Best Practices and Innovations: One year of PM-JAY implementation across states, India - Karnataka
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"Following others is easy but providing novel solutions to the meaningful problems is innovation; it endows resources with new capacity to enhance performance and create growth”

Background

Ayushman Bharat, PM-JAY a flagship Initiative of Government of India seeks to accelerate India’s progress towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goals - 3 (SDG3).

PM-JAY launched in September 2018, provides annual health cover of Rs. 5 Lakhs per family per year (on a family floater basis) to 10.74 crore poor and deprived families figured in 2011 Socio-Economic Caste Census (SECC) data (approx. 50 crore beneficiaries). Scheme covers medical and hospitalization expenses for almost all secondary care and most of tertiary care procedures with no cap on family size.

Objective of the document

PM-JAY under the ambit of National Health Authority (NHA) at Centre level has given the flexibility to the States to choose the mode of implementation- trust, insurance or hybrid model based on the capacity and experience in the States. Most of the states had either earlier experience of implementing schemes such as Employee State Insurance (ESI), Central Government Health Scheme (CGHS), and Rashtriya Swasthya Bima Yojana (RSBY) or running their own State specific schemes. However, NHA designs all the policy framework and guidelines with the provision of all possible customization and support. Special mention to some of the greenfield states such as Chhattisgarh, Jharkhand, Bihar. Madhya Pradesh (MP) and Uttar Pradesh (UP) which emerged as the largest beneficiaries of the PM-JAY and have not implemented health insurance programs in recent years. On the other hand, most of the southern (brownfield) and some of the north-eastern states were aware of insurance scheme modalities due to their prior experience of implementing the RSBY or state-run health insurance schemes.

But whether Greenfield or brownfield, every State/UT built upon their own strengths based on their geographical, political and local scenarios; and attempted to minimize the shortcomings, while implementing such a large flagship insurance scheme by Government. The section below highlights some of the praiseworthy and objectively viable solutions in terms of best practices and Innovations by the States/UTs for the said scheme; which are additional to the mandatory standard guidelines but are within the legal framework of the scheme.

The practices highlighted below are based on the sustainability of the model proposed, replicability in other states with cost efficiency, and reliability approach.
I. Information Technology

A real-time IT ecosystem, including Hospital Empanelment Management (HEM) system, BIS, Transaction Management System (TMS), Central Public Grievance Management System (CPGRAMS), etc., has been put in place for PM-JAY by the NHA. These real-time monitoring systems provide advanced analytics using business intelligence tools. NHA allowed States to onboard any beneficiary database they wanted as long as they implement through an open Application Programing Interface (API) database, which could be accessed by the NHA BIS. The process allowed the States to fully retain their existing software while providing all the necessary data to NHA required for monitoring and evaluation of the scheme. Further, few SHAs enhanced their indigenous IT platforms and application to support their daily operations. Some of the effective and efficient tools/apps are listed below.

I a. Call Centres as monitoring units

SHA Karnataka established a call centre as a monitoring unit of the scheme. The call centre contacts all the beneficiaries at the time of discharge for getting feedback regarding out-of-pocket expenditure of the scheme and co-payments made (if any).

This was highly effective in getting the procedure details and refund of any money collected by the hospital inadvertently towards the investigations and other charges. Through this unit, patient grievances’ redressal is done quickly and effectively.

I b. SMS Alerts

In Karnataka, medical coordinators are nominated from each empanelled hospital for case-to-case monitoring and implementation of the scheme at the hospital level. SMS alerts are sent to the consultants attending the scheme patients to get the information required for validating the pre-auth and claims processing and avoid any inordinate delays. SMS alerts are also sent to consultants including public health institutions, if there are delays in submitting claims.
II. Fraud and Abuse

For such a large-scale programme as PM-JAY, it is critical to put in place strong anti-fraud mechanisms not only from a financial perspective but also to safeguard people’s health from unethical malpractices. Under the watchful oversight of NHA, PM-JAY is being governed on a zero-tolerance approach towards any kind of fraud.

The NHA anti-fraud framework rests on 3 key pillars: Prevention, detection and deterrence.

The NHA has also defined a set of guidelines and regulation mechanism for fraud control through rigorous data analytics and field audits. At the grassroots level, the SHA is undertaking regular monitoring and audits for fraud identification. The following best practices of a few states will help other states for their future planning and implementation of fraud control mechanisms.

II a. Biometric authentication of beneficiaries

Eligibility and entitlement under the Ayushman Bharat-Arogya Karnataka scheme is based on Aadhaar authentication and entitlement as defined under the National Food Security Act. A health card called AB-ArKid is generated at the time of enrolment in the scheme by using biometric authentication that is verified with the Aadhaar database for eligibility and the PDS database for entitlement. Biometric authentication of the beneficiary is mandatory at the time of admission and discharge. For patients that get admitted for emergency treatment, an OTP is generated at the time of admission and biometric authentication at the time of discharge. This provision largely prevents impersonation.

II b. Approvals of treatment/packages by team of specialists

The tertiary care procedures are validated by a team of about 100 specialist and super specialists who work from home on a pro-rata basis. The round robin allotment of the cases submitted for pre-auth and claims effectively reduces the turnaround time for processing and prevents abuse as it is a random computer-generated allocation. Doctors work from home while team leaders are stationed in the office and they not only guide the validators but also verify a fixed percentage of the pre-authorisation approvals.
III. Hospital Empanelment and Treatment

To build an effective and accountable network of providers, a set of minimum criteria were developed, based on which hospitals under PM-JAY were empanelled. In addition, performance-linked payment system was designed to incentivise hospitals to improve quality and patient safety, based on successive milestones.

Continuous Quality Improvement (CQI) efforts were planned
- To undertake PM-JAY network hospitals
- To ensure that appropriate and consistent quality services are delivered to the beneficiaries
- To improve the permanency, safety and well-being of beneficiaries in care
- To reduce the possibility of adverse occurrences and to maintain a system for continuous quality improvement regarding patient centred outcomes

Three levels of PM-JAY quality certifications–Bronze, Silver and Gold in the said chronological order–was also developed to ensure hospitals comply with quality-based certification criterion. This section depicts some of the best practices by States adhering to and setting new standards under the framework of hospital empanelment and quality certification.

III a. Gate-keeping mechanism

To ensure effective utilisation of existing resources and strategic purchase of services not available in the PHIs, an effective gate-keeping mechanism has been established by SHA Karnataka.

Under this mechanism, treatment of tertiary care packages is done on reference from Public Health Institutes (PHIs). This referral system protects the patients from incurring out-of-pocket expenditure, saving them the cost of preliminary investigations and diagnostics in private hospitals.

Once it is confirmed that the patient needs tertiary care, he is provided referral to seek tertiary treatment in any empanelled hospital of his choice.

Referral from a PHI is exempted for treatment of tertiary and secondary emergency cases.
III b. Classification of treatment procedures to utilise in-house capacities at public hospitals

Karnataka has an integrated scheme wherein the hitherto existing procedures and those available under PM-JAY have been merged; and the scheme has 1,650 treatment procedures. Procedures have been categorised as simple secondary general, simple secondary complex, tertiary and emergency for effective implementation and gate keeping. About 545 general and secondary treatment procedures are reserved for PHIs, thereby giving scope and opportunity to fully utilise the capacities and capabilities of the PHIs and strengthening the same.
Way Forward

It is expected that all the best practices documented here will establish a cross learning ecosystem between PM-JAY implementing states, especially those states who on boarded later in the scheme. The discussed innovative models have demonstrated faster beneficiary identification, better hospitalisation services, smooth and timely claim management, all of which are very crucial for success of such a massive government-initiated health insurance scheme.

It is recognised that best practice and innovations that have given fruitful results in one region might not be suitable for other regions. State specific challenges due to geo-political diversity need specific solutions, so the best practices and innovative models discussed in this and other documents should be adapted by other States based on local relevance including geographical conditions, political environment and cultural settings.

The solutions mentioned in the document highlight the incredible work done by the States and shows that the teams at state level are tirelessly putting in extra effort to meet challenges and solve problems for better outcomes.

The NHA is thankful to the state teams who have documented/discussed their best practices and innovative models and hope in future that more such documents will come out with scaling of the scheme.