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DELAYED CLAIM PAYMENT AND THE THREAT TO HOSPITAL CASH FLOW UNDER THE NATIONAL HEALTH INSURANCE SCHEME IN INDONESIA

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ABSTRACT

Background: Indonesia commits to ensure health care access for all population through the National Health Insurance (JKN) managed by the BPJS Health. By February 2018, the JKN covered 193 million people (73% of the total population). To ensure health delivery, 2,104 public and private hospitals are contracted by the BPJS and prospective payment using Case-mix Based Group (CBG) that changes hospital managements. Hospitals become more dependent on payments by BPJS. Delay in claim payment will have serious impact on hospital managements. This study aims to identify current practices in timely payment to hospitals and finding factors correlate with delay in payments.

Methods: This study used trend analysis of the secondary claim data of BPJS with the total sample of 57,475 bundles of claims. Total claim population was used in this study. In addition, qualitative study via in-depth interview with six informants consisting of members of National Social Security Council, hospital director of three different classes, and BPJS.

Results: This study found 60% of claims were paid within one month (N-1) of claim submission, below the target of 100%. There were tendencies of delays in claim settlements since November 2017. Informants believed that late payments were correlated with non-compliance of doctor to complete medical records, incompetence coders, inadequate management information system, and financial condition of BPJS. There were three main problems faced by hospitals as a result of delay in payments: 1) disturbed drug availability, 2) decreased performance of doctors, 3) poorer maintenance of medical equipment.

Conclusion: Delayed in claim payments were occurred and led to a threat of decreasing quality of care to patients. The study suggests the government should fix the problems to protect patients from decreasing quality of care. Hospitals should provide reserve funds to protect them from financial hardship when delays occur.

Keywords: Claim management, hospital cash flow, national health insurance

INTRODUCTION

Since January 1st, 2014 the National Health Insurance Scheme (known as JKN, *Jaminan Kesehatan Nasional*) was established in Indonesia to achieve Universal Health Coverage (UHC) by 2019. This scheme is managed by the National Health Insurance Corporation (BPJS Health) [1]. The Law Number

40 Year 2004 and Law Number 24 Year 2011 prescribe a single payer compulsory social health insurance nationwide to ensure equity in financing and delivery of health care.

Based on BPJS data, the number of people enrolled into JKN has been growing from 132 million in the end of 2014 to 193 million (73% of the total population) by February 2018. The remaining population about 64 million people is expected to enrol by 2019. People who have enrolled and pay contribution, must chose a gate keeper (general practitioner) to get health care for 155 medical conditions defined as primary health care competencies [2]. When the primary care doctors encounter health conditions beyond those 155 conditions, the members is referred to hospitals (secondary health care providers). By February 2018; 21,843 public and private primary care providers have signed contract with BPJS. When the primary care providers are unable to take care of the medical conditions, then the primary care providers should refer the patient to hospitals. Direct or self-referrals are not covered. To date, 2,104 public and private hospitals have signed contract with the BPJS.

The number of private hospitals signing with BPJS indicated that access to hospital services are expanding along with the increasing number of membership. In the last four years, the total numbers of JKN patients in all contracted hospitals (outpatients and inpatients) have grown from 21.3 million outpatient's referral (RJTL) in 2014 to 64.43 million outpatients in 2017. The number of inpatients submitted by all hospitals grew from 4,2 million in 2014 to 8.72 million in 2017.

To ensure efficiency of the JKN, all primary care providers are paid on monthly capitation covering doctor consultation, simple laboratory, and all medicines for acute conditions. Drugs for chronic conditions are reimbursed separately. Outpatients and inpatients care in public and private hospitals are paid based on predetermined diagnosis and casemix medical conditions, called the Indonesian Casemix Based Groups (Ina-CBGs). This prospective payment induces many changes to the health system in Indonesia, such as financing management, health service management, information management, cross-sector coordination, and others [3]. The CBG payment is clustering diagnoses and procedures that have similar clinical characteristics and/or uses of similar resources grouped into three different severity levels of medical conditions [4]. The CBG payment put all hospitals under a budget constrain in treating a patient and certainly this payment put hospitals under pressure to conduct cost containment [5]. This payment mechanism also forces doctors to work in team to ensure efficiency in order to generate a surplus by hospital [5]. After four years of the implementation of the JKN, massive changes in hospital and medical managements have been observed.

Changes in claims payment systems to hospitals that were originally Fee for Services (FFS) to Casemix Based Groups (CBGs) certainly demanded a change in hospital's claim management [6]. Under the CBGs, hospitals must submit claims online to BPJS Health maximum on the 10th of the following month using the application provided by Ministry of Health. The BPJS's verified the claim and paid when the each individual claims were valid. In accordance with the Law, BPJS Health is obliged to pay hospitals within 15 days after clean claims are submitted. This policy aims at ensuring hospitals maintain good cash flow to ensure health care is delivered timely to patients. Based on BPJS Health data, in the first year of implementation (2014), BPJS Health can finish N-1 claim of 100%.

However, in recent years there has been delays in payments and in submitting claims due to internal factors of the hospitals and BPJS Health [7–9]. One of the hospitals in northern Sumatra was forced to terminate the contract with BPJS Health due to constrained in inadequate claims management personnel resulting in delayed submission of claims to BPJS Health [10]. In addition, Al Ihsan Hospital in West Java threatened can't treat patients timely due to financial problems that caused by delayed payment. The hospital still survives by relying on the capital reserves it still has [11].

Research by Atinga et al shows that pending claims in National Health Coverage is due to: 1) Technological systems that still use manual system so that have average claim processing time around 2-4 weeks; 2) The limited number of qualified staff in claim management; 3) Bad medical records both

in terms of writing and filling so that the coding officer takes more time to understand; 4) Non-conformance between diagnosis and action/therapy; 5) Provision of health services to patients who are already inactive insurance participants [12]. Cases of late payments certainly affect liquidity of hospitals and cause the hospital cash flows in jeopardy, the hospitals may not be able to purchase drugs and medical supplies if the hospitals having cash flow problems [13]. The longer period of claims submission to BPJS can cause negative hospital cash flow. This study aims to identifying current practices in timely payment to hospitals and finding factors correlate with delay in payments.

METHODS

This study used a trend analysis using secondary data available at the commission of monitoring of the National Social Security Council (DJSN). The DJSN receives monthly reports by the BPJS showing the total numbers of claims submitted by all hospitals to BPJS regions and the total numbers of claimed verified and paid by the BPJS. The study population was all hospitals who have signed contract with the BPJS from February 2017 to February 2018. Overtime the number of hospitals change due to new contract and termination of existing contract. Claims of all patients treated in contracted hospitals were submitted by the hospitals to regional office of the BPJS in a bundle of claims dated when the BPJS received the claims. During the period of the study, there were 57,475 bundles of claims submitted to the BPJS. The BPJS's verified the claim and paid when each claims were valid. The duration of claim submitted by the hospitals and the actual transfer fund to the hospital account by the BPJS then categorized by monthly differences. For example, for a patient discharged in June 1st, hospital can submit the claims early next month (July 1st). If the claims are accompanied by complete data, no later than 15 days after it is filed, BPJS have to transfer fund to the hospital account. This is categorized as N-1. On the other hands, if hospitals submit or complete these claims in August then it categorized as N-2. Unfortunately, the initial records (2014-2016) were not proper, very few records showing number of month of payment delays. So we decided to focus in 2017-2018.

The study was conducted in April 2018 as an effort to predict possible hospital cash flow problems. All claim data reported by the BPJS during that period were included in this study. To understand the reason for the delays in claim submissions and threat to hospital cash flows, qualitative information was collected via in-depth interviews with 6 informants consisting of 2 members of National Social Security Council (1 health expert and 1 financial expert), 3 hospital directors (1 class A hospital, 1 class B hospital, and 1 class C hospital) and 1 representative of BPJS Health (claim examiner). Selection of informants to be interviewed conducted in nonprobability with purposive sampling, the technique of sampling the source data with certain considerations. The principles used as consideration in the selection of research informants is that person are engaged with the topic of the study that will allow researchers to explore the object / situation under study.

RESULTS

Condition of Claim Submission

Changes in payment mechanisms to hospitals into prospective payments with the INA CBGs system require hospitals to make improvements in claims management. Claim management is a process since the claim is received at the BPJS Health branch office until the claim is verified, recorded, and paid. During the duration of the study; the BPJS Health complete on average 4.421 bundles of claims consist of hundreds of individual claims per month. These bundles of claims were differentiated based on patient discharged into N-1, N-2, and more than N-2 claims.

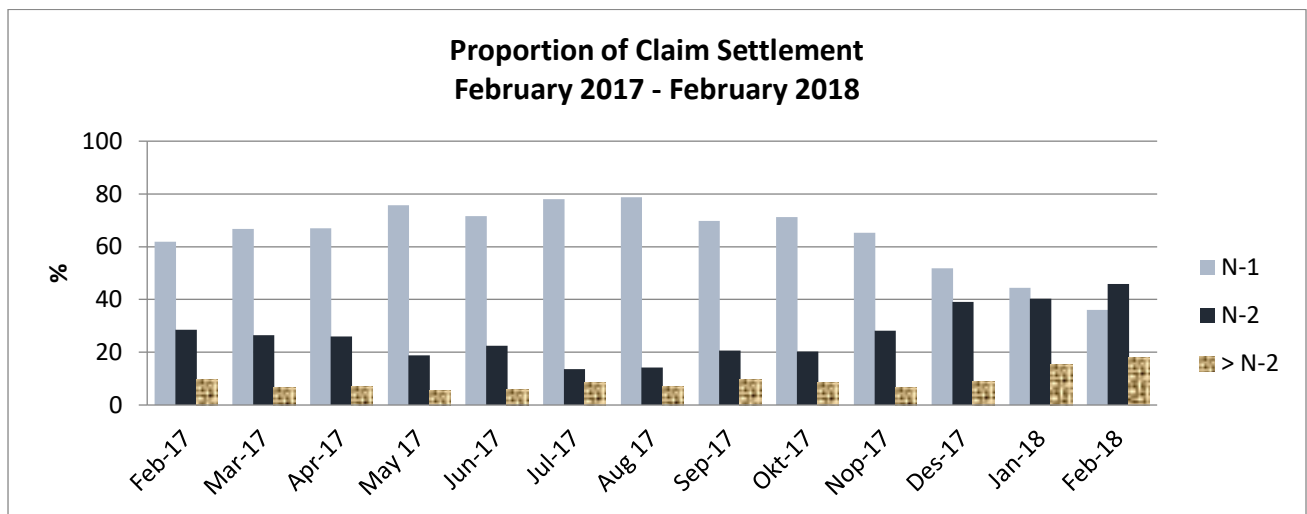


Figure 3. Proportion of Claim Settlement

To appraise how good claim management by hospitals BPJS, this study analyzed the trend of claim settlements across the study period as shown in Figure 3. This figure show there was tendency of delays in claim settlement indicated as increasing the proportion of N-2 and more than N-2 of claim, starting from November 2017. At the beginning of the study period, 61% claim was in the N-1 category but at the end of study period, this proportion dropped to only 36%. On the other hand, the N-2 claim increased from 28% in February 2017 to 46% in February 2018. Since November 2017 there was a significant change in claim settlements with declining N-1 claims sharply and increasing proportion of N-2 claims and more than N-2 claims settlements. This study found the average proportion of N-1 claims was 60%.

Causes of Delays in Claim Payment

From in-depth interview, it was found that the cause of the delay in claims can be derived from internal factors of the hospital "Non-compliance of some doctors to fill the medical record becomes an obstacle for the hospital to apply claim to BPJS ..." (I3), "inadequate of management information system makes claim processing longer..." (I4), "the number and competence of administrative personnel is not proportional to the number of claims charged ..." (I5), "the understanding of coding by each coder is different..." (I6).

However, the delay in payment of claims is not only caused by internal hospital, but also internal factors BPJS "BPJS financial condition that experienced deficit in last 4 years caused a tendency to delay the payment of claims to the hospital ..." (I1).

Hospital Management Condition

The delay in claims payment indirectly affects the quality of service in hospitals "hospitals can't place drug reservations and lack of medical equipment maintenance costs..." (I5). In fact, almost all hospitals that experienced late payment claims resulted in late payment of doctor's salary "medical doctor's salary has been delayed for 3 months..." (I4). This delay also caused patient care to be halted "one of the hospitals in Yogyakarta is threatened to close due to unpaid claims..." (I2).

Hospital Financial Condition

It is certain that the cash flow conditions in hospitals are also affected by the late payment of the claim "if it happens continuously then the hospital will certainly bankrupt" (I3). In order to overcome the disruption of cash flow the hospital did some ways "to overcome the financial problems the hospital has to ask loans from bank..." (I4). Government anticipatory steps need to be taken to prevent the cessation of hospital operations "it needs certainty of payment to the hospital so that the service that patient get can be well..." (I2)

DISCUSSION

Cause of Delays in Claim Payment

According to HIAA (Health Insurance Association of America) in Ilyas (2006) claims settlement encompasses collecting evidences or facts related to the incidences of services, comparing with the provisions of the policy and the benefits payable by an insurer. Several aspects are needed to make a claim is settled: a) the existence of two parties who are bonded by an agreement, b) clear rights and obligation of the two parties, c) informed consent, and d) documented evidences [14]. In the JKN scheme, those aspects are fulfilled in the contract between BPJS and each hospitals. Procedures and required documents are also written in the contract. Ideally all claims (100%) are categorized into N-1 to ensure the hospitals having healthy financial liquidity. In practice, claim settlements often face obstacles that made delays in settling the claims frequently occurred. This study found at the national level, the average of N-1 claims was only 60%. This number indicates that there is a delays in claim payment. Based on in-depth interviews with informants it is known that the cause of such delay could come from the hospital such as: medical compliance to fill the medical record, insufficient competencies of coder, inadequate number of claim administrator, and inadequate management information system. Many of hospital directors also confessed that their ability to manage claims timely needs improvements.

These results are in line with the research undertaken by Noviatry (2016) found the following factors: quality of verifiers, discipline of doctors, coding officers, inefficient information systems of hospitals, the implementation of clinical pathway to which doctors should adhere with clinical standards may also contribute to disputes and delays of claims processing [7]. Similarly, Pradani (2017) found five root causes of the delay of claim verifications, which were: (1) the physicians did not fill in medical records completely, (2) no regular feedback from claim managements to doctors, (3) lack of standard operating procedures on returning verification, (4) inadequate rewards and punishments for the claim administration unit, and (5) the absence of a system bridging on the current electronic medical record and claim processing to the BPJS [8].

The study showed declining proportion of N-1 claim during November 2017 - February 2018, this proportion dropped to only 36% in the end of February 2018. This decrease in proportion is in line with changes in claims mechanism applied by BPJS Health. Since October 2016, BPJS Health has made changes in the process of filing claims into digital verification claims intended to improve hospital satisfaction with claims administration process. Starting the implementation at 216 hospitals in October 2017, 583 hospitals in November 2017, 1,236 in December 2017, 1,528 hospitals in January 2018, and 1,745 hospitals in February 2018 [15]. Although, this change in claim administration aims at more accurate and faster reimbursement, the transition period might take some costs of delay in claim settlements.

In addition, financial condition of BPJS also correlated with delays in claim payment based on in-depth interview. Since the implementation of JKN, BPJS Health always faced with financial problems due to the imbalance between the amount of contributions and benefits provided. In almost five years of implementation of JKN, BPJS Health experienced deficit respectively [16].

Threat to Hospitals Management and Cash Flow

From in-depth interview with informants, it was found that there were three main problems faced by hospital management as a result of the late payment of claims: 1) disturbed in drug availability, 2) decreased performance of doctors due to delayed payment of medical services, 3) inadequate quality of services from infrastructure side due to lack of maintenance costs. These findings are similar to study in Ghana. The National Health Insurance (NHIS) in Ghana, which took place since 2001, also faces many obstacles in its implementation. Several issues in hospital management since the implementation of NHIS in Ghana include: late payment of claims from the insurance agency that affects hospital cash flow, drug procurement and medical consumables, inadequate logistics and human resources, limited

space in hospitals not proportional to the increase in the number of patients, as well as the moral hazard by the members [17]. The delay payment caused hospitals being unable to purchase and procure drugs and other supplies that affect the delivery of those goods from vendors, as also found by McCue in the US (1991) [13].

As the result, the Indonesia Association of Hospitals (PERSI) filed complaint to the DJSN for delay of payments in 164 hospitals, totalling up to IDR 3 Trillions. Certainly, for private hospitals that must pay salary monthly, the delays created serious cash flow problems. The managements of hospitals need to anticipate their financial consequences. Corbett (2005) recommend seven measurements to be considered in assessing financial conditions, namely: (1) financial strength index, (2) modified Z score, (3) operating cash flow ratio, (4) funds flow coverage ratio, (5) cash interest coverage ratio, (6) cash flow to total debt ratio, and (7) total free cash flow ratio [18]. The ratios can be used by hospital directors to provide early warning when financial conditions are in doubt.

To ensure hospitals are always solvent and the cash flows run smoothly to ensure timely treatment, the JKN requires the BPJS to pay claim within 15 working days of the claim submission. However, in reality, many hospitals are not ready to process claims timely. The rapid expansion of JKN membership has demanded hospital directors to change their management. Based on in-depth interview note that more than 80% of private hospitals patients are JKN members. This condition, create the hospitals in high risk, if the managements are unable to process claims timely. Although the BPJS have settled clean claims within 15 working days, the claim submissions and verifications of claims ended up many hospitals did not get claims within one month after the patient discharged.

CONCLUSION

The study found decreasing on schedule (N-1 claim) and increasing beyond schedule (N-2 and >N-2) claim settlements. There were several factor related to delayed in claim payments to hospitals were occurred and led to a threat of decreasing quality of care to patients. Modifiable factors causing delays were identified. The study suggests the government should fix the problems to protect patients from decreasing quality of care. Hospitals should provide reserve funds to protect them from financial hardship when delays occur.

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