

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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PHILHEALTH CIRCULAR

No. 029, s-2012

TO : **ALL PHILHEALTH MEMBERS, ACCREDITED
HEALTHCARE PROVIDERS, PHILHEALTH REGIONAL
OFFICES (PROs), AND ALL OTHERS CONCERNED**

SUBJECT : **Governing Policies on PhilHealth Benefit Package for Case Type Z**

I. RATIONALE

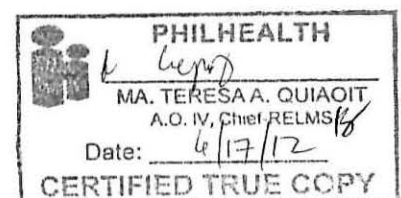
Philhealth members face a variety of primary disease conditions that are commonly referred to as economically and medically “catastrophic”. These illnesses push many into poverty even as Philhealth works to provide relevant financial risk protection especially for the members who belong to the lower income levels. With a national support value of 20-33%, Philhealth members, especially the poor, are often deprived of quality care necessary to attain better health outcomes. Medical and surgical expertise exists locally which can provide the care and services needed to improve outcomes and quality of life. However, health care providers with such expertise are limited.

In line with the thrust to achieve Universal Health Care for all Filipinos (Kalusugang Pangkalahatan or KP), and true to the aspiration of “Bawat Pilipino, Miyembro; Bawat Miyembro, Protektado; Kalusugan Natin, Segurado”, Philhealth benefits for catastrophic conditions must be improved and expanded to give relevant services that accord better health outcomes and financial risk protection to members.

In the face of consistently increasing costs of health care, inflation rates, inadequate health care delivery system, limited capacity and capital outlay for government facilities, fiscal limitations and other factors that impede the delivery of better healthcare services, it is necessary to create a strategic approach for financing “catastrophic” illnesses. This approach should 1) identify and support cost-efficient interventions; 2) employ rational cost-containment measures; 3) ensure quality of care for members; 4) incentivize and enable facility improvement.

Philhealth as mandated by RA 7875, as amended, must “prioritize and accelerate the provision of health services to all Filipinos especially those who cannot afford such services”. Further, Article 3, Sec. 5 mentions that “... This social insurance program shall serve as the means for the healthy to help pay for the care of the sick and for those who can afford medical care to subsidize those who cannot...”

Moreover, letter c, Sec.16 (Powers and Functions) of RA 7875 states that the Corporation shall have the power to set standards, rules and regulations necessary to



ensure quality of care, appropriate utilization of services, fund viability, member satisfaction and overall accomplishment of the Program objectives. Furthermore, letter j, Sec. 16 states that the Corporation shall have the power to negotiate and enter into contracts with health care institutions, professionals and other persons, juridical or natural, regarding the pricing, payment mechanisms, designs and implementation of administrative and operating systems and procedures, financing and delivery of health services.

Utilizing the powers as stated above, proposed reform and strategic direction were given approval by the Philhealth Board through Philhealth Board Resolution (PBR) No. 1629, s. 2012. This creates a policy environment for Philhealth to improve the way it carries out its business in the health care system.

Cognizant of the new direction as approved, it is necessary to institute reforms. As the current way of case typing (ABCD) focused more on claims and disease entity, a new case type Z is created where emphasis is on the patient member and his/her care. Z envisions to improve health outcomes through patient empowerment, higher payments for quality care, negotiating for cost-containment, among others.

Given these premises, this circular articulates the policies governing the benefit package for case type Z in order to realize better health outcomes and financial risk protection for Philhealth members, especially the poor.

II. OBJECTIVES

General objective: To develop a benefit package for case type Z.

Specific objectives:

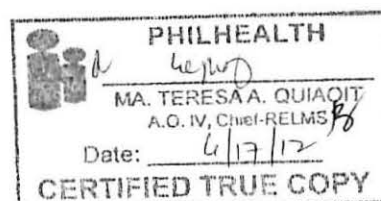
1. Identify the criteria for inclusion into case type Z;
2. State general guidelines for the required services given the rates for case type Z;
 - a. 100% support value for Sponsored Members
 - b. At least 50% support value for Non-Sponsored Members
3. Identify the criteria, roles and responsibilities of reference and contracted facilities;
4. Define the policies in the establishment of a patient tracking system; and
5. State general guidelines for developing a patient adherence and commitment form.

III. SCOPE AND COVERAGE

The case type Z benefit package shall cover all eligible Philhealth members and their qualified dependents.

For its initial implementation, the benefit package for case type Z shall only be provided by selected Philhealth accredited Level 3 or Level 4 government hospitals that have signed a contract on the provision of specialized care with Philhealth.

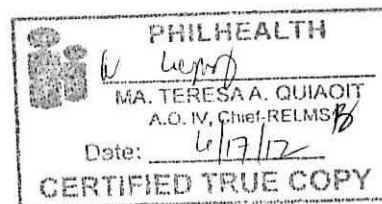
All other Level 3 or Level 4 hospitals may also enter into contracts on the provisions of specialized care with Philhealth after a period not less than 6 months from implementation



of this policy and subject to the same terms and conditions as that of government hospitals and whatever condition the Corporation sets.

IV. DEFINITION OF TERMS

- A. Case type Z - any illness as a primary condition that is life or limb-threatening and requires prolonged hospitalization, extremely expensive therapies or other care that would deplete one's financial resources, unless covered by special health insurance policies.
- B. Contracted hospital - any Philhealth accredited level 3 or 4 hospital that enters into a contract for specialized care with Philhealth.
- C. Reference hospital - is a contracted hospital (as defined) where, in addition, shall provide technical and administrative services, such as but not limited to, the creation and maintenance of a patient registry hub, costing and procurement of agreed mandatory services, and setting standards of care.
- D. Z benefit information and tracking system (Z-BITS) - electronic patient information, monitoring and tracking system for case type Z that intends to ensure the provision of service to Philhealth members.
- E. Mandatory services - essential services that contracted hospitals are obliged to provide based on clinical evidence and/or expert consensus as approved by the Corporation.
- F. Other Services- additional services that may be necessary to provide quality care based on clinical protocols/ guidelines /pathways accepted by the Corporation.
- G. Quality care- a true multidisciplinary-interdisciplinary team approach to patient care, with each discipline respecting the role and expertise of the other, in the delivery of complete managed care and course of treatment which comprises all mandatory and other services required to produce the desired health outcome.
- H. No Balance Billing (NBB) Policy- shall mean no other fees or expenses shall be charged to or paid for by the patient-member above and beyond the packaged rates.
- I. Fixed co-pay- a negotiated fixed amount for quality care (as defined) that may be charged by the contracted hospitals and approved by the Corporation.
- J. Referral Partner/Facility - any partner/facility with which a contracted hospital has a Memorandum of Agreement (MOA) as approved by the Corporation to provide services for continuity of care.



- K. Membership Empowerment (ME) Form – it is a document that ensures that the patient is informed of their case type Z benefits, the treatment choices and options, treatment schedule and follow-ups, member roles and responsibilities, member education and counseling and other pertinent courses of actions which is jointly signed by the beneficiary or his/her duly authorized guardian or representative and the attending health care provider in- charge upon diagnosis.
- L. Pre-authorization – is an approval process from Philhealth that gives the contracted hospital the information that the member has passed the eligibility and minimum clinical selections criteria required for availment of the case type Z benefit.

V. SELECTION CRITERIA FOR CASE TYPE Z

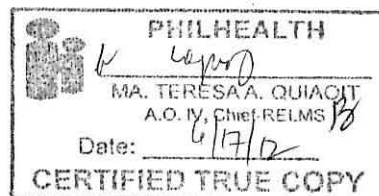
The following shall serve as the bases for identifying case type Z, for which benefit packages will be developed:

- A. The management of the condition or illness is known to be expensive because of the complexity of the disease and the expertise and procedures required, and may result in the depletion of one's resources resulting in their impoverishment;
- B. The Corporation offers a relatively low support value based on the average amount reimbursed for the care compared with the actual total expenses for quality care;
- C. The disease conditions have good survival rates based on medical literature and the success rate of the treatment is acceptable based on current standards of practice. The financial support given by the benefit package should improve health outcomes for such diseases or conditions.
- D. And other indicators /relevant data, such as but not limited to mortality and morbidity data, incidence and prevalence rates and claims data, expert opinion and value-judgment, among others.

VI. RATES FOR SERVICES, NBB & THE FIXED CO-PAY POLICY AND SUBTRACTION FROM THE 45-DAY LIMIT FOR CASE TYPE Z

The rates for the identified case type Z conditions and other details shall be stated in separate circulars.

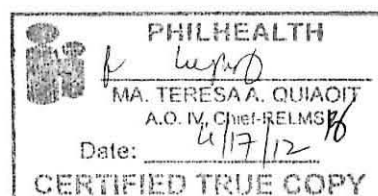
- A. Package codes shall be created for case type Z.
- B. Services for case type Z shall be paid through packaged rates.
1. The rates for case type Z should cover all mandatory and other services necessary to achieve high survival rates and the best outcomes for the member. These shall include, but are not limited to, hospitalization, drugs and medicines and professional fees.



2. Rates shall be identified through a process that considers the following, among others:
 - a. the average value per claim based on Philhealth data from the previous year/s;
 - b. current rates for complete care given by the reference and other hospitals;
 - c. consultations with experts and representatives from different stakeholders, and other studies on fair rates;
 - d. fair market prices of inputs to care.
 3. The packages should support complete course of treatment especially for the early stages of the chosen disease conditions to encourage early detection and treatment.
- C. A fixed number of days from the 45 days annual benefit limit for services rendered in the package shall be subtracted regardless of actual hospitalization days. The actual number of days subtracted shall be reflected in the appropriate Philhealth Circular.
- D. The NBB Policy shall be applied to all Philhealth Sponsored Program members and/or their qualified dependents for the specified cases.
- E. Non-sponsored members shall be charged fixed co-pay based on room accommodation and socio-economic classification, among others. Such fixed co-pay shall not exceed the amount of the package rate and shall be reflected in the contract for the provision of specialized care.

VII. STANDARDS OF CARE AND SERVICES

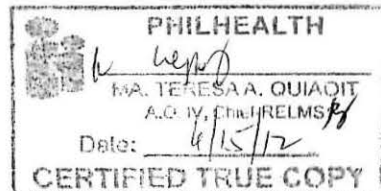
- A. Quality care for the Philhealth patient will be the rule, implementing true multidisciplinary-interdisciplinary team approach to patient care, with each discipline respecting the role and expertise of the other, all for the benefit of the Filipino patient. Each contracted hospital will mandate their core medical disciplines to take care of the cancer and/or transplant patients using the multidisciplinary-interdisciplinary team approach.
- B. The service provision for case type Z shall be guided by Philhealth appraised/approved treatment guidelines, protocols and clinical pathways. Philhealth approved clinical practice guidelines will be followed optimizing the case type Z benefit package.
- C. Treatment protocols/clinical guidelines shall be adopted from the current state of the art- internationally accepted treatment guidelines (such as the NCCN Cancer Treatment Guidelines updated each year) based on scientifically-sound body of evidence depicting the lowest recurrence rates and hence highest survival rates possible over at least a 2 year period.
- D. Eligible members shall be entitled to all mandatory and other services deemed necessary.



- E. Rational Drug Use (RDU) must be observed at all times. Rules on the use of the Philippine National Drug Formulary (PNDF) remain applicable, provided that non-PNDF medicines that are necessary and whose protocols are accordingly approved by Philhealth shall be deemed provisionally exempt, unless and until such time the Formulary Executive Committee (FEC) of DOH otherwise decides to the contrary and in writing. Philhealth shall facilitate the process of securing exemption with FEC.
- F. Members shall be accommodated in the specified bed type as agreed in the contract with the contracted facilities. Strict infection control should always be observed and isolation rooms must be made available whenever necessary.
- G. For the breast and prostate cancers, particularly, early detection programs are strongly recommended. Contracted hospitals should develop, implement and maintain early detection programs to be able to successfully increase survival rates for these cancers in the country.

VIII. MEMBER EMPOWERMENT (ME) FORM

1. To ensure that the patient is informed of their case type Z benefits, treatment choices and options, treatment schedule and follow-ups, member roles and responsibilities, member education and counseling and other pertinent courses of actions, a ME Form shall be jointly signed by the beneficiary or his/her duly authorized guardian or representative and the attending health care provider in-charge upon diagnosis. The patient shall be given information and education materials and shall be registered by the contracted hospital to the Z-BITS.
2. The ME Form shall contain at least the following:
 - a. Member information;
 - b. Clinical information as to diagnosis and treatment options agreed upon by the member and health care provider;
 - c. Schedule of treatment and follow-ups;
 - d. A list of mandatory and other services the patient is entitled to;
 - e. List of contracted hospitals where the patient can receive the needed services;
 - f. Member roles and responsibilities to ensure adherence and compliance to the agreed upon treatment option;
 - g. Limitations and rules surrounding the availment of case type Z benefits;
 - h. Other vital information the patient needs such as counseling, information as to disease condition, and information on financial and other means of support.
3. The patient's preference from where and from whom he/she will receive the health services due from his/her Z-benefit will prevail, given a list of such PHIC contracted service providers. Preferring another contracted service provider will not affect the patient's treatment at the other contracted hospital in any way.



The patient must be given the full benefit of being cared for by all the pertinent medical specialties present in the contracted hospital.

IX. ELIGIBILITY RULES FOR Z-BENEFIT AVAILMENT

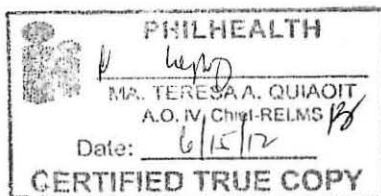
1. All existing eligibility rules shall still apply for all admissions from June 21, 2012 until Dec. 31, 2012.
2. In order that members and their qualified dependents can continuously avail of the case type Z benefit, premium contributions must be made for the next three (3) years. Beginning January 1, 2013 all members shall be required a 3-year lock-in membership prior to availment of the benefit to ensure that the member or his/her qualified dependent/s continuously receive all benefit entitlement for the entire duration of the treatment course.
 - a. Members for Individually Paying Program (IPP) and Overseas Filipino Workers (OFW) shall pay total amount of Php 7,200.00 (Php 2,400 x 3 years).
 - b. For employed members, a certification of approval/agreement from employer to the lock-in membership for the next 3 years must be submitted prior to availment.
 - c. The lock-in membership does not apply to life time members and sponsored program members.

For the three (3) year lock-in period, members may choose to pay their premium contributions from the following options:

- a) Full payment
Upon submission of Philhealth Membership Registration Form, member pays the amount equivalent of three (3) years
- b) Partial payment
Upon submission of Philhealth Membership Registration Form, member pays the initial annual amount for the current year. Subsequent annual contributions shall be paid not later than January 31 of the succeeding years.
- c) Signed commitment that premium contributions shall be ensured for the next three (3) years. However, this option does not guarantee the member and their qualified dependents eligibility to avail of any other Philhealth benefit, Z or other illnesses for the next three (3) years.

The three (3) year lock-in period ensures that the member and their qualified dependents can avail of all Philhealth benefit entitlements for the next three (3) years. Any gap in premium contributions will not qualify the member and his/her dependent/s to claim for other Z benefits or other illnesses under Philhealth's current payment schemes, such as case rates and fee-for-service.

3. In addition, all eligible members and qualified dependents must pass the set of clinical and other selections criteria approved by the Corporation. A pre-authorization clearance notification from Philhealth prior to the provision of service shall be required.



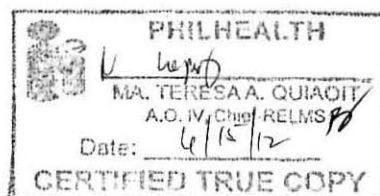
X. RESPONSIBILITIES OF CONTRACTED/REFERENCE HOSPITALS

A. Contracted Hospitals shall:

1. Provide all the services necessary to ensure quality care based on the approved protocols.
2. Submit all protocols and necessary data, such as standards of care, costing and professional fees used in the facility for the treatment of case type Z.
3. Submit complete and updated patient information through the Z-BITS.
4. Ensure that all patients are well informed of the Z Benefits. The said facility shall ensure that the patients and attending health care provider sign the ME form and shall assure that this form is complete and updated.
5. Conduct regular patient education and family support sessions following standard acceptable curricula that empower patients and their families to be part of the patient's healing and therapeutic processes. Such sessions should include education and information on the Philhealth benefits and procedures. They may do this in coordination with NGOs, private organizations and other government institutions.
6. Enter into a MOA with a referral partner/facility for contracting of care when certain services are not available. They shall ensure the quality of service rendered by the referral partner/facility and the costs are within the given rates. Such MOA should be approved by the Corporation. Reimbursements for case type Z shall only be made through contracted hospitals and not to those the latter have entered into a MOA with.
7. Timely submit pre-authorization requests and file Z-claims according to schedule.
8. Place information and educational materials on the case type Z benefit in conspicuous places.
9. Conform with all stipulations in the contract and abide by other rules of Philhealth that may be developed in line with the case type Z.
10. Timely report to Philhealth and effectively address issues concerning the implementation of the benefit for case type Z.

B. Reference Hospital shall:

1. Share the same roles and responsibilities as defined for contracted hospitals.
2. On top of the package rate for services, additional reimbursement payment for the following services may be made to reference hospitals:
 - a. Identification/appraisal of clinical guidelines, pathways, treatment protocols and regimen;
 - b. Identification of the acceptable rates for rendering the service;



- c. Establishment and maintenance of a Z-BITS and develop this into a patient registry system;
 - d. Development of cost-effective systems/networks that allow achievement of economies of scale and the lowest prices for goods and services of the best quality such as pooled procurement or transparent negotiation and acquisition of medicines.
3. Establish and implement acceptable capability building courses and assist to undertake health human resource training or facility improvements for contracted facilities to ensure the provision of high quality and up-to-date services.

XI. PENALTIES AND SANCTIONS

Non-compliance to this circular and violation of the terms and conditions of the contract shall be grounds for termination of the contract without prejudice to the application of appropriate sanctions and penalties stated therein.

XII. PERIODIC REVIEW, MONITORING, EVALUATION AND ADJUSTMENTS

This circular shall be subject to regular monitoring, periodic review (at least every 6 months), and adjustments as may be necessary.

XIII. EFFECTIVITY

This Circular shall take effect on June 21, 2012 upon due publication in Two (2) newspapers of general circulation and submission to the UP Law Center.

Please be guided accordingly.

DR. EDUARDO B. BANZON
President and CEO
Date signed: 6/14/12

