Republic of the Philippines
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PHILHEALTH CIRCULAR
No. 2016 - 0026

TO : ALL ACCREDITED HEALTH CARE PROVIDERS AND ALL OTHERSCONCERNED

SUBJECT : Health Care Provider Performance Assessment System (HCP PAS) *Revision 1*

I. RATIONALE

PhilHealth continues to implement reforms in member management, accreditation of health care providers and benefit payment. It is the Corporation's duty and responsibility to ensure that all accredited health care providers (HCPs) render accessible, safe, quality and affordable health care to beneficiaries that are covered by the National Health Insurance Program.

Consistent with the implementing rules of the 2013 National Health Insurance Act (RA 10606), PhilHealth shall strengthen the mechanisms to monitor the performance of accredited health care providers (HCPs), assess the outcomes of the services that they render and provide feedback to the *HCPs* as well as the public. Alongside the assessment of HCPs, PhilHealth shall establish the process to encourage better provision of care, *recognize best practices and provide* penalties and sanctions for *repeated violations of* PhilHealth rules and regulations.

* *Italicized parts of this issuance reflect the amendments and additional guidelines of the HCP PAS.*

II. OBJECTIVES

This policy aims to establish *guidelines* to monitor access to PhilHealth benefits, provision of quality health care and assurance of financial risk protection to all members.

Specifically, it intends to:

1. Establish the different tools to assess the performance of accredited *HCPs*;
2. Establish the performance indicators that will guide in the analysis and disposition of the output of the performance assessment;
3. Standardize the process of recording, reporting and analysing the performance of *HCPs*; and
4. Establish a feedback mechanism that will serve as a basis for evaluation and the recommendation/s on remedial measures or sanctions to accredited *HCPs*, whichever is applicable.

III. DEFINITION OF TERMS

1. ***Adverse Monitoring Findings*** - *performance of health care providers that shows deviations from PhilHealth policies and treatment protocols which may result to abuse or compromising the National Health Insurance Program (NHIP). These are identified during conduct of any of the monitoring activities prescribed by the Corporation.*

2. **Chart Review** – *a process of examining a medical record to determine the patient's information related, but not limited, to diagnosis, medical management, ICD-10 codes, etc.*

3. **Claims/services review and profiling** – *a process of reviewing filed claims retrieved from claims database, to establish the trends and to profile claims per HCP based on identified parameters such as volume per illness, length of hospital stay, and referrals, among others.*

4. **Feedback Mechanism** - *the process devised to inform both the Corporation and HCPs of the results of the performance monitoring and outcomes assessment processes. Part of the process is securing justification or explanation from the HCP for performance monitoring results that are inconsistent with PhilHealth policies including compliance to acceptable standards of quality and questionable/ unethical practices.*

5. **Field Validation** – *is the process of verifying the monitoring findings through the following activities:*

   a. *Facility inspection – an on-site visit to the HCP, announced or unannounced, to monitor and assess the compliance of health care institutions (HCIs) to their Performance Commitment and established standards of care;*

   b. *Domiciliary visits – conduct of patient/ beneficiary interview by visiting the member's/patient's residence or place of being.*

6. **Medical Validation through documentary and /or clinical chart review** - *a process of examining a medical record or any health facility document to determine the patient's information related, but not limited, to diagnosis, medical management, ICD-10 codes, etc.*

7. **Notice of Warning** – *a document which serves to inform an HCP of an apparent commission of an adverse monitoring finding of the NHIP.*

8. **Offense** - *any confirmed violation after due process as reflected in the revised IRR of RA 7875 amended by RA 10606.*

9. **Performance Commitment** – *a document signed by the health care provider who intend to participate in the program, which stipulate their undertakings to provide complete and quality services to PhilHealth members and their dependents, and their willingness to comply with PhilHealth policies on benefits payment, information technology, data management, and reporting and referral, among others.*

10. **Performance Monitoring Process** – *a systematic sequence of steps to evaluate accredited HCPs using the outcome indicators described in Annex A of this circular as guide to identify opportunities for improvement in health care delivery.*

11. **Positive monitoring findings** – *performance of health care providers that may either show 100% compliance to all PhilHealth policies and treatment protocols and/ or conduct of other mechanisms and innovations to promote the National Health Insurance Program (NHIP) and/ or protect it from abuse.*

12. **Questionable practice** – *practice patterns/ behavior of healthcare professionals that are found to be inconsistent with acceptable standards of quality and are not in accordance to the code of ethics set by a recognized healthcare professional body and/ or by the Professional Regulations Commission (PRC).*

13. **Red Flag** – *a tag used for HCPs with observed unusual practices that are not supportive of the National Health Insurance Program (NHIP) goals.*

IV. GENERAL GUIDELINES

1. The performance of *HCPs* shall be assessed using a set of indicators that will guide in the analysis and disposition of the output of the assessment. Core performance indicators shall be used to compare the performance of *HCPs* regardless of level or type of *HCI*. The set of *performance* indicators are grouped into the following four (4) domains (**Annex A**):

   a. Quality of Care
   b. Patient Satisfaction
   c. Financial Risk Protection (FRP)
   d. Fraud Detection

2. PhilHealth shall regularly monitor and assess the performance of accredited *HCPs*.

3. PhilHealth shall employ various tools in assessing the performance of accredited *HCPs*, such as, but not limited to the following:
   a. Medical Post-audit Module (MPAM)
   b. Mandatory Monthly Hospital Report (MMHR)
   c. Chart review
   d. Facility inspection
   e. Field validation
   f. Claims profiling or utilization review
   g. Domiciliary visits
   h. Patient exit surveys
   i. Relevant reports from internal and external stakeholders

4. Validation may be through facility *inspection*, *domiciliary visits*, review of facility reports, and/*or* chart review. Any validated *adverse monitoring finding* shall be *referred* to as *an adverse monitoring finding.*

5. The performance assessment process encourages *HCPs* to improve performance. As such, *the HCP shall be informed of any identified poor performance, adverse monitoring finding or administrative offense for corrective measure/s.*

6. *The Health Care Institutions (HCIs)* shall ensure that their affiliated health care professionals perform according to the Performance Commitment *(PC)* that they have signed. *The HCI shall be informed of any breach of PC committed by health care professionals affiliated with it and the case* may be taken against the facility.

7. All administrative offenses under the Implementing Rules and Regulations (IRR) of Republic Act (RA) 7875 as amended by RA 10606 *are* covered by this policy.

8. All questionable/unethical practices as determined by the *Quality Assurance Group (QAG) through the Quality Assurance Committee (QAC) from validated adverse monitoring findings as identified in Title IV Rule II Sec 47-e of abovementioned IRR, and other violations relative to quality healthcare delivery are also covered by this policy.*

9. *The provider assessment period commenced for all benefit claims with admission/coverage dates, as applicable, starting* ***January 1, 2014****, and shall be done on a regular basis and whenever deemed necessary.*

V. SPECIFIC RULES

1. *Questionable/ unethical practices/ adverse monitoring findings may come from post audit reports and other monitoring tools including field observations, facility inspection, document review (claims & medical records), domiciliary visits, reports, members' and patients' complaints, or the claims database.*

2. *All adverse monitoring findings shall be validated by the Corporation.*

3. *PhilHealth shall provide feedback on all adverse monitoring findings to the concerned HCP. The concerned HCP shall be required to submit a notarized justification/ an explanation letter for any validated adverse monitoring finding within ten working days from receipt of the feedback.*

4. *Adverse monitoring findings not refuted by the concerned HCP shall result to an issuance of notice of warning (**Annex B**) by the Corporation.*

5. *In case of admissions beyond accredited bed capacity, a written explanation from the HCI or LCE shall be supported by the following:*

    a. *Certification from the Department of National Defense, its Local counterparts or the LGU for armed conflict areas*
    b. *Certification from the following government institutions for force majeure*
        i. *The National Disaster Risk Reduction & Management Council (NDRRMC) or*
        ii. *Local Government Unit*
    c. *Certification from Department of Health and/or Center for Health Development for disease epidemics/ endemic areas.*

6. *In cases of apparent and probable presence of irregularities and/or abuses of the NHIP, the Corporation may issue a temporary suspension of payment of claims for health care providers (HCPs) with pending further evaluation/ verification of the monitoring findings subject to the following conditions:*

    a. *The temporary suspension shall be effective upon receipt by the HCP of the notice of suspension.*
    b. *The temporary suspension shall apply to specific claims already in the possession of the Corporation, and payment has not been released, including those still for submission after the effectivity of the temporary suspension of payment.*
    c. *All benefit claims subject to further verification shall no longer fall within the usual sixty (60) days processing period.*
    d. *If a health care professional is involved, specific claims in all of his/ her affiliated HCIs shall likewise be subject to temporary suspension.*
    e. *The HCP shall continue to provide PhilHealth benefit to qualified beneficiaries for the entire duration of said suspension order.*
    f. *The concerned HCP shall be given feedback on all validated reports within ten (10) calendar days from completion of validation. In case of adverse monitoring findings, the HCP shall submit an explanation/justification within ten (10) working days from receipt of the feedback from PhilHealth.*
    g. *Upon establishment that patterns of abuse and other monitoring issues that warranted the Suspension Order are no longer present, the order of temporary suspension shall be lifted accordingly.*
    h. *The suspension shall not exceed one hundred twenty (120) calendar days.*
    i. *Upon determination of the presence or existence of irregularities and/or abuse, the concerned PhilHealth Regional Office (PRO) may similarly opt to deny payment of claims in lieu of a Suspension Order. HCPs may file an appeal on the denial of claims within sixty (60) calendar days to the PRO from receipt of the written notice of the denial of payment of benefit claim.*
    j. *HCPs with adverse monitoring findings and served a suspension of payment of claims shall be subject to probationary accreditation for six (6) months. In case the remaining accreditation period is less than 6 months, the probationary accreditation shall extend to the next accreditation period.*

VI. MONITORING TOOLS

MONITORING TOOL	OBJECTIVE	FREQUENCY OF DATA COLLECTION
PRIMARY TOOLS		
1. Claims/services profiling	To determine the benefit claim characteristics of the health care providers	Quarterly
2. Mandatory Monthly HCI Report (MMHR) review	To determine the profile of HCPs in terms of patient load, bed occupancy rate and health service delivery through review of such reports.	Monthly
3. Medical audit	To determine the compliance of accredited HCPs to standards of care and PhilHealth policies	Daily
4. PhilHealth Patient Exit Survey (No Balance Billing and Case rates)	To determine the compliance of accredited HCPs to PhilHealth policies on No Balance Billing (quality of care and co-pay) and all case rates payment mechanism (benefit awareness, benefit utilization and co-pay) and determine which areas need improvement.	Daily
5. *Primary Care Benefit 1* (PCB1) Client Exit Survey	To obtain feedback from members on the benefit awareness, quality, financial risk protection and satisfaction on services provided by accredited PCB1 and/or TSeKaP providers as part of the system of outcomes assessment.	Annually
6. Member complaints	To evaluate the performance of HCPs based on member/patient complaints and address the concern accordingly.	As reported
7. Facility visits/ *inspection*	To validate the compliance of accredited HCPs to PhilHealth policies and standards of care, as well as to assess health outcomes using facility reports (eg. DOH reports, Morbidity/Mortality Reports, Infection Control Reports) For NBB compliance, review of financial statement vs. PhilHealth benefit applied	Annually or whenever necessary
SECONDARY TOOLS		
1. Chart Review	To validate the compliance of accredited HCPs to standards of care and PhilHealth policies as well as to assess health outcomes.	Whenever necessary
2. Field Validation	To validate initial monitoring findings as a result of claims profiling, medical audit, facility visits, surveys and member complaints.	Whenever necessary

VII. PROVIDER PERFORMANCE ASSESSMENT PROCESS

1. *The concerned PhilHealth offices shall conduct its monitoring functions in accordance with Section VI of this issuance.*

2. *Verified adverse monitoring findings due to lapses in the clinical management, which may be directly or indirectly adverse to a member/dependent-patient or contributory to a patient's death or permanent disability, upon issuance of the necessary warnings, shall be elevated to the appropriate regulatory body and/or provider organization such as, but not limited to, the Professional Regulations Commission (PRC), the Philippine Medical Association (PMA) or the Philippine Hospital Association, as applicable. The case shall also be forwarded to Legal Sector for appropriate action, if necessary.*

3. *All validated adverse monitoring findings regarding non-compliance to Statutory Laws, policies and other issuances shall be reported to the appropriate regulatory agency or provider organization.*

4. *All confirmed findings and for which warnings are issued shall be elevated to the Legal Sector for appropriate action and shall be tagged in the accreditation database for future reference.*

5. *The renewal of the accreditation of all HCPs with issues encountered during monitoring activities, including those involving the owners, members of its governing/ managing board, administrator or manager, shall be referred to the Accreditation Department for further evaluation and deliberation.*

VIII. ACTION ON ADVERSE MONITORING FINDINGS

1. *For verified adverse monitoring findings, corresponding warning shall be issued to the HCPs for immediate corrective actions.*

2. *An HCP shall be given up to two warnings for verified adverse monitoring findings. A third adverse finding shall be forwarded to the concerned PRO-Legal Services Unit, and, if found valid after due process, shall be considered an offense. If not valid, the monitoring finding shall not be counted.*

3. *Counting of adverse monitoring findings shall be based on the nature of the acts committed by the HCPs. The prescribed frequency of reporting shall be in accordance with Section VI of this Circular.*

IX. REPEALING CLAUSE

This Circular shall supersede PhilHealth Circular (PC) No. 031-2014 or the Health Care Provider Performance Assessment System (HCP PAS).

All other issuances inconsistent with this circular are hereby revised, modified or repealed accordingly.

X. EFFECTIVITY

This Circular shall take effect fifteen (15) days after publication in any newspaper of general circulation or in the Official Gazette with the National Administrative Register at the University of the Philippines Law Center.

RAMON F. ARISTOZA, JR.
OIC-President and CEO
EVP & COO
Date signed 8/12/16

MASTER DOCUMENT Date: 8/17/16

PERFORMANCE INDICATORS

ANNEX A

QUALITY OF CARE
1. Number of admitted patients with primary care sensitive cases
2. Number of patients who were given inappropriate *(irrational) drug use*
3. Number of patients who were given any of the drugs under Anti-Microbial Resistance Surveillance Program (ARSP) in non-ARSP-accredited facilities
4. Number of patients who were subjected to inappropriate diagnostic services/laboratory procedures
5. Complication rate in the following procedures: • Normal Spontaneous Delivery (NSD) • Cesarean Section (CS) • Dilatation and curettage (D and C) • Appendectomy • Thyroidectomy • Cataract extraction
6. Number of patients who experienced healthcare associated infections (HAIs) such as the following: • Bloodstream infections related to central catheter use • Urinary tract infections related to catheter use • Respiratory infections from mechanical ventilators and artificial airways • Surgical site infections • Drug resistant infections • Emerging infections
7. Annual Net Death Rate
8. Referral rate for caesarian section
9. Occurrence of bed sharing among sponsored members
10. Bed occupancy rate
11. Bed turn-over rate

PATIENT SATISFACTION
1. Number of validated member or patient complaints on medical and/or administrative management *(To determine any particular problems noted by members and/or patients)*
2. Number of patients satisfied with health care services *(To determine the level of satisfaction with health care services)*
3. Number of patients satisfied with childbirth-related care *(To determine the level of satisfaction with childbirth-related care)*

FINANCIAL RISK PROTECTION
1. Number of NBB patients with co-pay *(To determine compliance to NBB policy)*
2. Number of hospital claims with attached official receipts for drgus and medicines bought by PhilHealth members and/or dependents "out-of-pocket *(To determine which hospitals do not give the full benefits due to PhilHealth members)*
3. Number of members with directly filed claims from non-accredited facilities due to emergency *(To determine number of directly filed claims in non-accredited facilities due to emergency)*
4. Number of claims with under-deduction of case rates *(To determine HCPs that under-deduct benefits of members)*
5. Compliance to fixed-co pay for Z benefits
6. Compliance to service capability
7. *Presence of a* trust fund account intended for PhilHealth reimbursements in LGU-owned facilities.

1. Multiple admissions of members or dependents for different case illnesses within 90 days
2. Number of referred cases from MCP providers that were refused by receiving HCP
3. Number of patients with unjustified use of non-PNF drug(s)* *Note: This indicator shall be applied in govt hospitals only.*

*PNF - Philippine National Formulary

ANNEX B

Republic of the Philippines
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Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

NOTICE OF 1st/2nd WARNING
(sample template)

Date: _____

Name of Head of Facility/Name of Professional
Name of Facility
Address

Dear _____,

As an accredited healthcare provider, we urge you to strictly abide by your Performance Commitment. PhilHealth will continue to conduct its mandate of monitoring performance to ensure that all participating healthcare providers to the National Health Insurance Program are responsible and accountable in all their dealings with the Corporation and its members.

Based on the validation of your performance as an accredited Health Care Provider for the period _____, the following violations were noted:

1. *(Ex.) Unjustified admissions beyond accredited bed capacity*
2. *(Ex.) Unjustified prescription of a non-PNF drug*

This is to inform you that this serves as your 1st/2nd warning.

Thank you.

Very truly yours,

_____
Regional Vice President