Factors Affecting Delays in PhilHealth Electronic Claims Reimbursement Among Hospitals: An Initial Study

Gene A. Nisperos, MD[1]; Alvin B. Caballes, MD, FPCS[2] and Philip C. Zuñiga[3]

Background: In the continuity of care, family and community physicians take into consideration patient insurance coverage, especially for those who require higher levels of care. The Philippine Health Insurance Corporation (PhilHealth) has had its electronic reimbursement claims processing since 2011 but the utilization of this system by hospitals may be affected by delays in claims reimbursement. Factors associated with such delays warrant further investigation.

Objectives: This study aimed to determine the perceived factors by concerned hospital staff that affect delays in PhilHealth's electronic claims processing system.

Methods: Three focus group discussions (FGDs) were conducted using a predetermined set of questions. The hospitals were selected from respondents of a survey of a bigger study on the applicability of PhilHealth's electronic claims processing. Each FGD involved eight-to-ten participants, mostly PhilHealth officers or information technology personnel from different hospitals covering Luzon, Visayas, and Mindanao. The hospitals were of different types/levels and included both government-run and privately-owned.

Results: Factors affecting delays in electronic claims reimbursement are intrinsic to the hospitals' operations, with delays in obtaining the physician's signature as the most common cause. Accessing PhilHealth's server was another major factor and was aggravated by problems in clarifying patient eligibility, non-updated data, and variations in the emphasis of regional evaluators. Hospitals within the national capital region and those using their own electronic medical records and health information system had better experiences with the electronic claims reimbursement.

Conclusions: The main factors affecting delays in electronic claims reimbursement among hospitals are associated with the hospitals' institutional processes. The active participation of family physicians and primary care providers can help address these issues and subsequently improve service delivery, PhilHealth utilization, and overall patient satisfaction.

Keywords: PhilHealth, claims, electronic, reimbursement, delay

Introduction

Primary care physicians, family and community doctors alike, provide a continuity of care that may occasionally require higher levels of medical intervention. As such, they must take into consideration patient insurance coverage, especially for those who require hospitalization. In the Philippines over the last decade, the Philippine Health Insurance Corporation (PhilHealth) has taken a central role in health service delivery by providing financial support.

In 2011, PhilHealth introduced its claims portal with the aim of enabling the online submission of claims by health care institutions.[1] By improving the claims process, hospitals and physicians would be able to provide more efficient service, as they would be relieved of administrative burdens. As such, government-run and privately-owned hospitals across the country began changing their systems in order to adapt to the new processes.

* From the Department of Family and Community Medicine College of Medicine

[1] Department of Family and Community Medicine, College of Medicine, University of the Philippines-Manila

[2] Department of Surgery, Philippine General Hospital and College of Medicine, University of the Philippines-Manila

[3] Department of Computer Science, College of Science, University of the Philippines-Diliman

The benefits of electronic claims processing as opposed to paper-based systems was already cited by the American Medical Association as early as 2008.[2] The Association encouraged physicians to use electronic claims in their practice in order to provide significant financial savings for both the doctor and the patient. Similar benefits were later corroborated by Welte in 2012 and by Ramlet, et al. in 2013.[3,4] These were also the objectives of PhilHealth in establishing its online claims processes.

However, one issue attendant to electronic claims processes is the matter of delays. This meant that reimbursements were still not being released within the approved period despite following the prescribed procedures. In 2015, Marting cited six main reasons for denials in reimbursement claims and concluded that "poor management of the claims process can be detrimental to the financial health and sustainability of a practice, so avoiding claims denials should be the responsibility of everyone in the practice."[5] Holtrop, et al. also recognized the need for sufficient reimbursement to initiate and maintain care management for patients in primary care.[6]

In the Philippines, despite several studies on the utilization of PhilHealth and its reimbursement claims processes,[7,8] there remains a paucity of data as regards hospital utilization of PhilHealth's electronic claims processes. Since the time that PhilHealth rolled out its electronic claims processing in 2011, there had been no external objective assessment of its utilization and impact on health care providers and on patient care. A study by Caballes, et al. on computer-based health insurance claims processing and disparities in hospital capacities revealed that the use of PhilHealth's electronic systems was not significantly associated with duration of claims processing.[9]

The main objective of this study, therefore, was to determine the factors perceived to affect delays in PhilHealth's electronic claims processing system. More specifically, it aimed to gather the insights and actual experiences of different hospitals as a means to improve PhilHealth's electronic claims system. These concerns are important for family physicians as these may impact on their practice and on the effective delivery of services and care to their patients who are hospitalized.

Methods

This descriptive study was part of a bigger evaluation of PhilHealth's electronic enrolment verification system.[10] The present study focused on the qualitative assessment undertaken therein. The research protocol was designed in consultation with the Department of Health (DOH) and PhilHealth officials. The Ethics Review Board of the University of the Philippines in Manila approved the protocol, including the focus group discussion (FGD) questions. All of the participants provided written informed consent.

The hospitals were respondents in the aforementioned survey and were selected based on their location, level, and type of ownership. They were supposed to represent a cross-section of hospitals as health care institutions (i.e., DOH government-owned and controlled corporation (GOCC) hospital, DOH regional hospital, non-Metro Manila local government unit (LGU) secondary hospital, non-DOH/non-LGU government hospital, private tertiary hospital, non-Metro Manila private secondary hospital, and geographically-isolated and disadvantaged area (GIDA)-located hospital. The actual FGD participants were the hospital's PhilHealth officer or an information technology (IT) staff in charge of PhilHealth claims. Only one hospital sent its medical director, but their PhilHealth officer accompanied her.

The FGD questions were based on the trends established during the survey, which was an outcome of the bigger study.[10] The main areas of interest were 1) the ICT capacity of the hospitals, including the computerization of hospital processes and use of HIS; 2) ICT infrastructure such as internet connectivity; 3) experiences and hospital practices as regards PhilHealth's electronic claims processes; and 4) recommendations to improve PhilHealth's strategies. "Delay" was defined as claims reimbursement that took longer than the turnaround time set by PhilHealth for each specific region.

Three FGDs were conducted. The first was held on August 18, 2015 in Manila. Of the eight hospitals from the national capital region (NCR) that were invited, five participated. The second FGD was held on August 20, 2015 in Cebu City and focused on hospitals from the Visayas and Mindanao. All 10 invited hospitals came. The third FGD was held on September 29, 2015 also in Manila, but focused on hospitals from Northern Luzon and the Cordillera Administrative Region (CAR). Eight of the 12 invited hospitals participated. All of the FGDs were conducted by the principal investigators and were duly recorded. The responses were collated, reviewed, and analyzed. Common and frequent responses were tallied and taken as trends.

Results

Profile of Participating Hospitals

There were 23 hospitals from nine regions (five in Luzon, two in the Visayas, and two in Mindanao) that participated. They represented two metro cities (Metro Manila and Metro Cebu), three charter cities (Zamboanga, Cagayan de Oro, and Baguio), and 10 provinces (Benguet, Isabela, Cagayan Valley, Leyte, Southern Leyte, Cebu, Zamboanga del Sur, Bukidnon, Pangasinan,

and Nueva Ecija). Their specific characteristics are shown in Table 1.

Based on PhilHealth's classification, of the 23 hospitals, eight were level 1 (four private and four public), seven were level 2 (four public and three private), and eight were level 3 (seven public and one private) (Table 2).[11,12] The number of claims that they submitted to PhilHealth ranged from 200 per month (level 1) to at least 3,000 per month (level 3).

In-hospital Factors that Cause Delays in Electronic Claims Processing

The most common reason for delays in the filing of claims from the time of patient discharge was the delay in obtaining the signature of the attending physician. Hospital staff had to find ways of ensuring that doctors signed whenever they come to the hospitals. According to one participant in FGD 1, "Delays are caused

Table 1. Characteristics of participating hospitals in the focus group discussions

	Hospital	Location	Region	Ownership	Level
FGD 1: NCR	UP-Philippine General Hospital	Manila	NCR	Public	3
	Amang Rodriguez Medical Center	Rizal	NCR	Public	3
	Ospital ng Tondo	Manila	NCR	Public	2
	Alabang Medical Clinic	Muntinlupa City	NCR	Private	1
	Rizal Provincial Hospital System - Antipolo Annex	Rizal	NCR	Publi c	1
FGD 2:					
Visayas and Mindanao	Cebu Provincial Hospital - Danao City	Danao City, Cebu	7	Public	1
	Vicente Gullas Memorial Hospital, Inc.	Mandaue City, Cebu	7	Private	2
	Vicente Sotto Memorial Medical Center	Cebu City	7	Public	3
	Salvacion Oppus Yniguez Memorial Provincial Hospital	Southern Leyte	8	Public	2
	Tacloban Doctors' Medical Center	Tacloban City, Leyte	8	Private	2
	Mindanao Central Sanitarium	Zamboanga City	9	Private	1
	Zamboanga Puericulture Maternity Lying-In Hospital	Zamboanga del Sur	9	Private	1
	Navarro General Hospital	Zamboanga City	9	Public	1
	St. Joseph Southern Bukidnon Hospital	Maramag, Bukidnon	10	Private	2
	Northern Mindanao Medical Center	Cagayan de Oro City	10	Public	3
FGD 3:					
Northern and Central Luzon	Lingayen District Hospital	Pangasinan	1	Public	1
	Southern Isabela General Hospital	Isabela	2	Public	2
	Cagayan Valley Medical Center	Cagayan Valley	2	Public	3
	Isabela Doctors General Hospital	Isabela	2	Private	2
	Dr. Paulino J. Garcia Memorial Research and Medical	Nueva Ecija	3	Public	3
	Premiere Medical Center	Nueva Ecija	3	Private	3
	Baguio General Hospital and Medical Center	Baguio City	CAR	Public	3
	Benguet General Hospital	Benguet	CAR	Public	2

Table 2. Summary of participating hospitals in the focus group discussions

	Total	Type					
		Level 1		Level 2		Level 3	
		Public	Private	Public	Private	Public	Private
1: NCR	5	1	1	1	-	2	-
2: Visayas and Mindanao	10	2	2	1	3	2	-
3: Northern and Central Luzon	8	1	1	2	-	3	1
Total	23	4	4	4	3	7	1

by the declaration of final diagnosis or description of procedures, both of which are dependent on doctors. Obtaining the doctors signature is also a major problem." Another participant from FGD 2 commented that, "Doctors sometimes go to the hospital only once every week, not everyday. So the hospital personnel has to find ways of making sure that they sign when they come to the hospitals." This problem was more pronounced in public hospitals than in private ones, regardless of level.

In terms of the lag time for reimbursements, there was no discrepancy among hospitals of different levels. However, there was a notable discrepancy between hospitals within NCR and those outside NCR. For those within NCR, the fastest reported turnaround time from filing of claims to actual reimbursement was one week. The longest was 30 days. Even for hospitals in NCR that used manual processing, the period from patient discharge to claims filing ranged from 45-50 days, but the period from filing to reimbursement was only two weeks.

In contrast, those outside NCR reported an average of four months. Hospitals from the Visayas and Mindanao had the longest lag time between claims filing and reimbursement, ranging from two to six months. For hospitals from Region 8, there was the particular issue involving claims affected by Typhoon Yolanda. For hospitals in northern and central Luzon, the lag time is around one month.

The FGDs revealed that the current capacity of hospitals to engage in electronic processes was another factor. One-third of the FGD participants were still using manual or mixed manual and electronic health information systems (HIS). Most of these hospitals were public or government-owned but included level 1 to level 3 hospitals.

The mode of processing claims varied across hospitals from different regions and did not correlate with hospital level. For instance, the biggest government-run hospital still had a manual processing system for their PhilHealth claims. In contrast, a privately owned level 1 hospital in northern Luzon used an electronic HIS to process their PhilHealth claims. Not all of the participating hospitals had an IT department or dedicated staff.

Factors Inherent to PhilHealth's Electronic Claims Processes

The second most common reason for delays involved problems in clarifying the patient's eligibility status, particularly in terms of single period confinement. According to the FGD participants, this information was not always readily available from the electronic processes of PhilHealth. Many hospitals also experienced how PhilHealth's claims portal would verify and then later deny eligibility shortly after. Moreover, the portal did not offer many of the information needed by hospitals, including days of confinement, days available, violations of the single period of confinement/45-day rule, names of dependents, and status of claims.

The assistance provided by PhilCARES, who were the PhilHealth personnel assigned to particular hospitals in order to provide assistance in using PhilHealth's processes and expedite claims, drew varying reactions across FGDs. For participants of FGD 1, the PhilCARES staff members were not very reliable. "Mabagal din sumagot" was the description given in terms of providing assistance for inquiries on member qualifications. Nonetheless, participants of FGD 2, particularly those from hospitals in Regions 1, 2, 3, and CAR (FGD 2), noted that staff members of PhilCARES had much better access to certain pertinent information, thereby providing much appreciated assistance. One even asked, "Bakit po yung PhilCARES na staff, pareho lang naman yung system na ginagamit sa amin, pero mas may information sila na nakukuha. Di kaya pwede na may access din kami na ganun?"

Some major causes of delays were attributed to PhilHealth's own processes. Some claims were categorized as "RTH" (return to hospital) for several reasons related to PhilHealth's evaluators, since different evaluators asked for different things. For example, for participants of FGD 2, some were RTH because the evaluators had questions regarding the claims. Many of the participants from hospitals outside NCR expressed concern that evaluators missed things that were actually there. Thus, they merely returned the claims and informed the evaluators. There were also delays whenever PhilHealth had new evaluators because these evaluators asked for or emphasized different things. For hospitals in the Visayas and Mindanao, there were experiences wherein the "RTH" was even sent to the wrong hospital.

There were delays attributable to PhilHealth's regional processes. In FGD 3, some hospitals first submitted their claims to their local PhilHealth office. Only those who were near their PhilHealth regional offices submitted directly to them. There were also instances when the PhilHealth regional office set additional requirements. Again, in Region 3, the PhilHealth regional office added some more requirements due to suspicion of malicious claims.

Lastly, there was an overwhelming observation that the main problem with PhilHealth was the difficulty in accessing the PhilHealth server. The hospitals were told to get better Internet connection but this still did not ensure connection. The problem was supposedly more significantly felt during periods of "heavy traffic", or when many hospitals were using the system.

PhilHealth's electronic portal was useful but only for eligibility verification. Many participants also experienced how the portal would verify and then deny eligibility shortly after. The portal did not offer many of the information needed by hospitals, including days of confinement, violations of the single period of

confinement/45-day rule, names of dependents, and status of claims.

Discussion

The findings of this study reveal that factors affecting delays in electronic claims reimbursement are largely related to the hospitals' operational processes, with delays in obtaining the physician's signature as the most common cause of delay in claims filing. Hospitals within NCR and those with their own electronic medical records (EMR) and HIS have a faster turnaround time of claims reimbursement compared to those outside NCR or those with manual, paper-based systems because the former are able to deal directly to the system of PhilHealth's central office, thereby bypassing potential local and regional hurdles, like varying requirements and demands of regional evaluators. However, accessing PhilHealth's server is another major issue, as the massive volume of data inflow cannot be readily accommodated by PhilHealth's system. This is aggravated by problems clarifying patient eligibility status stemming from non-updated data.

Most of the studies on electronic reimbursement claims processing focus on EMR and telehealth and how these can improve the efficiency of claims processes. In a 2018 article, LePointe posited that the use of electronic claims management processes might reduce costs and administrative burden.[13] In 2015, Britton pointed out that the reimbursement mechanisms could be made more accurate and efficient, with subsequent improvements in the quality of medical care, when electronic data such as EMRs are used.[14] On the other hand, despite concerns that hospitals may use electronic health records to generate more revenue through higher reimbursements, the 2014 study by Adler-Milstein and Jha found no empirical evidence to this effect.[15]

Nonetheless, studies also link reimbursement delays to physician participation. A study on Medicaid and MD reimbursement in 2006 revealed, "Physicians' willingness to participate (in Medicaid) is based in large part to the reimbursement provided."[16] Similarly, the study by Cunningham and O'Malley in 2009 showed that slower reimbursement is associated with poorer physician participation. They also proposed the use of electronic claims processing to increase the speed of payment.[17] Given that many family medicine doctors also admit patients to level 1 hospitals, their participation will be key in expediting claims.

In the Philippines, the use of EMRs and digital health information systems may still be considered in its nascent stages. In several articles published in 2016, the National Telehealth Center recognized that while the Department of Health considers information and communications technology as a significant tool for achieving its health agenda, so much needs to be done in terms of governance, policy, financing, and infrastructure.[18,19] More recently, Obermann et al. included a stronger push for electronic health as part of the reforms needed to be instituted by PhilHealth in order to "leapfrog key processes" and "improve convenience for patients and providers".[20] Hence, obtaining a clearer picture of EMRs and electronic reimbursement claims in the landscape of Philippine health service delivery remains a work in progress.

Taken together, the findings here as well as those of previous studies on the issue of delays in claims reimbursement suggest an impact on primary care providers, from family medicine doctors with their private clinics to those who practice in level 1 and 2 hospitals. Their awareness of their roles in PhilHealth's electronic claims processes may affect the delivery of health services, which is essential in the continuity of care and in patient satisfaction.

One limitation of this study is the size of the respondents. More hospitals, particularly level 1 and level 2 hospitals, can provide a better landscape of issues affecting frontline health care institutions. Another limitation is that this study did not take into consideration the different types of HIS used by hospitals (i.e., iClinicsys, Community Health Information Tracking System [CHITS], Wireless Access for Health [WAH], and Secured Health Information Network and Exchange [SHINE]). The different HIS, by themselves, may contribute to delays in reimbursement claims owing to their inherent discrepancies that affect how electronic reimbursement claims are processed. While the findings of the current study remain valid in providing guidance to hospitals and to PhilHealth on how to improve their respective claims systems, further large-scale and longitudinal studies are warranted.

Conclusions and Recommendations

Factors affecting delays in electronic claims reimbursement among hospitals are mainly related to institutional processes. On one hand, hospitals cite difficulties in obtaining a doctor's signature as the most common cause of delay. This is aggravated by the hospital's lack of electronic systems like an EMR and HIS. On the other hand, PhilHealth itself contributes to delays, as difficulty in accessing its server is a major factor cited. There are also problems obtaining updated or complete patient information, such as eligibility status. Variations in the requirements demanded by regional PhilHealth evaluators can also cause delays.

Everyone involved in the provision of primary care, from family physicians to hospital administrators and medical directors can do well to consider improving claims reimbursement. Better

physician participation will decrease delays involved in obtaining their signatures, which will further expedite the claims process. Hospitals should continuously provide updated information to PhilHealth, while PhilHealth should improve its system to accommodate more e-traffic and allow better connections with its servers. Data available should also be complete and up-to-date. Lastly, PhilHealth should make its electronic claims process more simple and centralized to circumvent variations at the regional and provincial PhilHealth offices. The active participation of family physicians and those in community practice will help improve service delivery, PhilHealth utilization, and overall patient satisfaction.

Acknowledgements

The authors would like to thank the Department of Health for the funding of the research (through the Health Systems Management Research Fund), the Philippine Council for Health Research and Development for the administrative support, and Mr. Benjamin David for the clerical assistance.

References

1. Philippine Health Insurance Corporation. Implementation of Claims Eligibility Web Service (CEWS) Phase 1 of eClaims Project. PhilHealth Circular No. 14 series 2011.
2. American Medical Association and the Connecticut State Medical Society. Benefits of electronic claims submission – improve practice efficiencies. AMA/CSMS Educational Resource. 2013 [cited September 2018].
3. Welte I. A physician-led approach to telehealth enabled care coordination: innovation in reimbursement and delivery system models to support physician engagement. Int J Integr Care. 2012;12: Abstract.
4. Ramlet MJ, Randall D, Parente ST. Insurer payment lags to physician Practices: An opportunity to finance electronic medical record adoption. J Health Med Inf 2013; 4(4). Available from: doi: 10.4172/2157-7420.1000136.
5. Marting R. The Cure for Claims Denials. Family Practice Management. 2015 March/April [cited September 2018]. Available from: https://www.aafp.org/fpm/2015/0300/p7.html.
6. Holtrop JS, Luo Z, Alexanders L. Inadequate reimbursement for care management to primary care offices. J Am Board Fam Med 2015; 28(2). Available from: doi: 10.3122/jabfm.2015.02.140207.
7. Picazo OF, Ulep VGT, Pantig IM, Ho BL. A critical analysis of purchasing of health services in the Philippines: A case study of PhilHealth. Philippine Institute of Development Studies. 2015. Discussion Paper Series No. 2015-54.
8. Quimbo S, Florentino J, Peabody JW. Underutilization of social insurance among the poor: Evidence form the Philippines. PLoS One. 2008 October 13 [cited September 2018]. Available from: https://doi.org/10.1371/journal.pone.0003379.
9. Caballes AB, Nisperos GA, Zuniga P. Disparities in hospital capacities and efficiency of computer-based health insurance claims processing. Acta Medica Philippina 2018; 52(4): 374-9.
10. Caballes AB, Nisperos GA, Zuniga P. Institutional applicability and acceptability of PhilHealth's electronic membership enrolment and claims verification system. October 2015 [Unpublished report].
11. Philippine Health Insurance Corporation. Revised PhilHealth Category of Institutional Health Care Providers (IHCP) and Compensable Benefits in Primary Care Facilities. PhilHealth Circular No. 14 series 2013.
12. Philippine Health Insurance Corporation. Revised PhilHealth Category of Health Care Institutions (HCIs) and Compensable Benefits in Primary Care Facilities (PCF) (1st Revision). PhilHealth Circular No. 25 series 2014.
13. LePointe J. Medicaid Could Save $4.8B Through Electronic Claims Management [Internet]. Revcycle Intelligence. 2018 August 15 [cited September 2018]. Available from: https://revcycleintelligence.com/news/medicaid-could-save-4.8b-through-electronic-claims-management
14. Britton JR. Healthcare reimbursement and quality improvement: Integration using the electronic medical record. Int J Health Policy 2015; 4(8): 549-51. Available from: doi: 10.15171/ijhpm.2015.93.
15. Adler-Milstein J, Jha AK. No evidence found that hospitals are using new electronic health records to increase medicare reimbursements. Health Affairs 2014; 33(7): 1271-7. Available from: doi: 10.1377/hlthaff.2014.0023.
16. Rosenberg M, Cohen F. Medicaid and physician reimbursement. Pediatics 2006; 118(2): 808-9. Available from: www.pediatrics.org/cgi/doi/10.1542/peds.2006-0799.
17. Cunningham PJ, O'Malley AS. Do reimbursement delays discourage medicaid participation by physicians. Health Affairs 2009; 28(1): w17-w28. Available from: doi: 10.1377/hlthaff.28.1.w17.
18. Fernandez-Marcelo PH, Ongkeko Jr AM, Sylim PG, Evangelista-Sanchez AMA, Santos ADF, Fabia JG, Nisperos GA. Formulating the national policy on telehealth for the Philippines through stakeholders' involvement and partnership. Acta Medica Philippina 2016; 50(4): 247-63.
19. Salisi JA, Cruz JP, Lu SF, Fernandez-Marcelo PH. The Philippine policy context for eHealth. Acta Medica Philippina 2016; 50(4): 206-14.
20. Obermann K, Jowett M, Soonman K. The role of national health insurance for achieving UHC in the Philippines: a mixed method analysis. Global Health Action. 2018;11(1). Available from: https://doi.org/10.1080/16549716.2018.1483638