CHAPTER III

COMPLIANCE AUDIT

Compliance Audit of Departments of the Government and their field formations as well as autonomous bodies brought out several lapses in management of resources and failures in observance of norms of regularity, propriety and economy. These have been presented in the succeeding paragraphs.

HEALTH AND FAMILY WELFARE DEPARTMENT

3.1 Compliance Audit on 'Implementation of Chief Minister's Comprehensive Health Insurance Scheme'

3.1.1 Introduction

The Government of Tamil Nadu (GoTN) launched the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in the State from 11 January 2012. The objective of CMCHIS was to provide quality health care to eligible persons through empanelled Government and private hospitals. GoTN appointed Tamil Nadu Health Systems Project (TNHSP) as the implementing agency and through tender process, selected United India Insurance Company Limited (UIIC) as the Insurance Company for both Term I[1] and II[2] of CMCHIS. The Project Director (PD), TNHSP, heads the implementation of the scheme. The scheme covers all resident families of Tamil Nadu with annual family income of ₹ 72,000 or less. CMCHIS was integrated with Pradhan Mantri Jan Arogya Yojana (PMJAY), which was introduced in the State from September 2018 and operationalised from December 2018. Audit of implementation of CMCHIS, covering the period from 5th to 7th policy years[3], was conducted between April and August 2019 at TNHSP and nine Government hospitals selected through statistical sampling method.

Audit Findings

3.1.2 Enrolment of beneficiaries

All families having a family card and an annual income of less than ₹ 72,000 are enrolled as beneficiaries under CMCHIS based on income

[1] Term I of five years commenced from 11 January 2012 and ended on 10 January 2017 - Year I or 1H - 2012-13, 2H -2013-14, 3H-2014-15, 4H-2015-16 and 5H-2016-17.

[2] Term II of four years commenced from 11 January 2017 (6H) and continues up to 10 January 2021 - 6H-2017-18, 7H-2018-19, 8H-2019-20 and 9H-2020-21.

[3] 11 January 2016 to 10 January 2019.

certificate issued by Revenue Authorities[4] and self-declaration of the head of the family. Orphans, families having differently-abled persons, migrant workers and Sri Lankan refugees are eligible for enrolment without income limit.

3.1.2.1 Non-coverage of eligible beneficiaries

The scheme guidelines provide for enrolment of orphans, migrant workers and Sri Lankan refugees without any income limit. Audit noticed that

- 1,235 government and private orphanages in the State housed 55,384 orphans. Of these, only 664 out of 2,687 children staying in Government run orphanages were enrolled, which was only about one *per cent* of the total orphan children in the State.
- Against 32,555 Sri Lankan refugee families living in the State, only 4,815 families were enrolled (15 *per cent*).
- None of the 21,538 identified migrant workers were enrolled.

Audit found that no system was put in place to enroll all the eligible beneficiaries from these sections of the society by liaising with the line departments concerned. On being pointed out by Audit, GoTN replied (January 2020) that enrolment of orphans, Sri Lankan refugees and migrant workers was under progress with the assistance of District Administration and departments concerned. Thus, the Government's objective of bringing the marginalised sections of the society under CMCHIS to reduce their financial hardship was not achieved, rendering these vulnerable sections bereft of a medical cover.

3.1.2.2 Ineligible beneficiaries

(a) GoTN issued Priority House Hold (PHH) family cards under the Public Distribution System (PDS) to families having an annual income of not more than ₹ 1 lakh. As of May 2019, there were 96.46 lakh PHH families under the State PDS. However, CMCHIS with an annual income criteria of less than ₹ 72,000 had 1.57 crore (5H) and 1.47 crore (6H and 7H) beneficiaries. Audit observed that as the number of families with income less than ₹ 1 lakh, based on income criteria of PHH cards, was only 96.46 lakh, the number of families with income less than ₹ 72,000 could not be more than 96.46 lakh. However, enrollment of families under CMCHIS, in excess of 96.46 lakh indicated the lack of proper system to enforce the income eligibility criterion in enrolment of beneficiaries under CMCHIS. On being pointed out by Audit, GoTN replied (January 2020) that action would be taken for weeding out/updating CMCHIS health insurance cards as per updated PDS.

[4] Village Administrative Officers (VAOs) in rural areas and Revenue Inspectors in urban areas.

Audit worked out that the notional financial loss, during 2016-19, on account of excess payment of insurance premium in respect of the ineligible beneficiaries yet to be weeded out was ₹ 1,014.66 crore as given in **Table 3.1**.

Table 3.1: Excess payment of insurance premium

Policy Year	Enrolled beneficiaries	Enrollment in excess of 96.46 lakh PHH card families	Insurance Premium paid per beneficiary (₹)	Avoidable premium payment (₹ in crore)
5H	157.16 lakh	60.70 lakh	497	301.68
6H	147.46 lakh	51.00 lakh	699	356.49
7H	147.46 lakh	51.00 lakh	699	356.49
Total				**1,014.66**

(Source: Details furnished by TNHSP)

(b) Audit compared the beneficiary data with the data of State Government pensioners and found that 1.08 lakh pensioners, whose annual pension exceeded ₹ 72,000, were enrolled under CMCHIS. On account of this, GoTN incurred an avoidable premium payment of ₹ 20.19 crore during 2016-19. GoTN replied (January 2020) that CMCHIS data would be checked with pensioners', Government employees, ESI and CGHS data.

(c) Analysis of the electronic database of beneficiary details furnished by TNHSP disclosed that during 2009 to 2015, 0.83 lakh duplicate CMCHIS cards were issued to families with one ration card. As only one card was allowed per family and insurance premium is paid based on number of cards, issue of more than one card per family resulted in avoidable insurance premium of ₹ 15.64 crore during 2016-19 on these ineligible cards.

GoTN replied (January 2020) that in order to improve access to health care, more than one insurance card were issued with a single ration card number as newly formed families did not possess ration cards. GoTN, further, stated that action would be taken to check misuse of this facility. As the system of allowing more than one card per family is prone to a higher risk of misuse, the Government must relook at its policy. Such a leniency, though good intended, would lead to proliferation of insurance cards, and consequently higher premium outgo as the premium amount is calculated based on the number of insurance cards.

3.1.3 Empanelment of hospitals

Government and private hospitals get empanelled as network hospitals under CMCHIS through an online application and inspection process.

As of March 2019, a total of 1,008 hospitals were empanelled under CMCHIS comprising of 265 government hospitals and 743 private hospitals**.** The related issues are discussed below.

3.1.3.1 NABH accreditation not obtained by empanelled hospitals

With a view to provide quality health care, the CMCHIS guidelines stipulate that (i) all empanelled private hospitals are required to obtain entry level accreditation from the National Accreditation Board for Hospitals and Healthcare Providers (NABH) within one year of empanelment, and (ii) Government hospitals should also be accredited under the National Quality Assurance Standards (NQAS) framework of the Health and Family Welfare Ministry.

Audit found that as of March 2019, only 13 out of the 265 Government hospitals obtained the required accreditation under NQAS. Out of 651 private hospitals empanelled under Term II as of March 2018[5], 307 hospitals did not have the prescribed entry level NABH accreditation as per details furnished by TNHSP. As no supporting documents/records were produced to Audit to vouch for the correctness of the status of NABH accreditation, Audit independently compiled data relating to NABH accredited hospitals in Tamil Nadu from NABH website. Analysis of NABH data (updated up to March 2019) relating to 651 empanelled private hospitals revealed the following.

(i) 251 hospitals did not obtain NABH accreditation even after the lapse of one year.

(ii) NABH accreditation of 64 hospitals had expired. The period of expiry ranged from 1 to 28 months.

(iii) 154 hospitals were accredited belatedly (delay of 1 month to 12 months) after the expiry of the grace period of one year.

During March 2018 to March 2019, 1.10 lakh out of the 1.80 lakh private hospital patients under CMCHIS had availed treatment in non-NABH private hospitals. On being pointed by Audit, GoTN replied (January 2020) that only 14 *per cent* of the hospitals had not got into the NABH process and the remaining 86 *per cent* were at various levels of accreditation. Audit observed that the objective of the scheme was to provide quality health care and the quality of health care is assured by NABH accreditation by ensuring availability of infrastructure and manpower with reference to the benchmarked standards for accreditation. Therefore, continuing with non-NABH hospitals defeated the objective of ensuring quality medical care.

3.1.3.2 Issues in empanelment

Based on formal application by hospitals and inspection by the Insurance Company, hospitals get empanelled under CMCHIS. Empanelled hospitals which do not adhere to the terms of empanelment get de-empanelled. Deficiencies in the empanelment of hospitals are discussed below:

[5] In order to verify the NABH accreditation status as on March 2019 by allowing the 12 months grace period, only hospitals empanelled up to March 2018 were considered.

- During 2016-19, 57 hospitals which treated less than 10 patients were not de-empanelled as per agreement conditions, whereas 36 hospitals which treated more than 10 patients were de-empanelled. On being pointed out by Audit, GoTN stated that de-empanelment was a policy/administrative decision of the implementers to decide on the low level of performance by comparing with rest of the hospitals. The reply was not tenable as proper reasons were not attributed for de-empanelment.

- Empanelled private hospitals are awarded grading from A1 to A6 for medical and diagnostic procedures and S1 and S2 for surgical procedures based on facilities available in the hospitals. Package rates for different procedures are fixed based on the grade of the hospital, with A1 and S1 getting the highest rate and A6 and S2 getting the lowest rate. Grades were to be awarded based on the score obtained by the hospitals in the empanelment inspection. Multispecialty hospitals scoring 31 to 40 out of the maximum score of 100 are awarded the lowest grade of A6 and those scoring above 80 out of 100 are awarded the highest grade of A1. Similarly, for surgical package, the highest grade of S1 is awarded to hospitals with scores above 40 out of the maximum score of 50 and other hospitals are awarded S2 for package rate purpose. Audit found that 10 hospitals were awarded higher grades than what was eligible as per their score, and 11 hospitals were awarded lower than the eligible grades. This resulted in wrong guidance to patients on the quality of the hospitals. On being pointed out by Audit, GoTN replied (January 2020) that the error would be rectified.

3.1.4 Financial management

Budgetary allocations from Government are the main source of funds for the scheme. In addition, 28 *per cent* of the claim amount received by Government hospitals is ploughed back into the scheme towards meeting expenditure on notified high-end medical procedures, which is partially covered under the insurance policy, and for IEC activities. Penalties collected and interest earned are other sources of funds.

Premium payment, cost of printing health insurance cards, salaries of contract staff[6], capital and maintenance expenditure, reimbursement for high-end procedures, IEC activities, etc., constitute the categories of expenditure.

The insurance premium was worked out based on the number of beneficiaries enrolled under the scheme and Government bears the entire premium amount

6 The pay and allowances of regular employees who are deputationists are met from the budgetary allocation.

payable to UIIC. Details of the premium paid and claims settled for fifth, sixth and seventh policy years are shown in **Table 3.2**.

Table 3.2: Details of premium paid and claims settled

Year	Policy period	Premium paid (₹ in crore)	Claim settled (₹ in crore)		
			Govt. Hospitals	Pvt. Hospitals	Total
2016-17	5H	781.04	252.61	535.72	788.33
2017-18	6H	1,030.96	302.57	574.81	877.38
2018-19	7H	1,031.14	323.53	522.35	845.88
	Total	**2,843.14**	**878.71**	**1,632.88**	**2,511.59**

(Source: Details furnished by TNHSP)

3.1.4.1 Corpus Fund

In order to enable the needy and poor to undergo expensive surgical treatment like cochlear implant, liver transplantation, renal transplantation, bone marrow transplantation, etc., the Government in November 2012 created a Corpus Fund with an initial amount of ₹ 10 crore. The Corpus Fund maintained by TNHSP had accretions by way of assignment of 27 *per cent* of the claim amount released by the Insurance Company to Government hospitals. In addition, penalties collected from errant network hospitals and the interest accrued in the Savings Bank account of Government network hospitals were also credited to the fund. During 2016-19, ₹ 263.31 crore[7] accrued to the Corpus Fund. The Fund was mainly meant to meet the package cost of high-end procedures over and above the maximum of ₹ 2 lakh[8] fixed for specialised procedures.

As of March 2019, expenditure of ₹ 233.07 crore was met from the corpus fund. Of this, expenditure incurred towards reimbursement for high-end procedures was ₹ 194.96 crore (84 *per cent*).

3.1.4.2 Information, Education and Communication (IEC) Fund

As per extant Government orders, one *per cent* (part of 28 *per cent*) of receipts of Government network hospitals under CMCHIS, was to be utilised for IEC activities. Government in January 2016 created an IEC Fund and instructed the Insurance Company to remit the money directly into a separate bank account maintained by TNHSP for that purpose. During 2016-19, ₹ 9.04 crore accrued to the fund and ₹ 5.37 crore was incurred as IEC expenditure by TNHSP, mainly on sending IEC pamphlets by post to all beneficiaries. As no guidelines for utilising IEC funds were issued by the Government (August 2019), the proposals received from various hospitals for IEC activities were pending approval. On being pointed out, PD, TNHSP

[7] ₹ 227.16 crore by way of 27 *per cent* of insurance claims by Govt. Hospitals, ₹ 13.41 crore by way of interest receipts, ₹ 1.13 crore through penalties levied on empanelled hospitals and ₹ 21.61 crore from other sources.

[8] ₹ 1.5 lakh till 5H and ₹ 2 lakh in 6H & 7H.

replied (October 2019) that after receipt of guidelines from the Government, necessary actions would be taken for approval of pending proposals.

Audit observed that non-framing of guidelines for IEC activities, even after seven years of launching the scheme had resulted in inability of hospitals to familiarise the scheme through IEC activities. Audit found that while the percentage of enrolled beneficiaries who availed benefit under the scheme in the predominantly urban districts of Chennai, Madurai and Tiruvallur was 4.61 *per cent*, 3.89 *per cent* and 3.67 *per cent* respectively, the percentage in the rural districts of Krishnagiri, The Nilgiris and Thiruvarur were much lower at 1.90 *per cent*, 1.94 *per cent* and 2.08 *per cent* respectively. The low penetration of scheme in rural districts pointed to the need for more IEC activities for the scheme.

GoTN accepted the audit point and stated (January 2020) that action would be taken for framing guidelines and to ratify the expenditure incurred.

3.1.5 Implementation of CMCHIS in network hospitals

The empanelled hospitals extend cashless treatment to the beneficiaries for the identified 1,027 medical/surgical procedures. To avail treatment under the scheme, the beneficiary has to approach any network hospital for admission. On verification of eligibility under CMCHIS, the hospitals decide the course of treatment and approach the Third Party Administrator (TPA[9]) of the Insurance Company for pre-authorisation to provide the treatment. The TPA verifies the medical and non-medical records of the patients, as submitted by the hospitals, and after satisfying the eligibility of the patient and the need for the treatment proposed, issues pre-authorisation. After the pre-authorisation by the TPA, the hospital provides treatment to the patients. In respect of emergency cases, the hospitals can admit the patient after verifying eligibility with the TPA and start treatment, pending receipt of pre-authorisation. Audit reviewed the data maintained by the Insurance Company in digital format, as furnished by TNHSP. Audit observations are as follows:

3.1.5.1 Pre-authorisation and claims

A comparison of pre-authorisation 'cancelled' by the hospitals themselves and 'not approved' by the TPA in Government and private hospitals are shown in **Chart 3.1** and **Chart 3.2**. It revealed that the Government hospitals had higher incidence of cancellation and non-approvals. Pre-authorisation can be cancelled for valid reasons. Higher percentage of cancellation of pre-authorisation by Government hospitals pointed to higher withdrawal of patients from treatment after initially approaching the hospitals for treatment, which could possibly be on account of patients being dissatisfied with the course of treatment.

[9] Third Party Administrator - The agency which liaise between hospitals and the insurer.

Chart 3.1: Pre-authorisation cancelled (*per cent* and numbers (in bracket))

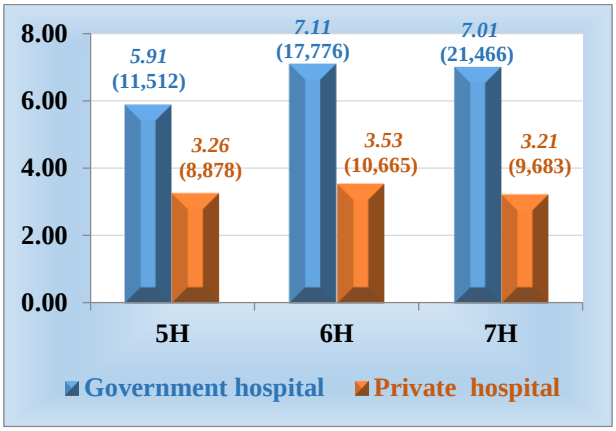
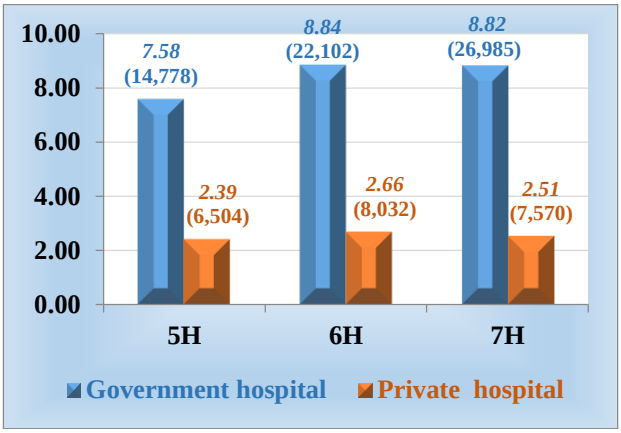


Chart 3.2: Pre-authorisation not approved (*per cent* and in numbers (in bracket))



(Source: Compiled from TNHSP/UIIC Data)

➢ It was found that pre-authorisation was not received from the Insurer within the stipulated two days in 18 *per cent* of cases during 5H, 6H and 7H. Delay in pre-authorisation with consequent delay in starting treatment would adversely impact the patients availing benefits under the scheme. From the database maintained, Audit found that it was not possible to conclude whether TPA or the hospital was responsible for the delay. In the exit conference, Director, TNHSP agreed to make suitable modification in the software.

Claim: The treating hospitals prefer their claims with the Insurance Company based on the pre-authorisation and treatment given to the patient. Details of pre-authorisation approved, claims submitted by the hospitals, that were not submitted, not approved (both denied and need more information) and approved by the Insurance Company during 5H to 7H are given in **Table 3.3**.

Table 3.3: Details of claims submitted and approved

Policy year	Pre-authorisation approved by the Insurance company	Claims submitted by hospitals	Claims not submitted by hospitals	Claims not approved	Claims approved
5H	4,25,701	4,22,033	3,668	4,901	4,17,132
6H	4,93,350	4,88,897	4,453	8,431	4,80,466
7H	5,41,526	5,33,869	7,657	9,204	5,24,665
Total	**14,60,577**	**14,44,799**	**15,778**	**22,536**	**14,22,263**

(Source: Compiled from TNHSP/UIIC Data)

➢ A comparison of claims not submitted and not approved revealed that Government hospitals had higher incidence of non-submission and non-approvals as depicted in **Charts 3.3 and 3.4**.

Chart 3.3: Claims not submitted (in *per cent*)

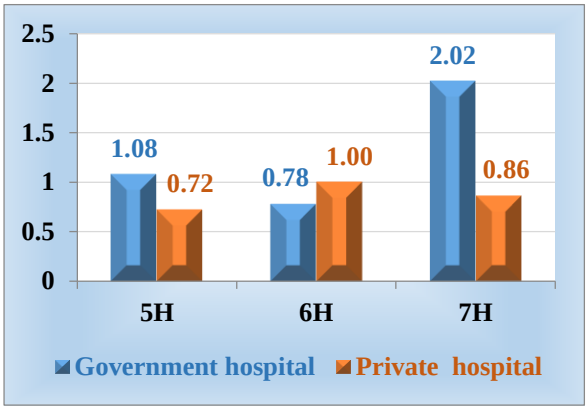
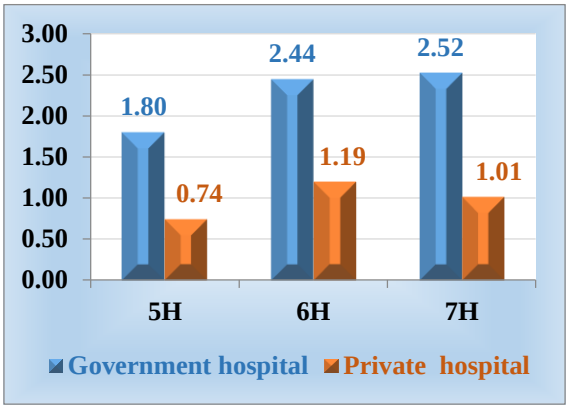


Chart 3.4: Claims not approved (in *per cent*)



(Source: Compiled from TNHSP/UIIC Data)

- The increasing trend in the number of not submitted claims (**Table 3.3**), which represents patients/hospitals withdrawing from treatment for various reasons, was a matter of concern. Audit observed that delay of more than two days in pre-authorisation was one of the possible reasons in respect of 5,100 out of 15,778 cases patients withdrawing from treatment after approaching the hospital for treatment.

- The Insurance Company was prompt in settlement of claims preferred by network hospitals. Over 99 *per cent* of claims were settled within seven days of filing the claim. It was, however, found that the claim amount settled, after the stipulated seven days, was on an increasing trend from ₹ 0.28 crore in 2016-17 to ₹ 10.07 crore in 2018-19. During 7H, claim settlements in respect of 4,187 cases were delayed by 7 to 30 days; and in 1,432 cases the delay exceeded 30 days. Delays in settlement of claims will impact the scheme's receptiveness among network hospitals.

On being pointed by Audit, GoTN replied (January 2020) that there are challenges in building capacity in the Government system on insurance claims in view of transfers, retirements, etc. The reply was untenable as the "challenges in capacity building", even after eight years of launching the scheme, pointed to deficiency in administering the scheme requiring concerted action at the Government level.

3.1.5.2 Government reserved procedures performed in private hospitals

Under CMCHIS, 84 procedures were reserved for being carried out only in Government hospitals based on facilities available and to avoid misuse by private hospitals. Any violation of the condition would result in levy of penalty on the Insurance Company at a minimum of five times the amount of expenditure incurred for each instance of violation.

Audit analysis of 6H and 7H data disclosed that 1,614 cases of medical/surgical procedures, reserved for Government hospitals involving ₹ 2.53 crore, were performed in private network hospitals during 2017-19.

This violated the agreement conditions and points to the Insurance Company's inadequate control over its operations which resulted in revenue foregone to Government hospitals to the tune of ₹ 2.53 crore. Audit also noticed that TNHSP failed to levy penalty on the Insurance Company for violating the agreement conditions. GoTN replied (January 2020) that the instances pointed out by Audit would be examined for taking necessary action.

3.1.5.3 Pre-authorisation permitted during suspension period

During January 2016 to March 2019, 18 private network hospitals were suspended as a punitive measure for negligent treatment, poor medical assessment, manipulation of medical reports, poor documentation, etc. The suspension was applicable either to all departments or any particular department of the hospital concerned except for dialysis and it ranged from one to three months. Audit found that notwithstanding the suspension, five suspended hospitals/departments continued to treat patients during its suspension period. The Insurance Company honoured 305 claims for a total value of ₹ 1.61 crore, raised by the suspended hospitals/departments for services rendered during their suspension period. This indicated lack of controls and defeated the deterrent nature of suspension. GoTN replied (January 2020) that irregularities pointed out by Audit would be examined and necessary action would be taken.

3.1.5.4 Non-utilisation of smart card features of CMCHIS health insurance cards

Under CMCHIS, a smart card, embedded with microprocessor chip, with facility to store the bio-metrics of all members of the beneficiary family is issued to beneficiaries. The objective of the smart card is to simplify beneficiary identification at hospitals using card readers to provide hassle free service to beneficiaries. At the end of Term I, 1.57 crore smart cards costing ₹ 78.62 crore (cost per card ₹ 50 x 1.57 crore beneficiaries) were issued. In Term II, similar provisions were included in tender conditions by which, the Insurance Company had to ensure that the biometric devices for the online Aadhaar validation were maintained by the network hospitals.

Audit undertook joint physical verification in the nine test-checked hospitals. It was found that none of the hospitals carried out the envisaged beneficiary identification through smart cards due to non-availability/non-functioning of bio-metric card reading devices. Instead, the facility to generate Unique Reference Number (URN) using family card and Aadhaar cards was used for identifying the beneficiaries. In reply to the audit enquiry, seven of the nine test-checked hospitals stated that they were either not issued the card reader devices or the devices supplied were not functioning due to software issues.

Thus, the envisaged system to simplify beneficiary identification did not function despite incurring huge expenditure. GoTN replied (January 2020) that there were challenges in linking the smart card with Aadhaar data and necessary action would be taken in this regard to replace the smart card.

3.1.6 High-end procedures

As the ceiling prescribed for benefits under the insurance cover was only ₹ 2 lakh, in respect of high-end procedures (HEP) such as kidney transplant, heart transplant, lungs transplant, cochlear implant, etc., the beneficiaries are helped using the Corpus Fund maintained by the TNHSP. Details of HEPs carried out in the network hospitals during 2016-19 are exhibited in **Chart 3.5 and 3.6**.

Chart 3.5: Number of High-end procedures performed

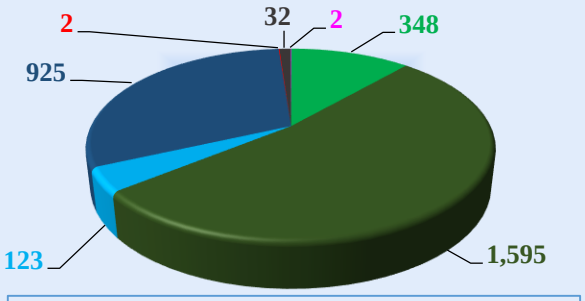
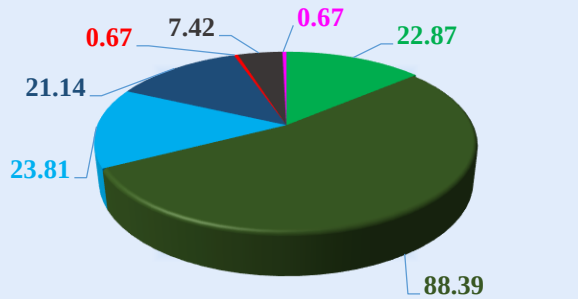


Chart 3.6: Value of High-end procedures performed (₹ in crore)



(Source: TNHSP/UIIC data)

The status of NABH accreditation and grading of 41 private network hospitals performing HEPs during Term II disclosed that only 23 private network hospitals had NABH accreditation. Thus, the quality of these HEPs were not ensured.

3.1.6.1 Procurement of cochlear implant at higher rates under HEP

Cochlear implant[10] is a high-end procedure performed in 3,425 cases under CMCHIS since its inception in 2013 to May 2019 in Government and private network hospitals. The package cost for this procedure was initially fixed (2013) between ₹ 7.01 lakh to ₹ 7.90 lakh, depending on rates offered by hospitals (₹ 7.01 lakh for Government hospitals) per patient. The major component of the package was the cochlear device, the cost of which was fixed as ₹ 5.35 lakh.

In May 2017, TNHSP came to know of the decrease in the price of the cochlear device based on a tender awarded to a firm by Kerala Social Security Mission (KSSM) for supply of cochlear implant at a lower cost of ₹ 3.84 lakh

[10] A surgically implanted device to restore hearing in cases with diseases of inner ear or the auditory nerve.

per implant. Accordingly, the package cost of cochlear implant surgery under CMCHIS was also reduced by ₹ 0.71 lakh to ₹ 1.51 lakh, depending on hospital, to match the price offered to KSSM. The revision was communicated (June 2017) to all network hospitals to procure the implants at a cost of ₹ 3.84 lakh or less. Audit found that TNHSP did not call for any tender even after coming to know of the tender awarded by KSSM.

Audit observed that the failure to periodically review the package rate had resulted in continued payment of ₹ 5.35 lakh for cochlear devices which had come down substantially as seen from KSSM's tender of October 2016. During the period between the month following the reduction of package rate by KSSM and the date of reduction of package rates by TNHSP, 416 cochlear implants were done and the excess expenditure on this count was ₹ 6.10 crore.

It was further observed that subsequent to the downward revision of price in July 2017, the GST on cochlear implant device was reduced in November 2017 from 5 *per cent* to 2.5 *per cent* and the custom duty of components of cochlear implant was reduced from 2.5 to 0 *per cent* in February 2018. The effects of these tax cuts should have been taken into account for further revision of package rate.

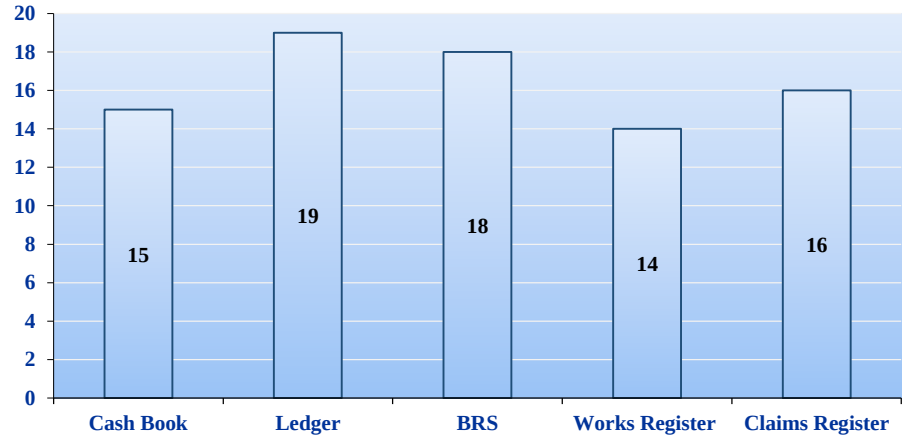
GoTN stated (January 2020) that the package cost was fixed based on actual cost/market condition. The reply was not tenable as no attempt was made to revise the package rate for more than four years.

3.1.7 Maintenance of accounts and registers

All Government hospitals empanelled under CMCHIS were required to maintain uniform accounts of transactions relating to the scheme with appropriate records such as Cash book, Ledger, Cheque Register, Bank Reconciliation Statement (BRS), Claim Register, Register of Works, etc.

During physical verification (June and July 2019) carried out by Audit in the 46 test-checked hospitals/departments, it was seen that many of them did not maintain the envisaged records as given in **Chart 3.7**.

Chart 3.7: Number of hospitals/departments not maintaining the prescribed records



Non-maintenance of stipulated records heightens the risk of diversion, misappropriation of funds, etc., and falsification of records. On being pointed by Audit, GoTN replied (January 2020) that orders had been issued for maintenance of accounts and was being monitored by Director of Medical Education (DME) and Director of Medical and Rural Health Services (DMRHS).

3.1.8 Monitoring

3.1.8.1 Complaint redressal mechanism

(i) At the district level, a District Monitoring and Grievance Committee (DM&GC) headed by the District Collector monitors the complaints relating to difficulty in availing treatments, lack of facilities, etc. In the test-checked Tirunelveli district, 11 complaints received against private hospitals during 2017-19 were disposed off without holding DM&GCs meetings. Seven complaints received at TNHSP were referred to the respective DM&GCs and five were pending as of March 2019. Thus, there was lack of effective grievances redressal mechanism at district level. PD, TNHSP, replied that TNHSP would ensure better monitoring in the coming days.

(ii) Any grievances and appeals against the decision of the DM&GCs should be preferred with the State Monitoring and Grievance Committee (SM&GC). Any dispute arising out of the implementation of the scheme which remained unresolved at SM&GC will be referred within 15 days to a High-Level Committee. However, SM&GC and High-Level Committee were formed only in October 2019.

3.1.8.2 Complaints against private network hospitals

CMCHIS guidelines provide for levy of penalty on network hospitals for deficiencies in services. The penal action on the negligent hospital is enforceable through the Insurance Company.

Details of complaints against network hospitals received through online portal/call centre during 2016-19 are shown in **Table 3.4**.

Table 3.4: Online portal/Call centre complaints against network hospitals

Sl. No.	Nature of complaint against private network hospitals	Number of complaints received			
		5H	6H	7H	Total
1	Money demanded/received etc.,	56	83	113	252
2	Treatment denied/Pre-authorisations cancelled	3	4	2	9
3	Unsatisfactory treatment	3	6	5	14
	Total	**62**	**93**	**120**	**275**

(Source: Details furnished by TNHSP)

Audit sampled 112 out of the 275 complaints received against 28 panel hospitals.

- Multiple complaints received against 14 network hospitals (ranging from 2 to 28) were treated as a single complaint. Clubbing of multiple complaints raised on different occasions allowed the delinquent hospitals to get off lightly.
- Though the minimum stipulated penalty was five times the money collected by the hospitals, it was not levied in 91 cases.
- Even though the Insurance Company was also liable, no punitive action was taken on the Insurance Company.

GoTN replied that a few concessions were provided to ensure continuity of service and treatment to the beneficiaries. It also stated that repeated offenders would be levied higher penalty and suspension.

3.1.8.3 Non-monitoring of network hospitals

As per scheme guidelines, the functioning of network hospitals were to be monitored by TNHSP, through the Insurance Company. Analysis of different medical procedures carried out by hospitals in various districts disclosed that 12 hospitals in Namakkal district performed 3,847 Total Knee Replacement (TKR) surgeries during 2016-19, of which 3,322 surgeries (86 *per cent*) were done by three private hospitals. The number of TKR surgeries conducted in Namakkal district was 23.1 *per cent* of the total number of TKRs done at State level. Considering that the total enrolled beneficiaries in the district was only 2.6 *per cent*, the number of TKRs in Namakkal was abnormal. TNHSP had not monitored the large number of surgeries as to whether they were need based or not. GoTN replied (January 2020) that to avoid misuse, instructions had been issued to UIIC to insist for second medical opinion from nearby Government Medical College Hospitals.

3.1.8.4 Deficiencies in CMCHIS database

Data analysis of cases processed and settled during 5H to 7H years (2016-19) disclosed the following inconsistencies.

(i) Family Card number is identified by a unique standardised 10 character (alphanumeric) length. Audit found that in 1,12,502 records non-standardised details of varying length were captured and stored in the field meant for storing Family Card number, indicating deficiencies in data capturing and need for validation checks to be inbuilt.

(ii) Discrepancies between date of admission and date of discharge were noticed in 613 cases wherein the beneficiary patient was shown as discharged prior to the date of admission into the hospital.

(iii) In 1,984 instances, pre-authorisations were raised even before the beneficiary patient was admitted to the hospital.

As the above inconsistencies arose due to the absence of validation controls, to prevent the recurrence of inconsistent data creeping into the database there was a need to address these lacunae in the system. GoTN stated (January 2020) that necessary action would be ensured for suitable validation control.

3.1.9 Conclusion

- There was no mechanism for verification/periodic updation of family income and exclusion of ineligible families.
- Marginalised categories like orphans, migrant workers and Sri Lankan refugees were not adequately enrolled as a suitable system was not put in place.
- Quality of medical care could not be fully ensured due to non-insisting of the mandatory NABH accreditation.
- Instances of delayed pre-authorisation showed an increasing trend leading to delay and possible denial of treatment to needy patients.

3.1.10 Recommendations

- Government may give wide publicity and launch a special drive to enroll orphans, migrant workers and Sri Lankan refugees.
- Time bound action should be initiated to obtain NQAS accreditation for all empanelled government hospitals; and fulfillment of conditions regarding NABH accreditation of empanelled private hospitals should be ensured.
- Government reserved procedures should not be allowed to be performed by private hospitals; and the Insurance company should be made accountable for issuing pre-authorisation to private hospitals during suspension periods.

MUNICIPAL ADMINISTRATION AND WATER SUPPLY DEPARTMENT

3.2 Compliance audit on solid waste management in Coimbatore City Municipal Corporation

3.2.1 Introduction

Solid Waste Management (SWM) is a crosscutting issue that affects and impacts various areas of sustainable development *viz*., living conditions, sanitation, public health and the sustainable use of natural resources. Sustainable Development Goals (SDGs) envisages environmentally sound management of all wastes in order to minimise their adverse impacts on human health and the environment. Government of India notified (April/ June 2016) the Solid Waste Management Rules, 2016 (SWM Rules) under Environment (Protection) Act, 1986 to regulate the management and handling