USING EVIDENCE TO STRENGTHEN HBP IMPLEMENTATION UNDER PMJAY

Owen Smith
World Bank
Guwahati
February 25, 2019

WORLD BANK GROUP
Health, Nutrition & Population

Outline

- Background: Monitoring HBP
- A closer look at fraud, waste & abuse
- (Briefly) Survey data

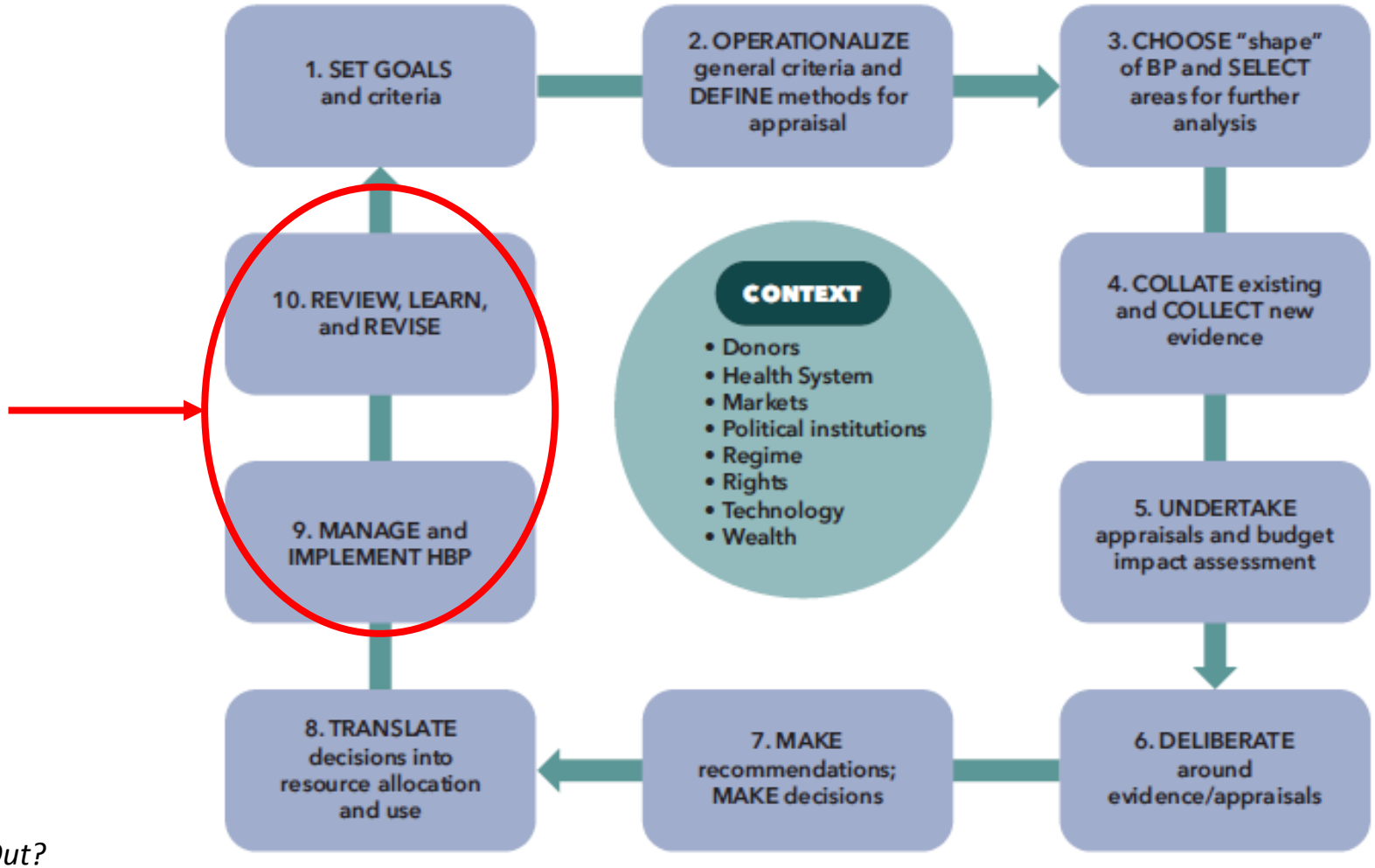
WORLD BANK GROUP
Health, Nutrition & Population

Background: Monitoring HBP

WORLD BANK GROUP
Health, Nutrition & Population

Using Evidence to Strengthen HBP Implementation

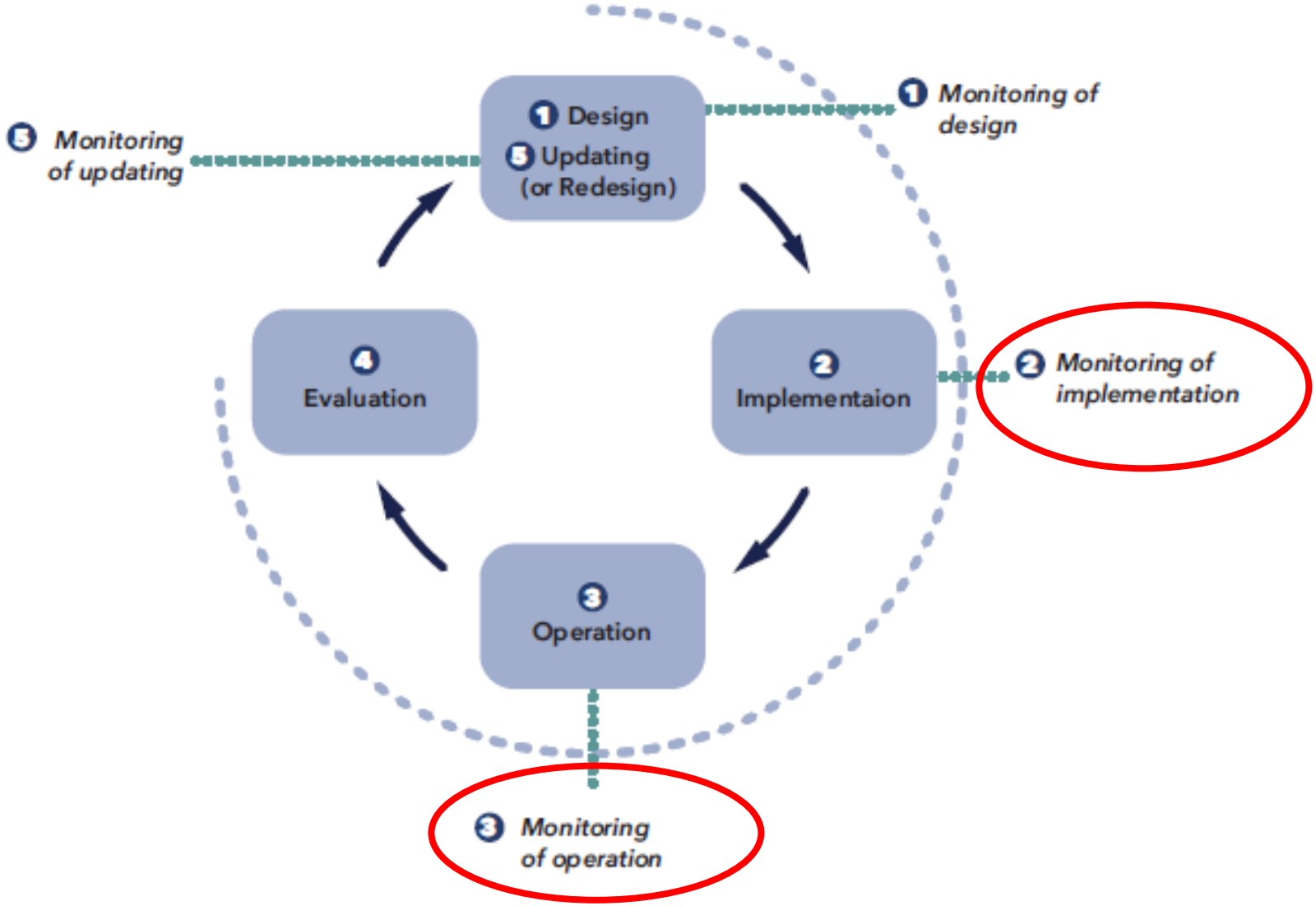
FIGURE 1. The Core Elements of HBP Design



Source:
What's In? What's Out?
Designing Benefits for UHC

Using Evidence to Strengthen HBP Implementation

FIGURE 1. The HBP Monitoring and Evaluation Cycle



Source:
What's In? What's Out? Designing Benefits for UHC

PMJAY Benefit Package

S.No	Speciality	No. of packages
1	Cardiology	38
2	Cardio-vascular surgery	71
3	Cardio-thoracic surgery	21
4	Opthalmology	44
5	ENT	99
6	Orthopaedics	101
7	Polytrauma	13
8	Urology	161
9	Obstetrics & Gynaecology	89
10	General Surgery	253
11	Paediatric medical management	99
12	Neo-natal	4
13	Paediatric surgery	34
14	Paediatric cancer	12
15	Medical packages	72
16	Neurosurgery	82
17	Interventional Neuroradiology	12
18	Oncology	110
19	Reconstructive surgery	9
20	Burns management	12
21	Dental	7
	Total	**1343**

Many Possible Dimensions for HBP monitoring (1)

Dimension

Population	Financing	Supply
Coverage Utilization Grievances	Fund flow Claims paid Claims processes	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?

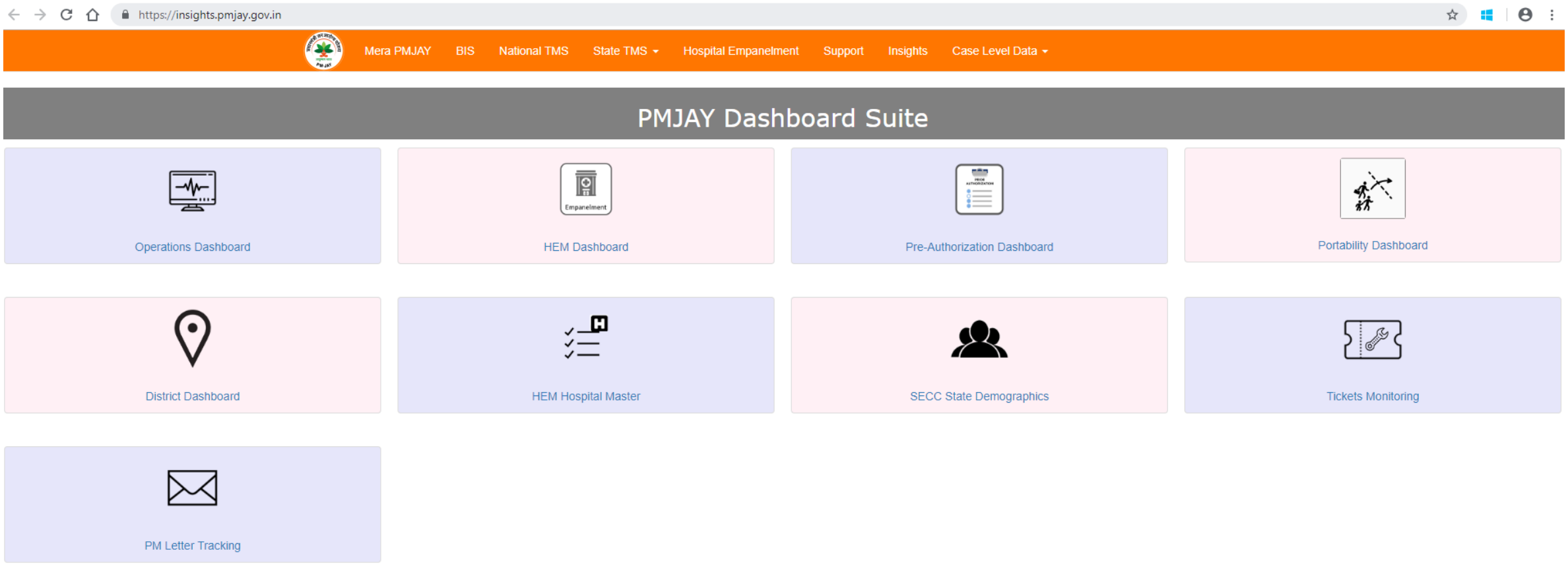
Are the empanelled facilities working near full capacity?

Is the care provided of adequate quality?

Integrity

Are beneficiary, payer and provider fraud prevented, detected and deterred?

PMJAY Dashboard



A Closer Look at Fraud, Waste & Abuse

WORLD BANK GROUP
Health, Nutrition & Population

“Integrity Violations” Undermine the Benefit Package

- **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

	FRAUD	ABUSE	WASTE	ERROR
Definition	▪ Intentional ▪ Illegal ▪ "Rule-breaking" behavior	▪ Without criminal intent ▪ "Rule-bending" behavior ▪ Not illegal, but inconsistent with medical, fiscal, business practices	▪ Not intentional ▪ Inadvertent use of resources	▪ Not intentional ▪ Mistakes during the process of healthcare delivery
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

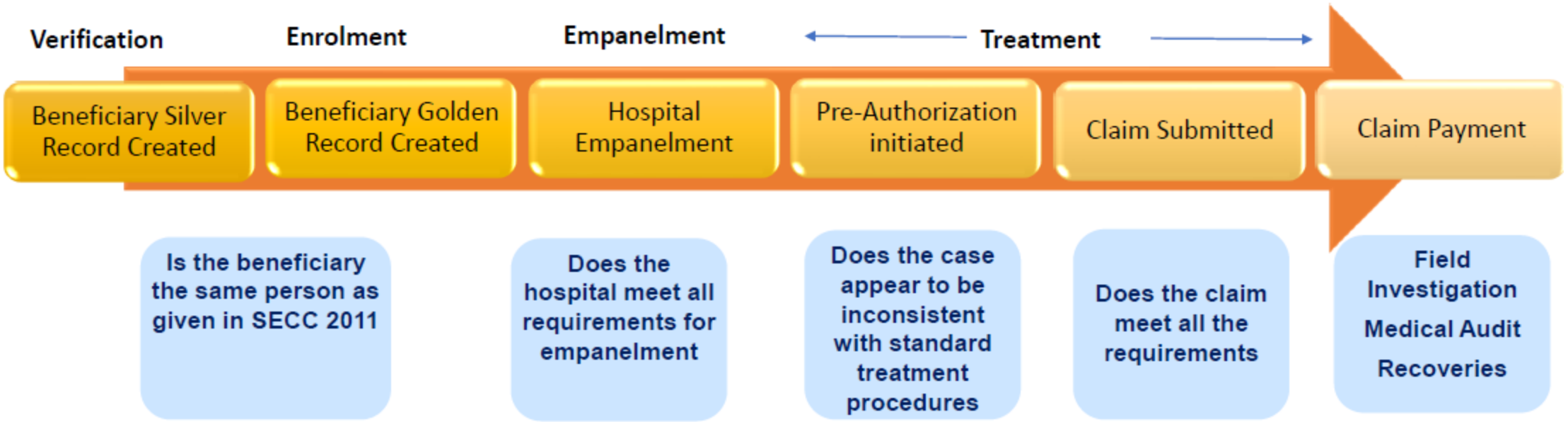
- Anti-fraud guidelines/framework
- Anti-fraud cell
- Legal & regulatory
- Anti-fraud clauses in contracts
- IT system design and advanced analytics
- Transactional triggers list
- Data standards & mining
- Development of clinical protocols
- Oversight, monitoring, trends, profiling, comparative analysis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

State Health Agencies: Stewardship & Implementation

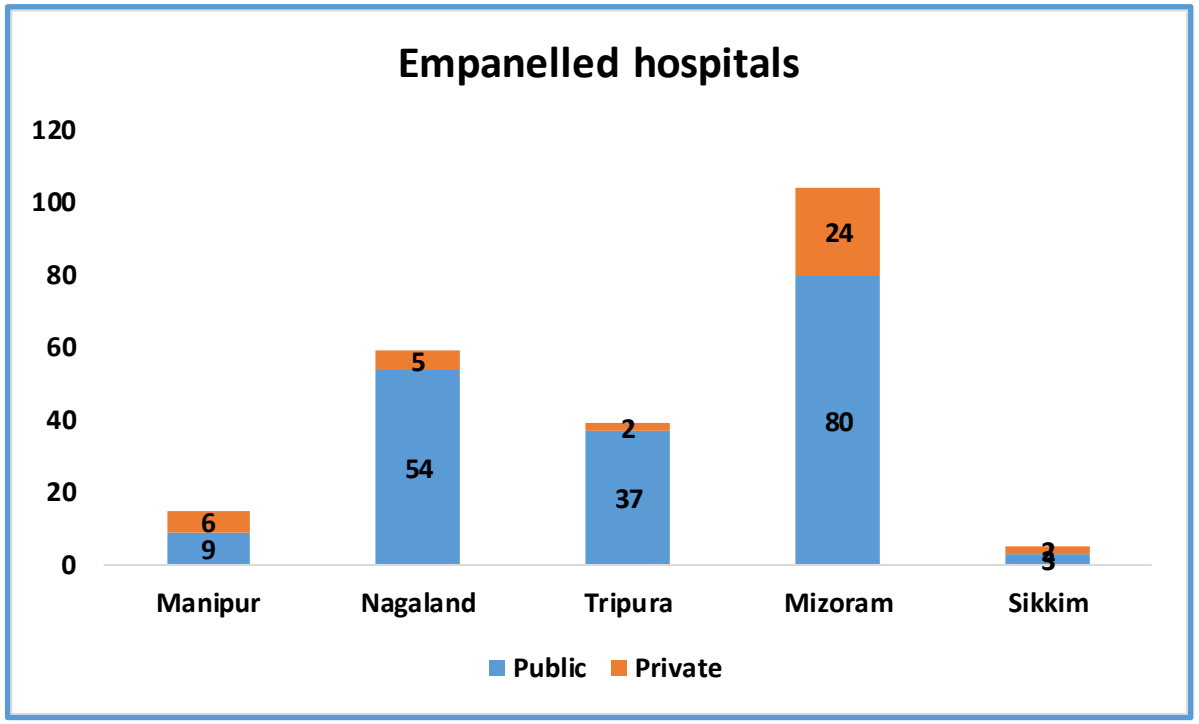
- Institutional structure
- Dedicated cell/staff and capacity-building
- Operational actions
- Anti-fraud awareness
- Oversight & monitoring
- Localized transactional triggers list
- Effective beneficiary identification & audits
- Data analysis
- Claims/medical audits, field investigations
- Adherence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

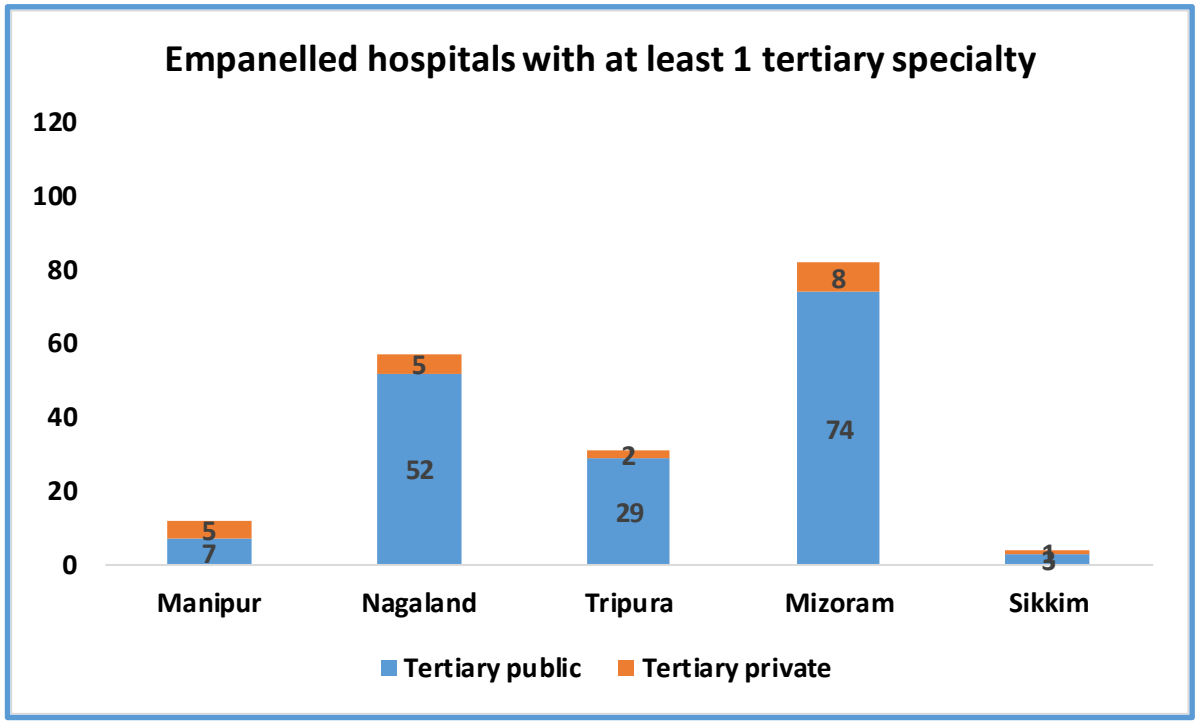
Source: National Health Authority

Fraud & waste can happen at any stage



Monitoring Supply/Capacity





Tamil Nadu Makes All Empanelment Data Public

Examples of Anti-Fraud Measures

Prevention

- Legal framework
- Beneficiary ID system
- Empanelment criteria
- Benefit package design
- Pre-authorization
- Clinical practice/ standard treatment guidelines
- Volume controls

Detection

- Data analytics
- Claims processing rules
- Medical audits
- Social audits

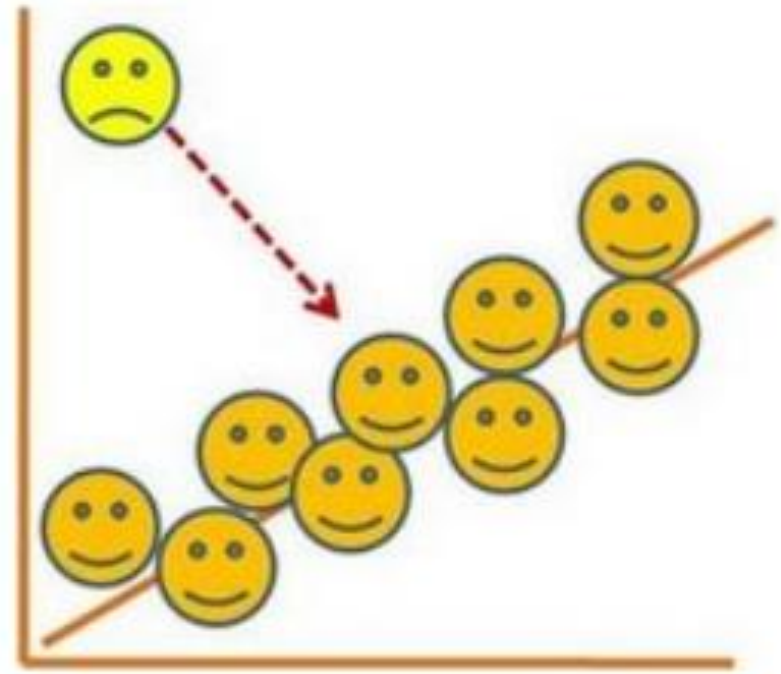
Deterrence

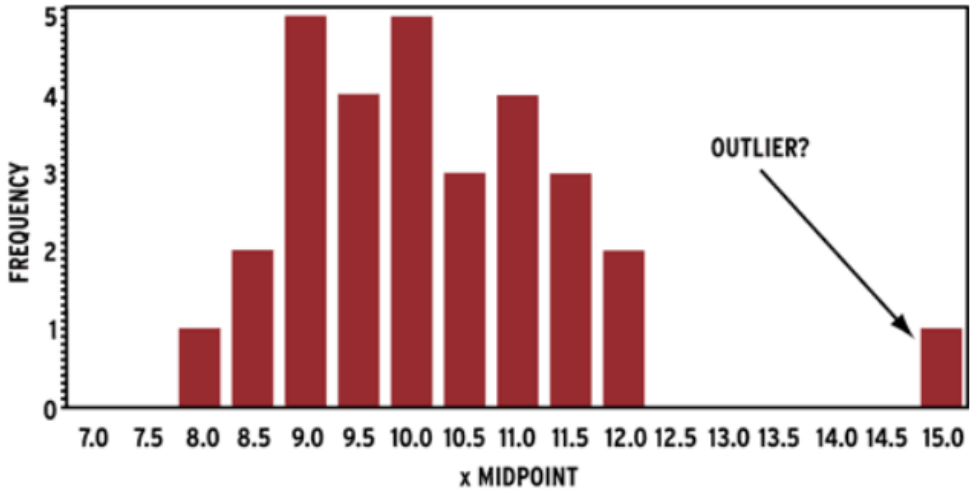
- Penalties
  - Fines
  - Suspension
  - Dis-empanelment
- Prosecution

Detecting Fraud: Examples from 4 Indian States

	Gujarat - MA	Maharashtra - MJPAY	Tamil Nadu - CMCHIS	Telangana - AHS
Audits	✓ Pre and post-payment audit; medical audits	✓ Pre and post-payment audit; medical audits	✓ Pre and post-payment audit; medical audits	✓ Pre and post-payment audit; medical audits
Hotlines/social audits	✓ Patient feedback; 24/7 helplines; feedback form	✓ Patient feedback; 24/7 helplines; feedback form	✓ Patient feedback; 24/7 helplines; feedback form	✓ Patient feedback; 24/7 helplines; feedback form
Data analysis	✓ Outlier analysis	✓ Outlier analysis	✓ Outlier analysis	✓ Outlier analysis
Claims processing	✓ Photos and videos submitted for all claims; rules-based	✓ Photos and videos submitted for all claims; rules-based	✓ Photos and videos submitted for all claims; rules-based	✓ Photos and videos submitted for all claims; rules-based

Data Analytics to Identify Outliers





SELCET STATE

SELECT RANGE (Preauth appr...

9/23/2018 1/23/2019

CASES

559

Last refreshed at:

2/. /20 11:32:19 AM

SELCET SPECIALITY

All

SELECT PACKAGE TYPE

All

SELECT Bucket for #Beds

All

SELECT #Preauths per hospital

All

Hospital State	# Active Hospitals	Avg # Preauths
	1	559
Total	**1**	**559**

Hospital Name	Hospital State	Hospital District	# Preauths Raised	% Preauths Raised	Buckets for # Beds
al Hospital And Research Centre			597	1.71%	50-100 Beds
Sadan			559	1.60%	100+ Beds
Multispeciality Hospital			649	1.86%	100+ Beds
eralhospital			587	1.68%	50-100 Beds

Buckets for # Beds	# Active Hospitals	Avg # Preauths
100+ Beds	228	179
No of Beds BLANK	176	163
0-10 Beds	281	106
50-100 Beds	336	99
25-50 Beds	626	70
10-25 Beds	627	49
Total	**2274**	**91**

Procedure Type (Med/Surg)	Procedure	# Preauths Raised	Preauth Amount	Average Preauth Amount
M	AKI/ renal failure(dialysis payable separately as an add on package for)	39	184,500	4,731.00
S	Unspecified Surgical Package	37	688,000	18,595.00
S	Laparoscopic Cholecystectomy	32	720,250	22,508.00
S	Laparoscopic Adhesinolysis	29	676,250	23,319.00
M	Haemodialysis/Peritoneal Dialysis (only for ARF) - per session	24	48,000	2,000.00
S	Ureteroscopy+stone removal with lithotripsy, upper ureter, unilateral	20	641,500	32,075.00

SELCET STATE

SELECT RANGE (Preauth appr...

9/23/2018 1/23/2019

CASES

883

Last refreshed at:

/201. 11:32:19 AM

SELCET SPECIALITY

All

SELECT PACKAGE TYPE

All

SELECT Bucket for #Beds

All

SELECT #Preauths per hospital

All

Hospital State	# Active Hospitals	Avg # Preauths
[redacted]	1	883
Total	**1**	**883**

Hospital Name	Hospital State	Hospital District	# Preauths Raised	% Preauths Raised	Buckets for # Beds
[redacted]spital	[redacted]	D[redacted]a	1009	2.89%	50-100 Beds
[redacted]g Health Care Centre	[redacted]	[redacted]h	883	2.53%	10-25 Beds
[redacted] Medica Superspecialty Hospital	[redacted]	[redacted]i	831	2.38%	100+ Beds
[redacted]i Cancer Institute	J[redacted]	[redacted]chi	823	2.35%	50-100 Beds

Buckets for # Beds	# Active Hospitals	Avg # Preauths
10-25 Beds	1	883
Total	**1**	**883**

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

Triggers

Triggers Points

1. Claim History Triggers

- Impersonation.
- Mismatch of in-house document with submitted documents.
- Claims without signature of the beneficiary on 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/ presenting 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.

- Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
- Claims with Length of Stay (LOS) which is in significant variance with the average LoS for a particular ailment.

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

Using Evidence to Inform Medical Audits

- 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.

Collecting Evidence from Beneficiaries

Call center data analytics

SMS messages to beneficiaries post-discharge

CM letters seeking feedback (Maharashtra & Telangana)

District vigilance officers (Tamil Nadu)

PHC Arogyamitras (Maharashtra & Telangana)

Whistle-blower policy

Monitoring Grievances

national health agency

GRIEVANCE REDRESSAL SYSTEM

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:

Share of grievances that are resolved within the prescribed time frame

Target: Over 98 percent

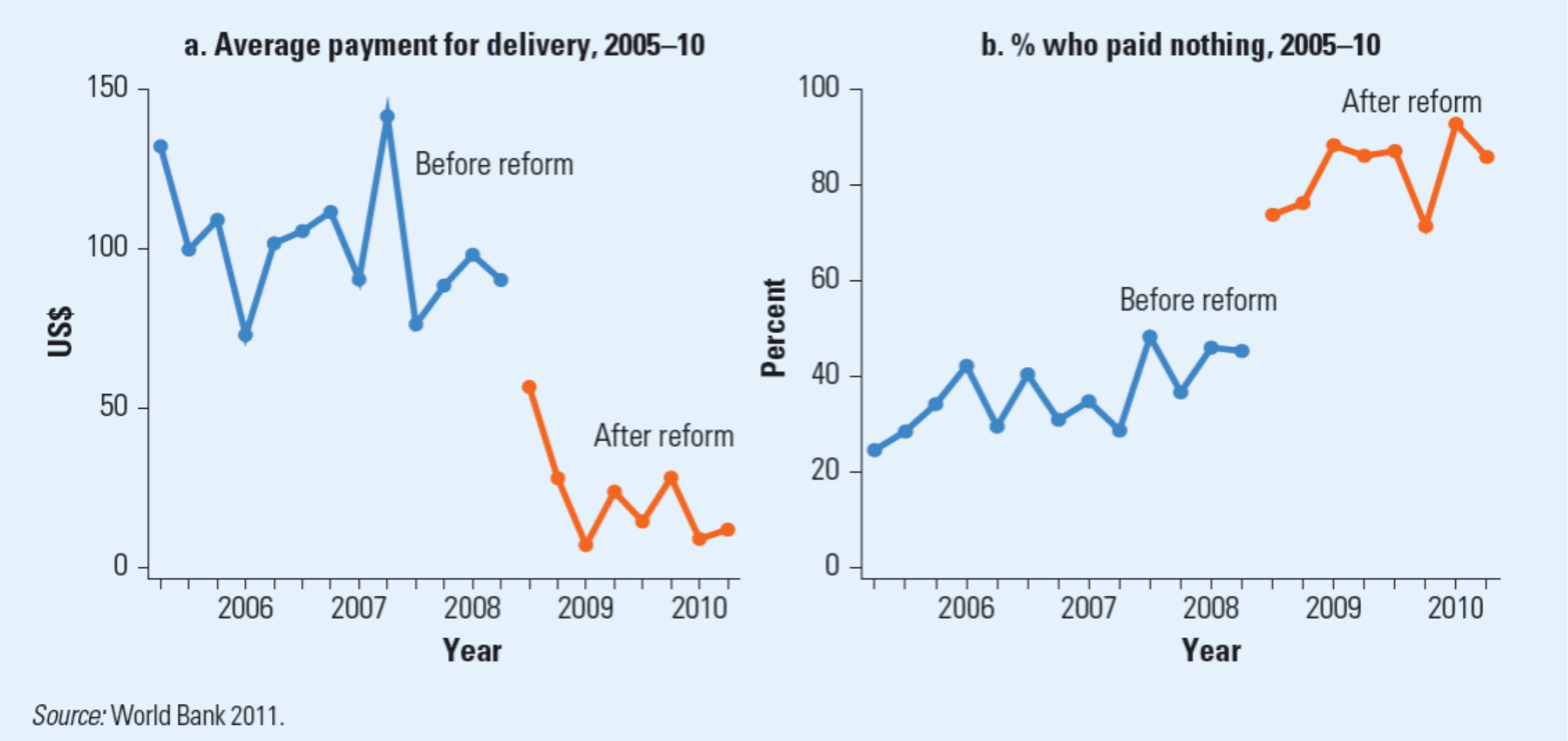
Share of grievances that needed escalation

Target: Less than 10 percent

a. Number of grievances resolved through **Direct Channel**
b. Number of beneficiary grievances related to **out-of-pocket payments**
c. Number of beneficiary grievances related to **quality of services**
d. Number of beneficiary grievances related to **denial of services**
e. Number of beneficiary grievances related to **delays in receiving services**
f. Number of grievances from empanelled providers related to **partially or fully rejected claims**
g. Number of grievances from empanelled providers related to **delays in receiving claims reimbursements**
h. Number of beneficiary grievances related to **portability benefits**
i. Number of provider grievances related to **portability claims**

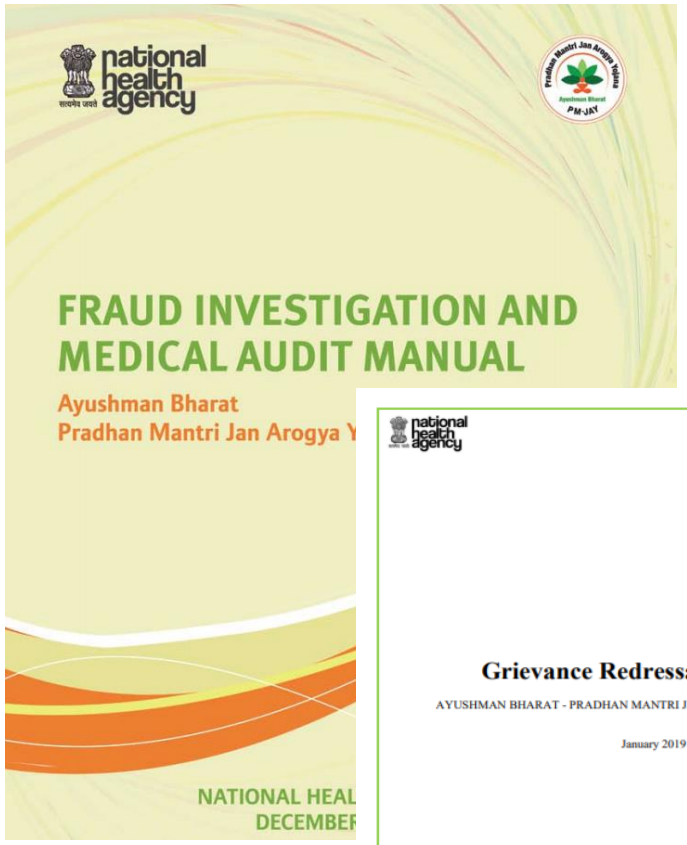
https://www.pmjay.gov.in/sites/default/files/2018-07/GuidelineforGrievanceRedressal_0.pdf

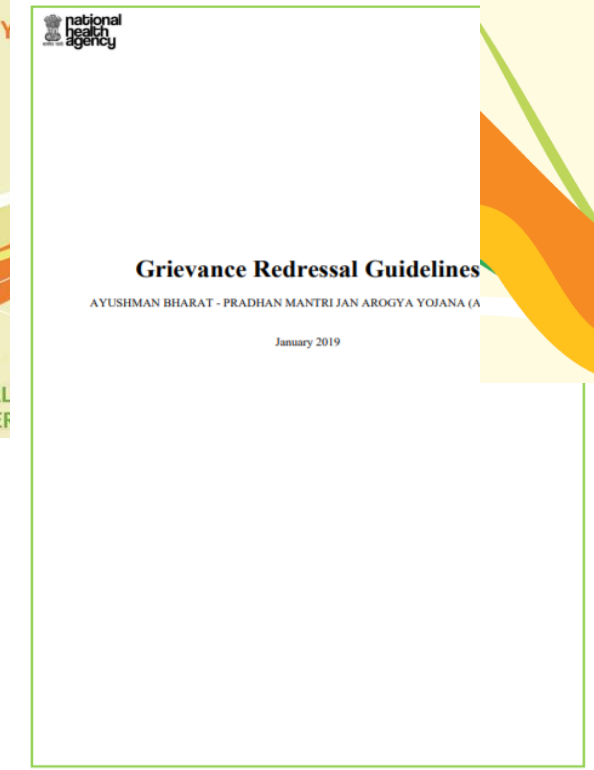
Using Hotlines to Address Informal Payments:
An Example from Europe

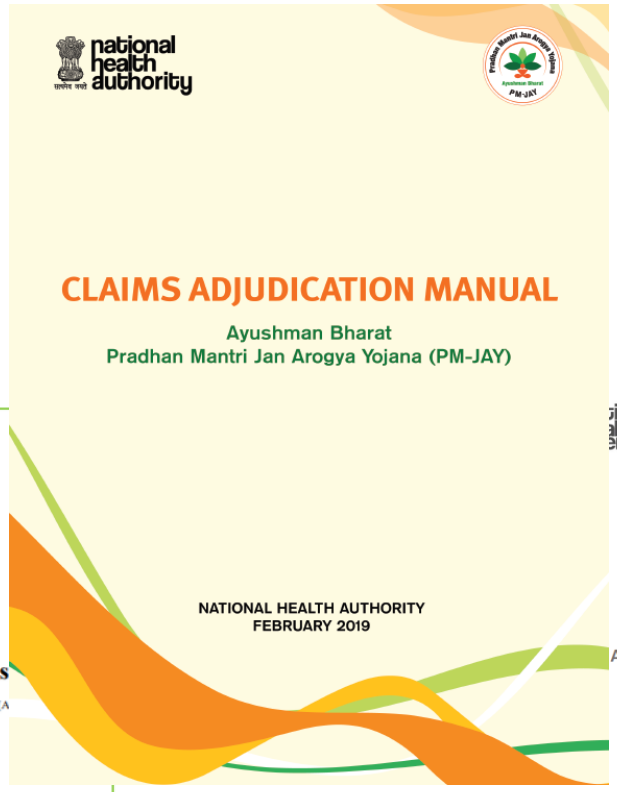


Source: World Bank 2011.

Resources





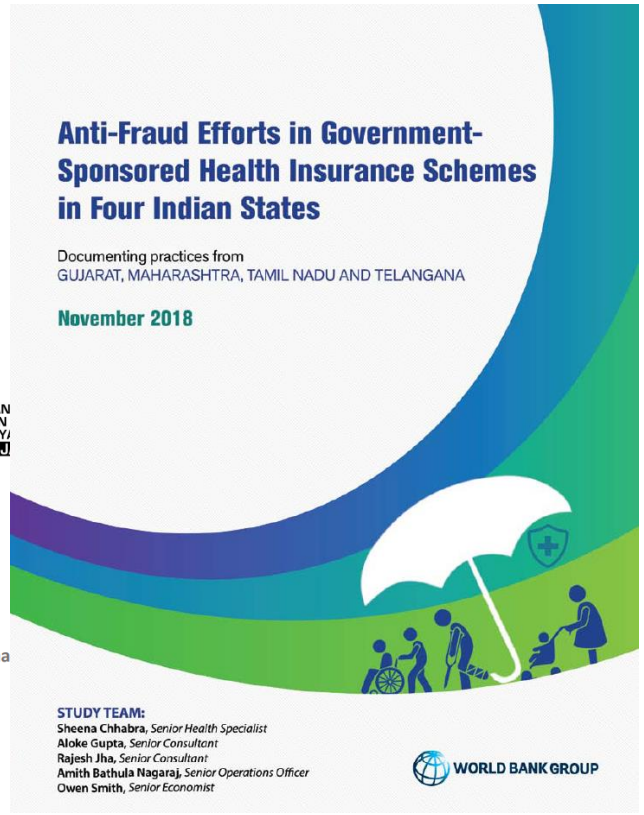


ANTI-FRAUD GUIDELINES

Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY)

National Health Agency
Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY)

August 27, 2018



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

Survey Data

WORLD BANK GROUP
Health, Nutrition & Population

Extending M&E to Survey-Based Indicators

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

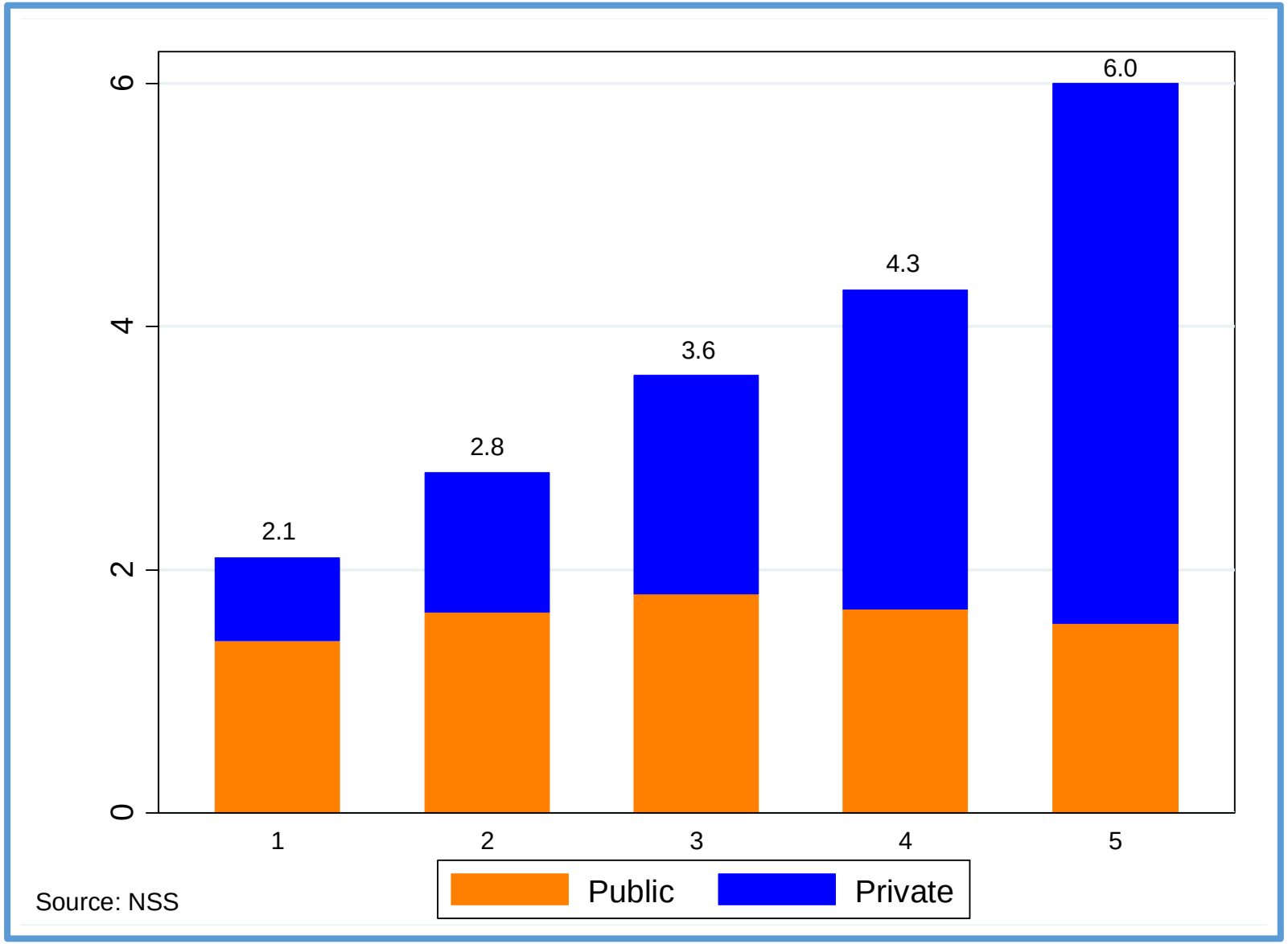
EQUITY

Note: Some indicators could be measured via exit survey, others would require NSSO data or other large sample-size household survey.

Hospitalization Rates by Quintile, all India

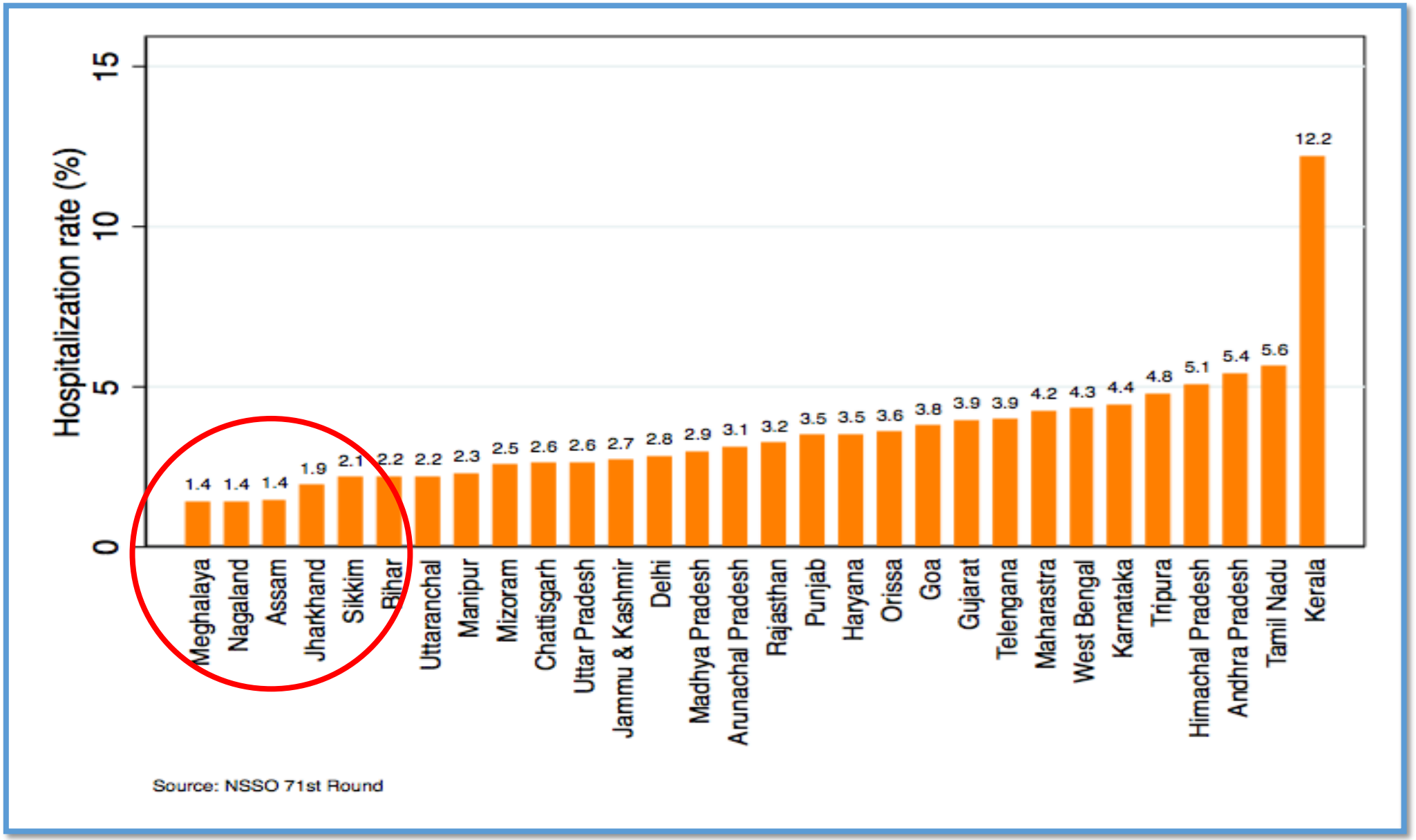
The better off seek inpatient care far more often than the poorest quintile

The better off are far more likely to seek care in the private sector



Hospitalization Rates

4 out of 5 lowest states in terms of hospitalization rate are in Northeast (2014).



Thank You

WORLD BANK GROUP
Health, Nutrition & Population