UNIVERSAL COVERAGE FOR EMERGENCY PATIENTS

UCEP

IN THAILAND

NHSO
National Health Security Office

WHAT IS THE UCEP POLICY?

The current UCEP policy (effective as of April 1, 2017) is a continuation of the original 'Emergency Claim Online' (EMCO) policy as implemented between April 2012 - March 2017 as a part of the national advocacy effort to standardize the three major public health insurance funds.

UCEP, or the Universal Coverage for Emergency Patients, is the right to medical treatment according to the government policy to ensure that all critical emergency patients are able to receive treatment in the nearest hospital anywhere without cost until the crisis is over, but not to exceed 72 hours, and the patient can be moved safely to their registered hospital if on-going inpatient treatment is needed.

DEVELOPMENT OF THE EMERGENCY MEDICAL SYSTEM IN THAILAND

PRIOR TO 1995

A basic service that simply transported the injured to the hospital, staffed by non-clinical volunteers from various foundations

1995

The Medical Services Department of the Ministry of Public Health (MOPH) established the 'Narenthorn EMS Center' at Rajavithi Hospital as a model for on-site medical treatment that uses the principles of emergency medicine, that is, to provide services to both the critically ill and injured

2002

The MOPH announced the development of the formal emergency medical service system throughout the country as one of the main policies of the MOPH and established the Office of Emergency Medical Service System (Narenthorn EMS Center, MOPH) as the agency responsible for the development and expansion of emergency medical services

2002

The Universal Coverage Scheme (UCS) was established. The cost for emergency services was calculated at ten baht per eligible beneficiary. This amount was the basis for preparing a budget for emergency services

2008

The Emergency Medical Act was enacted, and the National Institute for Emergency Medicine (NIEM) was established to support the development of emergency medicine and advocate for the standardized implementation of the service nationwide

2012

The government announced the policy called 'Emergency Claim Online' (EMCO) to cover every critical emergency patient, including the right to receive services in private hospitals outside the contracted provider of whatever scheme the patient was enrolled in.

2017

The policy entitled 'Universal Coverage for Emergency Patients' (UCEP) was formalized

WHY CHANGE FROM EMCO TO UCEP?

An evaluation of the EMCO policy identified the following major obstacles and gaps:

1 UNEQUAL ACCESS TO SERVICES AND HEALTH OUTCOMES

The level of access to emergency services from private hospitals was highest for beneficiaries under the Civil Servants Medical Benefits Scheme (CSMBS) (59.8%) among the three schemes, followed by those under the Universal Coverage Scheme (UCS) (34.1%), and lowest for those under the Social Security Scheme (SSS) (6.1%). Patients under the UCS and SSS had worse health outcomes overall, in that the condition did not improve or resulted in death upon discharge from the hospital, compared to patients under the CSMBS.

2 PATIENTS HAD TO CO-PAY

On average, emergency patients had to co-pay 70% of the total cost of care. That situation was directly contrary to the objectives of the policy, and caused unfair access to emergency services, specifically at private hospitals. This is because many private hospitals did not consider the NHSO reimbursement rates to be adequate to meet the actual cost of care. Generally, the cost of medical services at private hospitals is several times higher than the same services in public hospitals.

3 LACK OF LEGAL FRAMEWORK

The practical definition of the word 'emergency' was unclear. There were no laws, rules, or regulations to require private hospitals to comply with the EMCO policy. So, naturally there was confusion and alternative interpretations between the private service providers and the government.

4 LIMITED PUBLIC UNDERSTANDING

People's understanding of the scope of benefits under the policy was limited. Public relations communication regarding emergency care coverage according to the policy was not comprehensive or effective.

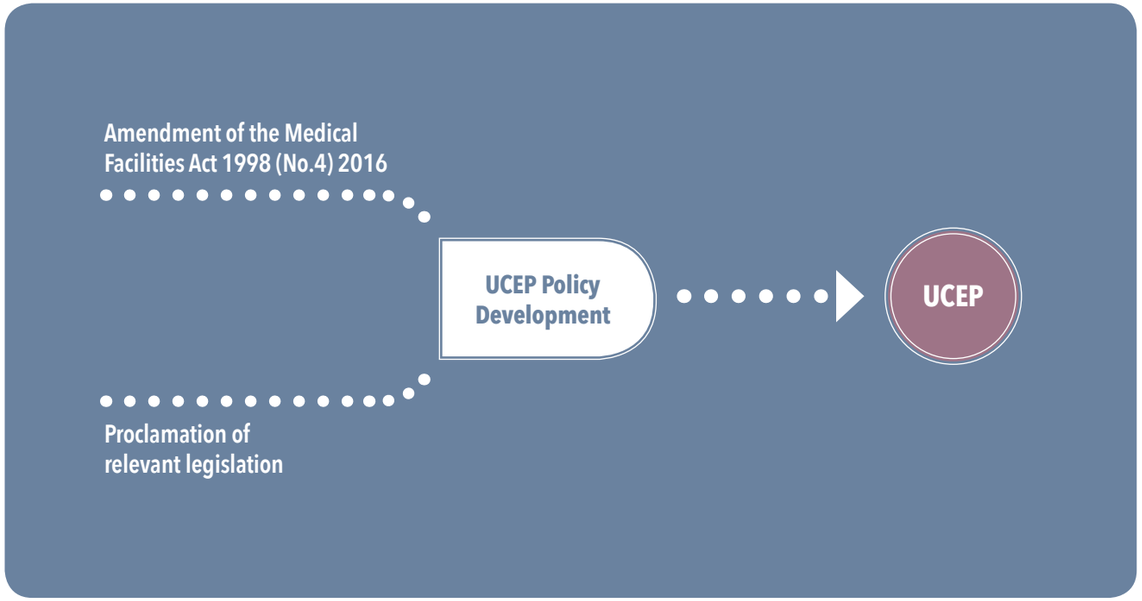
5 WEAK POLICY REGULATORY MECHANISMS

There was a lack of appropriate information systems in place to regulate the actions of private hospitals, both in terms of recording data for reimbursement of medical expenses, and preventing them from collecting medical expenses directly from patients and/or relatives of the patient.

In 2017, the government launched the UCEP policy as an improved version of EMCO.

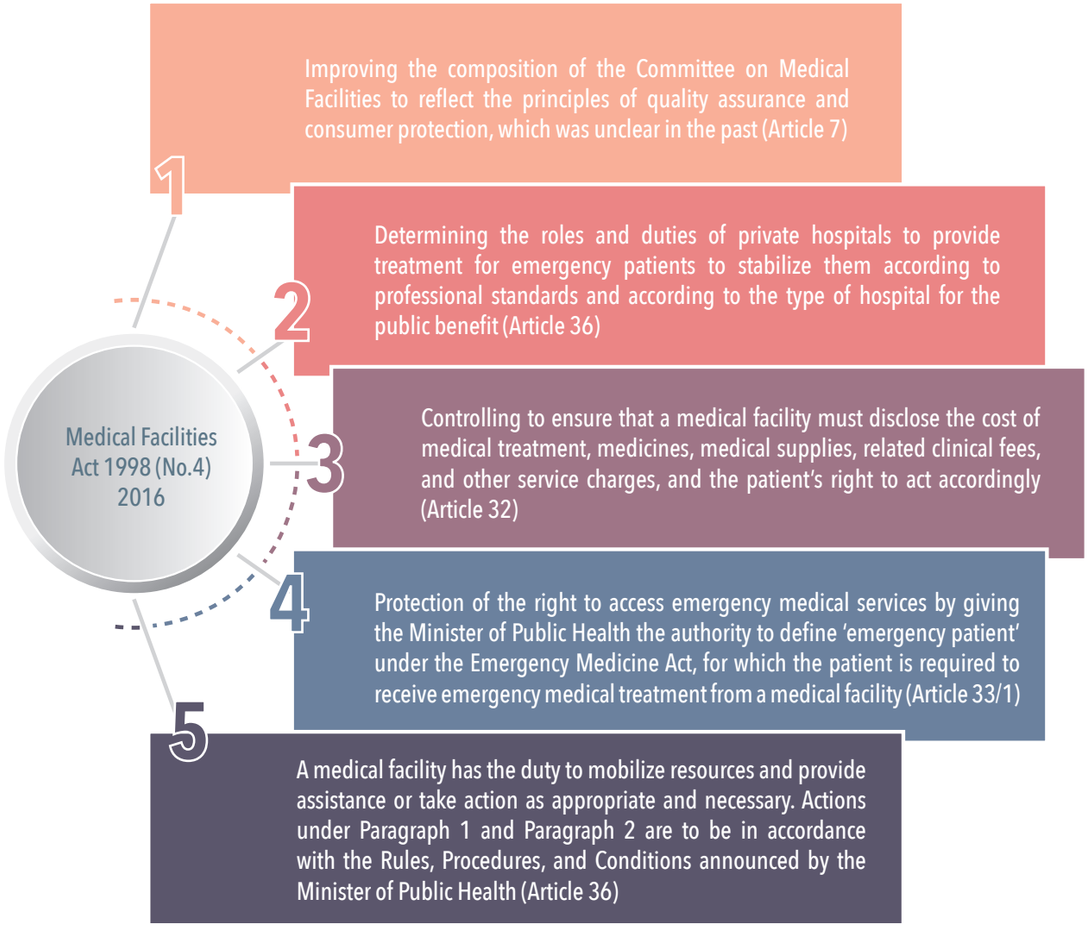
To bridge the gaps and barriers of implementing the EMCO policy mentioned above, the related agencies, including the MOPH, NIEM, NHSO, SSO, Comptroller General Department, and the Private Hospitals Association, brainstormed to develop a solution to the problems of the EMCO policy by establishing new guidelines for protecting the rights of critically ill patients so that they would not have to pay out-of-pocket for care at a private facility. The goal was to create a standard system of payments and reimbursements that would be accepted by private facilities, and manageable through reimbursement from one of the public health insurance funds. That way, a critically-injured or acutely ill patient could expect to receive affordable emergency care at the nearest facility, whether public or private.

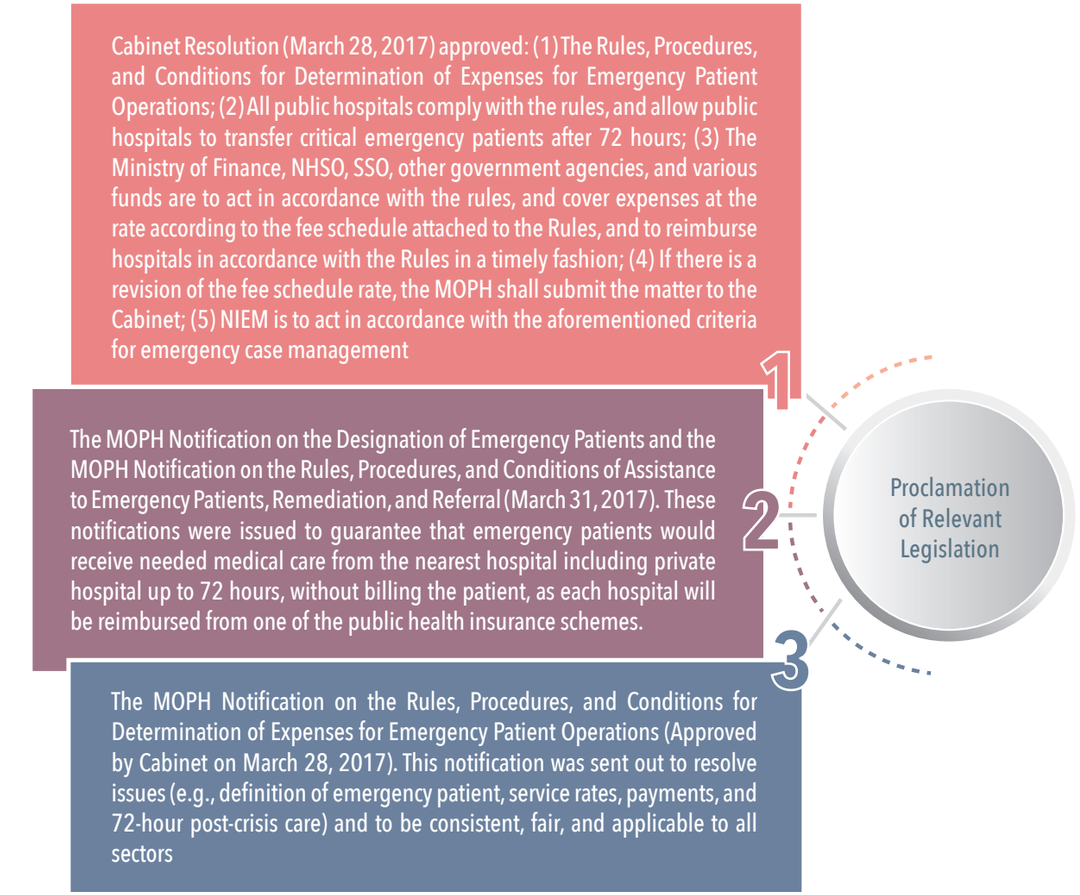
UCEP
POLICY DEVELOPMENT



AMENDMENT OF THE MEDICAL FACILITIES ACT 1998 (NO. 4) 2016

The government amended the Medical Facilities Act 1998 (No. 4) 2016, which became effective December 20, 2016. The amendments to the law have several intentions and themes that are reflected in the subsequent UCEP policy-based emergency guidelines.


Medical Facilities Act 1998 (No.4) 2016
1
Improving the composition of the Committee on Medical Facilities to reflect the principles of quality assurance and consumer protection, which was unclear in the past (Article 7)
2
Determining the roles and duties of private hospitals to provide treatment for emergency patients to stabilize them according to professional standards and according to the type of hospital for the public benefit (Article 36)
3
Controlling to ensure that a medical facility must disclose the cost of medical treatment, medicines, medical supplies, related clinical fees, and other service charges, and the patient's right to act accordingly (Article 32)
4
Protection of the right to access emergency medical services by giving the Minister of Public Health the authority to define 'emergency patient' under the Emergency Medicine Act, for which the patient is required to receive emergency medical treatment from a medical facility (Article 33/1)
5
A medical facility has the duty to mobilize resources and provide assistance or take action as appropriate and necessary. Actions under Paragraph 1 and Paragraph 2 are to be in accordance with the Rules, Procedures, and Conditions announced by the Minister of Public Health (Article 36)


Proclamation of Relevant Legislation
1
Cabinet Resolution (March 28, 2017) approved: (1) The Rules, Procedures, and Conditions for Determination of Expenses for Emergency Patient Operations; (2) All public hospitals comply with the rules, and allow public hospitals to transfer critical emergency patients after 72 hours; (3) The Ministry of Finance, NHSO, SSO, other government agencies, and various funds are to act in accordance with the rules, and cover expenses at the rate according to the fee schedule attached to the Rules, and to reimburse hospitals in accordance with the Rules in a timely fashion; (4) If there is a revision of the fee schedule rate, the MOPH shall submit the matter to the Cabinet; (5) NIEM is to act in accordance with the aforementioned criteria for emergency case management
2
The MOPH Notification on the Designation of Emergency Patients and the MOPH Notification on the Rules, Procedures, and Conditions of Assistance to Emergency Patients, Remediation, and Referral (March 31, 2017). These notifications were issued to guarantee that emergency patients would receive needed medical care from the nearest hospital including private hospital up to 72 hours, without billing the patient, as each hospital will be reimbursed from one of the public health insurance schemes.
3
The MOPH Notification on the Rules, Procedures, and Conditions for Determination of Expenses for Emergency Patient Operations (Approved by Cabinet on March 28, 2017). This notification was sent out to resolve issues (e.g., definition of emergency patient, service rates, payments, and 72-hour post-crisis care) and to be consistent, fair, and applicable to all sectors

THE ESSENCE OF THE UCEP POLICY

1 DEFINITION OF *'CRITICAL EMERGENCY PATIENT'* ACCORDING TO UCEP POLICY

Three types of emergency patients according to the severity of a patient's condition, as follows:

Critical emergency patient (Code Red): This is a person who is critically injured or has suddenly taken seriously ill and whose condition is life-threatening if not tended to immediately. The condition can be one that affects the respiratory, circulatory, or nervous system, and the patient has a high probability of dying or sustaining permanent damage from complications if not stabilized and treated in a timely fashion.

Urgent emergency patients (Code Yellow): These are persons who have sustained an injury or illness which is very acute or severe, and requires urgent medical attention in order to prevent permanent complications or exacerbation of the acute condition.

Non-serious emergency patients (Code Green): These are persons who have been injured or have an acute medical condition which is not life-threatening, and the patient can wait for medical attention for a period of time or can travel to a clinical facility by themselves. However, if the patient's condition is left unattended, it could exacerbate the injury or illness to become a more urgent and sever condition.

The UCEP policy covers the cost of treating critically ill/injured patients (Code Red) for up to 72 hours of care. The eligible beneficiaries under this policy are any person who is enrolled in one of the three public health insurance schemes, including persons with problems in accessing the right to treatment and foreigners who are entitled to the SSS and who meet the NIEM assessment criteria.

6 symptoms of critically injured/ ill person (Code Red)

1. Unconscious with faint or no breath
2. Tachycardia, extreme fatigue, and loud, labored breathing
3. Fainting with excessive perspiration, skin cool to the tough, or in shock
4. Acute and severe chest pains
5. Hemispherical limb weakness, slurred speech with acute or continual convulsions
6. Symptoms of a malfunctioning respiratory and/or circulatory system, and the condition of the brain is life-threatening

2 COMPENSATION FOR HOSPITALS USING A FEE SCHEDULE

The payment mechanism under the UCEP policy (2017-present) has changed from DRGs (during the EMCO policy era) to a fee schedule. The newly proposed fees are more in line with the average actual cost of private hospitals in providing emergency medical care. The fee schedule covers 4,292 items.

3 EMERGENCY SCREENING AND SORTING SYSTEM TO APPROVE RIGHT TO TREATMENT

NIEM developed the "Emergency Pre-authorization Program" to screen and classify emergency cases as a tool for hospitals to assess patient symptoms in a consistent and standardized way throughout the country. The program assigns a username for each private hospital and participating health insurance fund.

Medical facilities use the Emergency Pre-authorization Program to determine which emergency patients are eligible for UCEP subsidies and reimbursement. Therefore, the Program is one of the key mechanisms that helped win acceptance from all sectors, and avoid conflict between private hospitals and patients and/or their relatives. This action removed one of the shortcomings that plagued the implementation of the EMCO policy during 2012-17.

IMPLEMENTATION OF THE POLICY

1 GOVERNANCE: ROLES AND DUTIES OF VARIOUS AGENCIES

MEDICAL FACILITIES

- Classify emergency patients according to NIEM criteria
- Provide emergency medical care for critically ill patients until they are stabilized and out of immediate danger

MINISTRY OF PUBLIC HEALTH (MOPH)

- Create understanding among the public
- Coordinate with related agencies to make improvements to the rules and regulations
- Review and improve the fee schedule rates, and propose them to the Cabinet

NATIONAL INSTITUTE FOR EMERGENCY MEDICINE (NIEM)

- Manage the entire emergency medical system
- Manage the Emergency Pre-Authorization Program

NATIONAL HEALTH SECURITY OFFICE (NHSO)

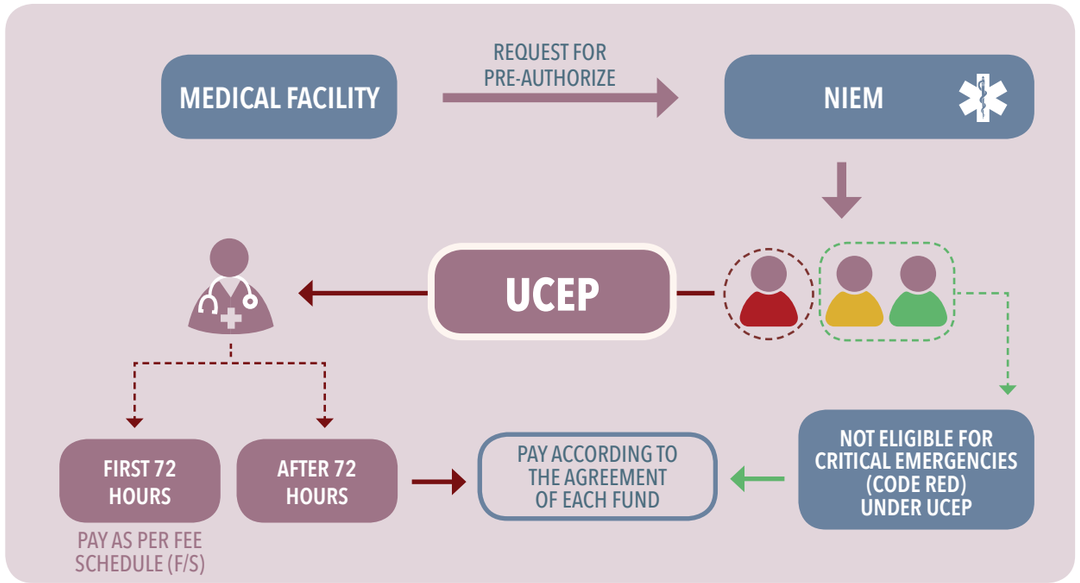
- Verify the accuracy of the disbursement information and produce a summary of expenses
- Notify the fund of the beneficiary within 30 days from the time the completed documents are received

FUNDS

- Amend the regulations to support payment of compensation and pay expenses at the rate of expenses attached to the rules
- Pay the hospital within 15 days

2 SERVICE COMPENSATION INNOVATION

2.1 PAYMENTS FOR REIMBURSEMENTS UNDER UCEP



IN THE FIRST 72 HOURS AFTER ADMITTING A PATIENT

1. The medical facility is eligible for reimbursement of the costs incurred during the period of care according to fee schedule payment;
2. The reimbursement should first be processed through any coverage or plan which the patient is a beneficiary of, namely the Motor Vehicle Accident Victims Act, or the Life Insurance Act; and
3. The medical facility is not to bill the patient directly unless the crisis is over and there is a referral bed available, but the patient chooses not to be transferred.

AFTER 72 HOURS

Any medical care expenses that are incurred after 72 hours shall be billed in accordance with the facility's medical expense rate or per the agreement between the medical facility and the eligible person's insurance fund.

If there is a dispute about whether the emergency condition is critical (Code Red) or not:

In the event of a diagnostic dispute in classifying a patient by the level of severity, the medical facility is to consult with the 'Coordination Center for the Protection of the Rights of Critical Emergency Patients.' At present, NIEM has assigned medical facilities to have the on-site physician assess admissions through the automated program system. Nevertheless, both patient and relatives can appeal the diagnostic decision at the Center by calling the 24-hour Hotline (02 872 1669), which will be forwarded to the Department of Health Service Support for further consideration.

2.2 RECEIVING COMPLAINTS

NIEM set up a working group to receive and investigate complaints. This is to protect critical emergency patients who have been processed in the Emergency Pre-authorization Program. Since the implementation of UCEP (April 1, 2017-September 30, 2020), there have been a total of 327 complaints filed with NIEM, and 106 were successfully resolved. Cases include hospitals that directly billed patients who were eligible for free services under UCEP (40.7%), patients who disagreed with the diagnosis (39.5%), hospitals which did not record data through the Emergency Pre-authorization Program but collected reimbursement (16.5%), and other matters (3.3%).

At present, the resolution of disputes or related issues has been transferred to the Department of Health Service Support. This is because that department is the agency that is responsible for administering the Medical Facilities Act, while the Coordination Center for the Protection of the Rights of Critical Emergency Patient only receives complaints.

IMPLEMENTATION PERFORMANCE

1 ACCESS TO EMERGENCY MEDICAL SERVICES UNDER UCEP

From the performance of UCEP implementation (April 1, 2017 - February 28, 2021), it was found that emergency patient information was sent through the Pre-authorization Program and met the criteria for UCEP, on average, 2,066 times per month.

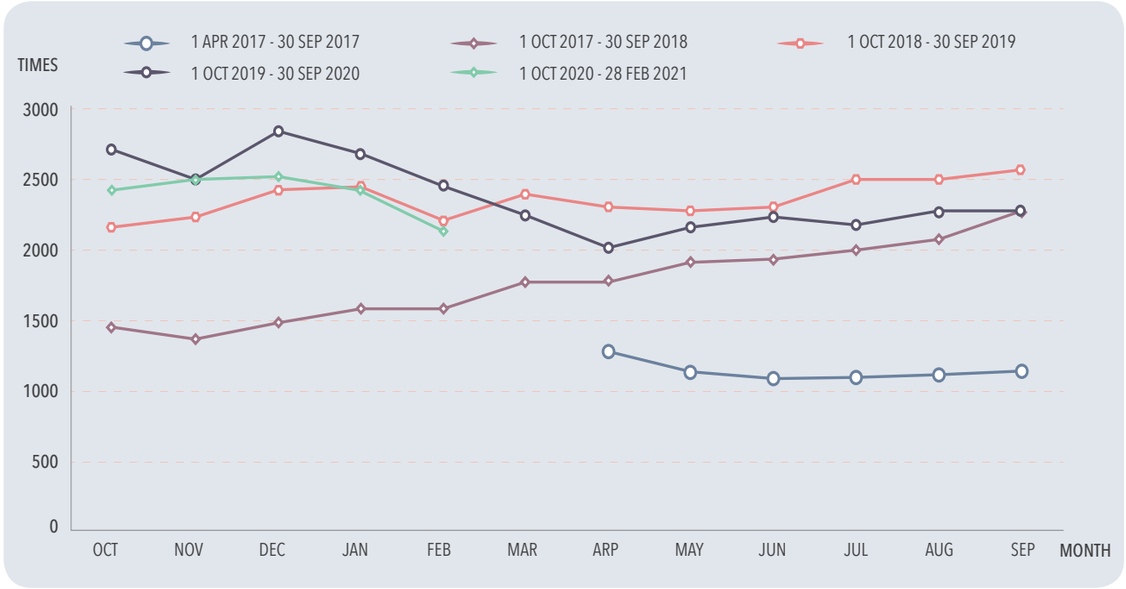


Figure 1: Results of Reports to the Pre-authorization Program under UCEP, April 2017-February 2021
Source: Data from the Emergency Pre-authorization Program, NIEM; UCEP program, NHSO, as of March 4, 2021

2 REDUCE DISPARITY AND INCREASE ACCESS TO EMERGENCY SERVICES

UCEP (2017-present) confers the right to emergency care for all critical emergency patients in Thailand, and has significantly improved access to emergency medical services compared to the EMCO policy during 2012 - 17. Cases served by the UCEP policy increased from approximately 986 cases/month (under EMCO) to 2,066 cases/month. UCS beneficiaries receiving critical emergency medical services increased from 27,152 times under the EMCO to 62,430 times under the UCEP policy.

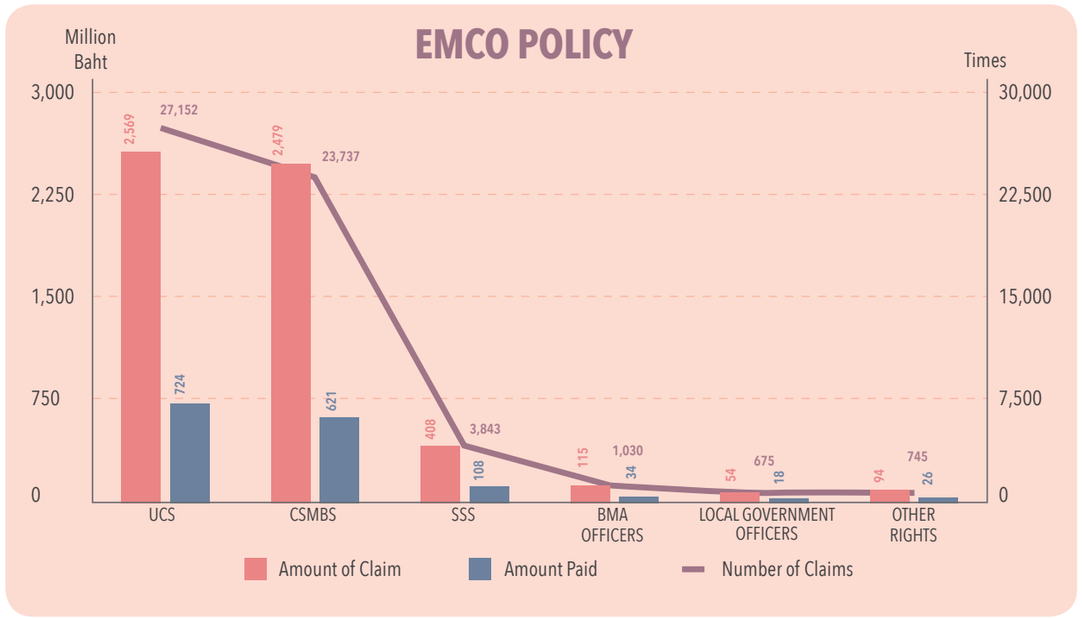


Figure 2: Results of Implementation under the EMCO Policy (April 2012-January 2017)
Source: NHSO

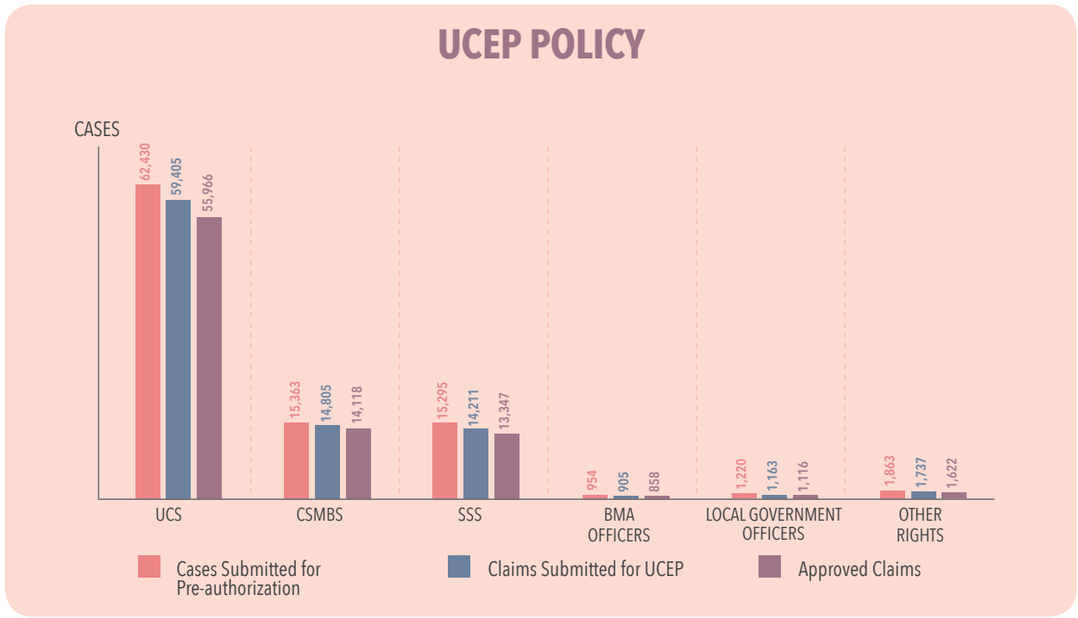


Figure 3: Patients Approved for Compensation under UCEP by Health Insurance Scheme (April 2017-February 2021)
Source: Emergency Pre-authorization program, NIEM; UCEP program, NHSO (as of March 4, 2021)

3 REIMBURSEMENT OF MEDICAL EXPENSES FOR CRITICAL/ EMERGENCY PATIENTS UNDER THE UCEP POLICY

There were 97,125 critical emergency patients processed through the Pre-authorization Program. Of these, 87,027 cases were approved for disbursement. The total medical expenses billed (all health insurance funds) was 5.059 billion baht, with disbursement amounting to 2.188 billion baht, accounting for 43.2% of the claimed amount. Compensation for emergency services in the first 72 hours according to the fee schedule amounted to 2.097 billion baht. Compensation after 72 hours (only for those eligible in the UCS system) according to the fee-for-service system amounted to 93 million baht.

Table 1: Reimbursements under UCEP (April 2017-February 2021)

Health Insurance Scheme	Percentage of claims approved (of claims submitted)	Amount of claims (million baht)	Amount advanced for care in the first 72 hours not counting insurance claims (million baht)	Percentage of amount in the first 72 hours	Amount paid for care after 72 hours (million baht)	Net compensation before private insurance Acts (million baht)	Net compensation (million baht)
UCS (Gold Card)	94.2	3,119	1,303	41.8	93	1,396	1,394
CSMBS	95.4	831	371	44.6	0	371	371
Social Security	93.9	877	327	37.3	0	327	327
BMA Government Officers.	94.8	71	31	43.7	0	31	31
Local Government Officers	96.0	50	23	46.0	0	23	23
Other Coverage	93.4	111	42	37.8	0	42	42
Total	**94.4**	**5,059**	**2,097**	**41.5**	**93**	**2,190**	**2,188**

Source: UCEP Program, NHSO

SUCCESS FACTORS

THE POLICY IS BACKED BY LAW AND THERE ARE CLEAR PROCEDURES AND REGULATIONS

Having a legal framework, comprised of the amendment to the Medical Facilities Act (No. 4) 2016 and the issuance of the three MOPH notifications stipulating the rules, procedures, and conditions for screening critical emergency patients and providing emergency patient assistance and referral, enabled the UCEP to have a clear policy-driven mechanism. These measures were enough to convince nearly all private hospitals to participate in the UCEP, and largely comply with the rules of the policy.

In addition, the UCEP policy is designed to have effective coordination and regulatory mechanisms. These include the Coordinating Center for the Protection of the Rights of Critical Emergency Patients and information systems through the Emergency Pre-authorization Program. Any question or concern about emergency case management can be relayed to the 24-hour NIEM Hotline.

COOPERATION FROM RELEVANT AGENCIES

The policy implementers ensured they would receive good cooperation from the relevant agencies in both the public and private sectors. These key players include the Office of the Permanent Secretary of the MOPH and the Department of Health Service Support of the MOPH, the NHSO, the SSO, the Comptroller General Department, the State Enterprise Policy Office, the Department of Labor Protection and Welfare, the College of Emergency Physicians of Thailand, the Private Hospitals Association, and private hospitals themselves.

As a result, the UCEP policy has increased people's access to emergency medical services for the intended objectives.

WIDESPREAD AND ACCESSIBLE PUBLIC RELATIONS MAKE PEOPLE AWARE OF UCEP AND AWARE OF THEIR RIGHTS

One of the problems with the EMCO policy was the lack of public understanding of the scope of the policy's benefits. As a result, the MOPH and NIEM developed various press releases and disseminated these in the form of printed documents, brochures, annual diary books, desk calendars, and standee banners to be delivered to every hospital so that staff and clients were fully informed. There was information dissemination through public relations spots on TV and radio, and online information through various channels media (such as Facebook, YouTube, and other websites) to make people aware of the guidelines, procedures, and implementation of the UCEP policy.

UCEP INCREASES ACCESS TO MEDICAL CARE OF COVID-19 PATIENTS

UCEP developed specific criteria (UCEP-COVID-19) for emergency patients with COVID-19. If a patient meets the criteria for a COVID-19 emergency, there is no need to process the case through the Emergency Pre-authorization Program. The medical facility will receive reimbursement for the expenses incurred based on the COVID-19 inventory fee schedule. Hospitals are not to bill the patient until discharge. Hospitals are kept up-to-date on adjustments to the guidelines through online meetings.

REMAINING CHALLENGES

SOME MEDICAL FACILITIES STILL TRY TO BILL PATIENTS FOR TREATMENT OUTSIDE THE UCEP GUIDELINES

Based on grievances submitted to NIEM, it was found that the most common complaint is from patients who believed they were eligible for free emergency care but were still charged by the private hospital. This is consistent with the findings in an independent evaluation which found that 20-30% of emergency patients at private hospitals are being asked to place a pre-service deposit. Some hospitals charge the patient first and then reimburse the patient once the hospital receives its funds from UCEP or the insurance provider. At the time of this study, the MOPH, the agencies responsible for health funds, and the Private Hospitals Association were jointly trying to address this issue through revising the fee schedule rates. These rates are reviewed and revised at least every three years, and this should help private hospitals have confidence in the UCEP policy and not burden the patient.

NON-INCENTIVE COMPENSATION RATE FOR SERVICES OF PRIVATE HOSPITALS

At present, the disbursement rate under the UCEP (2017-present) was 43.2% of the billed price. This is higher compared to the EMCO disbursement rate of 26.8%. The primary reason for clinical patient billing is that some private facilities provide treatment or services outside the UCEP fee schedule. In addition, some private hospitals may still feel that the UCEP rates are below the actual cost incurred by the hospital for emergency care.

Therefore, to ensure sustainability in implementation of the UCEP policy, cost data for emergency medical services at each level of the private medical facility should be empirically studied. Alternative compensation systems, such as DRGs, or a combination of DRGs-based payments and fee-schedule-based payments, may be more appropriate for certain service categories, such as the use of expensive (but essential) drugs and/or materials.

DEVELOPMENT OF THE EMERGENCY MEDICAL SYSTEM IN A PUBLIC CLINICAL FACILITY

The emergency medical system in public medical facilities still needs improvement. In particular, public hospitals need to provide emergency care more quickly to reduce unnecessary loss from disability or death, and to build confidence in the quality of public services. In addition, there should be a financial mechanism to support ongoing improvement in the emergency medical system in the government's medical facilities so that they are uniform and standard across the country.

DELAY IN IMPROVING STATE ENTERPRISE FUND REGULATIONS

Some of the relevant health insurance funds face obstacles in paying private medical facilities for emergency care of their beneficiaries. At the time of this study, there were 165 health insurance funds in operation in Thailand. However, only 13 of these funds have revised their regulations to conform to UCEP criteria, while the other 152 funds need to amend their regulations so that care and financing are uniform. This is one of the key challenges affecting access to emergency medical services. At the time of this study, discussions were ongoing to resolve this gap, including such agencies as the Department of Welfare and Labor Relations, the Office of the Public Sector Development Commission, and the State Enterprise Policy Committee.

SUMMARY

THE EMERGENCY MEDICAL SYSTEM AS AN INTEGRATION OF THE THREE MAJOR PUBLIC HEALTH INSURANCE SCHEMES TO REDUCE INEQUALITY

Implementation of the UCEP policy from April 2017 to the present is gradually closing the gaps in emergency care around the country. Compared to the Emergency Claim Online (EMCO) policy (2012-17), UCEP has significantly increased access to emergency medical services, boosted cooperation from private hospitals, and reduced the disparity among the three main public health insurance schemes. The UCEP policy ensures that patients will receive timely emergency medical services in the first 72 hours after an accident or acute illness, and not be billed. The implementation of the UCEP policy over the past four years has proven to be of great benefit to the people. In particular, UCS beneficiaries, under the responsibility of the NHSO, have greater access to emergency medical services compared to the previous policy. Although the implementation of UCEP still has some obstacles and challenges, all the relevant agencies in both the public and private sector, including the general public, are working together to further improve the emergency medicine system so that the UCEP policy serves as a *'good-practice model'* for integrating and reducing the disparity of health care in Thailand.

National Health Security Office