THE MANAGEMENT OF PROVIDER PAYMENTS

IN THE UNIVERSAL COVERAGE SCHEME (UCS) IN THAILAND

NHSO
National Health Security Office

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GLOSSARY

FEE SCHEDULE

Payments are made based on the established criteria and conditions. If a service facility requests reimbursement in the amount that is less than specified in the fee schedule, then they will receive only the amount claimed. However, if the claim is more than the fee schedule, then they will receive payment only up to the ceiling allowed.

E-CLAIM PROGRAM

This is a computer program which the NHSO developed to help service facilities submit data for claims that are consistent with the fee schedule and conditions of the NHSO.

NATIONAL HEALTH SECURITY BOARD (NHSB)

This Board was set up as stipulated in the National Health Security Act (2002) and comprises representatives from government agencies, professional associations, local administrative organizations, private hospitals, NGOs, and academics. The Minister of Health chairs the Board. The Board has the responsibility to establish standards for health services, and the service network, and implement other measures to promote efficiency of the health insurance system, define the scope and standards for health services, define criteria for implementation, and manage the National Health Fund.

THE QUALITY AND STANDARD CONTROL BOARD

This Board was also stipulated as part of the National Health Security Act (2002) and comprises representatives from government agencies, professional associations, local administrative organizations, private hospitals, NGOs, and academics. The Board is responsible for quality control and standards of services and service facility, reviewing complaints of patients, and making preliminary compensation payments as per Article 41.

NATIONAL HEALTH SECURITY OFFICE (NHSO)

This is a public agency under the supervision of the Minister of Public Health and has responsibility for business functions of the National Health Security Board, The Quality and Standard Control Board, and the various sub-committees. The NHSO oversees development of the universal coverage scheme system, registration of beneficiaries and service providers and management of the Fund in accordance to the NHSB policies.

NHSO REGIONAL OFFICES

These are branch offices of the NHSO and have the responsibility to implement as delegated by the NHSO. Currently there are 13 of these regional offices in all geographic regions of the country.

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1

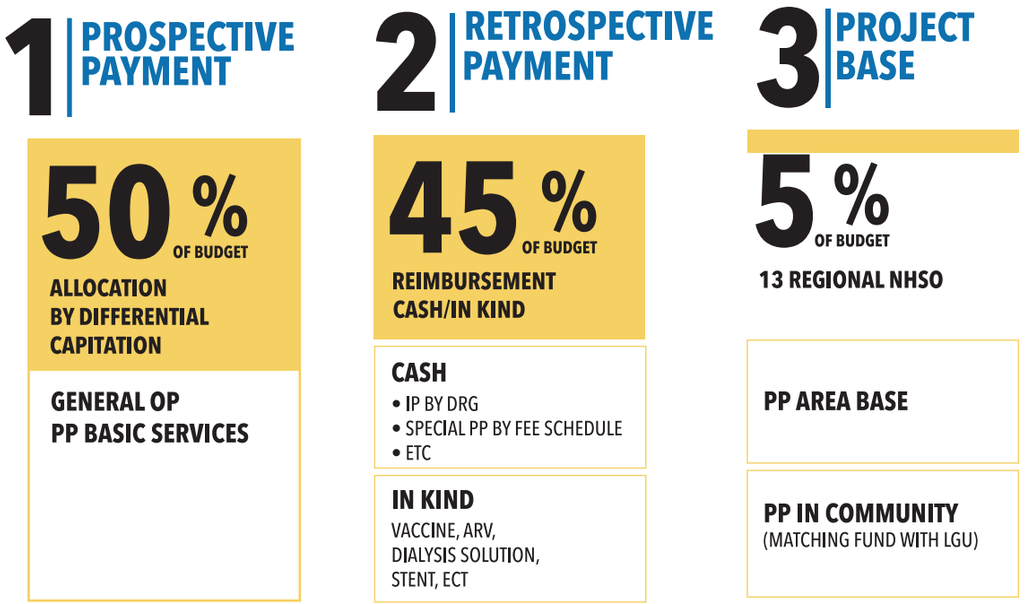
INTRODUCTION

The Thailand's Universal Coverage Scheme (UCS) covers approximately 48 million people and has over 10,000 health facilities registered to provide health services for the beneficiaries. The process of provider payments is an essential step in the national health insurance system. It is critical for facilitating and ensuring service provision to the people. The National Health Security Office (NHSO) acts as a representative of its beneficiaries in purchasing services from health providers using government budget. This book explains the current provider payment management employed by NHSO with reference to the Universal Coverage Scheme's Fund Management Guidelines for Fiscal Year 2019.

The NHSO mainly administers health services payments in three ways: prospective payment; retrospective payment, and project-based payment (Figure 1).

METHODS OF HEALTH SERVICES PAYMENTS OF THE NHSO

Figure 1



Remarks

OP = OUTPATIENT SERVICES
IP = INPATIENT SERVICES
PP = HEALTH PROMOTION AND HEALTH PREVENTION SERVICES
DRGS = DIAGNOSIS RELATED GROUPS
ARV = ANTI-RETROVIRAL DRUG
NHSO = NATIONAL HEALTH SECURITY OFFICE
LGO = LOCAL GOVERNMENT ORGANIZATION

The prospective payment refers to capitation payments to health facilities based on the number of beneficiaries registered with that facility. Capitation rates are age-adjusted to recognize different service utilization patterns of different age groups. For example, the elderly group uses out-patient services more often than the working-age groups. Thus, the amount of payment is weighted by the proportion of elderly in the registered population. NHSO spends around half of the total universal coverage scheme (UCS) budget by prospective payment for general out-patient care, health promotion and disease prevention services.

The retrospective payment is reimbursements of the services that health facilities have provided to the UCS beneficiaries. The payment can be made in cash or in-kind, in the form of medicines or medical supplies. For example, NHSO pays in cash for general in-patient care by DRGs and provides ARV when health facilities are reimbursed as a part of HIV service.

The project-based payment refers to block-grant or installment payments to health facilities, local governments, or civil society organizations (CSOs) for some health programs aimed to address area-specific health challenges. These funds are managed by 13 NHSO regional offices which include area-based health promotion and disease prevention service (PP area based), community-based health promotion and disease prevention service (PP in community) for which local governments are required to contribute based on specified contribution rates.

In summary, capitation payments, accounting for around 50% of all UCS budgets, are a main mechanism to ensure that all expenditures are within a finite UCS budget. However, capitation payment may cause under-provision of necessary services as health facilities are paid in advance based on population size irrespective of the services provided. The NHSO has tried to overcome this shortfall by introducing some other payments such as fee schedule and pay-for-performance based on outcomes and quality of additional services. This is to ensure that all UCS members can access the service they need. Table 1 summaries key payment methods.

SERVICES	PAYMENT	INCENTIVES
OP	**DIFFERENTIAL CAPITATION**	• FEE SCHEDULE (ADD-ON HIGH COST AND INSTRUMENT) • POINT SYSTEM UNDER GLOBAL BUDGET (ACUTE DISEASE OR EMERGENCY)
PP	**DIFFERENTIAL CAPITATION**	PAY FOR PERFORMANCE (QUALITY AND OUTCOME FRAMEWORK; QOF)
IP	**DIAGNOSIS RELATED GROUPS (DRGS) SYSTEM WITH GLOBAL BUDGET USING RELATIVE WEIGHT POINT**	• FEE SCHEDULE (ADD ON INSTRUMENT AND HEMODIALYSIS) • DISEASE MANAGEMENT INFORMATION SYSTEM (DMIS)

Table 1

KEY PAYMENT METHODS CATEGORIZED BY TYPES OF SERVICES

2

THE MANAGEMENT OF PROVIDER PAYMENTS IN NHSO

The fund allocation and provider payment management is the responsibility of the Bureau of Fund Allocation and Reimbursement under Cluster of Fund Management (Cluster 2). It is the mission of this Bureau to ensure that funds are allocated and reimbursements are paid to health facilities accurately and on time. Health providers can also check the status of fund allocation and reimbursement process in the NHSO website.

The fund allocation and provider payment management are guided by the National Health Security Board (NHSB) which is composed of multisectoral representatives such as ex officio members from related ministries; experts from relevant fields; professional councils and healthcare providers; CSO, and local governments. The Board makes decisions on benefits package's details and payment conditions and issues related regulations. These regulations will then be translated into annual NHSO fund management guidelines which aim to provide information about provider payment conditions in each year and ensure clear understanding across all contracted health providers.

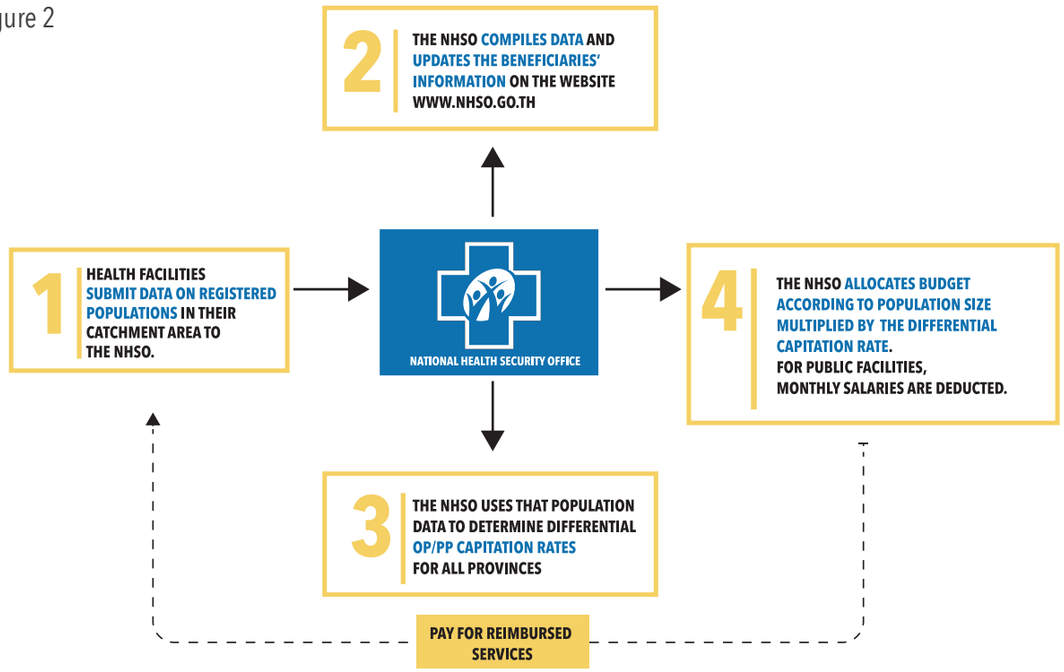
2.1

PROSPECTIVE PAYMENTS

Prospective payments are allocated using differential capitation rates by age group. That process begins when health facilities submit data on registered populations in their catchment area to the NHSO. The NHSO will then compile data and update the beneficiaries' information on the NHSO website (www.nhso.go.th) and ask health facilities to recheck. Once the information is confirmed, NHSO will determine the capitation rate for each province based on 80% age-adjusted rate and 20% flat rate. The total capitation payment for each facility is calculated based on the number of registered population multiplied by the provincial capitation rate. Capitation payments are paid to health facilities in advance. These steps are described in Figure 2.

KEY STEPS IN PROSPECTIVE PAYMENTS

Figure 2



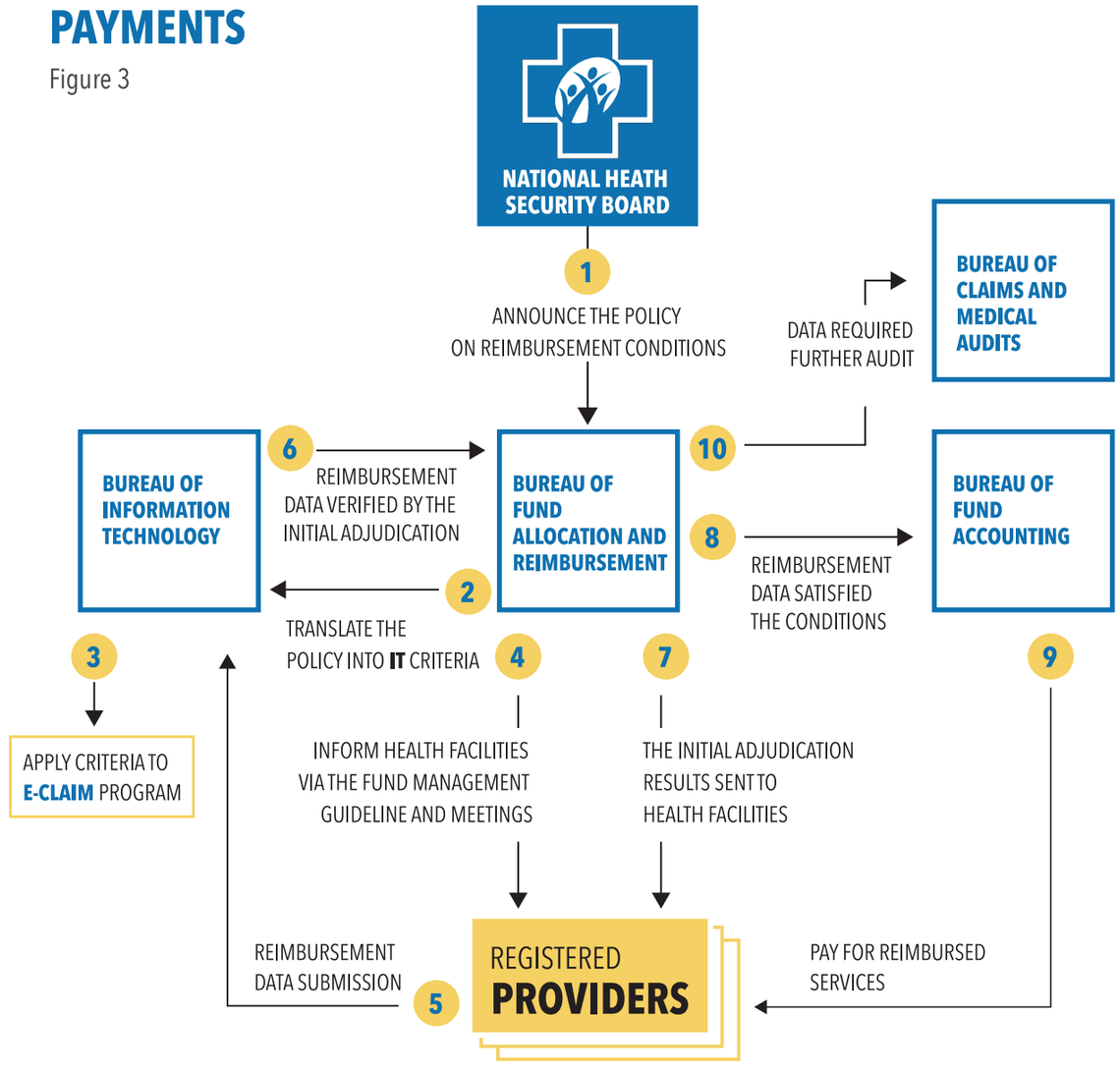
2.2

RETROSPECTIVE PAYMENTS

For retrospective payments, NHSO introduced 'e-Claim' which is an electronic reimbursement program that all health facilities need to use for submitting their claim data. NHSO translates the reimbursement conditions that the NHSB has announced into the information technology language used in the e-Claim program. Health facilities submit claim data by transferring the information about eligible services that they provided to UCS members from their health information system to e-Claim. NHSO will then issue acknowledgement reports and financial statement reports and send those back to health facilities to recheck and confirm. Once confirmed, the claim data will be sent to the Bureau of Fund Accounting to process payments. Some specific information will be audited by Bureau of Claims and Medical Audits. Figure 3 describes the process.

KEY STEPS IN RETROSPECTIVE PAYMENTS

Figure 3



2.3

PROJECT BASED PAYMENT

Project-based payments are participatory contributions among various sectors for health promotion and disease prevention services. The NHSO informs budget size for each area and delegates decision making authority to related local committees to decide on fund allocation in accordance with NHSO regulations. The related local committees are regional health security sub-committees in the case of area-based PP; and sub-district health security fund committees for PP in community.

payment

3

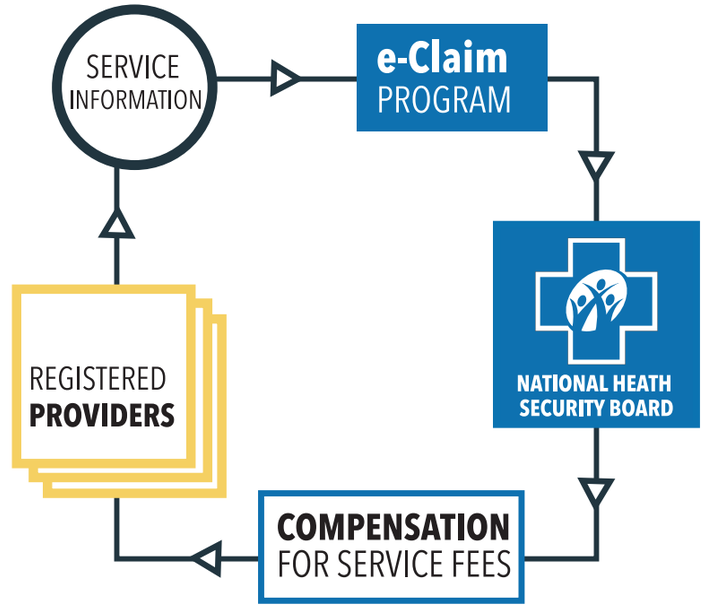
KEY PRINCIPLE OF REIMBURSEMENT SYSTEM

A reimbursement system cannot be efficient and fair without careful system design and participation from various parties within and outside NHSO. The participatory system design includes all steps from payment methods, fund allocation and paying process, audit system, and supporting functions to ensure "accurate, complete, timely" payments to health facilities.

In the reimbursement process, health facilities need to have a functioning health information system and skilled personnel who understand the e-Claim program to handle e-claim submissions. The NHSO also needs to establish a user-friendly and accurate analytical program and reliable money transfer system. The core structure of reimbursement system is described in Figure 4.

CORE STRUCTURE OF THE REIMBURSEMENT SYSTEM

Figure 4



3.1

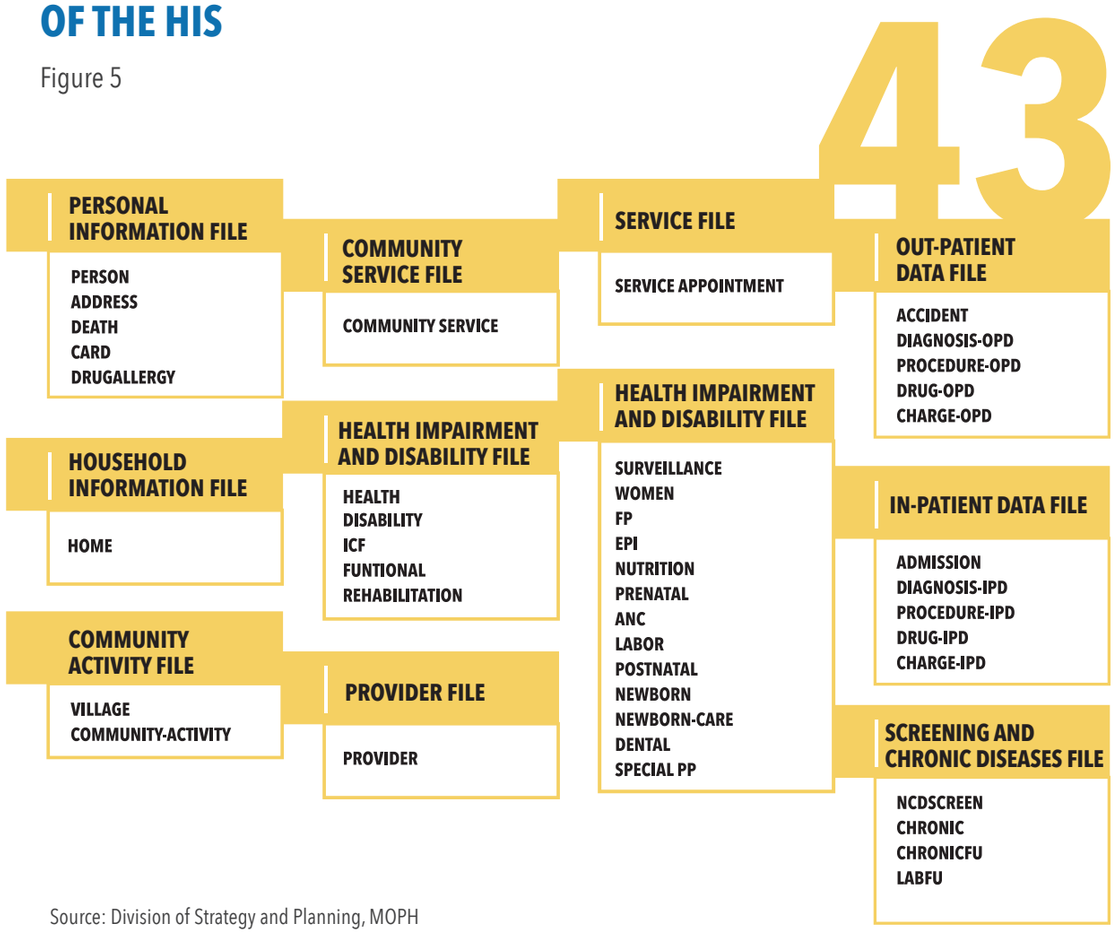
HEALTH INFORMATION SYSTEM FOR HEALTH FACILITIES

Over many decades, Thailand has continuously developed its health information system (HIS) to facilitate data analysis in order to manage and respond to health challenges of the population. The MOPH has established a Health Data Center (HDC) to gather health information submitted by health facilities across the country. All health facilities submit a standard data set called 'the 43 files' which is individual health data of the people who utilize services at each health facility such as gender, age, residential

address, occupation, heath status, all medical and health service records covering health promotion and disease prevention services, out-patient and in-patient curative care. The structure of the 43 files is described in Figure 5.

THE 43 DATA FOLDERS OF THE HIS

Figure 5



Source: Division of Strategy and Planning, MOPH

The UCS uses the data from these 43 files for estimation of annual budgets, and also uses some of the data for service reimbursement. The data from these 43 files is not adequate for or does not satisfy accurate service reimbursement. Thus, the NHSO has developed another specific program to support data submission for reimbursement purposes. The NHSO has guidelines for data preparation for reimbursement as follows.

1. **Use the WHO medical classification codes** 'International Statistical Classification of Diseases and Related Health Problems 10th Revision Version for 2010 (ICD-10') and ICD-10TM (only codes included in Thai DRGs and Relative Weight Version 5).

2. **Use procedural codes** from the International Classification of Diseases 9th Revision Clinical Modification 2010 Classification of Procedures (ICD-9CM version 2010).

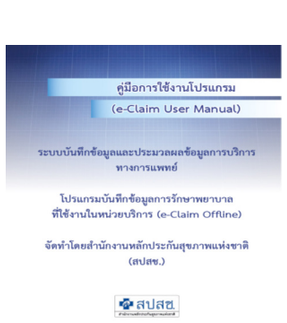
3. **Health facilities need to regularly update their drug catalogues and submit that to NHSO** so that it can be supportive. Service facilities must fill out a drug catalog and keep it up-to-date at all times. The information from the catalog is then sent to the NHSO as a basis for calculating reimbursements.

4. **Use Thai DRGs (version 5)** to calculate the relative weight (RW) for in-patient services.

3.2

PERSONNEL HANDLING HEALTH INFORMATION SUBMISSION

The process of data submission from health facilities' health information system to NHSO's health information database is a critical process to ensure accurate reimbursement. Hence, the NHSO holds training for the personal from health facilities who are responsible for data submission to ensure that they understand the structure and required components of health information and can appropriately handle data submission. In addition, the NHSO has provided necessary guidelines such as the Universal Coverage Scheme's fund management guidelines, guidelines for health service reimbursement, and the e-claim user's manual to support the data senders at health facilities. There are also multiple channels for communication between the data senders and the receivers, including a Call Center phone number and a web board.



GUIDELINES FOR HEALTH SERVICE REIMBURSEMENT AND E-CLAIM USER'S MANUAL

Figure 6

3.3

ELECTRONIC PROGRAMS FOR HEALTH SERVICE REIMBURSEMENT

The UCS's provider payment system was developed at the time of the UCS implementation as it is the key mandate of NHSO. The UCS's payment mechanisms include capitation, healthcare reimbursement, and pay-for-performance which require service provision data to support budget estimation and accurate payments to health facilities. During the early phase, the NHSO collaborated with the Central Office for Health Care Information to help gather service provision data from health facilities, especially for in-patient services. Subsequently, the reimbursement conditions became more complex and detailed. Therefore, the NHSO started to develop its e-Claim program to facilitate prompt data transmission, data processing, and convenient adjustment of reimbursement conditions to ensure that health facilities receive the payments in a timely manner.

e-Claim

PROGRAM	TYPES OF HEALTH SERVICES
e-CLAIM	• IN-PATIENT SERVICE (IP) • OUT-PATIENT REFER CASES (OP REFER) • HIGH-COST OUT-PATIENT SERVICES (OP HIGH COST) • ACCIDENT & EMERGENCY OUT-PATIENT SERVICES (OPAE) • SPECIFIC SERVICES (CENTRAL REIMBURSEMENT; CR)
DMIS AND OTHER SPECIFIC DISEASES	• HEMOPHILIA • CLEFT LIP & CLEFT PALATE • RENAL REPLACEMENT THERAPY (HD, CAPD, KT) • CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) • TB, HIV/AIDS • DOWN SYNDROME • THALASSEMIA
UCEP	• CASES OF PATIENTS WITH EMERGENCY CRISIS • CASES OF ACCIDENTS AND EMERGENCIES AS SPECIFIED IN ARTICLE 7 OF THE NATIONAL HEALTH SECURITY ACT

Source: Guidelines for health service reimbursement, Fiscal Year 2019

Table 2

ELECTRONIC PROGRAMS USED FOR HEALTH SERVICE REIMBURSEMENT

The e-Claim program was first developed in 2009 as computer software to record health services that health facilities provided and submit the data for reimbursement. This program can support both online data entry and offline data transmission from the facility's HIS. Most health facilities prefer to send data offline because e-Claim can directly obtain patient information from their HIS without having to key in this information again. In addition, the NHSO also communicates any information update about reim-bursement through the website http://eclaim.nhso.go.th and provides a web board for staff at health facilities and NHSO staff to communicate or ask questions about the e-Claim program. The data from the e-Claim program is also analyzed to help the NHSO improve the performance of the UCS. In addition to the e-Claim program, the NHSO has also developed a Disease Management Information System (DMIS) program and Universal Coverage for Emergency Patients (UCEP) program (Table 2).

3.3.1
DATA SUBMISSION PROCESS

All reimbursement data are submitted through electronic reimbursement programs according to the types of services as described above. Paper-based submission is only used when the electronic program is under development, for example, reimbursement of maxillary distractor services for patients with cleft palate for which health facilities need to submit paper-based reports.

3.3.2
TIMELINE FOR DATA SUBMISSION

Health facilities need to submit their reimbursement data to the NHSO within 30 days after the date that service was provided for out-patient care, and after the date of patient discharge for in-patient care. For fiscal year 2019, all claims must be received by the NHSO by September 30, 2020. Any data submitted after this date will not be processed for reimbursement.

The NHSO has the following procedures for late submission:

1 If the claim is submitted no more than **30 DAYS LATE,** then **95%** of the reimbursed costs will be paid

2 If the claim is submitted no more than **60 DAYS LATE,** then **90%** of the reimbursed costs will be paid

3 If the claim is submitted no more than **330 DAYS LATE,** then **80%** of the reimbursed costs will be paid

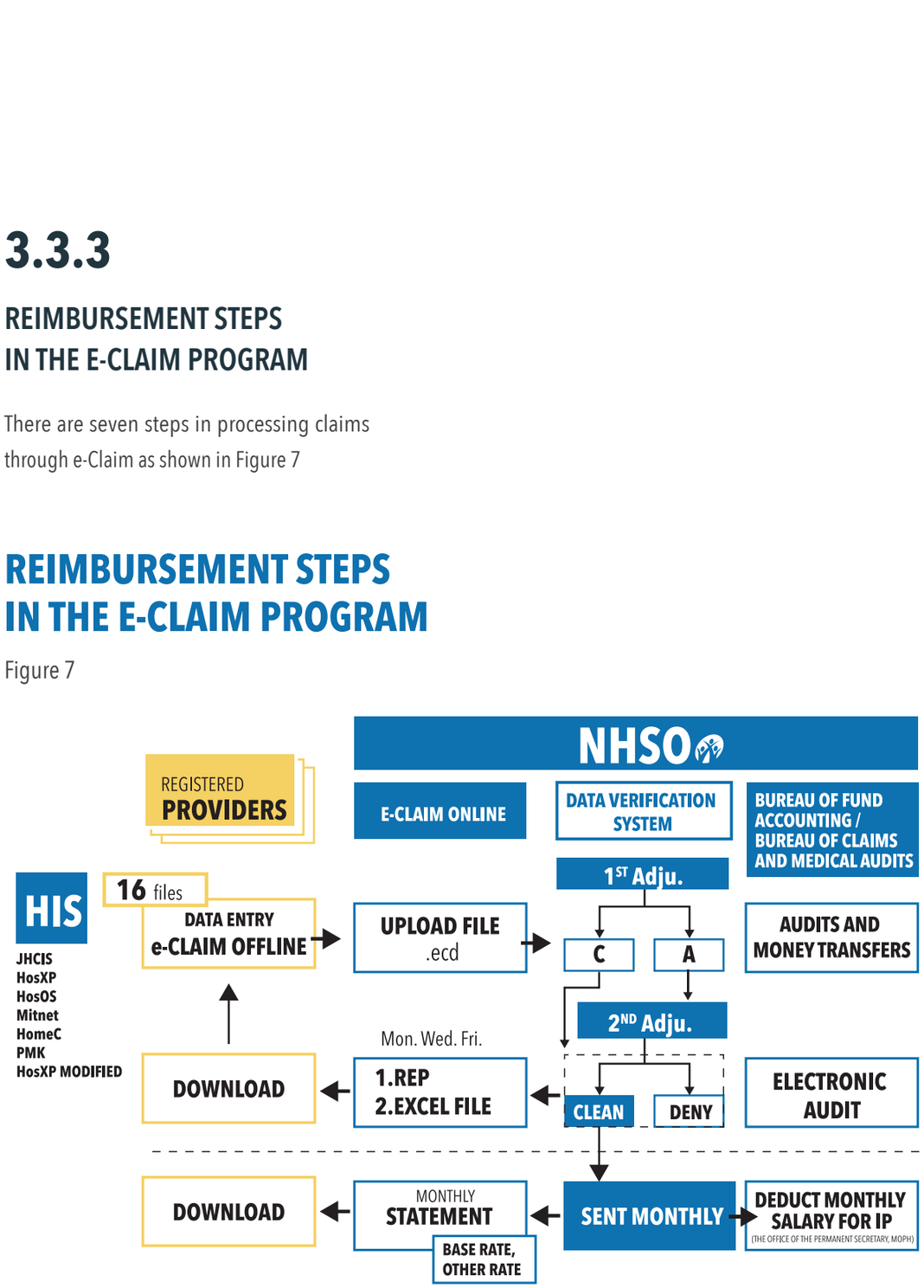
3.3.3

REIMBURSEMENT STEPS IN THE E-CLAIM PROGRAM

There are seven steps in processing claims through e-Claim as shown in Figure 7

REIMBURSEMENT STEPS IN THE E-CLAIM PROGRAM

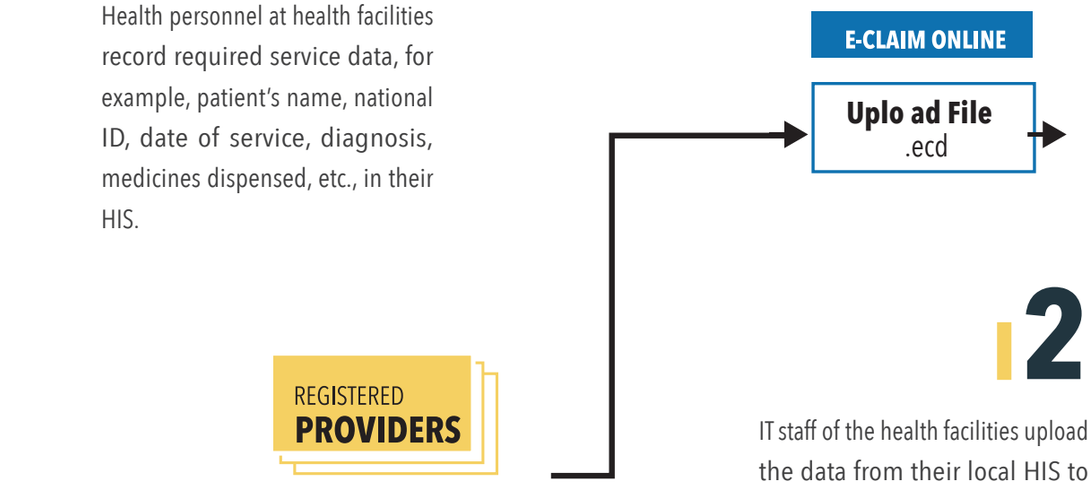
Figure 7



Source: e-Claim User's Manual

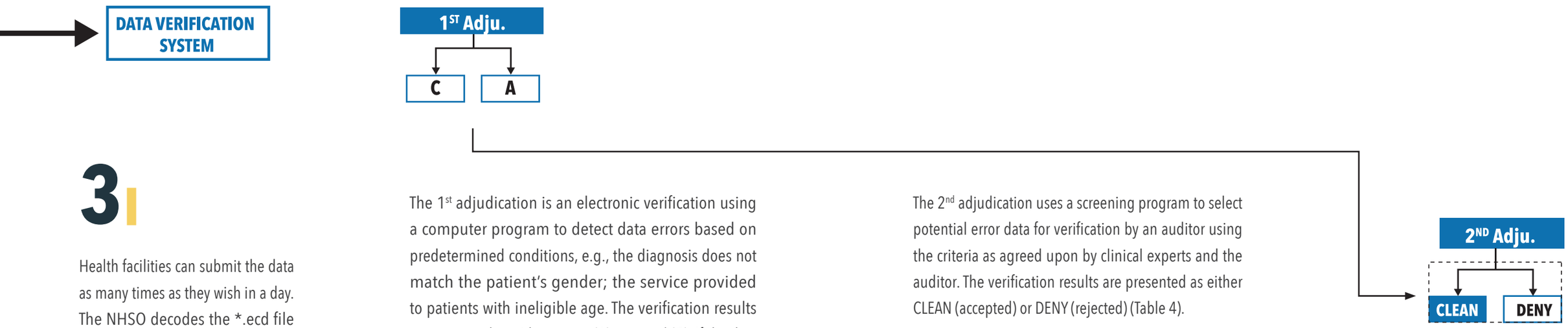
1

Health personnel at health facilities record required service data, for example, patient's name, national ID, date of service, diagnosis, medicines dispensed, etc., in their HIS.



2

IT staff of the health facilities upload the data from their local HIS to the offline e-Claim program to transform the data to match with the 43 files structure. The data will be saved in *.ecd format. After this process, health facilities can no longer open or edit the dataset.



3

Health facilities can submit the data as many times as they wish in a day. The NHSO decodes the *.ecd file into individual data every day at midnight. The NHSO conducts data verification in two steps as follows:

The 1st adjudication is an electronic verification using a computer program to detect data errors based on predetermined conditions, e.g., the diagnosis does not match the patient's gender; the service provided to patients with ineligible age. The verification results are presented as either accept (A) or cancel (C). If the data are accepted, then the 2nd adjudication will be made. See Table 3 for examples of data that did not pass the 1st adjudication.

The 2nd adjudication uses a screening program to select potential error data for verification by an auditor using the criteria as agreed upon by clinical experts and the auditor. The verification results are presented as either CLEAN (accepted) or DENY (rejected) (Table 4).

Table 3

EXAMPLES OF DATA THAT WERE REJECTED BY THE 1ST ADJUDICATION

Code	Error Details	Corrective Actions
101	Missing patient surname	Fill in the missing data and resubmit
102	Invalid or missing patient date of birth	Fill in or edit the data and resubmit
104	Invalid or missing national ID number	Fill in or edit the data and resubmit
105	Invalid or missing hospital number	Fill in missing data and resubmit
107	Invalid or missing date of admission or discharge	Recheck the dates, edit the data and resubmit
113	Inconsistent discharge type and health condition	Fill in or edit the data and resubmit
114	Invalid or missing bodyweight of newborns	Fill in or edit the data and resubmit
115	No information on health insurance entitlement or request not to use insurance	Recheck and specify insurance entitlement, then resubmit
116	Invalid national ID	National ID must be as appeared on the card; leave blank if not available; if the format is not correct, e.g., not 13 digits, edit and resubmit

Table 4

EXAMPLES OF DATA THAT WERE REJECTED BY THE 2ND ADJUDICATION

Code	Meaning
I04	ICD-10 / ICD-9CM does not match the instrument requested to be reimbursed
G37	Not an eligible facility to provide cardio-vascular surgery
D45	Patients with leukemia and lymphoma who are not registered
D46	Patients with leukemia and lymphoma who are under 15 years old
D47	Reimbursing outpatient treatment for inpatients with leukemia and lymphoma
D48	Patients with leukemia and lymphoma having ICD-10, ICD-9CM that do not match with the requested items
D49	Patients with leukemia and lymphoma without treatment protocol
D51	Reimburse more than 4 times which exceeds the limit for reimbursement for patients with leukemia and lymphoma
D53	Laser treatment of diabetic retinopathy exceeds 2 times in the fiscal year
D63	Request to reimburse streptokinase for patients with STEMI who have received the same medicine in the past 12 months
D64	Code for the procedure (ICD-9) does not match the number of surgeries
D66	Request to reimburse for cataract treatment but do not have secondary diagnosis code of H54.4, H54.5 or H54.6

4

The NHSO will report the results of data verification, both those with 'CLEAN' and 'DENY', back to health facilities as REP files every Monday, Wednesday and Friday. Health facilities will check and edit as appropriate and resubmit.

REGISTERED **PROVIDERS**

E-CLAIM ONLINE

CLEAN **DENY**

Mon. Wed. Fri.

DOWNLOAD

1.REP
2.EXCEL FILE

5

At the end of the month, the NHSO will send out statements of CLEAN data to health facilities for recheck.

SENT DATE รายเดือน

DOWNLOAD

MONTHLY **STATEMENT**

BASE RATE, OTHER RATE

audit

6

The CLEAN data will then be sent to the Bureau of Fund Accounting to process payments to health facilities, and to the Bureau of Claims and Medical Audits for random audit.

BUREAU OF FUND ACCOUNTING / BUREAU OF CLAIMS AND MEDICAL AUDITS

AUDITS AND MONEY TRANSFERS

ELECTRONIC AUDIT

7

Health facilities that wish to appeal the verification results can do e-Appeal in the e-Claim program within a year after the statement issued. After one year, it is assumed that health facilities accept the results.

DEDUCT MONTHLY SALARY FOR IP
(THE OFFICE OF THE PERMANENT SECRETARY, MOPH)

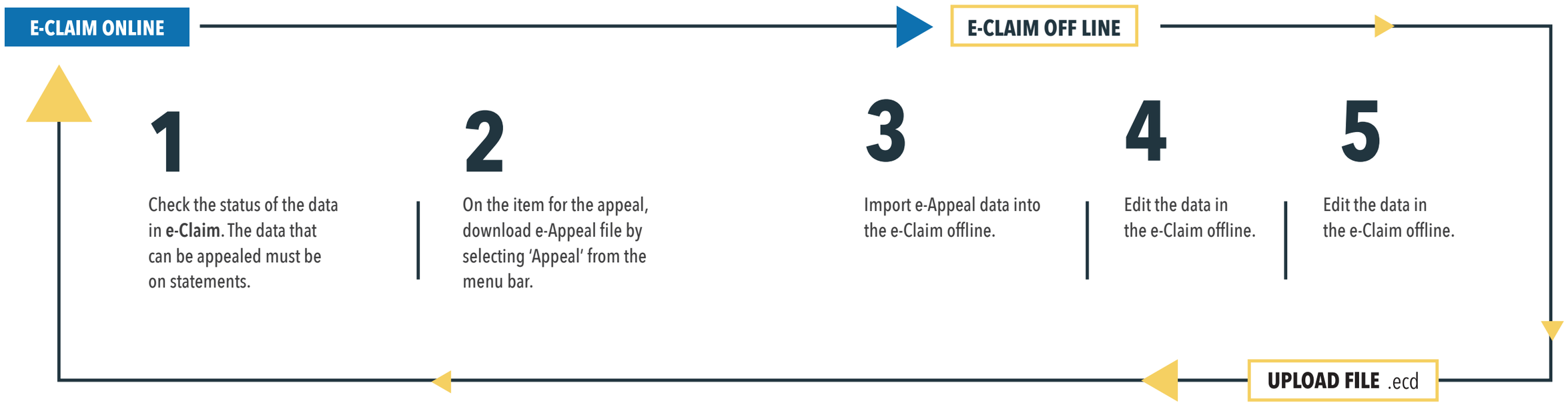
3.3.4

STEPS IN THE E-APPEAL PROCESS THROUGH THE E-CLAIM PROGRAM

e-Appeal

If health facilities disagree with the verification results, then they can appeal to the NHSO through the e-Claim program.

The data that can be appealed through e-Appeal are the data that passed the 1st adjudication with result A and appeared on monthly statements in the e-Claim program. The process of e-Appeal is as follows:



3.4

MONEY TRANSFER SYSTEM

At the end of each month, the NHSO sends out the monthly statement to health facilities. Within the NHSO, the Bureau of Fund allocation and Reimbursement will submit the statements to the management level to process payment approvals. Once approved, the Bureau of Fund Accounting transfers the money to the health facilities' bank accounts. The payments must be made within 15 calendar days after the statements are issued. NHSO will inform health facilities in advance about the day of money transfer (Figure 8). This predictable reimbursement and money transfer process allows health facilities to manage their budget appropriately.

REIMBURSEMENT CALENDAR FOR OUTPATIENT AND INPATIENT SERVICE, FISCAL YEAR 2019

Figure 8

Month (of OP service provided) / of discharge for IP)	Statement dates	Cutoff date for on time data submission	6110	6111	6112	6201	6202	6203	6204	205	6206	6207	6208	6209
OCT 2018	31 OCT 18	30 NOV 18	16 NOV 18	15 DEC 18	16 JAN 19	11 FEB 19	11 MAR 19	10 APR 19	10 พ.ค.62	10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
NOV 2018	31 NOV 18	31 DEC 18		15 DEC 18	16 JAN 19	11 FEB 19	11 MAR 19	10 APR 19	10 MAY 19	10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
DEC 2018	31 DEC 18	31 JAN 19			16 JAN 19	11 FEB 19	11 MAR 19	10 APR 19	10 MAY 19	10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
JAN 2019	31 JAN 19	28 FEB 19				11 FEB 19	11 MAR 19	10 APR 19	10 MAY 19	10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
FEB 2019	28 FEB 19	31 MAR 19					11 MAR 19	10 APR 19	10 MAY 19	10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
MAR 2019	31 MAR 19	30 APR 19						10 APR 19	10 MAY 19	10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
APR 2019	30 APR 19	31 MAY 19							10 MAY 19	10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
MAY 2019	31 MAY 19	30 JUN 19								10 JUN 19	10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
JUN 62	30 JUN 19	31 JUL 19									10 JUL 19	10 AUG 19	9 SEP 19	10 OCT 19
JUL 2019	31 JUL 19	31 AUG 19										10 AUG 19	9 SEP 19	10 OCT 19
AUG 2019	31 AUG 19	25 SEP 19											9 SEP 19	10 OCT 19
SEP 2019	25 SEP 19	31 OCT 19												10 OCT 19
DATES OF PAYMENT TRANSFER			30 NOV 18	29 DEC 18	31 JAN 19	28 FEB 19	30 MAR 19	30 APR 19	31 MAY 19	29 JUN 19	31 JUL 19	31 AUG 19	28 SEP 19	31 OCT 19

Source: The Universal Coverage Scheme's Fund Management Guidelines, Fiscal Year 2019

4

THE PERFORMANCE OF NHSO ON PROVIDER PAYMENT MANAGEMENT

result

The NHSO employs mixed methods of payments including capitation, fee schedule, and quality- and outcome-based payment for different services. The fund allocation and reimbursement systems are designed to ensure that health facilities are paid correctly, completely, and on time under the agreed conditions of payments. Health facilities can express their views on fund allocation and payment management. It is important that the payment system gains acceptance by health facilities to ensure that the beneficiaries can use the services within the benefits package adequately based on their needs.

The performance of NHSO on provider payment management in terms of correctness, completeness, timeliness, and improved access are detailed below.

4.1

CORRECTNESS AND COMPLETENESS

The NHSO has a combination of data verification processes with electronic programs, auditor, and cross check by health facilities. One dimension of performance is correctness. Correctness means that the NHSO's fund allocation and reimbursement system can correctly differentiate the valid and invalid data that were submitted by health facilities according to the reimbursement conditions that have been agreed to.

Completeness means that all reimbursement data that were submitted are completely received and stored in NHSO's system. Health facilities can check for completeness in the acknowledgement report that NHSO sends back to the facilities three times a week. If the facilities find any missing data, they can submit an enquiry to the NHSO. So far, there has never been any reports of incompleteness. This indicator is measured by the number of items either in A, C, or DENY that are equal to the number of items in the acknowledgement reports.

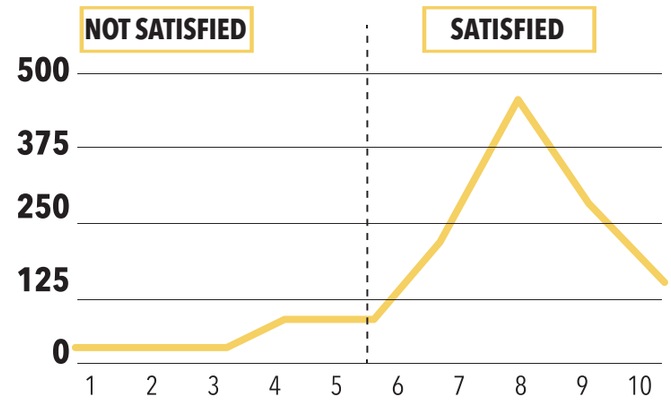
RESULTS FROM THE SATISFACTION SURVEY WITH THE E-CLAIM PROGRAM IN FISCAL YEAR 2017

Figure 9

SATISFIED

89.2%

One important indicator in assessing correctness and completeness of reimbursement data is the satisfaction of the health facilities with the e-Claim system. Since 2017, the NHSO has conducted electronic-based satisfaction surveys every fiscal year on health facilities that submit reimbursement data for at least consecutive six months. The first survey included 848 facilities from 1,092 target sites (yielding a 77.6% response rate). Most respondents were those responsible for data submission from district hospitals. The survey found that 89.2% of the participants were satisfied with the e-Claim program (see Figure 9).



Source: Bureau of Fund Allocation and Reimbursement, NHSO

In addition, the correctness and completeness of the reimbursement process is also reflected in the number of appeals by health facilities, medical records audit of the Bureau of Claims and Medical Audits, or from other bureaus within the NHSO, such as the NHSO regional offices. This routine performance monitoring allows continued improvement of the NHSO's fund allocation and reimbursement system.

4.2

TIMELINESS

The NHSO has set the time period for money transfer to health facilities to be within 15 days after the statements are issued. The timeliness of reimbursement payments provides reassurance to the health facilities that they can expect the payments within the agreed timeline.

To ensure timeliness, there needs to be good collaboration between the health facility (to submit data by the end of the next month) and the NHSO (to process the transfer of funds within the agreed timeline). A late submission will result in deducted reimbursement amount. Therefore, timely submission and payment can ensure that health facilities are reimbursed in full and can manage their budgets appropriately. The NHSO announces the cut-off date for submissions and time of payments for each fiscal year in the annual UCS's fund management guidelines (see Figure 8 in Section 3.4).

The NHSO sets the target for on-time payment for on-time submission at 90% for each fiscal year. So far, the NHSO has been able to achieve this target. This reflects effective work and good coordination between the Bureau of Fund Allocation and Reimbursement and the Bureau of Fund Accounting which can complete the process within 15 days after the statement is received. For Fiscal Year 2018, NHSO achieved its on-time payment target at the level of 98.4%.

The percentage of on-time payments, Fiscal Year 2018

NHSO ACHIEVED ITS ON-TIME PAYMENT TARGET AT THE LEVEL OF

98.37%

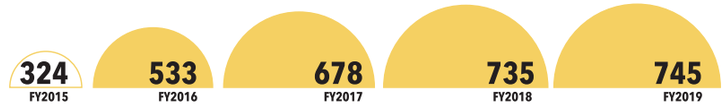
Source: Bureau of Fund Allocation and Reimbursement, NHSO

4.3

IMPROVED ACCESS

As aforementioned, the capitation payment may cause under-provision of high-cost services as they pose financial risk to health facilities. Thus, the NHSO separates out high-cost care, and pays by a fee schedule. One concrete example is the access to implants and intrauterine devices which are long-acting reversible contraception (LARC). LARC was previously included in the capitation payment for health promotion and disease prevention service. Despite being more effective, LARC has a higher price than oral contraception or DMPA injection making access suboptimal. After the change of payment method in fiscal year 2015, more health facilities provided LARC, increasing from 324 to 745 in five years (Figure 10).

NUMBER OF HEALTH FACILITIES REIMBURSED FOR LARC THROUGH E-CLAIM FROM FISCAL YEAR 2015 TO THE FIRST HALF OF FISCAL YEAR 2019



Source: Bureau of Primary Care Management, NHSO

Figure 10

More health facilities provided LARC, increasing to

745

5

ENABLING FACTORS OF PROVIDER PAYMENT MANAGEMENT AND REMAINING CHALLENGES

There are both successes and remaining challenges in the UCS's provider payment management system. The experience so far has provided important lessons for further improvement. The key success factor is the NHSO staff who demonstrate tremendous dedication and devotion to the work and always look for ways to improve the system. They have also built up a strong network with health facilities and academic partners. In addition, the NHSO has made excellent use of modern technology to support its fund allocation and payment management.

However, challenges remain. Firstly, there is a constant need to smoothly transfer technical knowledge and experience from the more senior NHSO staff to the newer staff. Secondly, the current process of adding new medicine and health technology to the benefits package cannot keep pace with rapid advancement in health technology which may delay access to some needed services. Thirdly, some health facilities still have problems with the information technology system. Fourthly, the HIS in Thailand is still fragmented.

5.1

ENABLING FACTORS OF PROVIDER PAYMENT MANAGEMENT

The success of the system requires the following attributes.

5.1.1

NHSO STAFF

Many of the personnel who are responsible for provider payment management have been working since the time of NHSO establishment. The continuity and preservation of institutional knowledge is a critical factor behind the smooth operations and continual improvements. These personnel have an intimate knowledge of operations of the UCS, and they display a singular dedication to the organization and their role. They continually search for ways to make improvements, large and small. For example, they have developed fact sheets about the e-Claim instrument reimbursement reports to make it convenient for the NHSO executives and partner organizations to use for research or policy decision-making.

The NHSO was the first public insurance agency to produce guidelines for reimbursement, and organize annual meetings to explain the fund allocation and reimbursement system for health facilities to ensure that all relevant staff understand the system and know how to obtain reimbursement in a timely manner. The operational guidelines also promote transparency of the UCS's provider payments as all health facilities understand the reimbursement conditions and can see that the same rules apply to everyone.

5.1.2

STRONG NETWORK WITH PARTNERS

The principles of operations of the NHSO, including provider payment management, are based on participation of all sectors, such as clinical experts, academia, policy makers and CSO. The Bureau of Fund Allocation and Reimbursement (which is responsible for provider payments) has built a network with clinical experts and relevant academic partners to support improvements in payment guidelines and conditions, medical equipment standards, data analysis, supporting information for reimbursement, or providing support at complaint centers.

Apart from technical and academic support, NHSO also partners with health facilities to provide help and support for the e-Claim program through a web board and social media. The Bureau of Fund Allocation and Reimbursement also invites clinical experts in various specialties and medical practitioners from health facilities to participate in the development of reimbursement guidelines and the reimbursement system to better meet the needs of health facilities.

5.1.3

USE OF TECHNOLOGY TO SUPPORT THE SYSTEM

The UCS has over 48 million beneficiaries. Thus, it is necessary to use information technology to help process the enormous amount of healthcare reimbursement data that the Bureau of Fund Allocation and Reimbursement has to deal with. The electronic programs, such as e-Claim, allow the Bureau to manage and quickly analyze data as needed.

5.2

REMAINING CHALLENGES

5.2.1

KNOWLEDGE TRANSFER WITHIN THE NHSO

New staff regularly join the NHSO and the Bureau of Fund Allocation and Reimbursement, and some senior staff retire each year. Thus, it is crucial to transfer the knowledge and wisdom of the more experienced staff to the new staff to sustain the capacity and ensure continuity and smooth service for participating health facilities. This knowledge transfer is currently done through on-the-job training as well as using work manuals and standard operating procedures guidelines for fund and information systems management.

5.2.2

MEETING THE NEEDS OF HEALTH FACILITIES

The UCS's benefits package cannot be updated fast enough to keep up with all the changes in health technology throughout the year. Any proposed changes to the benefits package require a rigorous process of review which often takes time. This challenge sometimes limits treatment options that health providers may wish to use which may lead to charging the patients for the medicines, procedures or equipment currently not in the benefits package.

5.2.3

HIS AT HEALTH FACILITIES

The participating health facilities in the UCS include over 10,000 public and private facilities throughout the country. These facilities record health status, medical records data, resource management data, and the health situation of the population in their HIS. The information from the local HIS is also sent out as reports to regulatory agencies or to insurance agencies. The challenge relating to HIS is that health facilities use different health information software which makes it hard to compile data at the central level. This is due to the uniqueness of the different HIS structures which does not always satisfy the data requirement by the NHSO. Thus, there needs to be a standard data set for all existing HIS. Another drawback is that the NHSO cannot provide specific manuals for all the different HIS to help the facilities know how to record information for reimbursement purpose. Without specific manuals, the staff at health facilities have a different level of understanding about how to record data appropriately.

In FY 2019, most health facilities did not have a complete understanding of data entry to satisfy the requirement of the MOPH's 43 files system. This lack of understanding has led to, for example, a low level of reimbursement for ANC services and cervical cancer screening. Thus, the NHSO collaborated with the MOPH and the National Center for Electronic Technology and Computers (NECTEC) to develop a guidebook for data entry for the 43 files as well as to integrate multiple health information databases to reduce duplication and reporting burden on health facilities.

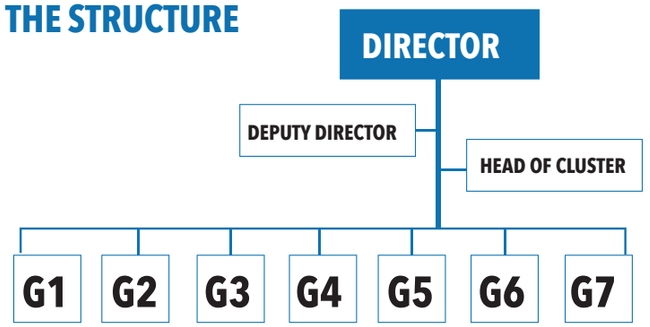
APPENDIX

BUREAU OF FUND ALLOCATION AND REIMBURSEMENT

Bureau of Fund Allocation and Reimbursement was established in accordance with the announcement of the NHSO in 2012, with the task of administering the allocation of compensation for services rendered in collaboration with Work Cluster 2 (Fund Management Group) with the following duties

1. Develop compensation system and check compensation payments
2. Create monitoring systems and administer standards for compensation
3. Provide an efficient compensation support system
4. Compensate for service fees for service facilities quickly, accurately and fairly.

THE STRUCTURE



G1 Work Cluster Administers the Fund Allocation and Management
G2 Work Cluster Administers Payment System in the UCS
G3 Work Cluster Administers Payment System for other Schemes and e-Claim Program
G4 Work Cluster Administers Payment System for Cases of Accidents or Emergency as per Article 7
G5 Work Cluster Administers Data on Claim for Medical Services
G6 Work Cluster Administers Strategy and Supporting Main Mission
G7 Work Cluster Administers Payment System for Special Conditions

POLICY ON QUALITY

The office allocates funds and compensates for service fees, and is committed to the continuous development of the quality of the administrative system to be an excellent unit with standards for allocation and compensation for public health services.

GOAL

1. Service facilities have been allocated and compensated for service fees accurately, completely, on time.
2. Listening/responding to the service facilities quickly and efficiently and being accepted by service facilities

VISION

To be an excellent organization and have standards for allocation of funds and compensation for public health services. UCS rights are recognized by all service facilities in 2021

STRATEGY

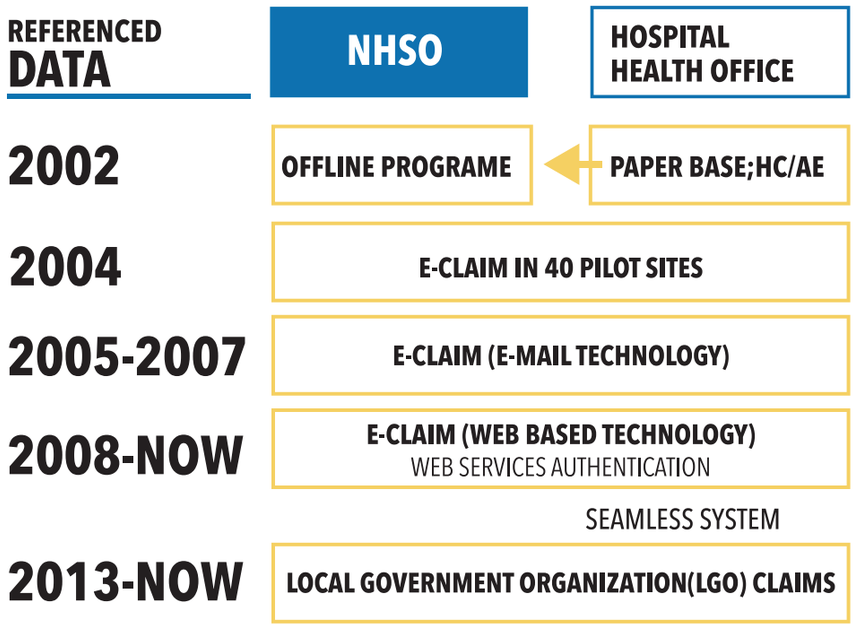
Administer, allocate and compensate effectively with participation from service facilities.

MECHANISMS

1. Develop the funds allocation system and pay compensation in a participatory manner using good governance with modern technology and standards;
2. Promote teamwork to achieve effective learning together.

APPENDIX

EVOLUTION OF THE E-CLAIM COMPUTER PROGRAM



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