders are eligible to seek treatment from private clinics and hospitals under their panel listing. However, this does not reflect real access to medical treatment as some MCOs may have limitations in term of number of panel clinics, geographical location and expertise of RMPs. The situation causes burdens to RMPs as they can only refer patients to panel specialist under the same MCOs. This also leads to a noncompliance of Clause 6.7 of MCO guidelines which stated that *all MCOs shall not, at all times, interfere with the management of any patient by the RMP which include the rights to refer a patient to any other suitable RMP to assist in the provision of healthcare to the patient.*

Preferred referral also encourages the act of fee-splitting (the payment of a commission for referral or co-management of a patient). Fee splitting occurs where there is an

[11] The practice of sharing fees with professional colleagues in return for referrals. It also involves the arrangement by a doctor or a group of doctors to co-manage a patient with another doctor or allied health professional, in return for some financial gain, which is not paid directly by the patient as a professional fee.

[12] based on 50% of total population in 2014

agreement between an MCO with the payer which result in a capped fees structure imposed by MCO to medical practitioners or panel clinics/hospitals. In return, these panels gain an upper hand over patients care. For TPA, patients who are the employees of the payers are only allowed to seek treatment from the panel clinics. Similarly, the said medical practitioners can only refer patients for extended care to the TPA's panel hospitals, indicating a possible breach of Section 3.2.2. Dishonesty: Improper Financial Transactions of the Code of Professional Conduct which stated that fee splitting is prohibited if it compromises the quality of healthcare. In particular a Registered Medical Practitioner (RMP) shall not engage in any fee-splitting or kick back arrangement when referring patients to another colleague. This is also reiterated in the Guidelines for Managed Care Organisations and *Private Healthcare Facilities and Services Act 1998*[13], Section 5.2 (a), stated that *irrespective of whichever health care delivery system a RMP practises in, he shall always place the best interests of the patients first.*

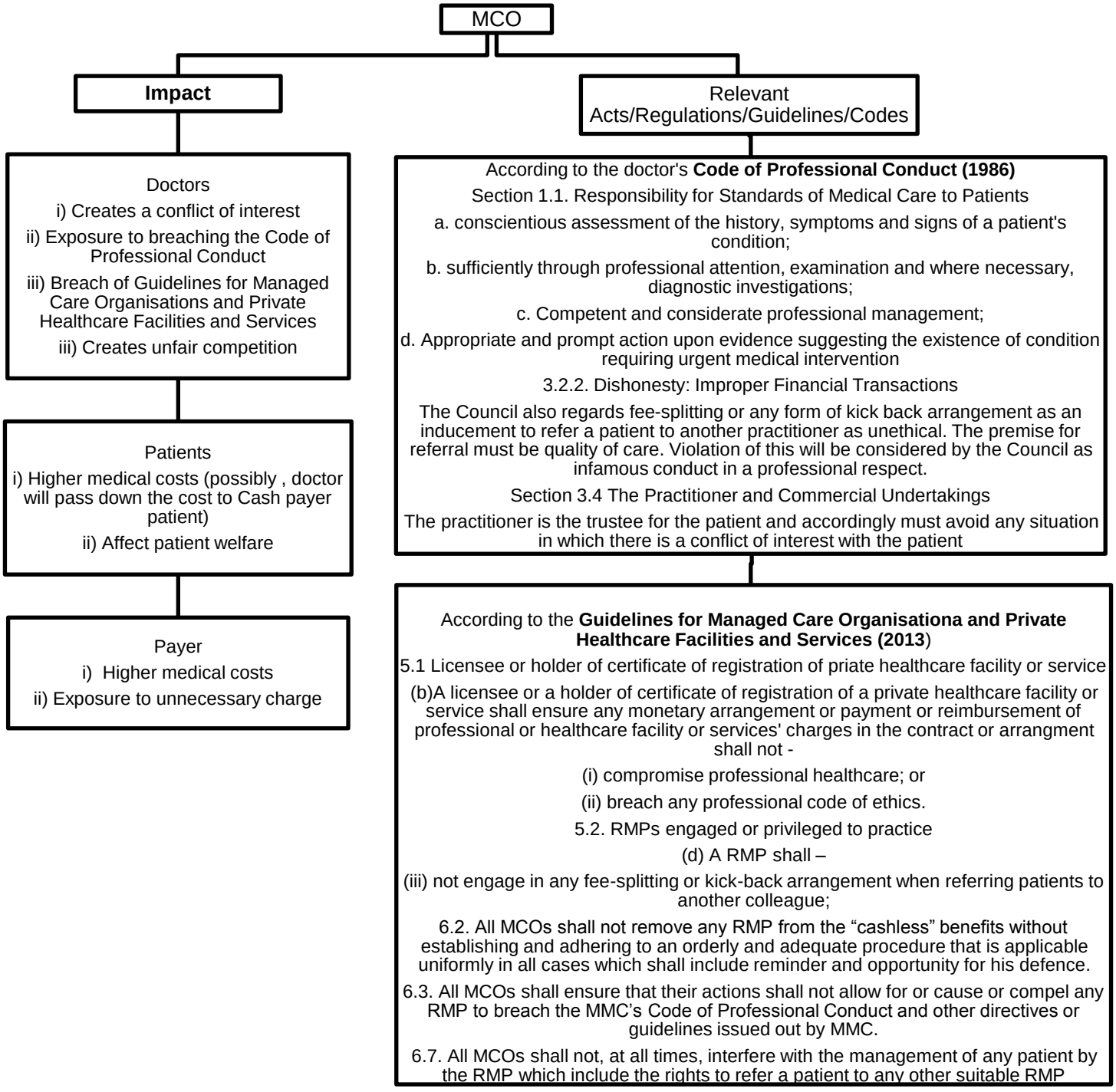
Feedbacks gathered during interviews with medical professionals, particularly owners of private clinics revealed that attempt to defy such practice has resulted in the removal of a number of clinics from TPA's panels, thus affecting their revenues. To date almost 2 million private sector employees are registered under TPA [14]. To protect their market share, panel clinics resume to adherence to TPA's terms whilst, exposing patients to the rippling effect of compromised healthcare.

Dr. Milton Lum in his article published by the Star in 2008, reported that there is an issue of discounts given by hospitals to MCOs due to the volume of patients' referrals. Healthcare is being treated as a commodity where discounts are given when bulk purchases of goods are made. Such principle is against the Code of Professional Conduct and may subject the practitioner to disciplinary punishment under the *Medical Act 1971*. This is supported by a statement from the then Director General of Health that any form of discount on professional fees can be construed as intention to induce that doctor to compromise his professional judgement for financial gain much to the detriment of his patient [15].

[13] Guidelines for Managed Care Organisations and Private Healthcare Facilities and Services (2013)
[14] Daniel Simonet (2009), Managed Care Expansion to Asia :A Critical Review
[15] Dr. Milton Lum (18 May 2008) Hospital charges and fee splitting, The Star Online: Available at: http://www.thestar.com.my/story/?file=%2f2008%2f5%2f18%2fhealth%2f21269252&sec=health

Figure 6.1 summarizes the chain reaction driven by the weak regulatory framework particularly with regard to the fee structure

Figure 6.3: Summary of the Chain Reaction Driven by Weak Regulatory Framework



6.2 Objectives of MCOs

In summary, the objective of MCO includes:

1) Helping to control the escalating cost of healthcare for the consumer while respecting the provider's ultimate authority in the treatment of patient (USA MCO, 2015)
2) Delivering or giving healthcare to consumers through a third party healthcare provider in accordance with the contract or arrangement between all parties concerned; and administering healthcare services to employees or enrollees on behalf of payers in accordance with contractual agreements between all parties concerned (Section 82 in PHFSA, 1998)

6.3 Options to resolve the issues

1. Status quo

   The situation remains the same without any changes to the Act or Regulation. If this option is chosen, the RMP will continue to face the same issue resulting from the weak enforcement and regulation over the operation of MCOs.

2. Revise Seventh Fee Schedule under the PHFSA (2006)

   This has its significance because Schedule Seven has not been revised since its establishment in 2006. Therefore, it is important that the fee matches the cost of living in current years. However, it is not recommended that the regulator increases the ceiling fee of RM35 for clinics for clinics with pharmaceutical services and RM65 for clinic without pharmaceutical services. This option recommends that the fee schedule be revised by increasing the minimum consultation fee from RM10 for clinics with pharmaceutical services and RM30 for clinic without pharmaceutical services to a more appropriate amount. This will then reduce the range between the minimum and the ceiling fee. Such a revision could provide a more competitive fee for RMPs. This could help the RMPs to better manage their clinical operations as well as reduce/eliminate the practice of treatment unbundling, prescription of generic / low cost medicine and prescription of medicine in reduced quantity. This option also promotes a fairer fee structure for RMPs which can avoid them from transferring their current financial burden to the cash-paying patients hence benefitting the general public.

Example:

		Current Fee	Proposed Fee
Clinics with pharmaceutical services	Consultation fee	RM10 - RM35	RM22.5 - RM35 RM22.5 = minimum fee calculated based on the median of RM10 – RM35.
	Range	RM25	RM12.5
Clinics without pharmaceutical services	Consultation fee	RM30 – RM65	RM47.5 – RM65 RM47.5 = minimum fee calculated based on the median of RM30 – RM65.
	Range	RM35	RM17.5

Based on the proposed fee revision of Schedule Seven, it is estimated that RMPs will receive a minimum increase of 83% of consultation fee, which will help to ease the financial burden faced by RMPs in clinical operation as well as improve the fee structure imposed by MCOs upon RMPs.

The 48% increased of minimum consultation fee should make up to the 10 years increment of approximately 5% per annum. This also coincide with the Aon Hewitt's new salary survey which stated that the salary increment for employees in Malaysia is at 5.8% in 2016 – up from 5.6% in 2015[16]. The survey supports the viability of the option to revise the Seventh fee Schedule.

In addition to that, it is also suggested that a regulation be established to enable RMPs to negotiate with MCOs over the fee structure based on their own practice costs without exceeding the ceiling fee of the schedule. This include the cost of running medical practices which varies across the country, includes employing practice staff, RMPs years of experience and operating expenses such as

[16] Aon Hewitt (2015) Aon Hewitt's View on Transforming the HR Landscape, Latest Insights on Attracting, Rewarding and Retaining Talent in Malaysia's Current Economic Situation, see: http://aon.mediaroom.com/Aon-Hewitt-s-View-on-Transforming-the-HR-Landsape

computers, rent, and electricity. This is as benchmarked against the Australian Medical Association[17].

3. Regulate MCO under the MCO Bill

MOH as a regulator should regulate the MCO's practice in Malaysia by drafting the MCO Bill. The new Bill should emphasize on the following areas:

i) All items stated in MCO Guideline so that the accountabilities of MCOs are regulated (currently the guidelines does not have legal influence over MCOs)

ii) The new fee schedule to ensure it is enforced effectively.

iii) Cover items on financial commitment by MCOs towards RMPs. This includes the obligation by MCOs to reimburse all costs due to RMPs within an agreed timeframe. MCOs should also be liable towards all liabilities as stated in the *Companies Act 1965* and *Insurance Act 1996*. Failure to comply should subject MCOs to legal action as deemed fit by the law.

iv) Registered MCOs are accountable to hire certified primary care practitioner (PCP), who will be responsible for coordinating subscribers' health care[18]. PCP will then refer the patients to specialists or other health care providers or procedures as necessary. This has been implemented in other country such as the United States as an initiative to maintain the quality of healthcare and management of patient through MCO.

v) Review of contracts between the MCO, health providers and subscribers. This is to benchmark the practice of the Department of Health, New York that requires the Division of Health Plan Contracting and Oversight (DHPCO)[19] to review and approve the HMO/MCO and IPA provider contracts to ensure that applicable laws and regulations are adhered to (for example, the fee schedules for medical professionals)

[17] Australian Medical Association (2016) Fees Lists, see: http://ama.com.au/resources/fees-list
[18] Department of Health (Feb 2016) Managed Care: Provider Contract Guidelines for MCOs and IPAs, see: https://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm
[19] Department of Health (Feb 2016) Managed Care: Provider Contract Guidelines for MCOs and IPAs, see: https://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm

vi) The responsibilities of MCOs to ensure that the list of panel clinics is revised annually based on quality of service, independence and patients' feedback.

vii) MCOs to declare annual financial status, and risk of insolvency to the Department. In the event where the MCOs are not able to fulfill the reimbursement schedule with the healthcare providers, early declaration to the both the Department and providers are also required, so that early measures could take place.

viii) Introduce stringent penalty clauses that regulate the practice of MCO in Malaysia

2. Promote Competition and allow Open Market - Third Party Administrator (Not including Insurance Companies).

   Promote open market whereby clinics could register as panel directly under companies (payer). To ease the management of payment by payer to individual clinics, each RMP and payer must employ an electronic system for claim and payment. However, details on responsibility for system installation and cost involved must be discussed between both parties involved.

   - This is relevant because:
     - ✓ The role of TPA in helping companies reduce medical cost has not been proven with any official studies and statistics.
     - ✓ However, there are many weaknesses in the implementation of TPAs practices against relevant Acts and Guidelines.

6.4 Recommended Option

Based on the options discussed above, the research party would like to recommend Option 2 and 3. Option 2 could provide a higher consultation fee for RMPs which will ease the financial burden faced by RMPs in clinical operations. This option also promotes a fairer fee structure for RMPs which can avoid them from transferring their current financial burden to the cash-paying patients hence benefitting the general public. The 48% increased of minimum consultation fee should make up to the 10 years increment at approximately 5% per annum. This also coincide with the Aon Hewitt's new salary survey which stated that the salary increment for employees in Malaysia is at 5.8% in 2016 – up from 5.6% in 2015[20]. This recommendation also provides flexibility as it enables RMPs to negotiate with MCOs over the fee structure based on their own practice costs without exceeding the ceiling fee of the schedule. This restriction will protect the public's interest as the ceiling fee is capped at RM35 and RM65, the same amount as when it was established in 2006.

Option 3 is essential because it provides legal weightage to the existing MCO Guideline. This is important in establishing control over MCO's operation as well as providing a fair contractual binding between MCOs and RMPs, which will lead to enhance protection for patients. The new bill would also include the obligation by MCOs to reimburse all costs due to RMPs within an agreed timeframe thus improving business cash flow. RMPs will also be protected against non-payment by MCOs as stated in the Company Act 1965 which was established to provide a mechanism to protect creditors and those found guilty of mismanagement are punished and where appropriate deprived of their right through disqualification, from being involved in the management of other companies[21]. In addition to that the bill should also refer to the Insurance Act 1996 where it covers the whole process of winding up until the responsibilities to fulfill all liabilities to policy

[20] Aon Hewitt (2015) Aon Hewitt's View on Transforming the HR Landscape, Latest Insights on Attracting, Rewarding and Retaining Talent in Malaysia's Current Economic Situation, see: http://aon.mediaroom.com/Aon-Hewitt-s-View-on-Transforming-the-HR-Landsape

[21] Aishah Bidin (2004), Liabilities of Directors under Malaysian Insolvency Laws and Recovery of Assets During Corporate Insolvency

owners and debtors which includes RMPs[22]. All these would help to protect both RMPs and MCOs as well as providing a more effective MCO operations for the country.

[22] Insurance Act 1996, Section 112