[ADMINISTRATIVE ORDER NO. 2018-0001, August 30, 2018]

STREAMLINING ACCESS TO MEDICAL ASSISTANCE FUNDS OF THE GOVERNMENT

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I. BACKGROUND

One of the key strategies of the Philippine Development Plan 2016-2022 is covering all Filipinos against financial health risk. This shall be done through mobilizing, streamlining, and harmonizing access to various, discrete fund pools to avoid inefficient overlaps in financing health. These include funds from the Department of Health (DOH), Philippine Health Insurance Corporation (PhilHealth), Philippine Charity Sweepstakes Office (PCSO), and Department of Social Welfare and Development (DSWD), among others.

From 2011-2014, PhilHealth set predetermined rates for essentially all inpatient conditions. The shift to case rates as the predominant payment mechanism enabled the implementation of the No Balance Billing Policy (NBB), which stipulates that indigent patients shall be provided with complete quality care and all necessary healthcare services to attain best possible health outcome, free of any other fees above and beyond the PhilHealth package rates during their confinement period. This is anchored on Section 2 of Republic Act

(RA) 10606, which declares that "the State shall provide comprehensive health care services to all Filipinos…and provide free health care services to indigents." The coverage of the NBB policy was further expanded to sponsored and household help members through PhilHealth Circular No. 2014-0003, and senior citizens by virtue of Section 4 of the Expanded Senior Citizens Act of 2010 and PhilHealth Board Resolution No. 1924 which mandates the entitlement to NBB policy of PhilHealth by all senior citizen members including Lifetime Members and Kasambahays who are 60 years old and above.

The published case rate, however, is not always sufficient to cover actual costs incurred, thus, requires augmentation from other funding sources such as PCSO and DOH Medical Assistance to Indigent Patients Program for direct health services. Hence, in the strengthened NBB Policy as espoused in PhilHealth Circular No. 2017-0017, Section III.B, partner agencies were explicitly recognized as sources of financing to fully cover all facility charges in the event of an insufficiency.

II. OBJECTIVES

This Order is being issued to (1) define the roles of DOH, PCSO, and DSWD in augmenting the financing provision of the NBB Policy for Case Rates and Z Benefits and (2) outline a streamlined process for accessing these funds by the members and dependents.

III. SCOPE AND COVERAGE

This Order applies to all PhilHealth-accredited health care providers catering to patients in non-private or service settings and all offices of the DOH, PhilHealth, PCSO, and DSWD excluding full complementation packages.

IV. DEFINITION OF TERMS

1. **Benefit Package** – services that PhilHealth offers to members, subject to the classification and qualification in its Revised Implementing Rules and Regulations.

2. **Case Rates** – a payment scheme where a standard, pre-determined rate/amount with professional fee component is reimbursed to a health care facility for each episode of care provided to a patient.

3. **Endowment Fund Program (EFP)** – funding assistance provided to DOH- licensed government hospitals to augment the NBB policy of PhilHealth.

4. **Total Charges** – total medical bill including professional fee incurred by a patient in seeking care in a facility.

5. **Individual Medical Assistance Program (IMAP)** – PCSO flagship program designed to augment the financial needs of individuals for the management of health-related concerns.

6. **Medical Assistance to Indigent Patients Program (MAIP)** – program of the DOH providing medical assistance to poor and indigent patients in government hospitals.

7. **NBB Patients** – patients covered under the No Balance Billing Policy of PhilHealth (PhilHealth Circular No. 0003, s. 2014), who are admitted in service accommodation.

8. **Non-medical expenses** – costs incurred by a patient in availing health services, outside of the actual costs of medical care, which may include transportation costs, accommodation, meals, etc.

9. **Quantified Free Service (QFS)** – the cost of treatment subsidized by the maintenance and other operating expenses (MOOE) received from the National Budget and Income of the hospital.

10. **Z Benefit Packages** – PhilHealth benefit packages that cover a unique set of high-cost, catastrophic illnesses.

11. **Malasakit Center** – an area in which various payors (e.g., PCSO and

DOH MAIP desks) will be housed to streamline the process for patients in availing financial assistance.

12. **Individual-based Intervention** – health care goods and services that can be definitively traced back to a singular person, can be public health (e.g. vaccines) or personal care (e.g. primary care consultation, hospital services). 13. Full complementation packages – benefit packages which PhilHealth and PCSO have agreed to jointly finance.

V. GENERAL GUIDELINES

1. All classified indigent patients in non-private or service settings in all PhilHealth-accredited government health care providers shall be entitled to No Balance Billing.

2. All direct medical expenses shall be augmented by PCSO and DOH MAIP while all non-direct medical expenses such as transportation shall be covered by DSWD.

3. All funds for medical assistance shall be coursed through the health care providers. Patients shall no longer need to file separate application to obtain support from PCSO and DOH MAIP.

4. All PhilHealth-accredited health care providers shall establish "Malasakit Center" in which the various funding sources (e.g. PCSO ASAP and DOH MAIP desks) will be housed in one area to streamline the availment of funding assistance of patients admitted in service accommodation.

5. All agencies shall jointly develop an effective communication strategy. Specifically, all government health care providers shall make available clear Information, Education and Communication (IEC) materials to inform patients regarding the harmonized medical assistance program and streamlined process of availment.

6. All agencies shall establish a joint mechanism to resolve grievances and meet regularly to discuss the progress of the implementation of this Order, specifically results of exit surveys of patients and availability of funds.

7. All complaints shall be lodged through the Citizen's Complaint Hotline, 8888. Only complaints with all the following information will be acted upon: a) name and address of the complainant; b) name of the offender and/or institutions; c) direct and concise statement of the offense; and d) name of the agency (PhilHealth, DOH, PCSO, DSWD) to which the relief is sought.

8. PhilHealth and PCSO shall publish the list of full complementation packages annually.

9. The health care providers shall bill all agencies according to existing guidelines and procedures.

VI. SPECIFIC GUIDELINES

A. Order of Charging

The health care provider's billing section shall coordinate closely with the Medical Social Worker to tap the sources of financing for the patient's bill in the following order:

1. **PhilHealth:** Support shall be based on the published case rates per PhilHealth Circular No. 0031, s. 2013 and other circulars pertinent to Z benefits.

2. **Private Health Insurance:** Support shall be based on insurance plan/policy with the private insurance or health management organization, if applicable.

3. **Mandatory Discounts and Benefits:** Discounts for Senior Citizens, Persons with Disabilities (PWDs), SSS members, DOH employees and other authorized discounts shall apply in the billing of the service patient/s.

4. **PCSO:** Funds shall be sourced from the Endowment Fund Program (EFP), if applicable. In cases where there is no EFP or once EFP has been consumed, the Individual Medical Assistant Program (IMAP) shall be tapped.

   a. For Case Rates, maximum support shall be equal to 100% of prevailing PhilHealth case rates.

   b. For Z Benefits, support will focus on services excluded in the package.

   c. No professional or room and board fees may be charged to: the patients, the PCSO or DOH MAIP funds. For DOH or LGU hospitals, the room and board and professional fees are covered by DOH's or LGU's subsidy as maintenance and other operating expenditures (MOOE) and personal services.

   d. All government hospitals shall establish PCSO ASAP (At Source Ang Processing) desks and all government hospitals shall receive periodic DOH MAIP sub-allotment.

5. **DOH MAIP.** Maximum support shall be based on its guidelines, subject to availability of funds.

6. **PhilHealth-Accredited Health Care Providers.** All remaining expenses shall be charged to the health care provider's MOOE or income as Quantified Free Services (QFS) for patients in service or non-private settings.

Table 1. Sources, Uses and Limitations of Funds for Direct Medical Expenses
