Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE

PHILHEALTH CIRCULAR
No. 2022- 0016

FOR : ALL ACCREDITED HEALTH CARE PROVIDERS AND ALL OTHERS CONCERNED

SUBJECT : Governing Policies on Transitioning the Provider Payment Mechanism (PPM) from all Case Rates (ACR) to Diagnosis-Related Groups (DRG)

I. RATIONALE

In alignment with the goal of the Universal Health Care (UHC) Act or Republic Act (RA) No. 11223 Section 18. b, the Philippine Health Insurance Corporation (PhilHealth) commits to ensuring financial risk protection for all Filipinos seeking essential health services. With this, PhilHealth shall adopt performance-driven, close-end, prospective payments based on disease or diagnosis-related groupings and validated costing methodologies.[1]

DRG are based on a broader set of components for determining clinical and economic costs of care. DRG intend to make payments more responsive to inpatient care's complexities and improve providers' efficiency by linking clinical standards and resource needs. Ultimately, this allows PhilHealth to take on a more substantial strategic purchasing role and incentivize optimal health outcomes with more rationalized resources and expenditures. Thus, the PhilHealth Board, per Board Resolution No. 2676, s.2021, approved the transitioning of the PhilHealth provider payment mechanism from All Case Rates (ACR) to Diagnosis-Related Groups (DRG).

II. OBJECTIVES

This PhilHealth Circular aims to provide the governing policies on the DRG-based provider payment mechanism that PhilHealth shall implement as part of its broader provider payment reform.

MASTER COPY Date: 7/4/22 DC: 1145

III. SCOPE

This issuance outlines the governing policies for designing and implementing the DRG provider payment method for inpatient services among PhilHealth-accredited health care providers.

IV. DEFINITION OF TERMS

A. All Case Rates (ACR)/Case Rates[2]– 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

[1] UHC-IRR_Signed.pdf (philhealth.gov.ph)
[2] https://www.philhealth.gov.ph/circulars/2013/circ35_2013.pdf

procedures, regardless of member category, that are admitted in accredited health care institutions.

B. **Base Rate**[3]- The aggregate average cost per hospital case across a group of hospitals.

C. **Case-Based Payment Method**[4]- This is a hospital payment method that reimburses hospitals a predetermined fixed rate for each treated case.

D. **Clinical Pathways (CPW)**[5]– These are tools used to guide evidence-based healthcare. Their aim is to translate clinical practice guideline recommendations into clinical processes of care within the unique culture and environment of a healthcare institution.

E. **Clinical Practice Guidelines (CPG)**[6]–These are statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

F. **Co-payment**[7]– The amount paid to a health care provider at the time services are received. It also refers to a flat fee or a predetermined rate paid at point of service.

G. **Co-insurance**[8]– A percentage of a medical charge that is paid by the insured, with the rest paid by the health insurance plan

H. **Costing Methods** –Methods involved in estimating the cost of care per inpatient case, from data collection to analysis through either top-down or bottom-up costing.

I. **Diagnosis-Related Group (DRG) Payment System**[9]- This is a patient classification system that utilizes an algorithm in assigning a case to a specific group by using special software called a grouper. A DRG system classifies hospital cases into groups that are clinically similar and are expected to use similar amounts of hospital resources When used for payment, the amount per episode of care is fixed for patients within a single DRG category (based on average cost), regardless of the actual cost of care for that individual episode, but varies across DRG.[10]

[3] Langenbrunner, J. C., Cashin, C., & O'Dougherty, S. (Eds.). (2009). Designing and Implementing Health Care Provider Payment Systems: How-To Manuals. The International Bank for Reconstruction and Development, The World Bank. https://openknowledge.worldbank.org/bitstream/handle/10986/13806/48599.pdf

[4] Langenbrunner, et., 2009, p. xix

[5] Rotter, T., Baatenburg de Jong, R., Lacko, S. E., Ronellenfitsch, U., & Kinsman, L. (2019). Clinical pathways as a quality strategy. In Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies [Internet] (Health Policy Series, No. 53 ed.). European Observatory on Health Systems and Policies. https://www.ncbi.nlm.nih.gov/books/NBK549276/

[6] Consensusreport, Institute of Medicine. Clinical practice guidelines we can trust. March 23, 2011. http://www.iom.edu/Reports/2011/Clinical Practice-Guidelines-We-Can-Trust.aspx

[7] [Republic Act No. 11223] An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System and Appropriating Funds Therefor. (2019, February 20). Philippines.

[8] Ibid

[9] Klein, A., Mathauer, I., Stenberg, K., & Habicht, T. (2020). Diagnosis-Related Groups (DRG): A Question & Answer guide on case-based classification and payment systems. World Health Organization. https://www.who.int/docs/default-source/health-financing/drg-q-a-guide-final-draft.pdf?sfvrsn=54f64dad_1

[10] Bredenkamp, C., Bales, S., & Kahur, K. (2020). Transition to Diagnosis-Related Group Payments for Health : Lessons from Case Studies. International Development in Focus World Bank. © World Bank

J. **Direct Health Care Costs**[11]- Cost that are directly attributable to patient care. Examples of direct costs include nursing services, drugs, medical supplies, diagnostic imaging, rehabilitation and food services.

K. **Global Budget**[12]– A type of prospective provider payment method to cover aggregate expenditures of a hospital over a given period (usually one year) to provide a set of services that have been broadly agreed on by the hospital and the purchaser.

L. **Health Care Providers (HCP)** – refer to any of the following:

1. A health facility which may be public or private, devoted primarily to the provision of services for health promotion, prevention, diagnosis, treatment, rehabilitation and palliation of individuals suffering from illness, disease, injury, disability, or deformity, or in need of obstetrical or other medical and nursing care;

2. A health care professional who may be a doctor of medicine, nurse, midwife, dentist, or other allied professional or practitioner duly licensed to practice in the Philippines;

3. A community-based health care organization, which is an association of members of the community organized for the purpose of improving the health status of that community; or

4. Pharmacies or drug outlets, laboratories and diagnostic clinics.

M. **Indirect Health Care Costs**[13]- Cost that are not directly related to patient care. Examples of indirect costs include: general administration, health records, information technology, physical plant and maintenance, human resources, volunteer services, capital expenses, and other regional services.

N. **Inpatient Services** - PhilHealth benefits corresponding to diagnoses and procedures for which beneficiaries would have to be admitted to a hospital.

O. **International Classification of Diseases (ICD)**[14]– provides critical knowledge on the extent, causes and consequences of human disease and death worldwide via data that is reported and coded with the ICD. Clinical terms coded with ICD are the main basis for health recording and statistics on disease in primary, secondary and tertiary care, as well as on cause of death certificates. These data and statistics support payment systems, service planning, administration of quality and safety, and health services research. Diagnostic guidance linked to categories of ICD also standardizes data collection and enables large scale research.

---

https://openknowledge.worldbank.org/bitstream/handle/10986/33034/9781464815218.pdf?sequence=2&isAllowed=y

[11] Boccuzzi, S. J. (2003) Indirect Health Care Costs: Overview. In Cardiovascular Health Care Economics (pp. 63-79). Humana Press https://doi.org/10.1007/978-1-59259-398-9_5

[12] Langenbrunner et al., 2009, p.11

[13] Boccuzzi, S. J. (2003). Indirect Health Care Costs: An Overview. In Cardiovascular Health Care Economics (pp. 63-79). Humana Press. https://doi.org/10.1007/978-1-59259-398-9_5

[14] https://www.who.int/standards/classifications/classification-of-diseases

P. **Prospective Payment** [15]- This refers to a method of reimbursement in which payment is based on a predetermined, fixed amount. The payment amount for a particular service is based on disease or diagnosis-related groupings and validated costing methodologies. The payment rate for a set of services is determined prior to the services being delivered.[16]

Q. **Provider Payment Method (PPM)**[17]– The mechanism used to transfer resources from the purchasers of health care services to the providers.

R. **Provider Payment System (PPS)**[18]– The provider payment method combined with all supporting systems, such as information systems and accountability mechanisms, considered in the context of surrounding payment systems (for outpatient services, for example) and referral rules.

S. **Retrospective Payment** [19]– The payment rate for a set of services determined after the services are delivered. An example of retrospective payment is fee-for-service.

T. **Z Benefits** – Benefit packages that focus on providing relevant financial risk protection against medically and economically catastrophic illnesses. The Z benefits include the full spectrum of the minimum standards of care from diagnosis, management, and follow-up delivered by contracted HCPs to pre-authorized patients that fulfilled standard selections criteria. The payment design of the Z Benefits is a prospective provider payment method where HCPs are reimbursed in tranches after services are delivered.

V. POLICY STATEMENTS

A. Case-based prospective provider payment method (PPM) in the form of DRG shall serve as the primary PPM for all inpatient benefits.

1. DRG shall be used to pay all inpatient services in the applicable facilities, except for the outpatient primary care and the Z Benefits, which have their separate payment scheme.

2. The capacity to implement DRG as part of claims filing and billing processes shall be a pre-requisite for the global budget payment to an accredited HCP.

3. PhilHealth shall collaborate with practitioners, medical societies, health facility administrators, and technical experts in the DRG development process.

4. PhilHealth shall develop a robust surveillance/monitoring and audit mechanism for quality assurance and health care fraud detection.

B. PhilHealth shall develop the IT system for the DRG implementation.

[15] UHC-IRR_Signed.pdf (philhealth.gov.ph)
[16] Langenbrunner et al., 2009, p.11
[17] Ibid
[18] Ibid
[19] Ibid

1. The coding terminologies for diagnoses and procedures used for hospital reporting and the development of the DRG shall be based on the International Classification of Diseases (ICD).

2. A DRG system should allow for claims submission from any hospital information system that has been certified by PhilHealth and in use by accredited hospitals.

3. All processes concerning the information exchange between providers and PhilHealth for claims administration, auditing, and monitoring processes, among others, shall be digitized whenever possible.

4. A DRG grouper software will be adopted or developed for the DRG system implementation.

C. PhilHealth shall reform and enhance its claims processing system to enable the submission of all additional requirements for the implementation of DRG.

D. DRG base rate shall be established and grounded on validated costing of the minimum standards of care.

1. Payment through DRG system shall cover direct health care costs based on the minimum standards of care. Indirect health care costs are excluded in the DRG.

2. DRG shall not differentiate between institutional and professional fees.

3. A cost-sharing scheme (i.e. co-pay and/or co-insurance) shall apply concurrently in the administration of DRG payments, following PhilHealth's guidelines.

4. PhilHealth will regularly refine the DRG system according to updates in costs and minimum standards of care.

5. Clinical practice guidelines (CPG), local clinical practice, and health system capacity shall define the minimum standards of care.

6. In collaboration with stakeholders and experts, PhilHealth shall translate the minimum standards of care into clinical pathways.

E. PhilHealth shall enhance its IT systems for claims auditing and monitoring the performance of health care providers (HCP).

1. PhilHealth shall ensure that all claims submissions of HCPs strictly follow the DRG system's data requirements.

2. PhilHealth shall develop standards and indicators to monitor HCPs' overall performance and compliance with DRG policies and guidelines.

F. PhilHealth shall issue a separate issuance on the guidelines for the DRG implementation.

G. Monitoring and Evaluation

PhilHealth shall conduct a periodic review of this policy and specific provisions shall be revised as needed.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of RA No. 11223, other relevant laws, and RA No. 7875, as amended by RA Nos. 9241 and 10606, and their respective Implementing Rules and Regulations.

VII. TRANSITORY CLAUSE

A. PhilHealth shall conduct the necessary capacity-building for concerned PhilHealth personnel and key external stakeholders during the DRG development and implementation.

B. PhilHealth shall develop the initial set of DRGs. Cost data collection, claims analytics, and consultations with relevant stakeholders are critical for the DRG system to adjust to the local context.

C. During the transition to the DRG system and new PPM, there will be a parallel implementation with the ACR system.

D. PhilHealth will conduct the pilot implementation of the DRG system in identified HCPs during the transition phase based on criteria set by the Corporation.

E. PhilHealth will establish the DRG steering committee and technical working group and sub-groups to oversee and facilitate the DRG development and PPM reforms.

MASTER COPY Date: 7/4/22 DC:

VIII. REPEALING CLAUSE

Previous issuances that are inconsistent with any provisions of this PhilHealth Circular are hereby amended, modified, or repealed accordingly.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days after its publication in the Official Gazette or in a newspaper of general circulation. A copy shall thereafter be deposited to 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: 06/29/2022