Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE

PHILHEALTH CIRCULAR
No. 2021 - 0012

TO : ALL PHILHEALTH MEMBERS, ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES, BRANCHES, LOCAL HEALTH INSURANCE OFFICES, AND ALL OTHERS CONCERNED

SUBJECT : Modification on the Payment Rules of Benefit Packages under All Case Rates (ACR) Policy including COVID-19 Benefit Packages

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I. RATIONALE

The All Case Rates (ACR) Policy was implemented in 2013 and shifted the provider payment mechanism from Fee-For-Service (FFS) to case-based payment. It simplified reimbursement rates and improved turnaround time of processing of claims. Subsequent benefits such as COVID-19 inpatient packages are also paid as case-based. While there were successes on the payment objectives of case rates, there still is a lot of room for improvement towards attainment of financial risk protection for Filipinos and increasing fiscal space for PhilHealth. In 2020, the payment system of PhilHealth had been the subject of inquiries of the country's legislative bodies and Commission on Audit (COA)'s performance audit. These led to recommendations for PhilHealth to reimburse providers based on either the set case rate or the actual charges, whichever is the lower amount of the two.

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With the enactment of Universal Health Care (UHC) Act, the ACR as provider payment is transitioning into "performance-driven, close-end, prospective payments based on diagnosis related groupings (DRG)[1]". While in the process of developing a DRG-based payment system, the ACR may not be responsive to the current situation. Hence, there is a need to consider modifying the payment rules of ACR to "pay whichever is lower".

As PhilHealth gears toward provider payment reforms mandated by the UHC Act, there is a need to address the operational and administrative challenges of the ACR policy. Hence, the PhilHealth Board of Directors approved PhilHealth Board Resolution No. 2609 s.2021 to modify the rules of ACR Policy, to pay whichever is lower between actual charges and the case rates.

[1] Republic Act No. 11223 or Universal Health Care Act

II. OBJECTIVES

This PhilHealth Circular aims to provide implementing guidelines on modified payment rules of All Case Rates (ACR) benefit packages including COVID-19 Benefit packages with actual charges lower than the case rates.

III. SCOPE

This policy issuance shall cover inpatient and outpatient benefit packages such as Anti-Tuberculosis Directly Observed Treatment Short-Course (TB-DOTS) and Outpatient HIV-AIDS Treatment (OHAT), day surgeries, repetitive procedures such as hemodialysis that are paid through case-based payment including COVID-19 inpatient benefit and SARS-CoV-2 testing packages. This shall be applied to all claims with admission dates starting on the date of effectivity of this PhilHealth Circular. This excludes the Z package and the COVID-19 Community Isolation Benefit Package.

IV. DEFINITION OF TERMS

A. **Case-based payment** – refers to a provider payment system in which a hospital is reimbursed for each discharged patient at rates prospectively established for groups of cases, with similar clinical profile and resource requirements.

B. **Case rate (CR)** – refers to fixed rate or amount that PhilHealth will reimburse for a specific illness/case, which shall cover for the fees of health care professionals, and all facility charges including but not limited to, room and board, diagnostics and laboratories, drugs, medicines and supplies, operating room fees and other fees and charges.

C. **Direct Healthcare Costs** - refer to costs of resources used that are attributable to the healthcare intervention or illness.[2] These include the following: 1) Hospitalization/inpatient care; 2) Drugs and medicines; 3) Medical supplies and equipment (including use of personnel protective equipment); 4) laboratory supplies; 5) medical care services/personnel; 6) Transport conduction service (e.g., ambulance).

D. **No Balance Billing Policy** – refers to a policy that provides that no other fees or expenses shall be charged or paid for by the indigent patients above and beyond the package rates

E. **Philippine National Formulary (PNF)** - the Philippine National Formulary (PNF) is a list of essential drugs of the Philippines which is prepared by the Department of Health. The PNF includes medicines that satisfy the priority health

[2] Winch and Gad, 2019

care needs of the population and are selected based on evidence of their efficacy, safety, and comparative cost effectiveness

F. **Return to sender / Return to Hospital (RTH Claims)** - A deficient claim after due adjudication and validation redirected back to HCI with instructions to comply with certain requirements, but from which the action of returning the complied claim to PhilHealth may result in the reversal of the deficiency into a good claim or non-compliance that may result into the denial of the claim.

G. **Statement of Account (SOA)** – refers to the document that is generated by the health facility/hospital on the day of the patient's discharge that reflects the health facility/hospital charges and professional fees for the episode of care or confinement.

H. **Total actual charges** – refer to the total expenses during the confinement/episode of care of a patient for a particular medical condition or procedure. These include all fees (to be) collected from the patient for the confinement/episode of care which is not limited to health facility and professional fees (PF). These shall also include laboratory procedures, medicines, and supplies, among others, that are paid for by the patient but not reimbursed by the health care institution. These also refer to the gross actual charges in the SOA or its equivalent before any partial payment, discounts, HMO coverage are deducted.

I. **Z Benefits Packages** – refers to benefit packages that focus on providing relevant financial risk protection against illnesses perceived as medically and economically catastrophic.

V. POLICY STATEMENTS

A. Determination of the payable amount

1. PhilHealth shall pay the providers based on the actual charges reflected in the SOA or its equivalent (including itemized billing statement) and claim form, after deduction of mandatory discounts (i.e., Senior Citizens, PWD), not exceeding the applicable package amount. These amounts shall be reflected on Part III.A of Claim Form 2 (CF2[3]) as illustrated on Annex A. (Illustration of Amount Reflected in CF2 Part III-A)

2. Claims of outpatient and inpatient benefit packages covered by this PhilHealth Circular shall have a statement of account (SOA) or its equivalent. The minimum information required on the SOA is provided in PhilHealth Circular No. 2017-0014.

[3] www.philhealth.gov.ph/downloads/claim/ClaimFo rm2_092018.pdf

3. The actual charges shall include health facility and professional fees. Any discrepancy in the SOA and claim form shall be Returned to Sender (RTS) for compliance.

4. If the actual amount based on the SOA or its equivalent is equal to or higher than the applicable case rate, payment of claim shall follow the applicable case rate and the prescribed allocation rules for health facility and professional fees. Sample computation of different scenarios is provided in Annex B. (Examples Computation and Scenarios)

5. If the actual amount based on SOA or its equivalent is lower than the applicable case rate, payment of claims shall be based on the actual charges (after mandatory discounts). The allocation of health facility and professional fees shall follow what is reflected in the SOA or its equivalent.

6. For COVID-19 claims wherein the actual amount based on SOA or itemized billing statement is equal to or higher than the applicable COVID-19 benefit packages, payment of claims shall be based on the amounts stipulated in PhilHealth Circular No.2020-0009[4] entitled "Benefit Packages for Inpatient Care Of Probable And Confirmed COVID-19 Developing Severe Illness/Outcomes" or amendatory circulars. The allocation of health facility and professional fees shall be based on the internal policy of the health facility as agreed with healthcare professionals.

7. For COVID-19 claims wherein the total actual charge is lower than the applicable benefit packages, payment shall be based on the actual charges (after mandatory discounts) as reflected in the SOA/itemized billing statement. The allocation of health facility and professional fees shall be based on the internal policy of the health facility as agreed with healthcare professionals.

8. All information required for claims submission shall be encoded at the level of healthcare institutions (HCIs). HCIs are required to encode the total amount reflected in the SOA or its itemized equivalent/itemized billing statement in Claim Form (CF) 2 Part III.A (Certification of consumption of Benefits).

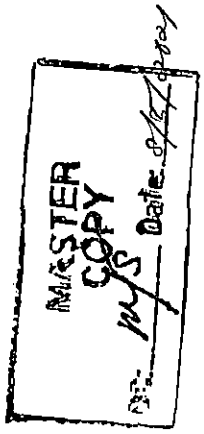
9. Any discrepancy between the SOA and CF2 shall be returned to sender for compliance.

10. For confinement abroad and claims filed directly by PhilHealth beneficiaries, if applicable, the payment of claims shall be paid based on the actual charges or case rate, whichever is lower. Filing and processing of these claims shall follow existing guidelines.

[4] www.philhealth.gov.ph/circulars/2020/circ2020-0009.pdf

11. Non-availability of room
    a. As stipulated in PhilHealth Circular No. 35, s-2013 entitled "ACR Policy No. 2-Implementing Guidelines on Medical and Procedure Case Rates", patients admitted or managed in the emergency room and other areas within the hospital premises pending the availability of rooms, but stayed in the hospital for 24 hours or more as documented in their medical records shall be covered by the applicable PhilHealth benefits. This includes patients who stayed in tents and other temporary structures that were put-up/constructed within the hospital premises to meet the increased demands for health services in times of public health emergencies.
    b. Payment shall cover direct cost of care for the entire stay in the facility.
    c. The claims shall be paid based on the total actual charges (after mandatory discount) with case rate as the cap.

B. Drugs or Medicines Not Listed in the Philippine National Formulary (PNF)



1. Rules on the Philippine National Formulary (PNF) shall be observed (DOH Administrative Order No. 2012-0023: Revised Implementing Guidelines for the Philippine National Formulary System ([PNFS]); Antimicrobial Resistance Surveillance Program (ARSP) and rational drug use shall be observed and monitored. Hence, charges for drugs and medicines not in the PNF shall not be counted as part of the actual charges.

2. The Universal Health Care Act states that investments on any health technology or development of any benefit package by the DOH and PhilHealth, shall be based on the positive recommendations of the Health Technology Assessment Committee (HTAC), subject to periodic review. Hence, medicines, procedures, and other interventions without HTAC recommendations shall not be charged to PhilHealth.

C. No co-payment policy

No Balance Billing policy based on PhilHealth Circular No. 2017-0017[5] entitled "Strengthening the Implementation Of The No Balance Billing Policy (Revision 2) shall be applied until revised or amended.

D. Exclusions

Z Benefit Packages and COVID-19 Community Isolation Benefit Package are excluded from this policy and shall be governed by existing circulars.

[5] www.philhealth.gov.ph/circulars/2017/circ2017-0017.pdf

E. Monitoring and evaluation

Healthcare providers shall be monitored on their compliance to this PhilHealth Circular and existing policies from other regulatory agencies.

VI. PENALTY CLAUSE

Violation of any provision of this PhilHealth Circular shall be penalized under the National Health Insurance Act per Republic Act (RA) 7875, as amended by RA Nos. 9241 and 10606 and the RA No. 11223 (Universal Health Care Act), their Implementing Rules and Regulations and other applicable laws, rules, and regulations.

VII. TRANSITORY CLAUSE

All other policies relative to the All-Case Rates, COVID-19, and Z Benefits not inconsistent with the foregoing shall remain in effect subject to further review. Depending on the result of the review conducted, the Corporation may issue supplementary guidelines as applicable.

MASTER COPY Date: 08/13/2021

VIII. SEPARABILITY CLAUSE

Should any provision of this PhilHealth Circular be declared invalid, unconstitutional, or unenforceable in whole or part by any competent authority, it shall not affect or invalidate the remaining provisions hereof.

IX. REPEALING CLAUSE

This PhilHealth Circular shall amend the claims reimbursement policies as stipulated on PC No. 35, s.2013, PC No. 2020 - 0009, PC No. 2020 - 0011 and other ACR policies. All other previous issuances that are inconsistent with any provisions of this Circular are hereby amended, modified, or repealed accordingly.

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days following publication in a newspaper of general circulation or the Official Gazette. It shall be deposited thereafter with the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

ATTY. DANTE A. GIERRAN, CPA
President and Chief Executive Officer (PCEO)

Date signed: 08/04/2021

MASTER COPY

DC: Date: 8/5/2021

Annex A: Illustration of amount reflected in CF2 Part III-A

PART III: CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled out.

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☐ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	Php 31,152
Total Professional Fees	Php 15,048
Grand Total	Php 46,200

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

Basis to identify whichever is lower

a.) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees	Php 31,152	Php 23,600	Php 26,600	Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promisory note, etc.)
Total Professional Fees (for accredited and non-accredited professionals)	Php 15,048	Php 11,400	Php 11,400	Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promisory note, etc.)

b.) Purchases/Expenses NOT included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None	☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None	☐ Total Amount P _____

* **NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

Annex B: Examples computation and scenarios