Outline

• Background: Monitoring HBP
• A closer look at fraud, waste & abuse
• (Briefly) Survey data
Background: Monitoring HBP
Using Evidence to Strengthen HBP Implementation

Source:
What’s In? What’s Out?
Designing Benefits for UHC
Using Evidence to Strengthen HBP Implementation

Source:
What’s In? What’s Out?
Designing Benefits for UHC
<table>
<thead>
<tr>
<th>S.No</th>
<th>Speciality</th>
<th>No. of packages</th>
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<tr>
<td>1</td>
<td>Cardiology</td>
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<tr>
<td>2</td>
<td>Cardio-vascular surgery</td>
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<td>ENT</td>
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<td>6</td>
<td>Orthopaedics</td>
<td>101</td>
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<td>7</td>
<td>Polytrauma</td>
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<td>8</td>
<td>Urology</td>
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<td>9</td>
<td>Obstetrics &amp; Gynaecology</td>
<td>89</td>
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<td>10</td>
<td>General Surgery</td>
<td>253</td>
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<td>11</td>
<td>Paediatric medical management</td>
<td>99</td>
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<td>12</td>
<td>Neo-natal</td>
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<td>13</td>
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<td>14</td>
<td>Paediatric cancer</td>
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<td>15</td>
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<td>72</td>
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<td>16</td>
<td>Neurosurgery</td>
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<tr>
<td>17</td>
<td>Interventional Neuroradiology</td>
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<tr>
<td>18</td>
<td>Oncology</td>
<td>110</td>
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<td>19</td>
<td>Reconstructive surgery</td>
<td>9</td>
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<tr>
<td>20</td>
<td>Burns management</td>
<td>12</td>
</tr>
<tr>
<td>21</td>
<td>Dental</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>1343</strong></td>
</tr>
</tbody>
</table>
Many Possible Dimensions for HBP monitoring (1)

- **Population**
  - Coverage
  - Utilization
  - Grievances

- **Financing**
  - Fund flow
  - Claims paid
  - Claims processes

- **Supply**
  - Access
  - Capacity
  - Quality

**Integrity**
Many Possible Dimensions for HBP monitoring (2)

**Population**
- How many are covered?
- How many have utilized?
- What is the patient experience?

**Financing**
- Are sufficient funds available to SHA/insurers?
- What is the size and structure of claims payments?
- How effective/efficient are internal processes for claims payment?

**Supply**
- Is the number of hospitals sufficient?
- Are the empanelled facilities working near full capacity?
- Is the care provided of adequate quality?

**Integrity**
- Are beneficiary, payer and provider fraud prevented, detected and deterred?
PMJAY Dashboard

PMJAY Dashboard Suite

- Operations Dashboard
- HEM Dashboard
- Pre-Authorization Dashboard
- Portability Dashboard
- District Dashboard
- HEM Hospital Master
- SECC State Demographics
- Tickets Monitoring
- PMJ Letter Tracking
A Closer Look at Fraud, Waste & Abuse
Average losses due to fraud estimated at 6.2% in 7 high-income countries (OECD)

One study estimated losses due to health insurance fraud in India at INR 600-800 crore in 2012 – likely far higher today

Increase in coverage from 30,000 (RSBY) to 5 lakh (PMJAY) increases risk of fraud

Impact of integrity violations in health sector is not merely financial – implications also for health

Some measures required to address fraud and waste are similar to those required to address quality
# Fraud vs. Abuse vs. Waste vs. Error

<table>
<thead>
<tr>
<th>Definition</th>
<th>FRAUD</th>
<th>ABUSE</th>
<th>WASTE</th>
<th>ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intentional</strong></td>
<td><strong>Intentional</strong></td>
<td><strong>Without criminal intent</strong></td>
<td><strong>Not intentional</strong></td>
<td><strong>Not intentional</strong></td>
</tr>
<tr>
<td><strong>Illegal</strong></td>
<td><strong>Illegal</strong></td>
<td><strong>Inadvertent use of resources</strong></td>
<td><strong>Not intentional</strong></td>
<td><strong>Not intentional</strong></td>
</tr>
<tr>
<td><strong>“Rule-breaking” behavior</strong></td>
<td><strong>“Rule-breaking” behavior</strong></td>
<td><strong>“Rule-bending” behavior</strong></td>
<td><strong>Inadventent use of resources</strong></td>
<td><strong>Mistakes during the process of healthcare delivery</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Not illegal, but inconsistent with medical, fiscal, business practices</strong></td>
<td></td>
<td><strong>Not intentional</strong></td>
<td><strong>Mistakes during the process of healthcare delivery</strong></td>
</tr>
</tbody>
</table>

| Examples     | Charging for laparoscopic surgery when conventional surgery is performed. | Ordering unnecessary tests for the purpose of increasing reimbursements | Prescribing high-cost medicines when cheaper generic is available | Prescribing wrong medications to a patient |
NHA & SHA Roles and Responsibilities for Fraud Control

National Health Authority: Stewardship
- Anti-fraud guidelines/framework
- Anti-fraud cell
- Legal & regulatory
- Anti-fraud clauses in contracts
- IT system design and advanced analytics
- Transactional triggers list
- Data standards & mining
- Development of clinical protocols
- Oversight, monitoring, trends, profiling, comparative analysis
- Dedicated cell/staff
- Capacity-building, technical assistance
- Course correction

State Health Agencies: Stewardship & Implementation
- Institutional structure
- Dedicated cell/staff and capacity-building
- Operational actions
- Anti-fraud awareness
- Oversight & monitoring
- Localized transactional triggers list
- Effective beneficiary identification & audits
- Data analysis
- Claims/medical audits, field investigations
- Adherence to clinical protocols
- Contract monitoring & enforcement, punitive action, recoveries

Source: National Health Authority
Fraud & waste can happen at any stage

- **Verification**
  - Beneficiary Silver Record Created
  - Is the beneficiary the same person as given in SECC 2011

- **Enrollment**
  - Beneficiary Golden Record Created
  - Does the hospital meet all requirements for empanelment

- **Empanelment**
  - Hospital Empanelment
  - Does the case appear to be inconsistent with standard treatment procedures

- **Treatment**
  - Pre-Authorization initiated
  - Does the claim meet all the requirements

- **Claim Submitted**

- **Claim Payment**
  - Field Investigation
  - Medical Audit
  - Recoveries
Monitoring Supply/Capacity

**Empanelled hospitals**

- Manipur: 6 (Public: 2, Private: 4)
- Nagaland: 9 (Public: 5, Private: 4)
- Tripura: 37 (Public: 2, Private: 35)
- Mizoram: 80 (Public: 24, Private: 56)
- Sikkim: 3 (Public: 3, Private: 0)

**Empanelled hospitals with at least 1 tertiary specialty**

- Manipur: 7 (Tertiary Public: 5, Tertiary Private: 2)
- Nagaland: 52 (Tertiary Public: 5, Tertiary Private: 47)
- Tripura: 2 (Tertiary Public: 2, Tertiary Private: 0)
- Mizoram: 74 (Tertiary Public: 8, Tertiary Private: 66)
- Sikkim: 3 (Tertiary Public: 3, Tertiary Private: 0)
Tamil Nadu Makes All Empanelment Data Public

Government of Tamil Nadu
Chief Minister’s Comprehensive Health Insurance Scheme

Multi Speciality Hospitals List

<table>
<thead>
<tr>
<th>ID</th>
<th>Hospital Name (For Empanelment)</th>
<th>District Name</th>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>123</td>
<td>East Coast Hospital</td>
<td>Govt. Hospita</td>
<td>43.3</td>
<td>A1</td>
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<tr>
<td>1239</td>
<td>Govt. Hospita, Tiruchirapalli</td>
<td>Virudhunagar</td>
<td>NA</td>
<td>A1</td>
</tr>
<tr>
<td>1240</td>
<td>Govt. Hospita, Tiruchirapalli</td>
<td>Virudhunagar</td>
<td>NA</td>
<td>A1</td>
</tr>
<tr>
<td>1277</td>
<td>Arun Praya Nursing Home</td>
<td>Nagapattinam</td>
<td>15.5</td>
<td>A6</td>
</tr>
<tr>
<td>1277</td>
<td>Fonera MultiSpeciality Hospital</td>
<td>Nagapattinam</td>
<td>45</td>
<td>A5</td>
</tr>
<tr>
<td>1277</td>
<td>Coxe Hospital</td>
<td>Nagapattinam</td>
<td>36</td>
<td>A6</td>
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<tr>
<td>1279</td>
<td>Vasudha Padubadi Hospital</td>
<td>Trichy</td>
<td>9.5</td>
<td>A6</td>
</tr>
<tr>
<td>1280</td>
<td>KIMS Hospital</td>
<td>Trichy</td>
<td>17.9</td>
<td>A6</td>
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<tr>
<td>1282</td>
<td>Thyagaraj Hospital Research Institut</td>
<td>Trichy</td>
<td>0</td>
<td>0</td>
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</table>

Showing 1 to 10 of 814 entries
## Examples of Anti-Fraud Measures

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Detection</th>
<th>Deterrence</th>
</tr>
</thead>
</table>
| • Legal framework  
  • Beneficiary ID system  
  • Empanelment criteria  
  • Benefit package design  
  • Pre-authorization  
  • Clinical practice/standard treatment guidelines  
  • Volume controls | • Data analytics  
  • Claims processing rules  
  • Medical audits  
  • Social audits | • Penalties  
  • Fines  
  • Suspension  
  • Dis-empanelment  
  • Prosecution |
## Detecting Fraud: Examples from 4 Indian States

<table>
<thead>
<tr>
<th></th>
<th>Gujarat - MA</th>
<th>Maharashtra - MJPAY</th>
<th>Tamil Nadu - CMCHIS</th>
<th>Telangana - AHS</th>
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<tr>
<td><strong>Audits</strong></td>
<td>Pre and post-payment audit; medical audits</td>
<td>Pre and post-payment audit; medical audits</td>
<td>Pre and post-payment audit; medical audits</td>
<td>Pre and post-payment audit; medical audits</td>
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<tr>
<td><strong>Hotlines/social audits</strong></td>
<td>Patient feedback; 24/7 helplines; feedback form</td>
<td>Patient feedback; 24/7 helplines; feedback form</td>
<td>Patient feedback; 24/7 helplines; feedback form</td>
<td>Patient feedback; 24/7 helplines; feedback form</td>
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<td><strong>Data analysis</strong></td>
<td>Outlier analysis</td>
<td>Outlier analysis</td>
<td>Outlier analysis</td>
<td>Outlier analysis</td>
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<tr>
<td><strong>Claims processing</strong></td>
<td>Photos and videos submitted for all claims; rules-based</td>
<td>Photos and videos submitted for all claims; rules-based</td>
<td>Photos and videos submitted for all claims; rules-based</td>
<td>Photos and videos submitted for all claims; rules-based</td>
</tr>
</tbody>
</table>
Data Analytics to Identify Outliers
## Hospital Preauth Summary

### Hospital State
- Total: 1
- Active Hospitals: 1
- Avg # Preauths: 559

### SELECT RANGE (Preauth approx...)
- # CASES: 559

### Bucket for #Beds
- 100+ Beds: 228
- No of Beds BLANK: 176
- 0-10 Beds: 281
- 10-25 Beds: 626
- 25-50 Beds: 626
- 50-100 Beds: 336
- Total: 2274

### Procedure Type (Med/Surg)
- **Unspecified Surgical Package**
- # Preauths Raised: 37
- Preauth Amount: 688,000
- Average Preauth Amount: 18,595

### Procedure
- **AKI/renal failure (dialysis payable separately as an add on package for...)**: 39
- **Laparoscopic Cholecystectomy**: 32
- **Laparoscopic Adhesiolysis**: 29
- **Haemodialysis/Peritoneal Dialysis (only for ARF) - per session**: 24
- **Ureteroscopy+stone removal with lithotripsy, upper ureter, urethra...**: 20

### Last refreshed at:
- 2/1/2019 11:32:19 AM
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Hospital State</th>
<th>Hospital District</th>
<th># Preauths Raised</th>
<th>% Preauths Raised</th>
<th>Buckets for # Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>King's Health Care Centre</td>
<td></td>
<td></td>
<td>883</td>
<td>2.53%</td>
<td>10-25 Beds</td>
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<tr>
<td>Madhubani Superspecialty Hospital</td>
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<td>831</td>
<td>2.38%</td>
<td>100+ Beds</td>
</tr>
<tr>
<td>Cancer Institute</td>
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<td>823</td>
<td>2.35%</td>
<td>50-100 Beds</td>
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</table>

<table>
<thead>
<tr>
<th>Procedure Type (Med/Surg.)</th>
<th>Procedure</th>
<th># Preauths Raised</th>
<th>Preauth Amount</th>
<th>Average Preauth Amount</th>
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</thead>
<tbody>
<tr>
<td>M</td>
<td>Enteric fever</td>
<td>229</td>
<td>668,700</td>
<td>2,920.00</td>
</tr>
<tr>
<td>M</td>
<td>Acute gastroenteritis with moderate dehydration</td>
<td>139</td>
<td>295,200</td>
<td>2,124.00</td>
</tr>
<tr>
<td>M</td>
<td>Neuromuscular disorders</td>
<td>116</td>
<td>323,100</td>
<td>2,785.00</td>
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<tr>
<td>M</td>
<td>Hypertensive emergencies</td>
<td>59</td>
<td>227,700</td>
<td>3,859.00</td>
</tr>
<tr>
<td>M</td>
<td>Severe anemia</td>
<td>39</td>
<td>82,800</td>
<td>2,123.00</td>
</tr>
<tr>
<td>M</td>
<td>Acute febrile illness</td>
<td>36</td>
<td>84,600</td>
<td>2,350.00</td>
</tr>
<tr>
<td>M</td>
<td>Pyrexia of unknown origin</td>
<td>34</td>
<td>88,200</td>
<td>2,594.00</td>
</tr>
</tbody>
</table>
Triggers Points

1. Claim History Triggers
   - Impersonation.
   - Claims without signature of the beneficiary or pre-authorisation form.
   - Second claim in the same year for an acute medical illness/surgical.
   - Claims from multiple hospitals with same owner.
   - Claims from a hospital located far away from beneficiary’s residence, pharmacy bills away from hospital/residence.
   - Claims for hospitalization at a hospital already identified on a “watch” list or black listed hospital.
   - Claims from members with no claim free years, i.e. regular claim history.
   - Same beneficiary claimed in multiple places at the same time.
   - Excessive utilization by a specific member belonging to the beneficiary Family Unit.
   - Deliberate blocking of higher-priced package rates to claim higher amounts.
   - Claims with incomplete/ poor medical history, complaints/pre existing symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
   - Claims with missing information like post-operative histopathology reports, surgical/anaesthetist notes missing in surgical cases.
   - Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the beneficiary family unit and different hospitals for other members of the beneficiary family unit).
   - Multiple claims towards the end of policy cover period, close proximity of claims.

2. Admissions Specific Triggers
   - Members of the same beneficiary family getting admitted and discharged together.
   - High number of admissions.
   - Repeated admissions.
   - Repeated admissions of members of the same beneficiary family unit.
   - High number of admission in odd hours.
   - High number of admission in weekends/holidays.
   - Admission beyond capacity of hospital.
   - Average admission is beyond bed capacity of the provider in a month.
   - Excessive ICU (Intensive Care Unit) admission.
   - High number of admission at the end of the Policy Cover Period.

3. Diagnosis Specific Triggers
   - Diagnosis and treatment contradict each other.
   - Diagnostic and treatment in different geographic locations.
   - Claims for acute medical illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
   - Ailment and gender mismatch.
   - Ailment and age mismatch.
   - Multiple procedures for same beneficiary – blocking of multiple packages even though not required.
   - One-time procedure reported many times.
   - Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
   - Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
   - Part of the expenses collected from beneficiary for medicines and screening in addition to amounts received by the Insurer.
   - ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of critical illnesses.
   - Overall medical management exceeds more than 5 days, other than in the case of critical illness.
   - High number of cases treated on an out-of-pocket payment basis at a given provider, post consumption of financial limit.

4. Billing and Tariff based Triggers
   - Claims without supporting pre/post hospitalisation papers/bills.
   - Multiple specialty consultations in a single bill.
   - Claims where the cost of treatment is much higher than expected for underlying etiology.
   - High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
   - Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
   - Claims submitted that cause suspicion due to format or content that looks “too perfect” in order.

Source: NHA
• On-site or off-site medical audits focused on:
  • Packages with high utilization
  • Packages with high potential of fraud, waste & abuse
  • High-cost procedures
  • Packages with high variation (e.g., length of stay, etc.)
  • Hospitals with highest pre-authorizations/claims vs. bed capacity
  • Hospitals with high use of “unspecified” package code

• Feedback into benefit package design
  • Review costing/package prices
  • Reserving packages for government hospitals
  • Etc.
Call center data analytics

District vigilance officers (Tamil Nadu)

SMS messages to beneficiaries post-discharge

PHC Arogyamitras (Maharashtra & Telangana)

CM letters seeking feedback (Maharashtra & Telangana)

Whistle-blower policy
13. MONITORING

13.1 The SHA shall be responsible for monitoring the functioning of the GRMS within the state.

13.2 Some of the key indicators for tracking the efficiency of the GRS system shall be:

- Number of grievances resolved through Direct Channel
- Number of beneficiary grievances related to out-of-pocket payments
- Number of beneficiary grievances related to quality of services
- Number of beneficiary grievances related to denial of services
- Number of beneficiary grievances related to delays in receiving services
- Number of grievances from empanelled providers related to partially or fully rejected claims
- Number of grievances from empanelled providers related to delays in receiving claims reimbursements
- Number of beneficiary grievances related to portability benefits
- Number of provider grievances related to portability claims

Share of grievances that are resolved within the prescribed time frame
Target: Over 98 percent

Share of grievances that needed escalation
Target: Less than 10 percent

Using Hotlines to Address Informal Payments: An Example from Europe

Resources
Ongoing Initiatives

• DHR/MoHFW & PGI-Chandigarh costing exercise
• Standard treatment guidelines
• M&E framework under development
• “Proof of Concept” (POC) exercise: 5 IT firms developing advanced analytical tools for fraud detection
• Package-by-package review to identify appropriate diagnostics to help inform pre-authorizations
## Extending M&E to Survey-Based Indicators

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Why important?</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial protection</td>
<td>To track whether OOP is decreasing and beneficiaries are financially protected</td>
<td>• OOP per hospitalization episode among insured/uninsured, by quintile&lt;br&gt;• OOP total (and breakdown by drugs/lab/etc.) among insured/uninsured, by quintile&lt;br&gt;• Catastrophic/impoverishing OOP among insured/uninsured, by quintile</td>
</tr>
<tr>
<td>Patient care-seeking</td>
<td>To track how AB-PMJAY affects patient care-seeking behavior and satisfaction</td>
<td>• Utilization of public/private hospitals among insured/uninsured, by quintile&lt;br&gt;• Utilization of outpatient/inpatient care among insured/uninsured, by quintile&lt;br&gt;• Hospital referrals from outpatient depts., by facility ownership&lt;br&gt;• Patient satisfaction with inpatient care among insured/uninsured</td>
</tr>
<tr>
<td>behavior and experience</td>
<td>To track whether AB-PMJAY is contributing to improved health outcomes</td>
<td>• Mortality from tracer conditions within 30/60 days of discharge</td>
</tr>
<tr>
<td>Health outcomes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Some indicators could be measured via exit survey, others would require NSSO data or other large sample-size household survey.*
The better off seek inpatient care far more often than the poorest quintile.

The better off are far more likely to seek care in the private sector.
4 out of 5 lowest states in terms of hospitalization rate are in Northeast (2014).
Thank You