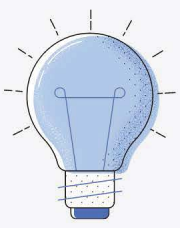
Development of a Diagnosis Related Group-System Based Global Budget Payment Mechanism

Alliance for Improving Health Outcomes, Inc.

PhilHealth's current ACR reimbursement system, despite having improved claims management has several inherent shortcomings.



OBJECTIVE

To determine the potential health system efficiency gains as well as the policy and governance reforms needed to shift the provider payment for inpatient care from the existing PhilHealth case rates to a Diagnosis Related Group (DRG)-system based Global Budget Payment (GBP)

METHODS

A MIXED METHOD APPROACH

Literature Review

- **Electronic Databases** (i.e., PUBMED, Science Direct, Google Scholar) were used.
- Studies in Developing Asian Countries and other localities were prioritized.

Quantitative Data

- **Determination of DRG Case rate**
  - Computed from PhilHealth Claims data
- **Modeling of Global Budget**
  - Estimated based on inpatient costs

Qualitative Data

- **Key Informant Interviews (KIIs)**
  - Selected DOH and PhilHealth Individuals
- **Focus Group Discussions (FGDs)**
  - Sectoral representatives

FINDINGS

57 Key References were selected.

Most of the included manuscripts concern country experiences in shifting to DRG or GB payment systems.

DRG PROJECTIONS

1,048,576 data points

represented claims from the last quarter of 2016. Sample claims data include the five conditions with the most claims filed with PhilHealth:

1. Normal Newborn Care Package 2. Community-acquired Pneumonia III
3. Hemodialysis Procedure 4. Acute Gastroenteritis
5. Radiation Treatment Delivery (Linear Accelerator)

Formula:

DRG Case Group Payment = Base rate (BR) x Case Weight Index (CWI) x Adjusment coefficient (AC)

BR : PHP 10, 400
Global average cost per case

Level of HCIs → Base rate

CWI : Varies *depending on the condition*
ACR values for specific diagnoses divided by the computed base rate

AC : Case Mix Index
Reflects the average resource intensity of cases treated in a specific hospital

Level of Hospitals
L1 = 0.95
L2 = 0.99
L3 = 1.08

0.9 Designated adjustment weights

Sponsored Program Ratio
Reflects the proportion of indigent, or Sponsored Program (SP) members that comprise the patient loads of specific hospital

Level of Hospitals
L1 = 63%
L2 = 48%
L3 = 51%

0.1 Designated adjustment weights

GB PROJECTIONS

Different reference points for PhilHealth' considerations

PSA Estimates

30%
of aggregate inpatient costs with the assumption that nearly all of PhilHealth's reimbursements pay for hospital expenditures

PSA datasets

<10%
of the total spending for government hospitals financed by PhilHealth

15%
of the government hospital expenditures accounted by PhilHealth reimbursements and all public sources of funding

POLICY AND IMPLEMENTATION MATTERS

- DRGs, if these do not adequately compensate expenses similar to ACR, will aggravate hospitals' losses.
- Necessary infrastructure and human resources, including IT requirements, should be in place before the new payment system is implemented.
- GBP funding may lead to the crowding out of their allocations.
- Allotment of GBP funds may be exploited for political ends.
- Handling of surpluses or deficits for a given period have to be delineated.
- The acceptability of the financial management procedures for the GBP funds with COA was deemed to be of paramount importance.

CONCLUSION AND RECOMMENDATIONS

- **DRGs as well as GBP, whether alone or in combination, provide the most promising alternatives.**
- If both systems are to be implemented by PhilHealth, then DRGs can serve as the monitoring mechanism, while GBP will be the payment system. Corporation's organizational structure will need to be revamped to accommodate these new functions.
- The following are needed if engaging to new PPMs: upgrading of accounting, IT, and human resource systems for all institutional stakeholders, COA approval and guidance for the related financial transactions, and adoption of better hospital governance mechanisms.