Concept Note for streamlining workflows for efficient payment of claims under AB PMJAY

Summary

There is a substantial time lag between the discharge of the beneficiary from the hospital and the payment of the claim to EHCPs. Various initiatives have been undertaken through interventions at the system, process and guidelines level to address the same. NHA guidelines also warrant claim payment within 15 days for non-portability claims and 30 days for portability claims. However, the actual time taken is far higher and one of the key components of delay is the step of final payment by SHA after approval by CPD. The purpose of this Note is to enhance the process at ACO and SHA levels through workflow automation for efficient payment of claims without diluting controls and to offer a Green-channel benefit to hospitals treating PMJAY beneficiaries on regular basis.

A. Analysis of data indicates that very negligible changes in claims decision and payable amount are made at ACO level and SHA level – less than 1% overall while there may be State-level variations. Also, the average TAT of 2 days at the ACO level and 3 days at the SHA level is adequate for due diligence at the respective level. It is thus recommended that:

a) At the ACO level, the window for due diligence shall be 2 days, post which the claims shall move automatically to the SHA bucket.
b) At the SHA level, the window for due diligence shall be 3 days, post which the claims shall automatically move for payment.

The claims which are triggered as suspicious would be excluded from the above automation and a claim which is later found to be wrongfully paid shall be recoverable from ISA/EHCP as the case may be as per present guidelines. The process of initiating Recovery against an errant/fraudulent entity would remain available at ACO and SHA level as at present.

B. To encourage greater participation of EHCPs in treating PMJAY beneficiaries, it is further proposed to offer a 'Green Channel' to EHCPs who are treating PMJAY beneficiaries on regular basis. The EHCPs which do not have any suspicious cases/confirmed fraud/disciplinary action and have been empanelled for at least 6 months with average Rs. 2 lakhs transactions per month would be eligible for green channel benefit. The hospitals will be asked to furnish an undertaking to comply with demand for recovery, if any, that may arise later.

Green Channel Benefit - Release of partial claim amount on claim submission by EHCP may be carried out as per one of the options listed below:

a) Partial payment of 50% for 'above board' claims (not triggered as suspicious or high risk). The partial payment shall be released automatically through the system at the time of claim submission while for the balance amount, the usual process of adjudication shall follow.

b) 50% of the average monthly outgo (based on last 6 months) shall be released as a lump sum against the claims submitted after with a 'just in time' mechanism to replenish the same against the claims settled.

Background

AB PMJAY is a cashless scheme for the beneficiaries wherein the patient receives treatment at the hospital without paying any money while the hospital receives payment for its services once the claim is submitted from its end and is approved and paid from the SHA end. The NHA guidelines for submission of claim by hospital prescribe TAT (Turn-around Time) limit of 7 days and for settlement/payment of non-portability claims it is 15 days and portability claims 30 days. It is observed that there is a delay during different stages - claims' submission, processing and payment. In this regard, a number of steps are being taken to enforce the guidelines through the issuance of advisories, automated workflows and alerts, penalties for delays etc.

The purpose of this Note is to address the issue of delay in payment after approval of the claim by CPD (Claim Processing Doctor). The delay in claim payment has a detrimental impact on EHCPs, especially small and medium facilities, as a sizeable part of their working capital is blocked for the intervening period of providing treatment and receiving claims money. The delay in claim payment also dissuades EHCPs (Empaneled Health Care Providers) from treating PMJAY patients in large numbers or actively participate/empanel under the Scheme.

To address the above issues, it is proposed to enhance existing workflows and semi-automate certain steps in the claims payment process without diluting essential controls and checks. No distinction is proposed for any differentiation due to the implementation model – Trust, Hybrid or Insurance model, the same shall apply uniformly. There is a greater onus, more than ever to carry out timely effective due diligence as regards suspicious claims and errant EHCPs and the same is essential for successful implementation of proposed recommendations.

The recommended enhancements and workflow automation have also been proposed in Claims Adjudication Strategy, in line with international best practices.

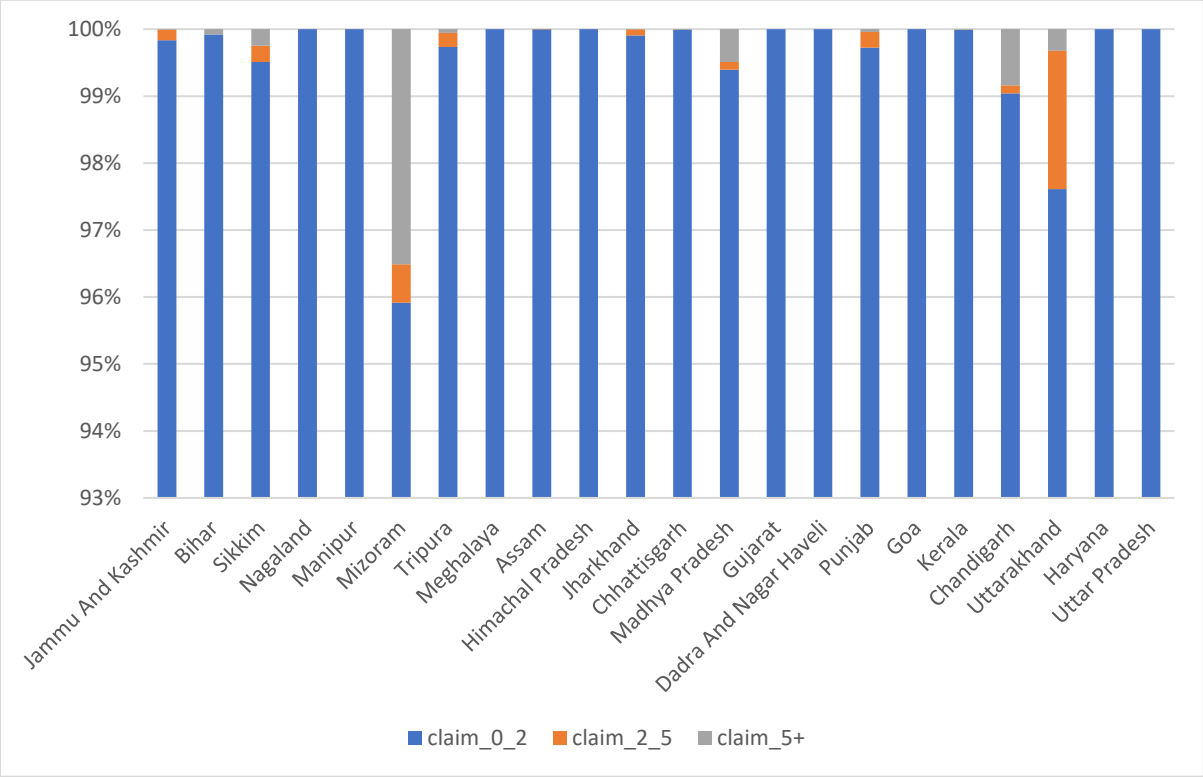
A. Reducing the time taken by ACO and SHA for approval/authorizing payment of approved claims

As per current workflow in TMS (Transaction Management System), after claim approval by CPD, the claim passes through two stages - Accounts Officers(ACO) and SHA (State Health Agency)/IC (Insurance Company) before the final payment is initiated. Few states have technical committee stages introduced in between before the case reaches the ACO bucket. For the purpose of this Note, the role of ACO and the SHA role has been examined in the claim payment process. There are modification rights available both at ACO and SHA level. The decision for a particular claim can be changed from 'Approved' to 'Rejected" and the amount to be paid can also be modified.

As per the NHA guidelines, the TAT for 15 days for non-portability claims has been bifurcated into 10 days for processing and approval up to CPD level and 5 days for payment by ACO and SHA). State-wise analysis for Greenfield/States using NHA IT system has been carried out to understand the time taken by ACO and SHA and also the changes in claim decision - to approve/reject/reduce the amount, made at the respective stage.
The period considered for analysis is Oct 2020 – March 2021 for Table 1 to Table 6.

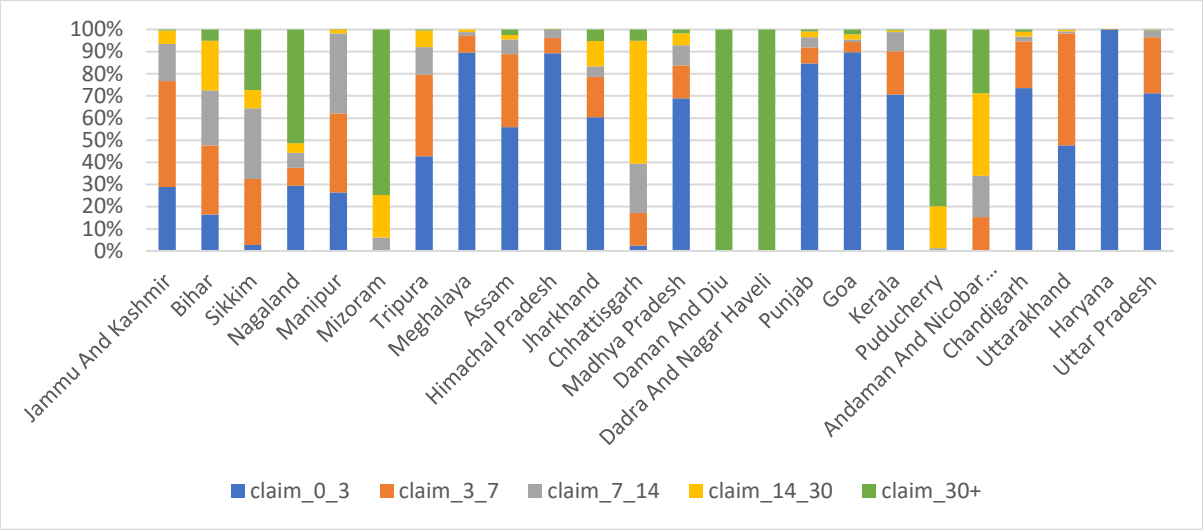
I. Time taken at ACO stage: It is observed that in most of the States, ACO takes a maximum of 2 days to forward the cases.

Table 1



II. Time taken at SHA/IC level: SHA stage takes high number of days to initiate the payment process and some States have rather poor record e.g. J&K, Sikkim, Mizoram, Chhattisgarh. Though as shown by data, it is quite possible for SHA to approve payment in 3 days if it so desired e.g. Meghalaya, Himachal Pradesh, Punjab, Haryana.

Table 2



III. Changes in claims' decision/amount made at ACO level: Since this Note relates to increasing efficiency in claims payment process, the change in decision – from Approved to Reject and reduction in claim amount have been taken into consideration for below analysis. The claims which are already rejected by CPD have not been included.

a) Decision change - Claim which has been approved by CPD is later rejected by ACO

Quite minimal number of CPD Approved cases are rejected by ACO. Out of 24 States/UTs, changes in decision were seen in only below mentioned 8 States for less than 1% of cases and the reason for same is the audit remark suggesting fraud. It appears that these cases might have been triggered as fraud post CPD approval, which would continue as at present and such cases would be pushed to SAFU bucket, unavailable for processing/automated payment till the time suspicion flag is cleared.

Table 3

Name of State	**%age of cases CPD approved claim is rejected by ACO**
Assam	0.01%
Bihar	0.45%
Chhattisgarh	0.66%
Haryana	0.40%
Kerala	0.01%
Madhya Pradesh	0.18%
Mizoram	0.11%
Uttar Pradesh	0.08%

b) Change in claim amount – reduction by ACO over CPD approved claim amount

Barring Assam, quite minimal or no changes are observed in rest of the States. For 99% of the cases, the amount recommended by ACO is same as approved by CPD.

Table 4

Name of State	**% of cases where CPD approved claim amount is reduced by ACO**
Assam	9.959%
Bihar	0.058%
Chhattisgarh	0.533%
Haryana	0.004%
Jharkhand	0.064%
Kerala	0.002%
Madhya Pradesh	0.072%
Manipur	0.242%
Meghalaya	0.032%
Punjab	0.028%
Tripura	0.053%
Uttar Pradesh	0.011%
Uttarakhand	0.838%

IV. Changes in claims' decision/amount at SHA level – rejection of claim approved by ACO or reduction in claim amount recommended by ACO

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a) Decision change- claim which has been recommended by ACO is rejected by SHA

It is observed that in most of the cases, there is minimal change in decision at SHA level barring Mizoram, Goa and Andaman & Nicobar islands.

Table 5

Name of State	**% of cases where ACO approved claim is rejected by SHA**
Andaman And Nicobar Islands	1.667%
Assam	0.090%
Bihar	0.137%
Chandigarh	0.819%
Chhattisgarh	0.008%
Goa	2.222%
Jammu And Kashmir	0.153%
Jharkhand	0.001%
Mizoram	1.206%
Punjab	0.041%
Sikkim	0.096%
Tripura	0.059%
Uttar Pradesh	0.001%

b) Change in claim amount – reduction by SHA over ACO approved claim amount

There is no change in amount at SHA level in any State/UT.

V. Recommendation for automated workflows at ACO and SHA level

From above analysis, it is clear that there is very little change made either in decision or claim amount both at ACO and SHA levels. ACO is able to complete his/her due diligence within 2 days in most cases/States, however at the SHA level, inordinate delay is observed without any corresponding change in decision or reduction in claim amount. Automation of work flow with pre-defined window is proposed at both levels to bring in greater efficiency:

a) At ACO level, the window for due-diligence shall be 2 days, post which the claims shall move automatically to SHA bucket.
b) At SHA level, the window for due-diligence shall be 3 days, post which the claims shall automatically move for payment.

This will be in- line with payment stage TAT guidelines - to pay the claim with in 5 days of approval and yet provide ample opportunity to verify the claims at both the stages.

Above proposal is recommended with following checks and controls so that no unwarranted claim is paid without proper due diligence.

a) No claim which is triggered as suspicious or triggered for adjudication audit shall form part of automated workflow, such claims shall be removed from automated workflow queue and remain in audit bucket till suspicion/audit flag is cleared as at present.
b) A paid claim which is later found suspicious/fraudulent/wrongly adjudicated shall be subject to due process of due-diligence and liable for punitive recovery from ISA/EHCP (as the case may be), as per existing guidelines.

B. Release of partial claim amount to EHCP on claim submission

To help EHCPs meet the issue of blockage of their working capital during the intervening period from the time of treatment of beneficiary to payment of claim and to further encourage them to treat PMJAY beneficiaries in greater number, the EHCPs with reasonable footfall of PMJAY patients and not found to be indulging in fraudulent practices can be given a special privilege, a kind of “green channel EHCP’s” for ‘above board’ claims.

The criteria for eligibility of an EHCP for Green channel would be:

1) The EHCP should not have any suspicious cases/confirmed fraud/disciplinary action pending or taken/should not have high Risk Score. The first instance of suspicious/confirmed fraud/negative medical audit findings shall make EHCP ineligible for the Green channel.
2) The EHCP should have been empanelled for at-least 6 months with average transactions value of Rs.2 lakhs per month.
3) The EHCP should agree to submit standard documents for claim submission for the faster claim processing.

4) The EHCP shall furnish an Undertaking to comply with demand for recovery, if any, that may arise later.

To examine the matter and understand present practices of due-diligence during adjudication, state-wise (Green field/States using NHA IT system) data analysis of claims submitted, fully paid, partially paid/disallowed and rejected has been carried out. For purpose of this analysis, the claim value has been considered instead of the claim count because it is the claim value which is of relevance to the hospital for payment purpose.

The analysis gives an idea about %age of claim amount which has been rejected, partially paid and fully paid vs the submitted claim amount. It would be observed that, barring Andaman & Nicobar, J&K and Tripura, in most of the States the range of claim value paid varies from 82% to 99% (net of fraudulent transactions).

Table 6 (Period of analysis – 1/10/20- 31/3/21

Name of State	**No. of Claims registered**	**Original Submitted Value (In lakhs)**	**Total Claim paid value**	**Partially Disallowed claim value**	**Rejected Claims value**	**Average Claim payment TAT (in Days)**
Andaman And Nicobar Islands	200	26	78%	9%	13%	287
Assam	56898	7,903	93%	6%	1%	29
Bihar	44273	3,608	97%	0%	3%	64
Chandigarh	2067	104	82%	8%	10%	40
Chhattisgarh	241892	24,788	89%	7%	3%	44
Dadra And Nagar Haveli	4970	334	97%	2%	1%	90
Daman And Diu	1871	211	98%	0%	2%	95
Goa	91	20	93%	1%	6%	6
Gujarat	169389	31,599	97%	3%	0%	85
Haryana	68292	7,501	92%	6%	2%	34
Himachal Pradesh	7093	948	89%	1%	10%	34
Jammu And Kashmir	28067	2,078	63%	3%	33%	17
Jharkhand	155844	14,691	92%	3%	5%	23
Kerala	334384	24,835	92%	4%	4%	97
Madhya Pradesh	188742	26,173	97%	2%	2%	43
Manipur	9089	884	98%	2%	0%	16
Meghalaya	66621	5,076	99%	1%	0%	16
Mizoram	7136	915	87%	9%	4%	65
Nagaland	4733	721	95%	4%	1%	94
Punjab	228991	24,521	93%	4%	3%	26
Sikkim	854	57	94%	6%	0%	67
Tripura	10316	785	79%	5%	16%	19
Uttarakhand	45777	9,413	86%	6%	8%	21
Uttar Pradesh	160015	13,998	92%	3%	5%	43

I. Recommendation for partial payment to EHCPs (Green channel)

From the above data analysis and control check from fraud control perspective, it would be safe to make a partial payment – 50% of claim value to 'above board' hospitals for 'clean' claims leaving enough margin for potential recovery in case need be. The partial payment shall be released automatically through the system while for balance amount, the usual process of adjudication shall follow.

a. **Option 1: Partial payment of 50% of individual claim value on claim submission.**

The above-proposed recommendation shall be subject to below controls and checks:

i. Only claims which are not triggered as suspicious, do not have high risk transaction score nor are under any audit bucket shall be considered for automated partial payment.
ii. Claims which are later discovered to be wrongfully paid (due to fraud or adjudication issue) shall be recovered from EHCP – from pending/future claims, specific recovery deposit or invoking Undertaking given by EHCP (in case pending claim amount is insufficient). Though in all likelihood there would always be a sufficient amount (balance claim amount) as well as pending claims (Pre-authorized claims not yet converted to submitted Claims) as the Green Channel is open to EHCPs with regular and sufficient number of transactions.

Pros	Cons
Simple to understand	Changes at IT and Accounting level expected to be high
Fixed Quantum is known (50 % of the submitted claim amount in each case)	Reconciliation issues at hospital end as multiple UTRs for one claim.

b) **Option 2 : Partial lump sum payment for 50% of average monthly transactions**

50% of the average monthly transaction value (based on previous 6 months utilization) can be paid as lump sum with a mechanism of just in time replenishment subjected to claims submitted for payment. The quantum can be reassessed at the gap of 6 months, 1 st April and 1st October every year.

Pros	Cons
Easy to reconcile	The lumpsum quantum would be fixed while actual utilization/claims is dynamic and Operational concerns of the hospital in understanding the concept
Easily implementable at IT level	Issues of mid-year revision