



Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

BUSINESS PROCESS REVIEW

FINAL REPORT

December 2002

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BUSINESS PROCESS REVIEW FINAL REPORT

PROJECT BACKGROUND

The Philippine Health Insurance Corporation (Philhealth) undertook a Business Process Review (BPR) of its core business processes to build stronger, dynamic, and effective processes. The initiative was undertaken in support of the Health Sector Reform Agenda and the National Health Insurance Program as embodied in R.A. 7875, and to enhance the provision of health insurance services at the national and local levels. Philhealth's core processes include:

- Manage membership and members relations
- Manage member contributions and collections
- Deliver and manage benefits
- Manage health care provider relations (Accreditation and Quality Assurance)

The project was undertaken with the assistance of the Management Sciences for Health (MSH) under its Health Sector Reform Technical Assistance Project (HSRTAP).

The Business Process Review was envisioned to be the first phase of the overall transformation project for PhilHealth.

Figure 1
PhilHealth Transformation Program



PROJECT SCOPE

The study was divided into two (2) components:

- Operational Assessment
 - Validation, confirmation, and review of current business processes and the related policies and guidelines
 - Identification of key performance indicators



- Conduct of business process impact analysis and identification of process issues
- Identification of issues arising from process assessment that will be input to technology assessment
- “To Be” Process Design and Development
 - Redesign of the “ideal” processes, based on the approved recommendations
 - Development of the Operations Manual
 - Development of a Communications Plan

PROJECT APPROACH AND METHODOLOGY

A participative approach was followed in the conduct of the project. Broad-based participation was obtained through interviews, focused group discussions (FGDs), process walkthroughs and brainstorming sessions. The following activities were undertaken to accomplish the project deliverables:

Figure 2
Project Methodology

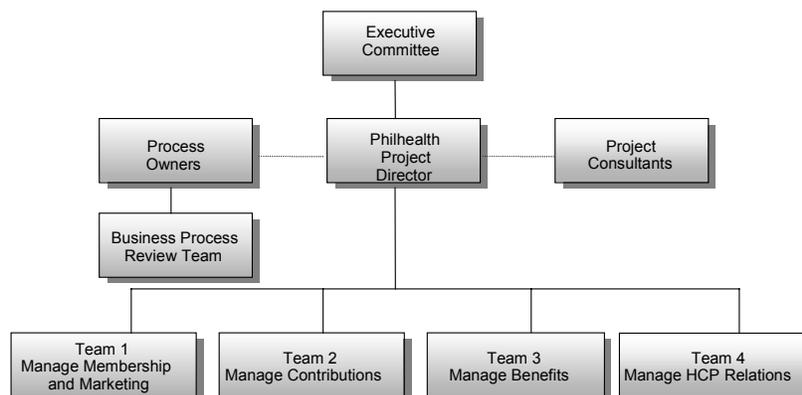


A total of 9 interviews were conducted with PhilHealth executives. A total of 123 employees representing 9 PROs and 8 CO units participated in the FGDs.

PROJECT ORGANIZATION

In line with the participative approach, a project organization mainly composed of key PhilHealth executives and staff was created and mobilized to manage project scope, resources, schedule, issues, and risks. Detailed description of project organization is shown in *Appendix A*.

Figure 3
Project Organization



BUSINESS PROCESS REVIEW GUIDING PRINCIPLES

In reviewing the core processes and developing recommendations, key process excellence guiding principles were adopted:

Figure 4
Process Excellence Principles

- Value maximization and elimination of waste
- Design documentation
- Simple yet flexible design
- Time Compression
- Real-time feedback
- Clear links to other processes
- Customer-focused and user-friendly
 - Single consistent point of contact
 - Complete transactions in one event
 - Increase access and convenience
 - Simplify --- eliminate or reduce paperwork



Process Excellence

A state in which an organization achieves superior business performance from superior processes within an enabling environment.

- Actively owned and managed
- Measured
- Supported by technology
- Performed by people who are trained in the process

OPERATIONS ASSESSMENT RESULTS

PhiHealth can immediately benefit from the Business Process Review by implementing 'quick-wins' within the next 1 to 3 months. These quick-wins are in the areas of:

- Process streamlining and forms simplifications
- Control mechanism
- Policy clarifications
- Organizational roles delineation

In the medium- and long-term, PhilHealth can implement innovative ideas in the way it approaches and conducts its business, which can have far-reaching impact in the long-term direction of the organization.

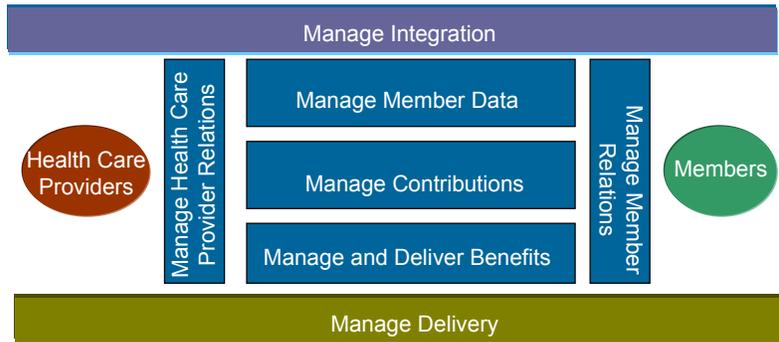
- *Redefine* organizational strategy
- *Refocus* policy and organizational roles
- *Realign* process, technology, and people to organizational strategy.

The detailed results are summarized in a matrix shown in *Appendices B to E*. The matrix shows the findings and recommendations, classified into quick-wins, medium-term and long-term. The matrix also shows the comments and feedback gathered from the process owners and business process review team on the findings and recommendations.



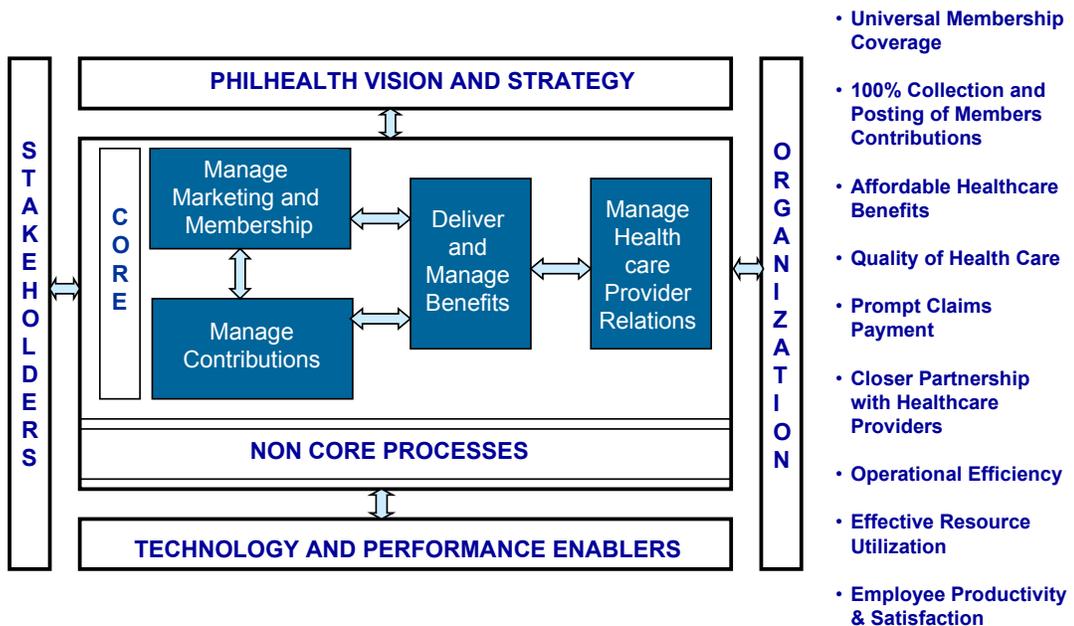
The proposed organization framework integrates the findings and recommendations into a cohesive model, which lays the foundation for strengthened customer relationship management coupled by process excellence in backroom operations to create tremendous opportunities for value optimization and customer satisfaction.

Figure 5
Proposed Organization Framework



The Business Integration Framework encapsulates the required alignment of key components of PhilHealth business such as processes, people and technology with the organization strategy to achieve its goals and objectives.

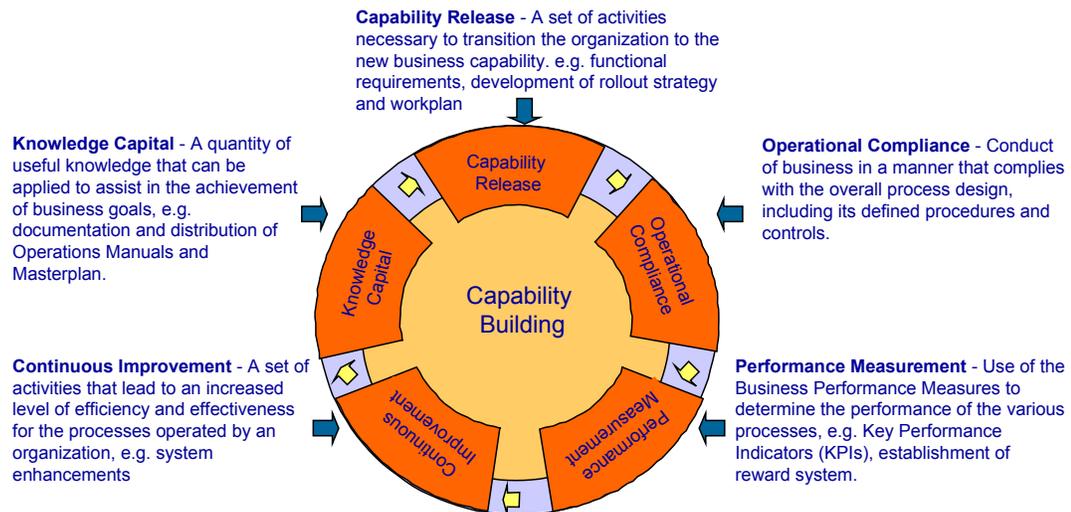
Figure 6
Business Integration Framework



IMPLEMENTATION GUIDELINES

The process owners should be responsible for implementing the recommendations. The model illustrates the various areas of process owner's accountabilities.

Figure 7
Process Owner Model



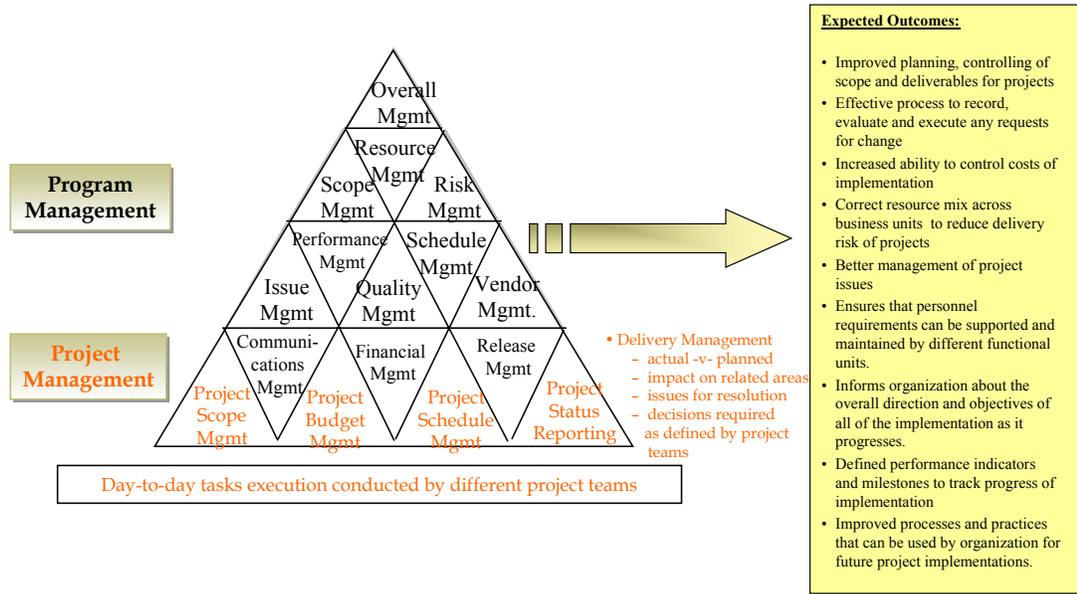
Effective sponsorship is very critical in ensuring successful implementation of the recommendations. An effective sponsor has the following characteristics:

- Power to legitimize the change
- Sufficient degree of pain with the status quo
- Clear definition of what change must occur
- Dedicate the resources to 'make it happen'
- Publicly demonstrates and support the change
- Privately convey strong personal support
- Communicate consistently and frequently
- Make sacrifices for the change implementation



If PhilHealth decides to pursue the larger transformation program, of which BPR is just the initial phase, an umbrella Program Management Office should be created to manage the entire program.

Figure 8
Program Management Office



The proposed Implementation Plan is shown in *Appendix F*. The proposed Communication Plan is shown in *Appendix G*.



APPENDIX A

BUSINESS PROCESS REVIEW

PROJECT ORGANIZATION



BUSINESS PROCESS REVIEW PROJECT ORGANIZATION

EXECUTIVE COMMITTEE

Members	Roles
Philhealth Executive Team	<ul style="list-style-type: none"> ▪ Provide overall project direction ▪ Decide on process, policy, and organizational issues that cannot be resolved at the project team level ▪ Approve project team recommendations and endorse the same to the Board

PROJECT DIRECTORS

Project Directors	Roles
<ul style="list-style-type: none"> • Mr. Ruben John A. Basa Manager, Corporate Planning 	<ul style="list-style-type: none"> • Ensure that project objectives are clear to the entire project team • Monitor project progress to ensure target schedules are met • Ensure project outputs are in accordance with management expectations and quality standards; participate in validation meetings • Resolve project issues that do not require PSC attention.
<ul style="list-style-type: none"> • Dr. Shirley B. Domingo Manager, Human Resources 	

PROCESS OWNERS

Process	Process Owners	Roles
Manage Marketing and Membership	<ul style="list-style-type: none"> • VP Rodolfo Balog • VP Val S. Valilla 	<ul style="list-style-type: none"> • Champions the process change, involves and supports the people to support the new capability • Communicates changes in , processes, responsibilities, and roles • Establishes key performance indicators • Resolves issues
Manage Contributions	<ul style="list-style-type: none"> • VP Mr. Gregorio Rulloda 	
Deliver and Manage Benefits	<ul style="list-style-type: none"> • DM Leticia Portugal, • Dr. Narisa Sugay 	
Manage Healthcare Provider Relations	<ul style="list-style-type: none"> • VP Eduardo Banzon 	



BUSINESS PROCESS REVIEW TEAM (CONTENT EXPERTS)

Process	Members	Roles
Manage Marketing and Membership	<ul style="list-style-type: none"> • Lolita Tullao • Lemuel Untalan • Delio Aseron • Myrna Godelosao • Edward Quilala 	<ul style="list-style-type: none"> • Serve as subject matter resource involving their respective processes, areas of responsibility, or expertise • Conduct first-line review of the project team's deliverables, in coordination with the Process Owners
Manage Contributions	<ul style="list-style-type: none"> • Rodolfo del Rosario, Jr. • Ellen Herrera 	
Deliver and Manage Benefits	<ul style="list-style-type: none"> • Dr. Narisa Sugay • Dr. Nenita Balbuena • Ms. Marilou Peredo 	
Manage Healthcare Providers Relations	<ul style="list-style-type: none"> • VP Madeleine Valera • Dr. Francisco Soria • Dr. Nelia D. Tanio 	

CONSULTANTS

Consultants	Roles
Vlademer B. Ferreras Project Manager	<ul style="list-style-type: none"> • In coordination with the Philhealth Project Co-Directors : • Manage day-to-day activities, schedules, and resources of the project team • Manage project issues, problems, and risks • Ensure submission of complete and quality deliverables • Act as liaison between the Project Team and the Project Steering Committee • Participate in Project Steering Committee meetings
Susan C. Niles	<ul style="list-style-type: none"> • Assist the Project Manager in the conduct of the day-to-day project management requirements • Assist the Project Teams in performing the project tasks and activities and preparing the deliverables



PROJECT TEAM

Process	Members	Roles
Manage member relations	<ul style="list-style-type: none"> Gilda Salvacion A. Diaz Josefina Q Dela Cuadra Helena Ruby Hernandez 	<ul style="list-style-type: none"> Perform the assigned project tasks and activities Prepare and submit the project outputs and deliverables, as scheduled
Manage membership	<ul style="list-style-type: none"> Gilda Salvacion A. Diaz Josefina Q Dela Cuadra Helena Ruby Hernandez 	
Manage member contributions and collections	<ul style="list-style-type: none"> Bonifacio P. Hagoriles, Jr. Susan Rebecca B. Romero 	
Deliver and manage benefits	<ul style="list-style-type: none"> Jennifer F. Enriquez Fernando Antonio 	
Manage healthcare provider relations	<ul style="list-style-type: none"> Maila O. Pascua Nadine Navarro 	



APPENDIX B

SUMMARY OF FINDINGS AND RECOMMENDATIONS

MANAGE MEMBERSHIP



Business Process Review Summary of Findings and Recommendations

Manage Membership Process

Findings	Recommendations	Comments
<p>1) Marketing strategies, processes, organization and role delineation are not clearly defined and/or communicated among key stakeholders of the marketing program. This results in potential confusion and uncoordinated, unsynchronized and redundant effort.</p> <ul style="list-style-type: none"> ➤ Overlap of functions between Corcom and NCR marketing in terms of conducting orientation sessions for the employed sectors. ➤ Unclear delineation of functions between Indigent marketing and contribution collections with respect to LGU premium collections; ➤ Unclear working or reporting relationship between Membership Program Management Group and the PROs (including the NCR Group): <ul style="list-style-type: none"> • Lack of uniform basic marketing strategies across PROs; • Weak knowledge sharing and management; success stories not shared or replicated; and • Lack of effective monitoring to assess marketing program effectiveness. ➤ Lack of training for marketing staff in the PRO. ➤ Insufficient marketing budget for some PROs, including the NCR, ➤ Marketing programs and strategies for self-employed and indigent sectors are not 	<p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • Establish and communicate clear marketing strategies, processes, organization and role delineation, Delineate functions between Program Management and PROs/NCR, Marketing and Corporate Communication, Marketing and Contribution Collections. • The Membership and Marketing Program Management Group should be the 'think-tank' arm of Operations for indigent, self-employed and employed sectors. Its responsibilities should include the following: <ul style="list-style-type: none"> ➤ Develop and identify integrated and effective marketing strategies for <u>all sectors</u> based on best practices as well as successful practices experienced by PROs. Implement a process where success stories are shared and replicated with other offices. . <i>Please refer to Selected Marketing Practices – PROs (Exhibit 1).</i> ➤ Define the performance standards and benchmark. ➤ Develop the rollout plan including the timeframe of implementation and determine the resource requirements (e.g., manpower, equipment and materials). Facilitate budgeting of the resource requirements based on unique needs of the PRO. ➤ Conduct pilot test for critical and massive rollout of initiatives; improve and refine the strategy based on results of the pilot test. 	<ul style="list-style-type: none"> • As much as possible, marketing efforts in the regions should be synchronized. For example, a marketing effort with a unified or common message can be undertaken simultaneously across all PROs for a given quarter, under close monitoring by the Program Management Group • Include during operational planning some discussions or brainstorming session on marketing practices that would be identified and undertaken per quarter for the succeeding year. • Strengthen HRD which should provide technical expertise in: <ul style="list-style-type: none"> ➤ translating the module / content into an effective training program ➤ developing and certifying trainers who will be capable of transferring the technology • Determine the advantage/ disadvantages of training budget under HRD. • There is a need to have a written PhilHealth Communication Plan.



**Business Process Review
Summary of Findings and Recommendations**

Manage Membership Process

Findings	Recommendations	Comments
<p>employed and indigent sectors are not integrated; Marketing programs and strategies for employed sector are not well established.</p> <ul style="list-style-type: none"> ➤ Marketing initiatives are not subjected to a pilot test before actual rollout. 	<ul style="list-style-type: none"> ➤ Provide performance support tools to PRO marketing staff, such as manual of procedures, job aids and guidelines. Coordinate training of staff with HRD. ➤ Coordinate with the Corporate Communications Department for nationwide tri-media campaign catering to general audience. ➤ Monitor implementation of marketing program and strategies; continuously gather feedback on program effectiveness; institute continuous program improvement. • The PROs and the NCR Group, as program implementers, should translate broad marketing program guidelines and strategies into specific and actionable activities. Its responsibilities include; <ul style="list-style-type: none"> ➤ Conduct of tri-media/information and education campaign at the local level (covering all sectors); ➤ Share effective and practical marketing strategies with other PROs. 	
<p>2) The self-employed and indigent programs are experiencing high 'drop-out' rates due to the following reasons:</p> <ul style="list-style-type: none"> ➤ Weak after sales service or follow-through: <ul style="list-style-type: none"> • Marketing focuses on initial enrollment but very lax on renewals; • Lack of manpower support; difficult to market or conduct follow through with self- 	<p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • Implement 'account management' approach where equal attention shall be given to after sales service or follow-through. The account management team shall serve as the single point of contact with the members to address wide range of member needs and concerns. <ul style="list-style-type: none"> ➤ A competent full-time PhilHealth employee shall lead the account management team, which 	<ul style="list-style-type: none"> • There is need to establish baseline data to generate statistics on drop out rates among self employed and indigent programs • Legislating automatic appropriation of IRA for NHIP cannot be realistically achieved.

Business Process Review Summary of Findings and Recommendations

Manage Membership Process

Findings	Recommendations	Comments
<p>employed sector due to unusual working hours;</p> <ul style="list-style-type: none"> • Lack of feedback mechanism. <p>➤ Some members experience problems in complying with payment: (refer to Manage Contributions):</p> <ul style="list-style-type: none"> • Payment centers not accessible; • Preference to pay monthly rather than quarterly. <p>➤ Difficulty to sustain LGU continuing support for indigent program:</p> <ul style="list-style-type: none"> • Lack of sufficient funding for indigent; • Low utilization rate of indigent; • Existence of other LGU health programs; • Lack of appreciation/ awareness/ knowledge of program's importance. 	<p>include qualified and trained external marketing agents as members (example: health volunteers for community campaign). Key responsibilities of the team shall include:</p> <ul style="list-style-type: none"> – Acquiring members (defining target market, profiling LGU, etc); – Keeping and retaining members; addressing account problems and issues; conducting information and education campaign; – Follow-up and close monitoring of accounts particularly problematic accounts (preparation of billing statements should be done by Contribution Collections); – Growing membership base. <p>➤ Key performance indicators will include number of members/employer/LGU registered, percentage of accounts paying, issue resolution and account satisfaction.</p> <p>➤ Effective incentive schemes for external agents may include payment of commission based on collections (contribution process should be designed to allow tracking of collections by agent).</p> <ul style="list-style-type: none"> • Work with legislatures to legislate automatic appropriation of IRA for NHIP to ensure continuing LGU participation in the indigent program. • Continue upgrading benefit package within the bounds of actuarial feasibility. For example: 	

**Business Process Review
Summary of Findings and Recommendations**

Manage Membership Process

Findings	Recommendations	Comments
	<ul style="list-style-type: none"> ➤ Implement no or fixed co-payment schemes for indigent; ➤ Expand outpatient benefits. 	
<p>3) The current process of identifying indigents through the means test is not entirely reliable.</p> <ul style="list-style-type: none"> ➤ No mechanism to validate information provided by indigent family. ➤ Indigent program becomes a political tool by local government officials; <ul style="list-style-type: none"> • Covering the poorest of the population may not be entirely achieved; • Political accommodation increases probability that non-indigent members are included. 	<p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • Strengthen and improve the means testing process aimed at identifying 'true' indigents. <ul style="list-style-type: none"> ➤ Include proxy indicators in the Family Data Survey Form (FDSF) such as type of house, access to safe drinking water/electricity, etc.; ➤ Implement control mechanisms to ensure compliance by the LGU to means testing guidelines and criteria. <ul style="list-style-type: none"> – Randomly inspect using proven statistical techniques the indigents information (actual visit, check with available data) based on an audit plan; – Tap marketing agents to conduct the spot/random checking; – As much as possible, strictly enforce results of means test; • Continue tapping religious/civic organizations/NGOs for sponsorship of indigents. 	<ul style="list-style-type: none"> • Tap barangay volunteers to conduct the spot/random checking • The PMG has on-going study on validation of proxy indicators, which will be presented to Execom for approval before the pilot testing.
<p>4) Lack of proactive and integrated effort to strengthen linkages with other government agencies (such as SSS, SEC, DTI) to establish reliable, consistent, adequate data on target membership base and identify unregistered employers.</p>	<p><u>Quick-Win</u></p> <ul style="list-style-type: none"> • Pursue top level inter-agency collaboration to share information/data among the following agencies: 	<ul style="list-style-type: none"> • Can also utilize LGU data on employers securing business permit • Cross matching the data from SSS, SEC, DTI, LGU is already being done; however,



**Business Process Review
Summary of Findings and Recommendations**

Manage Membership Process

Findings	Recommendations	Comments
<p>identify unregistered employers.</p> <ul style="list-style-type: none"> ➤ Large chunk of private sector not yet accounted for; ➤ Lack of appreciation of the value of data from other government agencies; ➤ Without clear definition of the target market base, difficult to measure success of coverage effort and gauge potential gaps. 	<ul style="list-style-type: none"> ➤ SSS – Employers, members and dependents data ➤ SEC – Employers data ➤ DTI – Employers data ➤ BIR – Employers, members; and salary data (annual alpha list) ➤ NSO – Potential IPM and IPP data ➤ GSIS – Gov't. agencies, members and dependents data <ul style="list-style-type: none"> • Based on the data, develop a master list of unregistered employers. Actively use the list to help prioritize, plan, and manage the marketing effort. <i>Please refer to Unregistered Employers Monitoring Worksheet (Exhibit 2).</i> 	<p>problem arises when employers change business address/contact numbers.</p> <ul style="list-style-type: none"> • Mapping is important in marketing. Later on, critical is the Geographic Information System (GIS) that can be applied to all sectors
<p>5) Incomplete and stand-alone membership databases in the Central Office and PROs result in processing inefficiencies and member inconvenience:</p> <ul style="list-style-type: none"> ➤ Most of the contributing employed members are not yet in the membership database. Thus, ID cards have not yet been issued. ➤ Member database cannot be entirely relied upon to establish member and dependents' eligibility because its not yet complete. Members need to repeatedly present supporting documents (such as birth certificate for dependents) each time claim is filed. ➤ Retirees need to resubmit supporting 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • To accelerate data capture and build up of employed member database, implement a well planned and managed effort to capture employed member data through the employers using the improved ER2. <i>Please refer to Revised ER2 Form (Exhibit 3):</i> ➤ If possible, the form should be pre-filled out – available information known to PhilHealth should be supplied in the form. Thus, employers shall only provide missing information (such as date of birth, address, and name of dependents). Employees who already have PNC need not be included in the form. 	<ul style="list-style-type: none"> • If the proposed revised ER2 is implemented, the following should be taken into consideration: <ul style="list-style-type: none"> ➤ marketing approach with big companies / employers – how to sell the idea to them. ➤ physical appearance of the form. There is also a need to ensure that the member-employee is certifying all the information reflected therein. ➤ best approach on how to process the form. ➤ need to include employee's address, religion, nationality. ➤ how about the supporting

**Business Process Review
Summary of Findings and Recommendations**

Manage Membership Process

Findings	Recommendations	Comments
<p>documents to register as a non-paying member.</p> <ul style="list-style-type: none"> ➤ There is a real possibility that a member can be issued with more than one PIN (within and across sectors); <ul style="list-style-type: none"> • Difficult to track and monitor payment; • Waste of resources; • Availment of benefits more than once, specially for the dependents, can be possible ➤ Legitimacy of the registering private firms and validity of the authorized signatory cannot be established. Validity of the premium payment certification in the Claims Form cannot be ascertained. 	<ul style="list-style-type: none"> ➤ The ER2 should be sent with a letter from the CEO explaining the rationale for the initiative and implications for non-compliance. Frequently Asked Questions (FAQs) should be included as well as telephone hotline in case of questions. The employer shall have the option to submit the softcopy. ➤ If the strategy proves to be effective, continue the practice on a regular basis for new/additional employees. • The Member Data Record (MDR) containing complete information about the member (including data on dependents) should be issued to members, instead of the membership card. <ul style="list-style-type: none"> ➤ The members applying for claims shall be required to show the MDR, instead of birth certificates, to the health care provider to check dependent's eligibility. ➤ MDR should be printed using a hard or security paper, if possible. <p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • A member should retain the original PhilHealth number despite change in membership category (indigent, self-employed, employed and retirees). Common membership database should be able to tag membership categories. • A central clearing module should be in place to determine and weed out double registrations. 	<p>documents?</p> <ul style="list-style-type: none"> ➤ Technical assistance from MIS is necessary for the transfer of soft copy or template to employers. • If a dependent is not reflected in the MDR, the dependent should present a proof of dependency. The document should be used to update the member records. • If possible, the signature of the employer should be reflected in the MDR. Require a new one if there is a change in employer

**Business Process Review
Summary of Findings and Recommendations**

Manage Membership Process

Findings	Recommendations	Comments
	<ul style="list-style-type: none"> Require new employer registrants to attach specimen signature of authorized official in the employer data form (ER1) and other requirements such as the SEC Article of Incorporation/partnership. Use the specimen signature for validating authenticity of Payment Certification in Claims Form. <p>Note: The practice of requiring employer payment certification for claims should be discontinued once a reliable, complete and accurate collection database is in place for eligibility checking.</p> <p><u>Long-Term</u></p> <ul style="list-style-type: none"> Implement on-line registration; invest in Wide Area Network. 	
<p>6) Long and slow turnaround time for processing and issuance of membership cards for employed members (2 to 3 months);</p> <p>a) Centralized processing causes long and multiple hand-offs; redundant screening of documents</p> <p>➤ Cards are sometime lost in transit or forwarded to wrong destination.</p>	<p><u>Quick-Win</u></p> <ul style="list-style-type: none"> Strengthen screening at the source (SO and PRO) to eliminate the need for screening in the Central Office. <ul style="list-style-type: none"> ➤ Re-orient staff at the Service Office and PROs on proper screening procedures. ➤ Explore possibility of incorporating errors committed in employee performance appraisal. Decentralize printing and issuance of MDR while maintaining centralized database build-up. MIS shall install the File Transfer Protocol (FTP) in the PROs. <p><u>Medium-Term</u></p> <ul style="list-style-type: none"> Decentralize database buildup of employed sector. Retain centralized build-up for centrally reporting employers. Provide copy of the database to the PRO 	<ul style="list-style-type: none"> Decentralization of database build-up of employed sector can be done through clustering by PROs.



**Business Process Review
Summary of Findings and Recommendations**

Manage Membership Process

Findings	Recommendations	Comments
	where employees are located.	
7) Issuance of ID to indigents takes time due to long processing time in premium payment by the LGU.	<p><u>Quick-Win</u></p> <ul style="list-style-type: none"> • Contribution should Issue the Bill Statement to the LGU immediately after commitment has been obtained and budget has been allocated, as evidenced by a Certificate of Funds Availability. <ul style="list-style-type: none"> ➢ Payment processing by the LGU will run parallel with processing of indigents applicants (finalization of the list of indigents, accomplishing of forms, and verification of forms and documents) ➢ The lag time between collection of payment and membership database build up will be minimized. 	<ul style="list-style-type: none"> • This is already being done in NCR.
8) Premium payments of potential individually paying members are not accepted due to lack of PIN.	<p><u>Quick-Win</u></p> <ul style="list-style-type: none"> • Allow the use of the M1b as payment form for initial payments. <ul style="list-style-type: none"> ➢ Speed up processing of membership to ensure issuance of PIN before the next payment. ➢ Use the regular payment form for succeeding payments. ➢ Update dependents' records upon submission of birth certificate to membership or through claims processing. 	<ul style="list-style-type: none"> • This can only be done for over-the-counter payments.
9) Unclear policy on documentary requirements for registration of indigenous/cultural/ ethnic groups	<p><u>Quick-Win</u></p> <ul style="list-style-type: none"> • In the absence of a birth certificate, enforce and communicate the policy of allowing an affidavit of two (2) disinterested persons as per revised IRR. 	

**Business Process Review
Summary of Findings and Recommendations**

Manage Membership Process

Findings	Recommendations	Comments
<p>10) Others</p>		<ul style="list-style-type: none"> • Need to reevaluate the current policy on eligibility requirements (minimum 3 months contribution within 6 months to avail of benefits) particularly for IPMs. There is a need to establish longer residency (like 1 year) for IPMs before they could avail of the benefits. • For example, there should be stricter eligibility criteria for pregnant women/IPMs, especially those who will undergo caesarian operation. Under the current rule, they are already entitled to benefits a month after paying the previous quarter premium. Afterwards, there is no compelling reason to continue paying until the time they see the need to resume payment (refer to Manager Benefits).

APPENDIX C

SUMMARY OF FINDINGS AND RECOMMENDATIONS

MANAGE CONTRIBUTIONS



**Business Process Review
Summary of Findings and Recommendation**

Manage Contributions

Findings	Recommendations	Comments
<p>1) The optimal operational goal of the Membership and Contributions Management Department at the Central Office and the Contributions Section at the Philhealth Regional Offices (PROs) is 100% collection of premium contributions from all enrolled Philhealth members in the employed, individually-paying (IPM), and indigent (IPG) sectors nationwide.</p> <p>To achieve this target, assigned personnel from these offices, in addition to sending reminder notices and doing phone follow-ups, personally visit employers, local government units (LGU), and organized groups (e.g. market vendor associations) to encourage them to remit their premium contributions.</p> <p>Considering that a significant percentage of Contribution tasks are backroom in nature, the issue raised involves the propriety and effectiveness of lodging in Contributions the collection follow-up responsibility, particularly that which requires direct interaction with the members.</p>	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Reassign the collection follow-up task to Marketing, specifically, that which would require direct personal interaction with the concerned employers, LGUs, and other member groups. Under this set-up, the proposed work distribution would be, as follows : <ul style="list-style-type: none"> ➢ For all the sectors (employed, IPM, and IPG), Contribution will : <ul style="list-style-type: none"> ○ Generate the reminder notices for late payments ○ Release the reminder notices to the concerned parties through the Records Section ○ Provide Marketing with a list of employers, LGUs , and other member groups with late remittances, together with their contact information, to serve as basis for their follow-up task ➢ For collection follow-ups within the employed sector, Contributions will perform the initial follow-up during the 30-day grace period. Marketing will handle the subsequent follow-ups as well as problematic and delinquent accounts. ➢ For the IPG and IPM sectors, Marketing will call up and visit the LGUs and member groups with unpaid premiums beyond their respective due dates. 	<ul style="list-style-type: none"> • Additional procedural details to be included are, as follows : <ul style="list-style-type: none"> ➢ Marketing will handcarry and deliver late payment reminder notices to delinquent members whom they will personally visit. ➢ For those who will not be site visited by Marketing, reminder notices will be released through the Records Section. ➢ Marketing will document the outcome of the site visit to serve as input for drafting the complaint affidavit. ➢ Contribution will draft, issue, and send the complaint affidavit to the concerned member through registered mail. • Under the current set up, the Collection Enforcement unit under CAMD does the personal follow-up of delinquent members. This set-up currently works. <ul style="list-style-type: none"> ➢ The proposed reassignment of this responsibility to Marketing is intended to further enhance the



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Findings	Recommendations	Comments
	<p><u>Medium Term</u></p> <ul style="list-style-type: none"> ➤ The Account Management Team concept proposed for “Manage Marketing and Membership” will support and reenforce this recommended reassignment of responsibility. Account Management Teams will be assigned specific clusters of potential and existing groups (e.g. by specific groups, geographic area) within which to capture, expand, and sustain membership in Philhealth. 	<p>collection effort by making the Marketing people responsible for ensuring initial premium payments as well as sustaining existing membership contributions through personal calls and follow-up visits</p> <ul style="list-style-type: none"> ➤ This approach will utilize and further sharpen the marketing and interpersonal skills of the Marketing personnel. ➤ This procedure is an application of the Account Management Team concept introduced in the process for “Manage Marketing and Membership”.
<p>2) Corollary to the above, there is also a need to reexamine the following related issues :</p> <ul style="list-style-type: none"> ➤ When is a member considered enrolled - upon member registration or upon initial payment of premiums due ? ➤ Where does the Marketing process end - upon member registration or upon collection of the initial premiums due ? ➤ Who is, therefore, responsible for ensuring that the initial payment has been made - Marketing or Contributions? 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Assign to Marketing the responsibility for ensuring that the first premium payment from a new member has been made. Include initial premium payment as part of their performance metrics. ➤ Since the Marketing staff are the first contact points of potential members, they are in the best position to solicit the initial premium payments from them. <p>However, while the Marketing staff should ensure initial payment of premiums due from potential members, they will not be authorized,</p>	<ul style="list-style-type: none"> • With proper internal controls in place, the Marketing personnel should be authorized to accept payments from members.



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Manage Contributions

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	as a control measure, to directly accept cash payments from members.	
<p>3) The document handoff between Marketing and Contributions (specifically, the Indigent Program Group) involving the preparation of the initial Billing Advice (estimates) to LGUs can be eliminated. The existing process is outlined below :</p> <ul style="list-style-type: none"> ➤ Marketing provides the Indigent Program Group (IPG) at the Central Office with the estimated number of households to be covered by the Memorandum of Agreement between Philhealth and the participating LGUs. ➤ IPG prepares the initial Billing Advice (or billing estimates) to LGUs, based on data from Marketing ➤ Marketing receives the initial Billing Advice from Contributions ➤ Marketing goes to the concerned LGUs to submit the Billing Advice, 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Authorize the Marketing staff assigned to the LGU to prepare the initial Billing Advice (estimates), if required by the LGU for fund allocation. • Train the Marketing staff to be assigned to LGUs on the mechanics of Billing Advice preparation. 	
<p>4) Philhealth experiences a high “drop-out” rate in self employed attributable, among others, to the following collection-related issues :</p> <ul style="list-style-type: none"> ➤ Inaccessible payment centers ➤ Quarterly payment contributions not affordable to some individually-paying 	<p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • Identify additional community-based collecting agents (e.g. municipal treasurer, barangay treasurer, cooperatives, associations, Bayad Centers, etc) who are closer to IPMs. • Expand the use of rural banks’ services to support 	<ul style="list-style-type: none"> • The Service Offices and Marketing personnel will also serve as collecting agents to address the issue on inaccessible payment centers.



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Findings	Recommendations	Comments
members	<p>Philhealth’s collection requirements, in areas where rural banks have not been accredited as collecting agents</p> <ul style="list-style-type: none"> ➤ Reassess the accreditation criteria for rural banks to ensure that only financially stable, effectively managed banks are accredited as payment centers. ➤ Constantly monitor the financial health of accredited rural banks to ensure that Philhealth deposits with these banks are safeguarded from possible bank closures. ➤ Implement in rural banks the same set of policies and guidelines used for accredited commercial banks (ACBs) and accredited government depository banks (AGDBs), with respect to collection remittances and supporting documentation. <ul style="list-style-type: none"> • Pursue the use of collection services of the Philippine Postal Corporation (Philpost) and the Philippine Postal Savings Bank. • Explore the possibility of allowing monthly premium payments for IPMs, through identified community-based collecting agents, as earlier mentioned. 	<ul style="list-style-type: none"> • Decentralization of collections to the PROs will be implemented within the short term. • Philhealth will directly accredit local and rural banks through the PROs, instead of through Land Bank.
5) There is a need to institute control procedures and related mechanisms to detect and prevent the occurrence of the following problems:	<p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Simplify the contribution structure: <ul style="list-style-type: none"> ➤ For the employed sector, modify and simplify the premium contribution structure geared 	<ul style="list-style-type: none"> • A single, fixed contribution rate for the employed sector violates the 50%-50% premium contribution



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Findings	Recommendations	Comments
<p><u>For Employers :</u></p> <ul style="list-style-type: none"> ➤ Underreporting / underremitting employers <ul style="list-style-type: none"> ○ Employee contributions and employer’s share not remitted or reported to Philhealth (deducted but not remitted) ○ Employee contributions and employer’s share not accurately reported and remitted (misdeclared salary brackets) ○ Employee not deducted at all for Philhealth premium contributions (employee not deducted for premium contributions) ➤ Nonreporting / nonremitting employers (employers with no remittance record for the past 6 months / employers with no remittance since 1999 for the private sector and 1998 for the public sector) <p>Under the existing procedure, employers submit a copy of their RF1s and ME5s quarterly to Philhealth.</p> <ul style="list-style-type: none"> ➤ However, some employers submit their RF1s and ME5s late, submit incomplete documents, or do not submit their documents at all. 	<p>towards a single, fixed rate, regardless of salary bracket</p> <ul style="list-style-type: none"> ➤ For the IPM sector, differentiate between the professionals and non-professionals, to stress the socialized contributions structure. <p>For example :</p> <p style="padding-left: 40px;">Professionals - P 200 / month Non-professionals - P100 / month</p> <p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • If the contribution structure continues to be multi-level, use the Annual Alphalists submitted by employers to the BIR as basis for validating completeness of employees reported to Philhealth. The Alphalist contains information on the gross taxable income of all company employees for a tax year. ➤ Undertake a MOA with the Bureau of Internal Revenue (BIR) granting Philhealth access to the Alphalist for a specific purpose ➤ Subject to resource constraints, select the employers to be reviewed, based on established criteria, such as, recurring reporting deficiencies, company size, etc 	<p>sharing ratio between the employer and the employee, as stipulated in RA 7875. Implementation of a fixed rate will require a legislative amendment and a thorough actuarial study.</p> <ul style="list-style-type: none"> • Government agencies should optimize and share information and resources across each other. • Cross-validation against the Annual Alphalists should be done on selective basis only, because of the large effort to be spent in undertaking this practice.



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Findings	Recommendations	Comments
<ul style="list-style-type: none"> ➤ Contributions spends additional time to validate and adjust contributions data as well as follow-up and send compliance requests letters to the concerned employers about these deficiencies ➤ Deficient reports cannot be posted immediately to the Employers database, pending compliance by the employers of their respective deficiencies. ➤ To issue reminder notices for late payments, Contributions has to reference RF2s and ME5s submitted by accredited banks to Treasury to confirm nonpayment of premiums by an employer. 	<ul style="list-style-type: none"> • Continue procedure of following-up underremitting / nonremitting employers identified by Claims in the process of undertaking eligibility checking; coordinate with Marketing in dealing with problematic accounts 	
<p><u>For Accredited Banks :</u></p> <ul style="list-style-type: none"> ➤ Underreporting / underremitting banks <p>Under the current procedure, accredited banks submit twice a month the following documents : RF2A, RF2, and ME5, together with their check remittances to Philhealth. The RF2s are used as basis in updating the Treasury Database for bank remittances.</p> <ul style="list-style-type: none"> ➤ The RF2s and ME5s are not accountable forms. Based on these documents, there 	<p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • Use pre-numbered Philhealth Official Receipts (PORs) as proof of payment. <ul style="list-style-type: none"> ➤ Require all ACBs, AGDBs, and other collecting agents to issue accountable PORs ➤ Develop clear implementation guidelines to enforce procedures and strict controls over : <ul style="list-style-type: none"> ○ Safekeeping and issuance of PORs by banks and other collecting agents 	



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Findings	Recommendations	Comments
<p>is no assurance that the bank remittance is complete.</p> <ul style="list-style-type: none"> ➤ Therefore, an added procedure to reconcile bank-submitted documents with employer-submitted documents is done to detect : <ul style="list-style-type: none"> ○ Underremittances / underreporting by banks ○ Nonpayment of premiums by employers ➤ In addition, the banks have no basis to determine the amount that the employers should remit to Philhealth. 	<ul style="list-style-type: none"> ○ Distribution of PORs from Philhealth to all collecting agents ○ Monitoring of inventory of PORs at Philhealth and collecting agents <ul style="list-style-type: none"> • If use of POR is implemented, adopt the proposed procedures, considering nonexistent connectivity between the computerized Treasury System and Member Accounts Information System (MAIS) : <ul style="list-style-type: none"> ➤ Require the employers to submit 2 copies of their RF1s to the collecting agent, to serve as basis for payment ➤ Require the collecting agent to stamp the RF1 and retain one copy ➤ Upon collection remittance to Philhealth, the collecting agent should submit the following documents to Philhealth Treasury : <ul style="list-style-type: none"> ○ RF2 ○ Bank-stamped RF1 ○ 2 copies of the POR ➤ After receipt and review of the documents, Treasury shall furnish Contributions with the RF2, RF1, and one copy of the OR. 	<ul style="list-style-type: none"> • The proposed procedures will eliminate the following activities: <ul style="list-style-type: none"> ➤ Separate submission of the RF1 by employers to Philhealth ➤ Collecting RF1s from dropboxes ➤ Generating and sending acknowledgment letters to employers for RF1s received through dropboxes and mail. • While the benefits of the proposed procedures are recognized, the banks will not accept the additional burden of receiving and temporarily safekeeping RF1s for subsequent transmittal to Philhealth. • The procedure will shift the responsibility over receipt and review of the RF1s from CAMD to Treasury.

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Findings	Recommendations	Comments
	<ul style="list-style-type: none"> ➤ Contributions can, then, process and post the RF1 to the Employers' Contributions DB. <p><u>Long-Term :</u></p> <ul style="list-style-type: none"> • Enhance PMAIS to electronically generate Billing Statements to employers at least two (2) weeks prior to the due date of the premium contributions • Adopt the following procedures, assuming system capability to generate Billing Statements, availability of current data on employees contributions, and an interface, at a minimum, between the Treasury System and PMAIS : <ul style="list-style-type: none"> ➤ Send Billing Statements to employers ➤ Require employers to present and submit the Billing Statement and Employee Contributions Amendment Form to the collecting agents, upon payment of their premium contributions ➤ Twice monthly, the collecting agents will submit to Philhealth Treasury a copy of the RF2, 2 copies of the Official Receipt, and the Employee Contributions Amendment Form, together with their check remittance ➤ After receipt and review of the documents, Treasury shall furnish Contributions with the RF2, Employee Contributions Amendment Form, and one copy of the OR. ➤ Contributions can, then, process and update the Employers and Employees Contributions 	<ul style="list-style-type: none"> • Billing Statement generation and issuance would be a costly solution for Philhealth. Alternatively, 'internal billing statement' can be implemented. • A recent office instruction states that Treasury will not capture the PENs / PINs of members into its database. • The Process Owner, however, indicated that : <ul style="list-style-type: none"> ➤ For the employed sector, the POR should contain the paying member's name, at the minimum ➤ For IPMs, the PIN should be captured by Treasury. • The Consultant's position is to require Treasury to capture the PIN / PEN, as part of the collection information. <ul style="list-style-type: none"> ➤ The PIN / PEN will serve as the



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Findings	Recommendations	Comments
	Databases.	<p>link between the Treasury database and PMAIS, if Billing Statements are not generated.</p> <ul style="list-style-type: none"> ➤ If Billing Statements are generated, the Bill No. can serve as the link between Treasury and Contributions ➤ Collection data captured by Treasury will be passed on to PMAIS for posting to the employers' and employees' contribution database <ul style="list-style-type: none"> • Partial payments by employers will not affect employees' contributions. ➤ Even with partial remittances from employers, employees' contributions are considered fully paid. ➤ Hence, there may be points in time when total employer contributions would not equal total employee contributions.
6) There is currently a large number of past years' employee contributions data to be encoded by a service bureau. Questions that arise are :	<p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • Focus available resources initially on updating 	<ul style="list-style-type: none"> • Past years' data on employee contributions will be needed to :



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Findings	Recommendations	Comments
<ul style="list-style-type: none"> ➤ Is there any significant information value to be derived from encoding past years' employee data - apart from accumulating the 120 monthly contributions that would qualify a member as nonpaying upon retirement ? ➤ What is the expected additional amount to be collected, if underremittances / nonremittances are established vs. the cost of encoding past years' data ? 	<p>employers' and employees' contributions database, based on current years' data (meaning the past 12 months) ; then, process backlogs, as necessary.</p> <ul style="list-style-type: none"> • If Billing Statement generation can be immediately incorporated in PMAIS and an interface with the Treasury System can be developed, pilot test the process described in No. 7 above involving Billing Statement generation and Employee Contribution posting to the database. 	<ul style="list-style-type: none"> ➤ Establish the 120 monthly contributions required to qualify a member as nonpaying upon reaching the age of retirement. ➤ Determine pastdue collectibles from employers due to nonremittance or underremittance • If backlog data on employee contributions are not encoded and captured into the system, the member's service records with his employers can be used as alternative documentation to support application for nonpaying membership upon reaching the legal age of retirement. • The issue on whether to encode backlog contribution data from 1999 to 2000, however, has become academic. The contract with the service bureau to encode past years' member contributions has been approved by the PBAC. Data from Year 2000 onwards will be encoded.
<p>7) The PROs do not have complete information on employer premium payments (or potentially, IPMs) to banks.</p> <ul style="list-style-type: none"> ➤ PROs do not have any record of centrally remitting employers. These records are 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • For non-centrally remitting employers, request the banks to provide the PROs with copies of their bank abstracts. 	<ul style="list-style-type: none"> • Information on centrally remitted premium contributions are needed by PROs for budgeting purposes only.



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Findings	Recommendations	Comments
<p>centralized at the Central Office.</p> <ul style="list-style-type: none"> ➤ Not all banks provide the PROs with their bank abstracts or the equivalent of the RF2s ➤ The value of inadequate data on employers' premium contributions is diminished for eligibility checking and follow-ups. 	<ul style="list-style-type: none"> • For centrally remitting, Central Office should provide the PROs with a copy of bank remittances for their respective regions. 	
<p>8) The process flow at CAMD can be further streamlined and standardized.</p> <ul style="list-style-type: none"> ➤ Work efficiency can be enhanced if similar work activities are done once within the assigned group or unit. <ul style="list-style-type: none"> ○ For example, there is screening at Central Records and another screening at Member Accounts Division (Private Sector) and Public Sector Data Management Division ➤ The offices use different computerized modules to serve their own purposes : <ul style="list-style-type: none"> ○ Transmittal List System (TLS) to generate the acknowledgment letters ○ Batch Control Module (BCS) of MAIS to encode employers data and 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Implement a standard process flow (team approach) for both private and public sectors - from Receiving to Posting of Contributions. <ul style="list-style-type: none"> ➤ Receive documents from Central Records ➤ Screen documents for completeness of documentary requirements and correctness of reported documents ➤ Adjust the report for underpayment / overpayment ➤ Encode contributions data ➤ Review encoded data <p><u>Medium Term</u></p> <ul style="list-style-type: none"> • Include a quick enhancement to PMAIS to enable the follow-up 	<ul style="list-style-type: none"> • The current CAMD organizational structure is the workable set up, given the existing resources and skills vs. the volume and nature of work being done. • Public Sector has a different collection pattern from the Private Sector. Remittances of the share of public sector employers in the premium contributions are dependent on budgetary releases from the Department of Budget and Management. • In anticipation of the implementation of PMAIS, CAMD has developed a simplified collection process. A more cohesive organization set up, margining the Public Sector, Private Sector, and Data Management



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Findings	Recommendations	Comments
<p>to encode employers data and generate the Batch Control Slips and Transmittal Lists for documents to be forwarded to the Service Bureau</p> <ul style="list-style-type: none"> ○ Premium Compliance System (PCS) to monitor employers' reporting deficiencies 	<p>following :</p> <ul style="list-style-type: none"> ➤ Generation of acknowledgment letters for reports submitted through mail or drop boxes or an interface with an email system -- to eliminate the Transmittal List System. <p>(Note, however, that if employers will no longer be required to submit documents directly to Philhealth, as earlier suggested, generation of acknowledgment letters may not even be necessary)</p> <ul style="list-style-type: none"> ➤ Monitoring of deficient reports and generation of deficiency letters - to eliminate the Premium Compliance System <ul style="list-style-type: none"> ● Consider merging divisions involved in the process from Receiving to Review of encoded data 	<p>Groups into one is also being considered.</p>
<p>9) There is a need to enhance and integrate the computerized application and build up an up-to-date employers / employees contributions database.</p> <ul style="list-style-type: none"> ➤ Employers' and employees' contributions data are not yet current ➤ Contributions data cannot be relied upon for eligibility checking ➤ Contributions have to be integrated with Membership and Claims. 	<p><u>Long-Term</u></p> <ul style="list-style-type: none"> ● Develop a computerized Contributions Account Management System that has the following features and capabilities : <ul style="list-style-type: none"> ➤ Integrate with Membership to obtain information on new members and updates to existing members' data ➤ Integrate with Treasury to access payments data ➤ Post premium payments received from all sectors (employed, IPM, IPG) to the database ➤ Track and calculate changes in premium 	<ul style="list-style-type: none"> ● The project team should look into potential issues related to over-the-counter (OTC) transactions. ● Collection of premium contributions should be properly booked and recorded in FMIS. ● There should be a master plan for implementing the approved quick wins, medium-term, and long-term recommendations. The project team will draw up a high-level implementation plan.



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	<p>remittances of employers – due to personnel updates (e.g. resignations, new hires, etc)</p> <ul style="list-style-type: none"> ➤ Establish underpayments and / or overpayments; apply underpayments or overpayments, based on Philhealth’s policy on application of payments ➤ Generate Billing Statements ➤ Generate Reminder Notices of Pastdue Accounts ➤ Accumulate members’ premium contributions (120 premium contributions to qualify as non-paying members) ➤ Generate certification of members’ contributions ➤ Integrate with Claims to enable electronic eligibility check ➤ Enable web-based premium payments (EPRS) <ul style="list-style-type: none"> • Implement standard computerized systems at the PROs • Implement Value-Added Network (VAN) 	<ul style="list-style-type: none"> • The existing MAIS interfaces with Membership and Treasury.

APPENDIX D

SUMMARY OF FINDINGS AND RECOMMENDATIONS

MANAGE HEALTH CARE PROVIDERS RELATIONS



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Summary of Findings and Recommendations**

Manage Healthcare Provider Relations

Findings	Recommendations	Comments
<p>1) Philhealth relationship with healthcare providers stands improvement -- anchored on trust and cooperation and working together towards raising the quality of affordable healthcare to all Filipinos.</p>	<p><u>Medium- to Long-Term</u></p> <ul style="list-style-type: none"> • Institutionalize a paradigm shift in health care provider relationship from policing to partnership, adversarial to collaborative/consultative. In line with this direction, transform the accreditation team to a relationship management team to serve as the single-point of contact, capable of addressing wide range of health care provider issues and concerns. Among others, its responsibilities could include: <ul style="list-style-type: none"> ➤ Monitor sustained compliance with quality health care standards (for accreditation or renewal). Recommend required quality interventions to achieve quality service. ➤ Act as 'quality advisors or consultants' to hospitals in relation to the implementation of benchbook. ➤ Conduct periodic consultative meetings with the providers involving new circulars, policies, guidelines, problems with claims applications (RTH), suggestions for improvement on benefits payments, policies, etc. ➤ Facilitate provision of training and performance support tools to medical staff of healthcare providers on new procedures or policies such as ICD-10 coding. 	<ul style="list-style-type: none"> • To carry out its new role as 'quality consultant', the Accreditation Staff need to undergo formal training and education on health care quality improvement.



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Findings	Recommendations	Comments
	<ul style="list-style-type: none"> ➤ Implement a well-designed incentive mechanism for outstanding health care providers. <p>Notes:</p> <ul style="list-style-type: none"> • Team composition: team lead and 2-3 assistants. Team assignments will be per cluster of healthcare providers, subject to rotation. • Performance and decision support tools should be available to the team, which include a 'dash board' of hospitals' key performance indicators. 	
<p>2) There are opportunities to improve the accreditation processes:</p> <ul style="list-style-type: none"> ➤ Compliance with accreditation requirements by the healthcare providers ➤ Accreditation process at the PROs ➤ Accreditation approval process at the Central Office. ➤ Dissemination of information on approved / disapproved applications for accreditation to the Philhealth Regional Offices (PROs) 	<p>PhilHealth Regional Office (PRO)</p> <p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Continue constant follow up of health care providers on compliance with requirements for accreditation or re-accreditation to ensure completion and submission of mandatory requirements to the Central Office, at least 1 month prior to accreditation expiry. • Promptly resolve issues that could deter approval of the accreditation by the Accreditation Committee. Set a reasonable turnaround response time for the Central Office to address the PRO queries. • If necessary, immediately refer questions to the Central Office for quick resolution through the fastest available mode of communications (e.g. mobile phone, landline, fax, email, PDAs) 	<ul style="list-style-type: none"> • Currently, there is plan to acquire PDAs.



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Findings	Recommendations	Comments
	<ul style="list-style-type: none"> For initial accreditation, as soon as the accreditation requirements have been complied with by the healthcare provider, inform the Central Office immediately – so that hospital inspection can be scheduled right away even without a copy of the application form. <p><u>Medium Term</u></p> <ul style="list-style-type: none"> Assign the Healthcare Provider Relationship Management Team to monitor and ensure compliance with the accreditation requirements and help respond to / resolve healthcare provider issues and questions promptly (refer to previous recommendation). <p>Central Office (CO)</p> <p><u>Quick Win</u></p> <ul style="list-style-type: none"> Delegate the authority to approve accreditation of fully compliant health care providers (without issues) to Head of Accreditation, upon the recommendation of the Accreditation Team. Alternatively, process approval of accreditation of fully compliant health care providers by Accreditation Committee through a referendum. Given the above scenario, determine if there are cases, which the PROs can directly recommend for approval. 	<ul style="list-style-type: none"> There is a need to receive the application prior to scheduling so that initial review can be done. This can be implemented for accreditation renewals only. The Accreditation Committee should approve all applications for initial accreditation.



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Findings	Recommendations	Comments
	<ul style="list-style-type: none"> • Document and compile all accreditation issues and their resolutions into case digests or knowledge database. Facilitate sharing of case digests or knowledge exchange among PROs. • Accelerate the development of new accreditation survey tools and evaluation rules for health 'outcomes' without replicating the DOH licensing procedures and requirements. Implement the Consolidated Licensing and Accreditation Survey Process (CLASP) with the DOH. • Other process improvement opportunities: <ul style="list-style-type: none"> ➤ For initial accreditation, the Central Office should schedule hospital inspection immediately after being informed of full compliance by the hospital to accreditation requirements – without the need to wait for copies of documentation from the PRO. ➤ Eliminate the preparation of narrative verification reports, which summarize information that can already be obtained from the hospital inspection and verification reports. ➤ Respond immediately and clearly to questions posed by PROs as well as by the healthcare providers (within the set response time frame) based on documented case digests or knowledge database. ➤ Upon receipt of documentation from the PROs, 	<ul style="list-style-type: none"> • In the long-term, accreditation will be capability-based. Hospitals can be mapped according to their capabilities. • Central Office Accreditation personnel need to receive the application forms prior to hospital visit so that they can prepare. Certain rules can be interpreted differently by the PRO.



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Findings	Recommendations	Comments
	<p>include the application in the agenda for the Accreditation meeting immediately.</p> <ul style="list-style-type: none"> • Require only one (1) countersignature on the on the 2nd copy of the certificate of accreditation. • Transmit electronic data to the PROs immediately – so that the accreditation data in UCPS can be updated right away. <ul style="list-style-type: none"> ➤ Create a separate file of a few relevant accreditation data (e.g. name of hospital, hospital category, accreditation number, accredited beds, validity period) for immediate data transmission to the PROs and printing of the certificate of accreditation. ➤ Or, if paper-based information is more readily available, transmit the information to the PRO right away and allow an authorized PRO officer to update the Accreditation database - but impose strict user access control to the system. <p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Enhance the Accreditation System to allow centralized and decentralized capture of information and update of healthcare providers database. The system should be properly interfaced with the Claims Processing System. 	<ul style="list-style-type: none"> • This will not be a problem if health care providers will submit application within reasonable time prior to expiration of accreditation. • Lack of enough manpower to handle accreditation at the PROs can be a reason for delayed processing. To address this, create a pool of accreditation personnel to handle clusters of PROs. Accordingly, schedule inspections of the cluster to maximize use of the pool. • Implement the document tracking system where selected information can be captured by PROs. <p>In the long-term, outsource the accreditation function to third-party organizations (example: PCAHO, JCAHO). Initially, PhilHealth will control and define the standards. This in line with transforming the PhilHealth Accreditation personnel into relationship managers.</p>



Business Process Review Summary of Findings and Recommendations

Manage Healthcare Provider Relations

Findings	Recommendations	Comments
<p>3) The accreditation forms can be redesigned to simplify format and eliminate redundant information.</p> <ul style="list-style-type: none"> ➤ Separate forms are used for primary, secondary, and tertiary hospitals – which can be simplified and merged into one form. ➤ Separate forms are used for application, inspection, verification and evaluation. 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Combine the separate applications for accreditation and the hospital inspection and verification forms into a single Accreditation form. ➤ Only one form will be used for primary, secondary, and tertiary hospitals. ➤ The information to be filled up and requirements to be complied with should be enumerated in a clearer, more organized format. ➤ Columns on the right hand side of the forms will be provided where the PROs and Central Office Accreditation staff can indicate the status of compliance, together with any additional comments. <p>The sample format is presented as Attachment A.</p>	<ul style="list-style-type: none"> • Combine secondary and tertiary hospital accreditation forms. Maintain separate accreditation form for secondary hospitals.
<p>4) Indications of fraudulent claims have been noted.</p> <ul style="list-style-type: none"> ➤ Higher amount of claims filed by the hospital vs. compensable claims deducted from patients' bills ➤ Examples of noticeable repeating cases of suspicious claims (e.g. non-existent patients) 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Enforce suspension / revocation of accreditation, based on proven fraud cases as a result of thorough data analysis and hospital visits. • Fast track conduct of training for Accreditation team on the required and legally acceptable documentary evidence necessary to file a legal case against the hospitals • Accelerate the development of clear policies and 	<ul style="list-style-type: none"> • Accreditation can deny application for renewal based on proven fraud cases as a result of data analysis and hospital visits.



**Business Process Review
Summary of Findings and Recommendations**

Manage Healthcare Provider Relations

Findings	Recommendations	Comments
<ul style="list-style-type: none"> ➤ Non-prosecution of healthcare providers with repeating cases of fraudulent claims 	<p>guidelines on the handling of fraudulent claims.</p> <ul style="list-style-type: none"> • Require the healthcare providers to attach a copy of the Summary Statement of Accounts paid for and signed by the member to the Claims documents • Continue to conduct an awareness campaign among members (through the Account Management Team of Marketing) regarding claims benefits • Continue the practice of conducting onsite inspections of patient admissions and other relevant records for problematic hospitals. 	
<p>5) One reason cited for long claims processing is the need to perform itemized checking of drugs, as per benefit design.</p> <ul style="list-style-type: none"> ➤ Associate drugs against diagnosis ➤ Check the quantity of dosage vs. illness ➤ Validate drugs dispensed vs. the PNDF ➤ Check the cost of drugs charged to the patient 	<p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Continue reviewing the benefits package for drugs and medicines and explore the possibility of defining compensable drugs by case payment - to eliminate tedious checking of drugs and medicines 	<ul style="list-style-type: none"> • Itemized encoding of drugs is required to help PhilHealth play its implicit role in drug price regulation in the country. • In line with this, case payments can be implemented, except for drugs. • Coding is required to simplify claims processing. ICD 10 implementation can be modified (down to 4 characters only)
<p>6) The policy of 45-day maximum confinement cannot be enforced due to technical difficulty to track confinement periods.</p> <ul style="list-style-type: none"> ➤ Inability to compile and consolidate all benefits utilized by a member: 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> ➤ Include information on previous confinements in the Philhealth Claims form. <p><u>Long-Term</u></p>	<ul style="list-style-type: none"> • Eliminate 45-day policy, instead, use number of availments as a control mechanism (subject to actuarial study).



**Business Process Review
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Findings	Recommendations	Comments
<p>benefits utilized by a member;</p> <ul style="list-style-type: none"> • Disabled UPS functionality to check confinement periods; • UPS in PROs not interconnected (in view of portability); • Hospital not connected to philhealth. <p>➤ Delayed claims information due to the 60-day grace period to file the claim and the additional 30 to 60 days to process a claim.</p>	<p>➤ Develop and implement a computerized Claims Processing System that :</p> <ul style="list-style-type: none"> • Integrates with Membership and Member Accounts Information System • Integrates properly with the Accreditation System • Keeps a history of past illnesses (ICD-10s) and compensable benefits utilized by members and members' dependents • Enables claims data sharing across Philhealth offices nationwide • Decentralize the implementation of the system to the PROs • Enable healthcare providers (through Hospital Operations Management Information System or HOMIS) to connect to the Philhealth System 	<ul style="list-style-type: none"> • There is a plan to implement electronic log-book system for hospitals.
<p>7) Relevant data and information which are needed to establish quality of care standards and monitor health care providers are not readily available.</p>	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Identify other research modes that can be adopted to obtain data to be used for outcomes assessment and benefits package design • As a stopgap measure, utilize existing historical claims data (e.g. 6 – 24 months back) to establish claims patterns of healthcare providers and, on that basis, identify those which need closer monitoring. <p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Implement an updated, integrated Claims 	<ul style="list-style-type: none"> • Several sources of information are: <ul style="list-style-type: none"> ○ Claims ○ MMHR ○ Survey ○ Logbook ○ Member feedback (complaints, etc) • There is a need for a separate Utilization Review unit for this function.



Business Process Review Summary of Findings and Recommendations

Manage Healthcare Provider Relations

Findings	Recommendations	Comments
	Processing System, as mentioned above, that will cater to the information needs of various key stakeholders (e.g. Claims, Accreditation and Quality Assurance, Corplan, Executive Committee members, etc).	
8) Accreditation (Central Office) has no operational control over the PROs which makes it difficult to obtain buy-in from the operating groups and get the new policies, guidelines, procedures, etc. implemented.	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> Continue holding consultative meetings with the operations groups to discuss and address issues with existing benefits, circulars, and policy guidelines as well as and /or discuss and anticipate potential issues and operational impact of policies, circulars, benefits, etc. being developed. <p><u>Medium-Term</u></p> <ul style="list-style-type: none"> Review the organizational setup and reporting lines between the Central Office Accreditation Group and the PRO Accreditation units. Explore a matrix organization where Accreditation Central Office has functional supervision over PROs accreditation personnel. The PRO would have administrative supervision of the PRO Head. 	•
9) Coordination and communication lines between the Central Office and the PROs with regard to the issuance of new circulars and guidelines can be further enhanced. <p>➤ Variations in the interpretation of Philhealth circulars;</p>	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> Manage the timing of the issuance of circulars. Avoid issuing circulars anytime, anyday. For example, a quarterly issuance can be arranged. Post new circulars or amendments to existing ones to the Philhealth website. Assign a staff responsible for posting circulars to the Philhealth website as 	<ul style="list-style-type: none"> Quarterly issuance can be implemented when situation has already stabilized (within a year's time) Posting to website is the responsibility of Corcom.



**Business Process Review
Summary of Findings and Recommendations**

Manage Healthcare Provider Relations

Findings	Recommendations	Comments
<ul style="list-style-type: none"> ➤ Delay in the transmittal of circulars to PROs -- in some cases, healthcare providers have received copies of the circulars, but PROs have not been provided with their copies of the circulars; ➤ Inability of healthcare professionals to receive their copies of Philhealth circulars. 	<p>soon as the circular is approved.</p> <ul style="list-style-type: none"> • Send follow-up emails to the PROs to inform them that new circulars have been released, with an electronic copy of the circular. • Update the mailing / emailing list of healthcare providers. Group email the circulars. • Publish the circulars in newspapers of general circulars and newsletters of medical associations; include an advisory to visit the Philhealth website to obtain copies of new circulars, guidelines, and updates to existing ones. • Require the hospitals to post Philhealth circulars in areas frequently visited by their medical staff. • Continue consulting the affected departments, divisions, or PROs on the viability and clarity of the circulars and guidelines prior to release or implementation • For greater clarity of the circulars: <ul style="list-style-type: none"> ➤ Anticipate and illustrate potential scenarios that could result from the implementation of the circular ➤ Present calculations to illustrate a point, for complex cases. ➤ Compile “Frequently Asked Questions” (FAQs) and official responses to these queries. Post to the Philhealth website to make it accessible to all 	<ul style="list-style-type: none"> • Publication of circulars quite expensive but a must for those with penalty clause or legal impact. Also need to inform UP Law Center. • Tap pharmaceutical representatives, academic institution, PHA, medical associations to help in information dissemination. • Guidelines should be set on the level of consultations needed. Too much consultation can be paralyzing. Currently, consultation is done at the execom level. Execom participants should be responsible for cascading the consultation process in their respective units/departments.



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Summary of Findings and Recommendations**

Manage Healthcare Provider Relations

Findings	Recommendations	Comments
	<p align="center">authorized personnel.</p> <ul style="list-style-type: none"> • Simulate the implementation of the circular over a designated area, as necessary. • Revisit the procedures of Central Records for releasing circulars to PROs and healthcare providers • Ensure that performance support systems to implement the circulars or guidelines are ready and operational. 	



APPENDIX E

SUMMARY OF FINDINGS AND RECOMMENDATIONS

MANAGE AND DELIVER BENEFITS



**Business Process Review
Summary of Findings and Recommendations**

Deliver and Manage Benefits

Findings	Recommendations	Comments
<p>1) Claims processing is time-consuming. Philhealth’s challenge is to reduce the processing turnaround time from 60 days to 30 days or even shorter. The issues that hamper processing are, as follows :</p> <ul style="list-style-type: none"> ➤ Numerous documentary requirements to support a claim (e.g. operative records); difficulty experienced by healthcare providers in complying with the requirements which results to incomplete submission of documentary requirements to Philhealth 	<p><u>Medium Term</u></p> <ul style="list-style-type: none"> • Deploy claims staff temporarily to selected healthcare providers (hospitals) to validate completeness of supporting documentary requirements before submitting the claims form to Philhealth. 	<ul style="list-style-type: none"> • The objective of the recommendation is to minimize the vicious cycle of handling and reprocessing of “return to hospital” claim applications. • As proposed, claims personnel will be deployed only to healthcare providers with frequently noted documentary deficiencies. • It was indicated, however, that the problem with documentary requirements is “internal” to the healthcare providers and cannot be resolved by assigning claims personnel to check completeness at source. • Extending the claims filing period from 60 days to 120 days would be a more responsive solution.
<ul style="list-style-type: none"> ➤ Absence of and / or erroneous encoding of ICD-10 by healthcare providers <ul style="list-style-type: none"> ○ Insufficient training of hospital medical clerk on the use of ICD –10 ○ Assigned medical clerks are not paramedics and, therefore, not qualified to identify the correct ICD-10 to use ○ Turnover in assigned medical records 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Provide healthcare providers with a specific timeframe (for ex. 6 months) within which to have their medical records staff properly trained in ICD-10 coding. Thereafter, strictly enforce Philhealth’s policy of denying claims due to absence of ICD 10 codes or grossly erroneous codes • Institutionalize the practice of conducting regular consultative meetings (e.g. semi-annually) with healthcare providers with regard to problems 	<ul style="list-style-type: none"> • ICD-10 coding has slowed down medical evaluation during the past months. However, with the medical evaluators’ increasing familiarity with the ICD-10 codes, the process has started to cope with its original target. • Philhealth has issued a circular to healthcare providers stating that failure to indicate ICD-10 codes in the claims form is a ground for outright denial of



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Findings	Recommendations	Comments
<p>staff in hospitals due to resignations</p> <ul style="list-style-type: none"> ○ Complexity of the ICD-10 codes ○ Need by the Philhealth’s medical evaluators to reevaluate and correct the erroneous ICD-10 codes ○ Learning process by Philhealth medical evaluators 	<p>healthcare providers with regard to problems encountered in claims applications, including those related to ICD-10 and RVS.</p> <ul style="list-style-type: none"> • Provide healthcare providers with performance support tools that will aid them in ICD-10 coding, such as, list of frequently used ICD-10 codes, procedures, job aids, etc. • Require trained medical records staff on ICD-10 as prerequisite to accreditation / renewal of accreditation • Assign an ICD-10 coder of the day or week who will focus on ICD-10 coding – as a mechanism to enable the medical evaluators to become thoroughly familiar with ICD-10 codes • Isolate ICD-10 coding from the regular claims process. Encode ICD-10 after the claim has been completely processed. <p><u>Long Term</u></p> <ul style="list-style-type: none"> • Assign a Healthcare Provider Relations Management Team, composed primarily of personnel from Accreditation and Quality Assurance to: <ul style="list-style-type: none"> ➢ Conduct the regular consultative meetings with the healthcare providers ➢ Gather evidence to support fraudulent claims ➢ Monitor compliance of pre-accreditation / accreditation requirements ➢ Educate healthcare providers on new Philhealth 	<p>claims. The circular, however, is silent on grossly erroneous ICD-10 codes.</p> <ul style="list-style-type: none"> • Some PROs have either developed their own electronic ICD-10 reference tables or have downloaded the data tables from the internet. • The ICD-10 reference file created by MIS at the Central Office is the most complete. The ICD-10 module to access this file is being pilot tested by the NCR Group. • It would be good for hospitals to prepare a list of frequently-used ICD-10 codes, to avoid having to reference the entire ICD-10 manual. • Assigning an ICD-10 coder of the day or week will not be viable because one or two coders of the day will not be adequate to process all the claims. • Since ICD-10 codes are used primarily for statistical reporting, ICD-10 encoding will be done after a claim has been processed.



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Findings	Recommendations	Comments
	<p>policies, circulars, accreditation requirements, etc.</p> <ul style="list-style-type: none"> ➤ Identify healthcare providers that need Philhealth claims staff assistance in validating completeness of supporting documentary requirements <p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Launch the computerized module for ICD-10 codification nationwide 	
<ul style="list-style-type: none"> ➤ Itemized checking of drugs and medicines – need to : <ul style="list-style-type: none"> ○ Associate drugs against diagnosis ○ Check the quantity of dosage vs. illness ○ Validate drugs dispensed vs. the PDNF and the PHIC short list ○ Check the cost of drugs charged to the patient ➤ Checking of drugs compounded by the need to check official receipts of drugs bought by the patient – due to nonavailability of prescribed drugs in government hospitals 	<p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Accelerate the process of defining compensable drugs by case payment - to eliminate tedious checking of drugs and medicines • For compensable drugs not identified by case payment —codify the PNDP – to provide medical evaluators with a convenient tool to determine the compensability and prescribed prices of drugs and medicines. • Institutionalize the process of LGUs setting up a revolving fund for use in procuring drugs -- frequently dispensed by the government hospitals. 	<ul style="list-style-type: none"> • Guidelines to implement case payment for certain types of illnesses have been developed but not yet implemented. • Tedious for Claims • Refer to “Manage Healthcare Provider Relations” for additional comments. • Philhealth segregates payments for drugs and medicines to government hospitals.



Business Process Review Summary of Findings and Recommendations

Deliver and Manage Benefits

Findings	Recommendations	Comments
<ul style="list-style-type: none"> ➤ Lack of information on the veracity of signatures in claims documents (e.g. authorized signatories from employers) 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Require corporations / companies to submit updated signature cards of their authorized signing officials – to be used for post-audit of claims. 	<ul style="list-style-type: none"> • MIS will operationalize a system that will capture digitized signatures of authorized signatories from employer companies. • In the long-term, when the Membership and Member Accounts' Databases can be relied upon for eligibility checking, verification of employers' signatures will no longer be necessary. • Signatures of authorized signatories of healthcare providers should be digitized and electronically recorded for online retrieval, as well.
<ul style="list-style-type: none"> ➤ At the PROs, nonavailability of officers to sign checks 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Schedule dates for signing of vouchers and checks • As a matter of policy, require one of two signing officers to be present at the office to sign the checks on the designated dates. • Review the list of authorized signatories and their corresponding limits of authority in each region. <p><u>Medium-Term</u></p> <ul style="list-style-type: none"> • Encourage healthcare providers to sign-up for auto-crediting of their accounts for approved claims. 	<ul style="list-style-type: none"> • The issue relates to a potential staffing problem at the PROs.



Business Process Review Summary of Findings and Recommendations

Deliver and Manage Benefits

Findings	Recommendations	Comments
<ul style="list-style-type: none"> ➤ In some PROs, lack of control over Claims-related accounting tasks, such as voucher and check preparation 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Assign an accounting staff to be primarily responsible over voucher and check preparation. 	
<ul style="list-style-type: none"> ➤ Potential area for lessening data validation <ul style="list-style-type: none"> ○ At the Central Office, verification is done after first encoding and validation, after second encoding ○ In some PROs, a Route Slip is generated after initial encoding, cut, then, attached to the documents. ○ Reprinting of Benefits Payment Notice (BPN) due to errors identified during voucher and check preparation 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Continue to implement the Team Approach at the Central Office. Implement at PROs, where applicable <p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Simplify and streamline the Claims process. <ul style="list-style-type: none"> ➤ Eliminate data verification after first encoding. ➤ Implement the following process : <ul style="list-style-type: none"> ○ Receive Claims documents ○ Encode members' PIN / healthcare provider Accreditation No. ○ Perform medical evaluation ○ For claims with adjustments or questions, pass through manual processing ○ Encode the processed claims data (e.g. room and board, drugs, etc) ○ Validate amount totals. ○ Generate vouchers and checks ○ Generate the Benefits Payment Notice (BPN) ➤ Allow the medical evaluators and other claims processing staff to sign on the Claims document 	<ul style="list-style-type: none"> • The proposed procedures seek to eliminate the verification of documents after initial encoding and the use of the route slip to track claims documents in process. <ul style="list-style-type: none"> ➤ As explained, initial verification is done to check on the following : <ul style="list-style-type: none"> ○ Correctness of members' data encoded into the system ○ Completeness of documents to support eligibility to avail of Philhealth's benefits as well as currentness of members' contributions ➤ On the other hand, the Route Slip is used to track the status of claims documents in process, identify the people responsible for processing claims documents, and logging documentary deficiencies. • The steps mentioned above can be dispensed with when the following conditions have been met : <ul style="list-style-type: none"> ➤ The Claims Processing System



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Findings	Recommendations	Comments
	<p>itself to eliminate the use of Route Slips</p> <ul style="list-style-type: none"> • Provide Service Office personnel with performance support tools, such as, Operations Manuals, etc. to help them perform their responsibilities effectively 	<p>fully integrates with the Membership System (for members' personal data) and the Philhealth Member Accounts Information System (for eligibility checking, based on contributions).</p> <ul style="list-style-type: none"> ➤ The Membership Database is up-to-date and cleansed of erroneous, obsolete, and duplicate data. ➤ The Membership Accounts Database is up-to-date with members' contributions. • The implementation of the proposed procedure should, therefore, be recategorized into long-term, rather than quick win.
<p>2) Indications of fraudulent claims have been observed.</p> <ul style="list-style-type: none"> ➤ Higher amount of claims filed by the healthcare providers vs. compensable claims deducted from patients' bills ➤ Examples of repeating cases of suspicious claims have been noted ➤ Non-prosecution of healthcare providers with repeating cases of fraudulent claims 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Require the healthcare providers to attach a copy of the Summary of Statement of Accounts paid for and signed by the member to the Claims documents • Conduct an awareness campaign among members (through the Account Management Team of Marketing) regarding claims benefits • Enforce suspension / revocation of accreditation, based on repeating indications of fraudulent claims • Coordinate with Legal on the level of documentary 	<ul style="list-style-type: none"> • There should be clear policy guidelines on how to handle fraudulent claims and what to look for to prosecute fraudulent cases. • There should also be an Operations Manual for Hospital Monitoring that spells out the following : <ul style="list-style-type: none"> ➤ Qualifications of Philhealth personnel to be involved in Hospital Monitoring ➤ Hospital Monitoring procedures to



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Findings	Recommendations	Comments
	<p>evidence necessary to file a legal case against the hospitals</p> <ul style="list-style-type: none"> • Authorize the Healthcare Provider Relationship Management Team to conduct onsite inspections of patient admissions and other relevant records (with appropriate permission from the healthcare providers) 	<p>be undertaken by the assigned personnel</p> <ul style="list-style-type: none"> ➤ Procedures for handling fraudulent claims and bringing legal action against the erring healthcare provider. • Refer to “Manage Healthcare Provider Relations” for additional comments
<p>3) Lack of information to perform eligibility checking</p> <ul style="list-style-type: none"> ➤ Absence of UCPS interface with the Membership and Member Accounts Information Systems ➤ Lack of information to do 45-day eligibility checking <ul style="list-style-type: none"> ○ Inability to compile and consolidate all benefits utilized by a member (because of portability of the benefits) ○ Delayed claims information due to the 60-day grace period to file the claim and the additional 30 or 60 days to process a claim 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Include information on previous confinements in the Philhealth Claims form. • Enable the 45-day eligibility checking module of UCPS at the PROs – to, at least, be able to implement the eligibility check within a region. <p><u>Long-Term</u></p> <ul style="list-style-type: none"> • Develop and implement a computerized Claims Processing System that : <ul style="list-style-type: none"> ➤ Integrates with Membership and Member Accounts Information System ➤ Keeps a history of past illnesses (ICD-10s) and compensable benefits utilized by member and member dependent ➤ Enables claims data sharing across Philhealth offices nationwide • Decentralize the implementation of the integrated 	<ul style="list-style-type: none"> • The 45-day eligibility checking for benefits payment can be strictly enforced only if healthcare providers can : <ul style="list-style-type: none"> ➤ Perform online eligibility checking of members against Philhealth’s database ➤ Record member or beneficiary admissions to Philhealth’s Claims database – immediately upon admission. • With the proposed extension of the claims filing period from 60 days to 120 days, the 45-day eligibility checking, given Philhealth’s current technology infrastructure, will become even more difficult. • A proposal has been floated in the past to delete the 45-day eligibility checking



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Findings	Recommendations	Comments
	<p>system to the PROs</p> <ul style="list-style-type: none"> Accelerate the implementation of HOMIS by DOH Enable electronic filing of claims 	<p>from the implementing guidelines. The proposal, however, has not been accepted by the Actuarial Group.</p> <ul style="list-style-type: none"> HOMIS is being pilot-tested by DOH. Refer to “Manage Healthcare Provider Relations” for additional comments.
<p>4) Delay in the receipt by the PROs of information about the accreditation / reaccreditation of healthcare providers</p>	<p><u>PROs</u></p> <p><u>Quick Win</u></p> <ul style="list-style-type: none"> Advise healthcare providers of the expiry of their accreditation 4 months in advance Monitor compliance by hospital providers of requirements for accreditation or re-accreditation Submit to the Central Office, at least 1 month prior to accreditation expiry, all the mandatory requirements for compliance Resolve issues that could deter approval of the accreditation by the Accreditation Committee <p><u>Medium Term</u></p> <ul style="list-style-type: none"> Assign the Healthcare Provider Relationship Management Team to ensure compliance with accreditation requirements <p><u>Central Office</u></p> <p><u>Quick Win</u></p> <ul style="list-style-type: none"> Upon receipt of documentation from the PROs, include the application in the agenda for the 	<ul style="list-style-type: none"> Clear policy guidelines for accreditation and renewal of accreditation should be developed – so that : <ul style="list-style-type: none"> ➤ Applications that fully comply with Philhealth’s accreditation requirements can be reviewed and approved by an Accreditation Group, composed of organic personnel of Philhealth. ➤ Only applications with problems and issues are passed on to the Accreditation Committee for deliberations and resolution. There is an existing interface problem between UCPS and the latest version of the Accreditation System, relating to the Accreditation number generated and issued by the Accreditation System. A workaround has been implemented by MIS to remedy the problem.



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Findings	Recommendations	Comments
	<p>Accreditation Meeting</p> <ul style="list-style-type: none"> Disseminate information on accredited healthcare providers immediately after approval by the Accreditation Committee. <p><u>Medium-Term</u></p> <ul style="list-style-type: none"> Allow the PROs to update their accreditation databases in their respective sites 	<ul style="list-style-type: none"> There is a plan to develop a new Claims Processing System to replace UCPS. The Terms of Reference (TOR) is being developed. Refer to "Manage Healthcare Provider Relations" for additional comments.
5) Policy of allowing individually paying members to avail of benefits after 3 premium payments within a 6-month period – subject to abuse	<ul style="list-style-type: none"> Revisit the policy – require at least 12 months premium payments (or as necessary) for specific compensable cases 	
<p>6) Coordination and communication lines between the Central Office and the PROs with regard to the issuance of new circulars and guidelines can further be enhanced.</p> <ul style="list-style-type: none"> ➤ Variations in the interpretation of Philhealth circulars ➤ Delay in the transmittal of circulars to PROs -- in some cases, healthcare providers have received copies of the circulars, but PROs have not been provided with their copies of the circulars ➤ Inability of healthcare providers to receive their copies of Philhealth circulars 	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> Manage the timing of the issuance of circulars Post new circulars or amendments to existing ones to the Philhealth website. Assign a staff responsible for posting circulars to the Philhealth website as soon as the circular is approved. Send follow-up emails to the PROs to inform them that new circulars have been released, with an electronic copy of the circular. Update the mailing / emailing list of healthcare providers. Group email the circulars. Publish the circulars in newspapers of general circulars and newsletters of medical associations; 	<ul style="list-style-type: none"> Corplan's SPREAD project will cover the up-to-date posting of circulars to the Philhealth website. Emphasis was placed on the need for clear guidelines and performance support tools before implementing a new process, policy, or guideline. Circulars to be mailed through the Central Records Section should be forwarded to Central Records at least two (2) months prior to effectivity. For example, circulars that will take effect in January 2003 should be submitted to Central Records for mailing by November 2002.



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Deliver and Manage Benefits

Findings	Recommendations	Comments
	<p>include an advisory to visit the Philhealth website to obtain copies of new circulars, guidelines, and updates to existing ones.</p> <ul style="list-style-type: none"> • Require the hospitals to post Philhealth circulars in areas frequently visited by their medical staff • Consult the affected departments, divisions, or PROs on the viability and clarity of the circulars and guidelines prior to release or implementation • For greater clarity : <ul style="list-style-type: none"> ➤ Anticipate and illustrate potential scenarios that could result from the implementation of the circular ➤ Present calculations to illustrate a point, if necessary. • Simulate the implementation of the circular over a designated area, as necessary. • Revisit the procedures of Central Records for releasing circulars to PROs and healthcare providers • Ensure that support systems to implement the circulars or guidelines are ready • Accomplish a Rollout Readiness Checklist to ensure that everything is in place to operationalize a system, new process, etc 	<p>November 2002.</p>



**Business Process Review
Summary of Findings and Recommendations**

Deliver and Manage Benefits

Findings	Recommendations	Comments
7) Cases of documents lost in transit from the Service Offices to the PROs	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Develop control procedures over the transmittal of documents <ul style="list-style-type: none"> ➤ Bundle and pack the documents safely in boxes, if voluminous ➤ Prepare Transmittal Control Slips (one copy to be signed by the recipient as acknowledgment copy) ➤ Pinpoint responsibility over the documents 	
8) Inaccurate information provided by Information staff to the members	<p><u>Quick Win</u></p> <ul style="list-style-type: none"> • Identify staff who have demonstrated competence in serving as information staff • Continuously train information staff on new Philhealth rulings and member requirements • Provide the information officers with tools (for ex. database of documentary requirements for membership, access to status of claims, etc) to be able to respond promptly to members' / potential members' queries 	



APPENDIX F

BUSINESS PROCESS REVIEW

IMPLEMENTATION PLAN



APPENDIX G

BUSINESS PROCESS REVIEW

COMMUNICATION PLAN



Business Process Review General Communication Plan

Target Audience	Key Messages	Medium	Timing	Responsible	Status
PhilHealth Employees	<ul style="list-style-type: none"> Introduce Business Process Review project; explain: <ul style="list-style-type: none"> Rationale Importance to PhilHealth Objectives Scope Organization and roles 	<ul style="list-style-type: none"> Memorandum Newsletter 	September 2002	<ul style="list-style-type: none"> Project Team Corporate Communication 	Done
PhilHealth Employees	<ul style="list-style-type: none"> Discuss status of the project Discuss next steps 	<ul style="list-style-type: none"> Memorandum Newsletter 	November 2002	<ul style="list-style-type: none"> Project Team 	To be scheduled <i>(Refer to Appendix H)</i>
Process Owners and Business Process Review Team	<ul style="list-style-type: none"> Validate findings and recommendations Gather comments and feedback 	<ul style="list-style-type: none"> Presentation / Discussion 	November 2002	<ul style="list-style-type: none"> Project Team 	Done
Executive Committee	<ul style="list-style-type: none"> Findings and recommendations Approval of the recommendations Implementation Plan Communication Plan 	<ul style="list-style-type: none"> Presentation / Discussion 	November 2002	<ul style="list-style-type: none"> Project Team 	On-going
Change Network (FGD Participants)	<ul style="list-style-type: none"> Provide update on steps taken after FGDs Discuss next steps Discuss future roles 	<ul style="list-style-type: none"> Letter Memorandum 	November 2002	<ul style="list-style-type: none"> Project Team 	To be scheduled
Process Owners and Implementation Team	<ul style="list-style-type: none"> Conduct Implementation Workshop 	<ul style="list-style-type: none"> Workshop 	December 2002	<ul style="list-style-type: none"> Program Management Secretariat 	To be scheduled

APPENDIX H

BUSINESS PROCESS REVIEW

LETTER TO FOCUS GROUP DISCUSSION PARTICIPANTS



Appendix H

November 29, 2002

Greetings!

We would like to reiterate our appreciation for your participation in the Focus Group Discussion (FGD), which we have conducted in relation to the Business Process Review initiative. As small token of our appreciation, we are providing you with a xxxxx and a Certificate of Participation.

We would also like to take this opportunity to give you an update on the status of the Business Process Review. After completing the series of FGDs, we have synthesized the results into an Operations Assessment Report containing our findings and recommendations. The recommendations are envisioned to help PhilHealth achieve operational and process excellence, improve organizational capabilities and address the concerns and issues that you have identified during the FGD.

To gather feedback and comments on the findings and recommendations, we have conducted series of validation meetings with the Process Owners. Presentation and discussion with the Executive Committee are still on-going to get the final management approval to implement the initiatives.

Moving forward, we would like to reiterate your valuable role in implementing the initiatives that will be approved by the Executive Committee, particularly within the next 3 months. As change agents, you are expected to take an active role in espousing the benefits of the initiative to your peers, participate in implementation briefings and training, and act as the role model for the new capabilities that will be rolled out.

The details of the initiative, in terms of scope, duration, extent of change and your specific roles will be communicated to you as soon as they get finalized.

Again, thank you very much.

Business Process Review Team