Anubhav Sadas

Cross Learning Workshop

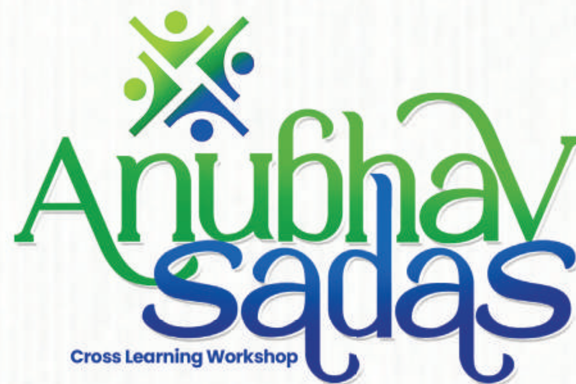
CROSS-LEARNING WORKSHOP

REPORT

31st May 2023

Organized By
State Health Agency, Kerala
@ Ktdc Mascot Hotel,
Thiruvananthapuram

ENTRY
EXIT



ABOUT ANUBHAV SADAS

The world's largest health insurance scheme Pradhan Mantri Jan Arogya Yojana (PM-JAY), is being implemented in various states of India in convergence with State-specific health insurance schemes. Over the year, the States have faced various challenges in implementing the scheme, and many have come up with innovative solutions to overcome these specific challenges and mitigate risk. Now that the PM-JAY has completed four years, States have gained enough experience–sharing which will fast-track implementation and reduce the time taken to reinvent the wheel.

In this context, SHA Kerala organised a workshop inviting subject-matter experts and PM-JAY states to share their experiences and knowledge. The workshop is an effort to foster the practice of cooperation between States by sharing knowledge and strengthening the implementation of government-sponsored health insurance schemes moving to Universal Health Coverage (UHC).

OBJECTIVES

Understand the experience of various States in implementing PM-JAY under different modes & claim adjudication methods.

Discuss efficient methods of strategic purchasing of services from private providers & strengthening public hospitals Identify scalable best practices adopted by states for better implementation of the scheme

KEY THEMATIC AREAS & POLICY QUESTIONS

Since the scheme's inception, different States have followed different modes of implementation--often switching between them–, observing various methods of claim adjudication, and adopting multiple strategies in purchasing health services from providers. The thematic area-wise deliberation points are described below:

1

Modes of Implementation: Discussions were held on choosing the right model for scheme implementation. Which model is more appropriate, efficient and better among the currently followed implementation mode–i.e. Insurance, Trust, and Hybrid modes. Attempts were also made to understand the necessary preparedness for the transition from one mode to another. States following different implementation modes were invited to share their experience.

2

Claim Adjudication: Learnings and challenges with the ISA-led model vs in-house claim adjudication were deliberated upon to draw insights on developing strategies to improve the efficiency and quality of claim adjudication. The adoption of Artifical Intelligence /Machine Learning (AI/ML) tools for claim adjudication were also discussed, along with the need to upgrade technology to ensure quality and efficiency.

3

Strategic Purchasing of Care from Private Providers & Strengthening Public Hospitals: PM-JAY/State schemes purchase services from private and public providers for their beneficiaries. While purchasing, the States must ensure the quality and pricing of the services procured from the providers. Procurement strategies may vary from State to State based on its health system's ability and priorities. Hence, measures adopted to ensure the efficiency and quality of services provided, how services should be procured, and States' experience in buying services were discussed.

4

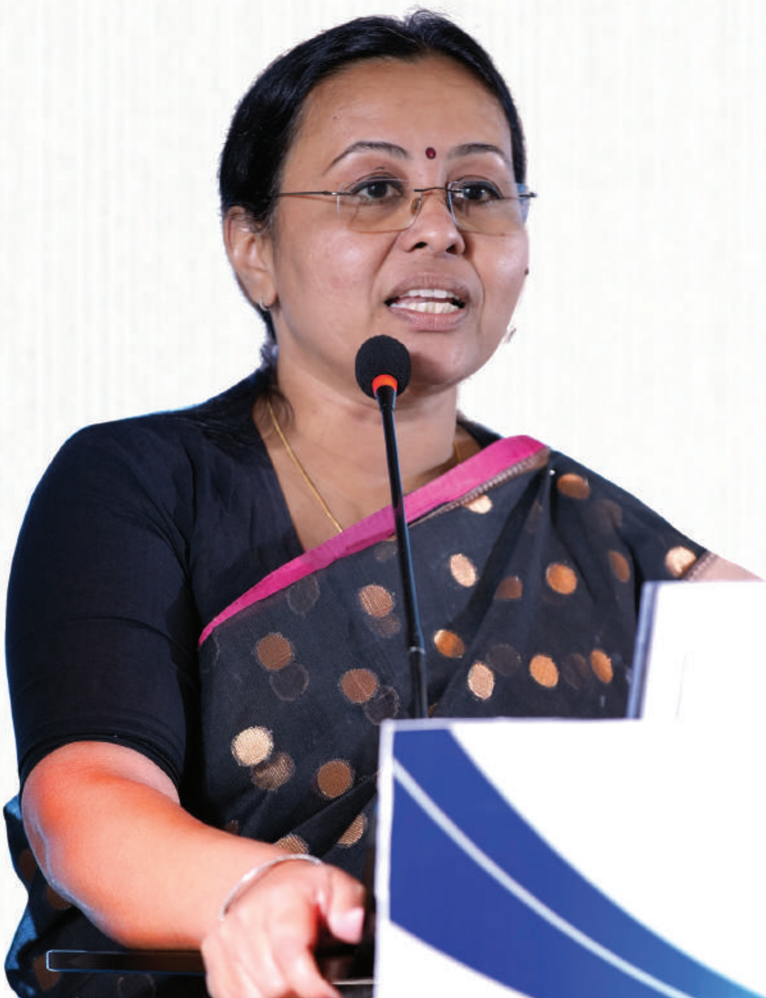
Strengthening public hospitals was also an essential component of the discussions. Strategies adopted to strengthen public hospitals and best practices followed by hospitals that can be replicated were also on the agenda.

OUTCOMES

Through the course of the workshop, SHAs shared their best practices and experiences. Discussions were held on strategic purchasing of healthcare services by adopting various practices such as reserving packages for public institutions, cutting costs through differential package rates, provider empanelment based on stringent quality criteria, adopting new payment mechanisms such as DRG, and linking performance with the outcome.

Choosing the right mode of implementation by the states is based on the context and dynamics. However, the discussions indicated that the transition from one mode to another should be considered carefully in a phased manner by strengthening the institutional capacity of SHAs. Similarly, SHAs should have a strong institutional capacity to manage the claims irrespective of the ISA model or in-house claim adjudication process.

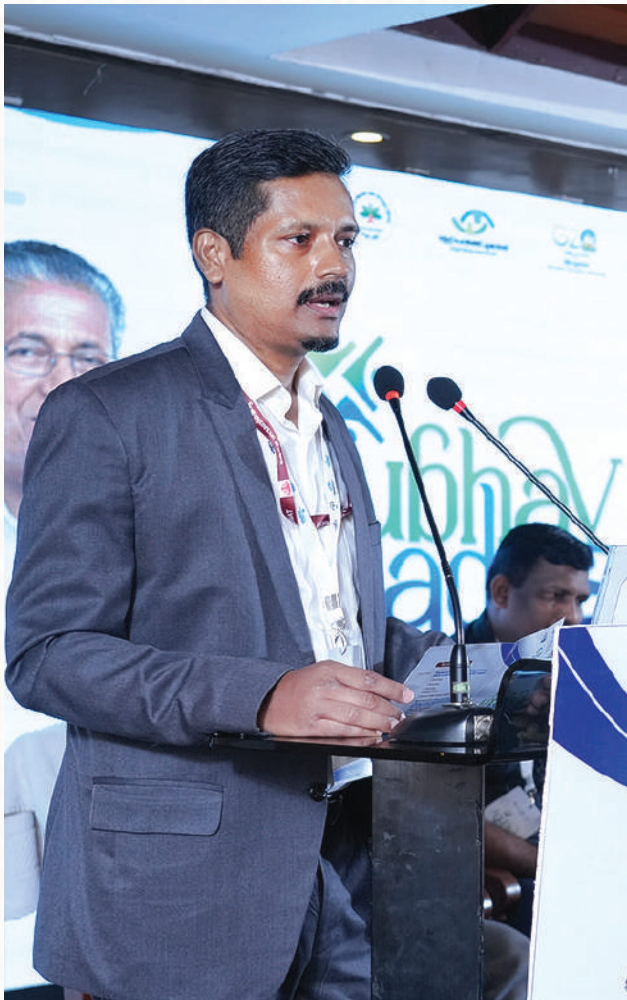
KERALA'S JOURNEY OF **IMPLEMENTING PM-JAY KASP**

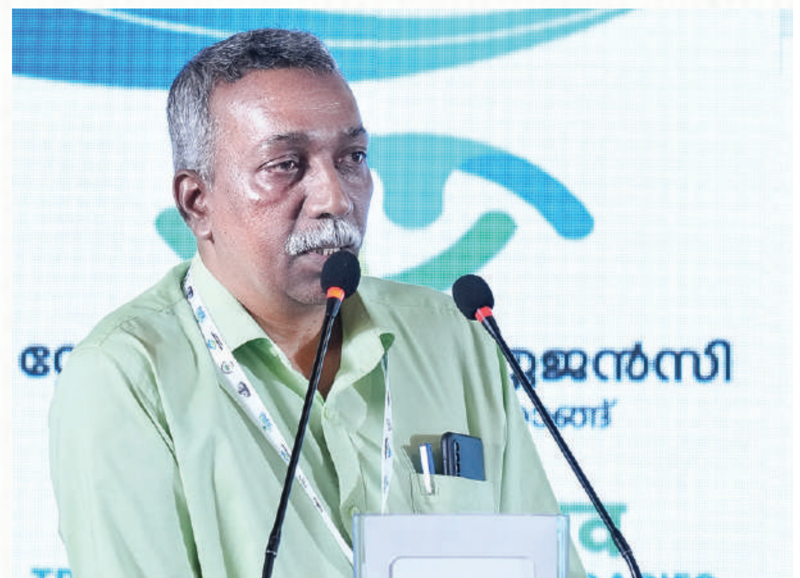


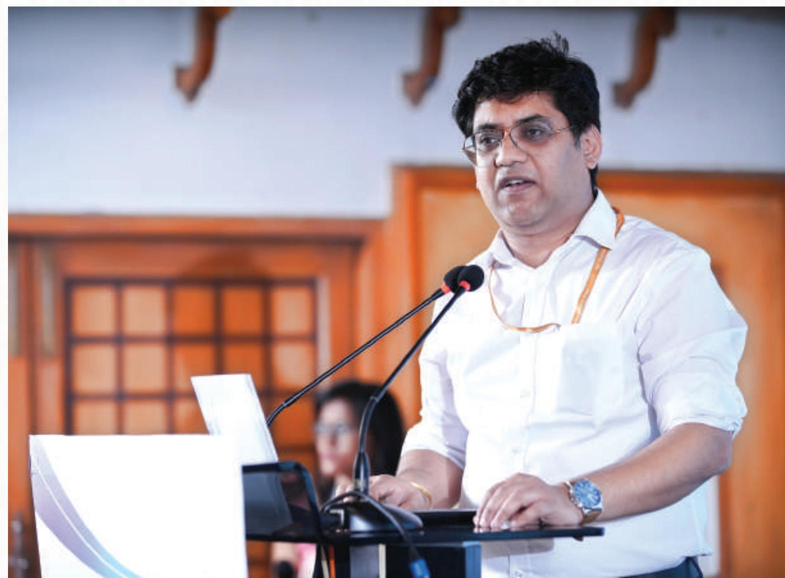
Kerala had been implementing publicly-funded insurance programmes since 2008. The existing State & Central Schemes converged in 2019 forming Pradhan Mantri Jan Arogya Yojana (PM-JAY) Karunya Arogya Suraksha Padhathi (KASP). Kerala has completed 100% beneficiary family verification and currently covers 42 lakh beneficiary families. The programme now has a network of 612 empanelled hospitals that includes 201 public and 411 private facilities. Karunya Benevolent Fund (KBF) and Arogya Kiranam (AK) schemes being implemented by the Department of Finance and Department of Health respectively were converged with KASP. Further, a few other schemes namely Talolam, Cancer Suraksha, and Sruthitharangam being implemented by State Social Security Mission are in the process of being converged with KASP. Over 20 lakh beneficiaries have availed of free treatments worth more than 4600Cr since 2019.

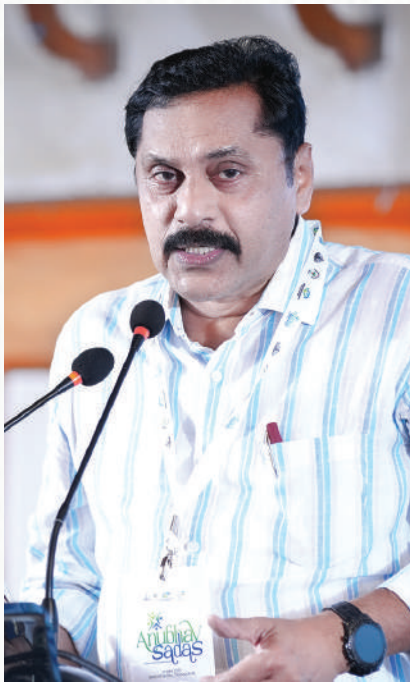
In 2020, the programme transitioned from insurance mode to trust mode. This change has led to an increased supply of care (the number of empanelled private hospitals rose from 216 to 411), brought down administrative costs to INR 4 crore for Third-Party Administrator (TPA) towards claim adjudication against an estimated INR 100 crore during the insurance period, ease in convergence and pandemic management, improved quality of service due to reduced friction at facilities because of reduced claim rejection, and finally flexible financial management for the Government.

During the transition period from insurance to trust mode, SHA experimented with claim adjudication with the help of National Health Mission (NHM)doctors. But this resulted in backlogs since the volume stood at over 4,000 claims per day. An internal evaluation of the adjudication process revealed that irrespective of the adjudication team, strengthening the monitoring mechanism through data analysis is necessary to








Anubhav
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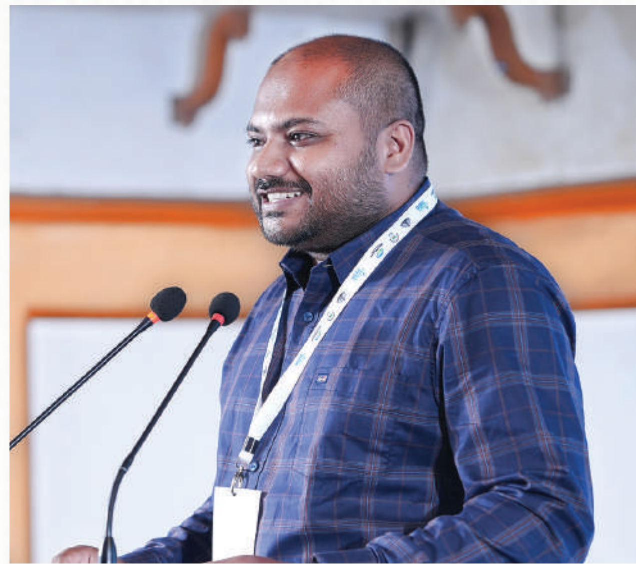
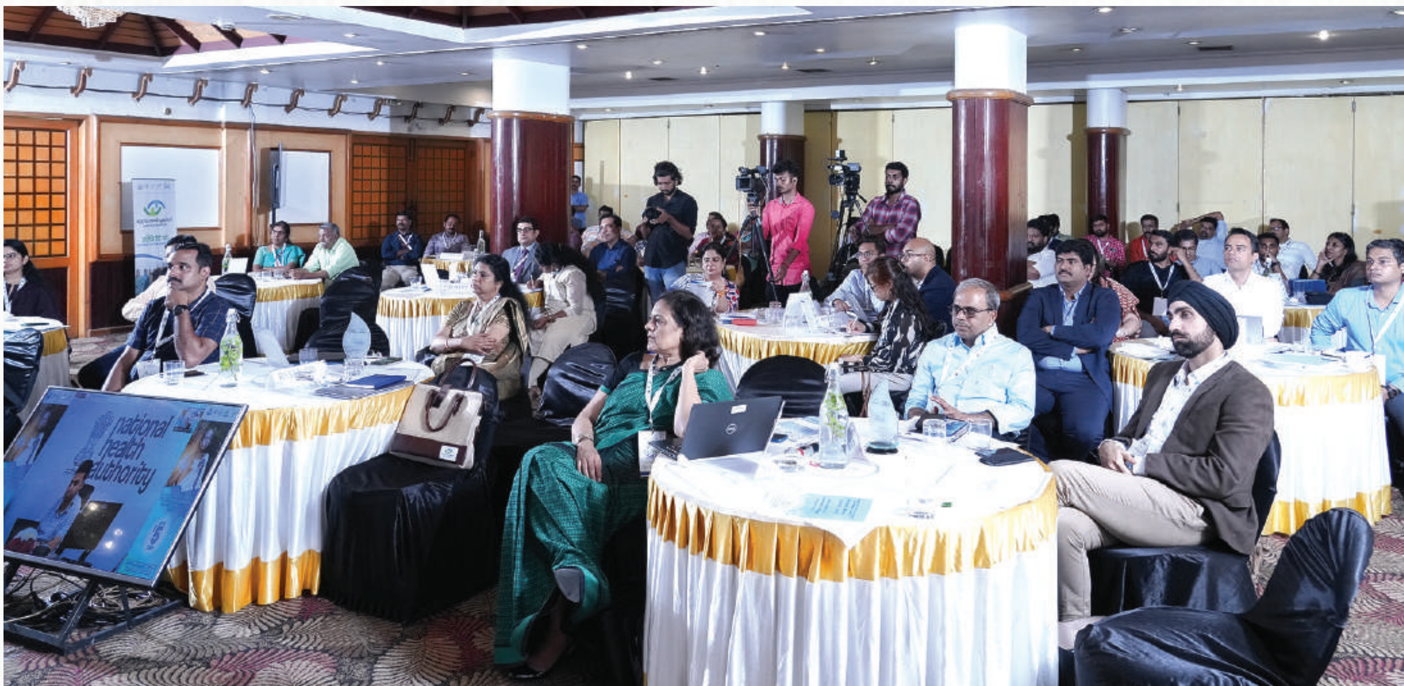
ensure the quality of adjudication. Further, leveraging technology for targeted adjudication can add more value to the process. The evaluation also found that adjudication staffing needs to be rationalised based on quality and value.

The State Health Agency has adopted innovative practices like disability-friendly IEC materials like the Braille-enabled PM-JAY cards, scheme brochures in Braille language, and awareness video in sign language in a bid to ensure that all beneficiaries are made aware of the benefits PM-JAY KASP holds for them. □





SESSION# 1
STATE PRESENTATION

State Experiences in Strategic Purchasing of Care from Private Providers and Strengthening of Public Providers

State
TAMIL NADU

Representative
Dr Sherene S.

Designation
Medical Officer

Implementing Agency
Tamil Nadu Health Systems Project (TNHSP)

State Scheme
Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS)

STATE BRIEF:

Tamil Nadu has been implementing a state health insurance scheme for 14 years, which was integrated with PM-JAY in 2018. Approximately 1.43 crore families are covered under the scheme, with enrolment kiosks in every district. For the last four years, the scheme has been implemented in a hybrid mode–transitioning from insurance mode. The State follows Health Benefits Package (HBP) version 1.0 with a total of 1513 packages covered and 1776 providers empanelled. In FY 2022-23, 9.11 lakh hospitalizations were reported, which comes to 2,500 per day.

BEST PRACTICES

- 396 packages are reserved for public providers, as there is sufficient manpower and infrastructure available to cater the beneficiaries.
- Stringent guidelines for provider empanelment, featuring a scoring method with weightage given to infrastructure, human resources, critical care and speciality-wise infrastructure.
- Measures taken to control implant costs to get the best possible rate through a tendering process initiated by the State Health Agency.
- Intensive monitoring mechanism with medical audits and vigilance at the district level to ensure quality treatment without out of pocket expenditure (OOPE).

CHALLENGES SUBDUED

- Beneficiaries were not producing hard copies of the required documents during pre-auth.
- Provision developed for the hospital ward manager and/or the liaising officer to download e-cards only if the patient has a ration card/URN number.
- To avoid delay in preauthorization in case of an emergency, a unique number is provided from the call centre and in the meanwhile based on the documents provided by the provider, the treatment is initiated for the patient.

State
MEGHALAYA

Representative
Steven Remdor Bareh

Designation
State Manager

Representative
Stacey M Passah

Designation
Finance & Accounts Manager

Implementing Agency
State Nodal Agency

State Scheme
Megha Health Insurance Scheme (MHIS)

STATE BRIEF:

Meghalaya has been implementing a state health insurance scheme since 2009. Introduced as Megha Health Insurance Scheme (MHIS) 11 years ago, this scheme targets universal health coverage excluding government employees. This scheme was converged with PM-JAY in 2018, and currently covers 6.88 lakh families and follows Health Benefits Package version 2022 with 2,264 packages.All public (158) and private providers (17) in the state have been empaneled; 57% of claims are reported by public providers.

BEST PRACTICES

- INR 30,000 as an OPD benefit, in addition to the sum insured of INR 5 lakh to all beneficiaries for certain selected specialties and medical conditions.
- All public and private providers with a minimum of 10 beds in the state are empaneled with registration certificates.
- State guidelines implemented for public providers to utilize the claim fund that focuses on improving the quality of treatment by upgrading infrastructure and maintaining the facilities.

CHALLENGES SUBDUED

- Introduction of performance-based incentives to keep the public provider's motivation high; it was acknowledged that there was a lack of ownership among the public provider's staff members.
- Deployment of a Block Accountant by the State Nodal Agency to address a few providers within the block to cater to the need for financial reports and maintenance of records. The salary of the block accountant is pooled in from the empaneled healthcare providers in the block.

State
KARNATAKA

Representative
Dr Suresh Shastri

Designation
Director,
Medical Management

Implementing Agency
Suvarna Arogya
Suraksha Trust (SAST)

State Scheme
Arogya Karnataka

STATE BRIEF:

Karnataka has experience in implementing multiple health insurance schemes. The State launched Arogya Karnataka in 2018 to bring in universal health coverage along with various schemes such as organ transplants, rare and high-cost diseases, cochlear implants etc. The scheme covers 1.15 crore families has empaneled 3,467 public and private healthcare providers. The state follows Health Benefits Package version 1.0 with a total of 1650 packages and is in the process of adopting Health Benefits Package 2022. In FY 2022-23, the average claim amount ranged between INR 3,000 to INR 39,000- simple secondary to complicated tertiary care procedures.

BEST PRACTICES

- No separate process for the empanelment of private providers if they have a certificate issued by the Karnataka Private Medical Establishment
- Reserved 294 packages for public providers. Efforts are also made to avoid claim duplication for procedures covered under national programs such as Pradhan Mantri National Dialysis Programme (PMNDP for Hemodialysis.
- Mandatory referral from any public EHCP for 251 complex secondary and 934 tertiary care procedures. Patients are referred to private EHCPs only if public providers don't have the capacity to perform the procedure.
- Differential payment system for public empaneled healthcare providers, bifurcated as 50% payment for secondary care procedures, 75% for complex procedures, and 100% for cardiology. 93% of the claims are raised by public EHCPs.

CHALLENGES SUBDUED

- Hiring freelance Data Entry Operators increased the number of claims submitted by the Primary Health Centres; their salaries are processed through the corpus fund.
- Paved the way for a reliable and transparent system of patient referral from public to private EHCPs through an online portal.

State
MADHYA PRADESH

Representative
Divya Patel

Designation
Executive Officer, Admin

Implementing Agency
Deen Dayal Swasthya Suraksha Parishad

State Scheme
Ayushman Bharat 'Niramayam'

STATE BRIEF:

Madhya Pradesh has been implementing PM-JAY since scheme inception, covering 1.08 crore families through trust mode. The SHA has empaneled 992 healthcare providers, and it follows Health Benefits Package 2.0 featuring 919 packages--gearing up to adopt HBP 2022. Two TPAs and one Beneficiary Facilitation Agency has been hired by the State. A total of 191 packages have been reserved for public EHCPs. Moreover, the state has also undertaken the Swasthya Samvad initiative where the Hon' Health Minister interacts weekly with patients admitted in the hospital.

BEST PRACTICES

- State Health Innovation Unit (SHIU) established within the SHA to identify areas of innovation. It primarily supports the claims adjudication process.
- The SHA is currently developing an application which will help document all field audits such as that conducted by District Quality Assurance Committee, beneficiary audits, desk audits etc.

CHALLENGES SUBDUED

- Considering the challenges faced by medical specialists in reaching tribal areas of the state, a provision of higher incentives has been made for those specialists working in remote areas

Provider Name
Government Medical College, Kottayam, Kerala

Representative
Dr Jayakumar T. K.

Designation
Medical Superintendent and Professor and Head, Department of CTVS

BEST PRACTICES

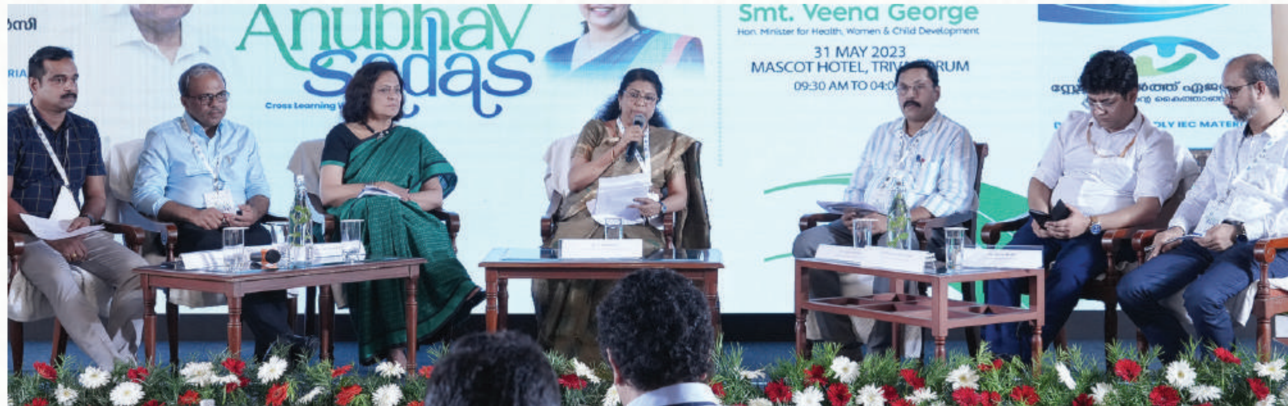
- Maintaining the quality of care for accreditation under LaQshya. It has also been awarded under the Mother-Baby Friendly Hospital Initiative. Currently, the medical college is in the process of NABH accreditation.
- Impactful interventions designed for high volume specialities such as CTVS, neurosurgery, interventional radiology etc. by utilizing claims funds, along with placing additional equipment and hiring manpower
- The medical college is supporting patient care through planned interventions, such as a new ward with trained staff for palliative care and cardiac rehabilitation, and strengthening emergency services with a Level I trauma care centre and stroke unit with a control room

CHALLENGES SUBDUED

- Created separate counters for high-volume specialities featuring trained manpower to mitigate claim management issues resulting from high pendency of queried cases and overcrowding.
- Appointed a public relations officer and set up a control room t to address patient complaints, grievances, and queries.

SESSION# 2
PANEL DISCUSSION

Strategic Purchasing from Private Providers and Opportunities and Challenges in Strengthening Public Providers



The panel discussion on "Strategic Purchasing in Selecting Providers and Opportunities and Challenges in Strengthening Public Providers" brought together policymakers, health financing experts, and healthcare professionals to discuss the importance of strategic purchasing in enhancing the scheme performance and understand the available opportunities and challenges to reinforce the public providers. Considering the services are purchased from the private sector because of the non-availability of services, infrastructure, human resources etc in the public sector, the context for the panel was set by highlighting a few key questions: what services should be purchased, where should they be purchased from, and at what cost and quality keeping both the providers and beneficiaries into consideration? Along with debating this, the session also identified opportunities and challenges at the level of public providers.

MODERATOR:
Dr P. K. Jameela,
Expert Member, State Planning Board,
Government of Kerala

Dr Pankaj Arora,
Director, Hospital Policy & Quality Assurance and Service Provider Engagement,
National Health Authority

Dr Thomas Mathew,
Director of Medical Education,
Government of Kerala

Ms Sheena Chhabra,
Senior Health Specialist, Health, Nutrition & Population Global Practice, World Bank

Dr Jayakumar T. K.
Medical Superintendent & Professor and Head, Department of CTVS, Government Medical College, Kottayam, Kerala

Dr Bijoy E.
Joint Director, Operations, State Health Agency,
Kerala

Dr Anvar Mohammed Ali
Director and Chief Operating Officer, Crescent Medical Centre, Palakkad, Kerala General Secretary, Kerala Private Hospitals Association

KEY DISCUSSION POINTS

Purchasing of Services:

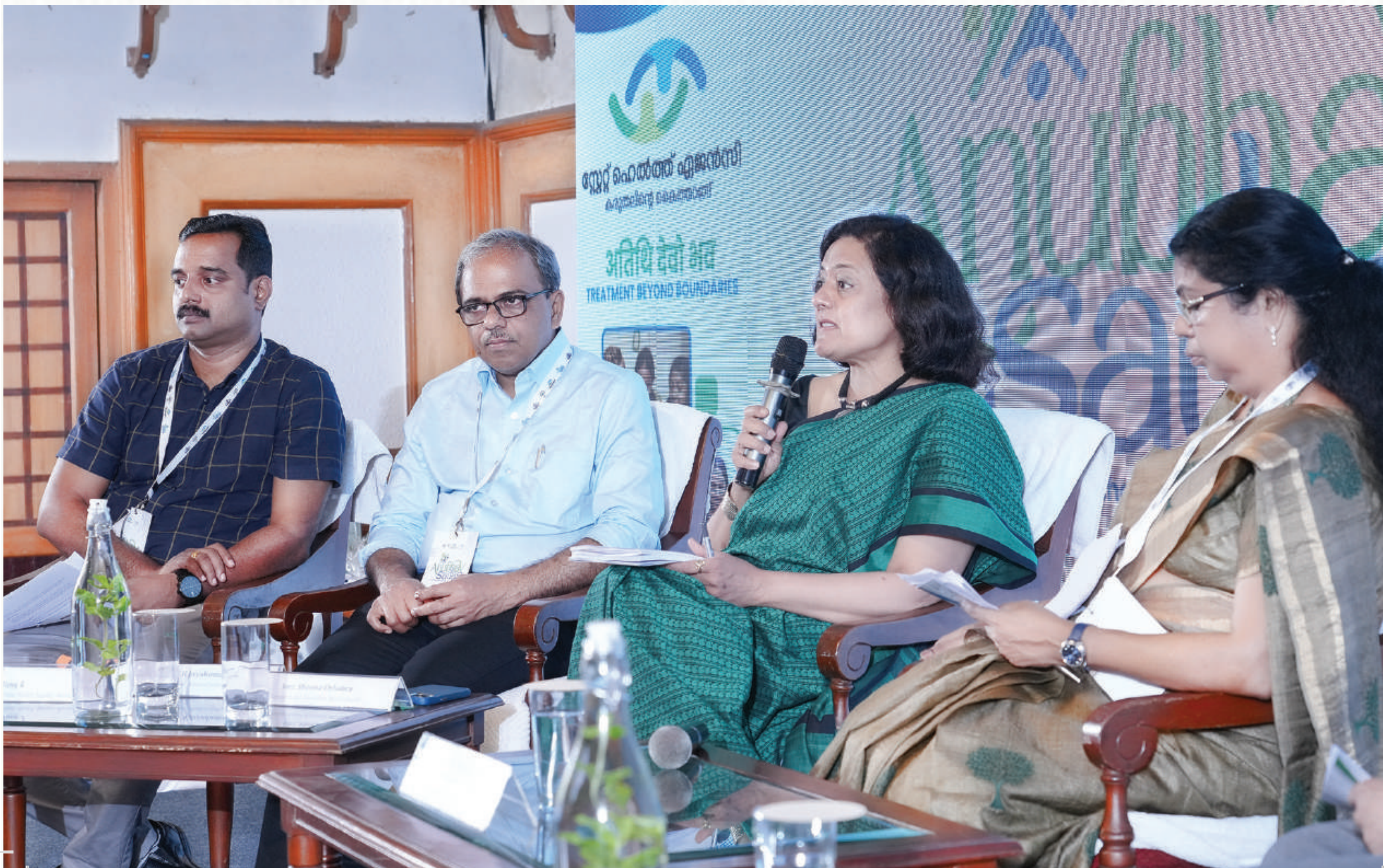
The Government of India laid down the National Health Policy in 2017 to strengthen the public sector and purchase services from the private sector for those in need. It also laid down the criteria for empanelment for private providers, basis the speciality offered and quality of services delivered. For the procurement of drugs, implants and other consumables, there are three main sources for public providers i.e., Government e-Marketplace (GeM), Amrit Pharmacy, and Jan Aushadhi—with the latter two being open to the private sector as well. Next was the fee-for-service model i.e., CGHS and other such schemes; but now with a case-based payment method under PM-JAY, purchasing has become easier. In the future, implementation of Diagnosis-Related Group (DRG) based reimbursements is also likely to yield good results.

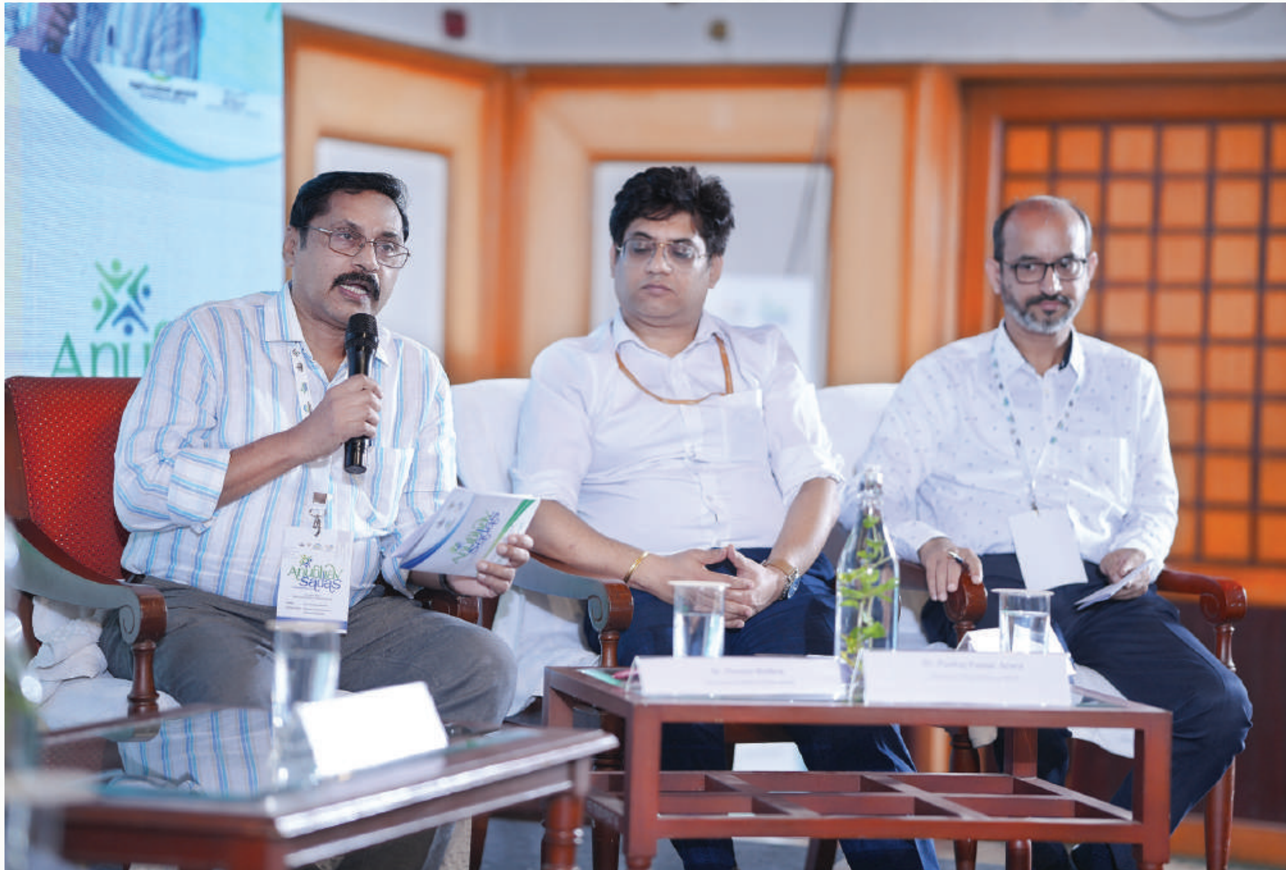
Public Sector Capabilities and Challenges

Healthcare services in the public sector have been established from the grassroot to the top-- i.e., primary, secondary and tertiary levels. Well-trained human resources starting from ASHA workers to the Junior Public Health Nurses (JPNHs) are the driving force in the implementation of various programs in the field. At the state level, good governance and political will are key, along with the regular monitoring and process evaluations of health programs. rewrite - There are challenges, such as delays from the administration side, out-of-pocket expenses and lack of forward and backward referral systems at the secondary level due to which two-thirds of the cases are reported at the tertiary level.

Redesigning Payment Mechanisms

Moving on from a case-based payment system which has a flat rate irrespective of any conditions and co-morbidities, the need of the hour is to explore alternative payment systems such as DRGs. Considering the implementation of DRG in some states, ICD-10, active engagement from participating providers, capacity building, and accuracy and completeness in documentation is required for





capturing data. Creating provisions for incentives for the participating providers to capture the diagnosis data will help in the classification of diseases. Before considering it as an alternative payment mechanism, however, DRG needs to be looked at carefully both in terms of implementation capacity and the challenges associated with the system.

Private Sector Participation

In India, currently private sector participation in terms of OPD cases is between 60% to 80%, which varies from state to state. For IPD cases, the number ranges between 50% and 60%. The private sector is quite varied in terms of the infrastructure and level of care compared to the public sector, as the availability of specialist doctors for specific/high-end procedures are mostly available. The government is depending on both the public and private sectors to cater for the needs of citizens. Recently, the public health sector has worked on infrastructure development but is still overburdened, with government doctors seeing more than 100 OPD patients in a day in many cases. Hence, some models that have already been implemented in a few states can be explored—such as differential packages, unrestrictive or package-specific approaches or referral systems, based on current scenarios and which are in the best interest of the citizen and State.

Incentivization

Incentives should become a part of the pricing package rather than something given to private providers over and above. Many states, like Tamil Nadu and Jharkhand, have made it mandatory for private providers to get quality certification to get empanelled under PM-JAY. The essential factor for the success of PM-JAY and moving towards UHC is quality--hence incentives should be discontinued, with the primary agenda being quality treatment. The focus now needs to be performance-based incentives which are followed by many states such as Chhattisgarh, Karnataka, and Uttarakhand. However, provision of incentives should continue for aspirational districts and hilly areas, where it is difficult to reach. In the time to come, the focus will shift to value-based care, where the providers will be rated based on certain pre-defined parameters.

SESSION# 3
STATE PRESENTATION

State Experiences in Implementation Models

State
TAMIL NADU

Representative
Dr Chitra M.

Designation
Medical Officer

Implementing Agency
Tamil Nadu Health Systems Project (TNHSP)

State Scheme
Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS)

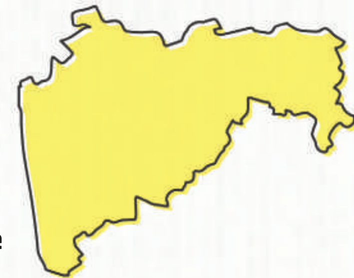
STATE BRIEF:

The Government of Tamil Nadu launched the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) for life-saving treatments in 2009 to ensure that poor and low-income population who cannot afford treatment can get free treatment in Government as well as private hospitals for serious ailments. In September 2018, the national flagship scheme PM-JAY was launched in integration with CMCHIS. The scheme is being implemented in hybrid mode (CMCHIS in insurance mode and PM-JAY in assurance mode), and currently it covers 1.43 crore families. The scheme is implemented by the Tamil Nadu Health Systems project through United India Insurance Company and three Third Party Administrators. HBP version 1.0 is being currently implemented in the state; mapping of HBP 2.0 is completed and awaiting approval from NHA for implementation.

The assurance mode covers coverage above INR 2 lakhs up to INR 5 lakhs. Also, the packages not covered in CMCHIS but covered in PM-JAY are paid through assurance mode.

BEST PRACTICES

- Periodic grievance redressal. Weekly grievance redressal committee meetings and monthly nodal officer review meetings are conducted.
- A strong audit mechanism is in place, including concurrent and retrospective audits, mortality audits, and call audits.
- To identify fraud, a strong software trigger is in place. Process-related triggers, beneficiary-related triggers, and hospitalization-related triggers are being developed.
- Quality assurance: Only NABH-accredited hospitals are empanelled. For implant and device procurement, US FDA or CDSCO approval is necessary.
- Rotation of field Personnel: Periodic rotation of DPO & district coordinators and transfer from one district to another.



State
MAHARASHTRA

Representative
Vinod Sheshrao Bondre

Designation
Deputy Chief Executive Officer

Implementing Agency
State Health Assurance Society (SHAS)

State Scheme
Mahatma Jyotiba Phule Jan Arogya Yojana

STATE BRIEF:

Maharashtra initiated the first phase of Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) on 2nd July 2012 in 8 districts. The Government then extended the scheme across the remaining 28 districts of Maharashtra from 21st November 2013, renaming it the Mahatma Jyotirao Phule Jan Aarogya Yojana (MJPJAY). Since 23rd September 2018, MJPJAY is being implemented in collaboration with AB PM-JAY, and around 2.22 crore families are covered under the schemes. The scheme is currently being implemented in hybrid mode, making the shift from insurance mode since the convergence with PM-JAY. Claims up to INR 1.50 lakh are paid by the insurance company and up to INR 5 lakh is borne by the trust. With the switch to hybrid mode, the average claim size was reduced from INR 23,000 to INR 22,000, claim TAT was reduced to 7 days from 10 days; however, claim rejection rate increased.

The hybrid mode is working well for Maharashtra as compared to the insurance model. The State is more focused on fraud control to bring down the incurred claim ratio. New packages are also proposed to reduce the out-of-pocket expenditure of the beneficiaries.

BEST PRACTICES

- The pre-auth and claim turnaround time (TAT) is below the national average. Pre-auth TAT is 3hrs versus the national average of 6.3 hours. TAT for claim payment is 7 days versus the national average of 55 days.
- Clinical Protocols of 1209 procedures have been finalized and uploaded on the website to date. Due to this, misuse of packages is avoided and hospitals can choose the appropriate treatment package.
- Fraud and abuse control: Continuous desk audits and surprise visits to network hospitals by the team of doctors from SHAs, insurance company, and TPAs.
- Letters issues to all beneficiaries who have availed treatment from the Chief Minister. Outbound calls to the beneficiaries to get feedback on the treatment availed.

State
CHHATTISGARH

Representative
Priyanka Lalwani

Designation
Senior Hospital Consultant

Implementing Agency
State Nodal Agency

State Scheme
Dr. Khoobchand Baghel Swasthya Sahayata Yojana (DKBSSY)

STATE BRIEF:

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) - Dr Khoobchand Baghel Swasthya Sahayata Yojana (DKBSSY) covering INR 5 Lakhs per year per family on a floater basis. The scheme is entitled to Priority as well as Antyodaya Ration Card Holder. APL families are eligible up to INR 50,000 per family annually. Mukhya Mantri Vishesh Swasthya Sahayata Yojana (MVSSY), the State Sponsored Scheme covers up to INR 20 Lakhs (including AB PM-JAY coverage) for Priority & Antyodaya Ration card holder and APL with relaxation. The scheme covers a 2.65 crore population and HBP 2.2 is being implemented with 2300 packages.

The state was implementing the scheme in insurance mode, later transitioning to hybrid mode and then to trust mode. Currently, the scheme is being implemented in trust mode with the help of an ISA. The reasons for a change of mode are a sense of ownership- accountability resting on the state though dependent on the insurance company, ownership conflict, and commercial and profit-oriented attitude of the insurance company against the assurance of financial protection. Insurance mode-smooth until burnout ratio of IC is reached. Problems like missing data, undue delay in payment, unexplained rejections, non-compliance with DGRC decisions arise at the end of every policy year etc.

BEST PRACTICES

- It was realized that the state still needs time for full assurance mode. To maintain transparency, separation of power and function is essential–with multiple entities handling multiple functions.
- Direct settlement of complaints and claims sometimes consumes a lot of time and energy- Gradually Online DGRC system is established.
- Implementation Support Agency capacity building is needed, and the State is aspiring to have in-house audits and keep field functions to be contracted out.

SESSION# 4
STATE PRESENTATION

State Experiences in Quality Adjudication of Claims

State
UTTAR PRADESH

Representative
Dr Ravi Kant Singh

Designation
General Manager, Operations

Implementing Agency
State Agency For Comprehensive Health and Integrated Services (SACHIS)

State Scheme
Mukhya Mantri Jan Arogya Abhaiyan

STATE BRIEF:

The state is implementing MMJAA in collaboration with AB PM-JAY. The scheme was launched on 23rd September 2018 in Uttar Pradesh and is implemented in trust mode with the help of ISAs. The scheme covers a total of 2.01 crore families and more than 20 lakh claims have been processed till date. Triple Layered Claim Processing System is followed in UP, and an external agency AVIGHNA conducts audits. Claim settlement TAT is 30 days and the average claim amount is INR 12,532; the rejection rate stands around 5%.

BEST PRACTICES

- Triple Layer Claim Adjudication Process. ISA -processed claims are verified by SHA medical auditors. Cases are verified based on internal triggers and field verifications are done. High-end claims sent to AVIGNA.
- The state conducts M Connect meetings on a monthly basis, which is a comprehensive knowledge sharing and monitoring platform for all stakeholders.
- Periodic audits are conducted by the State Health Team, DIU, and ISA teams. Penalties and recoveries are imposed in confirmed fraudulent practices.
- SEC meetings are conducted every month for quick action. Additional medical expertise is utilized for SAFU Cases in the State.

SESSION# 5
PANEL DISCUSSION

Implementation Modes and Quality Adjudication of Claims

MODERATOR:
Dr. Ratan Kelkar IAS,
Secretary, Electronic and IT and Medical Education, Government of Kerala, Executive Director, State Health Agency, Kerala

PANEL MEMBERS

Shri Rohit Deo Jha, IRS
Joint Director,
Scheme Policy, Co-ordination and IEC,
National Health Authority

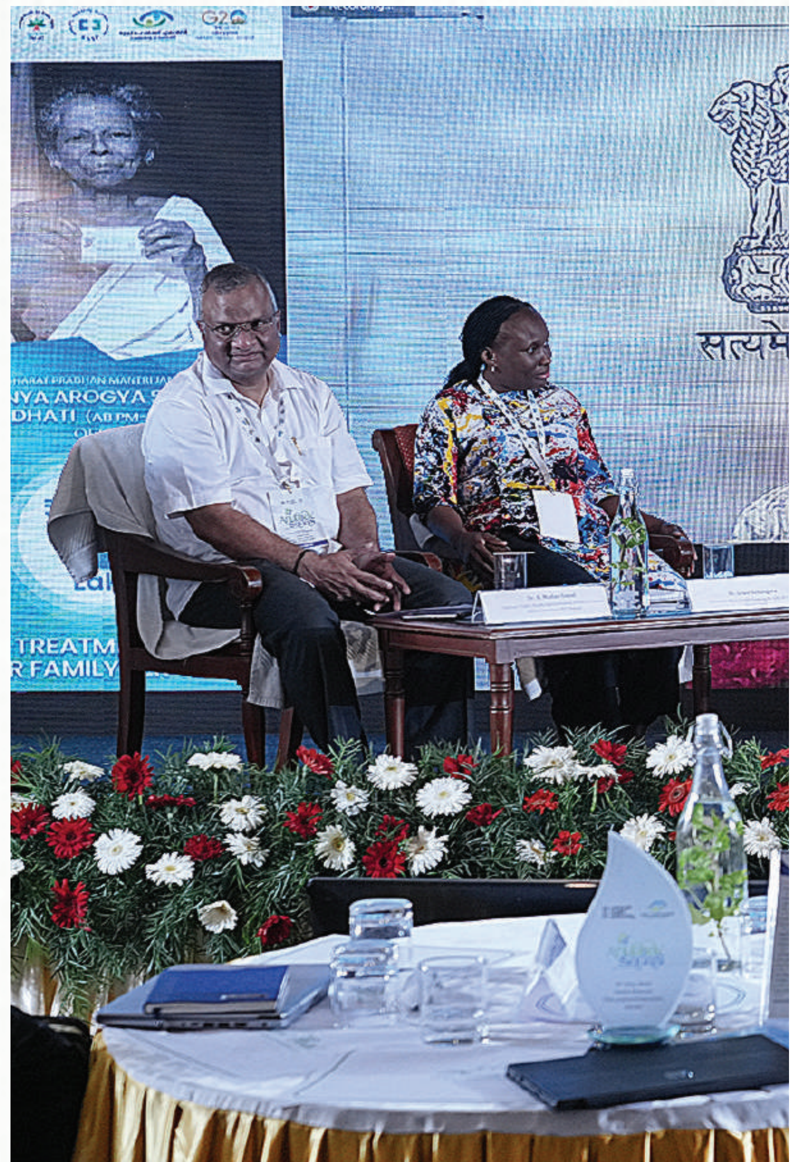
Dr Grace Achungura
Technical Officer
Health Financing for UHC-HCF,
World Health Organization

Dr K. Madan Gopal
Advisor-Public Health Administration, NHSRC & Former Senior Consultant, NITI Aayog

Dr Sudha Chandrashekar
Senior Consultant, World Bank

Dr Subodh Kandauthan
Professor and Director,
Administrative Staff College of India

The panel discussion on "Implementation Models and Quality Adjudication of Claims" brought together health financing experts, policymakers, and healthcare professionals to discuss the importance of selecting the right implementation model for demand-side health financing schemes and states' preparedness for transitioning from



one model to another. National Health Authority (NHA), the apex body at the National level, provides flexibility to States in adopting a suitable financial risk arrangement/implementation mode Assurance/ Trust Mode, Insurance Mode, and Mixed mode. Since the inception of the AB PM-JAY, many States have switched between these different modes. It is vital to understand which mode of implementation is more appropriate and efficient in a specific setting, discuss challenges under each mode, and devise solutions to pivot scheme implementation.

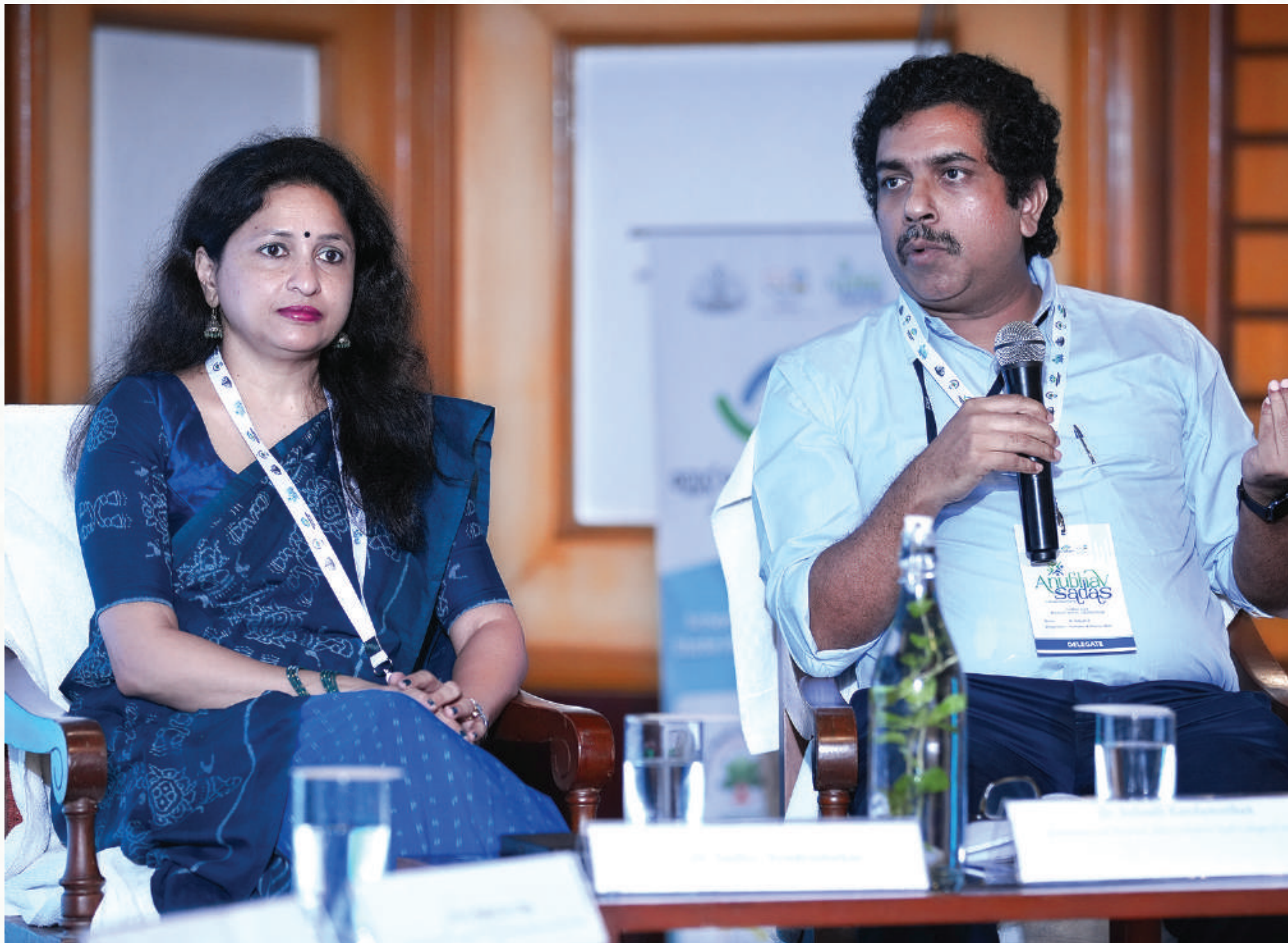
The panel discussed the learnings and challenges of claim adjudication and better strategies to achieve efficiency and quality of claim adjudication. Those States implementing the scheme in trust mode follow different claim adjudication models. Few States have contracted the claim adjudication task to Implementation Support Agencies (ISAs) or Third-Party Administrators (TPAs). These ISAs are responsible for the verification and approval of claims while SHA makes the payment. Other states have in-house claim adjudication teams who perform verification and approval, and payment of claims. In-house claim adjudication requires extensive resources and expertise of the SHA (institutional capacity) in handling the claims.

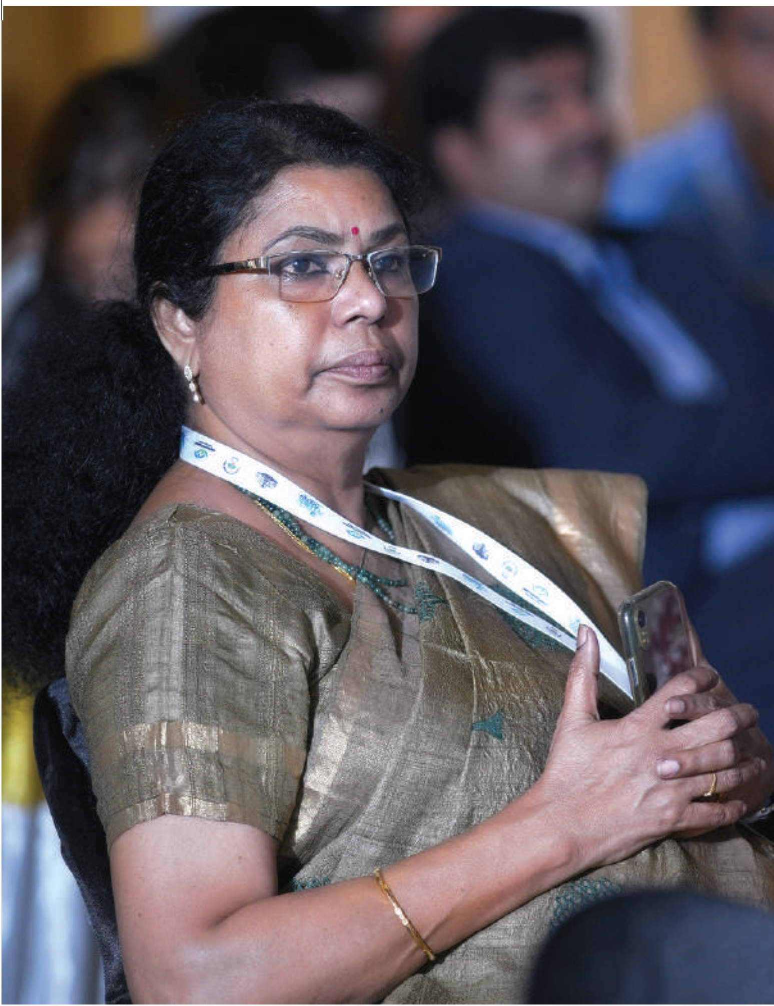
KEY DISCUSSION POINTS

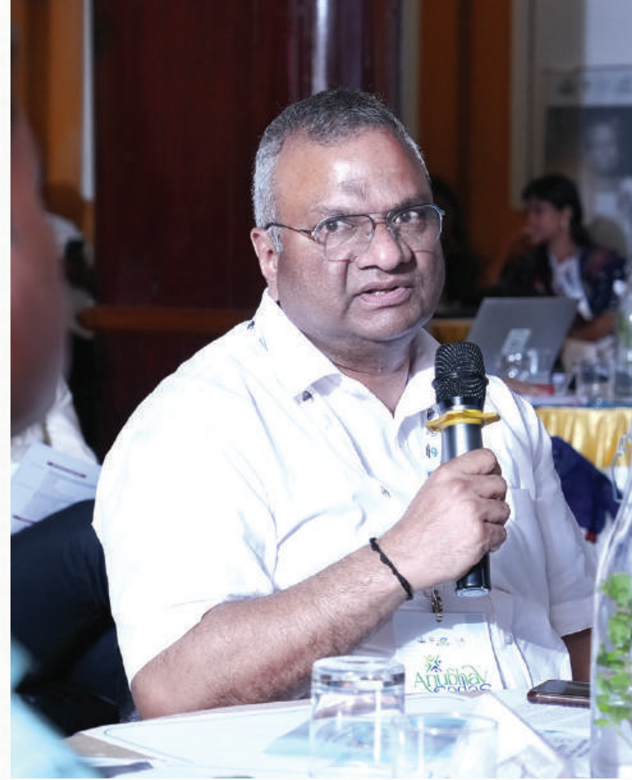
THEMATIC AREA:
IMPLEMENTATION MODELS

Selecting An Implementation Model

No delineable benchmarks or empirical evidence is available to consider which model works better– adoption is thus mostly context-driven. Currently, across 33 states implementing PM-JAY, 7 states /UTs are in insurance mode, 3 are in hybrid mode, and the rest 23 are in Trust Mode. States implementing the scheme in insurance mode report a higher creation of Ayushman cards and better claim and pre-auth processing (with a low TAT). The documentation of the provider was good due to the strict policies of insurance companies. However, the issues in claim settlement, such as high rejection rate and delay in settlements, persist in insurance mode. A trust deficit between the SHA and insurance company also seems to exist in this model. Also, in insurance mode, the state does not have the flexibility to introduce new







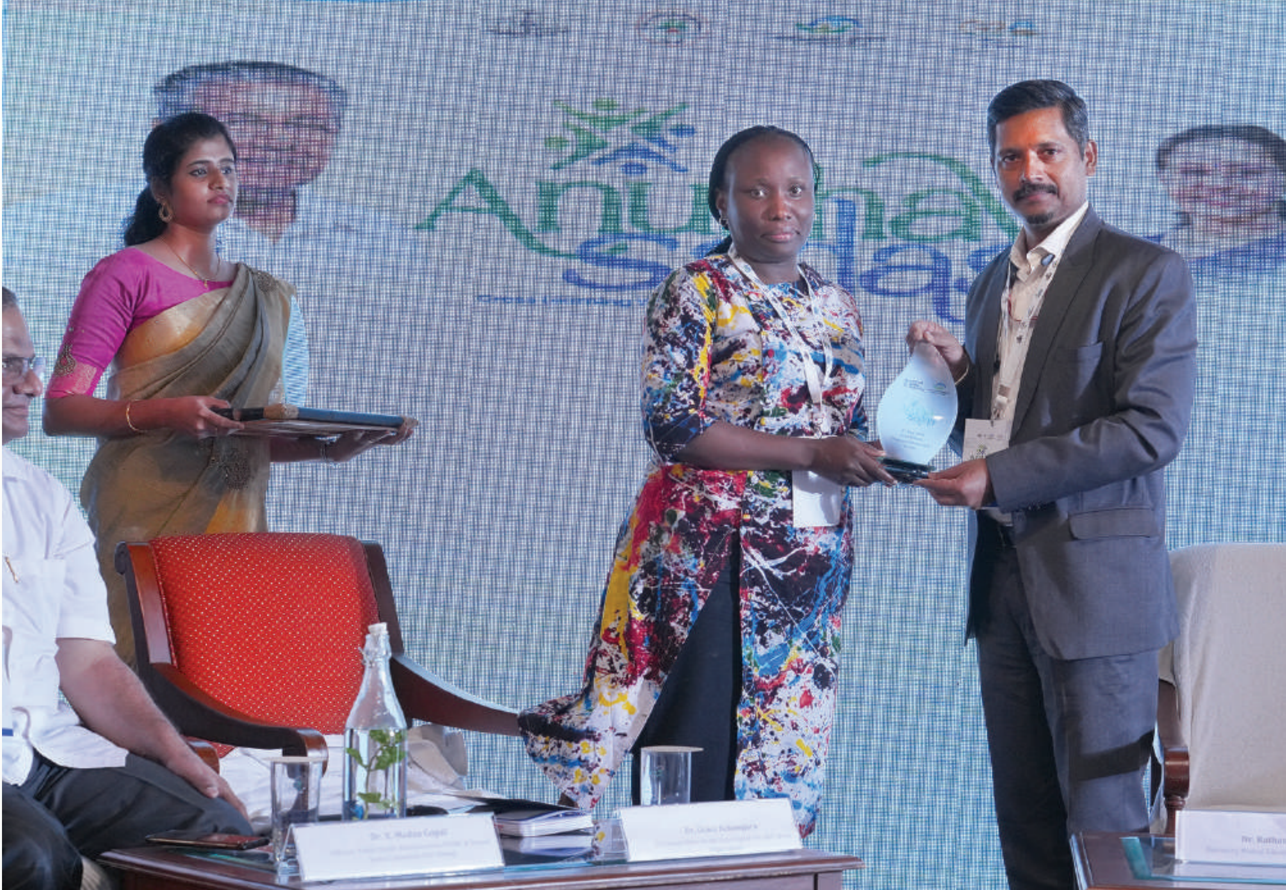
services or packages in the middle of the policy and introduce new rules and guidelines

States in Trust mode did better in terms of empanelment and fraud management as per a study conducted by WHO in collaboration with the Government Institute of Medical Sciences (GIMS). In terms of administrative costs, the insurance states incurred higher costs. However, insurance states did better in terms of cost per claim processed. Hence, states need to decide on the mode of implementation as per their state context and performance.

Institutional Capacity

The SHAs need to develop capacity and adapt to the dynamics and changes from time to time. The SHAs should have trained staff to handle the scheme efficiently. Even in the case of the insurance model, SHA should have the capacity to understand how the insurance model is performing. Training and capacity building up to the district level is an important aspect and all SHAs should have strong institutional capacity irrespective of the model being implemented.

Having a strong SHA is non-negotiable for the implementation of the scheme—especially given the experience of Punjab, where the insurance company withdrew in the middle of the policy period, disrupting the scheme implementation. The state



has the mandate to ensure health benefits to its people--hence it should have a strong institutional capacity to address this kind of issue. The SHA must also develop capacity for claim adjudication, with account officers who play a major role. Though claims handling is outsourced to ISAs, SHA must be having in-house doctors to audit the processed claims and ensure misuse and identify fraud is avoided. Overall, SHA needs to be autonomous with limited reliance on third parties.

SHAs should have a strong team to handle the providers to prevent denial of treatment, avoid/ reduce grievances, hold service providers accountable, control fraud & abuse and reduce friction during service delivery. The PM-JAY IT platform is agnostic of the mode of implementation hence, the SHA needs to have full knowledge and control. Keeping data privacy concerns in mind, SHAs are recommended not to rely on the insurance company's IT platform. SHAs can also partner with academic institutions to improve their capacity, which can help in terms of analytics and evaluations.

Transition From One Model to Another

Transition from one model to another should happen in a phased manner. SHAs should plan for a buffer transition phase wherein they can depend on an ISA as an intermediate step. So that gives the State some time to build capacity. The intention of transition may be good, but SHA may unable to implement it immediately considering SHA capacities and flip flop should be avoided. The transition time should be used to strengthen the SHA. SHAs must assess their capacity before embarking on a transition, utilizing aid from technical partners if need be. States must decide to transition from one model to another only when they are ready to fulfil the assurances given to beneficiaries without any interruption.

Addressing missing to achieve UHC selection of the right model

Usually, the mode of implementation is based on the State's fiscal space availability. Since the premium amount is to be paid upfront to the insurance companies, most States select assurance mode.

In India, 93% of workers are in the unorganized sector. Covering this population is very important. Their household earning is less than INR 40,000 per annum. Partially, this population is covered through PM-JAY; however, a larger population is left out. Private insurance is not a viable option since it costs between INR 6,000 to INR 10,000 per annum and also comes along with a waiting period, whereas more than 80% of families earn less than INR 40,000 per annum (NSSO data). Though many insurance products are available in the market, like the vanilla product of IRDA, the uptake is less due to affordability issues, and people usually buy when service is needed. Hence, it is needed to come up with an affordable insurance product for this section of the population by bringing down the cost and making it more lucrative is needed. However, making this viable product remains a challenge.

THEMATIC AREA: CLAIM ADJUDICATION

In-house Claim Adjudication vs ISA-Driven Model:

If an SHA decides to adopt in-house claim adjudi cation, they must see their workload first. If the new scheme is being undertaken or multiple schemes are converged, the SHA cannot directly jump into the in-house adjudication model considering many factors hindering the process. Recruitment of claim adjudicators, especially doctors, is a time taking process since the SHA has to follow certain recruitment procedures. Considering the scarcity of doctors, options like work from home and part-time work allocation can be explored by the SHAs. However, their IT system should be robust to control the whole claim adjudication process. However, since the current IT system is provided by NHA, this may not be possible immediately, but options need to be explored. SHAs can also train a few nodal officers from the health department trained as a backup option.

The claim adjudication handled by ISA should be closely monitored to control the quality of adjudication. The SHAs must have auditors to verify the claims processed by ISAs.

Quality of Adjudication:

Standard treatment guidelines developed by NHA help adjudicators process claims. Before the introduction of STGs, claim adjudicators were taking more time searching and deciding which document should be considered for adjudication. The introduction of STGs eased the process and identifying mandatory documents to process claims based on the package. The STGs helped in improving the quality of claim adjudication.

Use of Artificial Intelligence in Claim Adjudication

NHA is working towards using AI & ML for claim adjudication, with an aim to automate. It is thought to remove a few roles in claim adjudication such as claims executive in the next few months. An automated feature, i.e. "Document Quality Report" has already been introduced, which will automatically reject any document if it doesn't meet the required quality. A document classification feature is likely to be introduced to detect whether the right document is uploaded or not.

Additionally, new automated features—especially for packages which has a fixed pattern of documents, like dialysis—will be introduced soon to make the adjudication process easier, thus eliminating the role of Claim Processing Doctor (CPD). In the upcoming version of the Transaction Management System (TMS 2.0), the role of the account officer of SHA will be automated. Multiple stages of claims adjudication will be minimised in the future to improve the efficiency of the process.

OUTCOMES AND KEY TAKEAWAYS

States which participated in the workshop shared their experience in implementing the scheme. Learnings and best practices followed, in terms of strategic purchasing of healthcare services, public hospital strengthening, claim adjudication, and specific experience related to the mode of implementation.

Strategic Purchasing & Strengthening Public Providers

- Tamil Nadu and Karnataka selectively purchase services from the private sectors and reserve a few benefit packages for public health institutions.
- Tamil Nadu has stringent empanelment criteria where NABH accreditation is mandatory for private hospitals. The state also follows a scoring method with weightage given to infrastructure, human resources, critical care, and speciality-wise provisions. The state has taken steps to control the cost of implants and devices by supporting bulk procurement through a tendering process.
- Meghalaya is successfully implementing OPD benefit packages and reducing OOPE of beneficiaries. The state has implemented guidelines on the utilisation of claim funds by public hospitals that focus on improving the quality of treatment by upgrading infrastructure and maintaining the structure.
- Karnataka has introduced a differential payment system for public providers, bifurcated as 50% payment for secondary care procedures, 75% for complex procedures and 100% for cardiology to control the expenditure.
- PM-JAY has to shift to DRG-based payments from case-based payments gradually. However, before considering DRG as an alternative payment mechanism, the SHA needs to do its due diligence in terms of implementation capacity and the challenges associated with the system. Payments to the providers should be linked to their performance, and states should shift towards implementing value-based care.

Mode of Implementation & Claim Adjudication

- States like Maharashtra & Tamil Nadu implementing schemes in the hybrid mode can control the premium cost and cover those packages through assurance mode, which were not covered under insurance.
- Many states have switched from the insurance mode to trust mode for various reasons such as conflict of interest, denial of claims, high claim rejection rates, non-compliance of insurance companies, lack of flexibility, and the trust deficit between SHA and the Insurance Company IC. However, the transition was not smooth due to a lack of SHA capacity, lack of expertise, and increased claim cost amongst other things. The transition should happen in a phased manner.
- No clearly defined parameters or empirical evidence exists on which model of implementation is better than the others. The choice must be made on the context and dynamics in which the state is operating and
- Trust mode was found to be better in terms of empanelment of hospitals and fraud management but had high claim costs. States in insurance mode, on the other hand, incurred higher administrative costs.
- Irrespective of the implementation model, SHAs must have a strong institutional capacity. They should have expertise on how insurance schemes works, even when implementing the insurance model, and should be able to steer the scheme efficiently. SHAs need to be prepared to face challenges to avoid the disruption services to beneficiaries.

- Efforts need to be made towards making an affordable and lucrative insurance product to cover the missing middle population and move towards UHC.
- States in trust mode handling claim adjudication through ISAs should have a strong monitoring mechanism and should not completely rely on ISAs. Partnering with academic institutions and technical partners is needed to improve their capacity in terms of analytics and evaluations.
- If a State plans to have an in-house adjudication system, it should be done in a phased manner and the SHA should build capacity first to manage the workload. SHAs can also explore hybrid working cultures by allowing part-time work and work-from-home options for adjudicators considering the non-availability of medical experts. However, IT systems should be able to control the adjudication process and have a strong monitoring mechanism.
- The introduction of AI & ML in the claim adjudication process will enhance efficiency and quality. Having a multi-layer adjudication process leads to the duplication of efforts and reduces the speed of adjudication.

CONCLUSION

Schemes such as PM-JAY and other state-sponsored health financing schemes have evolved over a period of time. They have improvised over the years by adopting new strategies, replicating best practices, and learning from the past. Platforms like 'Anubhav Sadas' can bring states together to share experiences and best practices, which will help them steer the schemes in better ways. However, a single strategy or solution may not work in all cases and the context of the state matters. States should be able to configure policy solutions based on applicability and ability to meet the endpoint. It could be in terms of deciding the mode of implementation, having an in-house adjudication team, reservation of packages, having a differential package for public & private, supporting bulk purchasing of implants & devices etc. States need to adopt evidence-based strategies and leverage technology for efficient implementation of the scheme

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