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Winning the game: Strengthening PhilHealth's provider fraud control mechanisms toward improved service delivery and financial risk protection for Filipinos

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PIDS DISCUSSION PAPER SERIES 2025-52

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Winning the Game: Strengthening PhilHealth's Provider
Fraud Control Mechanisms toward Improved Service Delivery
and Financial Risk Protection for Filipinos

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Abstract

Fraud in social health insurance results in inefficient use of government resources and diverts funds away from paying for necessary health care needs and subsidizing the poor. We conducted a process evaluation of the fraud control mechanisms of the Philippine Health Insurance Corporation (PhilHealth) to identify gaps and challenges in fraud prevention, detection, and deterrence and to provide realistic and evidence-based policy recommendations to strengthen these mechanisms and ensure their coherence in light of the provider payment system's transition to a prospective global budget (GB) based on diagnosis-related groups (DRGs).

Through stakeholder consultations with relevant PhilHealth offices, literature reviews, and descriptive analyses of fraud data, we found that **PhilHealth fraud control mechanisms do not flag all potential fraudulent activities common to DRG-GB systems**. PhilHealth lacks an overarching fraud control strategy across prevention, detection, and deterrence mechanisms, leading to a focus on reactive detection measures that take effect only after health care is provided or claims have been filed. Rather than proactively monitoring providers, PhilHealth's reliance on pre-authorization to prevent fraud emphasizes cost-containment over setting incentives for efficient and quality service delivery.

These challenges are **exacerbated by limited human and information technology resources**, leading to a lack of routine data monitoring and analysis. Consequently, PhilHealth's current fraud control activities severely underestimate the incidence of health insurance fraud in the country.

Moving forward, PhilHealth's fraud control system requires **development of a framework that covers different types of gaming across the continuum of care and processes to translate provider performance monitoring into payment incentives, supported by increased investments in staff and technologies**. These findings and recommendations are especially relevant as the Philippines transitions to a DRG-GB payment system, which provides an opportunity to incentivize quality service delivery through pay-for-performance purchasing. Strengthening PhilHealth's fraud control mechanisms is a vital step to realizing the agency's commitment to guarantee affordable, acceptable, available and accessible health care services for the Filipino people.

Keywords: PhilHealth, health insurance fraud, Philippines, provider payment reform

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Winning the Game: Strengthening PhilHealth’s Provider Fraud Control Mechanisms toward Improved Service Delivery and Financial Risk Protection for Filipinos

Vanessa T. Siy Van, Jemar Anne V. Sigua, Therese Jules P. Tomas, Jhanna Uy, Valerie Gilbert T. Ulep¹

1. Introduction

Health care providers can intentionally defraud social health insurance systems to receive higher payouts through dishonest practices, such as upcoding or unbundling, providing unnecessary services, or extending patient confinement. Worldwide, losses to health insurance fraud account for around **6.19% of spending on health**, wasting limited government resources meant for actual health care needs, especially for poor patients who require financial assistance to access services (Button and Gee 2015; Chhabra, Menon, et al. 2018; Couffinhall and Frankowski 2017; Pande and Maas 2013; van Stolk and Tesliuc 2010). To address provider fraud, multiple and interdependent **fraud control strategies** aimed at prevention, detection, and deterrence can be implemented: *Prevention strategies* strengthen the health insurance system to limit opportunities for fraud; *Detection strategies* identify fraudulent claims to avoid undue payments; and *Deterrence strategies* establish penalties or sanctions to discourage fraud (Chhabra, Menon, et al. 2018; van Stolk and Tesliuc 2010).

The Philippine Health Insurance Corporation (PhilHealth) manages the country’s National Health Insurance Program (NHIP). Annually, PhilHealth pays around PHP 72.5 billion in inpatient care reimbursements through the All Case Rates (ACR), a case-based provider payment mechanism (PPM) which bundles the costs of treating a disease or performing a procedure into a **fixed case rate**. Controlling fraud is a fundamental aspect of efficient fund management and fulfilling PhilHealth’s mandate to ensure health services are accessible to all Filipinos (PhilHealth n.d.).

However, PhilHealth has faced scrutiny over the past decade due to high-profile cases of provider fraud. In 2014, multiple health facilities were found to have submitted claims for unnecessary and low-quality cataract procedures amounting to PHP 3.7 billion (Geronimo 2015a; Philippine Daily Inquirer 2015; PhilHealth 2018) More recent reports include padding of claims for higher reimbursements, including reporting minor respiratory symptoms as pneumonia or as COVID-19, submitting dialysis claims for ghost patients, and unnecessarily extending confinement (Estabillo 2021; Geronimo 2015b; Lacson 2019; PhilHealth 2019a, 2019b, 2021; Senate of the Philippines 2020; Yee 2019). These incidents reveal limitations of PhilHealth’s existing fraud control mechanisms, while the full magnitude of fraud remains unknown (Chhabra, Menon, et al. 2018; COA 2020; Ulitin et al. 2022; WHO 2024).

Efforts to control fraud are likely to become more complex with the implementation of reforms to PhilHealth’s PPM. The Universal Health Care (UHC) Act of 2019 mandates PhilHealth to shift to a prospective global budget (GB) based on diagnosis-related groups (DRGs) (Republic of the Philippines 2019). A hospital’s GB is determined in part by its historical case mix, using claims data to account for the volume, complexity, and severity of

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patients treated. Unlike the ACR, where providers are paid for individual claims, the GB is front loaded to contracted health care provider networks (HCPNs) and apex or end-referral hospitals to cover service delivery expenses for an entire year. Undetected fraud can inflate the hospital GB at the expense of paying for necessary health care services that were actually rendered. Thus, PhilHealth must anticipate and mitigate provider incentives to increase the number of admissions, or upcode patient clinical complexity to receive a higher GB (Barouni et al. 2020; Dredge 2004).

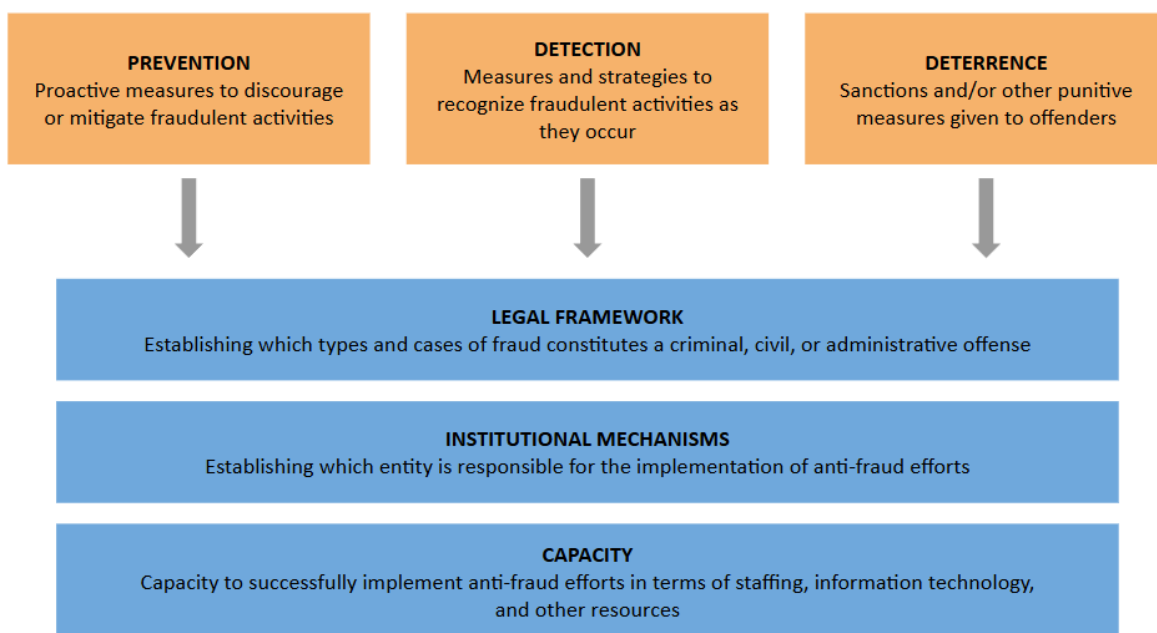
To address this issue, we conducted a process evaluation of PhilHealth’s fraud control mechanisms to identify gaps and challenges in the areas of fraud prevention, detection, and deterrence. Based on these findings, we provide contextually-feasible and evidence-based policy recommendations aimed to strengthen these mechanisms and promote alignment with the ongoing DRG-GB. As of writing, there has been limited assessment of PhilHealth’s fraud control mechanisms and PhilHealth has not yet implemented major changes to their fraud control system in anticipation of the transition to DRG-GB.

2. Methods

2.1. Strategic framework

The process evaluation of PhilHealth’s fraud control mechanisms followed a *framework analysis method* (Limbani et al. 2019; Skivington et al. 2021) based on an analytical framework for defining, assessing, and evaluating control strategies for errors, fraud, and corruption in government social protection programs developed by World Bank in 2010 (**Figure 1**) (Chhabra, Menon, et al. 2018; van Stolk and Tesluic 2010). Following the framework, fraud control mechanisms were classified into three domains as either prevention, detection, and deterrence, and evaluated based on the legal framework, institutional mechanism, and capacity present (Abdallah et al. 2016; Adams et al. 2006; Chhabra, Menon, et al. 2018; van Stolk and Tesluic 2010)

Figure 1. Analytical framework for defining, assessing, and evaluating control strategies for errors, fraud, and corruption in government social protection programs



2.2. Data and Analysis

For the process evaluation, we reviewed international literature to identify the activities that fall under the three domains of the fraud control framework employed by other countries with DRG payment systems. We also reviewed PhilHealth’s fraud control policies, including the National Health Insurance Act (NHIA) of 2013 Revised Implementing Rules and Regulations (IRR) and the 2023 PhilHealth Rules on Administrative Cases (PROAC) of the UHC Act (PhilHealth 2013, 2023a) to identify equivalent activities and map out PhilHealth’s fraud control processes. We then compared global fraud control activities with PhilHealth’s equivalents to identify gaps in the understanding and practice of fraud control.

Of the various PhilHealth Offices involved in fraud control (**Appendix 1**), we conducted stakeholder consultations with Fact-Finding Investigation and Enforcement Department (FFIED), Standards and Monitoring Department (SMD), Task Force Informatics (TFI), and the National Capital Region’s PhilHealth Regional Office (PRO) Benefits Administration Section (BAS) and Legal Department, and representatives from Benefits Development and Research Department, UHC Surge Team, and Project Management Team for Claims. The consultations gathered insights on the challenges implementing PhilHealth’s anti-fraud activities and the feasibility and acceptability of the fraud control practices employed by other countries. Although the UHC Surge Team is not involved in fraud control, we consulted with the team to understand and situate the study results in the coming provider payment reforms

We also analyzed **91,043 cases reported to PhilHealth FFIED between 2018 to 2024** to understand the magnitude of fraud that can be captured by PhilHealth’s current strategies. Of these, 96.12% (87,510) were filed against health care providers, with 63,147 (69.36%) cases filed against facilities and 24,363 (26.76%) cases filed against professionals. The remaining cases (3.98%) were filed against employers and PhilHealth members (**Table 1**). Note that a single case can identify more than one violation, and in total there were 159,098 violations.

Table 1. PhilHealth cases analyzed by offender type, 2018–2024

Offender type	2018	2019	2020	2021	2022	2023	2024	TOTAL
Blank	-	45 0.78%	-	3 0.02%	-	-	-	48 0.05%
Facility	3,295 62.26%	3,098 53.40%	10,124 55.60%	9,596 66.34%	9,350 73.97%	15,675 77.54%	12,009 83.27%	62,147 69.36%
Professional	1,887 35.66%	2,526 43.54%	7,131 39.17%	4,328 29.92%	2,593 20.51%	3,765 18.62%	2,133 14.79%	24,363 26.76%
Member	-	-	-	1 0.01%	-	-	-	1 0.00%
Employer	-	1 0.02%	1 0.01%	0	9 0.07%	-	-	11 0.01%
Other*	110 2.08%	132 2.28%	951 5.22%	536 3.71%	688 5.44%	776 3.84%	280 1.94%	3,473 3.81%

Offender type	2018	2019	2020	2021	2022	2023	2024	TOTAL
TOTAL	5,292	5,802	18,207	14,464	12,640	20,216	14,422	91,043

*Cannot be identified based on given information
Source: Authors' analysis of PhilHealth claims data, 2018-2024

2.3. Ethical considerations

This study did not undergo ethics review. The literature review utilized publicly available secondary data. Datasets and stakeholder consultations with PhilHealth were covered by a non-disclosure agreement and data-sharing agreement between PIDS and PhilHealth.

3. Results and discussion

Through the process evaluation and stakeholder consultations, we identified **three interrelated themes** from the analysis:

- The scope of fraudulent activities flagged by PhilHealth does not cover all potential fraudulent activities common to a DRG-GB system.
- There is a lack of an overarching fraud control strategy across prevention, detection, and deterrence mechanisms, restricting access to necessary health services.
- Lack of routine data monitoring and analysis underestimates the incidence of fraud.

3.1. Theme 1: The scope of fraudulent activities flagged by PhilHealth does not cover all potential fraudulent activities common to a DRG-GB system.

The scope of fraudulent activities flagged by PhilHealth does not cover all potential fraudulent activities common to a DRG-GB system. Based on global literature, these are upcoding, unbundling, increasing admissions, gaming with transfers, and cream skinning or cherry picking (Susanti et al. 2022; LHSSP 2022; Villegas-Ortega et al. 2021). PhilHealth does not use an explicit definition of fraud. Rather, the NHIA IRR and PROAC provide examples of offenses to game the health insurance system, which PROs use to flag offenses committed by providers (PhilHealth 2013, 2023a). These include fabricating forms, padding claims, postdating claims, and filing claims for non-admitted patients, upcoding, and extending confinement. Among these acts identified by PhilHealth, unbundling, unplanned or avoidable readmissions, and gaming are not explicitly considered as offenses (**Table 2**).

Table 2. PhilHealth classification for the different types of potential health insurance fraud from the NHIA 2013 Revised IRR and the 2023 PROAC of the UHC Act

Type and Description	PhilHealth equivalent classification	Limitations/ Implications
Upcoding Deliberately submitting claims with codes that have higher rates than the actual diagnosis or service provided	Unethical act: <i>Upcoding (or upcoding, diagnosis creeping, procedure creeping)</i> (PROAC Sec 55, 64, & 81) Fraudulent act: <i>Misrepresentation</i>	Upcoding is detected through a time-intensive review of individual claims and patient charts by medical evaluators, who must rely on their medical

Type and Description	PhilHealth equivalent classification	Limitations/ Implications
	<p><i>by furnishing false or incorrect information</i> (i.e., code substitution; adding non-existing conditions in the diagnosis) (PROAC Sec 55, 60, & 78)</p> <p><i>Note:</i> PhilHealth defines code substitution as claiming for <u>unrelated</u> illness or procedure with higher benefit payment in lieu of actual illness or procedure, while upcoding (or upcoding/diagnosis creeping/procedure creeping) is claiming for a <u>related</u> illness or procedure of higher severity or complexity to gain higher benefit payment (NHIA IRR Sec 154 & 162; PROAC Sec 60 & 78).</p>	<p>experience in the absence of comprehensive national clinical coding standards.</p> <p>In contrast, upcoding is typically monitored systematically (Levin et al. 2024) through statistical associations between coding intensity and payment variations or provider characteristics. Where individual-level detection is implemented, coding intensity should be compared to a “gold standard” to minimize variation in the sensitivity of detection.</p>
<p>Unbundling Creating separate claims for services that were provided in a single episode of care</p>	<p>Unbundling does not have a direct equivalent in PhilHealth’s policies, and it is not systematically monitored, only when individual claims have discrepancies.</p>	
<p>Increasing Admissions Excess or unnecessary admissions that are not essential to the patient’s plan of care</p>	<p>Fraudulent act: <i>Extending the patient’s period of confinement</i> (NHIA IRR Sec 152 & 169; PROAC Sec 55 & 58)</p>	<p>The definition does not cover unplanned or avoidable readmissions. As such, avoidable readmissions do not have a direct impact on PhilHealth payments to providers.</p>
<p>Gaming with transfers Intentionally transferring patients if the expected treatment costs exceed the set reimbursement for their condition</p>	<p>Has no current equivalent in PhilHealth’s policies (PROAC). In the NHIA it was classified as a grounds for penalty in claims payment: <i>Inappropriate referral practices</i> (NHIA IRR Sec 47).</p>	<p>Even under the NHIA, it was never explicitly defined as fraud or an offense. It is not systematically monitored, except when individual claims have discrepancies.</p>
<p>Cream Skimming Choosing or turning patients away based on profitability (also called <i>cherry picking</i>)</p>	<p>Fraudulent act: <i>Failure or refusal to give benefits to qualified members or dependents</i> (NHIA IRR Sec 159)</p> <p>Unethical act: <i>Refusal to admit and/or provide appropriate service</i></p>	<p>These definitions do not distinguish among incentives for failing to admit patients or give them PhilHealth benefits.</p>

Type and Description	PhilHealth equivalent classification	Limitations/ Implications
(PROAC Sec 55, 67, & 83)		

NHIA = National Health Insurance Act; IRR = Implementing Rules and Regulations; PROAC = PhilHealth Rules on Administrative Cases; UHC = Universal Health Care

Sources: PhilHealth 2013, 2023a

There is minimal consideration for fraud practices outside of claims processing, suggesting a limited understanding of what fraud constitutes. For instance, PhilHealth implements the Health Care Provider Performance Assessment System (HCP PAS), a performance monitoring system aimed to ensure quality assurance by evaluating compliance to PhilHealth policies. **However, within PhilHealth, HCP PAS is not conceived of as a fraud control mechanism, though it features three performance indicators on fraud detection on readmission, refusal of referrals, and drug prescription** (PhilHealth 2023b).

The lack of a comprehensive conceptualization of fraud creates gaps for providers to exploit. Aside from readmissions, transfer gaming or unbundling services are not systematically monitored and have no direct impact on provider payments. As such, providers also do not have an incentive to correct this behavior. Addressing this issue is especially important as PhilHealth transitions to DRG-GB, where payments are determined in part by the number and complexity of hospital admissions. **Box 1** presents three examples of how monitoring adverse provider behavior can be integrated into the payment system.

Box 1. Monitoring adverse provider behavior in a DRG-GB payment system

Several countries combine DRG with GB to balance the different incentive structures and manage health care costs of both payment mechanisms: the cost containment incentive of a GB can offset the potential overprovision of care that DRG can incentivize. This type of value-based purchasing utilizes a performance-based payment strategy, linking the GB and other financial incentives with providers' performance based on a set of defined targets or measures (Dredge 2004; Health Carousel n.d.; Milstein and Schreyögg 2024; Wolfe and Moran 1993). This necessitates a robust monitoring system to ensure that adverse incentives introduced by a GB (e.g., underprovision of services, deteriorating quality of care, or lack of transparency) are mitigated (Barber et al. 2019).

Maryland, United States (US) has been implementing a hospital GB since 2014. The independent Health Services Cost Review Commission (HSCRC) establishes an annual GB for each hospital based on historical data, and sets rates for services so that total payments based on expected utilization match the GB. The HSCRC monitors hospital's charges and service volume through monthly reports to ensure compliance with its GB. If more than 0.5% of the GB is underused, the hospital's GB can be adjusted down for the future years), and if more than 0.5% is overused, the surplus is deducted from the hospital's GB in the subsequent year (Parks 2016; Research Triangle Institute 2019).

In Taiwan, a national GB is calculated by the National Health Insurance Administration (NHIA) based on aggregate level of expenditure from the previous year, which is divided per region and per sector. Hospitals are paid fee-for-service from their regional GB, and fees for public and private services are standardized. The Bureau of National Health Insurance monitors provider volumes and audits providers who exceed historic service volumes: the top 10% providers by point volume are subject to administrative review. Each GB is also graded annually by the NHIA based on a criteria, including service delivery, quality, public satisfaction, and use of resources, and an annual increase is given based on the evaluation (Chang et al. 2015; Kan et al. 2014; Tikkanen et al. 2020; Tsai et al. 2024).

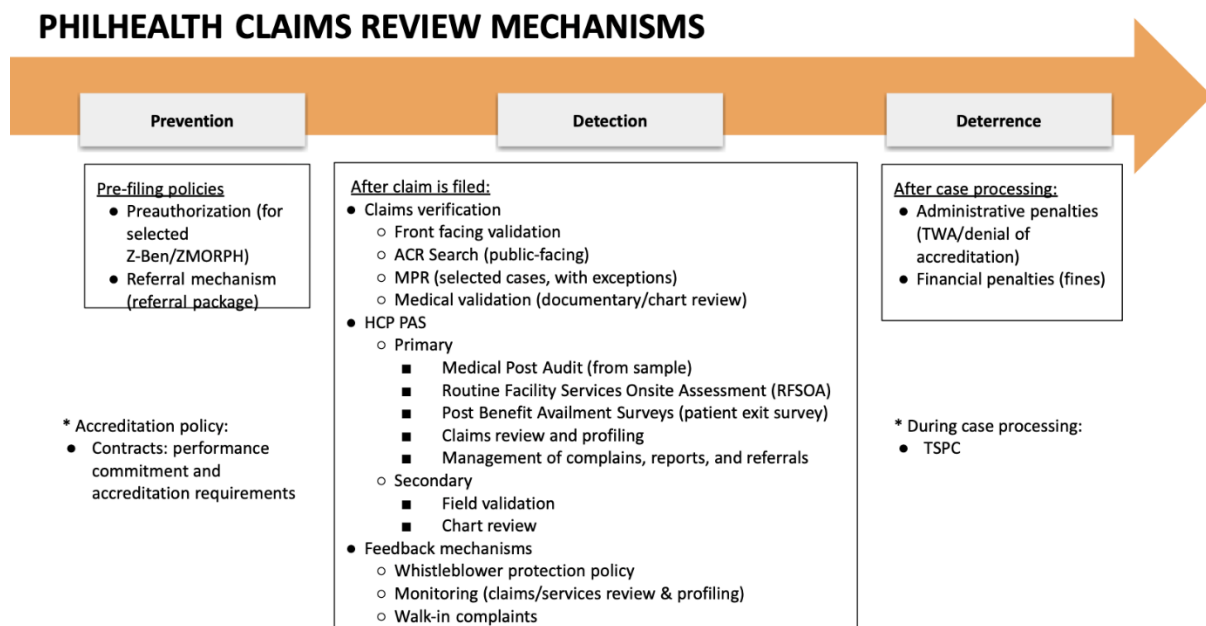
In Guizhou, China, hospital GB is paired with a pay-for-performance (P4P) measure. Thirty percent (30%) of hospital GBs are given separately based on hospital performance and quality of care. Twice a year, clinical experts assess hospital performance based on international treatment guidelines and medical outcomes. The goal of the policy is to counteract the potential risks of GB on quality of care such as underprovision of services. As a result of the P4P mechanism, county hospitals in Guizhou saw quality improvements among patients with acute myocardial infarction and pneumonia (Zhou et al. 2021).

These examples show that fraud control strategies should be embedded into PPM activities. A robust monitoring system is a powerful policy lever that incentivizes the efficient delivery of quality services for all patients. Monitoring quality indicators can highlight trends across and between populations, institutions, or regions that can be used to understand and improve management processes with more precise and targeted strategies (ADB 2025).

3.2. Theme 2: There is a lack of overarching fraud control strategy across prevention, detection, and deterrence mechanisms, restricting access to necessary health services

There are no overarching policies or guiding documents that discuss PhilHealth’s overall fraud control strategy. Offices are left to focus on individual policies with little coordination or information-sharing. This has led to focusing on fraud detection during the claims review process, rather than prevention (Figure 2). These are human resource intensive and introduce bottlenecks that hamper access to services and contribute to delays in the release of payments. Appendix 2 provides detailed descriptions of each of PhilHealth’s identified fraud control mechanisms, with an analysis of their gaps and impacts.

Figure 2. PhilHealth claims review mechanisms related to fraud control



PhilHealth = Philippine Health Insurance Corporation; Z-Ben = Z-Benefit Package; ZMORPH = Z Benefit Package for Mobility, Orthosis, Rehabilitation, Prosthesis Help; ACR = All Case Rates; MPR = Medical Prepayment Review; HCP PAS = Health Care Provider Performance Assessment System; MPA = Medical Post Audit; TWA = temporary withdrawal of accreditation; TSPC = temporary suspension of payment of claims

* Not part of claims processing

Source: Authors’ analysis

3.2.1. Prevention mechanisms

PhilHealth’s fraud prevention policies take effect only after services are provided and do not directly reduce provider incentives to commit fraud. Prevention mechanisms are meant to be proactive measures to discourage or mitigate fraudulent activities. In countries with mature PPMs, admissions and referral monitoring play a key role in performance-based payments and fraud prevention (Fung et al. 2008; Kristensen et al. 2015; Marshall et al. 2000). For instance, admission rates are typically monitored for gaming when there are updates that increase the payment rates of certain DRGs (Gluckman et al. 2020) (Box 1). In the US and England, hospitals receive lower reimbursements for readmissions that are considered to be excess or avoidable.

However, PhilHealth does not systematically monitor admissions, readmissions, and referrals, and there is no baseline data that can be used to flag systemic fraud by providers. Instead, readmission monitoring is used as a basis for payment denial at the level of individual claims (PhilHealth 2013b), limiting access to health care services in the process (ADB 2025). One example is the 90-day Single Period of Confinement (SPC) Rule, where

patients who were readmitted with the same condition within 90 days were not reimbursed. The main consequence for providers who violated this rule was only the rejection of their claim (PhilHealth 2013b). In October 2024, PhilHealth removed the SPC rule without a replacement policy amid criticism that the rule only penalized patients with recurring illnesses without a sound basis for its policy (Bosano 2024; Philippine Daily Inquirer 2024; Villanueva 2024). Another example is the referral package. Most countries have laws against self-referral, and require referral letters from a primary care facility before specialist care will be reimbursed by the insurer (Chhabra, Menon, et al. 2018). Although PhilHealth's referral package prohibits referral to lower-level hospitals (PhilHealth 2013b), evaluations cover only the individual-claim level and take place only after the episode of care has already been completed and claims were submitted.

Without performance-based monitoring, PhilHealth heavily relies on preauthorization as a prevention strategy. In the Philippines, preauthorization is needed before patients can avail of Z-Benefit Packages, such as kidney transplants. Though many countries require providers to submit evidence showing an expensive, non-emergency procedure is medically necessary, safe, and cost-effective before agreeing to cover it (Chhabra, Menon, et al. 2018; Levine 2024; NAIC 2024), an overreliance on preauthorization emphasizes the importance of cost-containment goals without clear positive impacts on health outcomes (MacKinnon and Kumar 2001). This further highlights the need for performance-based prevention strategies through monitoring avoidable admissions, inappropriate referrals, and intentionally unbundling services in a single episode of care. **As such, PhilHealth's strategies are more reactive than preventive.** Given the limited prevention strategies available, PhilHealth relies on fraud detection after services have already been rendered or payments have been released.

3.2.2. Detection mechanisms

PhilHealth's fraud detection mechanisms are inefficient, heavily focused on the manual verification of individual claims. The PhilHealth eClaims system features few validation rules, including verification of patient eligibility based on readmission policies (prior to October 2024) and the detection of overlapping or multiple filed claims (PhilHealth 2016). The system also automatically tags claims for Medical Prepayment Review (MPR) and Medical Post-Audit (MPA). For MPR, claims with four illnesses considered to be vulnerable to fraud are flagged. However, these are manually reviewed by Medical Evaluators before adjudication based on patient clinical data and adherence to standards of care and PhilHealth policies (PhilHealth 2019c). The MPA, on the other hand, is applied to a sample of claims based on a list of conditions determined by PhilHealth or as manually selected by the PRO, and is conducted after claims are processed and paid (COA 2020; Ulitin et al. 2022).

Limited standardized processes in claims adjudication overexpend limited staff at PROs. Evaluators must look through each claim for both simple quantitative checks and more in-depth qualitative assessments. While a guide for the MPR exists, parameters for medical evaluation were reported insufficient, leaving much of the effort to the evaluator (COA 2020). The lack of a standardized procedure in a manual process can lead to subjective interpretations of definitions, leading to inconsistencies in determining what is or is not a violation, or what type of violation has occurred.

An analysis of selected claims by the Commission on Audit (COA) found inconsistencies in the way violations are worded in different cases, as well as several instances of incorrect or inconsistent data in approved and paid claims (COA 2020). This was corroborated by our

analysis of FFIED data. Most violations were based on definitions of the PROAC, NHIA IRR, or specific PhilHealth circulars, which overlap or have slight differences. **However, 6.89% of the 159,098 violations in the FFIED database had no clear reference, making it difficult to assess overall trends in offenses committed.** This challenge is exacerbated by an insufficient number of Medical Evaluators in the PRO relative to the number of claims undergoing review (COA 2020; Ulitin et al. 2022; WHO 2024). The COA found a number of claims that were paid despite not undergoing MPR, and a substantial amount of claims were backlogged for MPA (COA 2020).

There are no dedicated staff to utilize fraud detection and evaluation data to shape provider behavior. There are no staff in the PROs and the PhilHealth Central Office dedicated to the implementation and assessment of findings from the HCP PAS and received feedback (LHSSP 2022). The HCP PAS Regional Monitoring Committee (HRMC) verifies quality of care concerns and the PRO issues up to two Notice of Corrective Action to violating providers. However, succeeding violations, or first violations with legal implications, are brought to the PRO Legal Office. **This process reflects reactive and case-to-case monitoring.** While FFIED compiles offenses that have been elevated to the Central Office, this is not standard protocol, and relies on FFIED to take initiative and request TFI to extract reports from PROs. Currently, there are no established procedures for how to use aggregate fraud detection data in the agency, leading to a dearth of macro-level quality monitoring policies.

3.2.3. Deterrence mechanisms

PhilHealth relies on hard penalties to deter fraud, but since 2023, these are no longer clearly established and must be individually arbitrated. PhilHealth uses administrative, financial, or legal penalties, such as fines and the suspension of payments or accreditation. In the NHIA IRR, fraudulent acts carried greater penalties compared to non fraudulent offenses. However, the 2023 PROAC amended this, providing only a blanket scale of penalties applicable to any type of offense depending on the arbitration of each case. Unlike other countries, which publicly report a list of offending providers, or score providers' overall performance to inform patients and encourage providers to improve their performance (Chhabra, Menon, et al. 2018; US HSS n.d.-a), **PhilHealth does not have soft measures to nudge provider behavior** (Willmington et al. 2022). Thus, penalties on providers only transfer costs to patients, and do not carry long-term consequences.

3.3. Theme 3: Lack of routine data monitoring and analysis underestimates the incidence of fraud

A narrow understanding of fraud and siloed fraud control mechanisms have led to a severe underestimation of the prevalence of fraud in the country. Analysis of FFIED's fraud data from 2018 to 2024 shows the annual incidence of fraud is less than 1% of all claims: 0.07% in 2018, 0.08% in 2019, 0.38% in 2020, and 0.38% in 2021. In contrast, other low- and middle-income countries, such as India, have an annual incidence of 15% (Chen et al. 2024; Chhabra, Gupta, et al. 2018; The Times of India 2024), Even in high-income countries, fraud can cost between 3% and 10% of the national health care expenditure (Button and Gee 2015; Couffinhal and Frankowski 2017; Pande and Maas 2013). Various offices concurred

that current fraud control practices may be insufficient to capture and report the actual incidence of fraud in the country.

Current methods of reporting fraud within PhilHealth hamper understanding trends and taking appropriate action against fraud. Among reported cases, the most common case rates (diseases or procedures) with reported violations are Hemodialysis Procedure and Pneumonia Moderate Risk. The top 10 case rates from reported fraudulent cases alone represent 38.42% of all offenses filed against providers and have cost PhilHealth PHP 473.6M. Even this is an underestimate, given that **there is no standardized format for recording and reporting fraud.** While some cases filed by PROs used International Statistical Classification of Diseases or ICD Codes, others contained plain descriptors, and others used PhilHealth’s package code. Similarly, hospitals and health professionals may have committed multiple offenses, necessitating the filing of multiple cases. Nonetheless, the true magnitude of an individual provider’s fraud cannot be determined, as many entries did not include a standard identification number, and names were not uniformly recorded.

Without addressing underlying **issues of planning, staffing, and technological resources**, additional measures to control fraud against PhilHealth will continue to be inefficient, reactive, and ultimately ineffective. One example in **Box 2** illustrates **how adopting new tools without strengthening PhilHealth’s core understanding and processes for fraud control eventually led to initiatives that were not sustained.**

Box 2. Example of an Inappropriate Fraud Control Solution: Using Artificial Intelligence (AI) in lieu of Core Indicators

PhilHealth has attempted to both automate fraud control and move beyond a focus on individual claims, but these remain plagued by the structural challenges identified in the study. In 2019, TFI developed the **Machine Learning Identification, Detection, and Analysis System (MIDAS)** to utilize unsupervised machine learning to identify fraudulent patterns. PRO information technology (IT) staff were envisioned to create dashboards and reports to predict possible cases of fraud before payments were released. However, because the initiative did not have the staff and IT structure to support it, MIDAS was never systematically implemented across regions.

Where MIDAS is used, there is no dedicated team to update the model and interquartile range thresholds are still based on data from 2014 to 2017. Moreover, without a strategic and operational understanding of fraud, many stakeholders were concerned about wrongful accusations, particularly given the model’s pivot towards AI, where methods for flagging a case as fraudulent can be opaque and enigmatic (WHO 2024). **Without a well-established framework for fraud, AI is an inappropriate tool for fraud control at best, and, at worst, an unreadable closed-book given the power to decide the financial and even criminal fates of health care professionals.**

Appendix 3 summarizes the findings and recommendations of this paper.

4. Discussion and implications

Health insurance fraud can increase costs of premiums and subsidies, and reduce resources for actual health care needs (ADB 2025; Chhabra, Gupta, et al. 2018; Davies

2024; Guntoro et al. 2024; Susanti et al. 2022). In prospective payment systems like DRG-GB, where funds are front loaded to hospitals to cover for a certain period, fraudulent acts like upcoding, unbundling, or unnecessary readmissions effectively reduce the pool of resources for all patients. Consequently, fraud inflates health care costs, especially for the vulnerable and medically underserved who already face barriers to accessing health care (ADB 2025; Davies 2024). While reduced financial risk protection hampers access to necessary care, inadequate safeguards for fraud compromise patient safety and care quality (Akinleye et al. 2019; Pande and Maas 2013).

However, highly reactive fraud control mechanisms can also compromise access to quality care. In the Philippines, the 90-day SPC rule was established to control hospital readmissions for the same condition or procedure. As a blanket rule, SPC did not distinguish between necessary readmissions and those that could be avoided, indicating poor discharge planning. PhilHealth reported that around 26,750 claims were denied in 2023 because of the SPC rule, and that some of these were for unpredictable conditions, such as pregnancy complications. Without PhilHealth’s financial support, the costs were shouldered by hospitals or passed along to patients. Other providers turned to gaming the system to protect patients, changing their primary diagnosis in the claims so patients could be covered by PhilHealth (Aagna 2024; Baja et al. 2014; Cabalfin 2016; COA 2020; Cordero 2021; Sampang 2024; Valmonte 2024).

Strengthening PhilHealth’s fraud control systems require **reshaping the agency’s understanding of fraud and its place in the provider payment system.** The use of pre-authorization and individual claims review and audits as the main policy levers for fraud control emphasize cost-containment and safeguarding against unnecessary payments while underutilizing the potential to shape provider behavior towards the delivery of safe, efficient, and quality care by systematically tying service outcomes to payments.

5. Policy insights and recommendations

To combat fraud and set up a PPM environment that incentivizes providers to deliver quality services, PhilHealth must focus on three areas of policy reform:

- Strategic planning to anticipate and respond to diverse forms of fraudulent behavior by developing policies to prevent unbundling, unnecessary transfers, and cream skimming;
- Incorporating fraud monitoring and feedback mechanisms in provider performance-based incentives; and
- Targeted investment in staff and IT resources to improve existing fraud control strategies.

1. PhilHealth must develop a strategic plan to broaden the definition of fraud, strengthen fraud prevention mechanisms, and deter providers from gaming the system.

Strategic planning involves an assessment of existing fraud control mechanisms and the creation of targeted strategies to address policy and implementation gaps (Cote 2020). To carry this out, PhilHealth should expand the current scope of fraud to include other potential fraudulent practices that occur within the continuum of care, as well as those that can emerge as the system transitions to a DRG-GB set up. This entails **developing policies to prevent unbundling services, transfers gaming, and cream skimming.**

With a framework for fraud, the three domains of control (prevention, detection, and deterrence) can be given appropriate attention. For instance, in the US, when hospital orders for **unnecessary transfers of uninsured or underinsured patients from private to public facilities increased**, The Department of Health and Human Services Office of the Inspector General and the Centers for Medicare and Medicaid Services (CMS) began penalizing hospitals that refused to treat patients through the *Emergency Medical Treatment and Labor Act* (US HHS 2024; Warby et al. 2025). **To prevent unbundling, CMS established a Global Period**, where anticipated procedures following an episode of care fall under a single billing period, preventing providers from inappropriately splitting services to claim for succeeding visits (CMS 2024a).

These policies require that PhilHealth assign a **dedicated team to oversee the coherence of fraud control policies** across the continuum of and ensure their proper implementation across offices.

2. PhilHealth must design a coherent fraud control process that incorporates fraud monitoring in evaluating provider performance and determining provider payment adjustments.

PhilHealth should **once again monitor patient readmissions** and leverage tools like HCP PAS for data on quality assurance in quality of care, patient satisfaction, financial risk protection, and incidental detection of fraud or offense in **P4P measures**.

The GB should be used as an instrument to incentivize provider behavior. In mature DRG-GB systems such as Australia, Germany, and the United Kingdom (Milstein and Schreyoegg 2016; Wolfe and Moran 1993), **hospital GBs are adjusted based on hospital performance compared to the established benchmarks or thresholds**. Targets include reducing wait times, lowering the incidence of “never events,” and minimizing avoidable readmissions. Benchmarks can be set at the national or regional levels, or across hospitals clustered according to a set criteria, such as hospital level, hospital ownership, or geographic location (NHS England n.d.). **Paired with technical or policy support from PhilHealth**, benchmarking can incentivize providers to improve service delivery, change their outlier behaviors, and enhance their overall performance as it directly feeds into their budget. In some states of the US, hospitals are required to implement performance improvement plans if they do not meet the benchmark (CMS 2024b; Tikkanen et al. 2020). Benchmarking and performance-based payments will not only help minimize PhilHealth losses from cases of fraud but it will also systematically improve provider performance, leading to better quality of care for patients.

Taken together, these reforms create a holistic approach to fraud control that extends **beyond the detection of fraudulent claims through medical audits**. South Korea’s approach in **Box 3 is an example of how a strategic approach to fraud control can also incentivize improvements in quality of** submitted data, provider service delivery, and efficiency of the national insurer.

3. PhilHealth must focus on key activities in fraud control where it can increase its investments in human and IT resources.

Consultations with PhilHealth offices have shown that one of the operational challenges of implementing fraud control activities is the lack of staff to handle the volume of claims for processing. However, hiring additional evaluators does not address the issue that claims are manually and individually processed. Instead, **fraud detection reforms should be conceived systematically**. For instance, **upcoding** is generally not detected by reviewing each individual claim; rather, evaluators look for statistical associations in changes to coding patterns following changes to payment policies (Levin et al. 2024). Upcoding was detected in the US between 2012 and 2016, when researchers found increases in the proportion of admissions assigned to a DRG with major clinical complications in 15 of the 20 highest-reimbursed DRG families. This shift in admissions was not associated with commensurate increases in disease severity, but were associated with USD 1.2 billion in increased payment (Gluckman et al. 2020).

For the MPR and MPA, PhilHealth can **develop a protocol to standardize the checks implemented by medical evaluators**. This will institutionalize the step-by-step process and identify **which checks can be automated** to lessen the amount of manual work, leading to improved efficiency and turnaround time (Chhabra, Menon, et al. 2018; Najjar et al. 2025).

Standardization can also be explored where data input requirements fall within established criteria or options (Chhabra, Menon, et al. 2018), such as **templates for fraud reporting**. For example, PhilHealth's ongoing Shadow Billing for DRG-GB makes use of Claim Form 5 (CF5) with front-facing validations and dictionaries that facilitate uniform encoding of facility characteristics, PhilHealth membership, and pertinent clinical information (PhilHealth 2023c). A similar form can be developed for PROs when reporting cases.

PhilHealth can also employ **automated flags based on historical data to review procedures, conditions, and providers with historically high associated rates of fraudulent activities or violations** (Chhabra, Menon, et al. 2018; HIRA n.d.). After designing these programs, PhilHealth should **hire and train additional technical personnel** who will implement anti-fraud reforms to ensure that these innovations are maximized by the end-users.

Box 3. Example of a Holistic Fraud Control Strategy: Claims Processing in South Korea

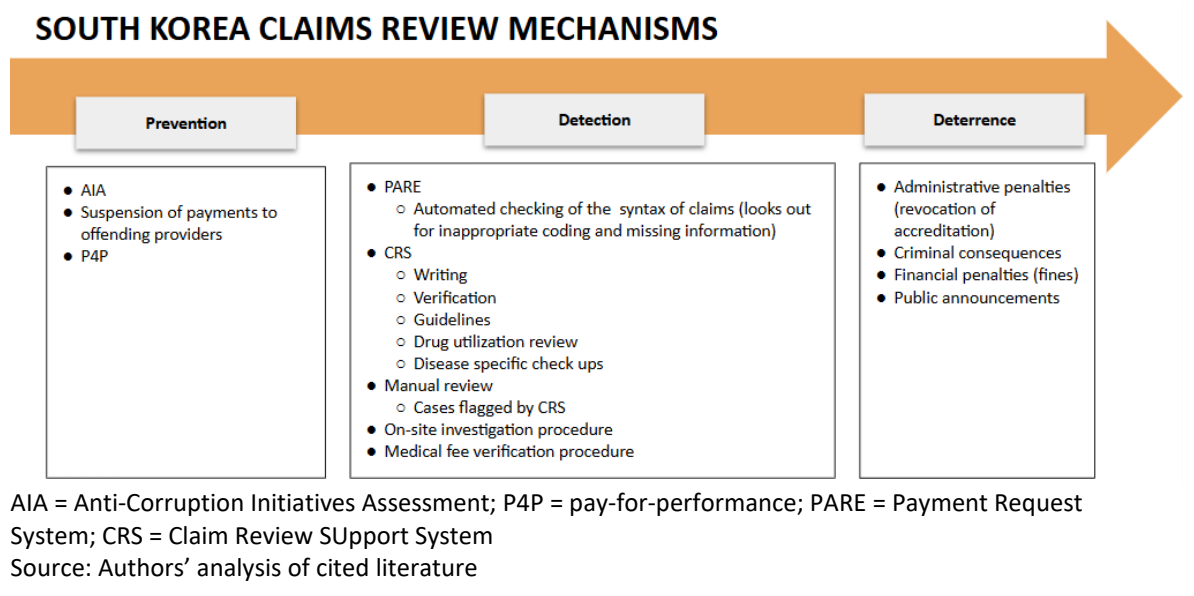
The National Health Insurance Service (NHIS) is South Korea's insurer for its NHIP. As the administrator of the NHIP, the Health Insurance Review and Assessment Service (HIRA) conducts claims review and quality monitoring of health care services in the country (**Figure 3**). Currently, 99% of medical institutions in South Korea utilize electronic claims submission to claim insurance payments, and the entire claims review process relies heavily on IT systems to accommodate the increasing demand for such service. Given the coverage of NHIP, South Korea's mechanisms against health insurance fraud are embedded in its claims review process (Chhabra, Menon, et al. 2018; Park et al. 2012).

Claims processing starts when providers submit their claims through an electronic portal. These claims are then received by the Payment Request System (PARE) which is an automated way of checking for the completeness and appropriateness of codes in the claims. After PARE, claims go through automatic data processing under the Claim Review Support (CRS) system in five stages. The writing stage verifies the required fields in a claim where claims with errors in more than 30% of the fields are returned to the providers. After this, claims go through the verification stage where codes, unit prices, and calculations are verified. Upon verification, the claims are checked against government guidelines and policies to see if services in a claim have been appropriately provided to the patients and properly filed. The claims are then screened for drug utilization where possibility of inappropriate use of medications are checked. These checks include (but are not limited to) contraindications and possible drug interactions. Finally, the disease-specific check up screens the correctness of health services in a claim against reimbursement guidelines. At this stage, the system may adjust the reimbursement rates. Claims tagged with issues or errors in any of the five stages are forwarded for manual review and investigation. Claims that successfully clear the CRS are forwarded to NHIS for reimbursement (Chhabra, Menon, et al. 2018; Park et al. 2012).

Providers who are likely to claim fraudulent charges may be subject to On-Site Investigations as requested by HIRA or the Anti-Corruption & Civil Rights Commission (ACRC) (HIRA 2018). Medical fee procedures where HIRA examines the medical fees paid for by patients for non-covered services are also available at a patient's request. Depending on the result, providers may be asked to return extra charges to the patient (Chhabra, Menon, et al. 2018; HIRA 2018).

Fraud deterrence mechanisms exist outside claims processing such as the public announcements of offending providers and administrative or criminal sanctions for offenders through fines and suspension of accreditation. In terms of prevention, ACRC implements the Anti-Corruption Initiative Assessment where anti-corrupt practices in public offices (including public medical institutions) are assessed (Son 2022). Institutions with highly rated anti-corrupt practices are given awards and additional training by the government (Lee and Lee 2022). Further, payments to offending providers or providers with pending cases of fraud may also be temporarily suspended to prevent potential fraudulent charges. A P4P program through the Value Incentive Program also incentivizes hospitals to improve quality of care by providing financial awards to facilities that meet performance measures for select diseases and procedures (HIRA 2021).

Figure 3. South Korea claims review mechanisms related to fraud control



6. Conclusion

We conducted a process evaluation of PhilHealth's fraud control mechanisms through stakeholder consultations, literature review, and descriptive analyses of fraud data. We found that PhilHealth's narrow definition of fraud resulted in fraud control mechanisms that were siloed within offices and focused mainly on detection. This was exacerbated by limited human and IT resources deployed to implement a fraud detection process that is heavily reliant on manual evaluation, leading to an underestimation of the true magnitude of health insurance fraud in the Philippines.

Moving forward, PhilHealth's fraud control system requires development of a framework that covers different types of gaming across the continuum of care and processes to translate provider performance monitoring into payment incentives, supported by increased investments in staff and technologies. These findings and recommendations are especially relevant as the Philippines transitions to a DRG-GB payment system, which provides an opportunity to incentivize quality service delivery and improved hospital performance. Strengthening PhilHealth's fraud control mechanisms is a vital step to realizing the agency's commitment to guarantee affordable, acceptable, available and accessible health care services for the Filipino people.

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8. Appendices

Appendix 1. PhilHealth offices involved in identified fraud control activities

Steps	PhilHealth office/s	Fraud control activities
Prevention mechanisms		
Provider accreditation	LHIO; AQAS	Processing of provider accreditation applications/renewals, such as the signed and notarized Performance Commitment
Health service delivery	LHIO; PRO-BAS	Processing of applications for preauthorization for Z-benefit packages
	SMD; PRO-Planning, BMU; MMG	Monitoring of implementation of referral and readmission policies
Detection mechanisms		
Patient billing	LHIO; P-CARES	Ensuring benefit packages reflected on patient bills are accurate, including the use of the ACR Search application
Claims receiving and processing	ITMD	Development and improvement of the eClaims System to integrate fraud detection mechanisms
	PRO-BAS	Claim adjudication (MPR and MPA); coordinating fraudulent claims with providers and elevating to PRO-Legal Sector
	IMS-TFI	Data extraction of collated claims; flagging potentially fraudulent claims beyond the MPR using the MIDAS; elevating fraudulent claims to the FFIED
Fact-finding investigation	Legal Sector - FFIED	Review of claims raised by TFI for fraudulent activities; elevating fraudulent claims to Legal Department
Appeals and cases	Legal Sector - ProSec; PARD; CAAC	Processing appeals from providers
Performance monitoring	SMD; PRO BMU & AQAS	Conduct of various performance monitoring tools under the HCP PAS
Feedback mechanisms	P-CARES; CAC	Manage feedback channels for public reports potential fraud cases (exit surveys, dedicated hotline and e-mail)
Deterrence mechanisms		
Enforcement of sanctions	Legal Sector - ProSec and Adjudication Office; FFIED; PRO Legal Office	Processes confirmed administrative and legal cases; execution of imposable administrative, financial, or legal fines or penalties, as well as restitution or reimbursement of unnecessary payments

PhilHealth = Philippine Health Insurance Corporation; LHIO = Local Health Insurance Office; AQAS = Accreditation and Quality Assurance Section; PRO = PhilHealth Regional Offices; BAS = Benefit Administration Section; BMU = Benefits Monitoring Unit; MMG = Member Management Group; P-CARES = PhilHealth Customer Assistance, Relations, and Empowerment; ACR = All Case Rates; ITMD = Information Technology Management Department; MPR = Medical Prepayment Review; MPA = Medical Post Audit; IMS = Information Management Sector; TFI = Task Force Informatics; MIDAS = Machine Learning Identification, Detection and Analysis System; FFIED = Fact-Finding Investigation and Enforcement Division; ProSec = Prosecution Department; PARD = Protest and Appeals Review Department; CAAC = Committee on Appealed Administrative Cases; SMD = Standards Monitoring Division; CAC = Corporate Action Center

Sources: PhilHealth 2022, 2023a, 2023b

Appendix 2. Analysis of fraud management mechanisms of PhilHealth

This table defines the different prevention, detection, and deterrence fraud control mechanisms currently employed by PhilHealth. These mechanisms were analyzed based on the existence of a legal framework, and the institutional mechanisms and capacity for implementation. The analysis was based on the conducted literature review and stakeholder consultations with representatives from PhilHealth offices involved in fraud control. Recommendations for the strengthening and improvement of these mechanisms based on policy and implementation experience of other countries are also presented, as well as the corresponding impacts and gaps that PhilHealth will have to address to adopt these recommendations.

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
<i>Prevention mechanisms</i>			
Performance Commitment A notarized document signed by the provider, which reflects their commitment to comply with PhilHealth policies (<i>PhilHealth Circular No. 2023-0012 & 2023-0024</i>)	<i>Legal:</i> Required submission of the Performance Commitment is embedded in the NHIA and is a requirement for accreditation <i>Institutional:</i> Providers take full responsibility for inaccuracies or falsities on submitted claims; facility accreditation may be revoked due to fraud	Expand the scope of fraud to cover all potential fraudulent activities across the continuum of care, which will be reflected in the Performance Commitment signed by providers	<i>Legal:</i> Requires operational policy research on expanding the scope and definition of fraud, especially as the system transitions to a DRG-GB payment system
Preauthorization An approval process that enables providers to provide Z Benefits Package to patients who have passed the eligibility and minimum clinical selections criteria (<i>PhilHealth Circular Nos. 029, s. 2012; 048, s. 2012; 2021-</i>	<i>Policy:</i> Established process for preauthorization (i.e., checklists, request forms, etc.) for Z benefits submitted to PRO BAS <i>Institutional:</i> Main criteria for approval only depends on completeness of documentation,	Improving checks for medical validity in the current approval process Expansion of the scope of preauthorization to cover high cost procedures, such as planned surgeries (e.g., transplants) or expensive equipment (e.g., IV infusion pump)	<i>Legal:</i> Requires revisions to the approval process; Requires operational research on what other procedures can be covered and to determine relevant criteria

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
0022)	<p>including a certification from the physician, and does not include a detailed medical evaluation</p> <p><i>Capacity:</i> Limitations on the amount of staff in the PRO for the approval process</p>	<p>(Chhabra, Gupta, et al. 2018)</p> <p>Exemption from preauthorization for emergency cases or procedures below an amount threshold (Chhabra, Gupta, et al. 2018)</p>	<p><i>Institutional & capacity:</i> Requires additional human resources to process preauthorization requests, which can be augmented by digitizing and/or automating the process</p>
<p>Referral mechanism</p> <p>Reimbursement of full case rate package shall be paid to the receiving hospital, while the referring hospital can file for a fixed amount of PHP 4,000, limited to specific conditions only. The package restricts transfers from higher- to lower-level facilities. (<i>PhilHealth Circular No. 035, s. 2013</i>)</p>	<p><i>Legal:</i> A dedicated referral benefit package has been developed</p> <p><i>Institutional:</i> Referral package claims are automatically tagged for MPA, but potential fraudulent cases can only be detected upon claims processing</p>	<p>Implementation of a <i>transfer fee</i> where the sending hospital must pay a fee to the receiving hospital</p> <p>Most useful for transfers from a higher level facility to a lower level facility, or from a private institution to a public institution. The transfer fee aims to discourage hospitals that can afford to treat the patient and offsets potential costs to recipient hospitals for treating complicated cases (Schumacher 2022).</p>	<p><i>Legal:</i> Requires revisions to PhilHealth’s payment policy on transfers</p> <p><i>Institutional & capacity:</i> Requires the development of a monitoring and evaluation framework for the effectiveness of the transfer policy and to routinely gather and analyze necessary data</p>
<p>Readmission Policies</p> <p><i>Single Period of Confinement Rule:</i> The SPC rule denies PhilHealth claims for readmissions for the same condition within a 90-day period. (<i>PhilHealth Circular No. 035, s. 2013</i>) This was discontinued in October 2024. (<i>PhilHealth Circular No. 2024-</i></p>	<p><i>Legal:</i> The SPC policy had no explicit definitions for planned and unplanned (or avoidable) readmission and also failed to account for vulnerable groups and other risk factors which only resulted in increased out-of-pocket payments from patients</p> <p><i>Institutional:</i> The eClaims system</p>	<p>Creation of robust readmission policies that promote quality of care and cost containment while considering risk factors such chronic illnesses and age groups (Kristensen et al. 2015)</p> <p>Defining a global period where procedures (usually surgeries and post-operative related visits) fall under a</p>	<p><i>Legal:</i> Requires the development of guidelines for what services should be bundled together or be considered one episode of care based on clinical practice guidelines; Requires development of a readmission policy tied to</p>

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
<p>0021)</p> <p><i>45-day Benefit Limit:</i> PhilHealth members are entitled to a maximum of 45 days of confinement per calendar year. Another 45 days for room and board allowance shall be shared by all the dependents of the member per calendar year. (PhilHealth Circular No. 21 s. 2006)</p>	<p>carries out validation rules on reimbursement for patient eligibility on the SPC and the 45-day benefit limit, but potential fraudulent cases can only be detected upon claims processing</p>	<p>single billing period where providers may not bill patients/PhilHealth for succeeding visits (CMS 2024a)</p> <p>Implementation of P4P policies that account for a hospital's case-mix and quality of care, which would sanction facilities that provide substandard care by reduced reimbursements for avoidable readmissions without unfairly penalizing hospitals that cater to vulnerable groups (MPAC 2007)</p> <p>Creation of a monitoring framework and database that will identify readmission trends across facilities and providers to help define planned and unplanned readmissions (AHRQ 2024; CMS 2024c; NHS England 2024)</p>	<p>financial incentives or penalties to effectively prevent providers from defrauding the system</p> <p><i>Institutional:</i> Requires the development of a monitoring and evaluation framework for the effectiveness of the readmission policy and to routinely gather and analyze necessary data</p>
<i>Detection mechanisms</i>			
<p>ACR Search</p> <p>Prior to discharge, patients can verify the correctness of case rates deducted from their statement of account using "ACR Search" mobile application or PhilHealth portal</p>	<p><i>Institutional:</i> Lack of patient awareness on the existence of the application</p>	<p>Ramping up of information campaigns online or through the P-CARES in hospitals</p>	<p><i>Capacity:</i> Requires ramping up of awareness campaigns for patients</p>

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
<p>eClaims System The eClaims System allows providers to submit and monitor most reimbursement claims electronically and allows PhilHealth to employ several automation mechanisms in the system to improve efficiency of claims processing. (PhilHealth Circular No. 2016-0016)</p>	<p><i>Legal:</i> All health facilities are required to submit their claims through the eClaims system</p> <p><i>Institutional:</i> Assessment of the eClaims system revealed several system design weaknesses that have enabled users to bypass controls, resulting in the approval and payment of claims that are otherwise ineligible, fraudulent, and/or with incomplete documentary requirements. While claims submission and some parts of processing are automated, actual adjudication and review of claims are still manually conducted, thus evaluation and decisions may be subjective.</p> <p><i>Capacity:</i> The development and improvement of the eClaims system is hindered by limitations in the capacity and resources of PhilHealth offices responsible for IT</p>	<p>Expansion and updating of current flags and thresholds aside from conditions based on historic trends, such as common case rates with high number of fraudulent claims, offending facilities and professionals, etc. (Chhabra, Menon, et al. 2018)</p> <p>Lessening the manual aspects of the claims review process by creating automatic flags for claims review, such as facilities, providers, procedures, and conditions with historically high associated rates of fraudulent activities or violations committed (Chhabra, Menon, et al. 2018)</p> <p>Shadow billing of PhilHealth for DRG-GB makes use of CF5 with front-facing validations that check for facility accreditation, PhilHealth membership, and DRG grouper (PhilHealth 2023c), which can be adopted in the claims processing system</p>	<p><i>Institutional:</i> Requires the development of a standardized protocol for claims review</p> <p><i>Capacity:</i> Requires strengthening of PhilHealth’s IT system to digitize and/or automatize claims processing, such as implementing automatic checks for additional flags</p>
<p>Medical Prepayment Review The process of reviewing and evaluating clinical data before claims payment to determine compliance to policies and widely</p>	<p><i>Legal:</i> A dedicated PhilHealth Circular has been released to guide providers on documentary requirements for MPR</p>	<p>Development of a standardized protocol for MPR that Medical Evaluators can refer to</p> <p>Development of a library of major</p>	<p><i>Institutional:</i> Requires the development of a standardized protocol for claims review, as well as a monitoring and evaluation</p>

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
<p>accepted medical practice; claims found to be not compliant are no longer processed. This is applied to four priority conditions: conditions with high volume of claims (community-acquired pneumonia, UTI, acute gastroenteritis, and sepsis) and conditions recommended by PROs due to prevailing quality issues based on monitoring findings. (PhilHealth Circular No. 2019-0002)</p>	<p><i>Institutional:</i> Evaluation is guided by the Guide for Evaluators MPR of the Four Prioritized Conditions (2019), however, parameters for medical evaluation have been reported to be insufficient, leaving decision on MPR subjective based on the evaluator</p> <p><i>Capacity:</i> Limitations in terms of Medical Evaluators responsible for the conduct of the MPR have resulted in a low accomplishment rate and the approval and payment of claims that were not subject to MPR; There are limitations in terms of technical staff who can develop MPR tools to expand the scope of conditions for MPR</p>	<p>violations, categorized into sections of the PROAC to minimize manual encoding of violations, which will allow for more standardized data on fraud</p> <p>Lessening the manual aspects of the claims review process by creating automatic flags for claims review</p> <p>Automation of aspects of the validation process that utilize quantitative criteria upon submission of claims, freeing medical staff to conduct audits for qualitative or complex criteria (Chhabra, Menon, et al. 2018)</p>	<p>framework to routinely gather and analyze necessary data</p> <p><i>Capacity:</i> Requires strengthening of PhilHealth’s IT system to digitize and/or automate claims processing, such as implementing automatic checks for MPR</p>
<p>Medical post-audit Review of patient's clinical data to determine compliance to standards of care and PhilHealth policies, conducted after payment of claims. A sample of claims are automatically selected based on a list of conditions determined by PhilHealth, or as manually selected by the PRO.</p> <p>A payment recovery policy has</p>	<p><i>Institutional:</i> . PhilHealth has internal guidelines for MPA, though there are limitations in terms of extracting data from the tagged claims as filing is done manually. While the eClaims system automatically tags claims for MPA following specific conditions identified by PhilHealth, assessments have revealed that there is no way to confirm that this automatic flag captures all claims that need to be</p>	<p>Involvement of PhilHealth SMD in monitoring compliance with standards of care and in flagging non-compliant claims</p> <p>Trends such as upcoding can be determined using linear models when adjustments to the payment rates or relative weights are made (Anthun 2022)</p>	

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
<p>been established to facilitate the return of overpaid claims from verified cases of fraud. (<i>Philhealth Circular No. 2021-0011</i>)</p>	<p>tagged. PhilHealth is currently updating its selection criteria for automatic tagging.</p> <p><i>Capacity:</i> Limitations in terms of human resource have been raised, such that not all claims tagged for post-audit are reviewed on time</p>		
<p>Health Care Provider Performance Assessment System A performance monitoring system aimed to ensure quality assurance by evaluating compliance to the Performance Commitment, including patient exit interviews and domiciliary visits aimed to measure patient awareness and satisfaction. The HCP PAS also includes a mechanism to inform facilities of poor performance, adverse monitoring findings, or administrative offense for corrective measures and to encourage facilities to improve their performance. (<i>PhilHealth Circular No. 2018-0019</i>)</p>	<p><i>Legal:</i> A dedicated PhilHealth Circular details the different monitoring tools and expected frequency of conduct</p> <p><i>Institutional:</i> An annual report consolidating findings collected from HCPPAS tools is submitted to PhilHealth’s Management and deliberated by the HRMC. However, there is currently no framework to systematically analyze trends and evaluate problem areas to trigger specific actions and inform improved standards of care and future fraud control mechanisms.</p>	<p>Patient reporting hotlines where beneficiaries can report suspected fraud and trigger an investigation of the provider in question(Chhabra, Gupta, et al. 2018)</p> <p>Benchmarking providers according to their performance (i.e., ranking by fraudulent activities) will inform providers of their position relative to others in their peer groups (e.g., among public hospitals, within geographical area, etc.). Providers are encouraged to change their outlier behavior on their own initiative. Benchmarking allows for the creation of cutoffs or standards and can measure provider improvement (CMS 2024b; Tikkanen et al. 2020).</p>	<p><i>Capacity:</i> Requires the strengthening of the IT system, including the centralization of fraud findings data, automated or standardized transmittal of fraud reporting from PROs to the PhilHealth head office, and clear uniform definitions for types of fraud</p>
<p>Other feedback mechanisms</p>	<p><i>Institutional:</i> Lack of patient</p>	<p>Ramping up of information campaigns</p>	<p><i>Capacity:</i> Requires ramping</p>

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
<p><i>Whistleblower protection policy:</i> Any concerned individual can anonymously report and provide information or testify as needed through dedicated online, e-mail, mail, or telephone channels. Under the policy, anyone who acts against protected whistleblowers will receive appropriate sanctions (PhilHealth 2023d).</p>	<p>awareness on established feedback mechanisms</p>	<p>online or through the P-CARES in hospitals</p>	<p>up of awareness campaigns for patients</p>
<p><i>Deterrence mechanisms</i></p>			
<p>Administrative penalties Several administrative penalties are put in place, depending on the results of the case, including the <i>temporary withdrawal of accreditation or denial or non-reinstatement of accreditation (NHIA IRR; PROAC)</i></p>	<p><i>Legal:</i> There are no established penalties for each case, rather the decision on the severity of penalty is based on the litigation or evaluation of each case</p> <p><i>Institutional:</i> Processing of appeals is conducted manually, thus variations in how appeals and cases are handled can vary across regions</p>	<p>Developing a standardized protocol for the litigation of fraud cases and the resulting penalties and lessening the manual aspects of the process</p> <p>Public reporting of offenders/violators found guilty of fraud: The list of offenders may be based on the global list of fraudulent providers like in the US, (US HHS n.d.-b) or may be based on pre-specified fraudulent activities like in South Korea (Chhabra, Menon, et al. 2018).</p>	<p><i>Legal:</i> Requires the development of a standardized protocol and an equitable and just penalty system that can adequately deter patients from defrauding the system</p> <p><i>Institutional:</i> Requires a large institutional shift from PhilHealth to be willing to publicly acknowledge offenders</p>
<p>Financial penalties <i>Temporary suspension of payment of claims:</i> Conditional stoppage of</p>	<p><i>Legal:</i> A dedicated PhilHealth Circular has been issued to establish rules for TSPC; Fines for offenses are stipulated</p>	<p>Developing a standardized protocol for the litigation of fraud cases and the resulting penalties and lessening the</p>	<p><i>Legal:</i> Requires the development of a standardized protocol and</p>

PhilHealth fraud control mechanisms	Analysis	Recommendation	Impacts and gaps
<p>payment for claims undergoing investigation (<i>PhilHealth Circular No. 2021-0013</i>)</p> <p><i>Fines:</i> Fraudulent acts, unethical acts, and abuse of authority committed by health care providers shall be penalized, after due notice and hearing (<i>NHIA IRR; PROAC</i>)</p>	<p>in the NHIA, the decision on the severity of penalty is based on the litigation or evaluation of each case</p> <p><i>Institutional:</i> Processing of appeals is conducted manually, thus variations in how appeals and cases are handled can vary across regions</p>	<p>manual aspects of the process</p> <p>Quality-based adjustments to the GB: Hospital performance is scored compared to benchmarks and thresholds, as well as other facilities. Depending on performance, GB payments are adjusted downward or may be rewarded for efficiency and quality use of resources (CMS 2024b)</p>	<p>an equitable and just penalty system that can adequately deter patients from defrauding the system</p> <p><i>Capacity:</i> Requires strong health information systems and the technical knowledge to consistently monitor provider activities</p>
<p>Criminal or civil sanctions</p> <p>A criminal complaint can be filed against officers, employees, or other representatives of the health facility found to be responsible, who acted negligently or with intent, or have directly or indirectly caused the violation (<i>NHIA IRR; PROAC</i>)</p>	<p><i>Legal:</i> Criminal and civil sanctions are stipulated in the NHIA, the decision on the severity of penalty is based on the litigation or evaluation of each case</p> <p><i>Institutional:</i> Processing of appeals is conducted manually, thus variations in how appeals and cases are handled can vary across regions</p>	<p>Developing a standardized protocol for the litigation of fraud cases and the resulting penalties and lessening the manual aspects of the process</p>	<p><i>Legal:</i> Requires the development of a standardized protocol and an equitable and just penalty system that can adequately deter patients from defrauding the system</p>

PhilHealth = Philippine Health Insurance Corporation; NHIA = National Health Insurance Act; DRG-GB = diagnosis-related groups and global budget; PRO = PhilHealth Regional Office; BAS = Benefit Administration Section; IV = intravenous; MPA = Medical Post Audit; SPC = Single Period of Confinement; P-CARES = PhilHealth Customer Assistance Relations and Empowerment Staff; IT = information technology; CF5 = Claim Form 5; MPR = Medical Prepayment Review; UTI = urinary tract infection; PROAC = PhilHealth Rules on Administrative Cases; SMD = Standards Monitoring Department; HCP PAS = Health Care Provider Performance Assessment System; IRR = Implementing Rules and Regulations; TSPC = temporary suspension of payment of claims

Sources: Authors' synthesis and analysis of cited PhilHealth Circulars and literature

Appendix 3. Summary of findings and recommendations

Area of Assessment	Findings	Next Steps
Prevention	<p><i>Narrow definition of fraud</i></p> <ul style="list-style-type: none"> PhilHealth’s understanding of fraud is limited to the provision of false information on claims Some types of fraud in global literature have PhilHealth equivalent; however, not all are classified as fraudulent activities There is little consideration for fraudulent activities that occur outside claims processing 	<p>PhilHealth must conduct strategic planning to broaden the definition of fraud, and strengthen fraud prevention and deterrence mechanisms</p>
Detection	<p><i>Siloed and incoherent fraud control processes</i></p> <ul style="list-style-type: none"> Different offices carry out PhilHealth’s fraud control strategies and there is neither oversight nor harmonization among them which also results in low information sharing across these offices Preauthorization is limited only to select cases and it merely serves a checklist for patient eligibility Admissions and referrals are only analyzed on a claim-by-claim basis and are not used to inform trends Fraud detection mechanisms rely heavily on manual verification <p><i>Underestimation of the incidence of fraud in Philhealth</i></p> <ul style="list-style-type: none"> Use of MIDAS without systematic implementation across regions Use of AI and unassisted technology for detection without an operational understanding of fraud 	<p>PhilHealth should increase its investments in human and IT resources</p> <ul style="list-style-type: none"> Hire and train staff who will work on the fraud control strategies especially at the PROs Educate stakeholders to prevent the occurrence of fraud at the onset Digitize and automate processes for fraud detection <ul style="list-style-type: none"> Create a protocol to standardize the checks during MPA and MPR Create automated flags based on historical data Create a template for fraud reporting
Deterrence	<p><i>Deterrence mechanisms focus on hard penalties without incentives to modify provider behavior</i></p>	<p>PhilHealth should implement P4P mechanisms to incentive provider behavior</p> <ul style="list-style-type: none"> Use HCP PAS as a measure of provider performance in terms of quality of care, patient satisfaction, financial risk protection, etc. Conduct provider benchmarking as a means to evaluate provider

performance against other providers

Publication of offending providers

- Deter fraudulent activities by publicizing the list of offending providers

PhilHealth = Philippine Health Insurance Corporation; MIDAS = Machine Learning Identification, Detection, and Analysis System; AI = artificial intelligence; PRO = PhilHealth Regional Office; MPA = Medical Post Audit; MPR = Medical Prepayment Review; HCP PAS = Health Care Provider Performance Assessment System

Source: Authors' analysis