TAMANG SAGOT

PhilHealth Circular No. 002 – 2015

Governing Policies on the Expanded Coverage of the Primary Care Benefit Package: Tamang Serbisyo sa Kalusugan ng Pamilya (TSeKaP)

Outline

I. Service Delivery

A. Coverage

1. Who are the Indigent and Sponsored Program members that are eligible for the first phase of Tsekap?

Indigent Program members are those enrolled by DSWD through the Listahanan or National Housing Targeting System (NHTS). Sponsored Program members are those whose premiums were paid for by sponsoring entities such as LGUs, provincial units, NGOs or other private groups.

2. Does Tsekap include services for DepEd personnel, Overseas Workers Program and Organized Groups similar to PCB1 package?

Tsekap Package is an enhancement of PCB1 and has, for the meantime, been approved for the SP/IP members only. PCB1 (formerly Tsekap) will still be provided for those previously eligible for PCB1.

3. Can an illegitimate child avail of PHIC benefits?

Yes, provided that they are declared dependents by their parent/guardian in their PhilHealth member data record.

4. Are families enrolled in Tsekap entitled to other PhilHealth benefits such as inpatient?

Yes, their premiums cover other PhilHealth benefits such as inpatient, Z-benefits and MDG-related benefits.

B. Concept of Preventive Care

1. Can DepEd-sponsored members use PCB1/Tsekap for their annual physical examination?

Annual physical examination (APE) is not a cost-effective way of managing patients. Tsekap is not intended as an APE and services for members and dependents will be given on a per-need basis, as recommended by their physician.

2. The Tsekap package does not seem to be focused on preventive medicine but rather curative side of care. Why not cover also vaccines, etc?

When we speak of preventive medicine we refer to three levels of prevention—primary, secondary and tertiary. Primary prevention refers to programs and services that prevent diseases such as mass immunization, environmental sanitation, and promoting healthy lifestyle. Secondary prevention aims for early diagnosis of a disease when one has no symptoms yet. There are diseases, like hypertension, diabetes and asthma that can be diagnosed and managed in primary healthcare facilities. The early diagnosis and treatment prevent the worsening of these common conditions and prevent the onset of their complications.

The Tsekap benefit is an adjunct to primary care programs under Department of Health including immunizations and promotion of healthy lifestyle. The Tsekap benefit will continue to evolve and PhilHealth will continue to expand it according to the needs of the population as well as the affordability of recommended interventions.

3. **How can we improve the health seeking behavior and compliance of clients, including coming back for follow-up? Can IEC materials be improved for such purpose?**

Educating the members on the importance of follow up and compliance is key to promote better health seeking behavior. Tsekap providers are highly encouraged to effectively educate patients on the importance of compliance including to their follow-up schedules. Part of Tsekap is the provision of orientation materials to the members. Health volunteers can be tapped to help monitor patients. Part of 5% PFR for non-professional health worker's share can be utilized to finance volunteers.

The principles underlying Tsekap is health promotion, disease prevention and management of common diseases that can be managed at the primary level. If the enlisted families remain sickly then the cost of caring for them will go higher. Thus, the Tsekap provider should promote better health seeking behavior.

C. Services

1. **Why are there obligated services?**

Obligated services are identified by guidelines as cost-effective interventions for early detection of a disease/condition. These services aim to prevent progression of the disease and ultimately prevent costlier health care.

2. **Enumerate the required dental health services. Why are dental services limited to 12 years old and below?**

Consistent with Garantisadong Pambata Program and as recommended by cost-effectiveness studies, oral check-up and prophylaxis for children below 12 years old are included in Tsekap. This is the recommendation from guidelines and cost-effectiveness studies. The benefit is dynamic and will be amended as necessary based on feedback and monitoring.

3. **What is an alternative screening for cervical cancer aside from VIA?**

While VIA is the recommendation from guidelines, pap smear is an acceptable alternative. Although, Paps smear is more costly and would require more time since specimen are still to be read by a specialist.

4. **Can family planning services be reimbursed?**

Although not under the Tsekap benefit, family planning services like intrauterine (IUD) insertion, bilateral tubal ligation (BTL) and non-surgical vasectomy (NSV) are benefits paid for by PhilHealth. IUD insertion can be paid at the RHU level provided that they have the necessary training for this service (See PC 22 s 2014), while BTL and NSV are paid only at accredited hospitals and Primary Care Facilities.

5. **What are the sanctions in the event that obligated services are not or only partially rendered?**

Although obligated services are not part of the current computation for payment, it is an integral part of the monitoring and evaluation framework. Non-compliant and outlier facilities shall undergo investigation.

D. Diagnostics

1. What can be done if some laboratory tests required in Tsekap are not available as the facility?

Consistent with PEN guidelines, less expensive equipment like glucometer and lipid profile meter are acceptable alternatives in low resource settings such as GIDA areas. Government providers are encouraged to utilize 80% PFR to purchase Tsekap equipment that they may need to complete the services required or partner with a referral facility through a Memorandum of Agreement to complete the service capability.

2. What if equipment and machines are available in the facility but this has no DOH license, can results be used for Tsekap?

Laboratory services must comply with quality and safety guidelines to ensure proper health care. Government providers can use 80% PFP to upgrade facility to meet the standards to be DOH licensed or contract with a licensed laboratory facility through MOA and charge to 80% PFP.

3. Some government facilities (i.e. RHUs) share a common med tech which limits the capacity of the RHU to perform the diagnostics. How can we improve on this?

Government providers can contract with a licensed laboratory facility through MOA and charge the costs to the 80% PFP. They may also encourage the LGU to hire additional MedTech (salary from LGU) to complete the human resource complement.

4. How can outsourced diagnostic exams be paid for?

Government providers can contract out laboratory procedures to another facility or laboratory, whether public or private, through a MOA which will be attached to your application for Tsekap accreditation. It is strongly recommended that prices for these services be negotiated to ensure efficient use of resources and it should be stipulated in the MOA. Government providers will be paying for these services using 80% of PFP.

E. Drugs

1. List of approved meds to be reimbursed by PhilHealth is very limited. There are medicines that are commonly prescribed that are not on the list. Can we expand this?

List of drugs and medicines are based on cost effective analysis as prescribed by current international and local clinical practice guidelines, recommended by agencies such as the WHO and several medical journals. All inclusions in the benefit packages of PhilHealth are supported by research, CPGs, costing and actuarial analysis.

Any drug prescribed outside the list should be recorded in the EMR. These data will be analyzed by PhilHealth. Eventually, a 'prescribing pattern' will be seen and more drugs may be added, which may be enhancement for the benefit package.

2. How about in conditions like patient is allergic or prone to resistance to drugs on this list? Can a doctor prescribe medicines outside of the Tsekap list?

PhilHealth is not restricting the prescription of drugs to those on the list. It is still the doctor's discretion on which drugs are most appropriate to prescribe to the patient, but PhilHealth will only reimburse medicines that are part of the package.

3. **Can we prescribe medications in the list but not for the condition indicated, for example cotrimoxazole as medication for pneumonia?**
   Cotrimoxazole is part of the array of medicines for Tsekap as medicine for UTI but pneumonia guidelines do not currently recommend use of cotrimoxazole. Providers are encouraged to use CPGs and reimbursement for medicines will only be for recommended medicines. PhilHealth shall pay for medicines based on the guidelines of Tsekap, only for the conditions to which it was indicated.

4. **Can only one family member avail of the non-communicative disease (NCD) package? What will happen if patient exceeds the maximum medication?**
   Unlike in the pilot implementation of Primary Care Benefit Package 2 (PCB2) wherein medications were limited to one member, there is NO LIMIT for any member of the family to avail of any of the drugs in the Tsekap package. Tsekap drug benefit is charged on a pooled fund and all eligible patients who will require medicines should be prescribed medicines on the list. PhilHealth shall pay for drugs received by the eligible benficiary according to the Tsekap guidelines.

5. **Why can only few patients avail of the PhilPEN-recommended drugs?**
   Based on PEN guidelines, patients whose risk falls below 30% should be given non-pharmacologic interventions including lifestyle modification. As such, the electronic prescription will not be triggered in these cases. However, the doctor may still prescribe medicines but this cannot be reimbursed to PhilHealth. It should be reflected in the patient's EMR.

6. **Can government providers (ex: RHUs) still dispense medications since patients are used to asking for medicines in these facilities?**
   RHUs can still dispense medicines procured through their regular budget from their LGU or those provided by NCPAM. But, the direction of FDA is to enforce the provision of the Pharmacy Law where dispensing function is separate from prescribing function. Under Tsekap, drug benefits can only be claimed in accredited drug outlets therefore PhilHealth will not be paying them unless they have an accredited Drug Outlet.

7. **Can IMCI-trained RHMs dispense drugs and claim payment?**
   RHMs can still dispense drugs based on IMCI guidelines, but this will not be part of theTsekap benefit. Under Tsekap, drug benefits can only be claimed in accredited drug outlets therefore PhilHealth will not be paying them.

8. **If there are drugs available in the health facility, where does the P1000 allotment for medicines go?**
   The P1000 allocation for medicines will be pooled nationally to create a global budget wherein reimbursements from drugstore based on the units of medicines dispensed shall be charged against. This payment system supports the provision of Pharmacy Law that separates the prescribing and dispensing functions.

9. **What will happen to the ComPack medicines?**
   ComPack medicines shall be dispensed in GIDA areas where there are no accredited drug stores. RHUs may also dispense them to non-PhilHealth members. DOH NCPAM commits to

provide ComPack medicines required by Tsekap benefits in areas where there are no accredited drug outlets.

10. Can you assure clients with the quality of medicine given the costing of Tsekap?
Accredited drug outlets are required FDA license under the assumption they have complied with quality standards.

11. How can NBB be implemented if patients coming in to the RHU bring in prescriptions from the hospital that the RHU cannot provide?
The accreditation policy requires that all accredited health facilities shall provide all the essential inputs to care (drugs and medicines, laboratories, service capabilities) appropriate to their care. Therefore, it is not the intention of PhilHealth that SP/IP members availing inpatient services to be getting medicines from an RHU or any other government health facility. Non-compliance to the NBB policy is a Breach of the Performance Commitment.

II. Accreditation Guidelines

A. Accreditation of Healthcare Provider

1. What if the PCB provider is not an RHU?
All government or private health facilities that can comply with accreditation requirements can apply to be a Tsekap provider.

2. How long will it take to get accredited?
The soonest you submit the complete requirements for accreditation; the faster you can be accredited. The accreditation process is decided at the regional office and should not take longer than one month after the submission of complete requirements.

3. Will you still be an accredited Tsekap provider even if some of the services offered are not available in your facility?
Government health providers may outsource laboratory services outside their capacity through a MOA with the referral facility attached in the application for accreditation. Private health providers are expected to provide all the services of Tsekap within the facility.

4. Training is needed to complete the Tsekap services. How can we get these trainings?
Those who were able to apply for the PREVENTS package in 2014 can use this fund for training in these Tsekap services. Local trainings can be coordinated with regional DOH office or private organizations. Government providers may use the 80% PFR for capacity building of health personnel.

5. What can be done for facilities with lack of human resource?
Government providers can encourage their respective LCEs to hire additional personnel for permanent positions. Or, they can use the 80% PFP for operational costs to outsource services that will need these personnel.

6. Tsekap requires a minimum number of hours/day for doctors to be present in the area. What if some providers cannot comply?

The minimum requirement is to have the human resource requirements available at the provider or referral facility for at least 4 hours a day for 5 days. Qualified alternative personnel are expected to perform the services when the original staff is not available. Special considerations may be allowed especially in GIDA areas, subject to the approval of PhilHealth Regional Offices.

7. **Can we extend the Tsekap accreditation of RHUs to its Barangay Health Stations? Meaning a complete professional team will go to the BHS on a regular basis to deliver the required services to the members/dependents?**
   Providers can be accredited as long as they can comply with the requirements of manpower, IT and capacity to provide all Tsekap services. Having satellite facilities to reach more members as an extension is acceptable as long as the base accredited facility is able to perform the complete Tsekap services as required in the guidelines.

8. **The distance of another facility with an established MOA with a given facility is far and patients can't afford the transportation fee. Is there a way we can improve on the accessibility?**
   A MOA should only be made with facilities closest to you and that which complement your services. For those with referral facilities that need transport, the provider can explore these options: 1) assess setting up own DOH-accredited laboratory facility in the area using 80% PFP, and 2) facilitate transport of members charged to 80% PFP (i.e. vehicle) although big purchases are allowed only for PFP savings.

9. **Sponsored members incur out of pocket spending when they avail of diagnostics in a laboratory that was contracted by the RHU through the MOA. How can we strictly implement NBB policy?**
   Providers should ensure that they will contract with a laboratory facility that complies with standards set by PhilHealth since non-compliance is a violation of performance commitment with corresponding measures for both the provider and the referral facility. You can change current MOA to a different facility if necessary.

B. Private Provider Participation

1. **Is Tsekap open to private clinics?**
   Yes, as long as they can comply with accreditation requirements such as complete service capability based on standards, IT connectivity and performance commitment.

2. **What is the rationale behind involving private providers when government facilities are supposed to be in the front line in providing Tsekap?**
   Initially PCB was only given to public facilities. But throughout the years, the government facilities could not cope with the demand of catering to all the eligible members. The involvement of private providers is also necessary when we will roll out Tsekap to all PhilHealth members.

3. **Is it okay if private will not join or participate in Tsekap program now?**

Accreditation is always voluntary, but we would surely like to have private providers on board this early. Since the plan is to roll it out to all member sectors, coming in late in the game may be to your disadvantage.

4. **How will PhilHealth avoid friction and competition between the public and private health providers? How will we address political issues?**
   Competition is viewed as a healthy arena to level the playing ground and for the government providers to step up and make their health services better. The intention of Tsekap is noble so as to provide quality health care to all members. For problems related to enlistment and political frictions, kindly seek the guidance from of the LHIO and the PhilHealthRegional Office.

5. **What will happen to those with group practices, those with more than one physician in the facility?**
   They may accredit themselves as a network wherein they will be treated as one entity. Internal arrangements for payment and other administrative matters may be done within the network.

C. Accreditation of Drugstores

1. **Why is dispensing of medicines no longer a function of health facility? How about if the LGU is willing to hire a pharmacist and the RHU will be the drug outlet?**
   FDA is removing the function of dispensing from LGUs because of lack of licensed pharmacist. LGUs can set up its own pharmacy to be accredited for Tsekap as long as they are able to comply with standards set by PhilHealth especially FDA license and IT requirements.

2. **What can be done for areas with poor access to accredited drug stores such as GIDAs? Can we have mobile drugstores for patients in GIDA areas?**
   Options include: 1) Assessing cost-effectiveness of setting up own drugstore; 2) Coordinating with PITC Pharma to help set-up pharmacies to address the need for GIDA areas.; 3) Create mobile dispensing teams with pharmacist within the accredited pharmacies; 4) In GIDA areas where there is no adequate demand, ComPack will be provided to patients.

3. **Is Generika the only drug store provider?**
   Generika was the only drug outlet to volunteer as partner with PhilHealth for pilot testing of PCB2, the arrangement ended in December 31, 2014. For Tsekap, ANY drugstore that is capable of meeting standards can be accredited.

4. **Can we utilize the Botika ng Barangay as our source of Medicines / partner pharmacy?**
   Botika ng Barangay outlets can be accredited if they are apply for PhilHealth accreditation and comply with the three requirements: FDA license, PhilHealth-certified IT system, signed commitment performance.

5. **Can pharmacies inside hospitals be accredited as PCB2 drug outlets?**
   Yes, they can be accredited if they apply for PhilHealth accreditation and comply with the three requirements: FDA license, PhilHealth-certified IT system, signed commitment performance.

6. **Is it possible to have a pharmacy that is owned by a cooperative of health workers that will provide medicines/supplies?**

Yes, they can be accredited if they apply for PhilHealth accreditation and comply with the three requirements: FDA license, PhilHealth-certified IT system, signed commitment performance.

7. Is it possible to have more than one pharmacy to partner with the health facility?

For the first six months, we will be limiting to it to one drug outlet per provider for ease of transactions. In the future, we will be allowing facilities with big catchment areas to partner with more than one pharmacy for the convenience of the members.

8. How do we monitor the availability of medicines?

This requirement is part of the accreditation process for drug stores, therefore drug outlets are expected to have adequate supply available all the time. Lapses in dispensing of medicines shall be monitored by Philhealth.

9. For old PCB1 providers, are we disallowing the purchasing of medicines through PCB since we will now direct them to local drugstores?

We do not disallow LGUs from buying medicines from their own local budgets. However, Tsekap policy is an enhanced outpatient benefit policy and in implementing it, PhilHealth supports the implementation of the provision of the Pharmacy Law where dispensing function is separate from prescribing function. Previous PCB capitation may be used to buy medicines as per previous guidelines, but capitation that shall come from Tsekap cannot be used for purchasing medicines.

10. Will the patient have the option to choose his or her brand of prescribed medicines?

Tsekap does not limit which drugs should be prescribed. But due to the price cap for medicine reimbursements, some brands may not be available options for the package. PhilHealth shall only pay for drugs/medicines under the package in the accredited drug store based on agreed price caps. Patient brand preference that is not available as part of the package may be charged to the patient.

III. Enlistment and Profiling

A. Enlistment

1. How will SP/IP members know about Tsekap especially on the process of enlistment?

PhilHealth shall provide information campaigns including TV infomercials, radio announcements and online presence for this purpose. Providers are also encouraged to create their own information campaigns or promotional events to introduce Tsekap and entice members to enlist within their facility.

2. Will the members be assigned to the facility or the facility chooses the members?

For Tsekap, there will no longer be assignment of SP/IP members and dependents to providers. Members will be allowed to choose their Tsekap provider expressed by enlisting with the facility. Members previously enlisted in a PCB1 provider shall remain enlisted in the same unless they decide to transfer.

3. Is there a minimum number of families per provider?

No. The number will depend on the capacity of the provider and the number of families willing to be enlisted in the facility.

4. **Can we be selective in accepting enlistment of members?**
   No. By applying for accreditation for Tsekap, providers agree to carry out the benefit to all eligible members and dependents that decide to enlist in their facility. We will be able to monitor enlistment through the electronic medical record. Patient satisfaction is a criterion in the monitoring and evaluation framework.

5. **How can provider-hopping be prevented?**
   Once an eligible member has enlisted or consulted with a Tsekap provider for the first time in a given year, the Tsekap provider must inform the patient that they will already be enlisted with that provider for the whole calendar year. The information system will show if the member is already enlisted in a different facility. If members wanted to change provider, they can only do so for reasons such as change of residence or place of work, other instances such as acts of God and upon processing of the LHIO.

6. **What if members enlisted in a private provider seek consult in a government provider?**
   Government health facilities have a duty to provide service regardless of PhilHealth membership and enlistment in their facility given their funding from LGUs. Other preventive programs provided by the Department of Health such as immunizations are also done in these facilities. For continuous instances of repeated consults that are part of the Tsekap package, providers can encourage the members to transfer to their facility on the next calendar year.

7. **Can a member enlisted in a facility avail of Tsekap in another provider? Who will get paid?**
   The IT system will indicate that a member has already enlisted with a different facility. There are certain allowable provisions for transfer of enlistment (i.e. transfer of residence, etc.) but members shall be eligible for the Tsekap only on the subsequent provider after transfer. Payment will go to the appropriate provider on the affected quarter. The member can be given services by another provider, but it will not be a part of the Tsekap package.

8. **Some members assigned to health facilities could not be located or are not from locality, who determines membership of sponsored indigents?**
   PhilHealth follows the list of NHTS provided by DSWD. The principle of non-assignment limits problems that arose due to assignment. PhilHealth Circ. 15 s. 2014 provides guidelines for unlocated members.

9. **Is there a timeline for the enlistment?**
   Enlistment to a facility can be done any time of the year, but will only be valid for that calendar year. Enlistment can be renewed starting every January.

10. **What if all members will go to RHU only, what will happen to the private practitioners?**
    Private providers who lose members throughout the year must continue to provide Tsekap services for those who enlist within the facility until the end of the calendar year. They may opt to be continuously accredited to Tsekap for the succeeding years or not.

11. **How do we validate the number of dependents of each member who are qualified to avail of Tsekap benefits?**

Accredited Tsekap provider can view the dependents of the enlisted members using the PhilHealth-certified information system. Updating the list of dependents can be coursed through the LHIO/PRO.

12. Can we enroll the non-members, indigents, TB patients, patients in labor to point of care package?

No. At the moment, point of care enrolment through Tsekap provider or birthing facility relative to availment of the Tsekap package is still being developed.

13. How often can a member/dependent avail of the Tsekap package?

There is no limit to the number of consults or service for the Tsekap package, as long as it is necessary for the member. The principle of risk pooling will give you some members who are physically fit and some members who would require more services.

14. What happens if a patent who consulted for a primary care consult then goes to a different hospital for further management? Will the Tsekap provider get payment even if patient is admitted?

Yes, currently our only trigger for capitation payment is completed profile reflected in the PhilHealth database. Outpatient and inpatient benefits are treated separately. The primary care provider will receive capitation while the hospital will receive the corresponding case rate.

B. Profiling

1. How do you do profiling?

Profiling is like filling up a patient medical record (patient data, medical history, family history, review of systems, physical examination) in an electronic format. The exact format will depend on the EMR used.

2. In the absence of the MHO, can nurses/midwives fill up the individual health profile and make diagnosis?

Yes, but not the entire health profiling. They may assist the physician in doing portions of the individual health profile depending on professional competency.

3. We recently conducted paper based health profiling for our members and dependents on 2014, can we use these data and upload to the PHIC portal once installed in our computer?

Yes, then update the information for 2015. Updating is easier because you don't have to change most of the parts of the profile form. You can also upload the profiles as early as now.

4. Profiling is an additional workload which will require additional manpower investment.

Profiling will trigger the release of half of the Per Family Payment (PFP), i.e. P400 of P800/family/year. The 80% PFP can be used to contract out tasks such as encoding for the purpose of ensuring that the facility can complete the requirements for reporting the profiling task.

5. How often do we need to profile the members?

Profiling is done yearly. Once profiled, providers just have to update the individual health profile on record and not necessarily to fill up everything again.

6. Do we need to profile members/dependents even if they are not sick? Do we profile individually or per household?

Yes. Individual health profiling means establishing the health status of all eligible beneficiaries, including the sick and healthy. The health profile should be done individually per member and per dependent.

7. If member was initially profiled by the one provider then re-profiled by a different provider, which record should be used?

Once the patient has enlisted and has been profiled in one Tsekap provider, another Tsekap provider cannot do that anymore. The system will no longer accept it. Although, if the patient transferred to another Tsekap provider, the profiled record shall be available to the second provider. Updating of the profile shall be allowed if necessary.

8. What is next after profiling?

After profiling, the Tsekap provider must provide specific laboratory tests or prescriptions of medications depending on their assessment. Obligated services must also be provided to them.

9. Do we really have to use ICD-10 in encoding the diagnosis?

Yes. ICD-10 is standardized and its use is highly recommended for tracking and quantification of services rendered. For purposes of classifying presumptive diagnoses, select the most appropriate ICD-10 code.

10. Do we include diagnosis not treatable at the provider in the EMR?

Yes. Tsekap providers are expected to refer these cases to higher level facilities. Reporting all diseases seen at the primary care level in the EMR will help DOH and PhilHealth design future health programs and benefit packages.

11. There is no information on schedule of submission of enlistment or profiling reports.

There will be no enlistment or profiling report under Tsekap. All of this can be extracted by PhilHealth based on EMR data that the accredited providers have uploaded. These data will be analyzed every quarter. PhilHealth shall pay based on electronic data received.

IV. Payment Mechanism

A. Computation

1. How do we compute the payment for Tsekap? Please elaborate the P800 PFPR and P1000 medicines allocation.

The P800 is paid as capitation to the facility to encompass all services and diagnostics of the eligible members in the same manner as in PCB1. The first P400 (50%) of the P800 is given to the facility for enlistment and is given per quarter. The rest of the capitation is an incentive for profiling all the members and dependents listed in the medical record. If all of them are profiled, the provider will get P800 (P400+P400). If some of the dependents are not profiled, the provider will get P600 (P400+P200) of the capitation.

The P1000 for medicine is given in a different mechanism. This is pooled nationally to form a global budget, wherein payment for billing statements from drug outlets will be charged against. Drugstores will be paid per unit of medicine released.

2. **What if patients were already profiled but these did not seek consult. Will the provider still get paid?**
   The trigger for payment is profiling. The provider can get paid as long as the profiles get updated.

3. **For a member with more than 10 dependents, can the payment be increased?**
   No, payment is for all the dependents of the members since premium to PhilHealth is also paid by the whole family. Non-provision of service or non-enlistment due to large family size can be captured through monitoring activities and is considered a breach of performance commitment.

4. **Will the computation of the payment be automatic? Can the computation of receivables be seen in real time?**
   Yes. Payment computation is automated. A benefit payment notice will be issued electronically that will show real-time updates.

5. **Is the computation of the PFP dependent on how much of the obligated services we were able to accomplish? Are we going to get paid for an obligated service that we recommended for a patient but the patient refused?**
   The PFP computation is not dependent on performance of obligated services. Compliance to provision of obligated services will be determined through monitoring of the quality of services under Tsekap. Patient 'refusal' must be properly documented (signing of waiver).

6. **What if same patient comes back to the provider several times, what will be the manner of payment for that?**
   PFP is a payment mechanism is based on the principle that the payment calculated was based on the expected health service needs of the enlisted members as a whole, not per family or per individual. The more health preventive and promotive services a Tsekap provider does, the healthier the families assigned to it becomes, thereby requiring less curative care. This is the reason why Tsekap providers will be paid a fixed amount regardless of whether their enlisted members come for consult or not. But there will be enlisted members who will require more services than others and their health care needs under Tsekap must be addressed.

7. **How do we know that the amount for services is already exhausted?**
   In case the PFP for a health provider will be exhausted, the provider has the option to use other funds. Thus, we encourage health providers to have rationale use of diagnostics but keeping in mind of not depriving the patients of the needed diagnostics.

8. **How do we know that the amount for medicines is already exhausted?**
   Amount provided for medicines will not be exhausted. There is no limit for amount of medicines to be dispensed.

B. <u>Professional Fees</u>

1. **How will private health providers go about payment sharing of the PFP?**
   There are no guidelines for the private providers sharing scheme. It is left to their discretion, in respect to their own rules and regulations. Payment is done per facility depending on the sharing guidelines of the health facility.

2. **Can payment sharing in government providers be revised?**
   We abide by the 20% - 80% sharing, for now. But this issue is already being assessed through the I3QUIP study which is expected to end by 2016. The disposition of PF will be revised in the future once more evidence become available to support the policy amendment.

3. **Will there be a standardized list of the occupations included in the allocation for government providers?**
   PFP is payment for Tsekap services both to professional and non-professional health workers providing the Tsekap services. The circular shows the definitions of this and examples of the titles. An LGU's signing of the performance contract (PC) binds the latter to comply with the rules of the Corporation. Violations and non-compliance to the PC will be addressed accordingly. Further, local Commission on Audit (COA) office also conducts their own monitoring for such transactions.

4. **Can a contractual or job order health personnel share in the budget allocated for health professionals?**
   Yes. All health workers regardless of employment status who provided Tsekap services must be included in the PF sharing. This includes, the DTTBs and nurses and midwives deployed by DOH to the LGUs, relievers, etc. Portioning the allocation to each eligible worker shall be done through internal arrangement within the facility.

5. **Are workers hired by LGUs like pathologist and radiologist included in PF sharing scheme?**
   Honoraria/ Reading fee for services that are part of provision of laboratory services may be charged against the 80% operational costs.

6. **What is the allocation of dentists?**
   Allocation of dentists is part of 10% PF for doctors, but actual allocation should be an internal arrangement among all doctors in the facility ideally depending on relative proportion of services rendered.

7. **What if the regular physician is on leave and there's an appointed OIC in the facility, to whom will the PF be given to?**
   The PF sharing should be given to whoever is providing the service during the affected quarter, regardless of position of the health personnel in the facility. Actual allocation should be an internal arrangement among all doctors in the facility ideally depending on relative proportion of services rendered

8. **If the PFP is large enough, can part of it be used as salary for an additional physician?**
   Salary to hire and retain a new physician must come from an allowable line item budget from the local government. The newly hired doctor however should be able to share with the 10% allocated for physician providers of Tsekap.

9. Where can we get payment for specialists that will interpret laboratory results in the facility?

If the physician is engaged on a regular basis, they can share in the 10% PFP. If they render specific health services (e.g. reading of ECG) only, their honorarium can be charged against the 80% PFP.

C. Taxation of the Professional Fee

1. How is the PF taxed?

The shift of the allocation from an honorarium to a PF is due to the principle of paying for services rendered. Following BIR rules, both PF and honorarium by nature has a corresponding tax levied on it. Tax on PF depends on job regularization and monthly income. Taxation is done per release of PFPR to the facility.

D. Compliance of LGUs

1. Can LGU workers who are not providing Tsekap services share in the PF allocation?

No. The 5% allocation is meant for non-professional health workers who are contributing to carrying out Tsekap services.

2. Will PhilHealth still require a trust fund? Is one or many required?

Yes, a trust fund is required for government providers.Only one trust fund is needed per LGU, a sub-ledger may be created for related benefits like MCP/NCP or TB-DOTS package.

3. Why does PFP pass through trust fund and instead of going directly to the RHU?

Government health facilities such as RHUs have no legal entities and are owned by the LGU. LGU receives payment in behalf of the provider, provides a receipt back to PhilHealth, and keeps the said amount in a Trust Fund. The trust fund ensures that PFP released for Tsekap shall only be used for Tsekap allowed allocations.

4. Can LGUs modify the PFP disposition and allocation guidelines?

Participation for the Tsekap benefit is voluntary, and participants are asked to sign aPerformance Commitment with PhilHealth indicating that they shall carry out services as described in the package. Because of this, local guidelines should follow or supplement (and not contradict) PhilHealth policy. Violation of Performance Commitment has corresponding remedies in line with the IRR of NHIA of 2013.Local COA are also expected to monitor expenditures of the LGU according to law.

E. 80% PFP

1. Can we use the 80% PFP (Tsekap) to fund Nutrition Program? Vehicle?

Tsekap payments should be used for expenditures that directly impact provision of Tsekap services. Preventive activities to promote health of the enlisted members are encouraged. Big purchases are allowed as long as it is from savings from the previous year. This is to ensure that the Tsekap services to be given will not be compromised due to lack of operating fund.

2. **Can we use 80% PFP to fund conventions (capacity building)?**
   Yes, as long as the topics are directly related to provision of Tsekap services.

3. **Can we use the 80% PFP to purchase laboratory machines? Dental equipment?**
   Yes. These are allowed expenses as stated in the circular.

4. **Can we use 80% PFP to enroll new members?**
   No. PFP is for Tsekap services and not enrollment of members. Do encourage your LGUs to invest in enrolling sponsored members using their health budgets. In enrolling indigents, verify first with the nearest LHIO if the prospective enrollee is really not yet a member of PhilHealth. The National Government has sponsored indigents through the Sin Taxes, the prospect enrollee may already be covered.

5. **What is the maximum laboratory fee per patient? Payment for dental services?**
   The recommended range of laboratory fees that Tsekap providers can use to negotiate with their partner laboratories are available in the Circular. Dental services may be outsourced and placed as part of the MOA or provided in-house wherein professional fees are taken from the sharing allocation. Laboratory and dental services are part of the Tsekap bundle of services and are not regarded as stand-alone. The cost is already covered in the capitation.

6. **What if PhilHealth payment is not enough to pay outside labs?**
   PFP payment should be pooled to pay for all services that are part of the Tsekap package. Judicious use diagnostic tests and price negotiation with the referral facility is encouraged to avoid these instances. In case payment for referred services is large, the provider may tap on funds for the next quarter, savings from previous quarters, or health budgets of the LGU counterpart. Accredited Tsekap providers must provide all necessary services to their enlisted members, and non-compliance will be monitored.

7. **Is the budget for medicine not anymore included in the 80% PFP?**
   Yes. Drugs and medicines included in the Tsekap Package shall be released and paid for in drugstores only starting 2015. However, those who are retained as PCB1 providers shall continue to be paid as PCB1.

F. Payment for Drugs

1. **Why are prices for medicine reimbursements too low?**
   Prices were based on costing analysis by DOH-NCPAM using drug price reference index plus 30% mark-up. Initial response from drug stores is that prices are workable.

2. **Will there be uniform pricing of meds nationwide? How about for GIDA areas where there are extra costs in handling and transporting medicines.**
   Yes, uniform prices based on Drug Price Reference Index. LGUs are encouraged to support transport of medicines and services to GIDA areas through their local health programs.

3. **What will happen to the PHP 1000 for the drugstores if the family did not avail of it? What will happen to the PHP 1000 if there is no drugstore in the area?**

The PHP 1000 was derived as an indicative figure in costing drug benefits for the entire population. For each eligible Tsekap family a P1000 is alloted for pooling. This pooled fund shall used to pay for all the drugs dispensed through Tsekap nationwide. Drugs/Medicines are paid directly to accredited drug outlets.

Timeliness of Payment

1. **What are the requirements for PFP payment for Tsekap providers?**
   The Tsekap provider need to ensure that medical records of Tsekap beneficiaries are encoded in their respective Electronic Medical Records. PFP will be computed quarterly using encoded data on enlisted and profiled members that are submitted to PhilHealth.

2. **What are the requirements for payment of Tsekap drug outlets?**
   Drug outlets are expected to submit eletronic files of Statement of Account and proof of claim of medications (signature logbook) to the LHIO/PRO every month. This will be cross-referenced to the e-prescriptions in the PhilHealth database.

3. **How long does it take for the PF to be given to the healthcare providers?**
   The target is to release payment within 30 days after completed quarter for providers and 30 days after submission of billing statement for drug outlets. Non-release of PFP signifies potential issues in the electronic submission done by the provider.

4. **Can you make guidelines on the specific time period to release reimbursement of PhilHealth from LGU to health workers?**
   Payment to LGU workers is at the discretion of the LGUs and should be handled locally. Non-payment of PF is a violation of Performance Commitment.

G. Others

1. **What is the role of COA in utilization of funds?**
   COA is not expected to interfere with fund utilization, as this should be the discretion of LCEs and MHOs. But, LGUs expenses are audited by their local COAs and these expenses are expected to comply with policies regarding Tsekap.

2. **Why not pay based on health outcomes rather than profiling?**
   Due to the new requirements of the Tsekap benefit and the goal of expanding coverage to providers who still need to be trained on EMR system, leeway for adaptation to the learning curve was placed in the initial year. Thus for 2015, PhilHealth will pay only on the basis of enlistment and profiling. But when the providers adjust with the system in place, we will eventually gear towards paying on the basis of health outcomes.

V. Connectivity

A. Interoperability and Use of the portal

1. **What if we don't have an EMR yet?**
   Tsekap providers may opt to avail of the PhilHealth portal or any PhilHealth certified EMR prior to application to be a TSeKaP provider.

2. **How do we choose among available EMRs?**
   Choosing an EMR should depend on needs, resources and infrastructure inside the health facility. There is a data standard common to all EMRs certified by DOH-PhilHealth and only the user interface (UI) and workflow is different. You may ask for a demo to see how each is used from the different EMR providers. This also depends on your connectivity to the internet. If you anticipate that you will be mostly offline, choose a provider with offline capability.

3. **Can we have more than one EMR?**
   It is recommended to have only one EMR for Tsekap to facilitate payment and monitoring. It is not practical to have more than one EMR because it performs basically the same function. The choice is up to the health facility to select which EMR they think is applicable to them.

4. **What if we have another EMR that is not yet PhilHealth-certified?**
   The EMR you use has to be certified by PhilHealth for interoperability for Tsekap use. You may contact PhilHealth for the process of certification.

5. **Is the online connection mandatory?**
   For some EMRs like the HCI Portal, stable internet connection is necessary. Other EMRs have offline capability. However, internet connectivity is still needed from time to time to sync with and upload data to the portal.

6. **Is the EMR connected to FHSIS and PIDSR also?**
   At this point, the EMR is not yet connected to FHSIS and PIDSR. But, this may be integrated in the future under the Philippine Health Information Exchange.

7. **Are EMRs free? How much will it cost to have an EMR?**
   EMRs offered by PhilHealth (HCI Portal) and DOH (iClinicSys) are free. Other EMRs are free for the meantime since it is under study. In the future, providers might be required to pay amount for the continuing subscription which can be charged against your capitation.

8. **Can we use the portal simultaneously from different facilities? (For example, multiple BHS under one RHU and only the RHU is accredited.)**
   Yes, if there are multiple computers connected to each other locally and the centralized data is on local server at RHU. User accounts shall be issued separately by PhilHealth for each facility.

9. **Once encoded in the iClinicsys, does it still need to be encoded in the PhilHealth portal?**
   No. Once encoded in one system there is no need to encode it on the other. If you are using iClinicsys, there is no need to use PhilHealth portal just to comply for Tsekap. Non-Philhealth members can be encoded in the PhilHealth portal.

10. **Will EMRs be available also to private facilities?**
    Yes. Providers may contact PhilHealth or the other accredited EMR providers for their application process.

11. Will PhilHealth provide an installer for the HCI portal?

For the PhilHealth HCI Portal, onsite help in the installation is not necessary since it is a web based application. PHIC will provided digital certificates for interested parties and this will used for encryption purposes. If the RHUs request other EMR providers, the developers/EMR provider will provide the needed support.

12. Who will set up the IT connection between the providers and the drug outlets?

PhilHealth system will be the conduit between transactions from the providers to drug outlets.

B. Encoding and Uploading issues

1. If a patient cannot be found in the system, what shall we do?

If the patient is eligible for Tsekap but is not encoded in the system, the provider should coordinate with the LHIO to update membership information.

2. Can you enter data wherever you are?

This depends on the EMR chosen. Some EMRs can use mobile data through tablet, cellphone or laptop or save offline first then sync when there is internet connection.

3. Can we input data at a different time from the point of patient encounter?

Yes, as long as the EMR has an offline capability. It is recommended that the uploading be done in a regular basis. Providers may opt to input it at their own pace. However, providers shall only be paid based on data encoded and uploaded before the cut-off time.

4. How do we edit data previously entered?

Editing the profile such as the medical history, assessment and management may be done using the EMR. Editing membership information such as name, birthday, dependents, PIN cannot be done in the system. For these cases, providers should report to PRO with a properly filled up PMRF, to be adjusted by MMG.

5. What if there are multiple PINs because of incorrect name spelling but the patient is the same person?

The member should be instructed to go to the PhilHealth office for their record to be corrected.

6. What would happen to data when member is not a dependent anymore?

Once member lose eligibility to be a dependent, they are automatically delisted and have to enroll as primary member in the LHIO. Their data (previous history) would still be present in the EMR.

7. Can we hire IT encoder?

You can contract IT encoders for the duration of encoding depending on how many will be encoded. Since providers will be using EMR, it is more practical that encoding is done by the appropriate health personnel. The 80% of PFP of government providers can be used for short-term engagement of for encoders. Salary for hiring of staff cannot be sourced from PHIC PFP, only honoraria payment for outsourced tasks related to Tsekap can be charged against the 80% PFP.

C. Generation of reports

1. Is reporting included in the system for Tsekap? Will PhilHealth be the one to cull out the report from the encoded data? Can the PMRF already be generated electronically?
Yes, this will be generated by the system automatically. There will be no need to submit a hard copy for these reports.

D. E-Prescription

1. Is the e-prescription already approved by the FDA?
Yes. The development of e-prescription during the pilot of PCB2 has already involved FDA. E-prescription is also allowed under the e-commerce law.

2. How can you ensure that the e-prescription really was from the physician?
There will be built-in encryption mechanism that will ensure the integrity of the e-prescription.

3. Is the synchronization between RHU/facility and the drugstore automatic?
As of now, the expectation is uni-directional information feed: from the provider to the pharmacy, to deliver the e-prescription. The drugstore will in turn inform PhilHealth that a prescription has been served. As of yet, there is no functionality for drugstores to report back to the provider.

4. How will the patient claim/ get the medications from the drugstores if there is no internet connection? How can a pharmacist dispense medicines if the internet connection is not accessible especially in remote areas?
The doctor may print the prescription which the patient has to show to the pharmacy. Providers are also encouraged to employ local solutions to their unique situations.

5. How can medical ethics and professionalism be observed in the practice of e-prescription?
The issuance of e-prescription will be governed by the E-commerce Act (RA 8792), the Generics Act (RA 6675), Cheaper Medicines Act (RA 9502) and the Pharmacy Law (RA 5291).

E. Privacy

1. Is the use of EMR legal?
Yes, this is legal under the e-commerce law.

2. What are the data privacy terms/mechanics? How can EMR ensure the privacy of the data installed?
PhilHealth and the Philippine Information Exchange treat data privacy seriously utilizing the best security technology in order to secure the system. Encryptions are incorporated into the systems to ensure only those with access can view the data. Providers are also asked to sign a Non-Disclosure Agreement upon using a PhilHealth certified EMR. Patient data forwarded to

drugstores will only contain name, medication type, dosage, etc. In addition, applicable privacy laws are guidelines to security implementation. The joint DOH-DOST-PhilHealth Privacy Guidelines Group is working together to create an IRR that is already for public hearing.

3. **Who can access the system?**
   Access to patient records will be limited to approved personnel during the application for access to the HCI Portal or EMR. These people shall sign a Non-Disclosure Agreement to ensure that access is guarded against improper use.

4. **What happens when data gets lost (corrupt files, virus, etc.)?**
   Since the data will be mostly situated using DOST system, there will be a back-up process and data will be safely retrieved.

F. Implementation

1. **Who will do the technical support for the HCI portal or other EMR?**
   There will be two types of support: one from the EMR provider and another from PhilHealth. A call center support will be set-up for PhilHealth provided IT system. Other EMRs will provide support for their respective EMR.

2. **How will capacity building and training go about for IT-related competencies needed for the implementation?**
   Trainings can be requested from PhilHealt and all other EMR providers depending on their set schedules.

3. **Is training for encoders shouldered by PhilHealth?**
   Philhealth will only cover the training for providers using HCI Portal. EMR of choice will provide training for their system. Government Tsekap providers can use part of 80% PFP for capacity building.

4. **What type of training is needed for their IT support personnel?**
   Basic IT course including use of internet and encoding will be sufficient. A training manual will be available for the system that will be deployed by PhilHealth and DOH.

5. **How much salary do we allot for our data encoders?**
   It is up to your discretion and decision if how much to pay encoders as honoraria.

G. Internet

1. **What are the solutions for areas without internet?**
   Neither PhilHealth nor any EMR has control over availability or speed of internet connection however we are attempting to negotiate in national service agreements with DOST. Providers may use the 80% PFP to pay for better internet services.

   Providers may also use EMR with an offline option. Providers just have to set a schedule to upload profiles in order to get be paid.

2. **What is the required minimum internet speed?**
   3 Mbps is sufficient as data will be mostly text files. A complete list of specs for IT requirement will be made available.

3. **What should we do if the internet service provider (ISP) does not allow the subscription to be named after RHU and only allows to have it named after individual people?**
   This should be settled with the LGU. They should be the one to subscribe to the telecommunication companies.

H. Resiliency

1. **What if there will be disasters or catastrophic events for example Yolanda typhoon? What will happen if devices are destroyed?**

   Once you uploaded it on your system, it will automatically be uploaded also in our portal, so if you need to have a copy of the data you owned, you can just download it from PhilHealth's database. Otherwise, PhilHealth may pay for PFP based on guidelines for fortuituous events (PhilHealth Circular 6 s. 2014. Sction III. B. 2.)

2. **Computer broke down after HCI was installed. What happened?**
   Once we install HCI, we're just going to install a digital certificate and it will run using the browser. Computer breakdown may have been caused by something else.

3. **System breakdown from virus intrusion**
   System is stable so very unlikely; possible computer break down, so facility should have back-up computer. May also partition storage into a data drive.

4. **What can we do in times of power outage?**
   In this setting, consider laptop and tablets rather than computers that will require uninterrupted power supply. Laptops and tablets are also less energy demanding. Also secure generator sets if possible. Providers can use their 80% PFP to purchase necessary equipment.