Case Study

Medical Audits in India

The Joint Learning Network for Universal Health Coverage (JLN) brings policy and technical leaders together to learn from each other and co-create solutions to their most pressing health systems challenges. Learning from each other what has and has not worked, they are able to build more equitable, resilient, and efficient health systems to accelerate progress towards universal health coverage. With the support of expert facilitation, the joint learning approach helps draw out country experiences in a structured way to frame problems, identify common issues, explore insights and knowledge, and synthesize practical solutions that are both country-specific and globally adaptable.

As part of this process, JLN members often co-develop new knowledge products, such as step-by-step costing and self-assessment tools. To date, JLN members have co-created 45 knowledge products on a variety of subjects. Members then bring knowledge products back to their countries, adapt them to their country's specific needs, and finally use or implement the knowledge product to solve a particular challenge. The use of JLN knowledge products is one clear example of the impact the JLN can have downstream in health systems; by enabling countries to use best-practices from JLN country experience as they work towards long-term health system goals, such as expanding and improving on UHC programs. This case study profiles the use of *Toolkit to Develop and Strengthen Medical Audit Systems* in India.

India drew on its participation in the JLN's Medical Audits Collaborative and adaptation of the *Medical Audit Toolkit* to implement a medical audit system that could be decentralized and scaled by India's states to review claims, identify fraud, and ensure the quality of health services being provided to patients.

JLN Knowledge Product:	Toolkit to Develop and Strengthen Medical Audit Systems
Country:	India
Use Case:	National-level adaptation & implementation
Leading Implementers:	National Health Authority
Technical Support:	World Bank
Primary Outcome:	Built medical audit capacity and systems at the national and state levels
Timeframe:	2018-2019

Data Collection Methodology

In order to document the link between JLN knowledge product development and country effects to-date, the JLN's case study series examines two evaluation questions:

1. What are the processes and preconditions necessary for JLN knowledge products to be used?
2. How has the JLN network and knowledge products contributed to health system changes?

The JLN's country case study series was structured as an explanatory single-case analysis, consisting of one or more key informant interviews per case study with key stakeholders identified by the relevant JLN Country Core Group (CCG). CCG leads were asked to use a snowball sampling methodology (a referral-based sampling approach) to identify the critical stakeholders involved in adaptation and implementation for each use case. In some instances a single key informant was sufficient to discuss the case and in other instances multiple

perspectives were required. Stakeholders interviewed are mostly mid to senior-level government staff involved in the implementation of a health system reform that used a JLN knowledge product or approach. Drafts of summaries were shared with key informants to check for accuracy and completeness.

Data collection was conducted through in-depth interviews using a structured questionnaire that also included open-ended questions and, if relevant, potential prompts to encourage more detailed responses. Data collection was done using a standard Adaptation & Implementation tool developed and piloted by the JLN Monitoring and Evaluation (M&E) Technical Working Group.

Limitations

Although the approach to the case study was informed by the JLN theory of change, document review, and pilots, the scope of each case study is limited to few key informants and all data have been collected retrospectively. Furthermore, case studies traditionally explore the complexity of a single or limited number of cases, so findings may not be generalizable.

In addition, while JLN Network Manager designed and conducted the case study with integrity and with sensitivity to bias, the data collection efforts were conducted by the JLN Network Manager M&E staff and not by an independent data collector. The JLN Network Manager attempted to mitigate the potential for bias in this situation by requesting that respondents be open and honest to improve JLN knowledge products.

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Country Context

India is committed to implementing universal health coverage (UHC) and launched the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) health insurance scheme in 2018, an unprecedented effort of the Government of India to ensure access to good quality hospitalization services without the risk of financial hardship to the bottom forty percent of the population.[1]

PM-JAY provides financial protection to more than 500 million vulnerable populations. The scheme offers a benefit cover of INR 500,000 (about USD 6,800 at current exchange rates) per family per year, and there is no cap on family size or age. The scheme is cashless and paperless at all public hospitals and empanelled private hospitals and beneficiaries of PM-JAY are not required to pay any charges for hospitalization expenses. India's states have the authority to regulate coverage of specific health service packages, reserving some for public hospitals only. However, PM-JAY covers medical and hospitalization expenses for almost all secondary care and most tertiary care procedures, bundled as 1,578 treatment packages covering surgery, medical, and outpatient treatments.[2]

As one of the JLN's founding countries, India has helped co-create numerous JLN knowledge

[1] National Health Authority, "About Pradhan Mantri Jan Arogya Yojana (PM-JAY)," Copyright 2018, https://pmjay.gov.in/about/pmjay
[2] National Health Authority, "Health Benefit Packages," Copyright 2018, https://pmjay.gov.in/hospital/hbc

products, including the *Toolkit to Develop and Strengthen Medical Audit Systems* that was published in December 2017. The toolkit was produced as part of a collaborative led by South Korea's Health Insurance Review and Assessment Service (HIRA) and ACCESS Health that brought together representatives from Colombia, Ghana, India, Indonesia, Kenya, Malaysia, Nigeria, and the Philippines to share their experiences and create generalized step-by-step guidance on how to establish medical audit systems. The India CCG had multiple country representatives participate in the collaborative and tool design. The World Bank provided technical assistance in multiple thematic areas, including medical audits and fraud management. The Indian National Health Authority (NHA) initiated the introduction of the *Medical Audit Toolkit* as part of their National Anti-fraud Unit (NAFU) effort, which institutionalized the medical audit process at NHA.

The toolkit synthesized and presented experiences from the countries, including how to set-up medical audit units and conduct step-by-step claims reviews, as practical guidance for practitioners. As part of the JLN Medical Audit Collaborative, the toolkit was shared with NHA and adapted for the specific features of the PM-JAY scheme.

Results

Adapting & Implementing the Toolkit to Develop and Strengthen Medical Audit Systems in India

Fraudulent claims in health insurance programs risk more than financial losses or inefficient health systems, they also impact people's health. Under PM-JAY, the ultimate responsibility to effectively prevent, detect, and deter fraud rests with India's State Health Agencies (SHAs). Strong anti-fraud efforts are important, not only from the perspective of reducing the adverse impact on the scheme's finances and for safeguarding beneficiary health, but also to mitigate any reputational risks faced by the SHA, states, and the scheme as a result of fraud. Hence, SHA's anti-fraud efforts are key for ensuring PM-JAY's effective implementation and provide a critical "zero tolerance" approach to fraud, which is internalized and permeated through all aspects of the scheme's management. Many states have expressed concerns about monitoring the quality of care provided in their hospitals and by adapting the *Medical Audit Toolkit* for their contexts. India has also helped monitor whether appropriate care is provided to the beneficiaries under the scheme. Avoiding fraud and promoting quality will over the long run also help maintain political support and funding for PM-JAY.

While the JLN collaborative ended in 2017, NHA with technical support from the World Bank, adapted the *Medical Audit Toolkit* developed under

How did the JLN support?

- **Co-development** of the KP and support from the World Bank team to **institutionalize the Medical Audit toolkit**

How did India use the KP?

- The National Health Authority **adapted the toolkit to fit the PM-JAY scheme**
- **States used a peer to peer approach to share learnings** and make improvements

What were the downstream changes?

- **Implementation of a medical audit system** that could be decentralized and scaled by India's states
- **Establishment of the NAFU and SAFU** to develop guidelines and processes against fraud at the national and state levels
- **Positive behavior changes among providers and hospitals**, including the roll-out of standard treatment guidelines

this collaborative and complemented it with global and in-country experiences to develop medical audit systems. The key highlights include:

- A National Anti-fraud Unit (NAFU) was established to develop guidelines, establish processes and systems, build state capacity, and monitor progress;
- State Anti-fraud Units (SAFUs) were formed in all states;
- Medical and Mortality audits became mandatory activities in the model tender document for hiring insurance companies, third party administrators entering agreements with state health agencies;
- The *Medical Audit Toolkit* developed by JLN was updated in line with the provisions of the PM-JAY scheme; and,
- Package-specific Medical Audit Questionnaires were developed to ensure that suspect claims are audited in a standardized way.[3]

To build state capacity, one national workshop in New Delhi and four regional workshops in Chennai, Guwahati, Lucknow, and Mumbai were held for SHA staff, implementing support agencies, and insurance companies. These workshops set the stage for an additional nine state-level trainings, including on-site field investigation support in conducting medical audits. India adapted the *Medical Audit Toolkit* to specifically fit the PM-JAY scheme, while keeping a simple and practical approach.

Capacity building workshops were first conducted at the state level to gather feedback about medical audit actions, the number of audits, and types of penalties followed for fraud detection. Through a peer to peer approach, states were encouraged to share learnings through various forums, including audit summaries and demonstrating examples of how they addressed challenges during workshops, joint audits, and state interactions. The information received from states was used to help other states take better action. Because of the flexibility in implementations of PM-JAY across states and variable state capacity, there were a lot of differences in audits. Joint audits were held to identify gaps and support was given to states to help their implementation of audits and to improve health outcomes. As part of the audits, hospitals were visited and audit findings were used to build their capacity.

The NHA developed a field investigation mobile application to improve the timeliness of audits, which had been rolled out but the use is currently suspended to resolve some technical issues. Future plans will integrate the mobile application with transaction management software to auto-populate data and integrate alerts and data into SHA and NHA systems to simplify taking appropriate actions.

Health System Changes from the Toolkit to Develop and Strengthen Medical Audit Systems

By learning from the experiences of other countries and adapting them to reflect the country and states' specific contexts, India created the NAFU and SAFUs to help develop anti-fraud guidelines and processes that will build capacity at the national and state levels, enabling states to detect, deter, and respond with appropriate action and ensure better implementation of the PM-JAY scheme. Policy changes are also taking place after the review and analysis of desk audits, including changes to claims and hospital guidelines based on lessons learned and recommendations.

Ensuring quality and reducing fraud have been India's core focus, and the country has seen positive behavior changes among providers and hospitals. Along with this, the roll-out of standard treatment guidelines integrated within the IT system has also complemented the efforts. Hospitals are already

[3] *Strengthening Medical Audit Systems Capacity of States for Enhancing Claims Adjudication of Pradhan Mantri Jan Arogya Yojana (PM-JAY).* Prepared by Dr. Sudha Chandrashekar, Ms. Parul Naib, and Dr. Rimy Khurana (International Symposium and Workshop on System Transformation Towards Sustainable Health Insurance, Seoul, Korea, 2019).

seeing a change in the types of claims being made after they have been audited, demonstrating the positive effects and increasing more genuine claims. Monthly monitoring reports are created. The vision is that by investing in medical audits, PM-JAY will save money, avoid leakage, and improve the quality of care.

Recommendations

Here are some considerations from the implementing team to future implementers:

Integration is critical to every country. Integrating medical audits with a national health insurance scheme is critical to any anti-fraud process. Having more examples in the *Medical Audit Toolkit* would benefit more countries, especially when countries are at the beginning stage of implementing their national health insurance schemes.

Data analytics and people are important. Data analytics has been very important in PM-JAY. It is important to have better data and provide input to providers, making sure the right tools are available. It is also important to use the right people to bring new tools and techniques and build staff capacity at the state level to perform the audits on a continuous basis through certified courses.

Constant learning and adapting. Constant learning and updating medical audit processes are also important to be able to adapt to new issues as they arise.

Conclusion

As part of its journey to UHC, the Government of India set out to exponentially expand access to high quality health services without the risk of financial hardship by implementing PM-JAY. One potential risk from implementing such a large health insurance scheme is that the added volume of coverage can contribute to increases in leakages, cost inefficiencies and substandard care. To mitigate these risks, PM-JAY drew on its participation in the JLN's Medical Audits Collaborative, the collaborative's *Toolkit to Develop and Strengthen Medical Audit Systems*, and other countries' and state experiences to develop a medical audit system that could be scaled by the various state level implementing agencies to review claims, identify fraud, and ensure the quality of health services provided to patients.

Authors

1. Dr. Sudha Chandrashekar, *Senior Consultant, World Bank*
2. Sheena Chhabra, *Senior Health Specialist, Health, Nutrition and Population Global Practice, World Bank*
3. Parul Naib, Consultant, *World Bank*
4. Owen Smith, *Senior Economist, World Bank*