

## Optimizing PhilHealth's case-based payment scheme to achieve greater financial protection

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**P**rovider payment mechanisms are defined as “types of contracts among two or more players—patients, providers, and payers—that create specific incentives for the provision of health care and minimize the risk of opportunistic behavior” (Maceira 1998, p. 1–5). However, payment schemes vary considerably in terms of their payment and reimbursement criteria that incentivize the provision of certain types and quantities of health services. These incentives, or disincentives, affect the type, amount, and, ultimately, the quality of health services that are being provided by influencing supply and demand in the health-care sector. Therefore, the choice and implementation of certain provider payment mechanisms may have a profound influence on the health-care delivery system as a whole. It is in this realm that insurers,

such as the Philippine Health Insurance Corporation (PhilHealth), may influence the health-care system for the better.

Implemented by PhilHealth in 2011 (PhilHealth Circular 11, 2011), the case-based payment (CBP) system was aimed at improving PhilHealth's benefits framework, enhancing hospital services, and ultimately, achieving greater financial protection for the corporation's patient clients under the Philippines' Health Care Financing Strategy 2010–2020 (DOH 2010). CBP is a provider payment mechanism wherein an institutional

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health-care provider “is reimbursed for each discharged inpatient at rates prospectively established for groups of cases with similar clinical profile resource requirements” (Telyukov 2001, p. 1–3). The CBP system was initially implemented with rates for the 23 most common medical and surgical cases. The shift from a fee-for-service (FFS) system, which traditionally has been PhilHealth’s financing scheme, was expected to benefit the three major players under the system, namely, the insurer (or PhilHealth), institutional health-care providers (or the hospitals), and individual health-care providers (such as physicians). The anticipated benefits of the CBP system were the streamlining of claims payments, increase in transparency in the pricing of health technologies, and optimization of the delivery of health services.

This *Policy Note* was based on a reconnaissance study on the implementation of the CBP conducted under the PIDS-DOH Health Systems Research Management

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Project. The study used qualitative methods such as desk review, survey using pretested questionnaire, and key informant interviews (KIIs). Purposive sampling was done in seven health facilities using the frame of all accredited private and government hospitals with updated PhilHealth accreditation. KIIs were conducted with the 16 hospital administrators as respondents. A self-administered survey questionnaire was used for 20 physicians to represent individual health-care providers. To represent the national insurer, the following PhilHealth head of offices were selected based on their direct involvement and role in the implementation of the CBP—the vice-president of Health Policy Sector, the head of Benefits Development and Research Department, and the chief for Standards and Monitoring Department. Thematic analysis was performed on the triangulated data obtained from the KIIs, survey questionnaire, and review of secondary data.

### **Key research results**

Observations by the different stakeholders related to implementation were thematically grouped into the following: administration, human resources, medical integrity, and financing. There was full compliance to the CBP. Except for the local government unit (LGU)-retained hospital, all hospital administrators perceived the CBP to be better than the FFS because it has shortened the turnaround time of reimbursement to facilities from six months to two months especially during the first six months of implementation.

However, turnaround time from claims to payments to physicians remained protracted from three months to even nine months in the LGU-retained hospital. With CBP, hospitals had to unbundle doctors' portions of the packaged reimbursements.

#### *On administration*

- PhilHealth did not allow enough time for the preparation and dissemination of policy, and actual operational transition from FFS to CBP.
- There is a lack of clear rules on CBP implementation as well as continuous monitoring and evaluation of CBP by both hospitals and PhilHealth.
- PhilHealth has not improved its documentation and feedback mechanisms that are in tune with the change in provider payment mechanism.

#### *On human resources*

- No additional staff was hired by PhilHealth to cope with the unique demands of implementing the CBP such as hiring information specialists to track down claims.
- Both DOH-retained and LGU-retained hospitals strengthened the capacity of the hospital staff liaising for PhilHealth and increased the number of their medical evaluators who were paid using the retained reimbursements from CBP.
- Patients in private hospitals paid out-of-pocket charges not covered by the CBP, while patients in public hospitals procured the drugs or medical supplies either not covered by the CBP or not available in their places of confinement.

#### *On medical integrity*

- Perceptions differed between PhilHealth and physicians on how cases should be managed or paid reflecting a lack of consultation and deliberation by PhilHealth.
- Upcoding was common for diseases that can deteriorate to a more serious condition but were not eligible for admission or CBP reimbursement at the time of consultation.
- PhilHealth has not provided for regular review of treatment and diagnostic guidelines.
- PhilHealth has not set quality indicators except to consider reimbursement turnaround time as an indicator of efficiency of CBP.
- There was a lack of transparency from PhilHealth on how these case rates were calculated.

#### *On financing*

- The costs and responsibilities of paying providers on time were shifted from PhilHealth to the hospitals by the CBP.
- With CBP, DOH-retained hospitals used the money saved from the CBP to add extra beds, build another wing or ward, and buy drugs and medical supplies.

#### **Conclusion**

Overall, administrators and physicians perceive that the CBP needs improvement on the following aspects:

- Further shortening of the turnaround time for reimbursements to both health-care providers and hospitals;
- Timely and electronic updating of statuses of claims by physicians and hospitals;

- Making membership directory and physicians' accreditation status accessible and readily available;
- Avoiding the denying of claims simply on the basis of typographical errors or inconsequential details;
- Intelligent and rational selection of diseases and procedures that can be packaged;
- Proper, adequate, and seamless way of shifting from one policy to another to be practiced by implementing agencies, in this case, PhilHealth;
- Transparency of PhilHealth in coming up with fair and appropriate rates for cases and procedures; and
- Adopting an ongoing impact evaluation of the efficiency and performance of CBP in improving health outcomes.

### Policy options and recommendations

The overall recommendation is to pursue more studies and research on the following:

- Feasibility of and logical framework for adopting mixed-provider payment schemes instead of one mechanism;
- An economic evaluation of whether the cost for a treatment/procedure is not only financially fair but also effective and inclusive of all socio-income groups;
- Possibility of outsourcing nonfinancial activities of PhilHealth (for example, selecting cases for CBP based on evidence);
- Assessment of the CBP from the PhilHealth members' perspective; and
- How LGU-retained hospitals should be reimbursed (based on the fact that reimbursements are paid to the local government and not to the health-care providers). 📄

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