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

LOK SABHA
UNSTARRED QUESTION NO. 5619
TO BE ANSWERED ON 04TH APRIL, 2025

SUSPENSION OF HOSPITALS FROM PANEL OF HEALTH INSURANCE SCHEME

5619. SHRI SELVAGANAPATHI T.M.:

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

(a) whether it is a fact that the National Health Authority has recommended suspension of over 600 hospitals and removal of nearly 1200 hospitals from the panel of Government′s health insurance scheme, if so, the details thereof;

(b) whether it is also true that the National Health Authority has also recommended penalties totaling Rs.122 crore against more than 1500 errant hospitals and if so, the details thereof; and

(c) whether the Government is considering to introduce a new regulation to check such fraud and if so, the details thereof?

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

(a) to (c): Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (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 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.

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.

Further, regular updation such as expansion of beneficiary base, inclusion of new procedures, empanelment of new hospitals and other improvements are done in the scheme as per requirements from time to time.

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