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Retrospective Analysis of Patients Covered Under RGJAY Scheme in a Tertiary Care Government Hospital– A Socioeconomic Study

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ABSTRACT
Introduction: *-Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY scheme) is a government funded insurance scheme for BPL/ APL families, implemented in hospitals all over Maharashtra.*
Objectives: *-This study was a retrospective analysis of implementation of the RGJAY scheme- study of trends and category of beneficiaries, cost-benefit analysis and scope of improvement in scheme.*
Methods:- *Records of RGJAY patients were retrieved over period from November 2013 to October 2015. Data retrieved was analysed for parameters like trends for number of cases; for cases in different speciality categories and locations over the period of 24 months, trends for number of claims getting paid; average amount paid per case and time required for claim approval, estimation of number of cases which usually required external funding and cases which were otherwise done free of cost.*
Results:- *Total 6797 claims were analysed. Overall number of cases went on increasing from 188 in Nov 13-Jan 14 to 1168 in Aug 15-Oct 15; but Cardiovascular and thoracic surgery (CVTS) cases were decreased. Percentage of claims getting paid was increased. Average of claim amount paid, deduction in amount paid and time for approval were decreased.*
Conclusions:- *Additional services were provided to patients in cashless manner. Good amount was generated through cases which otherwise done free before RGJAY. There is a need of application of RGJAY in all civil hospitals, inclusion of more categories, reduction in the number mandatory investigations and enforcement of information dissemination. Feedback from the treating doctors and hospital co-ordinator for RGJAY suggested certain changes that can improve the application of the scheme for providing free care to the BPL and APL patients.*
Keywords:- *RGJAY, Health Scheme, Socioeconomic Study.*

Introduction [1]

Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) is implemented throughout the state of Maharashtra in phased manner for a period of 3 years. In first phase 8 districts and in phase two all districts of Maharashtra have been covered.

Objective of scheme is to improve access of Below Poverty Line (BPL) and Above Poverty Line (APL) families (excluding White Card Holders as defined by Civil Supplies Department) to quality medical care for identified specialty services requiring hospitalization for surgeries and therapies or consultations through an identified network of health care providers.

The scheme provided 972 surgeries/therapies/ procedures along with121 follow up packages in 30 identified specialized categories:

Families holding yellow ration card, Antyodaya Anna Yojana card (AAY), Annapurna card and orange ration card. The families holding white ration card are not covered under the scheme.

The Scheme provides coverage for meeting all expenses relating to hospitalization of beneficiary up to Rs. 150,000/- per family per year in any of the Empanelled/Network Hospital subject to Package Rates on cashless basis through Health cards or valid Orange/Yellow Ration Card. The benefit is available to each and every member of the family on floater basis i.e. the total annual reimbursement of Rs. 1.5 lakh can be availed by one individual or collectively by all members of the family. In case of renal transplant surgery, the immunosuppressive therapy is required for a period of one year. So the upper ceiling for Renal Transplant is Rs. 250,000 per operation as an exceptional package exclusively for this procedure.

Implementation Procedure

The Entire scheme is implemented as cashless hospitalization arranged by the Insurance Company. The following represents the process flow of treatment to the beneficiary.

A) Process flow of the beneficiary treatment in the network hospital

Step 1: Beneficiary families have to approach nearby PHC/Rural, Sub district, General, Women/ District Hospital/Network Hospital. Aarogyamitras placed in the above hospitals facilitate the beneficiary. If beneficiary visits Government Health Facility other than the Network Hospital, he/she is given a referral card to the Network Hospital with preliminary diagnosis by the doctors. The Beneficiary may also attend the Health Camps being conducted by the Network Hospital in the Villages and can get that referral card based on the diagnosis. The information on the outpatient and referred cases in the PHC/Rural, Sub district, General, Women Hospitals/clinics and the camps are collected from all Aarogyamitras/Hospitals on regular basis and captured in the dedicated database through a well-established call centre.

Step 2: The Aarogyamitras at the Network Hospital examine the referral card and health card or Yellow/Orange Ration Card, register the patients and facilitate the beneficiary to undergo specialist consultation, preliminary diagnosis, basic tests and admission process. The information like admission notes, test done is captured in the dedicated database by the Medical Coordinator of the Network Hospital as per the requirement of the Rajiv Gandhi Jeevandayee Arogya Yojana Society.

Step 3: The Network Hospital, based on the diagnosis, admits the patient and sends e-preauthorization request to the insurer, same can be reviewed by Rajiv Gandhi Jeevandayee Arogya Yojana Society.

Step 4: Recognized Medical Specialists of the Insurer and Rajiv Gandhi Jeevandayee Arogya Yojana Society examine the preauthorization request and approve preauthorization, if, all the conditions are satisfied. This is done within 12 working hours and immediately in case of emergency wherein e-preauthorization is marked as "EM".

Step 5: The Network Hospital extends cashless treatment and surgery to the beneficiary. The Postoperative notes of the Network Hospitals are updated on the website by the medical coordinator of the Network Hospital.

Step 6: Network Hospital after performing the covered surgery/ therapy/ procedure forwards the Originals bills, Diagnostics reports, Case sheet, Satisfaction letter from patient, Discharge Summary duly signed by the doctor, acknowledgement of payments of transportation cost and other relevant documents to Insurer for settlement of the claim. The Discharge Summary and follow-up details are part of the Rajiv Gandhi Jeevandayee Arogya Yojana Society portal.

Step 7: Insurer scrutinizes the bills and gives approval for the sanction of the bill and makes the payment within agreed period as per agreed package rates. The claim settlement module along with electronic clearance and payment gateway is part of the workflow in Rajiv Gandhi Jeevandayee Arogya Yojana Society portal and will be operated by the Insurer. The reports are available for scrutiny on the Rajiv Gandhi Jeevandayee Arogya Yojana Society login.

Step 8: The Network Hospital provides free follow-up consultation, diagnostics, and medicines under the scheme up to 10 days from the date of discharge.

B) The claims procedure is under taken as detailed below:

i) Claim Intimation: The INSURER receives claim intimation from the Network hospital online in the form as agreed under the scheme. Rajiv Gandhi Jeevandayee Society portal has reports indicating claim intimations received.

ii) Collection of Claim documents: The INSURER offers single window service at the respective Project office to the Network hospital for receiving the claim documents. The Network hospital will send the claim documents along with the invoice to the INSURER. This also follows an electronic route.

iii) Scrutiny of Claim Documents: The INSURER shall scrutinize the claim documents at the initial stage regarding the medical and eligibility aspect. Deficiency of documents, if any, is communicated to the Network hospital within 7 working days.

iv) Claim Control Number: The INSURER settles all eligible claims and pays the sum to the Network hospital upon receipt of the complete claim documents. A separate Claim Control Number is provided by insurer for every claim made by Network hospital.

v) Repudiation of claims: The INSURER on repudiation of the claim not paid fully (as per the package sanctioned) under the policy, shall mention the reasons for repudiation on writing and online to the Network hospital. The INSURER shall also intimate the same to Rajiv Gandhi Jeevandayee Arogya Yojana Society online.

Aim and Objectives

This study is a retrospective analysis of implementation of the RGJAY scheme- study of trends and category of beneficiaries, cost-benefit analysis and scope of improvement in scheme, based on feedback of the treating doctors and hospital co-ordinator for the scheme. The data so retrieved was used for descriptive analysis and for studying the trends over time.

Methods

Records of all RGJAY cases were retrieved from the hospital RGJAY cell [2] over period from November 2013 to October 2015. All cases were grouped according to time of registration in eight groups/quarters, each of duration of three months- November 2013 to January 2014, February 2014 to April 2014, May 2014 to July 2014, August 2014 to October 2014, Nov 2014 to Jan 2015, February 2014 to April 2015, May 2015 to July 2015 and August 2014 to October 2015.

Data retrieved was analysed for parameters like

1) Total number of cases registered
2) Number of cases in different specialized categories
3) Number of cases in different surgeries/ therapies/procedures packages
4) Average time required for approval of claim
5) Number of claims getting paid
6) Average Claim amount paid per case
7) Average claim deducted amount- Sometimes claim paid amount was less than was preauthorization approved amount because of lacunae in follow-up and documentation.

8) Number of cases which were usually required to be done by external funding- because of very high cost of procedures, cases of cardiovascular and thoracic surgery (CVTS), medical oncology, orthopaedic surgeries requiring implants and spine surgery had usually required external funding like from Non-Governmental Organizations (NGO), social workers, private donors etc. But now all these procedures were included in RGJAY scheme.
9) Distribution of cases in beneficiary groups like yellow card holder, orange card holder with cases of national programs and medico-legal cases, senior citizens and others.

Results and Discussion

Total 6797 claims were analysed in 24 months period. Overall number of cases were increased from 188 in November 2013- January 2014 to 1168 in August 2015- October 2015 (Table 1). This is because increased awareness in general public and huge dissemination of information about RGJAY scheme in health care workers.

Cases were also analysed according to their specialized categories. In surgical cases cardiovascular and thoracic surgery and polytrauma specialty cases were of highest number (Table 1). In medical cases cardiology and pulmonology cases were highest (Table 1). CVTS cases were decreased. This is probably because more number of hospitals, capable of handling CVTS cases are empanelled in RGJAY scheme. But in contrast number of cardiology cases were increased because from June 2015 out Cath lab and cardiology unit had started functioning performing all types of cardiology procedures.

Out of all cases 37.6% cases were from outside of Pune district and in those CVTS, paediatric, medical oncology and polytrauma cases were more common (Table 1).

Numbers of cases enrolled under individual surgeries/therapies/procedures packages were checked. Highest number of cases, 697 (10.3% of total), were done under 'Open reduction and internal fixation (ORIF) of fracture of Long Bone' package followed by Palliative Chemotherapy- 338 (5% of total) and chronic Renal Failure- 307 (4.5% of total).

Average time required for preauthorization approval was decreased (Figure 1). It was average 7.35 days in November 2013- January 2014 term and 2.09 in August 2015- October 2015 term. Reason behind it was Aarogyamitras and resident doctors in hospital were acquired enough knowledge of claim process to make claim approval faster.

Number of cases getting claim paid were increased (50% in November 2013 to January 2014 to 76% in February 2014 to April 2014) due to improvement in efficiency in working of all stakeholders like hospitals and insurance company (Figure 2). Lower numbers of cases getting paid in last two terms May 2015 to July 2015 (70%) and August 2014 to October 2015 (31%) was due to some cases in these terms had not paid when study was undertaken but have been paid later. Also average difference between claim approval amount and actual paid amount was decreased.

In contrast average claim amount paid per case was decreased (November 2013 to January 2014- Rupees 67872, February 2014 to April 2014- Rupees 22985, May 2014 to July 2014- Rupees 28076, August 2014 to October 2014- Rupees 23629, Nov 2014 to Jan 2015- Rupees 25272, February 2014 to April 2015- 21193, May 2015 to July 2015- Rupees 22680 and August 2014 to October 2015- Rupees 19232). It was because cases during initial days, the cases enrolled were predominantly for CVTS and poly trauma surgeries of which CVTS cases have high claim value ranging from 120000 Rs to 150000rs per case. As the treating doctors got trained in the procedure for the scheme and due to increased awareness in general public about the RGJAY scheme, non CVTS cases like medical oncology, nephrology and non-interventional cardiology also started enrolling for RGJAY scheme. These cases had low package amounts ranging from mere 2000 Rs to 60000 Rs per case while high package value CVTS cases had decreased.

Due to increase in efficiency of functioning of claim process with good follow-up and documentation in later part of study average claim deducted amount was decreased. It means claim paid amount was nearly equal to pre-authorization approved amount.

Table 1: Trends and distribution of cases

	Nov13 -Jan 14	Feb 14- Apr 14	May 14-Jul 14	Aug 14-Oct 14	Nov 14-Jan 15	Feb 15- Apr 15	May 15-Jul 15	Aug 15-Oct 15	Total	% of All Cases
Medical Cases										
Cardiology	2	40	33	33	21	21	62	109	321	4.7
Critical Care	0	18	13	20	12	15	13	29	120	1.8
Gastroenterology	3	6	15	7	22	18	9	21	101	1.5
General Medicine	1	14	14	13	10	10	10	14	86	1.3
Pulmonology	3	11	7	6	42	49	31	70	219	3.2
Int. Radiology	0	0	1	1	1	0	0	0	3	0.0
Nephrology	7	51	69	54	60	45	34	72	392	5.8
Neurology	4	29	14	41	52	15	21	28	204	3.0
Dermatology	0	3	0	5	4	4	5	14	35	0.5
Infectious Disease	0	1	0	0	2	0	0	0	3	0.0
Medical Oncology	0	23	93	110	167	162	163	167	885	13.0
Paediatrics	8	67	38	171	159	305	231	161	1140	16.8
Total Medical	28	263	297	461	552	644	579	685	3509	51.6
Surgical Cases										
Polytrauma	30	125	64	101	158	142	128	110	858	12.6
Burns	2	8	8	4	1	2	0	4	29	0.4
CVTS	84	138	125	98	99	64	75	94	777	11.4
SurgicalGE	1	10	6	2	12	9	13	6	59	0.9
Surgical Ophthal	3	12	1	7	23	40	24	33	143	2.1
ENT Surgery	6	49	30	23	20	27	38	63	256	3.8
Orthopaedics	5	31	14	13	9	3	4	4	83	1.2
PaediatricSurgery	5	13	7	4	5	5	2	3	44	0.6
General Surgery	4	48	37	14	45	25	20	34	227	3.3
GU Surgery	6	17	11	15	23	18	16	16	122	1.8
OBGY	8	22	21	9	24	33	42	46	205	3.0
Plastic Surgery	0	3	3	0	2	0	2	2	12	0.2
Surgical oncology	0	17	36	10	31	36	26	37	193	2.8
Neurosurgery	5	29	24	30	62	53	44	31	278	4.1
Total Surgical	159	522	387	330	514	457	434	483	3286	48.3
Cases from Pune District and outside of Pune District										
Pune	98	471	396	483	672	754	610	758	4242	62.4
Outside of Pune	91	314	288	308	394	347	403	410	2555	37.6
All Cases										
	189	785	684	791	1066	1101	1013	1168	6797	100.0

Int. Radiology: Interventional Radiology, CVTS: Cardiovascular and Thoracic Surgery, Surgical GE: Surgical Gastroenterology, Surgical Ophthal: Surgical Ophthalmology, ENT Surgery: Ear Nose Throat Surgery, GU Surgery: Genitourinary Surgery, OBGY Obstetrics and Gynaecology Surgery.

Figure 1: Trend of average time required for approval of claim

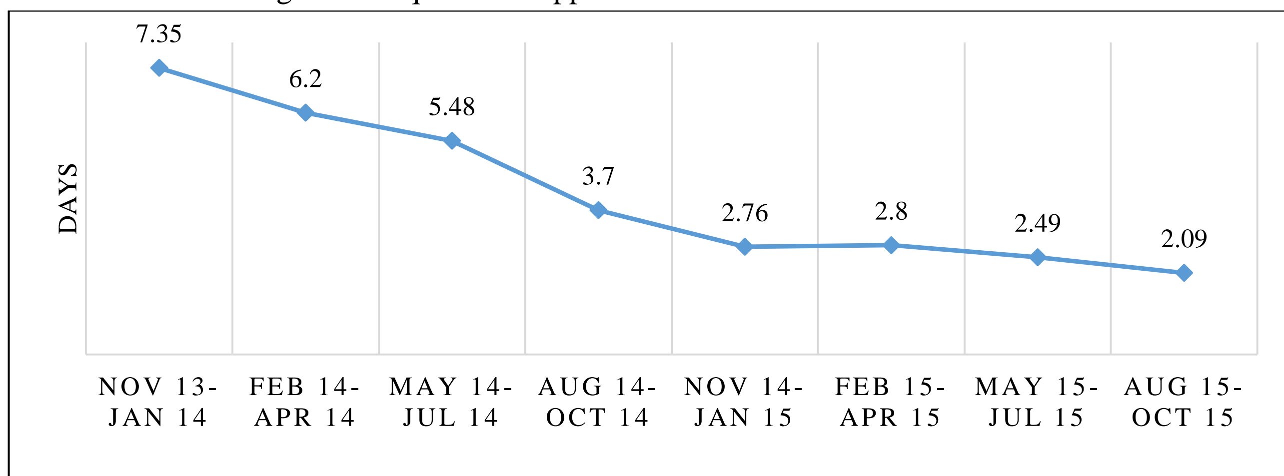
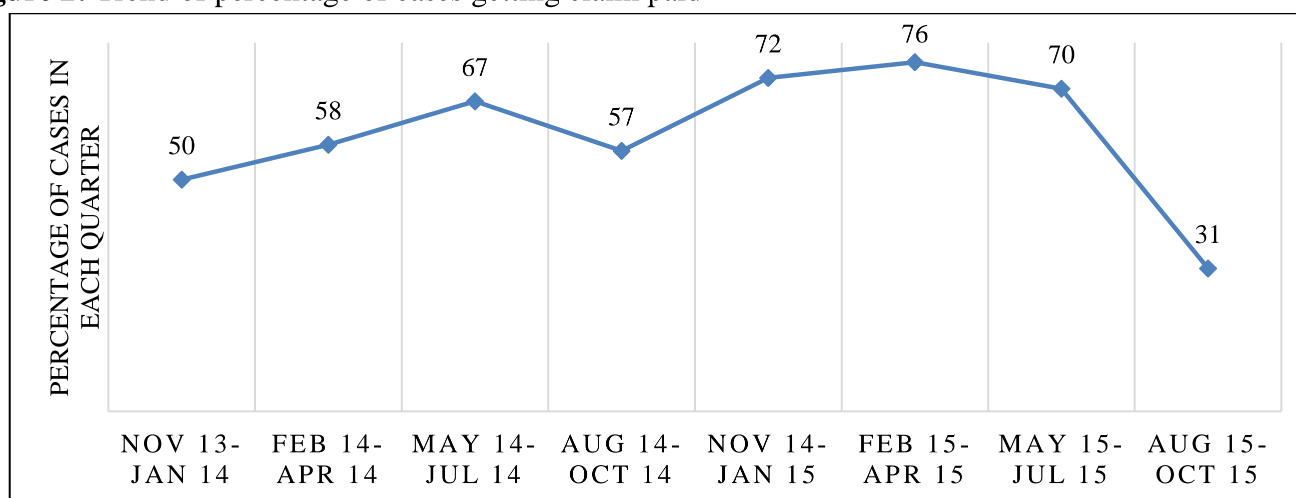


Figure 2: Trend of percentage of cases getting claim paid



Cases of cardiovascular and thoracic surgery (777, 11.4% of total), medical oncology (885, 13% of total), orthopaedic surgeries requiring implants (708, 10.4% of total) and spine surgery (2013, 3% of total) were covered under RGJAY scheme. So patient was not required to search for donor who will fund for his/her procedure. Collectively these all cases were 2573 which was 37.9% of total.

Cases with yellow card holder (25% of total), cases of national programs and medico-legal cases with orange card holder (19% of total) and cases of senior citizens (22% of total) were treated free at governments cost. But now through the RGJAY scheme government is getting reimbursement of cost of all these cases. Collectively these all cases were 66% of total. Number of these cases were increased and for hospital,good amount was generated through it.

The treating doctors and hospital coordinator was contacted for their suggestions for improving implementation of the scheme. The important comments were

1. Patients coming to hospital especially in case of emergency do not carry their ration card, so they cannot be enrolled under the scheme for cashless treatment. Even if enrolled provisionally as an emergency, the enrolment lapses if the ration card related formalities are not completed in 72 hours. This is difficult because patients coming to tertiary care hospitals come for distant places. So the 72 hour limit should be scrapped.
2. Investigations required are too many and sometimes not required for actual management of the cases.
3. Most of the patients coming to the government hospital fall into the free category BPL, senior

citizen, MLC, National program, pregnancy, neonates, government employees etc. Families of these subjects do not co-operate for enrolling under RGJAY because they feel the amount available may be used for other situations where they may have to undergo paid treatment.

4. Intraoperative photos/ videos, discharge photos and other paper work etc. are mandatory from claim. But these thing especially intraoperative photos actually cause distraction from actual procedure and reduces interest of participating doctors in the scheme.

5. Most common conditions are not included in the list of cashless procedures, so many subjects still land up paying for the treatment.

6. Patients coming for follow-up get their check-ups done as well as receive their follow up medication at a nominal registration fee of Rs. 10 per visit. As a result patients do not want to get into the exhaustive protocol for the follow-up packages at government hospitals.

Government of India had launched a social health protection program called Rashtriya Swasthya Bima Yojana (RSBY) in the year 2008 to provide financial protection from catastrophic health expenses to below poverty line households (HHs). Thakur assessed the status of RSBY in Maharashtra at each step of awareness, enrolment, and utilization. It was seen that that the RSBY had a very limited success in Maharashtra. Out of 6000 HHs, only 29.7% were aware about the scheme and 21.6% were enrolled during the period of 2010–2012. Only 11.3% HHs reported that they were currently enrolled for RSBY. Although 1886 (33.1%) HHs reported at least one case of hospitalization in the last 1 year, only 16 (0.3%) HHs could actually utilize the benefits during hospitalization. It is seen that at each step, there is an increase in the exclusion of eligible HHs from the scheme. The participants felt that such schemes did not reach their intended beneficiaries due to various SPEC factors. Study highlighted the limited success of the scheme in Maharashtra [3].

In Maharashtra, RSBY was withdrawn and a state sponsored health insurance scheme- RGJAY was started.

Conclusion

Additional services could be provided to patients in cashless manner. Good amount had generated through cases which were otherwise done free before RGJAY scheme. Still, there is lot scope to improve and generalize scheme across people of the state. RGJAY scheme should be implemented in all district/civil hospitals so that time and money in transport for patients will be saved. More categories should be included in the list of RGJAY. There is a need of information dissemination to increase registration of more number of cases. Precise and brief guidelines for resident doctor should be laid down for efficient conduct of registration and claim process. Government and insurance companies should try to decrease protocols of insurance, reduction in the number of mandatory investigations for eligibility and claims under this scheme.

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