POLICY BRIEF

Readiness of Selected Hospitals in Manila and Pasig City, Philippines, to adopt the Diagnosis Related Groups (DRG) Payment System

I. Rationale

Republic Act No. 11223 also known as the "Universal Health Care (UHC) Act, an act instituting universal health care for All Filipinos, prescribing reforms in the health care system, and appropriating funds mandating PhilHealth to shift to a prospective payment mechanism based on Diagnosis Related Grouping (DRG).

While PhilHealth prides itself of its commitment to formulate the DRG policy amidst the COVID-19 pandemic, and the scrutiny from the public due to alleged fraud and corruption, it is important to be reminded of one important element of policy development, Stakeholder Engagement.

In partnership with University of Santo Tomas (UST) University, Philippine Council for Health Council for Health Research and Development (PCHRD), PhilHealth embarked on a study to determine the existing capacity of selected accredited hospitals to adopt DRG:

- Gather the existing personnel complement and proficiency of the hospital in implementing the Diagnosis-Related Group payment system;
- Assess the readiness of the HCI to institute adjustments in their data collection and information management system vis-a-vie the DRG requirements;
- Assess the existing financial management structures, procedures vis-a-vie DRG implications

Should DRG be implemented, will accredited hospitals be ready to adopt it? What are the possible challenges they may encounter? What support will PhilHealth be able to provide to them? What are the key areas that must be considered in drafting the implementing guidelines on DRG?

II. What have we learned?

A qualitative study in a form of a "case study" assessed the readiness of hospitals via Key Informants Interview (KII) through an online platform using World Health Organization (WHO) recommended parameters in adopting the DRG - financial management, information management and human resource management. 16 hospitals in Manila and Pasig City participated in the capacity assessment.

DRG was received positively with the adaptation in financial management because it departed from the current flat case rate, modifiers, adjustment factors and cost weight, flexibility of prospective payment, advance payment, and shorter Turn Around Time (TAT) on claims processing. However, prospective payment, fixing co-payment or co-insurance, gathering health care cost, and differing tariff rates were identified as major areas of concern by the hospitals. Setting a budget limit based on estimate fund utilization is too much of a risk for the hospitals to handle. What about patient surges, inflation or other factors beyond their control?

The basis for the computation of Global Budget (GB) is also questionable given the effect of the current Covid-19 Pandemic. The controversy associated with the PhilHealth Interim Reimbursement Mechanism (IRM) is also a lingering concern among respondents.

Furthermore, modification and institutionalization of information management that includes data collection, DRG grouper software, and Service Providers, while intensive training and orientation to staff-coders, doctors, nurses, technical, administrative staffs, among others, are required.

A considerable amount of time, favorable and enabling IT software and solutions, and clear guidelines and processes for reform, among others, are significantly necessary to facilitate the readiness of the providers to adopt DRG successfully.

III. PhilHealth Provider Payment Reform

DRG is not new to the Philippines, PhilHealth starts working on DRG in 2009. The Corporations provider payment reform includes from Fee-For-Service (FFS) Provider Payment Mechanism transitioning to Case Rates for the top 11 medical condition and 12 procedures in the country and later expanded to all medical and surgical procedures labeled as ACR payment mechanism.

To make DRG happen, an IT-enabled costing and processing with the complete and accurate clinical cost of care, claims submission and processing, robust auditing and monitoring and evaluation, a DRG grouper software, and a standard coding system are prerequisites that need to be in place.

Strengthening PhilHealth's role as a national strategic purchaser of health care services, UHC Act provides the legal basis in shifting to paying providers using a performance-driven, close-end, prospective payments based on disease or diagnosis-related grouping and validated costing methodologies and without differentiating facility and professional fees; develop differential payment schemes that give due consideration to service quality, efficiency, and equity; and institute strong surveillance and audit mechanisms to ensures networks' compliance to contractual obligations.

However, at this time of uncertainties, the public, more especially the health care providers are waiting for the assurance from the Corporation. Can you really still pull this off? Do you have funding given the fund bleeding from COVID-19 pandemic response? Can we still trust PhilHealth?

IV. Policy Recommendations

1. Setting a definite timeline of implementation.

To prepare PhilHealth, its stakeholders, and partners in enhancing and modifying financial management systems, information management systems especially in data collection and processing, and capacitating human resources is highly recommended.

2. Investing on communication.

Despite all the hype on UHC Act and several public consultations, 15 of the 16 participating rated themselves the lowest score on level of awareness on DRG. As such, PhilHealth must maintain an open communication with the public, more especially with the providers.

Engaging Stakeholders will help PhilHealth to come up with a grounded and acceptable grouping of diseases/procedures, with corresponding cost weight, adjustable modifiers, and national base rate, accurately and appropriately.

3. Monitoring mindset shift
PhilHealth should not only be concerned on monitoring claims utilization and fraud detection. We need to intensify performance assessment of providers and encourage/incentivize performance-quality driven health care such as improved patient satisfaction, shorter length of stay of patients, lesser morbidity, and among others.

4. Shift in provider payment mechanism is not a one meal deal.
Shifting to DRG is not a guarantee that all beneficiaries will be secured from accessible health care and be protected financially. As such, DRG policy should not be a stand-alone policy but should have clear and progressive related policies mandated by UHC Act. To warranty, prospective payment, No Co-payment or fix co-payment or co-insurance, Health Care Provider Network Contracting, institutionalizing costing, Primary Care, National Health Care Related Data Management, Supplemental Benefits, among others should be thriving a coordinated and efficient health system without causing additional financial burdens. The increase in the benefit packages concluded with DRG will help translate to satisfactory and higher support value of PhilHealth on health care.

V. CONCLUSION:

"Can we turn away patients?"

A rather honest yet painful remark from one of the respondents. As the Corporation commits to abide with UHC mandates, we should always be reminded that at the end of the day, the most important puzzle piece of UHC is the patient, the Filipino member, Juan dela Cruz. Policy reforms will go all go to waste if a Filipino will be deprived of access to quality health care that should always be a right, and not a mere privilege.

And given the limitations of this study, a thorough separate study on prospective payment, fixing co-payment/co-insurance is recommended. Likewise, assessment of PhilHealth internal capacity and capabilities to support the providers and DRG implementation must be conducted