THE MANAGEMENT OF PROVIDER PAYMENTS

IN THE UNIVERSAL COVERAGE SCHEME (UCS) IN THAILAND

NHSO
National Health Security Office

PAYMENT MANAGEMENT
UNDER UCS

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. The National Health Security Office (NHSO) acts as a representative of its beneficiaries in purchasing services from health providers using government budget.

The NHSO mainly administers health services payments in three ways: prospective payment using capitation; retrospective payment both in cash and in kind, and project-based payment.

METHODS OF HEALTH SERVICES PAYMENTS OF THE NHSO

1 PROSPECTIVE PAYMENT

50 % OF BUDGET

ALLOCATION BY DIFFERENTIAL CAPITATION

GENERAL OP
PP BASIC SERVICES

2 RETROSPECTIVE PAYMENT

45 % OF BUDGET

REIMBURSEMENT CASH/IN KIND

CASH
- IP BY DRG
- SPECIAL PP BY FEE SCHEDULE
- ETC

IN KIND
VACCINE, ARV, DIALYSIS SOLUTION, STENT, ECT

3 PROJECT BASE

5 % OF BUDGET

13 REGIONAL NHSO

PP AREA BASE

PP IN COMMUNITY
(MATCHING FUND WITH LGU)

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

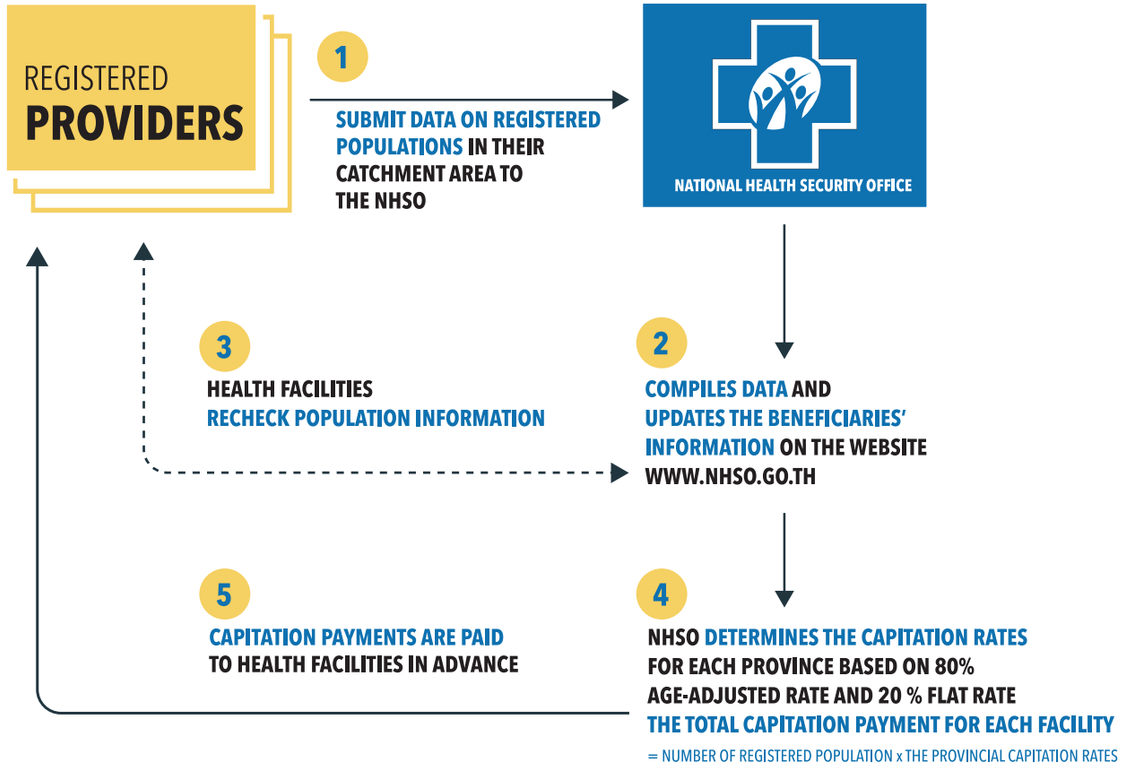
KEY PAYMENT METHODS CATEGORIZED BY TYPES OF SERVICES

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)

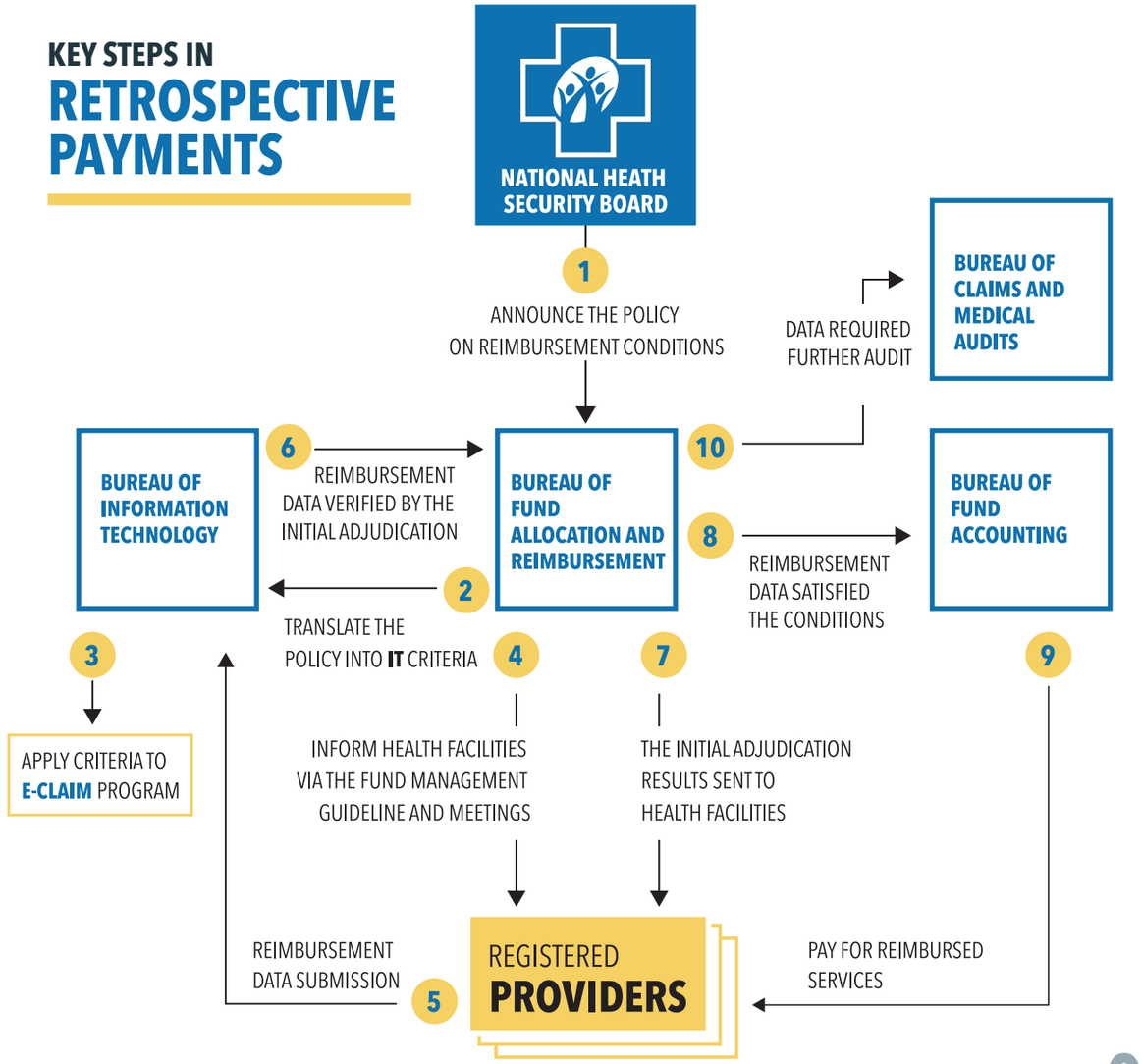
THE MANAGEMENT OF PROVIDER PAYMENTS IN NHSO

The fund allocation and provider payment management are guided by the National Health Security Board (NHSB). The Board makes decisions on benefits package 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.

KEY STEPS IN
PROSPECTIVE PAYMENTS



KEY STEPS IN
RETROSPECTIVE PAYMENTS



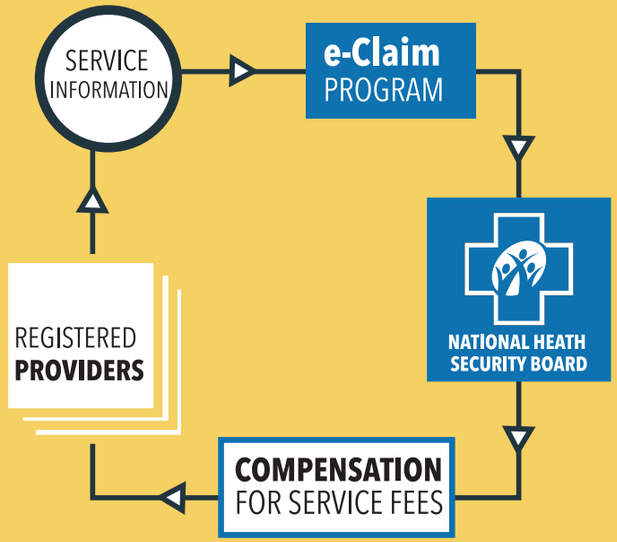
PROJECT-BASED PAYMENT

The project-based payment is a block-grant or installment payment to health facilities, local governments, or civil society organizations (CSOs) for some health programs aimed to address area-specific health challenges. Local governments are required to contribute based on specified contribution rates. 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.

ACCURATE
COMPLETE
TIMELY

KEY PRINCIPLE OF REIMBURSEMENT SYSTEM

The key guiding principle of the reimbursement system is to ensure "accurate, complete, timely" payments to health facilities.



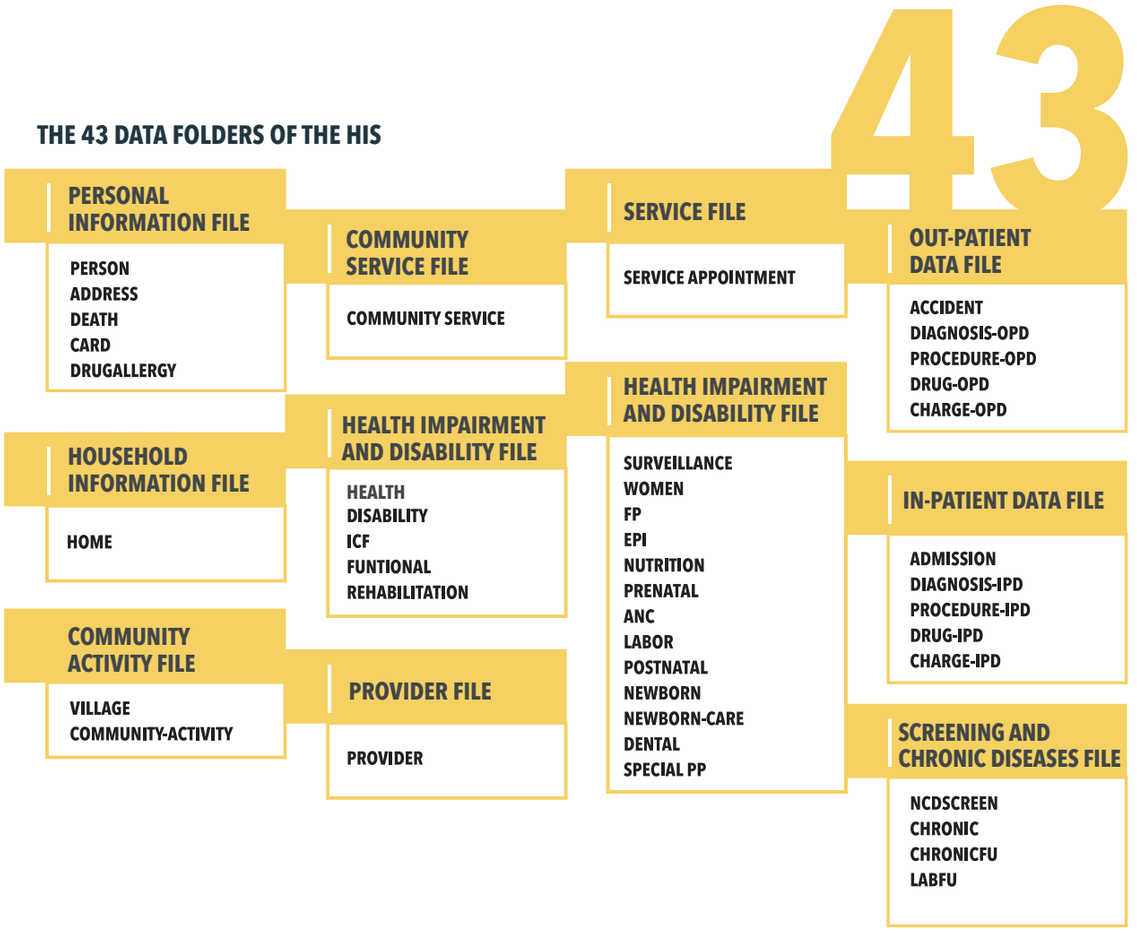
CORE STRUCTURE OF THE REIMBURSEMENT SYSTEM

1 HEALTH INFORMATION SYSTEM FOR HEALTH FACILITIES

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. The UCS uses the data from these 43 files for estimation of annual budgets, and also uses some of the data for service reimbursement.

In addition to the 43 files, the NHSO uses the following data for reimbursement purposes.

- 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)
- Procedural codes from 'the International Classification of Diseases 9th Revision Clinical Modification 2010 Classification of Procedures' (ICD-9CM version 2010)
- Drug catalogues of health facilities submitted to NHSO for calculating reimbursements
- Thai DRGs (version 5) to calculate the relative weight (RW) for in-patient services



2 PERSONNEL HANDLING HEALTH INFORMATION SUBMISSION

The NHSO holds training for the personnel 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.

ELECTRONIC PROGRAMS USED FOR HEALTH SERVICE REIMBURSEMENT

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

3 ELECTRONIC PROGRAMS FOR HEALTH SERVICE REIMBURSEMENT

EVOLUTION OF THE E-CLAIM COMPUTER PROGRAM

REFERENCED DATA	NHSO	HOSPITAL HEALTH OFFICE
2002	OFFLINE PROGRAME	PAPER BASE;HC/AE
2004	E-CLAIM IN 40 PILOT SITES	
2005-2007	E-CLAIM (E-MAIL TECHNOLOGY)	
2008-NOW	E-CLAIM (WEB BASED TECHNOLOGY) WEB SERVICES AUTHENTICATION	
2013-NOW	SEAMLESS SYSTEM LOCAL GOVERNMENT ORGANIZATION(LGO) CLAIMS	

The e-Claim program is a computer software package to record health services that health facilities provided, and submit the data for reimbursement. 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.

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. In case of late submission, different rates of reimbursement will be applied.

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

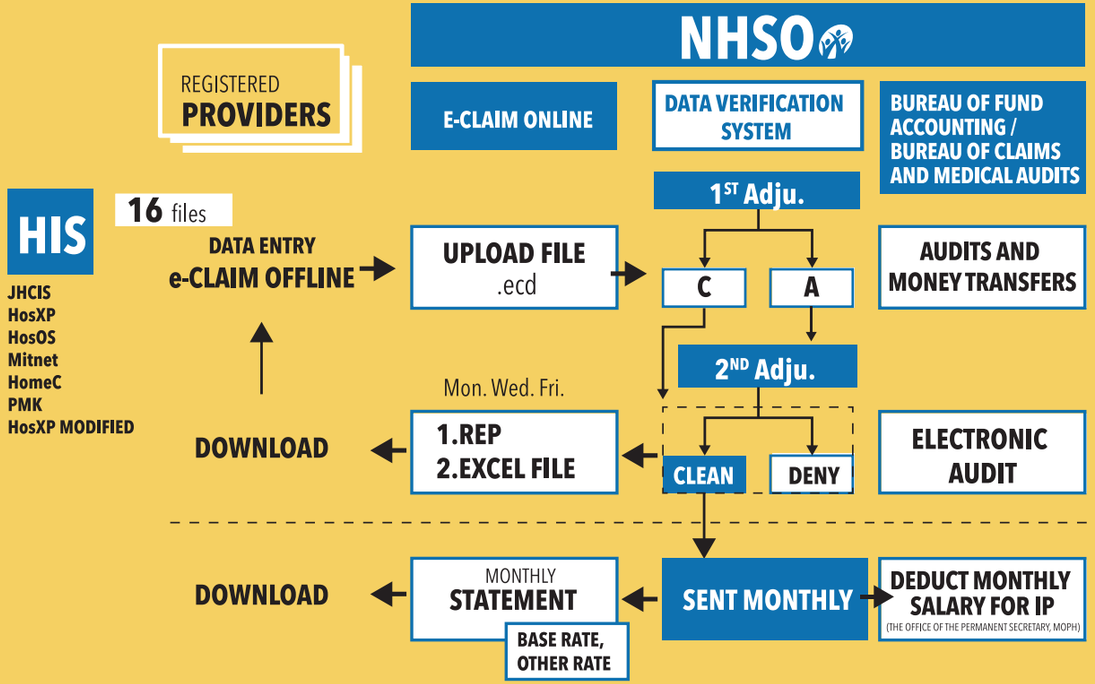
3

If the claim is submitted no more than

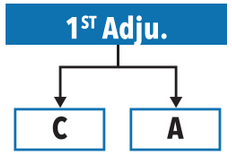
330 DAYS LATE,

then **80%** of the reimbursed costs will be paid

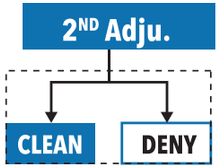
REIMBURSEMENT STEPS IN THE
E-CLAIM
PROGRAM



Health personnel at health facilities record required service data in their HIS. 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 to detect data errors based on predetermined conditions. The verification results are presented as either accept (A) or cancel (C).



The 2nd adjudication is 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).

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

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

The NHSO will report the results of data verification for both those with 'CLEAN' and 'DENY', back to health facilities every Monday, Wednesday and Friday. Health facilities will check and edit as appropriate and resubmit. At the end of the month, the NHSO will send out statements of CLEAN data to health facilities for recheck. 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.

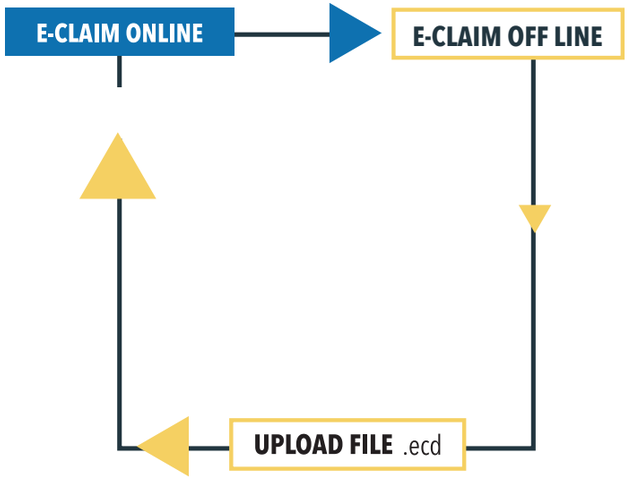
Health facilities that wish to appeal the verification results can do e-Appeal in the e-Claim program within one year after the statement is issued. After one year, it is assumed that health facilities accept the results.

STEPS IN THE

E-APPEAL PROCESS

THROUGH THE E-CLAIM PROGRAM

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



1. Check the status of the data in **e-Claim.** The data that can be appealed must be on statements.
2. On the item for the appeal, download e-Appeal file by selecting 'Appeal' from the menu bar.
3. Import e-Appeal data into the e-Claim offline.
4. Edit the data in the e-Claim offline.
5. Edit the data in the e-Claim offline.

MONEY

TRANSFER SYSTEM

NHSO sends out the monthly statement to health facilities at the end of each month. 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. 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

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

THE PERFORMANCE OF THE NHSO ON PROVIDER PAYMENT MANAGEMENT

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

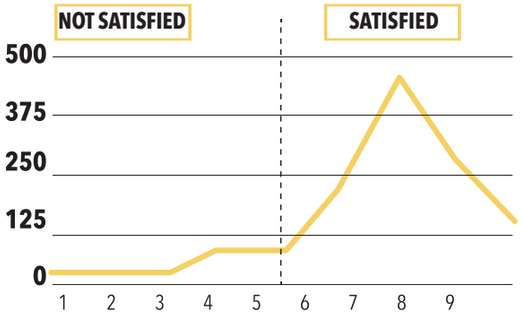
CORRECTNESS AND COMPLETENESS

SATISFIED

89.2%

An important indicator for assessing correctness and completeness of reimbursement data is the satisfaction of the health facilities with the e-Claim system. The first survey included 848 facilities from 1,092 target sites (yielding a 77.6% response rate). The survey found that 89.2% of the participants were satisfied with the e-Claim program.

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



Source: Bureau of Fund Allocation and Reimbursement, NHSO

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.

IN 2018 NHSO ACHIEVED ITS ON-TIME PAYMENT TARGET AT THE LEVEL OF

98.4%

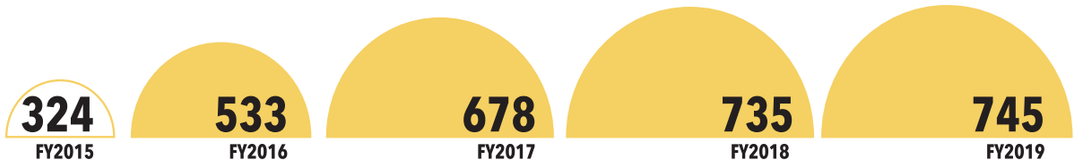
TIMELINESS

The NHSO has set the time period for money transfer to health facilities to be within 15 days after the statements are issued. The NHSO announces the cut-off date for submissions and time of payment for each fiscal year in the annual UCS's fund management guidelines. 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. For Fiscal Year 2018, NHSO achieved its on-time payment target at the level of 98.4%.

IMPROVED ACCESS

The capitation payment may cause under-provision of high-cost services. 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, with an increase in clients from 324 to 745 in five years.

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



ENABLING FACTORS AND REMAINING CHALLENGES

OF PROVIDER PAYMENT MANAGEMENT

Despite this progress, 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.

ENABLING FACTORS

OF PROVIDER PAYMENT MANAGEMENT

The success of the system requires the following attributes.

NHSO STAFF

The key success factor in the system is the NHSO staff who demonstrate tremendous dedication and devotion to the work, and who 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 systems.

STRONG NETWORKING 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 CSOs. Building a network with all stakeholders, including clinical experts and relevant academic partners and health facilities, helps improve the payment systems to meet the needs of health facilities.

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.

REMAINING CHALLENGES

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.

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, and that may lead to charging the patients for the medicines, procedures or equipment currently not in the benefits package.

HIS AT HEALTH FACILITIES

The participating health facilities in the UCS include over 10,000 public and private facilities throughout the country. The challenge relating to HIS is that health facilities use different health information software which makes it hard to aggregate data at the central level, and staff at health facilities have a different level of understanding about how to record data. Thus, there needs to be a standard data set for all participating health and clinical facilities in the HIS.

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.

NHSO

National Health Security Office