Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PHILHEALTH CIRCULAR
No. 2024 - 0001

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

SUBJECT : **Rules for Adjusting Case Rates**

I. RATIONALE

Section 10 of Republic Act (RA) No. 7875 as amended by RA Nos. 9241 and 10606 provide that PhilHealth members and their dependents are entitled to minimum services of healthcare services, subject to limitations, as may be determined by the Corporation, with the end in view of quality assurance, increased benefits and reduced out-of-pocket expenditure. Further, Section 27 of the same law provides that "case-based payment" is an acceptable provider payment mechanism (PPM) for public and private providers under the National Health Insurance Program (NHIP). In fulfilling its duty as the administrator of the NHIP, the Philippine Health Insurance Corporation (PhilHealth) created the All Case Rates (ACR) Policy, which shifted its PPM from fee-for-service (FFS) to case-based payment that instituted predetermined or prospective payment rates for specific medical conditions and procedures to pay healthcare providers for the quality services rendered. However, since the implementation of the ACR policy in 2013, most case rates have not been adjusted.

In enhancing the case rates, PhilHealth issued PhilHealth Circular (PC) No. 2023-0025, providing the "Guiding Principles of the Rationalized Inpatient Case Rates." Through PhilHealth Board Resolution (PBR) No. 2802, s. 2023 (Resolution Approving Rationalization of Selected Case Rates and Expansion of Case Rates for Pneumonia and Acute Stroke), PhilHealth adjusted and rationalized select case rates. Additionally, through PBR No. 2871, s. 2024 (Resolution Adopting a 30% Inflation Adjustment Factor for Select Case Rates), the Board approved an inflation adjustment factor of thirty percent (30%) for existing case rates to account for price changes over the past decade.

II. OBJECTIVES

This PhilHealth Circular aims to outline and operationalize the applicable rules in adjusting case rates. It defines the conditions, requirements, and parameters of when and how PhilHealth can adjust case rates. It also aims to promote efficiency, cost containment, and quality of care and align financial incentives

with the efficient and effective delivery of services by strengthening case-based payments and by adjusting the case rates to account for health inflation.

III. SCOPE

This PhilHealth Circular covers the adjustment of select case rates to improve financial coverage for quality healthcare delivery.

This policy shall apply to all accredited health facilities (HF), PhilHealth Regional Offices, and all others involved in implementing the 30% adjustment of case rates, subject to the specific rules provided in this policy.

IV. DEFINITION OF TERMS

A. Adverse Incentive[1] – refers to an incentive that has an unintended and undesirable result that is contrary to the intentions of the policy.

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

C. Balance Billing[2] - refers to the additional payments by insured patients on top of the amount paid by insurance when the provider's charges are higher than the amount covered by health insurance. Balance billing may result in increased financial burdens and limited access to health services by households due to financial and service coverage decisions.

D. Basic or Ward Accommodation[3] – refers to the provision of regular meals, bed in shared room, fan ventilation, and shared toilet and bath.

E. Bottom-Up Costing (Micro-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.

F. 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.

G. Co-payment - refers to a predetermined amount agreed upon by the accredited HF and PhilHealth chargeable to patients to cover the share for

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[1] Robinson, J. C. (2004, April 21). Reinvention of Health Insurance in the Consumer Era. *JAMA, 291*(15), 1880-1886. 10.1001/jama.291.15.1880

[2] Viriyathorn, S., Witthayapipopsakul, W., Kulthanmanusorn, A., Rittimanomai, S., Khuntha, S., Patcharanarumol, W., & Tangcharoensathien, V. (2023, May 11). Definition, Practice, Regulations, and Effects of Balance Billing: A Scoping Review. *Health Services Insights, 16*, 1-14. 10.1177/11786329231178766

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

amenities, choice of physician, or any additional or upgrade of services during the episode of inpatient care[4] prior to accessing a health service to manage moral hazards and adverse incentives. 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.

H. **Diagnosis-Related Groups (DRG)**[5] – 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.

I. **Efficiency Gains**[6] – refers to the increase in profit following a reduction in cost whereby health facilities generate surplus revenues which they can use for continuous quality improvements, such as upgrading facilities, procurement of additional supplies and equipment, or augmenting health human resources with the ultimate goal of ensuring client satisfaction. Thus, the surplus generated by HFs through efficiency gains shall not be interpreted as overpayments.

J. **Market Effect (Market Signals)**[7] – refer to any communication that provides information in excess of the message. This can include client feedback, industry reports, and price changes, among others, that can inform PhilHealth about unforeseen risks, changes in behavior and preferences, and/or changes in market practice.

K. **Maximum Out-of-Pocket (MOOP)** – refers to a predetermined and fixed ceiling for out-of-pocket payments set as a cost-sharing arrangement, that remains the same regardless of the total cost of the service per individual case.

L. **Minimum Standards of Care**[8] – refer to essential services that HFs are obliged to provide based on clinical practice guidelines or current best practices in the local setting.

M. **Moral Hazards**[9] – refer to situations where the economic actor (i.e., patient or healthcare provider) has an incentive to increase its exposure to risk or over utilize health services because it does not bear the full costs of that risk.

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[4] PC No. 2021-0022. The Guiding Principles of the Z Benefits (Revision 1)
[5] PC No. 2022-0016. Governing Policies on the Transitioning the Provider Payment Mechanism (PPM) from All Case Rates (ACR) to Diagnosis-Related Groups (DRG)
[6] PC No. 2022-0024. Statement of Account (SOA) Requirement for Z Benefits Claims Submission
[7] Spence, M. (1973). Job Market Signaling. *Quarterly Journal of Economics, 87*(3), 355-374. 10.2307/1882010. JSTOR 1882010
[8] PC No. 2023-0025. Guiding Principles of the Rationalized Inpatient Case Rates
[9] Feldstein PJ. Health Care Economics. 1979.

N. **Non-Basic or Non-Ward Accommodation** – refers to the provision of the minimum standards of care for patients plus fringe and/or additional amenities provided by the facility at the option of the patient.[10]

O. **Out-of-Pocket Payment (OOP)**[11] - 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.

P. **Published Case Rate**[12] – refers to the fixed, predetermined rate or amount that PhilHealth will reimburse for the 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.

Q. **Rationalization of Case Rates**[13] – 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.

R. **Shadow Billing for DRG**[14] - refers to the process whereby PhilHealth will provide sufficient time to allow accredited HF to adjust to the new rules in claims submission in preparation for the transition to a DRG system while following the All Case Rates (ACR) payment method to minimize disruptions in claims processing.

V. POLICY STATEMENTS

A. PhilHealth shall utilize a case-based provider payment mechanism to reimburse accredited HF for the minimum standards in delivering inpatient services in a basic or ward accommodation as one of its payment mechanisms.

1. PhilHealth's case-based reimbursement system for case rates shall provide a predetermined fixed payment for a specific case or episode of care where HFs deliver services in a coordinated and streamlined

[10] DOH AO No. 2021-0015. Standards on Basic and Non-basic Accommodation in All Hospitals
[11] PC No. 2023-0025. Guiding Principles of the Rationalized Inpatient Case Rates
[12] PC No. 2023-0025. Guiding Principles of the Rationalized Inpatient Case Rates
[13] PC No. 2023-0025. Guiding Principles of the Rationalized Inpatient Case Rates
[14] PC No. 2023-0014. Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG)

manner, manage resources efficiently, and focus on achieving positive patient outcomes.

2. The case rates shall be set in consideration of:

   a. The average cost of a case or an episode of care;
   b. The different sources of funds used in paying for the case;
   c. The available fiscal space of the Corporation; and,
   d. Any applicable laws and rules governing the use of the PhilHealth benefit fund in paying for healthcare services.

3. As such, the case rates shall not need to provide full coverage for the cost of care beyond the minimum standards in basic or ward accommodation.

B. PhilHealth shall utilize a tiered approach to adjusting case rates, whereas a set of prioritized case rates shall be rationalized based on micro-costing, and the remaining case rates shall be adjusted using an inflation adjustment factor.

1. PhilHealth shall utilize the following criteria to rationalize the prioritized case rates which include but are not limited to:

   a. Burden of disease;
   b. The volume of claims; and,
   c. Contribution to catastrophic expenditure.

2. The remaining case rates shall be subject to a secondary review for inflation adjustment, taking into consideration the frequency of updating, insurance risks, the appropriateness of current rates, and the anticipated market effects. A set of criteria shall be used for prioritization which includes but is not limited to the following:

   a. Inclusion Criteria:

      a.1. The volume of claims; and,
      a.2. Contribution to catastrophic expenditure.

   b. Exclusion Criteria:

      b.1. Benefits packages that have been adjusted in the past 5 years (Example: Hemodialysis);
      b.2. Benefits packages that are being re-costed and are scheduled for adjustment within the applicable year (Example: Z Benefits);
      b.3. Benefits packages that have been developed in the past 5 years (Example: Outpatient Package for Mental Health);
      b.4. Cases that are identified to have a high risk for moral hazard and/or adverse incentives (Example: cataract procedure); and,

b.5. Benefits packages that are paid through other provider payment mechanisms (Example: Konsulta)

The complete list of excluded benefits packages shall be uploaded to the PhilHealth website or disseminated through other official channels for public access. PhilHealth shall issue the appropriate Advisory for the information of all concerned.

C. PhilHealth shall retain flexibility in adjusting the case rates, as necessary, using the estimates from bottom-up or micro-costing, from applying an inflation-adjustment factor, and/or any other robust methodology or approach, and update in standards of care to promote the efficient delivery of services by healthcare providers as applied in the local context.

D. PhilHealth shall disseminate the schedule of rates for public access through the PhilHealth website and/or other appropriate official channels for the proper information and strict compliance of accredited healthcare providers and PhilHealth Regional Offices.

E. The schedule of rates shall serve as a list of fixed rates per case and shall serve as the basis for payment for the individual case managed by the accredited and/or contracted provider irrespective of the actual individual charges per admission or benefit utilization as captured in the SOA.

1. Conditions with a corresponding case rate shall be paid the full amount indicated in the schedule of rates.
2. Payments shall be credited to accredited and/or contracted providers in accordance with existing PhilHealth rules on claims filing.
3. Individual hospital charges as reflected in the SOA that fall below or above the case rates shall not be interpreted as either over or underpayment.

F. The inflation adjustment factor that will be applied for existing case rates shall be set at thirty percent (30%).

1. The adjustment shall apply to case rate claims of accredited public and private HFs.
2. The adjustment shall apply to the first and second case rates in accordance with the existing rules.
3. The adjustment shall likewise apply to the benefits packages under Sustainable Development Goals (SDG) paid as case rates (i.e., TB-DOTS, Outpatient HIV-AIDS Treatment Package, Animal Bite Treatment Package, Newborn Care Package, Maternity Care Package). Accordingly, the adjustment shall also apply to post-partum progestin subdermal implants (PSI) which shall therefore be paid as second case rate.

G. With the adjustment of case rates and the resultant increase in PhilHealth payments, all PhilHealth beneficiaries shall be entitled to no co-payment in basic or ward accommodation in public and private HFs.

H. Likewise, PhilHealth beneficiaries seeking care in non-basic accommodations in public HFs may be charged an MOOP to not exceed the value of the case rate.

I. Accredited public and private HFs shall not balance bill patients admitted in basic or ward accommodation.

J. Services in private non-basic accommodation, such as amenities, choice of physician, upgrade of services, or additional services, shall be subject to out-of-pocket payment, which should be thoroughly discussed with the patient as part of informed consent by the attending physician and/or healthcare provider.

K. Services in public non-basic accommodation shall be subject to a co-payment arrangement. Accredited public HFs shall not balance bill or charge patients staying in non-basic accommodation in excess of the value of the case rate.

L. Accredited public and private HFs shall participate in the shadow billing for diagnosis-related groups (DRGs) following PhilHealth Circular No. 2023-0014, "Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG)" or its succeeding revisions, as applicable.

M. Costs in excess of payments made through case rates shall be subject to cross-subsidization, using either other fund sources or efficiency gains, as may be applicable, or out-of-pocket spending, in accordance with PhilHealth rules and guidelines.

N. Any profit accrued or surplus by any accredited HF from PhilHealth reimbursements shall be used for continuous quality improvement (CQI) as part of their performance commitment and/or for implementation of "no balance billing."

O. 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 claim forms (CF), SOA, and other data and documentary requirements as stipulated in existing policies.

2. As stipulated in PC No. 2023-0026, "Electronic Submission of Statement of Account (SOA) for All Case Rates and Identified PhilHealth Benefits (*Rev. 1*)," accredited HFs shall provide data on professional and reader's fees and itemized charges for all services.

3. 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 an Act Expanding 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.

P. Claims Evaluation and Payment

1. PhilHealth shall reimburse its accredited HFs based on the published case rate. Any amount declared in the SOA that is below or above the published case rates shall not be interpreted as over or underpayment.

2. Claims of patients admitted in basic or ward accommodation in accredited public or private HFs with OOP and claims of patients admitted in non-basic accommodation in accredited public HFs with hospital charges above the MOOP shall be subjected to a post-payment audit following existing monitoring rules.

3. 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 rules.

4. Accredited HFs shall file all claims to PhilHealth on behalf of the patient. In cases of direct filing by the patient, PhilHealth shall pay the actual amount reflected in the SOA not exceeding the applicable case rate.

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

R. PhilHealth shall enforce current policies and guidelines on monitoring the performance of accredited HFs in implementing the adjusted case rates and establish strict control mechanisms to prevent adverse provider behaviors and non-compliance to existing rules.

S. PhilHealth shall conduct regular policy reviews of adjusting the case rates in parallel to the development and transition to the DRG provider payment mechanism in collaboration and consultation with key stakeholders.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized following the pertinent provisions of RA No. 7875, as amended by RA Nos. 9241 and 10606, and RA No. 11223, and their respective Implementing Rules and Regulation (IRR), and other pertinent laws and rules.

VII. TRANSITORY CLAUSE

PhilHealth shall upload in the PhilHealth website the complete list of adjusted case rates and shall update the "All Case Rates Search" mobile app for public access and disseminate the appropriate Advisory for the information of all concerned.

VIII. SEPARABILITY CLAUSE

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

IX. REPEALING CLAUSE

This policy amends the rates schedule of the medical and procedure case rates in PC No. 0035, s. 2013, "ACR Policy No. 2—Implementing Guidelines on Medical and Procedure Case Rates," to reflect the application of the 30% adjustment.

All other previous issuances or parts thereof that are contrary to or inconsistent with this policy are hereby amended, modified, or repealed accordingly.

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on February 14, 2024 following the completion of its publication in the Official Gazette or any 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: 01/29/2024

MASTER COPY
DC: Date: 01/30/24