GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
DEPARTMENT OF HEALTH AND FAMILY WELFARE

RAJYA SABHA
UNSTARRED QUESTION NO. 1403
TO BE ANSWERED ON 11TH MARCH, 2025

FRAUDULENT CLAIMS AND MONITORING MECHANISM UNDER AB-PMJAY

1403. DR. FAUZIA KHAN:

Will the Minister of **HEALTH AND FAMILY WELFARE** be pleased to state:

(a) whether Government has identified instances of fraudulent claims being processed under the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY);
(b) if so, the details thereof, including the number of such cases and the action taken against those responsible;
(c) whether any measures have been taken to address data management issues such as duplicate registrations and fraudulent claims; and
(d) the measures being implemented to strengthen anti-fraud systems, ensure proper oversight, and address any gaps in the monitoring and grievance redressal mechanisms?

ANSWER
THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE
(SHRI PRATAPRAO JADHAV)

(a) and (b): Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) is a flagship scheme of the Government which provides health cover of Rs. 5 lakh per family per year for secondary and tertiary care hospitalization to approximately 55 crore beneficiaries corresponding to 12.37 crore families constituting economically vulnerable bottom 40% of India's population. Recently, the scheme has been expanded to cover 6 crore senior citizens of age 70 years and above belonging to 4.5 crore families irrespective of their socio-economic status under AB-PMJAY with Vay Vandana Card.

AB-PMJAY is governed on a zero-tolerance policy towards misuse and abuse and various steps are taken for prevention, detection and deterrence of different kinds of irregularities that could occur in the scheme at different stages of its implementation. A robust anti-fraud mechanism has been put in place and National Anti-Fraud Unit (NAFU) has been set up with the primary responsibility for prevention, detection and deterrence of misuse and abuse under AB-PMJAY.

Suitable actions including rejection of 3.56 lakh claims worth Rs 643 crore, de-empanelment of 1114 hospitals, levying penalty worth Rs. 122 crore on 1504 errant hospitals and suspension of 549 hospitals have been taken against fraudulent entities as reported by the States/UTs.

(c) and (d): Under AB-PMJAY, triggers have been put in place in the Transaction Management System (TMS) related to the upcoding of the Health Benefit Packages, OPD to IPD conversion, ghost billing/treatment not rendered but claims raised, duplicate images/ documents used for multiple claims, forgery/concealment and beneficiary impersonation/counterfeiting so that automatic flags are raised for proper investigation of such suspected claims. Further, beneficiaries are verified through Aadhaar e-KYC only at the time of creation of the card and have to undergo Aadhaar authentication at the time of availing services, which helps in mitigating the issues of duplicate registration and fraudulent claims. To enhance detection of misuse or abuse, near real-time monitoring and AI-based systems are used to check the hospital claims. Further, hospitals undergo random audits and surprise inspections to ensure the authenticity of claims.

Under AB-PMJAY, a three-tier grievance redressal system at District, State, and National level with dedicated nodal officers and committees at each level. Beneficiaries can also file their grievance using different mediums including web-based portal Centralized Grievance Redressal Management System (CGRMS), Central & State call centers (14555), email, letter to SHAs etc. Based on the nature of grievance, necessary action, including providing support to the beneficiaries in availing treatment under the scheme, for resolution of grievances is taken.

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