[PHILHEALTH CIRCULAR NO. 0031, S. 2013, October 29, 2013]

ALL CASE RATES (ACR) POLICY NO. 1 – GOVERNING POLICIES IN THE SHIFT OF PROVIDER PAYMENT MECHANISM FROM FEE-FOR-SERVICE TO CASE-BASED PAYMENT

I. RATIONALE

Article 1 Section 2 of Republic Act 7875, as amended, states the guiding principles that PhilHealth must adopt in pursuit of achieving the intents of the National Health Insurance Program (NHIP). Among the principles, the following are hereby reiterated for emphasis in terms of benefit development, namely:

(b) **Universality** that states that "the National Health Insurance Program shall give the highest priority to achieving coverage for the entire population with at least a basic minimum package of health insurance benefits."

(c) **Equity** that emphasizes that "the Program shall provide for **UNIFORM BASIC BENEFITS** (emphasis supplied)."

(f) **Effectiveness** that stipulates that "the Program shall balance economical use of resources with quality of care,"

(m) **Cost Sharing** that mentions that "the Program shall continuously evaluate its cost sharing schedule to ensure that costs borne by the members are fair and EQUITABLE and that the charges by health care providers are reasonable," and

(q) **Cost Containment** that stresses that "the Program shall incorporate features of cost containment in its design and operations and provide a viable means of helping the people pay for health care services."

The adoption of the Fee-for-Service (FFS) Provider Payment Mechanism has intrinsic constraints that limited the Corporation from fully realizing the intents of the aforementioned guiding principles. Globally, studies have shown how FFS has led to prolonged hospital stays, overutilization of diagnostic procedures, and provision of unnecessary and inefficient health care services that insurances paid for without offering any additional value to members. These wasteful payments significantly reduced the already constricted financial and administrative resources of the Corporation. Moreover, though the FFS schedule is uniform across member categories, there is inequity in terms of claims paid for similar conditions when comparing payments to private and government health care institutions (HCIs). For a similar condition, PhilHealth beneficiaries may receive higher reimbursements if they go to private than government HCI. However, despite higher payments, Phil Health's support value in private HCIs remains lower than 30% as an average. Worse, indigent patient members still have to pay cost-shares for services even in government HCls whereby failure to produce the needed finances from their own pocket limits their access to quality health care services.

On the other hand, the global trend towards the achievement of Universal Health Care (UHC), locally embodied in the Kalusugan Pangkalahatan (KP) Program, is to have social health insurances (PhilHealth) shift to and implement Case-based Payments as Provider Payment Mechanism. Case-rated payments and the more advanced Diagnosis-Related Group (DRG) Payments are advantageous to the members and health care providers alike. These serve to have one uniform rate for the provision of a minimum level of quality care under the most modest of accommodations regardless of member category or the nature of the health care institution. Thus, it promotes an equitable basic standard benefit that is the same for similar conditions whether admitted in government or private HCIs. By having fixed amounts, Case Rate (CR) also allows PhilHealth to improve administrative efficiency and reduce turnaround time for paying health care providers. Case rate allows PhilHealth members to know how much they are entitled to in terms of benefit payments thereby strengthening their own power as a patient of said health care institution and member of the Corporation. It reduces the discretion of claims processors in terms of deductions and computation of reimbursements. It allows PhilHealth to effectively impose the No Balance Billing (NBB) policy for sponsored program members admitted in ward or ward-type accommodations in government health care institutions. The latter is a policy intended to assure financial protection for the poor and indigent members in order for the country to collectively enjoy the advantages and societal benefits of a healthier community.

Therefore, the mounting evidences of the advantages of paying case rates require PHilHealth to implement an all case rates at the soonest possible time. The initial experiences of Case Rates, implemented thru PhilHealth Circular 11 s. 2011, have proven its value. The NBB policy for sponsored program members admitted in government hospital wards was introduced for the initial 23 conditions under the Case Rates system. Turnaround time (TAT) for claims processing improved from more than 70 days before health care providers received their payments to 45-55 days with some regions reporting TATs of 17 days.

However, the fact that case rates were limited to only 23 conditions out of the vast number of possible procedures and medical conditions has strained the PhilHealth operational systems and has stymied the realization of the promises of case rates. In response to this, the PhilHealth Board through Board Resolution No. 1679 s. 2012 has approved the shift of the provider payment mechanism from FFS to Case Rates. In response to the Board directive, extensive consultations on the concepts of case based payments, the goals and intents of CR, the coverage of the NBB policy, and the determination of the rates were conducted with various stakeholders nationwide. For consistency, herein follows the policy statements and reforms devised to guide the implementation of case rates.

II. GENERAL OBJECTIVES

A. To phase out fee-for-service payment mechanism
B. To simplify reimbursement rates understood by all sectors
C. To improve turnaround time of processing of claims

III. SCOPE AND COVERAGE

A. Case rate payments shall be uniformly applied to all medical conditions and procedures, regardless of member category, that are admitted in accredited health care institutions.

B. It shall also apply to all identified day surgeries and select procedures done in accredited health care institutions.
C. It shall also be applied to directly filed claims by members subject to compliance to rules on direct filing.

IV. DEFINITION OF TERMS

A. Case-based Payment - Payment method that reimburses to health care providers a predetermined fixed rate for each treated case or disease; also called per case payment.
B. Case rate (CR) - Fixed rate or amount that PhilHealth will reimburse for a specific illness/case, which shall cover for the fees of health care professionals, and all facility charges including, but not limited to, room and board, diagnostics and laboratories, drugs, medicines and supplies, operating room fees and other fees and charges.
C. Day Surgery – Day surgeries, also known as ambulatory or outpatient surgeries, are services that include elective (non-emergency) surgical procedures ranging from minor to major operations whether requiring local, regional or general anesthesia, where patients are safely sent home within the same day for post-operative care (DOH Administrative Order No. 183 s2004).
D. Relative Value Scale (RVS) – A systematic listing and coding of surgical procedures where each procedure is assigned a corresponding Relative Value Unit (RVU). Each procedure or service is identified with a five-digit code. With this coding and recording system, the reporting of procedures performed by physicians are simplified and accurately identified.
E. Relative Value Unit (RVU) – A number assigned to surgical procedures identified by the Corporation that reflects its relative weight or its degree of complexity as compared to another. Therefore, the more difficult the procedure is, the higher its relative value unit.
F. International Statistical Classification of Diseases and Related Health Problems Tenth Revision (ICD 10) – A statistical classification that contains a limited number of mutually exclusive code categories which describe all disease concepts. The classification is hierarchical in structure with subdivision to identify broad groups and specific entities.
G. Critical Poor – Persons assessed and identified as poor by the hospital Medical Social Welfare Assistance Officer who are not listed or registered to the Sponsored Program but can immediately avail of NHIP benefits. Their continuous enrolment to the sponsored program in the succeeding years shall be subject to validation of the DSWD.
H. Sponsored Members – A member whose contribution is being paid by another individual, government agency, or private entity according to the rules as may be prescribed by the Corporation.
I. Geographically Isolated and Disadvantaged Areas (GIDA) – Refer to communities with marginalized population physically and socio-economically separated from the mainstream society and characterized by: (1) Physical Factors – isolated due to distance, weather conditions and transportation difficulties (island, upland, lowland, landlocked, hard to reach and unserved/underserved communities); (2) Socio-economic Factors (high poverty incidence, presence of vulnerable sector, communities in or recovering from situation of crisis or armed conflict)
J. Charge to future claims – A system of charging to reimbursements that will be claimed by the health care provider for sanctions to violations to PhilHealth