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PHILHEALTH CIRCULAR
No. 2023 - 0025

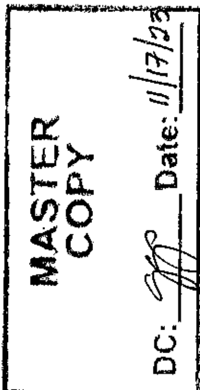
TO : **ALL ACCREDITED HEALTH FACILITIES, ACCREDITED HEALTHCARE PROFESSIONALS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED**

SUBJECT: **Guiding Principles of the Rationalized Inpatient Case Rates**

I. RATIONALE

In 2014, PhilHealth implemented the All Case Rates (ACR) to enable the shift from fee-for-service (FFS) to case-based payment and improve turnaround time for claims processing. However, despite the increasing discrepancies between the published case rates and the actual hospitalization charges, there have been no updates on the ACR. With this, PhilHealth commits to rationalizing priority conditions in the ACR to improve financial coverage for quality healthcare delivery and as an interim before fully implementing the diagnosis-related groups (DRG) provider payment mechanism.

Further, Section 37 of the Implementing Rules and Regulations of Republic Act (RA) No. 11223 also known as the "Universal Health Care Act" provides that the funding necessary to implement the Rules shall be sourced from 50% of the national government share from the income of the Philippine Amusement and Gaming Corporation (PAGCOR) and from 40% of the Charity Fund, net of Documentary Stamp Tax Payments, and mandatory contributions of the Philippine Charity Sweepstakes Office (PCSO), among others; provided, that the funds from these two agencies shall be transferred to, and used by, PhilHealth to improve its benefits packages. As such, the Department of Budget and Management, Department of Finance, Department of Health (DOH), PAGCOR, PCSO, and PhilHealth issued Joint Circular No. 0001-2022 which provides for the guidelines to operationalize the allocations/appropriations under Section 37 of RA No. 11223.



II. OBJECTIVES

This PhilHealth Circular establishes the guiding principles of the rationalized case rates for quality healthcare delivery and financial risk protection of members.

III. SCOPE

This PhilHealth Circular covers the rationalization of the ACR relative to financial coverage improvement for quality healthcare delivery.

This policy shall apply to all accredited health facilities (HF) that provide inpatient services, PhilHealth Regional Offices, and all others involved in implementing the rationalized case rates.

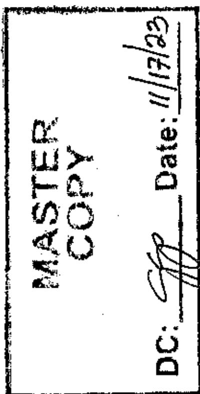
IV. DEFINITION OF TERMS

A. **All Case Rates (ACR)** - refer to PhilHealth's mechanism of paying for inpatient care through a case-based provider payment system.

B. **ACR Rationalization** – refers to PhilHealth's interim strategy to improve financial coverage for selected/priority conditions based on the volume of claims, disease burden, and support value until PhilHealth fully implements DRG as a provider payment mechanism for inpatient services.

C. **Bottom-Up Costing** - refers to a cost calculation method that considers the individual components and activities of delivering a healthcare service and analyzes its various elements separately, such as personnel, medical supplies, equipment, overhead expenses, and administrative costs, to determine the cost incurred for that specific component.

D. **Case-Based Provider Payment Mechanism** – refers to a provider payment system in which a hospital is reimbursed for each discharged patient at pre-determined rates based on the type of case or for groups of cases, with similar clinical profile and resource requirements.



E. **Co-Payment** - refers to a predetermined amount agreed upon by the accredited health facility (HF) and PhilHealth chargeable to patients to cover the share for amenities, choice of physician, or any additional or upgrade of services during the episode of inpatient care.[1] Co-payment is an example of an out-of-pocket payment or cost-sharing mechanism intended to share the cost of healthcare between the insured and the insurer.

F. **Diagnosis-Related Groups (DRG)**[2] - refer to a patient classification and provider payment system that groups patient cases, including services received, into standardized case groups according to diagnosis and treatment or procedure received. It combines a clinical logic with an economic logic that classifies hospital cases into groups that are clinically similar and are expected to have similar hospital resource use.

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[1] PhilHealth Circular No. 2021-0022. The Guiding Principles of the Z Benefits (*Revision 1*)

[2] PhilHealth Circular No. 2020-0016. Governing Policies on the Transitioning the Provider Payment Mechanism (PPM) from All Case Rates (ACR) to Diagnosis-Related Groups (DRG)

G. **Fixed Co-Payment** - refers to a flat-rate co-payment as a cost-sharing arrangement, that is, a predetermined, fixed amount of out-of-pocket that remains the same regardless of the total cost of the service.

H. **Minimum Standards of Care** – refer to essential services that HFs are obliged to provide based on clinical practice guidelines or current best practices in the local setting.

I. **Non-basic Accommodation** – refers to the provision of the minimum standards of care for patients, and includes fringe and/or additional amenities provided by the facility at the option of the patient.[3]

J. **Out-of-Pocket Payment (OOP)** - refers to the balance of healthcare provider charges that are paid directly by the patients from their own resources or cash reserves or health spending made directly from households to providers.

K. **Published Case Rate** – refers to the fixed, predetermined rate or amount that PhilHealth will reimburse for the rationalized case rates, which shall cover the fees of healthcare professionals and all facility charges, including but not limited to room and board, diagnostic imaging procedures, laboratory/chemistry tests, drugs, medicines, devices, supplies, operating room fees, infection control, healthcare worker salary, and other service fees. The case rate is not a cap but reflects the average cost of treating an episode of care. It may differ from the actual hospitalization charges indicated in the statement of account (SOA). The actual costs of care per patient can be higher or lower than the case rate. Therefore, PhilHealth retains the flexibility to adjust payment rates based on the services covered and the efficiency of healthcare providers in delivering quality care.

L. **Top-Down Costing** - refers to a cost accounting method adopted by PhilHealth that involves estimating the overall budget for the HF or healthcare organization and then breaking it down into various cost centers, such as different departments, clinics, or service lines. The allocation of costs to these individual cost centers can be based on revenue, patient volume, or historical cost patterns. This method allows PhilHealth to determine areas of high or low cost or high- or low-intensity use of resources in the HF.

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V. POLICY STATEMENTS

A. PhilHealth identified priority conditions in rationalizing the ACR to improve financial coverage while transitioning its provider payment mechanism to DRG.

[3] DOH AO No. 2021-0015. Standards on Basic and Non-basic Accommodation in All Hospitals

B. PhilHealth utilizes a case-based provider payment mechanism to reimburse HFs for the minimum standards in delivering inpatient services in a basic or ward accommodation.

C. PhilHealth's case-based reimbursement system for the ACR intends to promote efficiency, cost containment, and quality of care by providing a fixed payment for a specific case or episode of care where HFs deliver services in a more coordinated and streamlined manner to manage resources efficiently and focus on achieving positive patient outcomes rather than simply providing more services. Overall, PhilHealth's case-based provider payment system aims to align financial incentives with the efficient and effective delivery of services.

D. The minimum standards of care recommendations from clinical practice guidelines (CPG) disseminated by the World Health Organization (WHO), Department of Health (DOH), local medical societies, and other guideline sources, which are critically appraised and validated by current best practices in the local setting, are PhilHealth's basis for service coverage and costing analyses.

E. Any proposal for PhilHealth coverage to include new technologies, such as drugs/medicines and biologicals not listed in the latest Philippine National Formulary (PNF), diagnostic procedures, surgical interventions, and other treatment interventions, shall consider the Health Technology Assessment Council (HTAC) recommendation.

F. PhilHealth highly encourages continuous quality improvement initiatives to promote improving healthcare in the Philippines according to global best practices and collaboration efforts to standardize local practices and improve access to quality services delivered by accredited HFs.

G. PhilHealth shall engage key stakeholders to promote a deeper understanding of the ACR as a case-based provider payment system, which has critical implications for claims processing, medical evaluation, and audit.

H. PhilHealth shall propose the priority conditions for ACR rationalization to the Board for approval to set reimbursement rates and ensure equitable access to quality healthcare services.

I. PhilHealth shall formulate policies on the approved priority conditions in the ACR to protect members against financial catastrophe during illness and ensure quality healthcare service delivery by accredited HFs.

J. PhilHealth shall adopt the minimum standards of care for the rationalized case rates based on clinical practice guidelines (CPG) disseminated by the World Health Organization (WHO), DOH, medical societies, or international guideline sources that provide recommendations on the best available evidence and are validated by current best practices in the local setting.

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K. PhilHealth shall undertake a costing analysis of the rationalized case rates utilizing bottom-up and/or top-down costing methodology using hospital data, including information on professional fees submitted by accredited HFs, in collaboration with key stakeholders and costing experts.

L. Services beyond the minimum standards of care in non-basic accommodation, such as amenities, choice of physician, upgrade of services, or additional services unrelated to the episode of care, shall be subject to co-payment, which shall be thoroughly discussed with the patient as part of informed consent by the attending physician and/or healthcare provider.

M. Patients admitted in basic or ward accommodation shall not be charged co-payment by the accredited HFs.

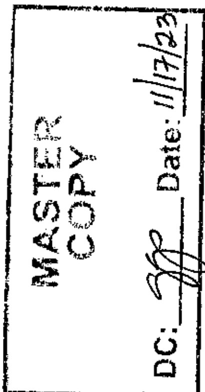
N. As stipulated in the UHC Act, Chapter IV, Sec. 18(b), there will be no differentiation between facility and professional fees. Therefore, PhilHealth shall credit all payments to the accounts of government and private accredited HFs. It is the sole responsibility of the HF to distribute the professional fees (PF) to the attending physicians or the health workers in the case of government HFs based on their internal agreements and processes.

O. PhilHealth shall provide the necessary support systems, such as information technology (IT) enhancements, IT solutions development, proper communications, and the required human resource complement to enable concerned PhilHealth units to implement the rationalized case rates efficiently.

P. PhilHealth shall issue appropriate guidelines and information updates for the strict compliance of accredited HFs and PhilHealth Regional Offices.

Q. Claims Filing

1. Accredited HFs shall strictly follow current PhilHealth policies on claims submission, including correct ICD coding of the primary diagnosis and/or procedure coding, submission of properly accomplished PhilHealth claims forms (CF), SOA, and other data and documentary requirements as stipulated in existing policies.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2. Accredited HFs shall follow all relevant laws, such as RA No. 9994 or the Expanded Senior Citizens Act of 2010 and RA No. 10754 or the Benefits and Privileges of Persons with Disability, including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on Joint Administrative Order No. 2020-0001, entitled: Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients Pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019."

With this, PhilHealth benefits and all mandatory discounts provided by law, such as, but not limited to, senior citizen and PWD discounts, shall be deducted first from the total hospital bill of the patient. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall complement the PhilHealth benefits packages.

R. Claims Evaluation and Payment

1. PhilHealth shall reimburse its accredited HFs the published case rates using a case-based provider payment mechanism based on the minimum standards of care in a basic or ward accommodation. Any amount declared in the SOA that is below or above the published case rates shall not be interpreted as over or underpayment.

   Accredited HFs receiving payments more than the declared amount in their SOA shall use the PhilHealth reimbursements exceeding the value of the published case rates for continuous quality improvement (CQI) as part of their performance commitment and/or for implementation of "no balance billing."

2. PhilHealth reserves the right to subject any or all claims to billing audit before and/or after payment or reimbursement of its accredited HFs, following existing guidelines.

S. Marketing and Promotion

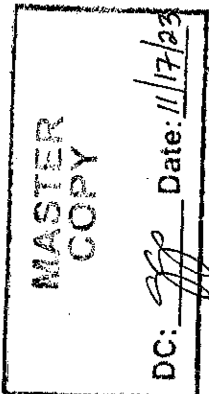
PhilHealth shall conduct communication and social marketing activities to educate healthcare providers and the public in increasing their awareness of the policy on rationalized case rates and case-based provider payment mechanisms following the current Social Marketing and Communication Plan (SMCP).

T. Monitoring

PhilHealth shall enforce current policies and guidelines on monitoring the performance of accredited HFs in implementing the rationalized case rates and establish strict control mechanisms to prevent adverse provider behaviors and insurance fraud.

U. Policy Review

PhilHealth shall conduct a policy review of the rationalized case rates in parallel to the development and transition to the DRG provider payment mechanism in collaboration and consultation with key stakeholders.



VI. TRANSITORY CLAUSE

While PhilHealth is developing the policy on cost-sharing (i.e., co-payment and co-insurance), accredited HFs shall set the co-payments of patients admitted in non-basic accommodation that shall not exceed the published case rates and fully inform patients of this cost-sharing arrangement. In cases of co-payment or OOP payment beyond the published case rates incurred by patients in non-basic accommodations as indicated in the SOA, these claims shall be processed and subjected to a post-payment audit following existing monitoring guidelines.

VII. SEPARABILITY CLAUSE

In the event that a part or provision of this Circular is declared unconstitutional or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

VIII. REPEALING CLAUSE

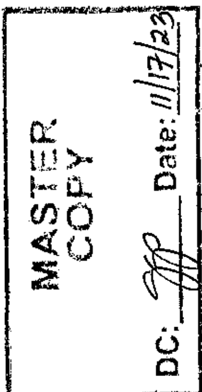
All other previous issuances that are inconsistent with any provisions of this PhilHealth Circular are hereby amended, modified, or repealed accordingly.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect after fifteen (15) days following the completion of its publication in a newspaper of general circulation. Three (3) certified copies shall thereafter be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer

Date signed: 11/16/2023



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