सत्यमेव जयते

Report of the Comptroller and Auditor General of India on Performance Audit of Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana

SUPREME AUDIT INSTITUTION OF INDIA

लोकहितार्थ सत्यनिष्ठा

Dedicated to Truth in Public Interest

Union Government (Civil)
National Health Authority
Ministry of Health and Family Welfare
Report No. 11 of 2023
(Performance Audit)

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Comptroller and Auditor General of India
on
Performance Audit of
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Contents

Preface

This Report of the Comptroller and Auditor General of India contains results of the Performance Audit on Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) covering the period September 2018 to March 2021.

This Report of the Comptroller and Auditor General of India has been prepared for submission to the President under Article 151 of the Constitution of India.

The Audit has been conducted in conformity with the Auditing Standards issued by the Comptroller and Auditor General of India.

Executive Summary

Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) was launched on 23 September 2018.

The Scheme aims to provide health cover of ₹ five lakh per family per year for secondary and tertiary care hospitalization to over 10.74[1] crore families from the poor and vulnerable section of the population, based on the deprivation and occupational criteria of the Socio-Economic Caste Census (SECC), 2011. The aim is to improve affordability, accessibility, and quality of care for the poor and vulnerable section of the population.

The Scheme has been launched for achieving a significant reduction in out-of-pocket expenditure due to health care costs and achieving reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment. The eligible beneficiaries are entitled under AB-PMJAY for cashless and paperless access to services at the empanelled hospitals.

Audit noted that the PMJAY Scheme, an ambitious and well-intentioned programme to provide healthcare access to most vulnerable sections in the country, has had a strong positive impact on the economically weaker sections of the society who need healthcare facilities. However, the implementation of the Scheme needs improvement in the light of the findings made in the report. It is expected that the compliance to the observations and recommendations made in this Report will help in improving the implementation of the Scheme.

Key findings in each of the focus area of examination are provided as under:

Beneficiary Identification and Registration

As per NHA records, 7.87 crore beneficiary households were registered, constituting 73 *per cent* of the targeted households of 10.74 crore (November 2022). Out of this, 2.08 crore households had been identified from SECC-2011 database, as envisaged in the Scheme guidelines. In reply, NHA conveyed that Government of India (GoI) has approved (January 2022) the expansion of the beneficiary base to cover 12 crore families based on NFSA data.

(Paragraph 3.2, Page no. 11)

The match confidence score, which the online system of beneficiary registration, generates based on matching the documents of a beneficiary with the SECC list of eligible beneficiaries, has been rendered ineffective as applications for registration were approved or rejected irrespective of the match confidence score. Data analysis revealed that match confidence score was not applied during the approval/rejection process of registration of a person.

(Paragraph 3.4, Page no. 13)

[1] GoI has approved (January 2022) the expansion of the beneficiary base to cover 12 crore families based on NFSA data.

In the absence of adequate validation controls, errors were noticed in beneficiary database *i.e.* invalid names, unrealistic date of birth, duplicate PMJAY IDs, unrealistic size of family members in a household etc. In 36 cases, two registrations were made against 18 Aadhaar numbers and in **Tamil Nadu**, 4761 registrations were made against seven Aadhaar numbers. Registration of multiple beneficiaries against same or invalid mobile number ranging from 11 to 7,49,820 beneficiaries were noted in the Beneficiary Identification System (BIS). In **Jammu & Kashmir** and **Ladakh,** during the period 2018 to 2021, 16865 and 335 ineligible beneficiaries respectively were identified by the SHA after cleaning the SECC data.

(Paragraphs 3.6.1 to 3.6.5, Page nos. 15 to 18)

In six States/UTs, ineligible households were found registered as PMJAY beneficiaries and had availed the benefits of the Scheme. The expenditure on these ineligible beneficiaries ranged from ₹0.12 lakh in **Chandigarh**, to ₹22.44 crore in **Tamil Nadu**.

(Paragraph 3.7, Page no. 19)

In nine States/UTs, there were delays in processing of rejection cases. The delay ranged from one to 404 days.

(Paragraph 3.8, Page no. 20)

In seven States/UTs, Information, Education and Communication (IEC) cell was formed. In 12 States/UTs, IEC Cell was not formed whereas no information was available in the remaining States. IEC plan was prepared only in four States, **Chhattisgarh, Madhya Pradesh, Manipur and Rajasthan**. In **Maharashtra**, although plan was prepared in 2020-21, it was not implemented.

In 14 States/UTs, expenditure on IEC activities ranged from 0 to 20.24 *per cent* of the allotted budget against the prescribed benchmark of 25 *per cent.*

(Paragraph 3.9, Page no. 21)

Hospital Empanelment and Management

In several States/UTs**,** there was shortage of infrastructure, equipment, doctors, etc. The available equipment were found non-functional. Some of the Empanelled Health Care Providers (EHCPs) neither fulfilled minimum criteria of support system and infrastructure nor conformed to the quality standards and criteria prescribed under the Guidelines.

In several States/UTs, mandatory compliances criteria for empanelment of hospitals relating to infrastructure, fire safety measures, Bio-medical waste management, Pollution Control and Hospital registration certificate were not fully followed. In some EHCPs, fire safety certificates had expired before empanelment under PMJAY.

Some of the EHCPs did not conform to the prescribed quality standards and criteria, which were crucial to the safety and wellbeing of the beneficiaries in care and were mandatory minimum conditions for empanelment.

(Paragraphs 4.2.1 and 4.2.2, Page nos. 25 and 26)

The availability of Empanelled Health Care Providers (EHCPs) per lakh beneficiaries is very low in the States/UTs, **Assam** (3.4), **Dadra Nagar Haveli-Daman Diu** (3.6), **Maharashtra** (3), **Rajasthan** (3.8) and **Uttar Pradesh** (5), etc. Further, availability of EHCPs per one lakh beneficiaries ranged from 1.8 EHCPs in **Bihar** to 26.6 EHCPs in **Goa.**

(Paragraph 4.3, Page no. 26)

Physical verification was not conducted by District Empanelment Committee (DEC) before empanelment in 163 EHCPs in **Manipur** (17)**, Tripura** (103) and **Uttarakhand** (43)**.**

(Paragraph 4.4, Page no. 27)

In **Jharkhand,** two private EHCPs were not providing three specialities under the PMJAY, which were otherwise available for the general public. In **Assam,** 13 EHCPs were providing 4 to 80 *per cent* of available facilities to PMJAY beneficiaries. In four States/UTs, lack of Specialties were noted in EHCPs.

(***Paragraphs 4.5 and 4.5.1, Page no. 28)***

In five States, **Assam** (18)**, Chhattisgarh** (65)**, Gujarat (**20)**, Jharkhand (**08) and **Manipur (**15**)**, EHCPs treated beneficiaries for non-empanelled specialities.

(Paragraph 4.6, Page no. 29)

In **Andhra Pradesh** (524 EHCPs), **Jharkhand** (59 EHCPs), **Punjab** (5 EHCPs), **Tamil Nadu** (19 EHCPs) and **Uttar Pradesh** (40 EHCPs), no treatment was provided by the EHCPs**.**

(Paragraph 4.7, Page no. 30)

In 14 States/UTs, 2,733 hospitals were empanelled with delay ranging for period of more than one day to 44 months. Further, in six States, empanelment of 418 Hospitals was under process with delay ranging from two days to 29 months.

(Paragraph 4.8, Page no. 31)

In **Himachal Pradesh** (50) **Jammu and Kashmir**, (459), **Jharkhand** (36) and **Meghalaya** (13,418) beneficiaries were charged for their treatment in empanelled EHCPs resulting in increase in out-of-pocket expenditure of beneficiaries.

(Paragraph 4.9, Page no. 32)

In **Bihar**, empanelment of Ananya Memorial Hospital was suspended on 30 August 2019, but payment of 12 claims amounting to ₹67,900 was settled during 2018-20. SHA did not

conduct necessary investigation of the claims paid to the hospital. In **Jharkhand,** five de-empanelled EHCPs treated 1,777 patients and got claim amount of ₹1.37 crore. In 11 States, 241 hospitals were de-empanelled either voluntarily or due to low-performance and mal-practices noted in EHCPs.

(Paragraph 4.10, Page no. 33)

In **Jharkhand,** eight EHCPs were empanelled twice by SHA with different identification, though locations of the EHCPs were the same. In **Tamil Nadu**, 57 empanelled Government/private EHCPs were allotted two or more unique ID.

(Paragraph 4.11, Page no. 34)

Claims Management

As of November 2022, 3.57 crore claims amounting to ₹42,433.57 crore were settled. Out of these, claims amounting to ₹22,619.86 crore (53.30 *per cent*) pertained to the six brownfield States *viz*. Andhra Pradesh, Arunachal Pradesh, Rajasthan, Karnataka, Maharashtra and Tamil Nadu. These States use their own IT Platform to process the claims and subsequently feed into Transaction Management System of PMJAY through an Application Programming Interface (API). With no segregation of PMJAY beneficiaries in such cases, there is a possibility of overlap of PMJAY with state specific schemes.

(Paragraph 5.1.1, Page no. 35)

Data analysis revealed that 39.57 lakh claims took more than the specified time of 12 hours in approval of pre-authorisation.

(Paragraph 5.1.3, Page no. 36)

In four States, excess payment amounting to ₹57.53 crore were made to the EHCPs.

(Paragraph 5.2, Page no. 37)

In several States/UTs, revenue received from PMJAY was not utilised by Public/Government Hospitals for the purpose defined under PMJAY scheme.

(Paragraph 5.3, Page no. 38)

In **Andhra Pradesh** and **Punjab**, private hospitals were performing procedures reserved for public hospitals.

(Paragraph 5.4, Page no. 42)

In six States/UT, there was delay in submission of claims by hospitals and payment was made to hospitals without any penalty and even inadmissible payments were also made to these hospitals.

(Paragraph 5.5, Page no. 42)

In **Gujarat** and **Uttarakhand**, payments were made in cases of death, without obtaining death summary by SHA and without receiving the mortality audit reports.

(Paragraph 5.6, Page no.44)

In eleven States/UTs, inadequate validation checks such as admission before pre-authorization, transaction before inception of the Scheme, surgery after discharge of patient, payment prior to submission of claims, non-availability/invalid dates and other entries etc. were noted.

(Paragraph 5.7, Page no. 44)

Common format for maintaining the data was not used by States specific IT Platform in **Andhra Pradesh, Arunachal Pradesh, Rajasthan, Karnataka, Maharashtra** and **Tamil Nadu**. Master data of these patient IDs was not being maintained and available in NHA. In the absence of the master data (in Beneficiary Identification System or otherwise) audit could not ascertain as to how the terms and conditions of scheme was being monitored in these States as well as ensured in NHA.

(Paragraph 5.8.1, Page no. 47)

Inadequate pre-validation control on data captured through Transaction Management System (TMS)/States specific IT Platform was noted. Many discrepancies such as invalid dates of admission/pre-authorization/claim processing, non-availability of certain crucial dates, date of surgery after date of discharge of the patient, invalid/null entries in patient age column were noted. In certain cases, the date of discharge was earlier than admission date. TMS allowed pre-authorisation request of treatment of a beneficiary shown as 'died' in many cases.

(Paragraphs 5.8.2.1 to 5.8.2.10, Page nos. 49 to 55)

Financial Management

In contravention of guidelines, NHA released grants of ₹ 280.20 crore, ₹ 217.60 crore and ₹ 112.62 crore in three different bank accounts to SHA **Chhattisgarh** during 2018-21.

(Paragraph 6.3.1, Page no. 63)

Three State Health Authorities (SHAs) **Chhattisgarh, Punjab** and **Uttarakhand** had not maintained separate escrow account for PMJAY and State sponsored scheme. Both the schemes were operated through combined account.

(Paragraph 6.3.2, Page no. 63)

During 2018-19, NHA released grant amounting to ₹ 185.60 crore to eight States without ensuring release of upfront shares by the respective States.

(Paragraph 6.3.3, Page no. 64)

NHA released excess grant to **Andhra Pradesh** (₹ 8.37 crore) and **Mizoram** (₹ 10.86 crore) without considering previous year's balances and upfront shares.

(Paragraphs 6.4.1 and 6.4.2 Page nos. 64 and 65)

In **Jharkhand**, the PMJAY was launched in September 2018 by subsuming Rashtriya Swasthya Bima Yojana (RSBY) but ₹ 96.63 crore is still lying in RSBY fund.

(Paragraph 6.4.3, Page no. 66)

NHA released grants amounting to ₹ 3.76 crore to SHAs Puducherry and Punjab before implementation of the Scheme in the respective State/UT. This resulted in avoidable parking of grants for a period ranging from four to nine months.

(Paragraph 6.4.4, Page no. 66)

Seven SHAs diverted the grant of ₹50.61 crore from one head to another head.

(Paragraph 6.5, Page no. 67)

In 20 SHAs, administrative grant of ₹ 98.98 crore, ₹ 128.13 crore and ₹ 139.67 crore remained unspent at the close of 2018-19, 2019-20 and 2020-21 respectively.

(Paragraph 6.6, Page no. 67)

10 SHAs did not remit interest of ₹ 22.17 crore earned by them on unspent grants to NHA.

(Paragraph 6.7, Page no. 67)

₹ 458.19 crore was recoverable from the insurance companies in six States/UTs.

(Paragraph 6.8, Page no. 68)

The State of **West Bengal** withdrew from PMJAY in January 2019 but did not refund ₹31.28 crore to NHA.

(Paragraph 6.9, Page no. 68)

18 SHAs furnished 212 Utilisation Certificates (UCs) amounting to ₹ 4,115.35 crore without audited statements of accounts during 2018-21. Out of these 18 SHAs, seven SHAs furnished UCs without signature of the competent authority. Six SHAs furnished to NHA, inflated Utilization Certificates amounting to ₹38.24 crore.

(Paragraph 6.10, Page no. 69)

The instructions of Government of India to track the expenditure flow through PFMS had not been fully complied with by NHA and SHAs.

(Paragraph 6.11, Page no. 70)

Monitoring and Grievance Redressal

In five States/UTs, District Implementing Units (DIUs) had not been formed by SHA. In **Tripura**, DIUs have only been constituted in five Districts.

(Paragraph 7.2, Page no. 72)

In 22 States/UTs, shortage of manpower at various posts in SHAs and DIUs were noticed.

(Paragraph 7.3.1, Page no. 73)

In three States/UTs, State Grievance Redressal Committees (SGRCs) were constituted with delay up to approx. one year. In **Punjab,** representation of members has not been made as required under grievance redressal guidelines. In **Rajasthan**, records related to the formation and function of the SGRC was not produced to audit. In **Puducherry**, SGRC has not been formed with requisite manpower.

(Paragraph 7.4.1 (a), Page no. 74)

In **Chhattisgarh** and **Manipur,** District Grievance Redressal Committees (DGRCs) have not been constituted in some districts. In **Jharkhand,** DGRCs have been constituted with delay. In **Ladakh** and **Madhya Pradesh,** DGRCs were not constituted at all. In **Punjab**, Chief Executive Officer or District Development Officer or Additional Deputy Commissioner/ Additional District Magistrate (Development) in charge of *Zilla Panchayat* was not nominated in the DGRC.

(Paragraph 7.4.1 (b), Page no. 74)

In five States/UTs, no meeting of State Grievance Redressal Committee (SGRC) was held while in **Punjab** and **Jharkhand** less than prescribed number of meetings were organised.

(Paragraph 7.4.2 (a), Page no. 75)

In six States/UTs, no meeting of DGRC was held while in three States, shortfalls in meetings of DGRC were 53 to 100 *per cent.*

(Paragraph 7.4.2 (b), Page no. 75)

Out of 37,903 grievances, only 3,718 complaints (9**.**80 *per cent)* were redressed within turn-around-time and 33,100 complaints (87**.**33 *per cent)* redressed beyond turn-around-time. While 1,085 complaints were under process for redressal.

(Paragraph 7.5.1 (i), Page no. 76)

Out of 1,111 appeals received, 593 appeals (53.38 *per cent)* were resolved beyond turn-around-time.

(Paragraph 7.5.1 (ii), Page no. 76)

Out of 40 grievances received, SHA **Chhattisgarh** had not redressed any grievance. In six States, 582 grievances were under process for disposal. Data related to the redressal of the

grievances within the Turn Around Time (TAT) and beyond TAT was not provided by nine States/UTs.

(Paragraph 7.5.2, Page no. 77)

In **Andaman and Nicobar Islands,** Nodal Officer has not been nominated to address the grievances at the State level under PMJAY.

(Paragraph 7.6, Page no. 77)

Anti-Fraud Cell in four States/UTs, Claim Review Committees in eight States/UTs and Mortality and Morbidity Review Committees in 11 States/UT were not formed.

(Paragraph 7.7, Page no. 78)

Three States/UT of **Bihar, Chandigarh** and **Uttar Pradesh** did not plan/conduct anti-fraud awareness activities.

(Paragraph 7.8, Page no. 79)

In **Assam** (01 hospital) and **Jharkhand** (12 hospitals) had indulged in mal-practices; however, no action was initiated against these hospitals.

(Paragraph 7.9.1 Page no. 79)

Seven States/UTs had not adopted Whistle Blower Policy to receive complaints relating to disclosure on any allegation of corruption, medical and non-medical fraud, etc. against any stakeholder involved with the implementation of PMJAY.

(Paragraph 7.10, Page no. 80)

In 22 States/UTs, audits were either not conducted or conducted in less numbers.

(Paragraph 7.11, Page no. 80)

Penalty amounting to ₹12.32 crore from 100 hospitals was pending in nine States/UTs. SHAs **Jammu & Kashmir** and **Ladakh** failed to levy penalties amounting to ₹20.93 crore and ₹ 39.66 lakh respectively on Insurer for non-performance of various activities.

(Paragraph 7.12, Page no. 83)

In two States, **Himachal Pradesh** and **Tamil Nadu,** PMAMs were not rotated frequently.

(Paragraph 7.13, Page no. 84)

Key initiatives undertaken in PMJAY are given in Chapter-VIII. These include launching of programme for converging major insurance schemes and programme for ESIC and CAPF, Building and other Construction workers on NHA IT Platform, issuance of PVC quality cards etc.

(Chapter-VIII, Page no. 85)

CHAPTER I

Overview

1.1 Introduction

Ayushman Bharat is a health scheme of the Government of India launched on 23 September 2018 to achieve Universal Health Coverage as recommended in the National Health Policy, 2017 which envisages the attainment of the highest possible level of health and well-being for all at all ages.

The Scheme has been rolled out in rural and urban areas, based on the deprivation and occupational criteria of the Socio-Economic Caste Census, 2011 (SECC-2011) respectively, for over 10.74[1] crore families. Aim of the Scheme is reduction in out-of-pocket expenditure of poor and vulnerable population.

Ayushman Bharat comprises of two inter-related components, which are:

i. Health and Wellness Centres (HWCs)

First component of Ayushman Bharat is the creation of Health and Wellness Centres (HWCs) by transforming Primary Health Centres (PHCs)/Sub-Centres (SCs) to provide Comprehensive Primary Health Care (CPHC). HWCs will enable a focus on wellness and health promotion, provide an expanded range of primary healthcare services, including access to medicines and diagnostics, to be delivered close to the community.

The objective is to set up 1,50,000 HWCs by December 2022 in order to facilitate universal health coverage and reduce out of pocket expenditure. As on 30 November 2022, 1,31,150 HWCs were functional.

ii. Pradhan Mantri Jan Arogya Yojana (PMJAY)

The Second component of Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY) provides a health cover up to ₹ five lakh per family per year, for secondary and tertiary care hospitalization services. PMJAY provides cashless and paperless access to services for the beneficiaries at the point of service.

[1] In January 2022, GoI approved the expansion of beneficiary base to 12 crore families based on National Food Security Act (NFSA) data.

The inclusion of households is based on the deprivation and occupational criteria of the Socio-Economic Caste Census 2011 (SECC-2011) for rural and urban areas, respectively. This number also includes families that were covered in the Rashtriya Swasthya Bima Yojana (RSBY) but did not form part of the SECC-2011 database.

Even though PMJAY uses the SECC as the basis of eligibility of households, many States are already implementing their own health insurance schemes. The States have been provided the flexibility to use their own database for PMJAY. However, they have to ensure that all eligible families based on the SECC database are necessarily covered. Beneficiary eligibility for PMJAY is detailed in **Annexure-1.1**.

This Report examines various issues relating to the implementation of the Pradhan Mantri Jan Arogya Yojana component of Ayushman Bharat.

1.2 Subsuming RSBY in PMJAY

A Committee of Secretaries constituted for transition of Rashtriya Swasthya Bima Yojana[2] (RSBY) from the Ministry of Labour and Employment to the Ministry of Health and Family Welfare had submitted (December 2014) its report to the Cabinet Secretary and cited multiple weaknesses in implementation of RSBY such as inadequate involvement of State Governments, lack of uniformity in database, no indicators for monitoring of scheme, lack of awareness about the Scheme among intended beneficiaries, non-enrolment of significant targeted population under the Scheme and increase in out of pocket health expenditure of beneficiaries etc. To integrate RSBY into the health system and make it a part of the comprehensive health care vision of Government of India, RSBY was transferred to Ministry of Health and Family Welfare (Ministry) on "as is where is" basis with effect from 01 April 2015.

Keeping in view the shortcomings of RSBY, Cabinet approved (March 2018) the launch of Ayushman Bharat National Health Protection Mission now known as Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). PMJAY was launched on 23 September 2018 across the country.

[2] A centrally sponsored scheme for unorganised workers and BPL Population providing cashless health insurance coverage of ₹30,000 per annum on a family floater basis for five members.

1.3 Salient features of PMJAY

The salient features of PMJAY are detailed in **Table-1.1**.

Table-1.1: Salient features of PMJAY

Health cover of up to ₹ five lakh per family per year on family floater basis, for secondary and tertiary care hospitalization through a network of Public and Empanelled Private Healthcare Providers
Cashless and paperless treatment for the beneficiary at the time of hospital admission, no money is required
No cap on family size, age or gender. Dependents of the registered beneficiary can avail benefits on his/her card
Coverage of three days of pre-hospitalization and 15 days of post-hospitalization expenses including medicines, follow-up consultation and diagnostic
Benefits are portable across the country. A beneficiary can avail AB-PMJAY benefits in empanelled hospitals from any State beyond his/her home State
Inclusion of 1,393 procedures in Health Benefit Package-1.0. HBP-2.0 released in December 2019. Presently covers 1949 procedures with 27 specialties (April 2022)
Treatment of COVID-2019 patients had also been covered under Ayushman Bharat w.e.f. 04 April 2020

1.4 Institutional Structure

The Union Cabinet on 21 March 2018 approved the Ayushman Bharat National Health Protection Mission and the National Health Agency was set up as a society, under Societies Registration Act, 1860, on 23 May 2018.

In September 2018, the Mission was renamed as Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY). On 2 January 2019, the Union Cabinet approved the restructuring of the National Health Agency as the National Health Authority (NHA) as an Autonomous Body under Ministry of Health and Family Welfare. With this restructuring, the National Health Agency which functioned as a registered society was dissolved and its status was enhanced to that of an Authority. NHA has been provided with full autonomy, accountability, and mandate to implement PMJAY through an efficient, effective, and transparent decision-making process.

NHA is governed by a governing board. It is chaired by the Union Minister of Health and Family Welfare and has a panel of 11 members[3].Organisational Structure of NHA is given in **Annexure-1.2**.

[3] Chief Executive Officer, NITI Aayog, ex officio. • Secretary, Department of Expenditure, Ministry of Finance, Government of India, ex officio. • Secretary, Department of Health and Family Welfare, Ministry of Health and Family Welfare (MoHFW), GoI, ex officio. • CEO, National Health Authority, Member Secretary. Two domain experts appointed by the Government of India in the areas of administration, insurance, public and private healthcare providers, economics, public health management. • Five Principal Secretaries of Health of State Governments, one representing each of the zones *viz.* North, South, East, West and North-Eastern States on a rotational basis.

Institutional Structure is outlined in **Table-1.2**.

Table-1.2: Institutional Structure

National Health Authority (NHA)	NHA, headed by CEO is divided into seven verticals, namely Finance, Administration, Policy & Knowledge Management, Information Technology, Beneficiary Empowerment, Hospital Networking & Quality Assurance (HNQA) and State Partnerships. These cover the operations and support functions in the implementation of PMJAY.
State Health Authority (SHA)	State Health Authority (SHA) is the nodal agency responsible for implementation of PMJAY in the States, headed by a Chief Executive Officer (CEO). The CEO, SHA is appointed by the State Government and is *ex-officio* Member-Secretary of the Governing Council of the SHA. The CEO is supported by a team of specialists dealing with specific functions. The team is counselled and overseen by a Governing Council set up at State level. Along with the day-to-day operations of PMJAY in the State, SHA is responsible for data sharing, verification and validation of family members, Information, Education, Communication and monitoring of the Scheme.
District Implementation Unit (DIU)	District Implementation Unit (DIU), chaired by DC/DM/Collector of the District has been established to support implementation in every District included under the Scheme. The DIU coordinates with the implementing support agency (ISA/Insurer) and network hospitals to ensure effective implementation and send periodic review reports.

1.5 Implementation modes

PMJAY is being implemented in three modes *i.e.* Insurance, Trust and Mixed as detailed in **Table-1.3**. The States may choose any of the implementation modes. The Central Government share is released to the State nodal agencies in three instalments of 45:45:10 in case of Insurance mode and 50:25:25 in case of Trust and Mixed modes.

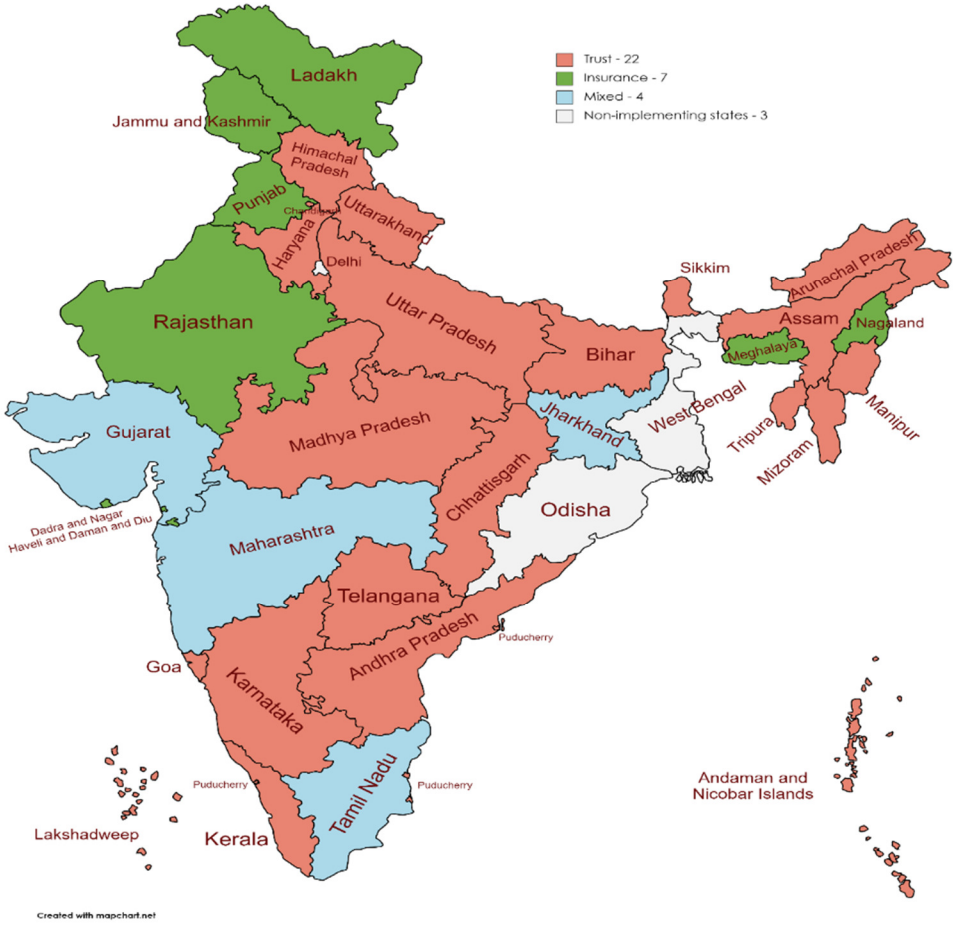
Table-1.3: PMJAY Implementation Modes

Insurance Mode	SHA selects an insurance company through a tendering process. Based on market determined premium, SHA pays premium to the insurance company per eligible family for the policy period, which in turn, settles the claims and makes payments to the service provider. The financial risk for implementing the scheme is, thus, borne by the insurance company.
Assurance/ Trust Mode	In this mode, the financial risk is borne by the Government, as the SHA directly reimburses the healthcare providers. SHA employs the services of an Implementation Support Agency (ISA) for claim management and related activities. SHA also has to carry out specialized tasks such as hospital empanelment, beneficiary identification, claims management and audits and other related tasks.
Mixed Mode	SHA engages both the assurance/trust and insurance models mentioned above, thus, providing flexibility and allowing convergence with the State scheme(s). This model is usually employed by those States which had existing schemes covering a larger group of beneficiaries.

As of March 2021, out of 36 States/UTs, 32 States/UTs had adopted the PMJAY. Out of these, 21 States/UTs adopted the Trust Mode, seven States/UTs adopted the Insurance Mode and four States adopted the Mixed Mode. Beneficiaries under the Trust mode constituted 62.11 *per cent* of the total beneficiaries, while the Mixed Mode and Insurance Mode covered 27.66 and 10.23 *per cent* respectively of total beneficiaries.

Delhi and **Odisha** are yet to adopt the Scheme. Telangana adopted the Scheme in May 2021, while **West Bengal** withdrew (January 2019) from PMJAY.

The following diagram depicts States/UTs with their corresponding mode of PMJAY implementation:



State-wise details of modes of Implementation are given in **Annexure-1.3**.

1.6 Financing of Scheme

Funding of PMJAY is shared between the Central and State Governments with the ratio of contribution between Centre and State at 60:40 in all States, except the North-Eastern States, two Himalayan States **(Himachal Pradesh** and **Uttarakhand)** and **Jammu and Kashmir** (a Union Territory with legislature), where the sharing ratio is 90:10. For Union Territories

without legislatures, the Central Government may provide up to 100 *per cent* on a case-to case basis.

1.7 Significant Modules of PMJAY

PMJAY is paperless and functions through an IT System. The IT system includes end-to-end information security and privacy of beneficiaries' data for beneficiaries' portability, grievance management and anti-fraud measures, etc. The Mission of PMJAY for the next five years is: "Creating the world's best health assurance programme on an efficient and technologically robust ecosystem". Significant Modules of PMJAY are detailed in **Table-1.4**.

Table-1.4: Significant Modules of PMJAY IT System

Beneficiary Identification System (BIS) Module under PMJAY helps verify beneficiaries from the database and create beneficiary registries	**Transaction Management System (TMS)** Allows for capturing of in-patient data on admission, treatment, and discharge, and onwards to hospital claims and financial settlement; and consists of two significant sub-modules. Pre-Authorization module Claims processing module
Hospital Empanelment Module (HEM) Module for empanelling hospitals	**RADAR and FACTS**[4] National Anti-Fraud Unit (NAFU), a fraud control vertical of NHA, has identified a certain number of instances which when detected, the transaction/set of transactions are flagged as suspicious transaction(s) and forwarded to State teams for further investigation at their end.
Central Grievance Redressal Management System (CGRMS) CGRMS is a system set by the National Health Authority for registering, processing, managing, monitoring and redressing all grievances from any of the aggrieved stakeholder under the PMJAY.	

Audit analysis of the data provided by NHA in respect of all the five significant Modules of PMJAY and findings thereon are discussed in the subsequent Chapters.

[4] RADAR-Risk Assessment, Detections and Analytical Reporting
FACTS-Fraud Analytics Control and Tracking System

CHAPTER II

Audit Approach

The audit aimed to examine the status of various activities required to be carried out by the National Health Authority, State Health Authorities, District Implementing Units, etc. for implementation of PMJAY and make suitable recommendations for augmenting implementation at various levels.

2.1 Audit Objectives

The Audit was conducted in order to ascertain:

a) Whether the beneficiary registration process is able to include all the eligible beneficiaries and filter any ineligible applicants,

b) Whether the controls in the process of empanelment of hospitals/laboratories are implemented in practice,

c) Whether the process/controls for reimbursement of claims to empanelled hospitals/laboratories are adequate and are effective,

d) Whether the financial management including release and utilization of funds was efficient, and

e) Whether there exists an effective monitoring system with anti-fraud and grievances redressal mechanisms.

2.2 Audit Criteria

The following were the sources of audit criteria:

a) Operational Guidelines for the implementation of PMJAY

b) Socio-Economic Caste Census (SECC), 2011 data

c) Relevant circulars, orders and notifications issued by the Ministry of Health and Family Welfare and National Health Authority

d) Provisions contained in General Financial Rules etc.

e) Physical and financial progress reported under Management Information System (MIS) available on website of the PMJAY.

2.3 Why this Performance audit

PMJAY aims at coverage of a large number of beneficiaries to provide them medical care and reduce out-of-pocket expenses. The Scheme involves considerable financial investment by both the Central and State Governments. The audit was taken up in view of the importance of the scheme and the considerable financial outlay.

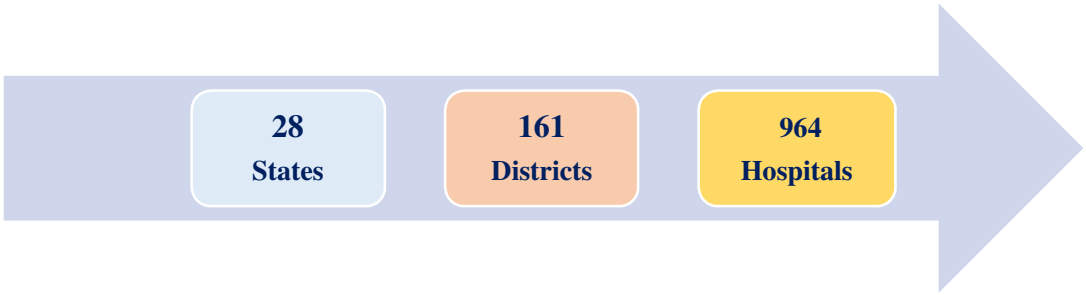
2.4 Audit Scope and Selection

All India Performance Audit of PMJAY covered the period from September 2018 to March 2021.The Performance audit was conducted in 28 States/UTs implementing the PMJAY. Each State was divided into different geographical regions and 25 *per cent* of Districts were selected. The process and mechanism for sampling and selection of Districts and hospitals are detailed in **Annexure-2.1**.

Entities covered during audit examination included the Ministry of Health and Family Welfare and National Health Authority at the Central level, State Health Agencies, District Implementation Units and selected Empanelled Hospitals at the State level.

The sample size covered during the Performance Audit is depicted in **Chart-2.1** and details in **Annexure-2.2**.

Chart-2.1 Sample size covered



2.5 Audit Methodology

Performance audit was conducted since inception of the Scheme *i.e.* September 2018 to March 2021. Data analysis at NHA was carried out on live server through Virtual Private Network (VPN) till the month of July 2021 and in the States on different dates.

The Performance audit commenced from 01 April 2021 with an entry conference with the National Health Authority on 24 March 2021 wherein the audit approach was discussed. Simultaneously, entry conference was held in each participating State by the respective Director General/Principal Director (Central)/Principal Accountants General/Accountants General with the nodal departments involved in the implementation of PMJAY.

In June-July 2020, a data analysis of NHA's IT System was conducted in which significant audit findings *viz.* presence of suspected (ineligible) beneficiaries in PMJAY ecosystem because of usage of uncleaned SECC database, unrealistic household size, pendency in approval of beneficiaries and hospitals, time taken for pre-authorization approval, delay and pendency in approval and payment of claims and inadequate validation controls were observed. Further data analysis was conducted again during the course of audit at NHA as well as SHA and the findings have been discussed in succeeding Chapters.

After conclusion of audit, an exit conference was held with the NHA on 27 July 2022 wherein the draft audit findings were discussed. Exit conferences were also held at the State level. On 17 February 2023, a presentation was made to the Ministry of Health and Family Welfare, wherein the updated status of Scheme implementation was shared by the Ministry with the Audit. Responses furnished by the Ministry and NHA have been considered and appropriately included in this Report.

2.6 Structure of the Report

The Report containing relevant findings is divided into five Chapters. The structure of the Report is as under:

Chapter Number	Title
III	Beneficiary Identification and Registration
IV	Hospital Empanelment and Management
V	Claims Management
VI	Financial Management
VII	Monitoring and Grievance Redressal

While Chapters-I and II provide an overview of the subject and audit approach adopted during the audit process, Chapter-VIII presents key Initiatives undertaken in the implementation of PMJAY. Recommendations for augmenting the Scheme have been given in Chapter-IX.

2.7 Acknowledgement

Audit acknowledges the co-operation and assistance extended by the Ministry of Health and Family Welfare, National Health Authority, State Governments and implementing departments and their officials at various stages during conduct of this Performance Audit.

CHAPTER III

Beneficiary Identification and Registration

3.1 Introduction

Pradhan Mantri Jan Aarogya Yojana envisaged (March 2018) coverage of about 10.74 crore beneficiary households based on the deprivation and occupational criteria of the Socio-Economic Caste Census, 2011 (SECC) for rural and urban areas respectively[5]. Additionally, the target also included families that were covered in the Rashtriya Swasthya Bima Yojana (RSBY) but were not present in the SECC database. The details of the envisaged targeted beneficiaries are given below in **Table-3.1**.

Table-3.1: Estimation of Beneficiaries

Rural	1. Households included on basis of fulfilling any of the five parameters of inclusion in SECC *viz.* (i) Households without shelter, (ii) Destitute, living on alms, (iii) Manual scavenger families, (iv) Primitive tribal groups and v) legally released bonded labour		0.16 crore
	2. Total deprived households targeted who belong to one of the six deprivation criteria amongst D1, D2, D3, D4, D5 and D7 in SECC[6]		8.03 crore
Urban	3. Urban Households under different categories		2.33 crore
	Rag picker	23,825	
	Beggar	47,371	
	Domestic worker	6,85,352	
	Street vendor/Cobbler/hawker/other service provider working on streets	8,64,659	
	Construction worker/Plumber/Mason/Labour/Painter/Welder/ Security guard/Coolie and other head-load worker	1,02,35,435	
	Sweeper/Sanitation worker/Mali	6,06,446	
	Home-based worker/Artisan/Handicrafts worker/Tailor	27,58,194	
	Transport worker/Driver/Conductor/Helper to drivers and conductors/Cart puller/Rickshaw puller	27,72,310	
	Shop worker/Assistant/Peon in small establishment/Helper/ Delivery assistant/Attendant/Waiter	36,93,042	
	Electrician/Mechanic/Assembler/Repair worker	11,99,262	
	Washer-man/Chowkidar	4,60,433	
RSBY	4. Such number of families enrolled under RSBY but not in targeted SECC data		0.22 crore
		Total households	**10.74 crore**

[5] As per Cabinet note (March 2018)

[6] Defined in Annexure-1.1

In addition to beneficiaries as per the SECC data, States have been provided the flexibility to use their own database for the implementation of PMJAY (used in respect of State specific health insurance schemes). However, States need to ensure that all the families/households eligible as per SECC-2011 database are also covered in PMJAY.

In January 2022, the Government of India approved the inclusion of 12 crore families as beneficiaries based on National Food Security Act (NFSA) data.

3.2 Coverage of beneficiaries under PMJAY

The scheme envisaged coverage of 10.74 crore households on the basis of the deprivation and occupational criteria of the Socio-Economic Caste Census, 2011 (SECC) for rural and urban areas respectively[7] as elaborated in Para 3.1 above.

During audit of the Beneficiary Identification System (BIS) module under PMJAY, it was noted that as of July 2021, 4.70 crore households have been registered in the BIS (**Annexure-3.1**). Out of these, 1.89 crore households have been registered as PMJAY households on the basis of their eligibility as per SECC database (**Annexure-3.2**).

In response, NHA stated (December 2022) that as of November 2022, 7.87 crore households had been verified using NHA's IT system out of which, 2.08 crore beneficiary households had been identified from SECC-2011 database.

Regarding the coverage of beneficiaries from SECC-2011 database, NHA replied that the Department of Expenditure has conveyed the Cabinet's approval (January 2022) on the following recommendations of the Expenditure Finance Committee:

> Considering the decadal growth of 11.7 *per cent* (as per institute of population science) on the base data of 10.74 crore families, inclusion of 12 crore families as beneficiaries based on National Food Security Act (NFSA) data.
>
> Ministry of Health and Family Welfare and NHA and/or State may decide suitable mechanism for identifying State-wise beneficiaries under the scheme.

NHA has (January 2023) issued instructions to the States/UTs with regard to the above increase in the beneficiary base.

Audit is of the view that Ministry and NHA along with implementing States/UTs may devise appropriate mechanism to ensure coverage of intended beneficiaries.

[7] As per Cabinet note (March 2018).

3.3 Process for Beneficiary Identification

NHA provides a detailed guideline for the process of beneficiary identification and registration under the ambit of the policy and technology. Different stages of beneficiary identification and registration process is summarised as:

a. Search of the beneficiary data through 'Beneficiary Identification System'(BIS)[8],

b. Identification of individual/family through prescribed documents, and,

c. Generation of the e-card after approval.

All beneficiaries require registration in the system (BIS) once, either in advance or at the time of their first treatment, for availing benefits of the scheme.

BIS has a provision for marking/flagging the beneficiaries to indicate whether they pertain to PMJAY or the State's own scheme. The Pradhan Mantri Arogya Mitra (PMAM) who registers beneficiaries on the BIS is required to create/select the appropriate flag code so that any beneficiary registered in BIS is clearly identified by NHA's IT system as pertaining to PMJAY or the State's own scheme. This flag is used by the IT system not only in BIS but also while availing Scheme benefits subsequently in the Transaction Management System. Some of the States are using their own IT system.

States/UTs implementing their own health insurance/assurance schemes are allowed to continue with their own datasets for beneficiary identification. States/UTs are required to map their own database with SECC within a reasonable period of time.

Audit noted that:

Some of the States (*e.g.* **Madhya Pradesh** and **Uttarakhand**) are not ensuring usage of the flag as intended.

As some of the States like **Andhra Pradesh, Assam, Karnataka, Rajasthan and Tamil Nadu** are using their own IT system and not NHA's BIS system, and beneficiaries from these States have not been mapped with SECC database.

It was also noticed that in the BIS, there is no field which shows the specific category and the parameters of rural and urban beneficiary households covered under PMJAY as detailed in **Table-3.1** (*e.g.* Rag picker, Beggar, Domestic workers, Street vendors etc.).

NHA stated (August 2022) that at the time of the launch of Ayushman Bharat PMJAY, Government of India (GOI) had allowed States/UTs implementing their own health insurance/assurance schemes to continue with their own datasets for beneficiary

[8] BIS is a process, of applying the identification criteria on the SECC and RSBY database to approve/ reject the applications entitled for the benefits.

identification. States/UTs were required to map their own database with SECC within a reasonable period of time. However, due to lack of a common identifier this could not be achieved. Further, it was stated that in January 2022, the Government of India approved the inclusion of 12 crore families as beneficiaries based on National Food Security Act (NFSA) data.

Audit is of the view that there is a need to review the beneficiary registration system so that the eligible beneficiaries are covered and a clear identification of beneficiaries under Central and State schemes is available.

3.4 Process of Registration

Beneficiary Identification Guidelines stipulate that on applying for registration, after matching details[9] of the person from the list of eligible[10] beneficiaries, relevant documents[11] are sent online for approval of the Insurance Company/Trust. The online system generates a match confidence score of one to 100 on the basis of the level of documents matched. However, no uniform threshold[12] match confidence score has been prescribed by NHA for approval or rejection of person.

The Insurance Company/Trust may approve or reject a case with reason. Further, the rejected cases would again be reviewed by a State team which may either approve or reject the recommendations of the Insurance Company/Trust. However, NHA has also not prescribed any objective criteria for such approvals and rejections by the Insurance company/Trust or the State team.

Data analysis[13] revealed that the match confidence score was not applied as a criteria during the approval/rejection process of registration of a person. In the absence of any prescribed threshold levels, approvals and rejections were made irrespective of the confidence score.

Out of 11,38,21,032 approved cases, 3,67,10,090 cases (32.25 *per cent*) were approved even though these did not fetch any match confidence score[14], while in 1,68,91,452 cases (14.84 *per cent*), the match confidence score was zero.

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9 Name and Location, Ration Card Number or Mobile number .

10 The list comprises of 10.74 crore households of SECC and RSBY database and households of State schemes, if any.

11 Aadhaar (or an alternative Government ID) and Ration Card (or an alternative family ID), RSBY Card, PM Letter etc.

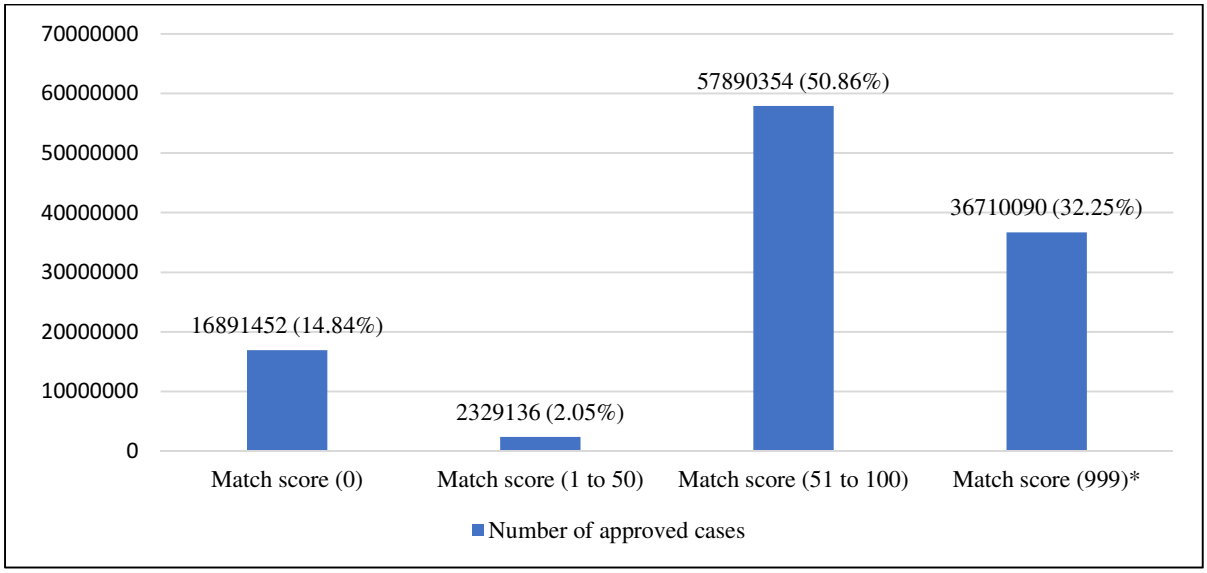
12 12 States have fixed a threshold limit; however, audit could not verify whether this criteria was applied in approval/rejection of registrations.

13 June 2021.

14 If the system fails to generate any match score within a prescribed stipulated time, a code (999) is returned instead of match score result.

Match confidence score-wise approval/rejection/disabling of registrations is depicted in **Chart-3.1**.

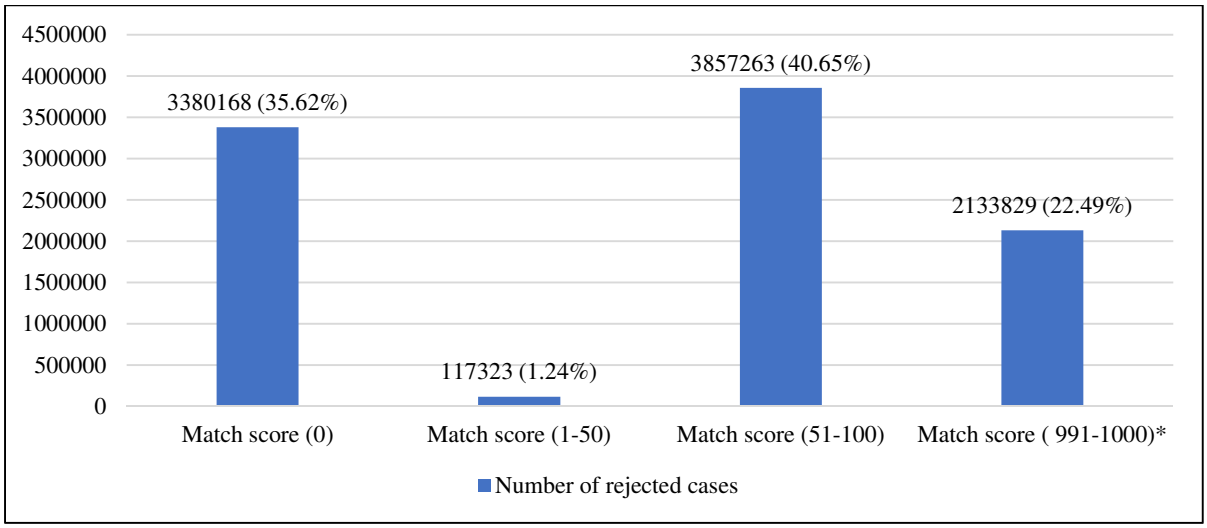
Chart-3.1: Match score-approved cases



**If the system fails to generate any match score within a prescribed stipulated time, a code (999) is returned instead of match score result.*

Similarly, out of 94,88,583 rejected cases, 38,57,263 cases (40.65 *per cent*) were rejected despite having a match confidence score of 51 to 100 as shown in **Chart-3.2**.

Chart-3.2: Match score-rejected cases



** Invalid match score*

NHA replied (August 2022) that the match score is generated using a machine algorithm which has been developed to assist the card approver in decision making and in some cases the confidence score generated by the system may be misleading. The decision of the card approver is primarily based on his/her own reading of the beneficiary records available from

different sources *i.e*. SECC database, e-KYC database etc. Further, apart from the match score which is based on the beneficiary details, the card approver also evaluates the details related to other members of the beneficiary family. Thus, the match score is only one of the tools to establish the veracity of the beneficiaries' credentials.

Audit is of the view that if the match score mechanism is not working as intended then it should be fine-tuned to make it more reliable or supplemented by identifiable objective criteria.

3.5 Registration under process for approval

PMJAY guidelines stipulate that during the process of registration of persons in the BIS, the Insurance Company/Trust should finalize approval/rejection within 30 minutes after online submission of data.

Data analysis revealed (21 June 2021) that 3,85,386 cases were under process for approval/rejection. Number of days of delay in these cases ranged from one to 940 days. Out of these, 91 *per cent* cases pertained to **Jammu and Kashmir** only as detailed in **Annexure-3.3.** Delays in registration requests for such long periods could lead to denial of benefit to the potential beneficiary during the intervening period.

NHA accepted the audit observation and stated (August 2022) that the time of 30 minutes was applicable when beneficiary identification drives are launched by the States. Pendency in Jammu & Kashmir, was attributed to prolonged suspension of internet services. Further, in order to expedite the beneficiary record approval process during the drives, NHA had on-boarded dedicated card approval agencies.

3.6 Quality of data in BIS database

Observations on quality of data in BIS database are outlined in the succeeding paragraphs:

3.6.1 Obsolete and erroneous SECC database used as criteria

NHA has used SECC database of 2011 as eligibility criteria for the Scheme. The database was more than seven[15] years old at the time of inception of the Scheme (2018). Looking into economic development and employment opportunities since then, it cannot be denied that many households may have become ineligible for inclusion while others may have become eligible for the SECC under the existing criteria.

Data analysis[16] of the BIS revealed several inconsistencies in the SECC database. The System showed different names and dates of birth of beneficiaries in two different columns. Other

[15] Scheme was launched in 2018.

[16] Of the entire BIS database.

errors included invalid or blank entries in the fields for name, year of birth and gender of beneficiary as detailed in **Table-3.2**.

Table-3.2: Obsolete and erroneous entries in BIS database

Type of Error	Column Field Name	Example of errors		Total number of cases
Name column is blank	'Name Secc'	(blank)		22,78,579
Invalid names	'Name Secc'	1.--- 2. ??? 3.AAAAAAAAA 4.ZZZZZZZZZ etc.		980
Unrealistic date of birth	'Dob ben'	1. 1814 2. 1824 3. 1841 etc.		717
Date of birth blank	'Dobben'*	(blank)		
'YobSecc' and 'Dob ben' columns showing different date of births	YobSecc and Dob ben	Dob ben	YobSecc	
		1814	1984	
		1824	1987	
		1841	1991	
Gender field left Blank	'Gender Secc'	(blank)		1,46,99,764
Invalid entry in gender field	'Gender Secc'	0,8,-,A,N,o and O		3,00,202

*(*Dob ben-Date of birth of beneficiary, Yob-Year of birth)*

In **Jammu & Kashmir** and **Ladakh,** during the period 2018 to 2021, 16865 and 335 numbers of ineligible beneficiaries respectively were identified by SHA after cleaning the SECC data, thus, indicating existence of ineligible beneficiaries in SECC database.

NHA accepted these deficiencies and stated (August 2022) that it has embarked on an exercise to enrich the beneficiary database by sourcing data of verified SECC beneficiaries from other flagship schemes such as Pradhan Mantri Ujjwala Yojana (through secure means). NHA is also mapping beneficiary data (verified from both SECC and non-SECC sources) with the more dynamic NFSA database to enrich the beneficiary data. Further, with regard to the premium paid corresponding to uncleaned SECC database in **Jammu and Kashmir**, NHA stated that whenever such inconsistences are reported/observed, necessary course corrections are taken to safeguard the interests of the public exchequer and the Scheme beneficiaries.

3.6.2 Generation of duplicate PMJAY ID (e-card number)

Scheme guidelines stipulate that once the eligible beneficiary is verified, a PMJAY ID is assigned to the beneficiary. This PMJAY ID is a nine digit alphanumeric code and serves as a unique identification key.

Data analysis revealed that PMJAY ID was not unique in 1,57,176 cases (approved cases only), as shown in **Table-3.3**.

Table-3.3: Details of same PMJAY IDs appearing more than once

Number of times a PMJAY ID is appearing in database	Number of PMJAY IDs appearing more than once
2 times	105138
3 times	51996
4 times	42
Total	**157176**

The presence of duplicate IDs in the system indicates failure of the system to generate a unique ID for each beneficiary. In such circumstances, possibility of presence of ineligible beneficiaries in the BIS database cannot be ruled out.

The NHA accepted the audit observation and replied (August 2022) that previously the system considered State code plus PMJAY ID as unique and within a State, the beneficiary ID is unique. However, this policy was being reviewed.

3.6.3 Unrealistic household size for registered beneficiaries

As per the Scheme guidelines, there is no definition of a family as in other schemes like CGHS, ESIC etc. Further, Guidelines also stipulate that there is no cap on family size for eligible households.

Data analysis[17] revealed that in 43,197 households, the size of the family was unrealistic, ranging from 11 to 201 members as detailed in **Table-3.4**.

Table-3.4: Unrealistic household size (size of family)

Range of members in a household	11 to 50	50 to 100	100 to 200	200 to 201
Actual number of cases	43180	12	04	01

Presence of such unrealistic members in a household in the BIS database indicates not only lack of essential validation controls in the beneficiary registration process, but also the possibility that beneficiaries are taking advantage of the lack of a clear definition of family in the guidelines.

NHA, while accepting the audit observation, stated (August 2022) that the National Anti-Fraud Unit has sent periodic reminders to the States UTs highlighting discrepancies in verified data. However, "Public Health" being a State subject, the final decision in this regard vests with the State Governments. Also, NHA is developing a policy to disable "Add

[17] Done on 21 June 2021

Member" functionality in case of any beneficiary family with more than 15 members. Further NAFU is sending a communication to the States/UTs to fully audit all such cases where family size is above a certain threshold.

3.6.4 Irregularities in validation of beneficiaries

PMJAY Guidelines stipulate 'Aadhaar' as one of the identity documents for a family member for registration under the AB-PMJAY. NHA has authenticated beneficiaries with Unique Identification Authority of India (UIDAI) through Aadhaar e-KYC[18] to ensure that information furnished is authentic. If any PMJAY family member does not have an Aadhaar card, they can get treatment only once without an Aadhaar and shall apply and obtain Aadhaar at the earliest for treatment in future.

In **Tamil Nadu**, linking of multiple beneficiaries with same/erroneous Aadhaar numbers were noted during data analysis as detailed in **Table-3.5**.

Table-3.5: Multiple beneficiaries linked with same/erroneous Aadhaar

Aadhaar number	Number of Scheme cards mapped
000000000000	1285
784545XXXXXX	1245
21547XXXXXX	975
2222XXXXXXX	780
3265987XXXXX	165
3265987XXXXX	160
2154785XXXXX	151
Total	**4761**

Successful generation of multiple e-cards (PMJAY ID) against same/erroneous Aadhaar number indicates lack of essential validation controls resulting in presence of duplicate beneficiaries in the system.

Regarding errors in linking of Aadhaar in Tamil Nadu, NHA replied that it is to be noted that the State is using its own IT platform (and database) for beneficiary identification. NHA has urged State to migrate to the Aadhaar-based BIS platform of NHA to strengthen beneficiary verification protocols.

3.6.5 Large numbers of beneficiaries registered against a single mobile number

Beneficiary Empowerment Guidebook provides that for communication with the beneficiary from admission in hospital to post discharge feedback, contact number will be used.

[18] Electronic Know Your Customer.

Guidelines on disabling a BIS e-card provides that the SHA shall send SMS intimation to the contact number provided at the time of card creation informing the beneficiary to check their eligibility.

Data analysis of BIS database revealed that there were large numbers of beneficiaries registered against same or invalid mobile number. Overall 11[19] to 7,49,820 beneficiaries were linked with a single mobile number in the BIS database as detailed in **Table-3.6**.

Table-3.6: Registration of beneficiary against invalid mobile number

Number of mobile numbers in system	Number of persons registered against them
3 (9999999999) (8888888888) (9000000000)	985166 (749820) (139300) (96046)
20	10001 to 50000
1435	1001 to 10000
185397	11 to 1000

Mobile numbers are significant for searching records related to any beneficiary in the database, who may approach the registration desk without the ID. In case of loss of e-card, identification of the beneficiary may also become difficult. This may result in denial of Scheme benefits to eligible beneficiaries as well as denial of pre and post-admission communication causing inconvenience to them.

NHA, while agreeing with audit observation, stated (August 2022) that with the deployment of BIS 2.0, this issue shall be resolved. Further, the BIS 2.0 system has been configured so that more than certain number of families cannot use the same mobile number. This shall arrest the prevalence of entering "random numbers" which constitute the overwhelming cases of mobile number inconsistency.

3.7 Ineligible households possessing PMJAY Cards and availing treatment

PMJAY's IEC Guidebook for State Health Agencies (SHAs) *inter-alia* states that beneficiaries whose household member is a Government employee should be automatically excluded from the list of eligible beneficiaries. States are advised to authorize the District Collectors/District Magistrates or Deputy Commissioners to exclude such beneficiaries from the eligible list.

[19] Taking a reasonable limit of 11 and more persons of a family linked with a single mobile number.

Audit noted that:

- In **Chandigarh,** a comparison of pensioners' database of UT Chandigarh with Scheme database revealed that 34 Government pensioners and 68 members from their families were included as beneficiaries and two of them had availed treatment under the Scheme at a cost of ₹ 11,700.
- In **Haryana**, a comparison of Government of Haryana pensioner's database with Scheme database revealed that 114 pensioners were included as beneficiaries and had availed treatment under the Scheme costing ₹ 26.81 lakh.
- In **Himachal Pradesh**, pensioner's database with Scheme database revealed that 22 pensioners were included as beneficiaries and had availed treatment under the Scheme costing ₹ 3.33 lakh.
- In **Karnataka**, a comparison of Government of Karnataka pensioner's database with Scheme database revealed that 1,558 pensioners were included as beneficiaries and had availed treatment under the Scheme costing ₹ 4.65 crore.
- In **Maharashtra**, a comparison of Government of Maharashtra's pensioners and General Provident Fund data was done with the data of beneficiaries. The analysis revealed that 477 Government servant/their family members had availed treatment under the Scheme and ₹ 1.47 crore was paid.
- In **Tamil Nadu**, a comparison of Government of Tamil Nadu pensioner's database with Scheme database revealed that 1,07,040 pensioners were included as beneficiaries. The premium amount paid by SHA to insurance company for these pensioners worked out to ₹ 22.44 crore.

Audit observed that delayed action in weeding out the ineligible beneficiaries resulted in ineligible persons availing benefits of the Scheme and excess payment of premium to the insurance companies.

NHA, while accepting the audit observation, replied (August 2022) that it is developing an SOP for adherence by the States to ensure that any SECC 2011 beneficiary family found ineligible as per AB-PMJAY criteria can be removed from the list of eligible individuals/families.

3.8 Delay in processing of rejection of beneficiaries

As per the Beneficiary Identification Guidelines, cases of registration recommended for rejection by the Insurer have to be decided by the Review Team of SHA within 24 hours. Data analysis in nine States/UT's revealed delay in processing of rejection cases as shown in **Table-3.7**.

Table-3.7: Delay in rejection

Sl. No.	State/UT	Rejected cases	Maximum delay (in days)
1	Assam	1,640	32
2	Chandigarh	632	70
3	Himachal Pradesh	5,287	199
4	Jammu & Kashmir	4,97,358	404
5	Kerala	1,149	223
6	Madhya Pradesh	1,98,555	NA
7	Manipur	90	18
8	Punjab	254	32
9	Uttar Pradesh	34,066	334

Delay in finalisation of approval/rejection is in non-compliance of the guidelines. Such delay implies that benefits of registration may be delayed/denied to potential beneficiaries during the intervening period. Further, it also delays re-application by potential beneficiary in case rejection was due to lack of documents.

NHA, while accepting the audit observation, stated (August 2022) that it has recently revamped the beneficiary identification system under Ayushman Bharat PMJAY. This revamped BIS 2.0 has simplified the process of beneficiary record verification. This will help expedite completely different process of beneficiary authentication in a time bound manner.

3.9 Creating awareness about PMJAY (non-implementation of IEC plan)

The success of the PMJAY is largely dependent on effective communication that should reach the last mile beneficiary. As per NHA guidelines the function of Information, Education and Communication (IEC) are:

- Understand the various target audiences for PMJAY, and their attitudes and perceptions towards PMJAY.
- Awareness drives to educate the target audience about PMJAY, by disseminating accurate information.
- Develop communication based on key insights, so that it drives changes in attitudes and behaviour.
- Create user friendly IEC material, select relevant communication channels and roll out messages at an appropriate time; to maximize reach and impact amongst the target audiences.

At the Central level, NHA has undertaken several IEC activities like posters, banners, leaflets, Train branding, outdoor branding, press meet and press release, Newsletters, Celebrity Endorsement for generating awareness about the Scheme entitlements, dedicated portal to provide Scheme details to various stakeholders, workshop to build capacity of SHAs etc.

During 2018-19 to 2020-21 NHA has incurred an expenditure of ₹ 64.07 crore on such activities as detailed in **Table-3.8**.

Table-3.8: Details of expenditure on IEC at NHA

(₹ in crore)

Year	BE/RE	Actual Expenditure
2018-19	No Separate Budget allocation for IEC	32.86
2019-20		10.42
2020-21		20.79
Total		**64.07**

However, NHA did not allot a specific budget for these activities, in the absence of which audit could not verify whether the expenditure was within the prescribed budget ceiling. However, NHA did not provide any details and records about a comprehensive IEC plan and its implementation status at the Central level. In the absence of these details and records, audit could not verify whether IEC activities were carried out at the central level in a planned manner and how far the planned targets were achieved.

NHA also did not provide any details of the mechanism for monitoring of IEC activities in various States all over India at the Central level and, therefore, audit could not verify whether NHA has monitored the IEC activities being carried out in States for creating awareness regarding benefits of the Scheme among beneficiaries in order to increase registration of beneficiaries and coverage of the Scheme.

Further, as per the IEC Guidelines, SHA had to constitute an IEC cell and recruit/assign required IEC staff. The SHA had to lay down the IEC objectives, design a comprehensive IEC plan and identify relevant target audiences to promote PMJAY**.**

The Guidelines for Release of Administrative Expenses provided that 25 *per cent* of the overall Administrative Expenses may be spent on the IEC activities related to promotion of PMJAY.

Audit observed following deficiencies in implementation of prescribed IEC activities in States:

In seven States, **Chhattisgarh, Himachal Pradesh**, **Jammu & Kashmir**, **Maharashtra, Punjab, Uttar Pradesh** and **Uttarakhand** IEC cell was formed. In 12 States, **Andhra Pradesh, Assam, Bihar, Dadar & Nagar Haveli and Daman & Diu, Gujarat, Jharkhand, Karnataka, Mizoram, Nagaland, Puducherry, Rajasthan** and **Tripura** IEC Cell was not formed whereas no information was available about remaining States.

IEC plan was prepared only in four States, **Chhattisgarh, Madhya Pradesh, Manipur** and **Rajasthan**. In **Maharashtra**, although plan was prepared in 2020-21 but was not implemented.

In 14 States, **Andhra Pradesh, Bihar, Chandigarh, Gujarat, Haryana, Himachal Pradesh, Kerala, Madhya Pradesh, Maharashtra, Punjab, Rajasthan, Tamil Nadu, Tripura** and **Uttar Pradesh,** expenditure on IEC activities ranged from zero to 20.24 *per cent* of the allotted budget against the prescribed benchmark of 25 *per cent.*

State-wise details of the deficiencies in implementation of prescribed IEC activities are detailed in **Annexure-3.4**.

The deficiencies in the implementation of IEC plan and inadequate expenditure may result in lack of awareness about the Scheme and its benefits. NHA needs to make special efforts and sensitise the entitled beneficiaries to generate awareness about the Scheme.

NHA replied (August 2022) that the guidelines shared by NHA regarding the utilisation of fund to States under different heads is only indicative in nature.

NHA needs to ensure that adequate expenditure is done by the SHAs to generate awareness about the Scheme.

3.10 Printing of booklets/pamphlets

As per the Beneficiary Identification guidelines issued by NHA, the State Government within a period of 15 days after receiving the approval from Ministry/NHA, may complete the preparatory activities to initiate the implementation and beneficiary identification process. These involved PMJAY e-card printing, availability of printed booklets/pamphlets for distribution to the beneficiaries at each contact points with details of the Scheme, process for availing the benefits under PMJAY, list of empanelled hospitals, toll free number of PMJAY call centre, etc.

Further, the State Government was required to identify and set-up teams to handle hardware and basic software support, troubleshooting etc.

The booklets/pamphlets were not printed or provided to beneficiaries in six States, **Assam, Himachal Pradesh, Jharkhand, Ladakh, Maharashtra,** and **Punjab.** In **Chhattisgarh,** booklets were printed but were not distributed at time of enrolment but distributed at a later stage without planning.

To increase the coverage of Scheme among beneficiaries, NHA should make efforts to create awareness through distribution of booklets/pamphlets, containing details of the Scheme so that the intended purpose of achieving universal health coverage may be achieved as soon as possible.

NHA stated (August 2022) that booklets/pamphlets were distributed by NHA and SHAs on different occasions. Such IEC materials have been distributed during the mass IEC campaigns, Melas, etc. NHA has also distributed millions of IEC material through NGOs with whom it has signed MOUs for IEC related to AB-PMJAY.

The reply is general and not specific to the audit observations relating to the above-mentioned States.

CHAPTER IV

Hospital Empanelment and Management

4. Introduction

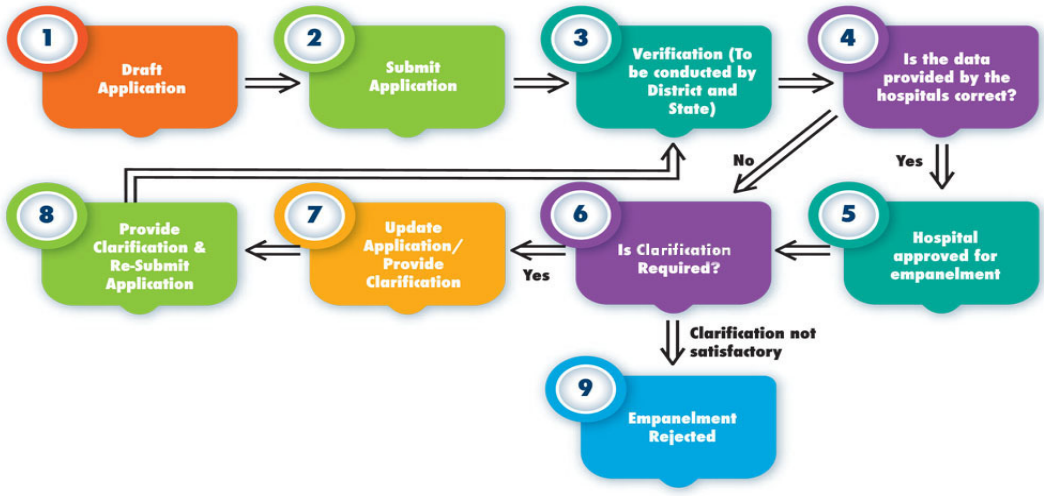
PMJAY covers medical and hospitalisation expenses for almost all secondary and tertiary care procedures covering surgery, medical and day care treatments for economically weaker segment of the population with an aim to bring low-cost quality treatment as well as to provide essential drugs and diagnostic services at affordable prices.

Preventive and quality health care are the core components to achieve Universal health coverage. In order to ensure that quality health care is provided to the beneficiaries under PMJAY, State Health Authorities through State Empanelment Committees (SEC) are empowered to empanel private and public health service providers in their respective State/UTs. The States are free to decide the mode of verification of empanelment applications, conducting the physical verification either through District Empanelment Committee (DEC) or using the selected insurance company (Insurance Mode), under the broad mandate of the instructions provided in the guidelines for hospital empanelment.

4.1 Process of Empanelment

All States/UTs are permitted to empanel Hospitals only in their own State/UT. In case any State/UT wants to empanel Hospitals in another State/UT, they can do so only till the time they are not implementing PMJAY. All public facilities with capability of providing inpatient services (Community Health Centre level and above) are deemed empanelled under PMJAY. The Private Hospitals may apply online through Hospital Empanelment Management (HEM) portal for empanelment. The process of empanelment of private Hospitals is defined in **Flow Chart-4.1**.

Flow Chart-4.1: Process of Empanelment



The State Health Department ensures that the enabling infrastructure and guidelines are put in place to enable all public health facilities to provide services under PMJAY.

4.2 Criteria for Hospital Empanelment

According to para 1.3 of Hospital Empanelment and Management (HEM) guidelines, the criteria for empanelment have been divided into two broad categories *viz.* General and Specialty. The Empanelled Health Care Providers (EHCPs) empanelled under PMJAY for providing general care should meet the minimum requirements of General Criteria. The main features of General criteria for empanelment of EHCPs are as under:

Requirement of round-the-clock facilities	Requirement of Medical staff
At least 10 in-patient beds. Round-the-clock support systems required for the services like Pharmacy, Blood Bank, Laboratory, Dialysis unit, Ambulance facilities. 24 hours emergency services managed by technically qualified staff, wherever emergency services are offered. Fully equipped Operation Theatre, Waste Management Support services (General and Bio Medical) in compliance with the Bio-medical Waste Management Act. Appropriate fire-safety measures.	Adequate and qualified medical and nursing staff. Round-the-clock availability (or on-call) of a surgeon and Anaesthetist where surgical services/day care treatments are offered. An Obstetrician, Orthopaedics, ENT, Ophthalmology, Dental, General surgery (including endoscopy).

Under the Specialty Criteria, Hospitals would be empanelled separately for certain tertiary care packages authorized for one or more specialities (*viz.* Cardiology, Oncology and Neurosurgery etc.) and the Hospitals are required to meet the advanced criteria to provide those facilities as specialty packages, over and above the general criteria.

As of November 2022, total 26209 (11,930 private and 14,279 public) Hospitals were empanelled across the States/UTs. The details are given in **Annexure-4.1**.

Audit noted instances of non-compliance with the general criteria for empanelment as detailed below:

4.2.1 Criteria regarding support system and infrastructure

As per Annexure-1 of HEM guidelines, a hospital should have adequate arrangements for round-the-clock support systems required for the services like pharmacy, blood bank, laboratory, dialysis unit, post op ICU care etc.

Audit noted that in 12 States/UTs namely **Andaman and Nicobar Islands, Assam, Bihar, Chandigarh, Gujarat, Himachal Pradesh, Jammu & Kashmir, Manipur, Nagaland, Puducherry, Tripura** and **Uttar Pradesh**, the minimum criteria of empanelment was not

met by some of the EHCPs. There were deficiencies such as medical equipment being out of order, lack of basic infrastructure such as IPD Beds, Operation Theatres, ICU care with ventilator support systems, Pharmacy, Dialysis Unit, Blood banks, Round-the clock Ambulance Services etc. Details are given in **Annexure-4.2**.

4.2.2 Non-compliance of safety measures

As per Annexure-1 of HEM guidelines, appropriate fire-safety measures, adherence to Standard treatment guidelines/Clinical Pathways for procedures as mandated by NHA from time to time, Waste Management Support Services (General and Bio Medical) – in compliance with the Biomedical Waste Management Act should be followed.

Audit noted that in seven States namely **Bihar, Himachal Pradesh, Jharkhand, Karnataka, Meghalaya, Puducherry** and **Uttarakhand**, some of the EHCPs were empanelled without fulfilling the above criteria. Details are given in **Annexure-4.3**.

This is indicative of the fact that EHCPs did not conform to the prescribed quality standards and mandatory conditions for empanelment.

NHA stated (August 2022) that safety measures like fire, bio-waste management etc. are not mandatory.

NHA's reply that the guidelines are not mandatory is not appropriate as SHAs are required to ensure that the EHCPs follow all the norms and safety measures.

4.3 Awareness Generation and Facilitation for Empanelment of EHCPs

According to para 1.4 of HEM guidelines, the State Government is to ensure that maximum number of eligible Hospitals participate in the PMJAY and this needs to be achieved through Information, Education and Communication (IEC) campaigns, collaboration with District, Sub-District and Block level workshops. The State and District administration are to encourage all eligible Hospitals in their respective jurisdictions to apply for empanelment under PMJAY. The SHA is to organize a District workshop to discuss the details of the Scheme (including empanelment criteria, packages and processes) with the Hospitals and address any query that they may have about the Scheme. Representatives of both public and private Hospitals (both managerial and operational persons) including officials from Insurance Companies are to be invited to participate in this workshop.

Audit noted that as of November 2022, total 26,209 (11,930 private and 14,279 public) Hospitals have been empanelled across the States/UTs. The EHCPs availability per one lakh beneficiary ranged from 1.8 EHCPs in **Bihar** to 26.6 EHCPs in **Goa.** In UT of

Lakshadweep, this availability ratio was 90.8 EHCPs per lakh beneficiaries. Details are given in **Annexure-4.1**.

The availability of EHCPs is very less in the States/UTs of **Assam** (3.4), **Dadra Nagar Haveli-Daman Diu** (3.6), **Maharashtra** (3) and **Rajasthan** (3.8). Audit noted that though beneficiaries in **Bihar** and **Uttar Pradesh** are numerous at 5.56 crore and 6.47 crore, availability of EHCPs was very low in comparison at 1.8 and five EHCPs respectively to a lakh of population.

The objective of the Scheme is to provide benefits to a poor and vulnerable population. In view of this, the State authorities should make concerted efforts through IEC activities to empanel more Hospitals.

While accepting the observation, NHA stated (August 2022) that continuous efforts are being made to empanel more number of hospitals.

4.4 Physical verification not conducted by District Empanelment Committee

According to para 1.6 of HEM guidelines, District Empanelment Committees (DEC) are responsible for hospital empanelment related activities at the district level and also to assist the State Empanelment Committee (SEC) in empanelment. After the empanelment request by a hospital is filed, the application is scrutinized by the DEC and processed completely within 15 days of receipt of application. After the verification of documents, the DECs physically inspect the premises of the hospital and verify the physical presence of the details entered in the empanelment application and submit a report to the SEC in a prescribed format through the portal along with supporting pictures/videos/document scans. Further, the SEC considers the reports submitted by the DEC and approves or denies or returns the empanelment request back to the hospital.

Audit noted that physical verification was not conducted in 163 EHCPs in **Manipur** (17), **Tripura** (103) and **Uttarakhand** (43).

Empanelment without conduct of physical verification has the risk of empanelment of EHCPs which do not fulfil minimum criteria of empanelment.

While accepting the observation, NHA stated (August 2022) that physical verification could not be completed because of pandemic issues and some hospitals were empanelled on the recommendation of CMO etc.

Audit is of the view that physical verification process should be mandatory for the empanelment of hospitals so that only those hospitals can be empanelled that fulfil requisite criteria are empanelled.

4.5 Non-empanelment of all available and eligible Specialities of EHCPs by SHA

According to HEM guidelines, DECs correlate the documents uploaded by the EHCPs with physical verification of original documents produced by the hospital. In case during inspection, it is found that a hospital has not applied for one or more specialties, but the same facilities are available, then the hospital will be instructed to apply for the missing specialties within a stipulated timeline (*i.e.* seven days from the inspection date). If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.

Audit noted that:

In **Assam,** out of 35 test checked EHCPs, 13 EHCPs were providing four to 80 *per cent* of available specialties to PMJAY beneficiaries. Details are given in **Annexure-4.4**.

In **Jharkhand,** two private EHCPs were not providing three specialities each under the PMJAY, which were otherwise available for the general public. Details are given in **Annexure-4.5**.

Failure to provide all available specialities by EHCPs reduces the availability of such services to beneficiaries, thus denying them benefits envisaged under the PMJAY.

4.5.1 Lack of Specialties

PMJAY aims to provide the poorest households with equitable access to a comprehensive package of patient-centred quality services. The development of comprehensive service packages is an important step towards this goal. However, the lack of the envisaged facilities/services in many States defeated the very purpose behind introduction of these packages.

In **Andaman and Nicobar Islands,** super speciality facilities were not available, neither at the referral hospital (545 bedded GB Pant Hospital, Port Blair) nor at two other District EHCPs. As a result, out of 316 hospitalization cases under PMJAY, 34 patients were referred by GB Pant Hospital, Port Blair to private EHCPs in Chennai, Kanchipuram, Kolkata, Madurai etc. at a distance of nearly 1,500 km from Port Blair.

In **Haryana,** 14 specialties were not available in various Districts of State. Hence, 1,178 PMJAY beneficiaries had to travel to another District/State to avail the treatment.

In **Maharashtra**, audit noted that 1,113 types of treatment were not provided in the hospitals located in Nandurbar, Washim, Osmanabad, Gadchiroli and Palghar Districts, where beneficiaries had to travel to other Districts for treatment.

In **Meghalaya,** due to lack of services in three Districts, 2,750 patients of West Jaintia Hills, West Garo Hills and Southwest Garo Hills took treatment in East Khasi Hills, while 884 patients from Southwest Garo Hills took treatment at West Garo Hills.

In many States, lack of speciality services necessitated the beneficiaries to move far off places which causes hardship and great amount of inconvenience to the beneficiaries and may lead to out-of-pocket expenditure. There is a strong need to upgrade the speciality services of EHCPs so as to fulfil the objective of the scheme.

4.5.2 EHCPs treated patients prior to up-gradation of specialties

In **Jharkhand,** 3 EHCPs in Ranchi treated 795 patients against certain specialities which are yet to be upgraded/empanelled in SHA and got payment of ₹ 0.63 crore. Details are given in **Annexure-4.6**.

Further, in **Jharkhand**, the Insurance Company informed (26 December 2019) SHA that Lifeline Nursing Home, Godda had performed 92 Phaco[20] procedures without having Phaco Machine in the hospital. SHA asked (March 2020) the Insurance Company to submit Beneficiary Audit report of all 92 Phaco procedures done by the hospital and details of claim payment made to the hospital. Although, the Insurance Company did not provide the details of beneficiary audit and claim amount, the SHA had not taken action against the Insurance Company or the hospital. Audit, however, noted that as per TMS data, hospital performed 72 Phaco procedures till 26 December 2019 and got payment of ₹ 5.98 lakh. NHA accepted the observation and quoted (August 2022) different reasons including laying responsibility on the SHA and absence of specialist doctors etc.

4.6 Treatment done by EHCPs for non-empanelled specialities

As per Guidelines on Processes for Hospital Transactions, PMJAY, Empanelled EHCPs are allowed to provide treatment to the beneficiaries only for those specialties for which they are empanelled.

Further, according to para 1.6 (g) of HEM Guidelines on procedure of empanelment of EHCPs for PMJAY, only that specialty which conforms to minimum requirements will be empanelled in a hospital even though the hospital may have applied for multiple specialties.

In **Assam**, 18 EHCPs provided treatments for non-empanelled specialities to 1,149 beneficiaries for which total claims amounting to ₹ 1.27 crore were paid to the hospitals.

[20] A small incision is made on the side of the cornea, the clear, dome-shaped surface that covers the front of the eye.

In **Chhattisgarh**, 65 EHCPs claimed packages amounting to ₹ 0.29 crore for which the hospital was not empanelled.

In **Gujarat,** out of 26 EHCPs, 20 EHCPs provided treatments for non-empanelled specialities for an amount of ₹ 38.38 crore.

In **Jharkhand,** 8 EHCPs[21] of six test checked Districts provided treatment to patients in a speciality for which the hospital was not empanelled, resulting in irregular payment of ₹ 0.46 crore in 358 cases.

In **Manipur,** 15 EHCPs treated patients under packages/specialties not empanelled in the respective EHCPs in 2,153 cases for an amount of ₹ 2.69 crore.

NHA stated (August 2022) that there may be some issues related to mapping of HEM portal and TMS portal but no supporting documents have been provided by the NHA.

4.7 Performance under PMJAY

Audit noted instances of either zero or low performance in the following States:

PHCs are generally empanelled for Gynaecology and CHCs are empanelled for the Gynaecology, Paediatrics and General medicine specialties by the SHA.

In **Andhra Pradesh**, out of 1,421 empanelled EHCPs, 524[22] EHCPs submitted zero claims while 81 EHCPs submitted one to five claims. This indicates that the EHCPs are not fully functional.

In **Jharkhand,** 59 empanelled EHCPs[23] were not treating patients since empanelment or from the year 2019-20 and 2020-21. SHA directed (January 2021) the Civil Surgeons (CS) of the concerned Districts to investigate the matter. However, the CSs did not submit any reply as of December 2021. Further, Mahatma Gandhi Memorial Medical College and Hospital, Jamshedpur did not provide treatment for 761 days during the three years period from 23 September 2018 to 22 September 2021 (1,096 days).

In **Punjab,** five selected EHCPs in five test-checked districts did not provide any treatment up to March 2021 despite being empanelled between October 2019 and July 2020.

In **Tamil Nadu**, none of the 19 Government of India EHCPs empanelled in September 2020 were entertaining patients under the scheme as of 31st March 2021. The SHA replied that the

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21 **Dhanbad**-Seven EHCPs-333 cases, ₹ 0.38 crore, **East Singhbhum**-One EHCP-25 cases, ₹ 0.08 crore.

22 Public EHCPs-461 and Private EHCPs-63.

23 Private EHCPs-51 and Public EHCPs-8.

EHCPs were empanelled based on the directions of NHA. However, they were not willing to participate in the State Insurance Scheme.

In **Uttar Pradesh**, out of 416 (160 public and 256 private) EHCPs in seven Districts, 27 public and 13 private EHCPs did not provide any treatment.

The zero/low performance of EHCPs may lead to denial/delay of intended benefit to the beneficiaries.

While accepting the observation, NHA stated (August 2022) that due to the pandemic, EHCPs were reluctant to provide the services to PMJAY beneficiaries.

4.8 Hospitals empanelled with delay and under process for empanelment

According to para 1.7 (i) of HEM guidelines, the final decision on request of a Hospital for empanelment under PMJAY, shall be completed within 30 days of receiving such an application.

i) In 14 States/UTs, **Andhra Pradesh, Assam, Bihar, Chandigarh, Chhattisgarh, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Manipur, Puducherry, Punjab, Rajasthan, Uttar Pradesh** and **Uttarakhand**, 2,733 Hospitals were empanelled with delays ranging from (beyond 30 days) 1 day to 44 months as detailed in **Table-4.1**.

Table-4.1: Number of Hospitals empanelled with delay

Sl. No.	State/UT	Number of hospitals empanelled with delay	Delay in number of days
1	Andhra Pradesh	247	32-1315
2	Assam	61	30-365
3	Bihar	269	1-898
4	Chandigarh	12	3-51
5	Chhattisgarh	7	30-180
6	Jammu and Kashmir	15	32-524
7	Jharkhand	169	2-379
8	Madhya Pradesh	378	1- 823
9	Manipur	18	1-180
10	Puducherry	20	1-365
11	Punjab	717	1-953
12	Rajasthan	214	1-156
13	Uttarakhand	60	1-365
14	Uttar Pradesh	546	30-365
Total		**2733**	

ii) In six States, **Bihar, Gujarat, Jharkhand, Punjab, Rajasthan** and **Uttar Pradesh**, empanelment of 418 Hospitals was under process with delays from two days to 873 days with

reasons like non-submission of replies of required documents, details of manpower, hospital infrastructure etc. from hospitals as required by DEC. Details are given in **Table-4.2**.

Table-4.2: Number of Hospitals under process for empanelment

Sl. No.	State	No. of hospitals	Delay in number of days
1.	Bihar	55	2- 873
2.	Gujarat	224	30-408
3.	Jharkhand	60	30-690
4.	Punjab	10	28-53
5.	Rajasthan	47	219-400
6.	Uttar Pradesh	22	5- 845
Total		**418**	

While accepting the observation, NHA replied (August 2022) that delay is mostly because of procedural issues like delay in uploading of documents, incomplete documentation and technical issues.

4.9 Money paid by beneficiaries for treatment under PMJAY

PMJAY intends to provide cashless access to health care services for the beneficiary at the point of service, that is, the hospital.

The agreement signed by the SHA and the empanelled private EHCPs states that 'the treatment/interventions to PMJAY beneficiaries should be provided in a completely cashless manner. After admission of a patient in hospital, expenditure for all diagnostic tests, medicines, implants, etc. is to be borne by the hospital since the costs for the same have been included in the cumulative package amount**.** However, audit noticed instances where patients had to pay as part of their treatment under the PMJAY.

In **Himachal Pradesh,** 50 beneficiaries of five EHCPs had to manage their diagnostic tests from other hospital/diagnostic centre and cost of tests was borne by the beneficiaries. The amount of expenses was not available with the SHA.

In **Jammu and Kashmir**, in 10 public EHCPs, 459 patients paid ₹ 43.27 lakh initially out of their own pocket for which reimbursement was made to the patients after verifying the bills. Reimbursement is yet to be made to 75 patients amounting to ₹ 6.70 lakh.

In **Jharkhand,** the Insurance Company observed that 36 patients of Life Care Hospital, Godda paid varying amounts for purchase of medicines, injections, blood, etc. The details of expenses were not available with the SHA. On the basis of the Insurance Company's observation, SHA asked (28 August 2020) the hospital to submit its explanation within five days to avoid a penalty, failing which the hospital would be suspended. However, the hospital neither submitted any explanation, nor did the SHA initiate any action against the hospital.

In **Meghalaya,** out of 19,459 beneficiaries who availed treatment in five private EHCPs from February 2019 to March 2021, 13,418 (69 *per cent*) had to pay an additional amount of ₹ 12.34 crore at the time of discharge.

NHA replied (August 2022) that the out-of-pocket expenditure may be due to non-availability of health facilities, upgradation to private ward.

Audit is of the opinion that the hospitals should collaborate with various interrelated service providers to provide free facilities to the beneficiaries.

4.10 De-Empanelment of EHCPs

De-empanelment process can be initiated by the Insurance Company/SHA after conducting proper disciplinary proceedings against empanelled hospitals on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries. During audit, following instances of de-empanelment were noticed:

In **Bihar**, empanelment of Ananya Memorial Hospital was suspended on 30 August 2019, as the treatment provided by the hospital was not as per the MoU and guidelines. After necessary field investigations, SEC de-empanelled (December 2020) the hospital. Though payment of 12 claims amounting to ₹ 67,900 had been settled during 2018-20 to the hospital, SHA did not conduct necessary investigation of the same.

In **Jharkhand,** five EHCPs of Palamu District which were de-empanelled in 2019 had treated 1,777 cases and got claim amount of ₹ 1.37 crore **(Annexure-4.7)**.

i) SHA de-empanelled a hospital in Palamu in December 2018, but the hospital changed its name to Aashirbad Hospital (HOSP20P92995), and again applied and was empanelled on 2 May 2019. However, due to lack of infrastructure, the hospital was again de-empanelled on 31 January 2020. Thus, a blacklisted hospital had been re-empanelled and treated 130 patients between June 2019 to September 2019 and got payment of ₹ 1.72 lakh in 25 cases.

ii) DEC, Ranchi recommended (June 2020) de-empanelment of Om Sai Chirayu Hospital, Shalini Hospital Narayan, Soso Suyog Hospital and Sri Sai Shirdi Hospital. However, except Sri Sai Shirdi Hospital, SHA de-empanelled three EHCPs only on 25 November 2020 *i.e.* after a delay of five months of recommendations of DEC as against the prescribed time limit of two months.

In 11 States, 241 hospitals were de-empanelled from PMJAY either voluntarily or due to low performance and mal-practices adopted by EHCPs. Details are given in **Annexure-4.8**.

This shows that the SHA had not initiated the process of de-empanelment of EHCPs in timely manner. It is also clear that SHA needs to have an appropriate mechanism to prevent the empanelment of a de-empanelled hospital once again.

NHA stated (August 2022) that in respect of Bihar, the recovery has been made. However, NHA did not furnish any documentary evidence in support of recovery made. As regards Jharkhand, NHA stated that the State Audit Office referred to the wrong letter while framing the audit observation. But NHA did not furnish any document in support of their claim. Further, NHA's reply was silent about other SHAs.

4.11 Allotment of more than one Unique ID

As per Para 1.7 (D) of empanelment guidelines, a hospital is intimated as soon as a decision is taken regarding its empanelment and the same is updated on the PMJAY web portal. The hospital is notified of the final decision through SMS/email. If the application is approved, the hospital is assigned a unique national hospital registration number under PMJAY.

- In **Jharkhand,** one EHCP in Dhanbad and seven EHCPs in Ranchi were empanelled twice by SHA with different identification, though locations of the EHCPs were same.
- In **Tamil Nādu**, data analysis of empanelled Government/private network EHCPs revealed that 57 EHCPs were allotted two or more unique ID.

Allotment of more than one ID by SHA may lead to delay in timely processing and admitting the claims.

While accepting the observation, NHA stated (August 2022) that in the EHCP every specialty is tagged against a unique ID in the same hospital once empanelled for PMJAY. NHA's reply is not acceptable as one EHCP should have only one unique id.

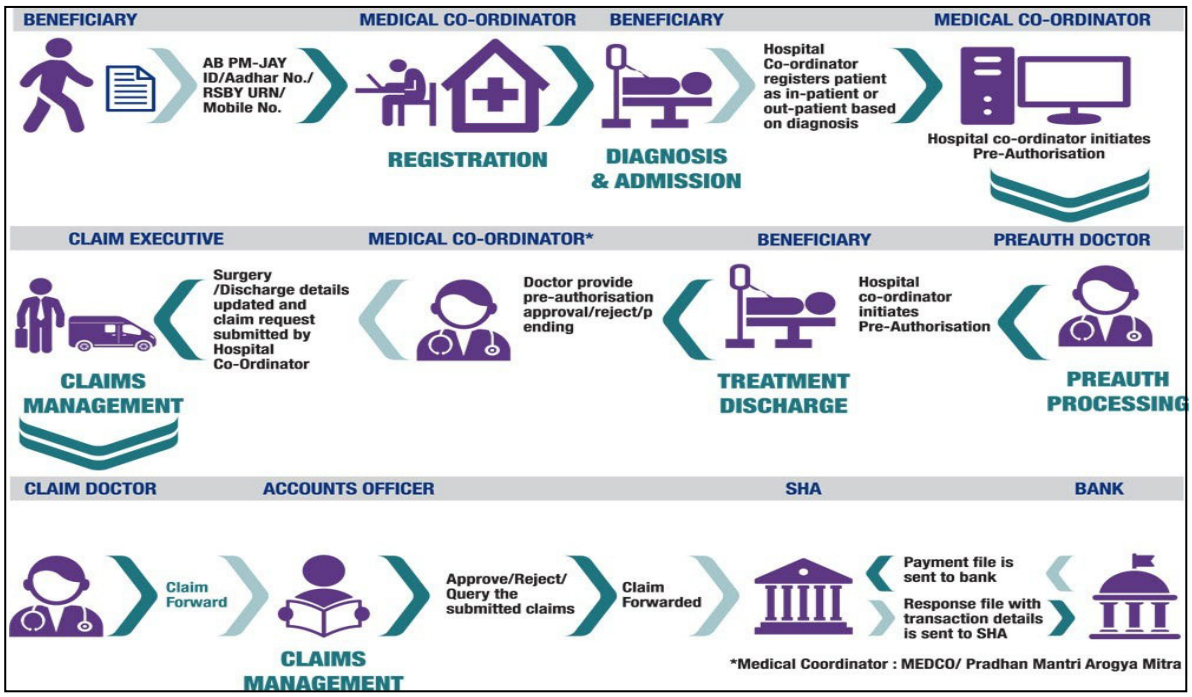
CHAPTER V

Claims Management

5.1 System of settlement of claims of Empanelled Health Care Providers (EHCPs)

PMJAY provides cashless and paperless services for beneficiaries at the point of service. These services include in-patient treatment, medical investigations, etc. After providing treatment/investigations, Empanelled Health Care Providers (EHCPs) upload all the claim related documents in the Transaction Management System (TMS) and submit the claims to State Health Authority/Agency (SHA)/Insurance Company. Thereafter, the SHA/Insurance Company scrutinizes the claims and makes payments to EHCPs. The process of approval of claims is described in **Chart-5.1**.

Chart-5.1: Process flow for Transaction Management System



An efficient and timely system of settlement of claims is the backbone of the Scheme as this is a time bound medical service. A timely and efficient system would ensure the smooth functioning of the scheme.

5.1.1 Claims settled

Transaction Management System (TMS) is an IT application which enables the empanelled hospitals to carry out paperless and cashless transactions by providing services to the beneficiaries of PMJAY starting from registration of beneficiary till payment to the hospital.

Apart from TMS, six States referred as Brownfield States *viz*. **Andhra Pradesh, Arunachal Pradesh, Rajasthan, Karnataka, Maharashtra** and **Tamil Nadu,** which were implementing

their own schemes, use their own IT Platform to process the claims. The data of claims settlement in respect of these States is subsequently fed into TMS through an Application Programming Interface (API).

As per the information given by NHA, 3.57 crore claims amounting to ₹ 42,433.57 crore were settled as of November 2022. Details of claims settled is given in **Annexure-5.1**. Out of these, claims amounting to ₹ 22,619.88 crore (53.30 *per cent*) pertained to the Brownfield States which are sharing the data through API, where the transaction did not capture PMJAY Id of beneficiaries (as detailed in Para 5.8.1). With no segregation of PMJAY beneficiaries in such cases, there is a possibility of overlap of PMJAY with state specific schemes.

5.1.2 Claims under process

As per the Claims-Adjudication-Manual of PMJAY, action has to be taken within 15 days of claim submission for claims within the State and 30 days for claims from outside the State (Portability cases).

As per the information given by NHA, 40.23 lakh claims of EHCPs amounting to ₹ 6,052.47 crore were under process for final decision (approval or rejection) as of November 2022. Details of claims under process for settlement is given in **Annexure-5.1**.

NHA, while accepting the audit observation, stated (August 2022) that the reasons for such delay were lack of human resources, non-performance of ISA/TPA, migration to other mode of implementation (Insurance to trust) etc. NHA further stated that concerted efforts are being made to achieve full bank integration for all the States for timely settlement of claims.

5.1.3 Delay in pre-authorization

In TMS, approvals are required mainly at three stages (i) Pre-authorization, (ii) claim verification, and (iii) claim payment. Claim Adjudication and Payment Manual for the scheme stipulates a Turn-around Time (TAT) of six hours for a pre-authorization approval. However, in cases where a query is raised with the Hospital, another six hours is allotted for the hospital's response.

Data analysis revealed that 39.57 lakh claims (in both API and TMS tables) took more than the specified 12 hours for approval of pre-authorization. Details in **Annexure-5.2**.

NHA replied (August 2022) that a preauthorisation case which is pending with the hospital for query response cannot be processed further until the hospital responds to the query. Thus, six hours TAT is not applicable for the hospitals. The working hours are defined as 11:00 AM to 06:00 PM. The auto approval is triggered if six hours within the working hours are consumed. Therefore, pre-authorization approval time is within six hours as per the approved calculation of period.

Audit is of the opinion that delay in pre-authorisation may lead to denial of health care benefit to eligible beneficiaries in time.

5.2 Excess payment of ₹ 57.53 crore to EHCPs

Audit noted that in four States, **Andhra Pradesh, Madhya Pradesh, Punjab** and **Tamil Nadu** excess payment amounting to ₹ 57.53 crore were made to the EHCPs as discussed below:

In **Andhra Pradesh**, the SHA is providing free health care services through a network of Hospitals and the rates for each package was fixed. On scrutiny of the claims data, it was noticed that the SHA approved 20,354 claims with higher package rates and made excess payment of ₹ 19.12 crore to the Hospitals. Further, PMJAY guidelines do not allow booking of surgical and medical packages at the same time. It was seen that claims amounting to ₹ 4.63 crore were made for medical procedures in addition to surgical procedures and approved by SHA in full, resulting in excess payment of ₹ 4.63 crore.

NHA in its reply stated that many States have added new packages or have altered the cost of package as per the State specific needs.

The reply is to be viewed from the fact that the Claim Adjudication Manual of PMJAY does not allow booking of surgical and medical packages at the same time and SHA cannot pay higher package rate than that fixed by NHA.

In **Madhya Pradesh**, 25 hospitals submitted claims twice in respect of 81 patients (162 claims) for various surgical procedures during the same length of stay (LoS). SHA paid the full amount for both claims as against the prescribed rate of 50 *per cent* payment on second claim[24] which resulted in over-payment of ₹ 29.61 lakh to EHCPs. The SHA also made double payment of ₹ 3.27 lakh to 13 hospitals which submitted claims twice in respect of 35 patients for caesarean delivery during same length of stay.

NHA accepted (August 2022) the audit observation.

In **Punjab,** in 13 cases, an amount of ₹ 21.26 lakh was paid to the empanelled hospitals by SHA against admissible payment of ₹ 13.35 lakh resulting in excess payment of ₹ 7.91 lakh.

In **Tamil Nadu**, (i) Settlements of claims by SHA amounting to ₹ 18.53 crore were made for 5,990 URNs[25] (Unique IDs) which were not available in the beneficiary database, (ii) Hospital claims amounting to ₹ 14.84 crore were settled by the SHA for 3,310 State Government pensioners' families which were not eligible under the PMJAY. This resulted in excess payment of ₹ 14.84 crore to the Hospitals, and (iii) In 15 cases, claim settlement was

[24] In case of multiple surgical procedure in OT session, procedure with highest rate shall be reimbursed at 100 *per cent*, second at 50 *per cent* and subsequent procedures at 25 *per cent* of package rate.

[25] Health card's Unique Request Numbers

made twice for the same treatment by SHA which resulted in duplicate claims settlement amounting to ₹ 0.61 lakh.

NHA, in its reply (August 2022), assured that it would look into the matter and get the fact verified by the insurance coordinator in the empanelled hospitals. NHA further stated that the database had now been cleaned and the cases were from the earlier period.

Thus, lack of adequate internal controls and absence of checks in the application resulted in extra expenditure on the part of SHAs.

5.3 Utilization of claim amount by Public/Government Hospitals

All public hospitals empanelled under PMJAY to provide in-patient services to the eligible beneficiary families are reimbursed by the insurance companies/trusts for the services rendered by them as per package rates under PMJAY as claim amount.

Deemed empanelment under the PMJAY provides Government hospitals an opportunity to mobilise and independently manage revenues earned through claims (hereinafter referred to as "claim revenues") for treatment provided to PMJAY beneficiaries.

Claim revenues earned under PMJAY by Government hospitals are credited directly into the bank accounts of the hospital-level entities such as Rogi Kalyan Samiti (RKS) or Hospital Development Societies/Committees or other specific hospital-level entities tasked with this role.

The Government hospital may use the PMJAY claim revenues as per the indicative categories and allocation shares mentioned in **Table-5.1** below:

Table-5.1: Indicative categories and allocation shares for use of claim revenues

Indicative items where PMJAY claim revenues may be used (Expenditure categories)	Allocation shares in percentage
Staff incentives	15
Human Resources: Salaries for personnel recruited primarily for PM-JAY in the hospital	15
Medicines, consumables, and pathology/radiology tests	40
Hospital upgradation & Quality Improvement	20
Administrative expenses	10

SHAs have the flexibility to determine their expenditure categories and allocation shares as per their requirements. States may opt for anywhere from three to seven expenditure categories, with fewer categories implying greater flexibility but potentially less clarity for hospitals.

Discrepancies in various States relating to utilization of claim amount earned by the Public/Government Hospitals under the scheme are discussed in succeeding paragraphs.

Audit observed that despite earning a claim amount of ₹ 9.12 lakh for treatment of PMJAY patients up to March 2021, no expenditure had been incurred therefrom, till October 2021 in **Andaman & Nicobar Islands**. In case of **Andhra Pradesh**, in test checked hospitals, it was observed that the claim amount received was either used for inadmissible purposes or kept idle.

In **Assam**, it was observed that (i) one hospital (Dr. B. Borooah Cancer Institute, Guwahati) adjusted the entire amount received against the treatment provided to the PMJAY beneficiaries in the budget of the hospital. As such, incentive to the staff, contribution towards Infrastructure, Arogya Nidhi, and Hospital Management Society etc. has not been paid, (ii) six hospitals have not paid any incentive to their staff as of March 2021.

In **Bihar**, information in respect utilization of claim amount by Public Hospitals was provided by Bihar Swasthya Sewa Samiti (BSSS) only in respect of 2019-20. Audit observed that claims amounting to ₹ 63.85 crore were released to 530 public hospitals during the financial year 2019-20 by SHA out of which only 86 hospitals (16 *per cent*) submitted expenditure report for ₹ 3.50 crore to BSSS as of August 2021. Further, scrutiny of information provided in respect of utilization of claim by selected public hospitals under sampled districts for the year 2018-21 disclosed (i) less/more amounts of claim spent on development of infrastructure facilities, and (ii) No expenditure was incurred for incentive to medical and paramedical team.

Nearly no expenditure was incurred on Hospital up-gradation and Quality Improvement as well as no incentive was paid to medical staff in **Chandigarh**, **Jammu and Kashmir**, **Rajasthan**, **Uttar Pradesh** and **Uttarakhand**.

In **Uttarakhand**, NHA directed that claim amount received by Public Hospitals empanelled under AB-PMJAY shall be utilized as incentive to hospital-staff (25 *per cent*) and the remaining amount can be utilized for improving the over-all infrastructure.

Audit observed that till 31 March 2021, SHA retained ₹ 4.65 crore which was not utilised for the purpose specified in the guidelines.

In **Punjab** and **Rajasthan**, committee for utilization of claim on development of Infrastructure of public hospitals and for giving incentive to medical staffs was not formed and nodal officer was not aware of guidelines issued in this regard.

SHA **Gujarat** instructed (November 2018) that a committee may be formed in the public hospitals for deciding the distribution of incentives amongst the hospital staff involved in the procedures. Audit observed that in five[26] out of 10 district hospitals visited, no committee had been formed by the public hospitals for deciding the distribution of the incentives amongst the hospital staff involved in the procedures and, thus, no incentives had been distributed to the staff in these Districts. The percentage of distribution of incentives by the remaining five district hospitals ranged from 1.12 *per cent* (Devbhoomi Dwarka) to 14.60 *per cent* (Bharuch) against the stipulated 25 *per cent* of the claim amount. Audit observed that Government hospital, Bharuch distributed the incentive amount to PMJAY staff (Arogya Mitra/MEDICO and RMO of the hospital) and not to medical/para-medical/non-medical staff who are instrumental for the success of the scheme as they are involved in procedure/treatment of the patients.

In **Ladakh**, as per the guidelines for implementation of PMJAY in public hospitals of **Jammu** & **Kashmir** regarding utilization of claim revenue in the hospitals, the same is to be divided into three heads namely RKS share (75 *per cent*), Incentive share (20 *per cent*) and SHA share (5 *per cent*). The status of utilization of claim revenue (till March 2021), for the three selected hospitals for **Ladakh** is given in **Table-5.2**.

Table-5.2: Status of utilization of claim revenue

EHCP	Claim Settled (in ₹)	RKS Share (in ₹)	Incentive Share (in ₹)	SHA share (in ₹)
SNM Hospital	1331792	486861 (36.56%)	142317 (10.68%)	0
CHC Sankoo	14974	0	0	0
DH Kargil	822340	820817 (99.81%)	0	0

From the above, it is clear that the public hospitals have not been utilizing the claim revenue in line with the guidelines prescribed for the same. Further, Audit noted that no clear guidelines have been framed for utilization of RKS share by EHCPs for infrastructure development and for usage of SHA share by SHA.

In **Madhya Pradesh**, out of the selected 26 public hospitals, 19 hospitals either did not utilize or utilized only one to 25 *per cent* of amount so earned.

In **Maharashtra**, the Public Health Department, Government of Maharashtra issued (January 2019) instructions for utilisation of claim amount received by Government hospitals. As per the instruction, 25 *per cent* of the claim amount received was to be remitted to Government account, 20 *per cent* to be used as incentive to treating doctors and staff,

[26] Banaskantha, Botad, Morbi, Sabarkantha, Surat.

three *per cent* was required to be used for outsourcing the work of claim processing and 52 *per cent* for meeting any emergency expenditure.

Out of total ₹ 80.58 crore received as claim revenue, ₹ 20.14 crore (25 *per cent*) was not remitted to Government account, no incentive was granted to doctors and medical staffs. Further, 12 hospitals incurred an expenditure of ₹ 7.81 crore for meeting emergency expenditure without the approval of the committee.

In **Nagaland**, the hospital made an expenditure of ₹ 7.50 lakh against repayment of capital loan and also hospitals did not submit reports of utilization of funds to the SHA.

In **Manipur**, claim amount was utilized either on payment to pharmacies for supply of medicines or reimbursement to beneficiaries for purchase of medicines.

In **Meghalaya**, as per the guidelines issued by the NHA (May 2020) for 'Use of claim amount earned by public hospitals, 70 *per cent* of the claim amount should be used for infrastructure up-gradation while 30 *per cent* for incentive of staff'.

Out of the ₹ 52.56 crore available, an amount of ₹ 9.57 crore (18 *per cent*) was utilized towards reimbursement to beneficiaries and for payment of pharmacy bills for medicines & diagnostics, which was not to be provided by the public hospitals. ₹ 5.18 crore (10 *per cent*) was utilised towards incentive payment of staff against stipulated 30 *per cent*. An amount of ₹ 0.76 crore (Two *per cent*) was diverted to two hospital accounts. An amount of ₹ 18.02 crore (35 *per cent*) was utilized for medicines/equipment purchase, COVID expenses, repair & maintenance, etc. while, ₹ 19.03 crore (35 *per cent*) remained unutilized as on 31 March 2021.

In Mizoram, hospital share of the claims amount was deposited into the common bank account of Rogi Kalyan Samiti and the hospital did not maintain separate cash book, vouchers etc. for utilization of claims amount under PMJAY. Thus, audit could not verify the expenditure incurred specifically under the claims amount of PMJAY. No incentive was given to the medical staff by public hospitals from the claim amount.

In **Puducherry**, 11 Public/Government Hospitals had received ₹ 2.37 crore of claim revenue earned from the medical services rendered to PMJAY beneficiaries. Out of these, six hospitals did not utilize the claim revenue, while the remaining five hospitals utilized claim revenue ranging from 6 per cent to 52 *per cent* only.

In **Tripura,** during 2018-2021, hospitals received ₹ 778.56 lakh as claim amount from SHA and ₹ 12.48 lakh as interest from bank. An expenditure of ₹ 534.13 lakh was incurred by the selected hospitals during the period covered by audit.

Thus, the Public/Government Hospitals failed to adequately tap the feature of PMJAY that enables them to utilize the reimbursed claims for improving the overall infrastructure, functioning of the hospital, quality of services and delivery of services etc.

NHA, while accepting the audit observation, stated (August 2022) that from time-to-time NHA issues guidelines for effective utilization of such funds by Public Hospital. NHA has been encouraging SHAs to ensure that the funds released to the public hospitals are used for the purpose of improved infrastructure and better amenities for the beneficiaries.

5.4 Private Hospitals performing procedures reserved for Public Hospitals

PMJAY guidelines mandate reservation of a list of procedures to be performed only in Public Hospitals. In HBP 1.0 (Health Benefit Package), 124 packages were reserved for treatment in Government hospitals and in HBP 2.0, 180 packages have been reserved for treatment in Government hospitals. However, audit noticed instances of violation of this in some of the States as outlined in the succeeding paragraphs.

Andhra Pradesh reserved 133 packages (June 2018) exclusively for public hospitals. However, 123 of these 133 packages were allowed in Private Teaching Hospitals. Audit noted that private hospitals performed procedures in 458 cases involving packages reserved for public hospitals and claims amounting to ₹ 1.37 crore were approved and paid by the Trust.

Referral Guidelines issued by SHA, **Punjab** in August 2020 allowed 25 Government reserved packages for treatment in private empanelled hospitals. Analysis of TMS database with HBP 1.0 and HBP 2.0 relating to **Punjab** showed that in 1080 cases, packages reserved for Government empanelled hospitals were booked by the private empanelled hospitals against which payment of ₹ 3.61 crore was also made to private empanelled hospitals in contravention of the provisions.

NHA stated (August 2022) that during COVID period many public hospitals were designated as COVID Care facility hence many States had temporarily opened Public reserved packages for the Private Hospitals.

5.5 Delay in submission of claims

The Claim Adjudication Manual Guidelines (applicable from May 2020 to September 2020) prescribe that claim documents should be uploaded/submitted by private hospitals as soon as possible but not later than seven days post discharge of patient. If claim documents are uploaded after seven to 21 days of discharge, approval of Chief Executive Officer (CEO) of

SHA must be obtained before settlement of claims and, thereafter, claims of hospitals are not admissible.

With effect from October 2020, the guidelines relaxed the time limit and allowed private hospitals to get approval of CEO, SHA if claim documents were uploaded between 21 days to 45 days post discharge of patients and after 45 days, claims of hospitals were not to be admitted. In case of public hospitals, claim documents uploaded after 60 days of discharge of patients are not admissible. Delays in claim submission invites non-standard settlement of the claim with the reduction in claim payable amount by 0.1 *per cent* per day for each day of delay beyond seven days from the date of discharge. The cases of delay in submission of claims by hospitals are discussed in the succeeding paragraphs.

In **Jharkhand**, (i) EHCPs have uploaded the claims after the stipulated time but the Insurance Company paid ₹ 1.66 crore to the EHCPs without obtaining approval from the CEO, SHA, (ii) In 3,460 cases, public hospitals received payment of ₹ 1.45 crore without obtaining approval of SHA though they had submitted/uploaded the claim documents with delay ranging from one day to 108 days beyond the prescribed time limit of 60 days of discharge.

In **Ladakh**, claims in 160 cases were initiated by test checked hospitals 16 to 504 days after the turn-around time (TAT) of 15 days.

In **Rajasthan**, 3,796 claims were not submitted by 288 hospitals within the prescribed time; however, the entire claim amount of ₹ 1.26 crore was paid to them without imposing any penalty.

In **Tamil Nadu**, in 170 cases, the delay in submission of claim was more than 300 days.

In 51 cases in **Tripura**, claims amounting to ₹ 9.39 lakh were submitted by the private hospitals beyond 45 days of discharge and payment made to the hospitals. Further, in 1,628 cases, claims amounting to ₹ 1.12 crore were submitted beyond 60 days of discharge (ranging from 60 to 353 days) of the beneficiaries but, payment was made to the hospitals which was inadmissible.

In **Uttar Pradesh**, 726 claims amounting to ₹ 1.14 crore were rejected by the SHA on grounds of late submission (*range of delay was up to 685 days*) of claims. On the other hand, 2,04,654 claims amounting to ₹ 201.55 crore which were also submitted late (*range of delay was one day to 831 days*) were approved by the SHA which shows inconsistency in adherence to prescribed guidelines in approval of claims.

NHA, while accepting the audit observation, replied (August 2022) that shortage of required human resources to raise and submit the claims within prescribed timelines and deployment of resources in COVID management led to delay in submission of claims.

5.6 Processing of claims in death cases

As per the PMJAY Guidelines, every death occurring in EHCP should have a mortality report prepared by the hospital. Each EHCP should submit a mortality report to SHA at the time of claims submission within seven days. State Mortality and Morbidity Committee conducts desk/ field mortality audit of all mortality cases. If it is observed that the death occurred due to negligence or mortality audit has significant findings, suitable action is required to be taken against the hospitals and claim amount is to be withheld till satisfactory explanation received and reviewed by SHA.

In **Gujarat**, mortality reports of death cases (1,547) were not available on records in SHA and number of mortality audits (death review) done by State Mortality and Morbidity Committee was also not available with SHA. Further, Civil Hospital, Ahmedabad, has not submitted mortality reports for 128 death cases that had occurred in the hospital and thus, claim amount of ₹ 40.03 lakh was yet to be settled.

NHA stated (August 2022) that the State has confirmed that it has already paid the hospital; however. since uploading of UTR was pending, cases are shown as pending for settlement. The reply is not acceptable as NHA has not provided any document or evidence for it.

In **Uttarakhand,** payment of ₹ 15.35 lakh was made without receiving death summary from the hospitals in 120 cases. Death certificate and cause of death was also not mentioned.

NHA stated (August 2022) that all death cases are processed by CPD/ISA as per guidelines and if any case is found with deficiency in documents during post claim audit, then same is rejected by SHA. However, the reply has not addressed the audit observation.

5.7 Inadequate Validation checks

Data validation refers to the process of ensuring the accuracy and quality of data. It is implemented by building several checks into a system to ensure the logical consistency of input and stored data. The inadequate validation checks such as admission before pre-authorization, transaction before inception of the Scheme, surgery after discharge of patient, payment prior to submission of claims, non-availability/invalid dates and other entries etc. noted during the course of audit at SHAs are tabulated in **Table-5.3**.

Table-5.3: Inadequate Validation checks

Sl. No.	State	Error	Amount Involved	Comment
1.	Assam	Transaction before inception of Scheme	3.06 lakh	Date of payment was prior to the inception of Scheme in 59 cases.
		Payment prior to submission of claim.	4.70 lakh	Claim was paid prior to claim submission date in 70 cases.
		Date of approval of claim is nil.	2.68 crore	Date of approval of claim is nil in 1,908 cases.
		Surgery after discharge of patient	7.03 crore	Date of surgery was after the date of discharge in 6,663 cases.
		Claim paid amount less than claim approved amount	6.89 crore	-
		Claim paid prior to claim approval	0.07 crore	-
2.	Haryana	Non-availability of certain crucial dates	-	Non-availability of certain crucial dates was also noted in TMS platform *viz.* admission date, discharge date, pre-authorization date, claim submission date and claim approval date were marked as 'Null' in 56,702 cases in the State.
3.	Jammu & Kashmir	Incorrect household IDs	3.76 lakh	System is unable to detect incorrect household IDs while processing the claims.
		Treatment before disabling of card	3.89 crore	17,458 card holders availed treatment before disabling of cards and claim amount of ₹ 388.98 lakh was approved against 12,633 disabled cards mainly due to non-conducting of periodic review of verified cards in a time bound manner by SHA J&K.
		Treatment on disabled card	5.51 lakh	₹ 5.51 lakh was approved against 241 disabled cards indicates lack of auto rejection of claims in the system against disabled cards.
4.	Jharkhand	Invalid/null entries in patient age column	17 lakh	EHCPs have treated 150 cases in which the patients having invalid or null entries of age. EHCPs have not taken care during admission/registration of patients due to which claim amount of ₹ 17 lakh paid for the above-mentioned irregularities
5.	Ladakh	Non-availability of certain crucial dates	-	Date of discharge of patient from the hospital was not available in 15 cases.
6.	Madhya Pradesh	Non availability of certain crucial dates	-	1,32,836 claims had either date of pre-authorization or date of admission as `NULL` in TMS database. Also, 1,66,193 claims amounting to ₹ 0.11 lakh had either date of initiation of pre-authorization or date of approval

Sl. No.	State	Error	Amount Involved	Comment
				of pre-authorization as `NULL` in TMS database.
		Admission before pre-authorization initiation date	-	Beneficiaries were admitted before approval of pre-authorization in 16,643 claims after that it was rejected
7.	Maharashtra	Data of discharge earlier than date of admission/pre-authorization	-	3,231 records (233 EHCPs) were found where the date of discharge was before either the date of admission to the hospital or the date of surgery/therapy in the EHCP.
8.	Punjab	Follow-up of triggers raised by NHA on TMS	-	NHA raised 995 triggers on account of suspicious activities under TMS database. Final action against 775 triggers had been taken by the SHA, and action on 220 triggers is still under process.
		Patient unique id in TMS database not found in the BIS	6.32 lakh	In 29 cases the card number (PMRSSM_ID) in TMS database did not match with PMRSSM_ID of the beneficiaries in BIS database whereas the Household ID (HHID) of these beneficiaries matched in both the databases. The claim amounting ₹ 6.32 lakh was also paid to the hospitals in these cases.
9.	Rajasthan	System allowing date of payment earlier than date of claim submission and date of pre-authorization at a later date than the date of discharge	-	Results of data analysis (performed on 8 January 2022) revealed that the date of claim submission was later than the date of claim payment for 281 claims, amounting to ₹ 0.21 crore and that 942 claims were submitted before patients' discharge, of which 803 claims (₹ 0.47 crore) were paid. Further, data analysis (performed on 3rd January 2022) revealed that in 15,530 claims (0.85 *per cent*) out of 18,30,487, pre-authorization was done at a later date than the discharge date. Moreover, 12,826 claims (82.59 *per cent*) amounting to ₹ 12.48 crore out of these 15,530 claims were paid.
		Patients aged above 18 years were provided treatment under 'Paediatrics Speciality' packages	18.16 crore	-
		Transaction ID of patient in normal admissions	5.13 crore	Transaction ID of patient in normal admissions was not generated on the date of admission in 15,100 processed claims, out of which, 12,072 claims (79.95 *per cent*) were paid.

Sl. No.	State	Error	Amount Involved	Comment
		Transaction ID (TID) of patient in emergency admissions	₹ 0.09 crore	Transaction ID (TID) of patient in emergency admissions was not generated within 72 hours from the time of admission in 185 processed claims, Out of which, ₹ 0.09 crore for 158 claims (85.41 *per cent*) had been paid
		Cancellation of TID generated in the TMS.	-	11,96,869 TIDs were generated (Patients Enrolled) in normal admission, out of which, 1,05,240 (8.79 *per cent*) TIDs were cancelled due to non-selection of package in the TMS.
10.	Tamil Nadu	Data of discharge earlier than date of admission/pre-authorization	-	In 11,779 records out of 16,73,504 records, date of pre-authorization was after the date of discharge
		Reduction in package cost without valid reasons-loss of insurance claim amount	4.38 lakh	In Coimbatore Medical College, the claim amount settled by insurer was less than the approved package cost for three procedures. Reduction of claim amount for approved package resulted in loss to the Government hospital.
11.	Uttar Pradesh	Data of discharge earlier than date of admission/ pre-authorization	-	In 57,476 cases pre-authorization was done after the date of discharge. Out of which in 49,682 cases (86.44 *per cent*) payment amounting to ₹ 1,543.28 lakh was also made.

NHA accepted (August 2022) the audit observations.

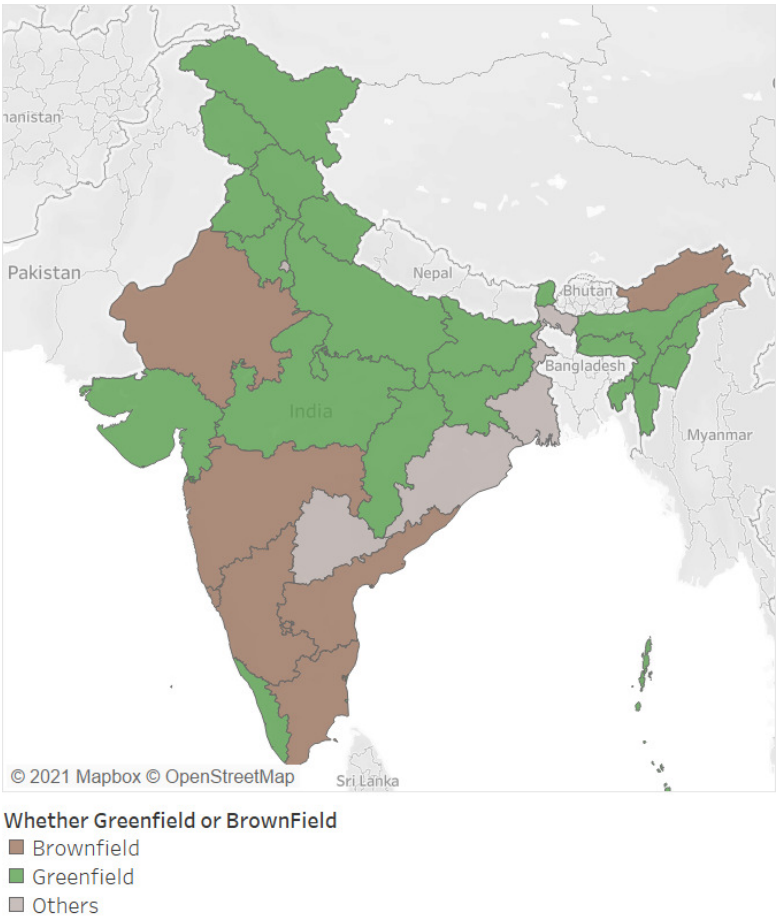
5.8 Deficiencies in claims processing and settlement system

With respect to claims processing and settlement system (TMS as well as API), following irregularities were noted as detailed in succeeding paragraphs. These observations are the result of data analysis done at NHA during the month of July 2022.

5.8.1 Non usage of common format for maintaining the data by State specific IT Platform

As stated, there are a few brownfield States, *i.e.* States where beneficiary data is not kept by NHA and these States share the data with NHA through external systems as shown in the following map.

As per data available with NHA, as of July 2021, six States were sharing data with NHA through external systems (APIs), as listed below:



1. Andhra Pradesh
2 Arunachal Pradesh
3 Rajasthan
4 Karnataka
5 Maharashtra
6 Tamil Nadu

In addition to the above States, **Assam** also used its own IT system till 31 March 2020 and therefore transactions for that period in respect of Assam were available in API table only. None of these transactions captured PMJAY id of beneficiaries claiming the benefit in these brownfield States and instead another system generated (or State specific patient ID) was available. Master data of any of these patient IDs was not being maintained and available in NHA. In the absence of this master data (in Beneficiary Identification System or otherwise), audit could not ascertain how the terms and conditions of the Scheme were being monitored in these States by NHA. It was also not clear as to how States segregated these claims into State-specific schemes and PMJAY for submission of Utilization Certificates. Further, audit could not ascertain how these brownfield States were allowing the benefit of the Scheme to patients belonging to other States (portability cases as admissible under PMJAY). In fact, data analysis revealed that value of portability-flag field was null (not available) in respect of all claims/transactions available in API table.

NHA accepted (August 2022) the audit observation and stated that API integration has been completed with most of the States. However, the issue of intermittent loss of data is being addressed for more reliable data transfer.

5.8.2 Inadequate pre-validation control on data captured through TMS/API (States specific IT Platform)

TMS/API capture records with respect to claims submitted by EHCP for online processing and settlement. The records consist of data such as patient number, case number, card number, patient age, patient gender, patient state-code, admission date, surgery date,

discharge date, claim submission amount, claim approved amount, claim paid amount, etc. along with attachment option for scanned copy of discharge bill/summary.

A robust system should not accept data in any particular field which is logically not possible or which is beyond PMJAY defined criteria. For example; date of surgery should be before date of discharge or date of discharge should be after date of admission, etc. Such invalid/illogical entries would reduce the reliability of data thus resulting in false disclosure of transitions.

However, during analysis of claim settlement data, various discrepancies were observed which are discussed in succeeding paragraphs:

5.8.2.1 Invalid dates of admission/pre-authorization/claim processing

Audit noted that several transactions were available in the API systems where date fields related to crucial information were invalid, *i.e.* either before scheme inception date or after current date. State-wise details are given in **Table-5.4**.

Table-5.4: Invalid dates captured through API

State	Number of invalid dates					
	Admi-ssion date	Discharge date	Pre-authorisation initiation date	Pre-authorisation approval	Claim submission	Claim approval
Arunachal Pradesh	4	4	2	2	-	-
Assam	15	7	-	-	-	-
Karnataka	77	14,888	4	6	4	
Maharashtra	-	6,140	-	-	-	-
Tamil Nadu	334	19,958	526	208	119	489
Total	**430**	**40,997**	**532**	**216**	**123**	**489**

NHA accepted the observation and stated (August 2022) that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.2 Non-availability of certain crucial dates

Similarly, several crucial dates were left blank/not available in the data shared with NHA. In all of these records, it was further ascertained that amount paid on these claims was not null. Details are given in **Table-5.5**.

Table-5.5: Non availability of certain crucial date

State	Dates not available (in number)			
	Pre-authorization initiation date	Pre-authorization approval	Claim submission	Claim approval
Andhra Pradesh	23,973	19,298	26,961	33,656
Assam	4	6	16	72
Karnataka	2,532	6,421	4,260	80,469
Maharashtra	7,951	8,030	7,103	7,525
Tamil Nadu	1,800	2,066	985	1,381
Total	**36,260**	**35,812**	**39,325**	**1,23,103**

In addition to above, NHA had provision of capturing 'date of death', in case where any patient dies during treatment. In such cases, date of discharge is not captured. In API table, date of death was left blank in all the cases, indicating that brownfield States are not capturing this crucial piece of information.

NHA accepted the observation and stated (August 2022) that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.3 Date of surgery after date of discharge of related patient

In 2,25,827 cases, even the simplest of validation rules were not built into the API system, which resulted in claims being paid in cases where date of surgery was later than discharge of that patient from the hospital. State-wise details are given in **Table-5.6**.

Table-5.6: Date of surgery after date of discharge

(Amount in ₹)

State	No. of Claims	Amount paid on these claims
Andhra Pradesh	2	28,602
Arunachal Pradesh	41	4,06,050
Assam	26,425	12,75,48,124
Karnataka	19,223	6,41,95,947
Maharashtra	1,79,584	3,73,08,27,276
Tamil Nadu	552	46,19,030
Total	**2,25,827**	**3,92,76,25,029**

NHA accepted the audit observation and stated (August 2022) that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.4 Invalid and null entries in patient age column

Patient age field in API table was not correctly mentioned in the database. State-wise details are given in **Table-5.7**.

Table-5.7: Invalid patient age

State	Patient Age (in years)			Total
	0 or Null	100 to 139	259	
Andhra Pradesh	37,602	7	0	37,609
Arunachal Pradesh	1	0	0	1
Assam	196	54	2	252
Maharashtra	46,688	6	0	46,694
Total	**84,487**	**67**	**2**	**84,556**

Similar error was also noted in TMS. It is evident from the above that both systems namely API and TMS lack proper validation controls to prevent suspicious entries in the age column in the system.

NHA accepted the observation (August 2022) and assured to incorporate the necessary validation in the system.

5.8.2.5 Admission before pre-authorization initiation date

Audit noted that in several claims date of admission was earlier than pre-authorization initiation date in TMS system. State-wise details are given in the **Table-5.8**.

Table-5.8: Admission before pre-authorization date

State/UT	Number of Claims where date of admission earlier than date of pre-authorization initiation	Number of Claims where date of pre-authorization approval earlier than date of pre-authorization initiation
Andaman & Nicobar Island	182	Not Available
Gujarat	34,409	3
Madhya Pradesh	305	55
Kerala	1959	Not Available

NHA stated (August 2022) that back-date of admission is allowed in system for various operational reasons. Currently pre-authorization can be raised within 3 days of actual date of admission in case of private hospital and in five days for public hospitals.

5.8.2.6 Date of discharge earlier than date of admission

Audit noted that in 45,846 claims in the API system, date of discharge was earlier than date of admission of these patients. State-wise details are given in the following **Table-5.9**.

Table-5.9: Date of discharge earlier than admission date

(Amount in ₹)

State	Count of Claims	Amount paid on these claims
Assam	21	2,74,842
Karnataka	19,223	6,41,95,947
Maharashtra	26,049	15,58,71,719
Tamil Nadu	552	46,19,030
Total	**45,845**	**22,49,61,538**

NHA accepted the audit observation and stated (August 2022) that the data validation in API has been relaxed in order to capture maximum data without rejecting them. It has also assured that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.7 Admission of same patient in multiple hospitals during same hospitalization period

Scheme provides a cover of ₹ five lakh per family per year for secondary and tertiary care hospitalization across public and private empanelled hospitals in India. Out-patient care/treatment is, however, not covered under PMJAY.

Data analysis during desk audit (July 2020) revealed that the IT system (TMS) did not prevent any patient from getting admission in multiple hospitals during the same period of hospitalizations. NHA, while acknowledging the lapse, stated (July 2020) that primarily these cases arise in scenarios where a baby is born in one hospital and shifted to neo-natal care in another hospital using PMJAY ID of mother.

However, illustrative[27] data analysis revealed that 78,396 claims of 48,387 patients were initiated in TMS where date of discharge of these patients for earlier treatment was later than admission date for another treatment of the same patient. Contrary to the claim of NHA, these patients included 23,670 male patients. These claims pertained to 2,231 distinct hospitals. State-wise details are given in **Annexure-5.3**.

Highest number of cases were noted in the States such as **Chhattisgarh, Gujarat, Kerala, Madhya Pradesh** and **Punjab** and lowest number of cases were noted in **Daman and Diu, Goa, Karnataka, Puducherry** and **Tamil Nadu**.

Successful payment of such claims further indicates lapses on part of SHAs in processing the claims without even verifying the requisite checks therein.

[27] For cases where admission date pertained to period between 1 January 2021 and 31 March 2021.

NHA stated (August 2022) that the observation is primarily due to non-synchronization of date and time of computer, cases of neo-natal babies, recording of pre-authorization after the date of admission.

Audit is of the opinion that the TMS should be able to synchronize the date and time first and only then accept any entry. Regarding the contention about neo-natal cases, it is reiterated that there are cases of male patients also.

5.8.2.8 Treatment of a beneficiary shown as 'died' during earlier claim/treatment

Guidelines[28] for payment of claims submitted by hospitals provide different payment structure for 'mortality' cases. These further stipulate that if death of the patient happens after admission in hospital and before discharge, payment to the hospital is done after audit of such cases. These three dates, as the case may be, are captured in TMS. During desk audit (July 2020) audit had earlier reported to NHA that the IT system (TMS) was allowing pre-authorization request of same patient who was earlier shown as 'died' during her/his earlier treatment availed under the scheme. NHA, while acknowledging the audit comment, stated in July 2020 that necessary check(s) have been put in place on 22 April 2020 to ensure that PMJAY ID of any patient who has been shown as died in TMS is disabled for availing further benefit under the scheme.

However, audit noted that patients earlier shown as 'died' in TMS continued to avail treatment under the Scheme. Data analysis of mortality cases in TMS revealed that 88,760 patients died during treatment specified under the Scheme. A total of 2,14,923 claims shown as paid[29] in the system, related to fresh treatment in respect of these patients.

Audit further noted that in 3,903 of above claims amounting to ₹ 6.97 crore pertaining to 3,446 patients were paid to hospitals. State-wise details are given in **Annexure-5.4**.

Maximum number of such cases were observed in **Chhattisgarh, Haryana, Jharkhand Kerala** and **Madhya Pradesh** and minimum number of cases were observed in **Andaman & Nicobar Islands, Assam, Chandigarh, Manipur** and **Sikkim**.

Similarly, as reported in the desk audit report, audit noted that the TMS was not only allowing initiation of pre-authorization request for beneficiaries already shown as dead in the system but was also allowing all other entries such as admission date, surgery date and discharge dates.

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[28] Claim Adjudication and Payment Manual

[29] Amount of Claim payment is greater than 0

NHA stated (August 2022) that back-date of admission is allowed in the system for various operational reasons. Currently, pre-authorization can be raised within three days of actual date of admission in case of private hospital and in five days for public hospitals.

The reply is not tenable, as pre-authorization initiation, claim submission and final claim approval by ISA[30]/SHA for beneficiaries already shown as died during treatment earlier, indicate flaws in application and make it susceptible to misuse at user levels. NHA as well as SHA should ensure a comprehensive investigation of all cases to obviate the risk of irregular payment and malfeasance.

5.8.2.9 Number of patients admitted to hospitals exceeded declared bed strength of that hospital

During desk audit we reported that the system (TMS) allowed both pre-authorization requests and admissions of patients simultaneously, at any given point of time by any hospital empanelled in the PMJAY system, counting more than its declared/updated bed strength. To illustrate, audit noted that there were 195 such hospitals (103 private and 92 public hospitals) which allowed beneficiaries more than their declared bed strength during the month of January 2020. NHA, in its reply dated July 2020 had stated that National Anti-Fraud Unit (NAFU) had a trigger which is raised when any hospital exceeds its bed strength. Reasons may include cases of day care procedures such as cataract, hemodialysis, chemotherapy, etc.

Data analysis of claims of patients admitted during January 2021 to March 2021 excluding day care cases[31] revealed multiple cases in 224 hospitals where declared bed strength exceeded on at least one day during the period (Jan-Mar 2021). State-wise list of such hospitals is given in **Annexure-5.5**.

NHA stated (August 2022) that in respect of Public hospitals, the updated data on bed strength was filled from the back-end which may not be correct. In case of private hospitals, the bed strength is filled at the time of empanelment and the same is not updated by the hospital on the HEM portal whenever they upgrade the facilities in their hospital. NHA further stated that the day care packages (dialysis, chemotherapy, radiotherapy) do not occupy the bed for the whole day and in some scenarios, the package is blocked for multiple sittings for administrative convenience.

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[30] Implementation Support Agency.

[31] Excluding cases where either of these conditions was matched (i) discharge date is missing, (ii) discharge date is equal to admission date; (iii) discharge is next day of admission date, and (iv) bed-strength of hospital is not available in the system.

NHA's reply is not convincing as during data analysis, day care cases had been excluded. Further, NHA admitted that bed strength data is not available on real time basis which implies that NHA does not review the bed strength of the hospitals periodically.

5.8.2.10 Payment of claims over and above the allowable limit of ₹ five lakh per household per year

PMJAY provides free hospitalization coverage of ₹ five lakh per entitled family (household) per year, through a network of public and private empanelled health care providers.

During desk-audit[32] (data analysis on table containing claims data in respect of Greenfield States only) in July 2020, audit noted that in two cases, the claims exceeding ₹ five lakh were paid in one policy year. NHA, while acknowledging the audit comment, in its reply (dated 27 July 2020) stated that the errors will be rectified after due diligence.

However, data analysis (September 2018 to March 2021) revealed that NHA has still not put in place the relevant validations in the TMS database, as we noted five cases (in TMS application only) where the amount released per household per policy year exceeded the threshold of ₹ five lakh, as shown in **Table-5.10**.

Table-5.10: Over and above allowable limit of ₹ five lakh

State	Patient family Id	Total claim amount	Last claim date	No of claims
Chhattisgarh	22CK223751218468	504000	18-03-2021	32
Chhattisgarh	22CK223870477539	500500	02-12-2020	1
Chhattisgarh	22R22240208516001921	500500	20-03-2020	2
Uttarakhand	5S0513002001100000002700003	552600	26-04-2021	10
Uttarakhand	5SGHSG3C01S95502	699410	22-03-2021	3

Besides this, following two fields which may flag any transaction as (i) PMJAY or non-PMJAY and (ii) Mention of policy year in API data (pushed by brownfield States) were also found missing. In the absence of these fields, it is not possible to ascertain to which scheme (*i.e.* PMJAY or State scheme) and to which Policy year any transaction or bunch of transactions for each family, relate. Further, in the absence of these fields, audit could not ascertain how NHA was monitoring validations of threshold limits to be placed in claims management as stipulated in scheme guidelines.

State-wise payment where the amount released per household per policy year exceeded the threshold of ₹ five lakh is shown in **Table-5.11**.

[32] Query on public.tms_t_patient table performed on 11 July 2020.

Table-5.11: Amount released in excess of ₹ five lakh per household per policy year

Sl. No.	State	Cases	Amount (in ₹)
1.	Manipur	3	76,775
2.	Rajasthan	17	13,61,187
3.	Nagaland	2	5,62,000
4.	Tamil Nadu	2	3,88,790

Payment of claim amount exceeding the permissible limit indicates lack of adequate validation controls in TMS system as well as State-specific system which needs to be reviewed/corrected in the system to prevent any further misuse.

The reasons for excess payment beyond the permissible limit were given by NHA (August 2022) as (i) Few States like Chhattisgarh provides a top-up beyond ₹ five lakh to their beneficiaries under the State-scheme, (ii) under insurance mode when the policy period is extended beyond 12 months then the wallet id is fully refreshed to ₹ five lakh, though the premium is paid on pro-rata bases for the incremental period. Such extension is given by insurance company when the tendering process is delayed. Any cover beyond ₹ five lakh is borne by the State Government.

The reply is not acceptable as in no case the wallet amount should exceed the permissible limit of ₹ five lakh.

5.8.2.11 Claims paid without Aadhaar authentication (for a second time)

Scheme guidelines stipulate that if the PMJAY family member does not have an Aadhaar card and the contact point is a location where no treatment is provided, the operator will inform the beneficiary that they are eligible and can get treatment only once without an Aadhaar or an Aadhaar enrolment slip. They may be requested to apply for an Aadhaar as quickly as possible. A signed declaration is taken from the Beneficiary that they do not possess an Aadhaar card and understand that they will need to produce an Aadhaar or an Aadhaar enrolment slip prior to the next treatment.

Data analysis further revealed that out of 118.47 lakh claims processed in TMS application, 47.46 lakh claims (40 *per cent*) pertained to patients who availed the benefit of scheme second time or onwards. Out of these claims, claims amounting to ₹ 39.51 lakh (83 *per cent),* however, were processed and paid in TMS without biometric authentication at the time of registration/admission. Further, 69 *per cent* of these claims pertained to those beneficiaries who were registered in BIS on the basis of Aadhaar authentication. Details of patients and amount paid in respect of these claims is given below in **Table-5.12**. State-wise details is given in **Annexure-5.6**.

Table-5.12: Claims paid without Aadhaar authentication (for a second time)

Total Claims in TMS	Claims Count Patient Count Amount Paid on these claims	1,18,47,059 56,56,498 ₹ 7,321.33 crore
Claims of Second time onwards	Claims Count Patient Count Amount Paid on these claims	47,45,950 10,07,766 ₹ 2,072.03 crore
Out of above, Claims where biometric authentication at the time of patient registration/admission was not done	Claims Count Patient Count Amount Paid on these claims	39,50,818 8,20,182 ₹ 1,678.68 crore
Out of above, Claims where patients were already registered in PMJAY with Aadhaar authentication	Claims Count Patient Count Amount Paid on these claims	27,40,245 5,45,979 ₹ 1,111.98 crore

Acceptance of second and onward pre-authorization request of any patient, in contravention to scheme guidelines indicates lack of effectiveness controls in the PMJAY IT system over such transactions.

Due to inadequate pre-validation checks and in the absence of mandatory filling of essential fields, audit could not derive assurance about accuracy, completeness, and reliability of data in the TMS/API.

NHA accepted the audit observation and stated (August 2022) that during the COVID period Aadhaar authentication via bio-authorization was disabled to avoid the spreading of infection. Now Aadhaar has been made mandatory for availing treatment under PMJAY.

Audit is of the view that SHAs may initiate re-verification of such claims to rule out any possibility of payment in respect of any unentitled beneficiary therein.

5.9 Internal control for fraud detection

5.9.1 Payment of claims on disabled and rejected cards

PMJAY cards, where malpractices or unintentional errors were noticed, were being disabled by NHA after conclusive investigation. As of July 2021, NHA had disabled 14.81 lakh PMJAY cards.

Audit noted that TMS could not restrict disabled cards for pre-authorization, as 1,081 claims were initiated after the cards were disabled in BIS database and payment of ₹ 71.47 lakh was made against these disabled cards. State-wise details are given in **Annexure-5.7**.

TMS system allowed initiation of 590 claims after their rejection date and an amount of ₹ 55.31 lakh was paid on 462 of these claims. State-wise details are given in **Annexure-5.7**.

NHA accepted the audit observation (August 2022).

5.9.2 Suspected card and beneficiary registration

NHA has generated several trigger alerts for identification of suspicious beneficiary registration. As of July 2021, 33.11 lakh trigger alerts were raised on 11.04 lakh beneficiaries. Details are shown in **Table-5.13**.

Table-5.13: Trigger Alerts

Sl. No.	Trigger Reason	Count of Triggers	Count of Distinct Beneficiaries involved
1.	Added Member	10,17,303	3,39,101
2.	Fuzzy Analysis	9,58,725	3,19,443
3.	Mobile number analysis	4,71,525	1,57,175
4.	Null HHID SECC	2,96,976	98,992
5.	BIS Image Analytics	2,12,700	70,900
6.	Ghost Beneficiaries with Multiple Cards	1,46,643	48,881
7.	Single set of document images used to create multiple PMJAY cards in same or multiple families	80,262	26,754
8.	Same document used to create multiple PMJAY cards in same or multiple families	71,517	23,839
9.	Invalid image in beneficiary image and set of documents	36,273	12,091
10.	Multiple cards of a single beneficiary in same family	17,664	5,888
11.	Beneficiary image not identifiable	1,446	482
12.	NULL SECC Name	207	69
	Total	**33,11,241**	**11,03,615**

These cases were forwarded to SHA's anti-fraud teams (SAFU) for further investigation. The State-wise responses captured by NHA are given in **Annexure-5.8**.

A summary of investigation carried out by states and their responses is summarised in **Table-5.14**.

Table-5.14: Summary of Investigation

Response	Cases	Percentage	Distinct Cards	Percentage
Fraud	13,51,299	40.81%	4,36,711	40.86%
Inconclusive	2,32,470	7.02%	77,490	7.25%
Not Fraud	5,81,274	17.56%	1,92,872	18.04%
Pending	10,59,039	31.98%	3,33,037	31.16%
Under Investigation	87,159	2.63%	28,806	2.69%
Grand Total	**33,11,241**	**100.00%**	**10,68,916**	**100.00%**

Out of 10.69 lakhs cards identified, only 7,07,073 cards constituting 66 *per cent* were investigated by SHAs. Investigation in respect of 77,490 cards (out of 7,07,073 cards) could not reach any conclusion. Remaining 3,61,843 cards (3,33,037+28,806) constituting 34 *per cent* of total suspected cards, were awaiting investigation.

Highest number of cases were noted in **Gujarat, Madhya Pradesh, Meghalaya** and **Uttar Pradesh**, while lowest number of cases were noted in **Andaman & Nicobar Islands, Karnataka, Lakshadweep** and **Tamil Nadu**.

Audit noted that any mechanism of submission of field investigation remarks/ report by States was also not made in the system of NHA which could have helped in ensuring that SHAs were following a uniform methodology while investigating such suspected cases.

NHA accepted the audit observation (August 2022).

CHAPTER VI

Financial Management

6.1 Introduction

As per the Cabinet note of December 2018 for implementation of PMJAY, the operational guidelines for managing PMJAY's administrative and financial policies/procedures related to hiring/retention/utilization/mobilisation of resources, budgetary support and release of funds including guidelines for escrow accounts for the management and administration of PMJAY is to be done as per the extant provisions of General Financial Rules, etc. Further, the Government money from the Consolidated Fund of India is not to be parked in Savings Bank accounts. NHA is to comply with the GFR provisions including accountability of all statutory authorities.

6.2 Financing of Scheme

PMJAY is completely funded by the Government and costs are shared between Central and State Governments. The ratio for all States, except North-Eastern States and the three Himalayan States and Union Territories with legislature, is 60:40, with the Centre's share being 60 *per cent* and the State's, 40 *per cent*. For North-Eastern States and the three Himalayan States/UT (*viz.* **Jammu & Kashmir, Himachal Pradesh** and **Uttarakhand**), the ratio is 90:10, with the Centre's share being 90 *per cent* and the State's, 10 *per cent.* For Union Territories without legislatures, the Central Government may provide up to 100 *per cent* on a case-to case basis.

The annual maximum budgetary ceiling under the scheme is ₹1,102 per family, which has two components of ₹ 1,052 towards Grants-in-Aid for implementation purpose and ₹ 50 towards Administrative Expenses. The process of release of Grant-in-Aid (Premium in case of Insurance Mode) is detailed in **Annexure-6.1**.

The Central Government share is released in three tranches of 45:45:10 in case of Insurance mode and 50:25:25 in case of Trust and Mixed modes.

6.2.1 Opening of Escrow Account

The Central and State Government/UT have to open a separate designated escrow account *viz.* for Premium and Administrative Expense, with any of the banks as permissible by Ministry of Finance, through which the payment of premium *i.e.* States/UTs and Central

Government's Share of Premium is released. PMJAY guidelines provide for opening of designated 'Escrow Account' by the SHA.

6.2.2 Grants-in-Aid

NHA receives Grant-in-Aid from Ministry of Health and Family Welfare (MoHFW) for implementation of PMJAY as follows:

Grant-in-Aid for Administration is the operating fund for general administration expenses of the SHA/State offices to run the scheme smoothly and effectively.

Under Grant-in-Aid for Implementation, NHA releases the proportionate share of premium depending upon the category of State/UT based on the number of eligible families to the respective SHA.

Grant-in-Aid for Headquarter Expenses is NHA's primary operating fund. It accounts for all financial resources of the general NHA Administration, expenses of the Head office to run the Scheme smoothly and effectively, except those required to be accounted for in another fund.

The estimation, allocation and utilization of Grant-in-Aid under PMJAY is given in **Table-6.1.**

Table 6.1- Estimation, allocation and utilization of Grants-in-Aid

(₹ in crore)

Purpose	2018-19				2019-20				2020-21			
	BE	RE	Grant received#	Grant released to SHAs	BE	RE	Grant received#	Grant released to SHAs	BE	RE	Grant received#	Grant released to SHAs
Administrative	2835	128.00	322.20	125.89	5795	150	150	101.83	5995	120	120	93.67
Implementation		1721.92	1530.95	1723.66		2729	2729	2891.12		2439.43	2439.43	2450.45
NHA (HQ)*	300	310.08	310.08	115.70	605	321	321	136.38	405	121.14	121.14	92.53
Total	**3135**	**2160**	**2163.23**	**1965.25**	**6400**	**3200**	**3200**	**3129.33**	**6400**	**2680.57**	**2680.57**	**2636.65**

*(# Grant received from Ministry of Health & Family Welfare, * Utilized by NHA)*

State-wise release of grant is given in **Annexure-6.2**.

On being enquired regarding the reduced allocation, the Ministry replied that this was due to relatively slower than estimated pace of expenditure, the structural reasons for which are as under:

i. Four States (**Delhi, Odisha, Telangana**[33] and **West Bengal**[34]), which account for 20 *per cent* of the eligible beneficiary population, are not implementing PMJAY.

ii. Three large States (**Bihar, Madhya Pradesh** and **Uttar Pradesh**), which account for 30 *per cent* of the beneficiary population, are implementing the Scheme for the first time and the demand for healthcare services under PMJAY is still picking up.

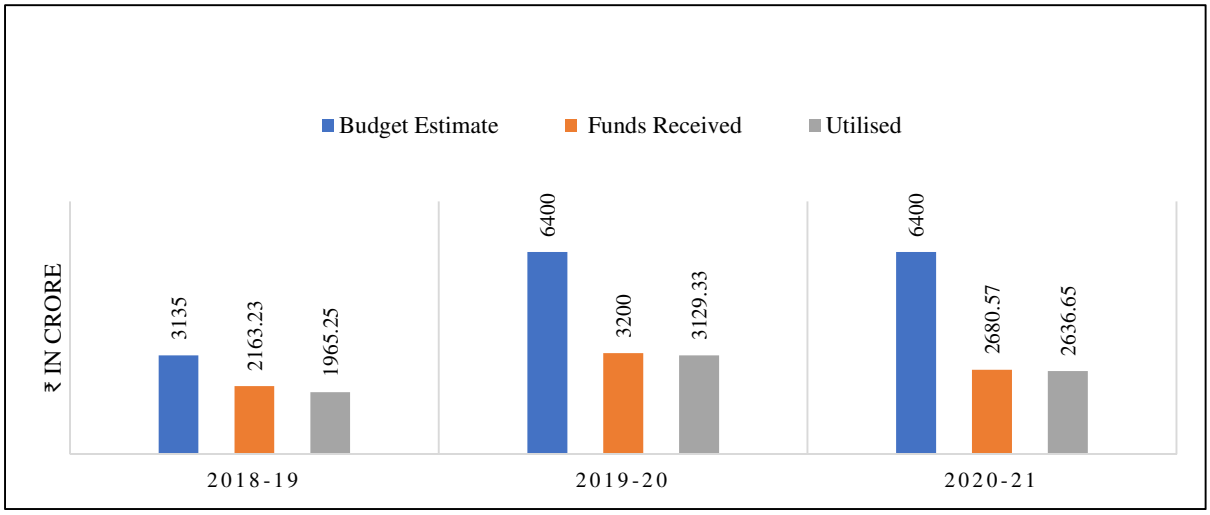
iii. Issues related to quality of decade old SECC data has posed serious challenges in beneficiary identification as some of the deprived poor families are not covered under the Scheme and approx. 30 *per cent* eligible beneficiary families are not traceable.

iv. The average premium is lesser than ₹ 1,052 per beneficiary family as was estimated at the time of inception of PMJAY.

The Ministry further submitted that utilization of PMJAY was adversely impacted by the onset of the COVID-19 pandemic. Demand for healthcare services experienced a sharp downward trend. The States/UTs utilized the funds under National Health Mission (NHM), National Disaster Response Fund (NDRF), State Disaster Response Fund (SDRF) and, wherever applicable, through District Mineral Foundation Funds for providing treatment related to COVID-19. This also contributed to limited utilization of funds through PMJAY.

Ministry also stated (March 2023) that in the current FY 2022-23, the budget allocation has not been reduced.

Chart 6.1: Estimation, Allocation and Utilization of Grants-in-aid



[33] Telangana adopted the Scheme in May 2021.

[34] West Bengal withdrew from the Scheme in January 2019

6.3 Release and Utilization of Grants

Irregularities/shortcomings noted in release and utilization of Grant are discussed in the succeeding paragraphs:

6.3.1 Grants released to Chhattisgarh in three different bank accounts

Audit noted that NHA released grants of ₹ 280.20 crore, ₹ 217.60 crore and ₹ 112.62 crore in three different bank accounts to **Chhattisgarh** during 2018-21, in contravention of the guidelines which stipulate opening of two separate designated 'Escrow Accounts' by the SHA, for receiving Scheme implementation grant and administrative grant. Details are given in **Table-6.2.**

Table 6.2: Grants released to Chhattisgarh in three different bank accounts

(₹ in crore)

Sl. No.	Year	Escrow a/c no.	Name of bank	Grants in aid released		Total
				Implemen-tation	Adminis-trative	
1.	2018-19	50200033142906	HDFC	211.84	5.59	280.20
2.	2019-20	50200033142906	HDFC	62.77	0	
3.	2019-20	919010033624877	Axis	212.01	5.59	217.60
4.	2020-21	920020073896851	Axis	112.62	0	112.62
Total				**599.24**	**11.18**	**610.42**

NHA accepted the facts and stated (August 2022) that the State of Chhattisgarh first implemented the Scheme in hybrid mode and subsequently, migrated to trust mode and converged with the State-scheme Dr Khubchand Bhaghel Scheme. Hence, it opened multiple accounts. NHA may ensure that the PMJAY guidelines are followed uniformly.

6.3.2 Non-maintenance of separate escrow account for PMJAY

PMJAY (opening of escrow account) guidelines provide for opening of two separate designated 'Escrow Accounts' by the SHA for receiving and incurring scheme implementation grant and administrative grant for effective implementation of the scheme.

Audit noted that three State SHAs, **Chhattisgarh, Punjab** and **Uttarakhand** had not maintained separate escrow account for PMJAY and State sponsored scheme. Both the schemes were operated through combined account. Details are given in **Table-6.3**.

Table-6.3: Non-maintenance of separate escrow account for PMJAY

Sl. No.	State/UT	Name of health scheme in State/UT
1.	Chhattisgarh	PMJAY and Dr. Khubchand Baghel Swasthya Bima Yojana
2.	Punjab	PMJAY and Sarbat Sehat Bima Yojana
3.	Uttarakhand	PMJAY and Atal Ayushman Uttarakhand Yojana

NHA admitted the facts and replied (August 2022) that many States implemented the Scheme in convergence of State scheme with a larger beneficiary base. States/UTs were expected to map the beneficiaries in expended database with eligible SECC families. However, this exercise could not be completed in absence of a common identifier between SECC database and non-SECC database used by the State. Hence, in the absence of separate list of SECC beneficiaries there were common bank accounts.

Escrow accounts are important for tracking and monitoring the flow and utilization of funds. The reply is not tenable as the PMJAY guidelines prescribe designated escrow account for operation of the scheme. NHA may ensure that specific accounts be maintained.

6.3.3 Release of grant without ensuring release of upfront share by SHAs

PMJAY guidelines provide that the State/UT shall release its share upfront, depending upon category of State/UT into the designated escrow account of SHA for implementation of the scheme. Thereafter, NHA shall release its share to SHA.

Audit noted that NHA released grant amounting to ₹ 185.60 crore to eight SHAs in **Assam** (₹ 6.08 crore-administrative), **Bihar** (₹ 16.34 crore-administrative), **Haryana** (₹ 24.49 crore-implementation), **Jharkhand** (₹ 4.21 crore-administrative), **Kerala** (₹ 25 crore-implementation), **Tamil Nadu** (₹ 11.66 crore-administrative), **Tripura** (₹ 12.81 crore[35]) and **Uttar Pradesh** (₹ 85.01 crore[36]) during 2018-19 without ensuring release of upfront shares by the respective States.

NHA, while admitting the facts, replied (August 2022) that in the initial year of the scheme, funds were released upfront to ensure early implementation of the scheme.

6.4 Excess release of grant by NHA

Audit noted that excess implementation and administrative grant was released by NHA to several States, as discussed in succeeding paragraphs:

6.4.1 Excess implementation grant of ₹ 10.86 crore to Mizoram

The State of **Mizoram** rolled out the Scheme in September 2018 in Insurance mode with a premium of ₹ 1,396 per beneficiary family. Under the PMJAY, Mizoram had 1,94,859 eligible beneficiary families as per SECC Data with sharing ratio of 90:10.

[35] ₹ 11.70 crore (GIA-Imp) + ₹ 1.11 crore (GIA-Admin) = ₹ 12.81 crore
[36] ₹ 67.30 crore (GIA-Imp) + ₹ 17.71 crore (GIA-Admin) = ₹ 85.01 crore

In 2018-19, total liability of NHA and State of **Mizoram** were ₹ 18.45 crore[37] and ₹ 8.75 crore[38] respectively. However, the State released its upfront share of only ₹ 2.72 crore and NHA, which should have released only ₹ 5.74 crore[39] on pro-rata basis, released implementation grant of ₹ 16.60 crore to SHA, resulting in excess release of grant of ₹ 10.86 crore.

NHA stated (August 2022) that till date SHA Mizoram had released ₹ 9.88 crore as its upfront share for GIA-Implementation and GIA-Admin. Corresponding share of NHA should have been ₹ 88.92 crore. However, only ₹ 63.40 crore had been released. Therefore, no excess funds have been released.

NHA's reply is silent on the audit observation which highlights excess release of grant of ₹ 10.86 crore to Mizoram during 2018-19.

6.4.2 Excess release of ₹ 8.37 crore to Andhra Pradesh

The Central Government share is released in three tranches of 45:45:10 in case of Insurance mode and 50:25:25 in case of Trust and Mixed modes.

Audit noted that NHA released excess implementation grant of ₹ 8.37 crore to SHA **Andhra Pradesh** for the period from 01.01.2020 to 31.12.2020 (2nd year) as per details given in **Table-6.4.**

Table-6.4: Excess release of ₹ 8.37 crore to Andhra Pradesh

(Amount in ₹)

State	Mode	Sharing ratio	Total no. of eligible beneficiary families	Annual ceiling of central share	Total Central share	Amount of 1st tranche to be released	Amount released by NHA	Excess amount released
1	**2**	**3**	**4**	**5**	**6 (4*5)**	**7 (50% of 6)**	**8 (52.40%)**	**9 (8-7)**
Andhra Pradesh	Trust	60:40	5530825	631.20	3491056740 (₹ 349.11 cr.)	1745528370 (₹ 174.55 cr.)	1829202013 (₹182.92 cr.)	83673643 (₹ 8.37 cr.)

NHA replied (August 2022) that 50 *per cent* release requirement is not very crucial and more than 50 *per cent* funds can be released to States depending on the need of States, if other conditions including upfront release of State share are met.

NHA's reply is not convincing as the release of excess grant to Andhra Pradesh was in contravention of the provisions of the guidelines.

[37] ₹ 1052*90%*194859 beneficiaries = ₹ 18.45 crore
[38] ₹ 1396 – ₹ 946.80 (90% of ₹ 1052) = ₹ 449.20*194859 = ₹ 8.75 crore
[39] ₹ 18.45 crore/₹ 8.75 crore*₹ 2.72 crore = ₹ 5.74 crore

6.4.3 Blockage of fund under RSBY - ₹ 96.63 crore

Rashtriya Swasthya Bima Yojana (RSBY) was a Centrally sponsored scheme implemented by Ministry of Labour and Employment in 2008. With the launch of PMJAY, the existing RSBY was subsumed in PMJAY. The scheme was transferred to Ministry of Health and Family Welfare on "as is where is" basis with effect from 01 April 2015.

Audit noted from records of RSBY in the State of **Jharkhand** that an amount of ₹ 121.63 crore was lying on the date of implementation (23 September 2018). Later on, ₹ 25 crore was transferred to the Insurance company in September 2018. The remaining amount of ₹ 96.63 crore is still (March 2021) lying in RSBY account.

NHA stated (August 2022) that it would inform MoHFW for necessary action including adjustment of funds as RSBY related affairs are being handled by a separate division in MoHFW.

6.4.4 Injudicious release of ₹ 3.76 crore to Puducherry and Punjab

PMJAY Guidelines provide that State/UT shall release its share upfront, depending upon category of State/UT along with its administrative expense share into the separate designated escrow account of SHA opened by the States/UTs for implementation of the Scheme. The Central Government shall then release its share of grant-in-aid into the designated Escrow Accounts of the SHA of respective State/UT.

Audit noted that:

i. NHA released grants amounting to ₹ 1.52 crore (₹ 0.31 crore in October 2018 and ₹ 1.21 crore in March 2019) to SHA Puducherry before the commencement of the Scheme in the UT of Puducherry *i.e.* July 2019.

ii. Similarly, NHA released ₹ 2.24 crore to SHA Punjab in March 2019 before the commencement of the Scheme in the State *i.e.* August 2019.

The above resulted in avoidable parking of grants in the two State/UT for a period ranging from five months to nine months.

NHA accepted the audit observation and stated (August 2022 and September 2022) that in the initial year, funds were released to States/UTs on urgent basis to kick start the Scheme implementation. However, in the subsequent years, funds have been released only after following the due process.

6.5 Diversion of grant by SHAs

PMJAY guidelines for release for administrative expenses stipulate that grant released for administrative expenses is to be utilized by SHA only for the specific purpose of incurring administrative expenses towards implementation of PMJAY.

Audit noted that seven SHAs, **Dadra Nagar Haveli and Daman Diu, Himachal Pradesh, Jharkhand, Nagaland, Rajasthan, Tamil Nadu** and **Uttarakhand** diverted the grant of ₹ 50.61 crore from one head to another head *i.e.* administrative grant to implementation and *vice-versa* and to State health scheme. Details are given in **Annexure-6.3.**

NHA, while admitting the facts, replied (August 2022) that due to insufficient amount of grant and delay in receipt of grants by SHAs the grants were diverted from one head to another.

6.6 Grants lying unspent with SHAs

PMJAY guidelines on utilization of Grant-in-Aid for administrative expenses provide that under no circumstances should the Grant-in-Aid be left unspent. Audit noted unspent balances amounting to ₹ 98.98 crore, ₹ 128.13 crore and ₹ 139.67 crore at the close of 2018-19, 2019-20 and 2020-21 respectively ranging from 16 to 100 *per cent* lying with 20 SHAs[40], thereby resulting in underutilization of administrative grants as detailed in **Annexure-6.4**.

NHA, while admitting the facts, replied (August 2022) that in the absence of any estimation and plan, release of grants at the fag end of the financial year and outbreak of COVID, the administrative grants could not be utilised.

In this context, audit is of the view that the scheme is in its fourth year of implementation. However, the administrative grants have persistently remained unspent since inception of the scheme. NHA is to ensure that administrative grants should not remain unspent.

6.7 Non- remittance of Interest

PMJAY guidelines stipulate that in case any interest is earned due to funds lying unspent in the account designated for receiving the Grant-In-Aid for administrative expenses, the Central Government shall have the first right of claim on such interest earned and the interest shall be transferred back to the NHA.

[40] Andaman and Nicobar Island, Assam, Bihar, Chandigarh, Dadra Nagar Haveli, Daman Diu, Himachal Pradesh, Jammu & Kashmir, Kerala, Ladakh, Madhya Pradesh, Manipur, Meghalaya, Puducherry, Punjab, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and Uttarakhand.

Ten SHAs in **Andaman and Nicobar Island, Bihar, Chandigarh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Puducherry, Rajasthan, Tamil Nadu** and **Uttarakhand** did not remit interest of ₹ 22.17 crore earned by them on unspent grants to NHA. Details are given in **Annexure-6.5**.

NHA, while accepting the facts, stated (August 2022) that it has issued instructions to all States to deposit the interest earned on central share provided. Those States who have not complied with, will be asked to strictly comply this within the given time period. Those States/UTs who have spent the interest earned will be asked to return the amount.

6.8 Non-refund of premium by Insurance Companies

PMJAY Guidelines provide that the Insurer will be required to refund premium if they fail to reach the claim ratio specified in comparison with the premium paid (excluding GST & Other taxes/Duties) in the full period of the insurance policy. The premium refund shall be computed as per the formula elaborated in **Annexure**.**6.6**.

Audit noted that refund of premium of ₹ 700.10 crore was recoverable from the insurance companies in six States/UTs *viz.* **Gujarat, Jammu and Kashmir, Ladakh, Maharashtra, Meghalaya** and **Tamil Nadu.** Out of this, partial recovery of only ₹ 241.91 crore in three States/UTs, **Jammu and Kashmir** (₹ 16.85 crore), **Maharashtra** (₹ 193.55 crore) and **Meghalaya** (₹ 31.51 crore) had been made and remaining amount of ₹ 458.19 crore for the period from 2018-19 till June 2022 was still recoverable from Insurance Companies (ICs) in all six States/UTs. Detail are given in **Annexure-6.7**.

NHA replied (August 2022) that it will seek final settlement statement from all States/UTs, implementing the Scheme in insurance/mixed mode.

6.9 Non-refund of ₹ 31.28 crore by West Bengal due to non-implementation of PMJAY

A Memorandum of Understanding (MoU) was signed (July 2018) between NHA and Government of **West Bengal** for the implementation of the PMJAY. NHA released (17 September 2018) central share of ₹ 193.34 crore (₹ 176.56 crore and ₹ 16.78 crore on account of grant-in-aid and administrative expenses respectively).

Government of **West Bengal** communicated (January 2019) to the NHA its decision to withdraw from the Scheme.

NHA asked (February 2019) the State Government to refund the grant-in-aid amount along with any interest amount earned by them. The State Government (March 2019) refunded ₹ 162.06 crore as detailed in **Table-6.5**.

Table-6.5: Non-refund of ₹ 31.28 crore by West Bengal

(₹ in crore)

Sl. No.	Particulars	Grants released by NHA	Grants utilized by State Government	Grant refunded
1	Grants-in-aid (Implementation)	176.56	30.45	146.11
2	Grants-in-aid (Administrative)	16.78	0.83	15.95
Total		**193.34**	**31.28**	**162.06**

NHA replied (August 2022) that money was spent on treatment along with GIA-Admin (used for setting up SHA etc.) and was hence not returned by the State. Therefore, there are no dues pending as on date.

However, in December 2019, NHA had stated that the matter would be referred to the State Government to refund the remaining amount of ₹ 31.28 crore along with interest earned on grant.

The two sets of replies from NHA are contradictory. Audit is of the view that NHA should issue specific instructions to address such cases.

6.10 Release of grants to SHAs without obtaining audited statements of accounts

As per sanction letter issued to SHAs while releasing the grants, SHAs are required to furnish to the NHA an annual Utilization Certificate along with audited Statement of Accounts in respect of Grants-in-aid received during various quarters in Form 12-C, as per GFR 2017 which shall furnish that the Grants-in-aid has been utilized for the purpose for which it was sanctioned to the SHA by NHA. The utilization certificate shall be signed by CEO, SHA along with Head of Accounts/Finance Department.

During the period 2018-21, audit noted that 18 SHAs furnished 212 UCs amounting to ₹ 4,115.35 crore without audited Statements of Accounts. Out of these 18 SHAs, seven SHAs furnished UCs without signature of the competent authority. State-wise detail is given in **Annexure-6.8**. Grants released by NHA to SHA without obtaining audited Statement of Accounts is detailed in **Table-6.6**.

Table-6.6: Release of grants to SHAs without obtaining audited Statements of Accounts

(₹ in crore)

Year	No. of States/UTs	Total
2018-19	16	1076.62
2019-20	16	1843.40
2020-21	17	1195.33
Total		**4115.35**

By accepting UCs without audited Statements of Accounts and UCs without signature of the competent authority, it wasn't clear as to how NHA ensured that grant was utilized for the purpose it was released.

NHA, while accepting the audit observation, stated (August 2022) that it has been constantly pursuing with the States/UTs to share the audited Financial Statement.

Audit also noted that six SHAs, **Himachal Pradesh, Jammu & Kashmir, Madhya Pradesh, Rajasthan, Tamil Nadu** and **Uttarakhand** furnished inflated UCs amounting to ₹ 38.24 crore to NHA as per details given in **Annexure-6.9**.

NHA replied that SHAs furnished UCs as per the actual expenses incurred during the year and not as per financial year.

NHA's reply is to be read with Rule 238 (2) of GFR which provides that subsequent grant shall be released only after Utilization Certificate in respect of grants of preceding financial year is submitted to the Ministry/Department concerned.

6.11 Non-implementation of PFMS

Expenditure reforms implemented by the Government include introduction of sunset clauses in all public expenditure programmes so that unproductive legacy expenditures can be brought to an end; introduction of Public Financial Management System (PFMS) for tracking expenditure flows to its objectives; reorganisation of development schemes leading to rationalisation, and merger and dropping of schemes so as to ensure efficient management of public expenditure.

In September 2017, Government of India also directed[41] that releases for Central Sector schemes for all level of implementing agencies are only to be made through PFMS and further releases shall only be made based on balances available in PFMS as per the EAT module for the respective agency in line with Rule 230 of GFR- 2017.

Both NHA and SHAs are registered on PFMS for receiving grants-in-aid from Ministry and NHA respectively, whereas hospitals (*sub level implementing agency*) were not registered on PFMS. In the absence of PFMS, NHA has been accepting manual UCs furnished by SHAs, which are based on amounts released by SHAs to hospitals and implementing agencies.

NHA replied (August 2022) that it releases Central share of funds using PFMS to the SHA's account. However, funds to the hospitals are released to hospital against the claims submitted by them through TMS which is integrated with the bank for smooth and paperless transfer of

[41] https://dbtbharat.gov.in/data/circulars/OM_MANDATORY_USE_OF_PFMS_IN_ALL_CENTRAL_SECTOR SCHEMES FROM 01.10.2017.pdf

funds. For every transaction, a unique UTR no. is generated which ensures money released to hospitals are duly accounted for. Every amount released to States using TMS can be duly tracked and monitored.

However, NHA's reply is silent about accepting manual UCs from SHAs despite the latter being registered on PFMS. NHA is to ensure receipt of UCs from SHAs through PFMS. Further, due to lack of clear mapping of PMJAY beneficiaries and beneficiaries of state specific schemes, there was no clarity on how states segregated these claims into state specific schemes and PMJAY for submission of UCs.

CHAPTER VII

Monitoring and Grievance Redressal

7.1 Introduction

Monitoring and evaluation help organizations to extract relevant information from past and ongoing activities that may be used as the basis for programmatic fine-tuning, reorientation and future planning. Without effective planning, monitoring and evaluation, it is impossible to examine, if a scheme is functioning in the right direction, whether progress and success may be claimed, and how future efforts might be improved. Good planning, combined with effective monitoring and evaluation, plays a major role in enhancing the effectiveness of schemes. At the Central level, National Health Authority (NHA) is the Nodal Agency set up for scheme implementation and oversight of PMJAY. It is responsible for monitoring through the following functional domains:

- Beneficiary Management System (BMS)
- Transaction Management System (TMS)
- Provider Management System (PMS)
- Support Function Management (comprising functions such as capacity building, grievance management, fraud and abuse control, call centre, etc.)

In order to facilitate the effective implementation of the Scheme, the State Governments have set up State Health Agency (SHA) or entrusted this function to any existing agency/trust/ society designated for this purpose. All key functions relating to delivery of services under PMJAY shall be performed by the SHA including monitoring of the Scheme at State level.

Issues related to the support function management such as capacity building, grievance management and fraud and abuse control are discussed in succeeding paragraphs.

7.2 Non-Formation of District Implementing Units (DIUs)

PMJAY Capacity Building Guidelines stipulate constitution of District Implementation Units (DIUs) in each District for functional coordination of Scheme activities at the District level.

Audit noted that in five States/UTs namely **Andaman & Nicobar Islands, Dadra Nagar Haveli** and **Daman & Diu, Himachal Pradesh, Puducherry** and **Uttarakhand,** DIUs had not been formed by SHA. In **Tripura**, DIUs have only been constituted in five out of eight Districts.

District Implementing Unit is the lowest level for implementation of the Scheme. Non-formation of the DIUs poses constraints in the proper implementation of PMJAY.

NHA, while accepting the audit observation, replied (August 2022) that DIUs are expected to work under the leadership of CMO or District Collector and wherever DIUs have not been formally constituted the Scheme implementation has been taken care by the office of CMO.

7.3. Adequacy of staff and infrastructure in SHA and DIUs

7.3.1 Shortfall of human resources in SHAs and DIUs

Audit noted that in nine States *viz*. **Andhra Pradesh, Chhattisgarh, Gujarat, Haryana, Karnataka, Rajasthan, Tripura, Uttarakhand** and **Uttar Pradesh,** there was shortfall of human resources deployed in SHA ranging between 15 *per cent* and 50 *per cent*, against actual sanctioned strength, while in eight States/UTs of **Andaman & Nicobar Islands, Assam, Bihar, Dadra Nagar Haveli-Daman & Diu, Jammu & Kashmir, Madhya Pradesh, Manipur** and **Punjab,** the shortfall was between 51 to 75 *per cent*. Details are provided in **Annexure-7.1.**

In **Ladakh,** while at the SHA level**,** State Programme Officer, State Programme Manager and State Accountant were working at district level Program Coordinators, Information Systems Manager and District Grievance Manager were still not appointed.

In **Puducherry**, out of 18 posts across various categories in the SHA, only two posts of Medical Officer and Finance Manager had been filled while the remaining 16 posts were vacant.

In **Nagaland**, eight posts of various managers have not been filled in SHA while only one officer was designated as District Nodal Officer against five officers/staffs at District level.

In **Jammu and Kashmir** and **Maharashtra,** no District Program Coordinator, District Medical Officer, District Information Systems Manager and District Grievance Manager was appointed in any of DIUs while **Kerala** has appointed only District Project coordinator in all 14 Districts entrusted with the duties of the DIUs.

NHA, while accepting the audit observation, replied (August 2022) that States were constantly urged to strengthen their human and technical resources. In addition to this, NHA has empanelled four agencies which can be used by the States for hiring of Human Resources.

7.4 Grievances Redressal

To ensure that disputes and grievances of beneficiaries, healthcare providers and other stakeholders are resolved in an efficient, transparent and time bound manner, NHA has

developed Grievance Redressal Guidelines and has established a Central Grievance Redressal Management System (CGRMS). CGRMS is a system for registering, processing, managing and monitoring the redressal all grievances under PMJAY.

Grievance Redressal Guidelines stipulate a three-tier institutional structure to ensure timely redressal of grievances *i.e*. National Grievance Redressal Committee (NDRC) at the National level, State Grievance Redressal Committee (SGRC) at State level and District Grievance Redressal Committee (DGRC) in each District.

7.4.1 Formation of State Grievance Redressal Committee (SGRC) and District Grievance Redressal Committee (DGRC)

PMJAY Grievance Redressal Guidelines stipulate that SGRC is to be constituted by SHA within 15 days of signing of MoU with the NHA. The District Grievance Redressal Committee (DGRC) is to be constituted by the SHA in each district as per the following schedule:

- For insurance mode: Within 15 days of the SHA signing of MoU with the Insurance Company.
- For assurance mode: Within 15 days of the SHA signing of MoU with the NHA.

(a) Constitution and functioning of SGRC

SGRC performs all functions related to handling and resolution of all grievances received either directly or escalated through the DGRC.

Audit noted that:

In three States/UTs; **Karnataka, Chandigarh** and **Jharkhand,** SGRCs were constituted with a delay of one year, seven months and 67 days respectively.

In **Punjab,** representation of members from the Departments of Rural Development, Women and Child Development, Labour and Tribal Welfare as required under grievance redressal guidelines had not been made.

In **Rajasthan**, records related to the formation and functioning of the SGRC were not produced to Audit.

In **Puducherry**, SGRC has not been formed with requisite manpower for analyzing the grievances of stakeholders under the scheme.

(b) Constitution and functioning of DGRC

DGRC performs all functions related to handling and resolution of grievances within their respective districts. Audit noted that:

In **Chhattisgarh**, DGRCs had not been constituted in six out of 27 Districts.

In **Jharkhand,** DGRCs had been constituted with delay of 67 days.

In **Ladakh,** DGRCs were not constituted.

In **Madhya Pradesh**, DGRCs were not constituted in any of the Districts and all complaints regarding grievances of beneficiaries were scrutinized and finalised by SGRC itself.

In **Manipur**, DGRCs had not been constituted in 11 out of 16 Districts.

In **Punjab**, though DGRCs had been constituted, however, Chief Executive Officer or District Development Officer or Additional Deputy Commissioner/Additional District Magistrate (Development) in charge of *Zilla Panchayat* was not nominated in the DGRC as required under Grievance Redressal guidelines.

In **Rajasthan**, records regarding constitution of DGRC was not produced to Audit.

Audit notes that the non-formation of SGRC and DGRC, at SHA and DIU level as highlighted above may result in ineffective grievance redressal.

NHA, while accepting the audit observation, replied (August 2022) that with the advancement in the implementation of Scheme, the States/UTs had started the process of constitution of District Grievance Redressal Committee (DGRC) and State Grievance Redressal Committee (SGRC).

7.4.2 Shortfall in conducting meetings by DGRC and SGRC

As per para 6 of the Grievance Redressal guidelines, the DGRC and SGRC meeting should be conducted every month on a specific day. States may decide a particular date, depending on the convenience and availability of the members of the committee.

(a) Meetings of SGRC

In five States/UTs of **Andaman and Nicobar Islands, Bihar, Chhattisgarh, Gujarat, Jammu & Kashmir,** no meeting of SGRC was held. In **Punjab,** only three meetings of SGRC were held against the required 19 meetings. In **Jharkhand**, only three meetings of SGRC were held against 27 meetings due during the period covered under audit. Failure to hold meetings and less than the prescribed number of meetings of SGRC can adversely affect monitoring of the redressal.

(b) Meetings of DGRC

Audit noted that in six States/UTs of **Andaman and Nicobar Islands, Chhattisgarh, Jammu and Kashmir, Jharkhand, Rajasthan** and **Tamil Nadu,** no meeting of DGRC was

held. In **Gujarat, Punjab** and **Uttar Pradesh**, shortfalls in meetings of DGRC were 53 to 100 *per cent*.

NHA, while accepting the audit observation, replied (August 2022) that SGRC & DGRC meetings could not be held during 2020 and 2021 due to COVID pandemic. Also, during the pandemic the members of DGRC and SGRC diverted for containing, controlling and treating COVID.

SHAs should ensure the regular meetings of DGRCs be held so that the scheme can be properly monitored and shortcomings, if any, may be rectified timely.

7.5 Grievance redressal management-fraud prevention/detection control

DGRC monitors the grievance database to ensure that all grievances are resolved within 30 days or earlier. Further, there would be State Grievance Nodal Officer (SGNO) nominated by SHA to address the grievances at State level and District Grievance Nodal Officer (DGNO) nominated by SGRC to resolve the grievances at district level under PMJAY.

7.5.1 Redressal of grievances/appeals at NHA level

i. Delayed disposal of grievances

As per para 12.3 of the Grievances Redressal guidelines "NHA shall provide overall supervision and monitoring of the implementation of the CGRMS across all States. This may include site visits, and internal and third-party process audits". Further, at least 98 *per cent* grievances are to be redressed.

Audit noted that out of 37,903 grievances, only 3,718 complaints (9.80 *per cent*) were redressed within turn-around-time (TAT) of 15 days. While, 33,100 complaints (87.33 *per cent*) were redressed beyond the TAT, 1,085 complaints were yet to be redressed. Outcome of four complaints escalated to NGRC for redressal was not made available to audit.

ii. Delayed disposal of appeals

Para 7.2.5 of Grievance Redressal Guidelines stipulate that if any party to a grievance is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the higher Grievance Redressal committee or other authority having powers of appeal as set forth in the guideline.

Audit noted that out of 1111 appeals received from 24 States, 518 appeals (46.62 *per cent)* were resolved within the turn-around-time (TAT) of 30 days and 593 appeals (53.38 *per cent)*

were resolved beyond TAT (234 appeals resolved between 31 to 60 days, 97 appeals resolved between 61 to 90 days and 262 appeals resolved in more than 90 days).

NHA, while accepting the audit observation, replied (August 2022) that in the initial days of Scheme implementation, States were primarily focused on service delivery and with the passing time, grievance redressal is being assigned its due priority. More effective monitoring mechanism would be put in place to ensure that grievances are redressed in defined TAT.

7.5.2 Grievances redressal at States/UTs

Audit noted that SHA **Chhattisgarh** had not redressed any of the 40 grievances received. In six other States/UTs of **Andhra Pradesh, Assam, Chandigarh, Nagaland, Punjab** and **Uttarakhand,** status of grievances redressed is mentioned in **Table-7.1.**

Table-7.1: Status of Grievances redressal at States/UTs

Sl. No.	Name of State/UT	No. of Grievances to be redressed	No. of Grievances redressed	No. of Grievances redressed within TAT	No. of Grievances redressed beyond TAT	No. of Grievances yet to be redressed	% of grievances redressed within the TAT
1.	Andhra Pradesh	782	431	334	97	351	42.71
2.	Assam	364#	177	140	37	187	38.46
3.	Chandigarh	106	100	20	80	6	18.87
4.	Nagaland	53	52	48	4	1	90.57
5.	Punjab	917	893	234	659	24	25.52
6.	Uttarakhand	1045	1032	482	550	13	46.12
Total		**3267**	**2685**	**1258**	**1427**	**582**	

(# 371 grievances registered - 7 withdrawn from the portal = 364 grievances)

Data related to the redressal of the grievances within the TAT and beyond TAT was not provided by nine States/UTs of **Dadra Nagar Haveli, Gujarat, Himachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Meghalaya, Tamil Nadu** and **Tripura**.

NHA, while accepting the audit observation, replied (August 2022) that the grievance redressal has been streamlined and State-specific guidelines has been issued to avoid the same.

7.6 Nodal Officer for resolving of grievances at district level not appointed

Para 5.4 of Grievances Redressal Guideline provide that District Grievance Nodal Officer (DGNO) is a person who is nominated by SGRC to resolve the grievances at District level. While, the State Grievance Nodal Officer (SGNO) is nominated by SHA, to address the grievances at the State level under PMJAY.

Audit noted that in **Andaman and Nicobar Islands,** Nodal Officer has not been nominated.

NHA, while accepting the audit observation, replied (August 2022) that with the advancement in the implementation of scheme the States/UTs started the process of establishing the institutional framework for grievance redressal in the form of appointing DGNOs and SGNOs.

7.7 Formation of Anti–Fraud Cells and Other Committees at the State level

PMJAY is governed by a zero-tolerance approach to any kind of fraud under the watchful supervision of NHA**.** PMJAY is aimed at assisting State Governments in designing and managing a robust anti-fraud system in PMJAY. The scope of anti-fraud guidelines covers prevention, detection, and deterrence of different kinds of fraud that could occur in PMJAY at different stages of its implementation:

Fraud management approaches	Stages of implementation
Prevention	Beneficiary identification and verification Provider empanelment Pre-authorization
Detection	Claims management Monitoring Audits
Deterrence	Contract management Enforcement of contractual provisions

The National Anti-Fraud Unit (NAFU) has been set up for implementing the anti-fraud and abuse control framework and monitoring performance with the support of State Anti-Fraud Units (SAFU) created at the State level.

Anti-Fraud Guidelines set out the mechanisms for fraud management and lay down the legal framework, institutional arrangements, and capacity that will be necessary for implementing effective anti-fraud efforts.

As per the Anti-Fraud Guidelines, SHA shall be responsible for developing institutional structure and operationalising Dedicated Anti-Fraud Cells, Claim Review Committee (CRC) and Mortality & Morbidity Review Committee (MMRC).

Audit noted that Anti-Fraud Cell in four States/UTs, CRC in eight States/UTs and MMRC in 11 States/UT were not formed as detailed in **Table-7.2**.

Table-7.2: Formation of Anti-Fraud Cells and Other committees at State level

Sl. No.	State /UT	Implementing Units not formed
1.	Andaman & Nicobar Island	Anti-fraud Cell, CRC & MMRC
2.	Dadra & Nagar Haveli and Daman & Diu	CRC
3.	Himachal Pradesh	CRC & MMRC

Sl. No.	State /UT	Implementing Units not formed
4.	Jammu and Kashmir	Anti-fraud Cell & MMRC
5.	Ladakh	Anti-fraud Cell, CRC & MMRC
6.	Maharashtra	MMRC
7.	Manipur	CRC & MMRC
8.	Meghalaya	CRC & MMRC
9.	Nagaland	MMRC
10.	Punjab	CRC & MMRC
11.	Puducherry	Anti-Fraud Cell
12.	Rajasthan	MMRC
13.	Tripura	CRC & MMRC

NHA, while accepting the audit observation, replied (August 2022) that NHA-NAFU has been issuing directives and reminders to all the States through anti-fraud guidelines and also various advisories regarding implementation of all anti-fraud guidelines.

Due to non-constitution of required Committees, the fraud cases communicated to NHA, death audit, claim audit and other activities may be hampered.

7.8 Non-conducting of Anti-Fraud awareness activities

As per para 3.2.5 of Anti-Fraud guidelines, it is the responsibility of SHA to design and implement strategies for beneficiary awareness on possible episodes of fraud under the PMJAY. The awareness may include understanding types of fraud, its impact on beneficiaries, preventive measures that the beneficiaries could take and whom to report to. It may be done by using mass media and interpersonal communication at the point of service.

Audit noted that three States/UT, **Bihar**, **Chandigarh** and **Uttar Pradesh** did not plan/conduct anti-fraud awareness activities. The documentary evidence regarding organising of camps for fraud awareness were not made available to Audit in any of the selected districts of **Himachal Pradesh**. Thus, the aim of apprising the beneficiaries of the possible irregularities in implementation of the programme remained unachieved.

NHA, while accepting the audit observation, replied (August 2022) that innovative measures have been taken for improving beneficiary awareness regarding fraud/abuse.

7.9 Fraud Cases

7.9.1 No action taken on defaulters

Audit noted that 12 hospitals in **Jharkhand** and one hospital in **Assam** indulged in various malpractices, *i.e.* illegal collection of money from beneficiaries, repeated submission of same photograph for multiple claims, non-disclosure of facts, etc. However, follow-up action like

recovery of amount of money collected and imposition of penalty, action against errant medical and paramedical professionals, de-empanelment of hospitals etc. had not been initiated.

NHA replied (August 2022) that SHA Jharkhand had taken appropriate action against the defaulters but did not furnish any documentary evidence in support of action taken. The reply in respect of SHA Assam was awaited.

7.10 Non-adoption of Whistle Blower Policy

National Health Authority issued the PMJAY Whistle Blower Policy as a step towards strengthening transparency and accountability in the implementation of PMJAY. The primary objective of the policy was to establish a mechanism to receive complaints relating to disclosure on any allegation of corruption, medical and non-medical fraud, etc. against any stakeholder involved with the implementation of PMJAY and to inquire or cause an inquiry into such disclosure and to provide adequate safeguards against victimisation of the person making such complaint and for matters connected therewith and incidental thereto.

Audit noted that seven States/UTs, **Andaman & Nicobar Islands, Bihar**, **Chhattisgarh**, **Madhya Pradesh**, **Punjab**, **Rajasthan** and **Tamil Nadu** had not adopted the Whistle Blower Policy.

Due to the non-adoption of the policy, the stakeholders involved in the Scheme were deprived of the mechanism for complaining regarding cases of corruption, medical and non-medical frauds etc.

NHA, while accepting the audit observation, replied (August 2022) that States would be pursued to constitute these Committees at the earliest and necessary directions would be issued for the implementation of whistle blower policy within defined timeline.

7.11 Shortfall in conduct of medical and other/social audit by ISA and SHA

Para 5.2.8 of anti-fraud guideline stipulates minimum sample for audit to minimize fraud prospects. Details of various types of audit to be conducted by the Implementing State Agency (ISA) and SHA and minimum sample for audit by ISA and SHA for each type of audit is given in **Annexure-7.2**.

Audit noted that NHA had not properly monitored the various types of audit conducted by the ISA/SHA in States. NHA only had information regarding Medical audit conducted by SHA, while the information/data in respect to the other types of audit was not available with NHA except for the States of **Nagaland** and **Tripura**.

Deficiency in medical audits conducted by SHAs defeated the very purpose of implementing anti-fraud investigation and audit system to detect, prevent and deter fraud losses under PMJAY.

Audit further noted that in two States, *viz.* **Nagaland** and **Tripura**, there was heavy shortfall in conducting various types of audits.

Shortcomings noted in 21 States/UTs[42], are detailed in **Table-7.3**.

Table-7.3: Shortcomings in States/UTs

Sl. No.	State/UT	Audit Observation
1.	Andhra Pradesh	No medical and death audits were conducted by SHA in 48 sampled hospitals.
2.	Bihar	Documents regarding Medical Audit in respect of Mortality cases were not provided by Bihar Swasthya Suraksha Samiti. Moreover, separate committee for high-value pre-authorization requests had also not been constituted to monitor the pre-authorization activities and claim payment.
3.	Chandigarh	Neither any annual audit plan was prepared nor any document in support of the cases audited were found on record.
4.	Chhattisgarh	ISA appointed for the hospital audit, conducted only 176 hospital audits against target of 1,692 hospitals during January 2020 to July 2021.
5.	Dadra & Nagar Haveli and Daman & Diu	Audit reports related to medical, hospital, claim summary reports were not being submitted by the insurance company, which showed lack of internal control/monitoring over Insurance Company Claims by UTHA.
6.	Haryana	767 cases of mortality had been audited against the total mortality cases of 1,022 (75.05 *per cent* against the prescribed 100 *per cent*).
7.	Himachal Pradesh	Shortfall ranging from 21 to 86 *per cent* in conducting medical audit by ISA in 23 selected EHCPs had been noted.
8.	Jammu & Kashmir	i) Though SHA provided the number of audits conducted, no details on date of audit, name of the auditor was provided. No audit in respect of certain audits *viz.* Beneficiary audit (post discharge–through home visit), Pre-authorization audit, claims audit (approved claims) and Beneficiary audit (during hospitalization) was conducted by SHA from December 2018 to December 2020 and Beneficiary audit (post discharge–through telephone), from December 2018 to February 2020. ii) In 112 cases the dates of hospital audit were shown before admission of patients and in 3,404 cases the date of hospital audit was shown after discharge of patient, which clearly indicates that fake audit reports were submitted by insurer and accepted by SHA J&K.
9.	Jharkhand	Out of deaths of 4,352 patients, only 563 death audits (13 *per cent* against the prescribed 100 *per cent*), had been conducted by the agency engaged by SHA.

[42] Andhra Pradesh, Bihar, Chandigarh, Chhattisgarh, Dadra & Nagar Haveli and Daman & Diu, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Ladakh, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Puducherry, Punjab, Rajasthan, Tripura and Uttarakhand.

Sl. No.	State/UT	Audit Observation
10.	Karnataka	There was a shortfall of 19 *per cent* in conduct of medical audits (60,773 medical audits against the target of 75,083). Further, SHA had not conducted any beneficiary audit (during hospitalization and post discharge through home visits) and claim audit of the rejected claims.
11.	Kerala	SHA had not conducted any Medical audit, Death Audit, beneficiary audit (post discharge through home visit), pre-authorization audit, and claim audits (rejected as well as approved claims). Moreover, the Third Party Administrator (TPA) had also not conducted any beneficiary audit (post discharge through telephone and home visits) and pre-authorization of claims audit.
12.	Ladakh	Neither the Insurer submitted any report of audit (Medical and other Audits) to SHA Ladakh nor did SHA Ladakh frame any targets for conducting of sampled audits.
13.	Madhya Pradesh	Shortfalls of 91, 71 and 76 *per cent* was observed in conducting of Hospital Audit by ISA during 2018-19, 2019-20 and 2020-21 respectively.
14.	Maharashtra	Out of 3,381 medical audits, only 1,262 medical audits conducted. No other kinds of audits conducted by SHA.
15.	Manipur	SHA did not conduct any type of audit and ISA also did not conduct Death Audit and Beneficiary Audit (post discharge through home visits)
16.	Meghalaya	Due to the non-formation of Claims Review Committee (CRC) and Mortality and Morbidity Review Committee (MMRC), claim audits (approved and rejected) and death audits were not conducted. In respect of the medical audit, there was a shortfall of 91 *per cent*, as only 146 medical audits against target of 1644 medical audits were conducted by SHA.
17.	Puducherry	No audit of any kind conducted in the UT.
18.	Punjab	No audit conducted by SHA
19.	Rajasthan	Due to non-formation of CRC, any claim audit was not conducted by SHA. No separate MMRC formed, but it is a part of State Anti-Fraud Unit (SAFU). Further, the records related the medical audits done by TPA and SHA not provided to Audit.
20.	Tripura	Shortfall of 63.44 *per cent* in death audits, 66.23 *per cent* in medical audit and 83.68 *per cent* in claim audits was noticed. No other audit conducted by the SHA.
21.	Uttarakhand	Out of 5,884 death cases in three years, death audit of 750 cases had only been conducted *i.e.* (12.75 *per cent* against target of 100 *per cent*)

Thus, shortfall in conduct of audits resulted in a lax control environment with possibility of unauthorized/excess payments of claims, fraud and shortcomings in facilities to be provided to the beneficiaries.

NHA, while accepting the audit observation, replied (August 2022) that SHAs were busy with COVID management activities and not in a position to achieve the targets specified for auditing. Now the auditing system had been streamlined and it was expected to achieve the auditing goals set by NHA.

7.12 Recovery to be made from defaulting hospitals

As per anti-fraud guidelines, SHA is responsible for developing institutional structures and operationalizing guidelines. Dedicated Anti-Fraud Cell in the State is responsible to carry out surprise inspection, impose penalty, de-empanelment, prosecution, and other deterrence measures, etc. against fraudsters/defaulters.

Audit noted that in NHA, out of ₹ 17.28 crore on account of penalty imposed on 184 defaulting hospitals pertaining to 13 States, **Andhra Pradesh**, **Chhattisgarh**, **Gujarat**, **Haryana**, **Jammu & Kashmir**, **Jharkhand**, **Karnataka**, **Madhya Pradesh**, **Maharashtra**, **Nagaland**, **Punjab**, **Uttar Pradesh** and **Uttarakhand**, recovery of only ₹ 4.96 crore had been effected. The remaining amount of ₹ 12.32 crore from 100 hospitals was to be recovered in nine States, **Andhra Pradesh**, **Chhattisgarh**, **Gujarat**, **Haryana**, **Jharkhand**, **Karnataka**, **Madhya Pradesh**, **Nagaland** and **Punjab** pertaining to the period from February 2019 to May 2021.

Audit further noted that ₹ 4.66 crore of penalties imposed against the grievances raised by beneficiaries against 164 defaulting hospitals from three States, **Andhra Pradesh**-160, **Chhattisgarh-2** and **Uttar Pradesh-2** pertaining to the period from February 2019 was still to be recovered. In the State of **Tamil Nadu**, penalty of ₹ 55.80 lakh was not recovered from 16 private hospitals.

NHA did not have any information of the amount to be recovered in respect of 15 States/UTs *viz.* **Arunachal Pradesh**, **Assam**, **Haryana**, **Himachal Pradesh**, **Manipur**, **Meghalaya**, **Mizoram**, **Nagaland**, **Puducherry**, **Punjab**, **Rajasthan**, **Sikkim**, **Tamil Nadu**, **Telangana** and **Tripura**.

State performance index of recoveries to be made

(Amount in ₹)

Sl. No.	State/UT	Recovery imposed	Recovery effected	Recovery yet to be done	% of recovery yet to be done
1.	Andhra Pradesh	13203919	9354897	3849022	29.15
2.	Chhattisgarh	9774942	0	9774942	100
3.	Gujarat	7284611	833960	6450651	88.55
4.	Haryana	3666500	1981250	1685250	45.96
5.	Jammu & Kashmir	1931250	1931250	0	0
6.	Jharkhand	104081157	8764891	95316266	91.58
7.	Karnataka	313984	283282	30702	9.78
8.	Madhya Pradesh	3357893	131580	3226313	96.08
9.	Maharashtra	1556290	1556290	0	0
10.	Nagaland	13464	0	13464	100
11.	Punjab	3994058	1120805	2873253	71.94
12.	Uttar Pradesh	75000	75000	0	0
13.	Uttarakhand	23588500	23588500	0	0
Total		**172841568**	**49621705**	**123219863**	

As per the above table it is seen that in **Jammu & Kashmir**, **Maharashtra**, **Uttar Pradesh** and **Uttarakhand,** pendency of recovery is nil. However, in **Chhattisgarh**, **Gujarat**, **Jharkhand**, **Madhya Pradesh**, **Nagaland** and **Punjab** pendency of recovery is very high.

Audit further noted that SHA, **Jammu & Kashmir** and **Ladakh** failed to levy penalties amounting to ₹ 20.93 crore and ₹ 39.66 lakh respectively on the Insurer for non-performance of various activities mentioned as Key Performance Indicators in Contract Agreements. Since no penalties were levied by the SHAs, no such recoveries were made from the defaulting hospitals, thereby not deterring the hospitals from deviating from the performance indicators specified under the scheme. Further, due to delay in payment of premium to the Insurance company up to 161 days under Contract Agreement (PS–4), SHA, **Jammu & Kashmir** failed to recover penalty of ₹ 2.91 crore on account of delayed claim payments from the Insurance Company.

NHA, while accepting the audit observation, replied (August 2022) that NHA is working on a guideline wherein central share would be released to the State only for clean cases *i.e.* cases where no action is pending.

7.13 Non rotation of Pradhan Mantri Arogya Mitra (PMAM)

Pradhan Mantri Arogya Mitra (PMAM) is a certified frontline health service professional present at each EHCP who serves as a first contact point for beneficiaries in order to streamline the health service delivery and provide a seamless experience.

As per anti-fraud guidelines, to avoid collusion among PMAM, hospitals and patients, if possible, SHA should rotate PMAM/insurance coordinator every three to six months preferably within the same city/town.

Audit noted that in two States, **Himachal Pradesh** and **Tamil Nadu,** PMAM in test checked hospitals were not rotated frequently.

NHA replied (August 2022) that as per anti-fraud guideline, it was suggested by NHA to rotate the PMAM periodically to avoid collusion, however, it was not made mandatory.

Reply is to be viewed from the fact that Para 4.2.2 of anti-fraud guidelines nowhere stipulates that it is not mandatory in nature.

CHAPTER VIII

Key Initiatives undertaken in PMJAY

8.1 Key initiatives by NHA

National Health Authority has been provided with full autonomy, accountability, and mandate to implement PMJAY. Some of the key initiatives undertaken by NHA in PMJAY are given below:

NHA launched a mission mode campaign "Aapke Dwar Ayushman" to ensure free issuance of cards to beneficiaries undergoing verification during January 2021 to April 2021.

NHA has unveiled Arogya Shiksha – a digital platform to support capacity building initiatives for PMJAY stakeholders.

It facilitated the launch of Ayushman Bharat Sehat Universal Health Insurance scheme for UT of Jammu & Kashmir in December 2020.

It has facilitated a campaign for migrant workers: "Ayushman Bharat ki Chhanv – Shahar Ho Ya Gaon".

NHA entered into MoUs with CSC and UTIITSL for mass issuance of PVC quality Ayushman cards. The cost of ₹ 20 of such cards is fully borne by NHA.

NHA call centre took initiative of dissemination of information on COVID-19 precautionary measures via National Helpline Number "1075".

NHA has launched a program to converge PMJAY with other major health insurance schemes and programs for ESIC and CAPF, Building and Other Construction Workers, Rashtriya Arogya Nidhi and Central Government Health Scheme on NHA IT Platform.

8.2 State-specific initiatives

State-specific initiatives noted during the course of Performance Audit are discussed as under:

In **Andaman** and **Nicobar Islands,** geographic landscape makes it uniquely challenging to provide access to healthcare. To make the portability feature convenient, SHA of the UT collects all medical documents of patient and informs SHA of the State, where patient is intending to receive healthcare services. All beneficiaries using the portability feature under PMJAY are also provided reimbursement of transport cost and wage loss compensation by SHA.

In **Andhra Pradesh,** treatment is provided beyond the limit of ₹ five lakh per family for Cancer and Heart diseases.

In **Assam,** beneficiaries who went outside the State were given air fare of up to ₹30,000 per annum per beneficiary and one attendant. Additionally, TA/DA of ₹1,000 per visit in case of treatment outside the State and ₹300 per visit within the State is provided for a maximum of 10 days. This amount was given from the State fund.

In **Gujarat**, the State Government is providing ₹300 as transportation expenses to all PMJAY beneficiaries per hospitalisation. Out-of-pocket expenditure and overall healthcare costs incurred by the beneficiaries are thus minimized.

In **Haryana**, 100 *per cent* Aadhaar seeding of Ayushman card and 100 *per cent* biometric authentication at the time of hospitalization except neonates has been done.

In **Himachal Pradesh**, District Kullu achieved 100 *per cent* enrolment of all the eligible beneficiaries as per SECC data.

In **Jammu and Kashmir**, extra expenditure on patients over and above approved amount of claim is being borne by Public hospitals from hospital fund.

In **Karnataka**, SHA established a call centre as a monitoring unit of the Scheme. The call centre contacts all beneficiaries at the time of discharge for getting feedback regarding out-of-pocket expenditure of the Scheme and co-payments made (if any).

In **Kerala**, Government hospitals caters to all the procedures notified through HBP 2.0. ₹179.61 crore was paid against 73,790 claims relating to COVID-19 treatments.

In **Manipur**, SHA had collaborated with Tourism Department, MAHUD, Manipur State Legal Services Authority leveraging in the events organized by these departments for generation of awareness and increase in enrolment and currently taking active participation in Government sponsored programme, 'Go to Villages'.

In **Mizoram**, SHA followed the system of offline collection of data in regard to the Beneficiary Identification System (BIS). Teams from SHA were deployed in the peripheral areas of the State who collected all details of village-wise beneficiaries.

In **Nagaland,** State Government had engaged six organizations to undertake outreach beneficiary identification and verification drives in eight districts.

In **Puducherry**, SHA took up with NHA issue of mismatch of SECC data which was the main hindrance in identification of eligible beneficiaries. Accordingly, SHA got NHA's approval for utilizing the dynamic data of National Food Security Act for identification of beneficiaries and target was increased from 1,03,434 families to 1,77,733 families.

In **Rajasthan**, after treatment, a feedback form is filled by the beneficiary stating that no charge of any kind is collected from beneficiary for the treatment given and whether he is satisfied or not with the treatment given.

In **Tamil Nadu**, a corpus fund has been created. 27 *per cent* of every insurance claim of Government hospitals is being credited into the corpus fund. High end procedures involving more than ₹ five lakh per case is paid from Corpus fund for the poor persons.

In **Uttar Pradesh**, State Government conducted an Additional Data Collection Drive to identify left-out eligible families on the same deprivation and occupational parameters of SECC 2011 to ensure that these additional families are provided with same benefits of PMJAY.

CHAPTER IX

Recommendations

PMJAY aims at providing a health cover of ₹ five lakh per family per year for secondary and tertiary care hospitalization to over 12 crore poor and vulnerable families. Audit noted that the Scheme envisaged well-intended benefits for the deprived and marginalised beneficiaries; however, the implementation of the scheme was hindered by several issues as discussed in this report. The following recommendations are suggested for improving the implementation of the scheme:

Chapter-III: Beneficiary Identification and Registration
Ministry and States/UTs may put a suitable mechanism for identifying State-wise beneficiaries under the Scheme and to weed out ineligible beneficiaries in a time-bound manner.
The registration process needs to be strengthened to avoid delay in registration beyond the prescribed time.
Validation checks should be in place so as to avoid invalid entries and increase the accuracy and reliability of the data.
NHA may ensure that SHAs set up a designated IEC cell to promote awareness about the scheme and maximize reach, impact and awareness amongst targeted beneficiaries.
Chapter-IV: Hospital Empanelment and Management
There is a strong need to invest in public hospitals to improve and upgrade the quality of the existing health facilities in accordance with prescribed criteria.
NHA/SHA/DIU may encourage more private hospitals to join under the Scheme in all the Districts in order to build an effective and accountable network of health service providers as per quality standard.
Monitoring of EHCPs through physical inspections and necessary audits so that mal-practices may get detected and action may be initiated against the errant EHCPs.
NHA/SHA should have a mechanism to monitor and curb instances involving out of pocket expenditure by the beneficiaries.
Chapter–V: Claims Management
Processing and payment of the claims must be done on time after ensuring necessary scrutiny by SHA.
SHAs must ensure that claim amount is utilized by Public/Government Hospitals for improving the overall infrastructure, functioning of the hospital, quality of services and delivery of services and for incentives to staff.
Chapter-VI: Financial Management
NHA may exercise due diligence while releasing the grant to SHAs to ensure fulfilment of corresponding State commitments, actual expenditure against past releases and also avoid idling of funds.
Diversion of grant from one head to another should be discouraged and NHA/SHA should ensure that grant is utilized for the purpose it was released.
Amount due from Insurance companies and interest from SHAs may be recovered at the earliest.

	NHA should ensure that every SHA in the State/UTs has opened designated escrow account into which their upfront share has been deposited in a timely manner.
	NHA must put in a mechanism to map and identify PMJAY beneficiaries so that there is no overlap of PMJAY and state specific schemes.
	PFMS may be implemented on priority to track the flow of expenditure.
Chapter-VII: Monitoring and Grievance Redressal	
	SHAs should ensure that District Implementing Units are formed in every District with adequate manpower and infrastructure for smooth functioning of Scheme.
	Anti-fraud activities must be taken-up on urgent basis and defaulters should be penalized in a timely manner.
	All the required audits/checks must be conducted by concerned authorities in order to avoid mal-practices by EHCPs so that beneficiaries may get proper treatment without undue harassment.
	It must be ensured that grievances are effectively redressed and corrective measures taken for improving the working of the Scheme.

New Delhi
Dated: 28 April 2023

(RAJIV KUMAR PANDEY)
Director General of Audit
(Central Expenditure)

Countersigned

New Delhi
Dated: 01 May 2023

(GIRISH CHANDRA MURMU)
Comptroller and Auditor General of India

Annexures & Glossary

Annexure-1.1

(Refer Para-1.1(ii)

Beneficiary eligibility for PMJAY

Rural Beneficiaries: Out of the total seven deprivation criteria for rural areas, PMJAY covers all such families who fall in at least one of the following six deprivation criteria (D1 to D5 and D7) and automatic inclusion (Destitute/living on alms, manual scavenger households, primitive tribal group, legally released bonded labour) criteria-

1. D1- Only one room with *kuccha* walls and *kuccha* roof
2. D2- No adult member between ages 16 to 59
3. D3- Households with no adult male member between ages 16 to 59
4. D4- Disabled member and no able-bodied adult member
5. D5- SC/ST households
6. D7- Landless households deriving a major part of their income from manual casual labourer.

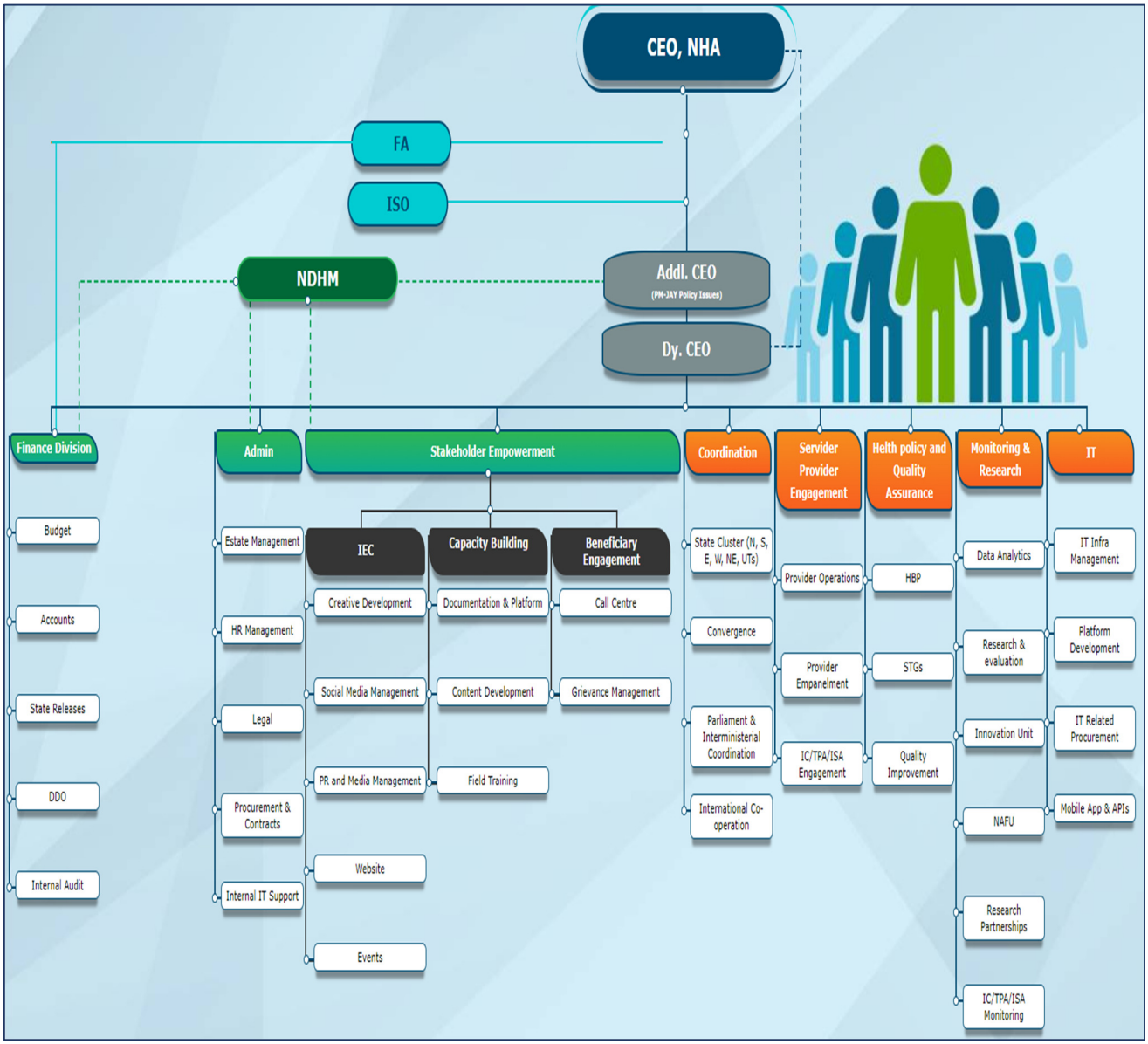
Urban Beneficiaries: For urban areas, the following 11 occupational categories of workers are eligible for the scheme-

1. Rag picker
2. Beggar
3. Domestic worker
4. Street vendor/ Cobbler/hawker / other service provider working on streets
5. Construction worker/Plumber/Mason/Labourer/Painter/Welder/ Security guard/ Coolie and other head-load worker
6. Sweeper/Sanitation worker/Mali
7. Home-based worker/Artisan/Handicrafts worker/Tailor
8. Transport worker/Driver/Conductor/Helper to drivers and conductors/Cart puller/Rickshaw puller
9. Shop worker/Assistant/Peon in small establishment/ Helper/Delivery assistant/Attendant/Waiter
10. Electrician/ Mechanic/Assembler/Repair worker
11. Washer-man/Chowkidar.

Annexure-1.2

(Refer Para-1.4)

Organizational structure of NHA



Annexure-1.3

(Refer Para-1.5)

Implementation modes and dates of on-boarding of States/UTs

(Trust-22, Insurance-7, Mixed-4)

Sl. No.	State	Implementation mode adopted	Date of roll- out	Remarks - shift in Implementation mode
1.	Andaman & Nicobar Islands	Trust	23.09.2018	--
2.	Andhra Pradesh	Trust	01.01.2019	--
3.	Arunachal Pradesh	Trust	23.09.2018	--
4.	Assam	Trust	23.09.2018	--
5.	Bihar	Trust	23.09.2018	--
6.	Chandigarh	Trust	23.09.2018	--
7.	Chhattisgarh	Trust	16.09.2018	Mixed to Trust on 16.12.2019
8.	Dadra & Nagar Haveli and Daman & Diu	Insurance	23.09.2018	--
9.	Goa	Trust	23.09.2018	--
10.	Gujarat	Mixed	23.09.2018	--
11.	Haryana	Trust	15.08.2018	--
12.	Himachal Pradesh	Trust	23.09.2018	--
13.	Jammu and Kashmir	Insurance	01.12.2018	--
14.	Jharkhand	Mixed	23.09.2018	--
15.	Karnataka	Trust	30.10.2018	--
16.	Kerala	Trust	01.04.2019	Insurance to Trust on 01.07.2020
17.	Ladakh	Insurance	01.03.2020	--
18.	Lakshadweep	Trust	23.09.2018	--
19.	Madhya Pradesh	Trust	23.09.2018	--
20.	Maharashtra	Mixed	23.09.2018	--
21.	Manipur	Trust	23.09.2018	--
22.	Meghalaya	Insurance	01.02.2019	--
23.	Mizoram	Trust	01.10.2018	Insurance to Trust on 01.10.2019
24.	Nagaland	Insurance	23.09.2018	--
25.	Puducherry	Trust	29.07.2019	Insurance to Trust on 30.12.2020
26.	Punjab	Insurance	20.08.2019	--
27.	Rajasthan	Insurance	01.09.2019	Mixed to Trust on 13.12.2019 and Trust to Insurance on 30.01.2021
28.	Sikkim	Trust	23.09.2018	--
29.	Tamil Nadu	Mixed	23.09.2018	--
30.	Tripura	Trust	23.09.2018	--
31.	Telangana	Trust	19.05.2021	--
32.	Uttar Pradesh	Trust	23.09.2018	--
33.	Uttarakhand	Trust	23.09.2018	--

Mode-wise detail of States/UTs

Trust Mode (22 States/UTs)	Insurance Mode (7 States/UTs)	Mixed Mode (4 States)
Andaman & Nicobar Islands	Dadra & Nagar Haveli and Daman & Diu	Gujarat
Andhra Pradesh	Jammu & Kashmir	Jharkhand
Arunachal Pradesh	Ladakh	Maharashtra
Assam	Meghalaya	Tamil Nadu
Bihar	Nagaland	
Chandigarh	Punjab	
Chhattisgarh	Rajasthan	
Goa		
Haryana		
Himachal Pradesh		
Karnataka		
Kerala		
Lakshadweep		
Madhya Pradesh		
Manipur		
Mizoram		
Puducherry		
Sikkim		
Tripura		
Telangana		
Uttar Pradesh		
Uttarakhand		

(Source: pmjay.gov.in>states at glance)

Annexure-2.1

(Refer Para-2.4)

Process of Sample selection

Stage-II: Selection of lower-level units in the States/UTs

The selection of districts was done by the State/UTs concerned by using following methodology of sampling as detailed below:

i. **Selection of Districts:** The Division of States/UTs, into different geographical regions and then selection of 25 *per cent* of the Districts (with minimum of two and maximum of 10) from each State using Simple Random Sampling (SRS). During the selection of Districts, it was ensured that at least two Districts are selected from each geographical region by the State audit office.

ii. **Selection of Hospitals:** 25 *per cent* of the hospitals (with minimum of two and maximum of eight) in a District were selected. It was also ensured that the selected sample has the representation of both Private and Public Hospitals, only for female (if any), General and Speciality criteria during the course of performance audit. District hospitals in each of the sampled district were also selected for the audit. The Urban and Rural hospitals were also selected.

iii. **Representation of Packages:** The State audit offices ensured that all the packages were adequately covered at all India level and important packages w.r.t. cost expenditure component or criticality of health were adequately covered in each of the States.

Annexure-2.2

(Refer Para-2.4)

Detail of Samples selected

Sl. No.	State/UT	Selected Districts	Selected Hospitals
1.	Andaman & Nicobar Islands	2	2
2.	Andhra Pradesh	6	48
3.	Assam	9	35
4.	Bihar	10	63
5.	Chandigarh	1 (7 wards)	5
6.	Chhattisgarh	8	55
7.	Dadra **&** Nagar Haveli and Daman **&** Diu	2	4
8.	Gujarat	10	45
9.	Haryana	6	40
10.	Himachal Pradesh	5	23
11.	Jammu & Kashmir	6	21
12.	Jharkhand	6	48
13.	Karnataka	8	64
14.	Kerala	4	30
15.	Madhya Pradesh	10	46
16.	Maharashtra	9	72
17.	Manipur	4	10
18.	Meghalaya	4	21
19.	Mizoram	2	10
20.	Nagaland	4	12
21.	Puducherry	2	9
22.	Punjab	6	41
23.	Rajasthan	8	65
24.	Tamil Nadu	10	76
25.	Tripura	3	11
26.	Uttar Pradesh	10	80
27.	Uttarakhand	4	25
28.	Ladakh	2	3
Total		**161**	**964**

Annexure-3.1

(Refer Para-3.2)

Details of households and members registered in Beneficiary Identification System

Sl. No.	State/UT	Date of implementation	Households covered	Members registered
1.	Andaman and Nicobar Islands	23-09-2018	11,268	32,479
2.	Andhra Pradesh	01-01-2019	11	11
3.	Arunachal Pradesh	23-09-2018	7,702	22,223
4.	Assam	23-09-2018	1,21,108	1,51,761
5.	Bihar	23-09-2018	33,28,424	68,40,754
6.	Chandigarh	23-09-2018	20,100	60,892
7.	Chhattisgarh	16-09-2018	60,30,615	1,28,24,960
8.	Dadra and Nagar Haveli	23-09-2018	60,155	2,53,579
9.	Daman and Diu	23-09-2018	32,697	1,20,117
10.	Goa	23-09-2018	8,477	19,905
11.	Gujarat	23-09-2018	24,35,565	74,57,117
12.	Haryana	15-08-2018	8,74,715	26,02,647
13.	Himachal Pradesh	23-09-2018	4,38,119	10,09,508
14.	Jammu and Kashmir	01-12-2018	15,50,923	47,55,457
15.	Jharkhand	23-09-2018	36,32,614	89,77,276
16.	Karnataka	30-10-2018	336	415
17.	Kerala	01-04-2019	41,70,297	62,92,368
18.	Lakshadweep	23-09-2018	420	1,636
19.	Madhya Pradesh	23-09-2018	97,76,438	2,47,38,533
20.	Maharashtra	23-09-2018	27,85,024	71,08,453
21.	Manipur	23-09-2018	1,08,292	2,90,129
22.	Meghalaya	01-02-2019	4,57,847	8,05,960
23.	Mizoram	01-10-2018	1,25,877	3,00,324
24.	Nagaland	23-09-2018	1,02,808	1,93,480
25.	Puducherry	29-07-2019	63,735	1,82,194
26.	Punjab	20-08-2019	31,31,115	68,48,392
27.	Sikkim	23-09-2018	12,176	33,900
28.	Tamil Nadu	23-09-2018	340	386
29.	Tripura	23-09-2018	4,98,973	11,73,567
30.	Uttar Pradesh	23-09-2018	54,32,670	1,40,00,533
31.	Uttarakhand	23-09-2018	18,09,011	43,65,471
Grand Total			**4,70,27,852**	**11,14,64,427**

Annexure-3.2

(Refer Para-3.2)

Details of households and members registered on the basis of eligibility (SECC database) in Beneficiary Identification System

Sl. No.	State/UT	Households registered with at least one active member	Beneficiaries registered
1.	Andaman & Nicobar Islands	10,919	32,129
2.	Andhra Pradesh	11	11
3.	Arunachal Pradesh	7,702	22,223
4.	Assam	51,698	77,189
5.	Bihar	33,28,387	68,40,717
6.	Chandigarh	20,076	60,861
7.	Chhattisgarh	13,40,267	28,52,810
8.	Dadra and Nagar Haveli	22,925	1,02,262
9.	Daman and Diu	3,628	10,220
10.	Goa	8,477	19,905
11.	Gujarat	22,53,190	71,86,954
12.	Haryana	8,74,715	26,02,647
13.	Himachal Pradesh	1,20,688	3,17,240
14.	Jammu and Kashmir	4,65,612	15,07,040
15.	Jharkhand	12,02,502	29,77,509
16.	Karnataka	336	415
17.	Kerala	1,14,121	1,43,551
18.	Lakshadweep	420	1,636
19.	Madhya Pradesh	2,51,536	4,46,633
20.	Maharashtra	27,85,024	71,08,453
21.	Manipur	1,01,856	2,75,435
22.	Meghalaya	1,16,008	2,17,978
23.	Mizoram	21,154	52,159
24.	Nagaland	64,021	1,34,765
25.	Puducherry	41,545	1,32,242
26.	Punjab	1,85,497	2,91,206
27.	Sikkim	12,176	33,900
28.	Tamil Nadu	340	386
29.	Tripura	2,98,983	7,42,634
30.	Uttar Pradesh	51,41,334	1,34,05,598
31.	Uttarakhand	1,21,641	2,65,258
	Grand Total	**1,89,66,789**	**4,78,61,966**

(Note: The scheme is not being implemented in Delhi, Odisha, Telangana and West Bengal during audit period.)

Annexure-3.3

(Refer Para-3.5)

Beneficiary registrations under process for approval

State/UT	Number of cases	Maximum delay (in days)	Average delay (in days)
Andaman & Nicobar Islands	1	2	2
Andhra Pradesh	50	662	104
Arunachal Pradesh	32	65	30
Assam	13	932	187
Bihar	650	931	94
Chandigarh	60	921	145
Chhattisgarh	37	932	581
Dadra and Nagar Haveli	19	845	788
Daman and Diu	2	922	917
Delhi	588	881	56
Goa	14	223	85
Gujarat	5068	940	9
Haryana	365	916	115
Himachal Pradesh	28	879	183
Jammu and Kashmir	349345	862	120
Jharkhand	170	929	212
Karnataka	100	588	55
Kerala	305	710	95
Lakshadweep	24	575	424
Madhya Pradesh	461	940	116
Maharashtra	1574	898	33
Manipur	352	129	65
Meghalaya	120	2	0
Mizoram	4	3	1
Nagaland	5	222	45
Odisha	3	892	298
Puducherry	17224	508	7
Punjab	2194	240	7
Rajasthan	70	190	24
Sikkim	21	2	1
Tamil Nadu	281	732	113
Telangana	9	174	64
Tripura	22	726	55
Uttar Pradesh	6012	926	17
Uttarakhand	122	922	228
West Bengal	41	222	73
Total	**3,85,386**		

Annexure-3.4

(Refer Para-3.9)

IEC Cell, Plan and expenditure details

Sl. No.	State	Formation of IEC Cell	Preparation of IEC Plan	Expenditure on IEC activities in percentage
1.	Andaman & Nicobar Islands	NA	No	NA
2.	Andhra Pradesh	Not formed	NA	0per cent
3.	Assam	Not formed	No	NA
4.	Bihar	Not formed	No	0.1 to 19.28 *per cent*
5.	Chandigarh	NA	No	0 to 6.86 *per cent*
6.	Chhattisgarh	Formed	Yes	NA
7.	Dadra and Nagar Haveli and Daman and Diu	Not formed	No	NA
8.	Gujarat	Not Formed	No	6 *per cent*
9.	Haryana	NA	No	9.4 *per cent*
10.	Himachal Pradesh	Formed	No	12.02 *per cent*
11.	Jammu and Kashmir	Formed	No	57.52 *per cent*
12.	Jharkhand	Not formed	NA	NA
13.	Karnataka	Not formed	No	NA
14.	Kerala	NA	NA	20.24 *per cent* (2020-21)
15.	Ladakh[1]	NA	No	NA
16.	Madhya Pradesh	NA	Yes	19.22 *per cent*
17.	Maharashtra	Formed	Prepared but not implemented till Nov 21	1.13 *per cent*
18.	Manipur	NA	Yes	27.37 *per cent*
19.	Meghalaya	NA	No	NA
20.	Mizoram	Not formed	No	NA
21.	Nagaland	Not Formed	No	NA
22.	Puducherry	Not formed	NA	NA
23.	Punjab	Yes	No	5 *per cent*
24.	Rajasthan	Not formed	Yes	12.81 *per cent*
25.	Tamil Nadu	NA	No	0 *per cent*
26.	Tripura	Not formed	No	1.19 *per cent*
27.	Uttar Pradesh	Formed	No	8.5 *per cent*
28.	Uttarakhand	Formed	NA	NA

[1] Consequent upon creation of UT Ladakh on 31.10.2019, the State Health Society of UT Ladakh started implementing AB-PMJAY scheme in UT Ladakh from 01.03.2020.

Annexure-4.1

(Refer Para-4.2 & 4.3)

EHCPs availability ratio

Sl. No.	State/UT	Public	Private	GOI	Total	SECC eligible beneficiary	Hospital availability Per 1lakh
1.	Andaman & Nicobar Islands	7	0	0	7	80,127	8.7
2.	Andhra Pradesh	1239	1225	11	2475	1,99,75,159	12.4
3.	Arunachal Pradesh	44	2	16	62	4,26,966	14.5
4.	Assam	162	214	53	429	1,25,08,674	3.4
5.	Bihar	574	381	34	989	5,55,62,406	1.8
6.	Chandigarh	5	26	2	33	3,08,005	10.7
7.	Chhattisgarh	1000	561	49	1610	1,52,74,556	10.5
8.	Dadra & Nagar Haveli and Daman & Diu	7	0	0	7	1,94,505	3.6
9.	Delhi	4	75	30	109	26,04,160	-NA-
10.	Goa	21	15	1	37	1,39,207	26.6
11.	Gujarat	1962	884	18	2864	2,12,84,770	13.5
12.	Haryana	164	524	12	700	73,49,722	9.5
13.	Himachal Pradesh	138	122	10	270	11,37,946	23.7
14.	Jammu and Kashmir	121	96	78	295	31,50,959	9.4
15.	Jharkhand	224	574	54	852	1,39,94,648	6
16.	Karnataka	2916	811	12	3739	1,74,04,802	21.5
17.	Kerala	195	549	5	749	72,88,329	10.3
18.	Lakshadweep	6	0	0	6	6,607	90.8
19.	Madhya Pradesh	449	527	30	1006	3,73,05,019	2.7
20.	Maharashtra	306	787	6	1099	3,60,84,776	3
21.	Manipur	33	22	37	92	14,08,348	6.5
22.	Meghalaya	157	18	8	183	17,75,299	10.3
23.	Mizoram	79	7	10	96	4,57,118	21
24.	Nagaland	103	24	19	146	9,96,085	14.7
25.	Odisha	0	2	26	28	2,44,40,661	-NA-
26.	Puducherry	11	20	1	32	4,13,597	7.7
27.	Punjab	217	685	33	935	70,55,971	13.3
28.	Rajasthan	846	202	46	1094	2,86,95,425	3.8
29.	Sikkim	11	1	5	17	1,71,398	10
30.	Tamil Nadu	834	956	0	1790	2,88,44,541	6.2
31.	Telangana	385	337	13	735	1,01,32,938	7.3
32.	Tripura	127	3	15	145	20,70,365	7
33.	Uttar Pradesh	1048	2149	66	3263	6,47,03,155	5
34.	Uttarakhand	102	121	21	244	24,63,043	10
35.	West Bengal	1	10	60	71	4,76,77,708	-NA-
Total		**13498**	**11930**	**781**	**26209**		

Annexure 4.2

(Refer Para 4.2.1)

Details of States in which hospitals were empanelled without fulfilling minimum criteria of support system & infrastructure

Sl. No.	State	Observations
1	Andaman and Nicobar Islands	In GB Pant Hospital, Port Blair, four medical equipment had no power backup, and eight medical equipment were out-of-order. Further, in RP Hospital, Mayabunder, medical equipment like fully automatic Biochemistry Analyser and Semi-Auto Biochemistry Analyser were out of order and an ELISA Microplate Reader and ELISA Microplate Washer were unavailable being sent for repairs to Port Blair.
2	Assam	Deficiencies in respect of basic infrastructures like IPD beds, Operation Theatres (Six EHCPs had no OT), Post operation ICU care with ventilator support (Five EHCPs lacking), Pharmacy, Blood Bank, Dialysis unit, X-ray facility, Diagnostic Centre, Round-the-clock Ambulance facilities, etc. were noticed in 33 test checked EHCPs.
3	Bihar	Physical verification reports of 23 EHCPs disclosed 16 EHCPs did not fulfill the essential criteria pertaining to adequate space, staff, surgical services, round the clock ambulance, 24x7 emergency services, etc.
4	Chandigarh	In Dasam Kirat Dialysis Centre Private Limited hospital, 10 bedded Dialysis Centre had only one doctor, one nurse and one dialysis technician operating for 24 hours, physically in charge round the clock. Further, Nimbus Hospital offered eye care services round the clock with only one nurse deployed against minimum criteria of three. Further, bed strength was shown as five, whereas, hospital had obtained registration under Bio-Medical Waste Management Rules, 2016 for clinic (non-bedded) establishment.
5	Gujarat	District Hospital and Civil EHCPs had deficient infrastructure. The public EHCPs had been empanelled for the specialities which were not available in these EHCPs.
6	Himachal Pradesh	Following deficiencies in availability of Ultrasound, X-Ray, and CT Scan Machines, etc. were noted in 23 test checked empanelled EHCPs. Out of these 23 EHCPs in eight EHCPs, Ultrasound Machines were either unserviceable and in 12 EHCPs, X-Ray machines were either not installed or unserviceable for substantial duration of time during. In 11 EHCPs, there was no CT scan machines. Further, in four EHCPs the machines remained out of order for substantial periods of time during the period 2019-20 to 2020-21. In Zonal Hospital (ZH) Dharmashala and in Regional Hospital (RH) Nahan, various machines were not functional since 2014 and 2018 respectively.

Sl. No.	State	Observations
7	Jammu & Kashmir	In eight EHCPs, three to 19 testing facilities were not available.
8	Manipur	Jivan Hospital, Kakching private hospital did not have the facilities/doctors for treatment of Mental Disorders and Orthopaedics even though the specialties were empanelled in the hospital.
9	Nagaland	Out of three test checked empanelled PHC/CHCs (PHC Chare, CHC Aboi and CHC Viswema), PMJAY benefits in PHC Chare and CHC Aboi were not extended to the beneficiaries due to lack of in-patient facilities in these centres.
10	Puducherry	Out of 23 EHCPs (as of March 2021), in eight EHCPs, minimum criteria *viz.* availability of Operation theatres, round the clock availability of specialist and medical support services were not fulfilled.
11	Tripura	X-ray facility was not available in 3 out of 11 test checked EHCPs, In three EHCPs facility for various blood test by analyser was not available.
12	Uttar Pradesh	Seven out of 40 test checked private EHCPs were empanelled without fulfilling the minimum basic criteria.

Annexure 4.3

(Refer Para 4.2.2)

Details of States in which hospitals were empanelled without fulfilling safety measures

Sl. No.	State	Observations
1	Bihar	Fire safety certificate was not obtained from three hospitals and clinical certificates were not obtained from three hospitals before execution of contract.
2	Himachal Pradesh	Out of 23 test-checked EHCPs, in 16 EHCPs, no objection certificate (NoC) from Directorate of Fire Services in 12 EHCPs, NoC from State Pollution Control Board and in eight EHCPs, certificates of collection of Bio Medical Waste were not obtained.
3	Jharkhand	EHCPs had been empanelled without fulfilling the mandatory minimum criteria of empanelment in six Districts. Audit noted that SHA issued notice to one private hospital on 10 February 2020 for non-adhering the norms of guidelines of PMJAY. However, hospital neither furnished any reply nor SHA took any action against the hospital. The hospital continued providing treatment and got claim amount of ₹ 116.33 lakh in 1,594 cases. As per State Clinical Establishment Act (CEA), 2013, no one can run a clinical establishment without registration and shall be renewed in every year. Also, the act *ibid* provides that the application for renewal of registration shall be made to the authority within 30 days before the expiry of the validity of the certificate of provisional registration. In two test checked Districts (East Singhbhum and Ranchi), 154 EHCPs were test checked out of which 14 EHCPs[2] were empanelled on expired registration certificate and 54 EHCPs[3] were empanalled without uploading of hospital registration certificate. Further, registration of four EHCPs in two Districts had expired after empanelment but renewed after five days to 272 days of lapse of registration. During expired period of registration, these EHCPs provided treatment in 386 cases and got claim payment of ₹ 0.74 crore.
4	Karnataka	Audit noted from records of test checked EHCPs that they are functioning without required mandatory certificates/licenses as detailed below: Pharmacy Licence (11), Hospital registration certificate (3), Blood Bank Licence (9), State Medical Council/Association Registration (5) Ambulance Registration Certificate (4) Fire Department Clearance Certificate (16) PCPNDT Act Registration (7) Pollution Control Board Certificate (3) *Figures in bracket means number of EHCPs were empanelled without required documents

[2] East Singhbhum-2 and Ranchi-12
[3] East Singhbhum-14 and Ranchi-40

Sl. No.	State	Observations
5	Meghalaya	Out of 21 test checked private EHCPs, two private EHCPs (Dr. Norman Tunnel Hospital, Jowai and Tura Christian Hospital, Tura) were not registered under the Meghalaya Nursing Homes (Licensing and Registration) Act, 1993.
6	Puducherry	Basic requirement compliance with Fire Safety measures was not ensured in 14 EHCPs.
7	Uttarakhand	Out of 93 test checked EHCPs**,** certificate in respect of Fire Department Clearance (70 EHCPs), Bio Medical Waste Management (49 EHCPs), Pollution Control Board Compliance (78 EHCPs) were not available.

Annexure-4.4

(Refer Para-4.5)

Non-empanelment of all available and eligible Specialities at Assam

Sl. No.	Name of the hospital	Type of hospital (Public/Private)	Number of Specialty Available		Percentage of speciality available under PMJAY
			Under PMJAY	Total in Hospital	
1.	Bhogeswari Phukanani Civil Hospital, Nagaon	Public	4	22	18
2.	SM Dev Civil Hospital, Silchar	Public	4	5	80
3.	RNB Civil Hospital	Public	7	10	70
4.	Diphu Medical College Hospital	Public	13	24	54
5.	Northeast Cancer Hospital & R/Institute	Private	2	4	50
6.	Dew Care Hospital & Research Centre	Private	3	5	60
7.	Down Town Hospital Pvt Ltd	Private	1	24	4
8.	Swagat Hospital	Private	11	19	58
9.	MRM Memorial Hospital	Private	4	7	57
10.	Hamm Hospital & Research Centre	Private	10	14	71
11.	Sun Valley Hospital	Private	3	13	23
12.	Health City Hospital	Private	5	15	33
13.	Swargadew Siu KaPha Multispecialty Hospital	Private	3	10	30

Annexure-4.5

(Refer Para-4.5)

Non-empanelment of all available and eligible Specialities at Jharkhand

Name of District	Name of hospitals	Specialities provided to General Public	Specialities for empanelled in PMJAY
Ranchi	Medanta Abdur Razzaque Ansari Memorial Weavers Hospital	General Surgery, Cardiology, Cardio-Thoracic & Vascular Surgery, Orthopaedics, Urology, Nephrology, Neurosurgery, General Medicine, Plastic & Reconstructive Surgery	General Surgery, Cardiology, Cardio-Thoracic & Vascular Surgery, Orthopaedics, Urology, Nephrology
	Bhagwan Mahaveer Medical Super speciality Hospital	Emergency Room Package, Paediatric Medical Management, Paediatric Surgery, Urology, Oral and Maxillofacial Surgery, General Medicine, General Surgery, Cardiology, Cardio-thoracic and Vascular Surgery, Otorhinolaryngology, Ophthalmology, Obstetrics and Gynaecology, Orthopaedics and Neuro-Surgery	General Medicine, General Surgery, Cardiology, Cardio-thoracic and Vascular Surgery, Otorhinolaryngology, Ophthalmology, Obstetric and Gynaecology, Orthopaedics, Polytrauma, Neuro-Surgery and Medical Oncology.

Annexure-4.6

(Refer Para-4.5.2)

EHCPs treated patients prior to up-gradation of specialities at Jharkhand

Sl. No.	Name of the Hospital	Enhancement approved by SHA/SEC	Enhanced procedure	Period	SECC	
					No of cases	Claim amount
1.	Singhpur Nursing Home, Ranchi	28/4/2021	General Medicine	10/10/2018 to 15/4/2021	792	62,66,070
2.	Rinchi Trust Hospital, Ranchi	18/3/2019	Ophthalmology	13/02/2019 to 15/3/2019	1	5,000
3.	Raj Hospitals, Ranchi	1/10/2020	General Medicines	28/12/2018 to 4/7/2019	2	48,780
Total					**795**	**63,19,850**

Annexure-4.7

(Refer Para-4.10)

Statement showing the details of hospitals treated patients during de-empanelled at period at Jharkhand

Name of District	Sl. No.	Name of the Hospital	Date of de-empanelment	SECC	
				Number of cases	Amount paid to hospitals
Palamu	1.	Maa Gulabi Sewa Sadan	5/2/2019	266	21,94,350
	2.	Sanjeevani Hospital	5/2/2019	211	13,47,310
	3.	Shri Lilawati Hospital	5/2/2019	585	34,21,330
	4.	Long Life Hospital	5/2/2019	637	62,21,060
	5.	Maa Tara Sewa Clinic	5/2/2019	78	4,76,860
Total				**1777**	**1,36,60,910**

(Source: Audit findings and TMS portal)

Annexure-4.8

(Refer Para-4.10)

Details of de-empanelled Hospitals

Sl. No.	State	Number of voluntarily de-empanelled hospitals	Reasons of voluntarily de-empanelment	Number of de-empanelled hospitals	Reason of de-empanelment
1.	Chhattisgarh	--	--	3	Extra money taken and fake cases
2.	Karnataka	13	Closure of unit/specialization, no infrastructure etc.	1	--
3.	Maharashtra	47	No reason provided	46	Collection of money from beneficiaries
4.	Tamil Nadu	7	No reason provided	9	Collection of money and low performance
5.	Kerala	3	Economically non-viable etc	--	--
6.	Andhra Pradesh	23	Personal reason, administrative reason	1	Due to non-obtaining NABH
7.	Jharkhand	--	--	28	Non availability of infra and doctors
8.	Madhya Pradesh	3	Financial constraints and low packages rates	3	Fraudulent card irregular package selection etc.
9.	Punjab	16	Non availability of doctors	16	
10.	Himachal Pradesh	7	Due to reasons of low treatment packages	13	Involvement in mal practices/lack of in-patient facility
11.	Assam	1	Due to low package rates	1	Illegal collection of money etc.
	Total	**120**		**121**	

Annexure-5.1

(Refer Para-5.1.1, Para-5.1.2)

Details of claims settled and claims under process for settlement (as of November 2022)

(₹ in crore)

State/UT	Claims Settled		Under process for Settlement	
	No. of cases	Amount	No. of cases	Amount
Andaman and Nicobar Islands	1,369	3.54	101	0.41
Arunachal Pradesh	2,343	3.43	66	0.52
Assam	4,57,895	596.81	37,930	98.96
Bihar	4,16,721	419.66	23,961	39.03
Chandigarh	18,356	10.74	3,372	3.60
Chhattisgarh	24,02,630	2,247.45	5,12,318	609.32
Dadra & Nagar Haveli and Daman & Diu	88,972	52.22	497	0.68
Goa	569	1.15	16	0.02
Gujarat	14,12,311	3,507.72	1,18,673	533.79
Haryana	4,99,210	589.24	54,979	79.54
Himachal Pradesh	1,16,747	139.41	40,106	52.71
Jammu and Kashmir	5,19,733	728.89	55,762	118.89
Jharkhand	12,32,790	1,178.03	71,969	226.72
Kerala	35,34,798	2,682.43	8,43,790	985.28
Ladakh	2,795	3.18	892	1.91
Lakshadweep	217	0.66	39	0.06
Madhya Pradesh	16,49,758	2,455.51	3,52,049	638.57
Manipur	68,829	82.79	7,562	9.95
Meghalaya	5,02,692	359.93	13,796	25.68
Mizoram	67,347	67.15	10,658	14.69
Nagaland	29,532	44.70	633	1.44
Puducherry	21,868	10.08	6,517	7.68
Punjab	11,56,514	1,267.20	1,20,901	184.92
Sikkim	7,092	5.33	1,152	1.53
Tripura	1,53,571	106.13	14,399	17.53
Uttar Pradesh	13,70,739	1,422.56	1,54,143	293.31
Uttarakhand	5,38,121	884.28	10,206	22.59
Andhra Pradesh	16,94,533	3,755.83	1,63,473	370.01
Karnataka	27,69,335	4,324.58	8,35,447	652.69
Tamil Nadu	80,86,471	4,445.42	1,47,696	108.46
Telangana	4,87,487	946.92	75,893	308.63
Maharashtra	26,45,888	5,954.86	1,74,902	454.28
Rajasthan	38,16,961	4,135.74	1,69,024	189.03
Grand Total	**3,57,74,194**	**42,433.57**	**40,22,922**	**6,052.43**

Source: NHA' reply in December 2022

Annexure-5.2

(Refer Para-5.1.3)

State-wise details on time taken (in hours) where claims took more than 12 hours in pre-authorization approval

	State (Hospital)	Max. time taken in Hours	Number of records
API	Andhra Pradesh	18,929	8,81,656
	Arunachal Pradesh	2,429	178
	Assam	5,553	33,460
	Karnataka	13,566	1,85,335
	Maharashtra	8,405	2,97,530
	Tamil Nadu	10,657	16,28,699
	Total	**18,929**	**30,26,858**
TMS	Andaman and Nicobar Islands	697	25
	Andhra Pradesh	224	23
	Arunachal Pradesh	99	4
	Assam	7,826	20,073
	Bihar	12,821	9,195
	Chandigarh	6,533	6,996
	Chhattisgarh	11,131	1,45,027
	Dadra and Nagar Haveli	3,205	3,283
	Daman and Diu	3,094	627
	Delhi	314	385
	Goa	623	111
	Gujarat	7,704	63,181
	Haryana	14,524	38,482
	Himachal Pradesh	11,329	3,928
	Jammu and Kashmir	8,534	53,602
	Jharkhand	15,240	90,383
	Karnataka	1,093	272
	Kerala	9,315	1,26,037
	Madhya Pradesh	11,513	1,46,580
	Maharashtra	5,782	3,325
	Manipur	6,838	1,174
	Meghalaya	6,719	5,261
	Mizoram	6,189	1,882
	Nagaland	4,369	1,176
	Odisha	50	5
	Puducherry	1,131	705
	Punjab	9,526	1,30,322
	Rajasthan	412	86

	State (Hospital)	Max. time taken in Hours	Number of records
	Sikkim	1,177	257
	Tamil Nadu	955	264
	Telangana	481	145
	Tripura	1,343	863
	Uttar Pradesh	15,407	68,460
	Uttarakhand	10,156	7,829
	West Bengal	216	46
	Total	**15,407**	**9,30,014**
Grand Total (NATION-WIDE)		**18,929**	**39,56,872**

Annexure-5.3

(Refer Para-5.8.2.7)

Admission of same patient in multiple distinct hospitals during same hospitalization period

State/UT	Cases	Patients Involved			Hospitals Involved
		Female	Male	Total	
Assam	1,869	380	584	964	52
Bihar	361	90	203	293	44
Chandigarh	46	7	23	30	8
Chhattisgarh	9,640	3,794	2,073	5,867	234
Dadra and Nagar Haveli	129	51	47	98	2
Daman And Diu	1	0	1	1	1
Goa	2	1	1	2	2
Gujarat	21,514	5,436	8,424	13,860	302
Haryana	2,667	620	801	1,421	134
Himachal Pradesh	96	31	57	88	18
Jammu and Kashmir	521	166	201	367	38
Jharkhand	1,942	652	673	1,325	148
Karnataka	4	0	2	2	1
Kerala	9,632	4,003	3,008	7,011	234
Madhya Pradesh	8,081	2,258	2,332	4,590	213
Maharashtra	247	52	56	108	23
Manipur	147	23	43	66	4
Meghalaya	3,506	1,977	497	2,474	43
Mizoram	104	34	47	81	9
Nagaland	167	23	43	66	8
Puducherry	29	4	9	13	2
Punjab	9,061	2,898	1,807	4,705	321
Sikkim	28	5	3	8	3
Tamil Nadu	15	2	7	9	2
Tripura	180	68	106	174	20
Uttar Pradesh	3,502	878	993	1,871	321
Uttarakhand	4,905	1,264	1,629	2,893	44
Grand Total	**78,396**	**24,717**	**23,670**	**48,387**	**2,231**

Annexure-5.4

(Refer Para-5.8.2.8)

Details of payment made with respect to patient who died in previous admission

(Amount in ₹)

State/UT	Number of claims	Number of patients	Amount paid	Maximum of pre-auth date of these claims
Andaman and Nicobar Islands	3	3	1,72,909	21-12-2020
Assam	15	15	1,71,978	08-04-2021
Bihar	59	56	5,55,291	06-05-2021
Chandigarh	2	2	45,100	04-12-2020
Chhattisgarh	404	365	33,70,985	19-04-2021
Dadra and Nagar Haveli	138	133	11,61,625	06-05-2021
Daman and Diu	22	20	1,02,900	05-02-2021
Gujarat	51	47	17,91,748	11-02-2021
Haryana	406	354	54,00,995	09-06-2021
Himachal Pradesh	23	21	2,62,540	04-05-2021
Jammu and Kashmir	59	48	10,96,909	28-06-2021
Jharkhand	323	250	30,37,440	23-06-2021
Kerala	1,022	966	2,60,09,723	03-07-2021
Madhya Pradesh	447	403	1,12,69,664	08-07-2021
Manipur	15	15	2,60,853	26-06-2021
Meghalaya	140	127	12,05,034	01-07-2021
Mizoram	38	34	3,41,420	30-03-2021
Nagaland	38	8	1,68,590	19-06-2020
Punjab	265	207	47,90,424	08-07-2021
Sikkim	5	4	22,830	08-09-2020
Tripura	43	42	1,31,580	26-04-2021
Uttar Pradesh	201	183	20,79,978	05-07-2021
Uttarakhand	184	143	62,45,614	10-07-2021
Grand Total	**3,903**	**3,446**	**6,96,96,130**	

Annexure-5.5

(Refer Para-5.8.2.9)

List of hospitals where patients admitted at any given point of time during January 2020, exceeded its bed strength

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
Private	Bihar	Dropadi Netralaya Private Limited	23-01-2021	9	19
		Sarvdrishti Eye Hospital Private Limited	22-01-2021	5	12
	Chhattisgarh	Aashary Multispeciality Hospital	25-01-2021	25	29
		Ganga Nursing Home	22-01-2021	10	12
		Nayak Maternity And Surgical Centre	12-03-2021	10	42
		NKH Multi Speciality Hospital And Trauma Centre	15-03-2021	30	34
		Prabha Hospital And Trauma Centre	09-03-2021	15	17
		Prabha Nursing Home	22-01-2021	20	26
		RSM Hospital	23-03-2021	20	31
		Shivamrita Hospital	13-01-2021	10	14
		Shri Sankalp Chhattisgarh Mission Hospital	30-03-2021	45	65
		Someshwar Hospital	08-02-2021	10	14
	Gujarat	Agaman Dialysis Centre	03-03-2021	9	79
		Apollo Cbcc Cancer Care A Unit Of Apollo Amrish Oncology Service Pvt. Ltd.	06-03-2021	55	240
		Arpan Hospital	19-03-2021	25	64
		Avishkar Dialysis Centre, Himatnagar	06-03-2021	5	23
		Ba Smt Lilaben Chimanlal Parikh Cancer Centre	30-03-2021	25	131
		Bankers Heart & Multispeciality Hospital	02-02-2021	70	75
		Bharat Cancer Hospital & Research Institute	20-03-2021	100	161
		Charotar Multispeciality Hospital	12-03-2021	30	33
		Dharmanandan Orthopaedic Hospital	26-02-2021	25	26
		Divyam Hospital	31-03-2021	15	23
		Hcg Hospitals Bhavnagar	17-02-2021	100	126
		Health And Care Foundation	02-02-2021	46	53
		Himalaya Cancer Hospital & Research Centre	24-02-2021	50	190

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
		Jamnagar Critical Care Centre Pvt. Ltd.	23-03-2021	25	44
		Kameshwar Medical Centre	27-03-2021	6	10
		Karuna Trust	15-02-2021	10	47
		Kejal Life In Multiispeciiality Hospital	09-03-2021	50	57
		Kidney Health	27-02-2021	10	31
		Kidney Health Maninagar	30-03-2021	10	40
		Kiran Multi Super Specialty Hospital & Research Centre	27-03-2021	549	628
		Krishna Dialysis Centre	22-02-2021	10	35
		L & T Health And Dialysis Centre	24-03-2021	8	20
		L&T Health & Dialysis Centre	25-01-2021	8	40
		Lions City Charitable Trust Medical Centre	11-03-2021	5	18
		LNM Group Lions Hospital & Research Centre	25-02-2021	40	108
		Madhuri Dialysis and Research Centre	09-03-2021	6	26
		Maheshwari Dialysis Centre	18-03-2021	13	51
		Manav Seva Sangh Sanchalit Jivan Jyot Diagnostic and Health Centre	09-02-2021	12	54
		Mavani Kidney Care	19-03-2021	6	30
		Medico Multispeciality Hospital Pvt Ltd	08-03-2021	34	97
		Medipolis Life Care Llp	22-03-2021	52	71
		N.M Virani Wockhardt Hospital, Rajkot	06-03-2021	168	200
		Neuro1 Stroke And Critical Care Institute	26-02-2021	26	37
		Prathana Critical Care Hospital	05-02-2021	10	31
		Rajkot Cancer Society and Allied Hospitals	12-03-2021	160	283
		Renus Kidney Hospital	19-03-2021	6	40
		Saboo Kidney Care	27-02-2021	27	77
		Satasia Surgical Hospital	25-03-2021	10	12
		Shaleen Healthcare Private Limited	04-03-2021	38	202
		Shankus Hospitals	23-03-2021	65	397
		Shree Anandabava Kidny Dialisis Centar	04-03-2021	15	34
		Shree Sainath Charitable Trust Dharampur	31-03-2021	5	39

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
		Shri Devarajbhai Bavabhai Tejani Cancer Institue. Managed By Lions Cancer Detection Centre Trust	18-03-2021	50	104
		Shri Dhirajlal Tokarshi Kapadia Dialysis Centre	19-03-2021	11	49
		Smitaben V. Shah Dialysis Center Managed By Sadvichar Parivar Godhra	23-03-2021	35	65
		Star Hospital	04-03-2021	65	105
		Sterling Cancer Hospital	25-02-2021	72	216
		Sterling Hospital	18-03-2021	190	297
		Sterling Ramkrishna Speciality Hospital	10-03-2021	150	255
		Upasna Kidney Hospital	04-03-2021	40	143
	Haryana	Ahooja Eye And Dental Institute	19-03-2021	16	18
		Centre For Sight Faridabad	27-03-2021	5	7
		Prabha Eye Hospital	01-03-2021	5	13
		Rama Superspeciality and Critical Care Hospital	21-01-2021	35	43
		Saraswati Eye Care Centre	12-03-2021	8	20
	Himachal Pradesh	Eshan Eye Hospital	21-01-2021	5	6
	Jammu and Kashmir	Well Care Dialysis Centre	30-03-2021	10	35
	Jharkhand	Advanced Diagnostic Centre	22-03-2021	16	24
		City Hospital	25-01-2021	10	27
		Crest Care Hospital	21-02-2021	12	22
		Curie Abdur Razzaque Ansari Cancer Institute	18-03-2021	100	112
		Dubey Nursing Home	11-03-2021	15	20
		Durga Nursing Home	07-02-2021	10	12
		Durgamani Arogyam Clinic & Nursing Home	05-02-2021	20	21
		Gurukripa Nursing Home	06-03-2021	10	11
		Hopewell Hospital	24-03-2021	19	22
		J P Hospital & Research Centre	02-03-2021	24	45
		Jharkhand Seba Sadan Nursing Home & Diagnostic Centre	20-02-2021	25	28
		Kamal Eye Clinic	09-02-2021	10	18
		Kidney Care Centre	27-03-2021	12	55
		Life Hospital	03-02-2021	20	27
		Lok Nayak Jayprakash Eye Hospital	17-03-2021	44	45

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
		Maa Jagdambey Prabhu Sewa	20-03-2021	15	18
		Madhuri Nursing Home	24-03-2021	30	32
		Mahalaxmi Nursing Home	19-03-2021	15	20
		Manglam Netralaya	29-01-2021	10	12
		Meditrina Hospital	12-03-2021	58	128
		Mundhra Hospital Pvt Ltd	27-03-2021	27	51
		Navjeewan Hospital	12-01-2021	20	24
		New Udhwa Nursing Home	19-01-2021	23	26
		Nucare	05-02-2021	15	19
		Om Nursing Home	21-01-2021	20	28
		Parwati Clinic and Research Centre	31-03-2021	20	32
		Patlawati Sewa Sadan	07-03-2021	15	22
		Prakash Eye Care	10-02-2021	10	17
		Purnima Netralaya	08-03-2021	10	34
			18-03-2021	35	60
		Rainbow Children Nursing Home	15-03-2021	15	29
		Reno Plus Dialysis Unit	18-03-2021	10	15
		Rjsp Cancer Hospital & Research And Rehabilitation Centre	01-03-2021	30	51
		Rnb Hospital And Pal Eye Research Center	06-03-2021	20	38
		Sabitri Nursing Home	15-03-2021	15	16
		Sai Poly Clinic Nursing Home	25-01-2021	21	23
		Sanjeevani Seva Sadan	07-03-2021	20	23
		Savitri Devi Memorial Charitable Trust	20-03-2021	30	103
		Shambhavi Centre For Cancer And Gynaecology	17-02-2021	17	29
		Shiva Nursing Home	17-03-2021	25	48
		Shree Vishwanath Nursing Home	10-03-2021	40	84
		Shreshtha Netra Chikitsalaya	27-01-2021	11	49
		Shri Lilawati Hospital	18-01-2021	15	21
		Shrinivas Hospital	25-02-2021	30	37
		Sudhir Hospital	09-02-2021	20	21
		Sunita Eye Hospital	16-01-2021	10	13
		The Raza Hospital	11-01-2021	10	17
		Vishal Sewa Sadan and Research Center	08-01-2021	14	20
	Kerala	Anithara Hospital	22-03-2021	30	41
		Iqraa Hospital Sulthan Barhery	15-01-2021	60	65

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
		Mother Care And Health Centre Private Limited	26-03-2021	100	126
		Thanal Karuna Dialysis Centre	27-02-2021	10	15
	Madhya Pradesh	Aarogya Nidhi Hospital	27-02-2021	30	36
		All Is Well Multi Speciality Hospital	03-03-2021	100	102
		Anantshree Hospital	11-01-2021	25	28
		Asha Cancer Care	11-03-2021	50	52
		Asha Hospital	13-03-2021	20	25
		Bhopal Test Tube Baby Centre	26-02-2021	10	17
		Care Multi Speciality Hospital	14-01-2021	20	40
		Deepshikha Hospital	04-03-2021	21	22
		Guru Ashish Hospital	30-03-2021	30	43
		Indian Institute of Head and Neck Oncology Indore Cancer Foundation Charitable Trust	31-03-2021	30	48
		Jawaharlal Nehru Cancer Hospital and Research Centre	20-03-2021	100	233
		Kishnani Hospital	24-02-2021	15	23
		Leelawati Memorial Hospital	10-03-2021	20	46
		Navodaya Cancer Hospital	12-03-2021	35	48
		Ra Stone & Surgical Care	19-01-2021	15	34
		Rajdeep Hospital	24-02-2021	25	44
		Rana Uday Hospital Sehore	27-02-2021	30	49
		Retina Eye Hospital	26-02-2021	10	11
		Sai Hospital	21-01-2021	30	32
		Samadhan Fracture Hospital	23-02-2021	10	11
		Sanjeevani Multispeciality Hospital	20-01-2021	15	18
		Shree Shubh Hospital	06-03-2021	20	33
		Vandana Hospital And Trauma Centre	31-03-2021	25	29
		Vidhata Multispeciality Hospital	22-03-2021	30	40
	Maharashtra	Reliance Hospital A Unit Of Mandke Foundation	22-03-2021	10	22
	Punjab	Arora Eye Hospital & Retina Centre	25-03-2021	10	17
		Behgal Institute of IT and Radiation Technology and Behgal Hospital	05-03-2021	35	36
		Gurunanak Multispeciality Hospital	19-03-2021	15	16

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
		Mittal Hospital And Heart Centre	19-01-2021	18	46
		PMG Children Hospital	13-01-2021	25	28
		Punjab Cancer Care and Multi-Specialty Hospital	15-03-2021	25	27
		Punjab Eye Hospital	22-03-2021	10	14
		Rajan Clinic & Hospital	24-03-2021	10	16
		Sahara Multispeciality Hospital	20-03-2021	20	37
		Sanjivini New Born & Child Care Hospital	10-02-2021	20	36
		Sethi Children Hospital	22-01-2021	10	34
		Shivratan Children Hospital	09-01-2021	10	16
		Ujala Charitable Children Hospital	10-03-2021	18	29
		Vijay Kids Superspeciality Hospital	07-02-2021	20	24
		Vikram New Born Children Hospital And Gagan Maternity Home	12-01-2021	27	33
	Uttar Pradesh	Amethi Hospital Conducted By Amethi Charitable Evam Medical Sansthan	27-02-2021	10	30
		Aryavart Eye Hospital And Research Centre	11-03-2021	5	9
		Balaji Eye Care	14-03-2021	5	10
		Chauhan Chikitshalay	21-03-2021	20	53
		Eye Life Centre	21-01-2021	5	8
		Eyenova Hospital	18-03-2021	10	78
		Focus Multispeciality Centre Llp	10-02-2021	10	26
		Garima Hospital	09-02-2021	30	64
		Gupta Hospital And Eye Care Centre	05-02-2021	10	29
		Hindustan Child Hospital	19-01-2021	50	54
		Mata Javitri Devi Charitable Hospital Tundla	04-03-2021	5	7
		Mustafa Hospital	10-02-2021	20	29
		Nav Jeevan Jyoti Hospital Pvt Ltd.	26-02-2021	20	31
		Paarth Eye Hospital And Retina Centre	17-01-2021	5	6
		S S Hospital And Sargical Center Pachphenava	08-01-2021	15	16
		Shreya Hospital	21-02-2021	10	13
		Umedha Eye Hospital	03-02-2021	10	11
	Uttarakhand	Arihant Advance Surgery & Fertility Center Dehradun	20-01-2021	20	26

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
		Drishti Centre For Advanced Eye Care	28-02-2021	5	8
		Medicare Hospital	23-02-2021	19	21
		Rahi Care Pvt Ltd	25-03-2021	12	49
		Sanjeevani Multispeciality Hospital A Unit Of Avinova Lifesciences Private Limited	03-03-2021	30	40
Public	Assam	Dr. Borooah Cancer Institute	18-03-2021	279	414
	Chhattisgarh	PHC Anandgaon	23-02-2021	5	6
		PHC Chhindnar	25-02-2021	6	11
		PHC Gudheli	17-02-2021	6	9
		PHC Kongud	27-03-2021	6	13
		PHC Lachhanpur	18-01-2021	6	9
		PHC Mirtur	15-01-2021	10	23
		PHC Ilmidi	18-02-2021	10	17
		PHC Nawanagar	22-02-2021	5	10
		UPHC Changorabhata	07-03-2021	6	8
		UPHC Heerapur	12-01-2021	5	6
		UPHC Ramnagar	05-02-2021	5	7
	Gujarat	PHC Chitrasani	22-03-2021	6	48
	Jharkhand	CHC Bhawnathpur	22-01-2021	10	13
		CHC Kuru	17-02-2021	10	15
		District Hospital Khunti	25-02-2021	60	67
		District Hospital Ramgarh	09-02-2021	60	104
		Sadar Hospital	03-03-2021	100	106
			05-03-2021	200	336
		Sadar Hospital Latehar	01-03-2021	30	34
	Kerala	Malabar Cancer Centre Thalassery	08-03-2021	203	228
		Regional Cancer Centre	19-02-2021	600	1,887
	Madhya Pradesh	Government Cancer Hospital	31-03-2021	108	129
	Punjab	CHC Ahmedgarh	02-03-2021	30	45
		CHC Banga	19-02-2021	30	50
		CHC Bhawanigarh	25-02-2021	30	33
		CHC Bhunga	16-03-2021	20	34
		CHC Dhanaula	25-03-2021	30	31
		CHC Kairon	13-03-2021	4	18
		CHC c Kalomazra	30-01-2021	6	9
		CHC c Khiala Kalan	16-03-2021	30	31
		CHC Kurali	09-02-2021	30	32
		CHC Nihal Singh Wala	08-03-2021	30	36
		CHC Payal	28-03-2021	30	44
		CHC Tanda	24-02-2021	30	39

Type	State	Hospital	Example Date	Bed Strength	Occupancy on date
		CHC Tripari	12-02-2021	20	27
		Sdh Balachour	20-03-2021	30	46
		Tata Memorial Centre	15-03-2021	81	150
	Tripura	Uptakhali Primary Health Centre	31-01-2021	6	7
	Uttar Pradesh	CHC Huzoorpur	12-02-2021	30	37
		CHC Saifai	15-02-2021	2	4

Annexure-5.6

(Refer Para-5.8.2.11)

State-wise details of claims/patients who availed their second and onward treatment without biometric authentication

(₹ in crore)

State/UT	Claims	Claims without biometric authentication	Claims of Aadhaar Authenticated patients	Patients	Patients without biometric authentication	Aadhaar Authenticated patients	Amount paid	Amount paid without biometric authentication	Amount of claims of Aadhaar Authenticated patients
Andaman and Nicobar Islands	206	106	69	81	40	26	0.14	0.08	0.06
Arunachal Pradesh	20	20	5	6	6	1			0.00
Assam	64,874	64,873	185	10,638	10,637	36	40.97	40.97	₹ 0.20
Bihar	76,858	38,276	24,052	15,704	8,358	4,803	33.46	17.99	10.50
Chandigarh	8,750	2,665	2,329	611	379	307	2.33	1.26	1.02
Chhattisgarh	6,12,862	6,03,378	3,65,637	2,08,754	2,03,624	1,32,339	240.30	234.86	138.11
Dadra and Nagar Haveli	29,639	24,968	20,858	4,384	3,770	2,812	10.97	9.62	7.42
Daman and Diu	11,282	8,737	6,960	921	737	585	3.83	3.01	2.39
Goa	137	123	101	20	15	8	0.19	0.17	0.13
Gujarat	3,39,836	2,05,902	1,16,607	85,562	52,715	36,307	150.28	93.91	50.54
Haryana	1,41,529	25,915	22,497	31,028	6,903	6,195	74.32	16.21	14.37
Himachal Pradesh	38,574	33,979	24,780	12,201	11,084	8,485	30.26	28.47	20.97
Jammu and Kashmir	1,22,190	1,21,175	74,588	11,540	11,223	8,876	35.52	35.11	23.34

State/UT	Claims	Claims without biometric authentication	Claims of Aadhaar Authenticated patients	Patients	Patients without biometric authentication	Aadhaar Authenticated patients	Amount paid	Amount paid without biometric authentication	Amount of claims of Aadhaar Authenticated patients
Jharkhand	2,92,924	1,26,032	93,663.00	85,183	37,727	25,596.00	143.28Cr	60.29	41.91
Karnataka	52	47	26.00	36	35	17.00	0.02Cr	0.02	0.01
Kerala	15,62,760	15,14,458	12,31,835.00	2,12,704	2,01,790	1,48,714.00	482.37Cr	472.64	360.84
Madhya Pradesh	3,66,083	2,66,706	2,00,818.00	75,918	54,950	44,432.00	232.85Cr	160.70	126.03
Maharashtra	1,754	1,365	892.00	270	179	127.00		0.00	0.00
Manipur	23,881	23,451	15,687.00	2,351	2,269	1,561.00	15.86	15.63	10.41
Meghalaya	1,15,025	1,14,930	1,108.00	45,411	45,359	538.00	68.98	68.93	0.65
Mizoram	20,885	20,560	6,811.00	6,794	6,656	2,359.00	19.89	19.24	6.98
Nagaland	9,549	7,748	3,944.00	2,038	1,579	786.00	8.99	6.25	3.28
Puducherry	4,599	3,822	1,859.00	158	139	80.00	0.55	0.46	0.21
Punjab	3,57,508	2,43,468	1,44,842.00	79,241	56,798	40,517.00	208.25	146.80	100.62
Sikkim	2,313	2,299	1,334.00	298	287	142.00	0.74	0.72	0.38
Tamil Nadu	81	70	22.00	20	19	5.00	0.05	0.05	0.03
Tripura	32,113	30,664	24,412.00	16,347	15,069	11,962.00	15.69	14.94	11.73
Uttar Pradesh	3,42,978	3,05,161	2,12,798.00	73,586	63,387	47,013.00	148.57	129.99	92.51
Uttarakhand	1,66,688	1,59,920	1,41,526.00	25,961	24,448	21,350.00	103.35	100.33	87.36
Grand Total	**47,45,950**	**39,50,818**	**27,40,245.00**	**10,07,766**	**8,20,182**	**5,45,979.00**	**2,072.03**	**1,678.68**	**1,111.98**

Annexure-5.7

(Refer Para-5.9.1)

Payment on disabled cards

(Amount in ₹)

State/UT	Count of claims	Claim Paid Amount
Punjab	756	53,50,388
Haryana	114	8,49,369
Chhattisgarh	48	3,01,520
Madhya Pradesh	11	1,34,080
Jammu And Kashmir	49	1,15,500
Kerala	13	84,423
Uttar Pradesh	21	76,260
Meghalaya	15	73,785
Jharkhand	4	64,680
Bihar	2	36,300
Nagaland	3	18,315
Uttarakhand	28	16,980
Tripura	3	14,450
Dadra and Nagar Haveli	1	9,000
Himachal Pradesh	1	2,200
Gujarat	7	--
Chandigarh	4	--
Assam	1	--
Grand Total	**1,081**	**71,47,250**

Payment on rejected cards

(Amount in ₹)

State	Count of claims paid after rejection date	Count of Claims Paid	Claim Paid Amount
Punjab	233	189	20,42,285
Chhattisgarh	101	77	9,55,460
Madhya Pradesh	61	53	7,16,745
Nagaland	16	16	3,51,180
Jharkhand	63	56	3,39,212
Assam	24	18	3,12,702
Uttar Pradesh	7	4	2,96,723
Bihar	40	30	2,83,500
Jammu & Kashmir	25	12	1,51,365
Kerala	10	6	80,700
Haryana	2	1	1,500
Gujarat	8	0	0
Grand Total	**590**	**462**	**55,31,372**

Annexure-5.8

(Refer Para-5.9.2)

State-wise responses of trigger alerts

States-SAFU	Fraud	Inconclusive	Not Fraud	Pending	Under Investigation	Grand Total
Andaman and Nicobar Islands						
Triggers	42		828	201	216	1,287
Cards	14		258	67	66	405
Arunachal Pradesh						
Triggers				1,356		1,356
Cards				396		396
Assam						
Triggers	12		8,418	6,360	1,941	16,731
Cards	4		2,543	1,341	625	4,513
Bihar						
Triggers	15,792		1,029	15,900	699	33,420
Cards	5,195		340	5,270	233	11,038
Chandigarh						
Triggers	132		1,365	1,020		2,517
Cards	44		455	339		838
Chhattisgarh						
Triggers	19,911		76,380	55,866	7,086	1,59,243
Cards	5,948		25,217	18,226	2,284	51,675
Dadra and Nagar Haveli						
Triggers	3,936		68,466	9,372	1,182	82,956
Cards	1,241		22,752	3,124	389	27,506
Daman And Diu						
Triggers	1,503		1,872	3,696	357	7,428
Cards	500		622	1,225	119	2,466
Goa						
Triggers	30	153	1,173	87		1,443
Cards	10	51	391	29		481
Gujarat						
Triggers	4,29,960	2,31,447	58,344	24,660	20,163	7,64,574
Cards	1,36,220	77,149	19,438	8,209	6,690	2,47,706
Haryana						
Triggers	19,338		33,675	34,647		87,660
Cards	6,445		11,225	11,537		29,207
Himachal Pradesh						
Triggers	22,776		53,022	37,248		1,13,046
Cards	7,210		17,618	8,888		33,716
Jammu and Kashmir						

States-SAFU	Fraud	Inconclusive	Not Fraud	Pending	Under Investigation	Grand Total
Triggers	48,879		6,261	62,616	3	1,17,759
Cards	16,124		2,087	20,577	1	38,789
Jharkhand						
Triggers	1,05,987		47,655	11,574		1,65,216
Cards	34,897		15,883	3,852		54,632
Karnataka						
Triggers				3		3
Cards				1		1
Kerala						
Triggers	2,841		27,381	53,547	50,811	1,34,580
Cards	809		9,027	17,356	16,834	44,026
Lakshadweep						
Triggers				3		3
Cards				1		1
Madhya Pradesh						
Triggers	1,27,998			1,02,516		2,30,514
Cards	42,436			33,714		76,150
Maharashtra						
Triggers	1,01,259		23,856	27,729	4,635	1,57,479
Cards	33,616		7,893	9,231	1,544	52,284
Manipur						
Triggers	1,647	3	12,600	3,783	18	18,051
Cards	543	1	4,196	1,261	6	6,007
Meghalaya						
Triggers	55,881		12,867	2,03,085	12	2,71,845
Cards	18,502		4,289	67,169	4	89,964
Mizoram						
Triggers	6,225		35,427	1,311		42,963
Cards	1,924		11,809	407		14,140
NA						
Triggers				15		15
Cards				5		5
Nagaland						
Triggers	63,879		50,505	21,012	3	1,35,399
Cards	21,060		16,783	6,982	1	44,826
Puducherry						
Triggers	2,082		19,848	783		22,713
Cards	630		6,616	211		7,457
Punjab						
Triggers	1,07,703	21	18,777	30,450		1,56,951
Cards	32,548	7	6,257	9,832		48,644
Sikkim						
Triggers			465	3,780	33	4,278
Cards			155	1,259	10	1,424

States-SAFU	Fraud	Inconclusive	Not Fraud	Pending	Under Investigation	Grand Total
Tamil Nadu						
Triggers	3			3		6
Cards	1			1		2
Tripura						
Triggers	14,052		20,808	3,516		38,376
Cards	4,633		6,934	1,154		12,721
Uttar Pradesh						
Triggers	1,21,323	846	42	2,86,038		4,08,249
Cards	40,222	282	14	82,504		1,23,022
Uttarakhand						
Triggers	78,108		210	56,862		1,35,180
Cards	25,935		70	18,869		44,874
Total Triggers	**13,51,299**	**2,32,470**	**5,81,274**	**10,59,039**	**87,159**	**33,11,241**
Total Cards	**4,36,711**	**77,490**	**1,92,872**	**3,33,037**	**28,806**	**10,68,916**

Annexure-6.1

(Refer Para-6.2)

Release of Premium (Grant-in-Aid)

Insurance Mode

A flat premium per family, irrespective of the number of members under Ayushman Bharat National Health Protection Mission (ABNHPM) in that family, will be determined through open tendering process.

The State Government/Union Territories shall upfront release their respective share of premium for the eligible beneficiary families considered for the implementation of AB-NHPM into a separate designated escrow account opened for this purpose, from where it shall be paid to the Insurance Company on a per family basis. Upon releasing of States'/UT's share, the States/UTs shall send the proposal to the Central Government for release of respective Central Government's Share of Premium along with the prescribed documents.

(i) First instalment of Premium for all States and UTs:

The Insurer, upon the issue of policy, shall raise an invoice for the first instalment of the Premium payable for the Beneficiary Family Units that are targeted or identified by the SHA. Thereupon, the State/UT shall upfront release 45 *per cent* of their respective share *viz.* (out of 10 *per cent*/ 40 *per cent*) of premium within 15 working days from the receipt of invoice from insurance company, depending upon category of State/UT based on the number of eligible families that have been targeted/identified by the SHA and the data for whom has been shared with Insurance Company along with their respective administrative expense share into a separate designated escrow account opened by the States/UTs for the implementation of AB-NHPM.

Thereafter, within 15 working days from the release of their respective share, the State/UT shall raise the proposal for release of proportionate share of Central Government's Share of Premium along with the proposal, documentary proof for release of State's/UT's Share of Premium and requisite documentary evidences & compliance of applicable financial provisions. The Central Government will release 45 *per cent* of its respective share depending upon category of State/UT based on the number of eligible families that have been targeted/ identified by the SHA within 21 working days from the receipt of duly completed proposal from the State/UT.

However, in case of Union Territories without legislation, where the Central Government has to bear 100 *per cent* premium, the Central Government shall pay 45 *per cent* of its respective share of premium (*viz.* out of 100 *per cent*) through the designated escrow account into the designated Escrow Account of the State/UT within 21 working days from the receipt of duly completed proposal (including and not limited to all information/clarifications demanded by Central Government).

Thereafter, upon the receipt of Central Government's Share of Premium, the State/UT shall release the aforesaid instalment of premium within seven working days through the designated Escrow Account to the Insurance Company under intimation to the Central Government.

(ii) Second instalment for all States and UTs:

The Insurer upon the completion of 2nd quarter shall raise an invoice for the second instalment of the Premium payable for the Beneficiary Family Units for which first instalment was released earlier. The State/UT (with Legislature), within 15 working days upon the receipt of invoice from the insurance company, shall release their 2nd instalment of premium i.e., 45 *per cent* of their respective share *viz.* (out of 10 *per cent*/40 *per cent*) into the designated escrow account. Thereafter, within 15 working days from the release of their respective share, the State/UT shall raise the proposal for release of proportionate share of Central Government's Share of Premium along with the proposal, documentary proof for release of State's/UT's Share of Premium (Grant-in-Aid) and requisite documentary evidences & compliance of applicable financial provisions. The Central Government will release 45 *per cent* of its respective share depending upon category of State/UT based on the number of eligible families that have been targeted/identified by the SHA within 21 working days from the receipt of duly completed proposal from the State/UT.

Thereupon, the receipt of Central Government's Share of Premium, the State/UT shall release the second instalment of premium within 7 working days through the designated Escrow Account to the Insurance Company under intimation to the Central Government.

(iii) Third Instalment for all States and UTs

Upon completion of 10 Months of Policy, the Insurer shall submit the Claim Settlement Report along with the invoice for the last instalment of the Premium payable for the Beneficiary Family Units for which the first and second instalment was released earlier. The State/UT (with Legislative) Government shall, upon receipt of the Claim Settlement report from the Insurance Company/Real Time Data available with States/UTs and upon due satisfaction of permissible claim settlement ratio, release the remaining due premium of 10 *per cent* or demand for the refund of premium from the insurance company or release the proportionate States/UTs Share of premium based upon the claim settlement scenario, as the case may be, within 15 working days into the escrow account. Thereupon, within 15 working days of their release of premium, shall raise the proposal to the Central Government for the release of 10 *per cent* of Premium or the proportionate premium based upon the claim settlement scenario, as the case may be into the escrow account as last tranche of premium to the Insurance Company.

The Central Government will release the due proportionate respective share of premium depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA within 21 working days from the receipt of duly completed proposal from the State/UT.

Thereafter, upon the receipt of Central Government's Share of Premium, the State/UT shall release the last instalment of premium within seven working days through the designated Escrow Account to the Insurance Company under intimation to the Central Government.

Trust Mode

The process of funds release shall be as follows:

The State/UT shall upfront release its share, depending upon category of State/UT along with its administrative expense share into the separate designated escrow account of SHA opened by the States/UTs for implementation of AB-PMJAY.

The Central Government shall then release its share of grant-in-aid through the designated escrow account of NHA into the designated Escrow Accounts of the SHA of respective State/ UT within 21 working days from the receipt of duly completed proposal from the State Government.

Thereafter, upon receipt of Central Government's Share of Grant-in-Aid, the State/UT shall release the aforesaid instalment of premium within seven working days from the SHA Escrow Account to the Insurance Company.

In 1st Year:

The first tranche of grant-in-aid of 50 *per cent* out of the annual maximum ceiling of Central Government's Share of Grant-in-Aid, shall be released as advance through Escrow Account for the total targeted beneficiary families as per the SECC Database or the number of beneficiary families mapped with the SECC Database, as the case may be. The second tranche of 25 *per cent* will be also be paid as advance by the end of second quarter, subject to the submission of documentary proof of utilization of at least 75 *per cent* of the earlier released first instalment to the SHA. Further, the last tranche of grant-in-aid as full and final release shall be made upon receipt of the Utilization Certificate of the earlier released tranches in the last quarter and actual amount of certified expenditure incurred by the States/UT.

For 2nd Year and onwards:

The first tranche of grant-in-aid of 50 *per cent*, out of the total Central Government's Share of Grant-in-Aid, shall be released as advance through Escrow Account based upon the actual total actual expenditure incurred in the previous year towards the treatment of ABNHPM Beneficiary Families, subject to the maximum annual permissible ceiling decided by Government of India, whichever is less, as the case may be. The second tranche of 25 *per cent* will be also be paid as advance by the end of second quarter, subject to the submission of documentary proof of utilisation of at least 75 *per cent* of the earlier released first instalment to the SHA. Further, the last tranche of grant-in-aid as full and final release shall be made upon receipt of the Utilization Certificate of the earlier released tranches in the last quarter.

Annexure-6.2

(Refer Para-6.2.2)

State/UT-wise and mode-wise release of grants to States/UTs

(₹ in crore)

Sl. No.	State/UT	Mode of Implementation	2018-19		2019-20		2020-21	
			Imp	Admin	Imp	Admin	Imp	Admin
1.	Andaman & Nicobar Islands	Trust	0.10	0.05	0.00	0.41	0.14	0.13
2.	Andhra Pradesh	Trust	174.55	8.30	357.47	16.59	248.99	12.24
3.	Arunachal Pradesh	Trust	2.10	0.20	0.00	0.00	0.00	0.67
4.	Assam	Trust	15.00	6.08	126.03	7.21	11.36	0.75
5.	Bihar	Trust	71.93	16.34	78.07	4.42	0.00	0.00
6.	Chandigarh	Trust	0.50	0.18	3.28	0.53	1.84	0.00
7.	Chhattisgarh	Trust	211.84	5.59	274.78	5.59	112.62	0.00
8.	Dadra and Nagar Haveli	Insurance	3.09	0.16	1.69	0.34	3.17	0.00
9.	Daman and Diu	Insurance	0.96	0.05	0.00	0.00	1.07	0.00
10.	Goa	Trust	0.58	0.06	0.00	0.06	0.00	0.49
11.	Gujarat	Mixed	70.78	6.73	212.33	0.00	90.53	9.31
12.	Haryana	Trust	24.49	2.33	53.51	5.17	68.89	3.04
13.	Himachal Pradesh	Trust	16.56	0.62	19.12	0.00	30.44	2.48
14.	Jammu & Kashmir	Insurance	19.26	1.38	28.88	4.56	22.70	0.00
15.	Jharkhand	Mixed	165.96	4.21	126.50	0.00	100.32	0.00
16.	Karnataka	Trust	150.00	9.31	241.48	12.65	145.72	15.13
17.	Kerala	Trust	25.00	0.00	97.56	0.00	138.11	7.50
18.	Ladakh	Insurance	0.00	0.00	0.00	0.00	1.12	0.50
19.	Lakshadweep	Trust	0.00	0.004	0.00	0.00	0.00	0.00
20.	Madhya Pradesh	Trust	60.00	12.57	118.46	0.00	150.37	14.43
21.	Maharashtra	Mixed	253.77	12.55	241.88	0.00	376.65	0.00
22.	Manipur	Trust	6.56	0.62	14.24	2.87	11.45	0.00
23.	Meghalaya	Insurance	14.78	0.78	18.07	0.00	47.64	1.88
24.	Mizoram	Trust	16.60	0.88	10.36	2.06	14.44	0.54
25.	Nagaland	Insurance	4.20	0.52	9.32	1.57	12.27	0.00
26.	Puducherry	Trust	1.21	0.31	0.00	0.00	1.23	0.00
27.	Punjab	Insurance	0.00	2.24	47.90	7.65	46.85	0.00
28.	Rajasthan	Insurance	0.00	0.00	200.07	0.00	251.71	6.60
29.	Sikkim	Trust	0.94	0.09	0.00	0.09	1.51	0.34

Sl. No.	State/UT	Mode of Implementation	2018-19		2019-20		2020-21	
			Imp	Admin	Imp	Admin	Imp	Admin
30.	Tamil Nadu	Mixed	293.32	11.66	441.77	0.00	359.81	0.00
31.	Tripura	Trust	11.70	1.11	15.10	5.08	8.98	0.00
32.	Uttar Pradesh	Trust	67.30	17.71	129.80	17.69	150.00	17.63
33.	Uttarakhand	Trust	10.12	2.42	23.44	7.29	40.52	0.00
34.	West Bengal	Not Implementing	30.45	0.83	0.00	0.00	0.00	0.00
Grand Total			**1723.66**	**125.89**	**2891.12**	**101.83**	**2450.45**	**93.67**

(Note: Imp = Implementation, Admin = Administrative)

Annexure-6.3

(Refer Para-6.5)

Diversion of grants by SHAs

(₹ in crore)

Sl. No.	State/UT	Year	Funds diverted from	Funds diverted to	Amount	Remarks
1.	Dadra and Nagar Haveli and daman and Diu	2019-20	PMJAY Administrative	PMJAY Implementation	0.09	Insurance premium of ₹ 0.09 crore (UT share of DNH) paid from Administration a/c.
2.	Himachal Pradesh	2018-19	Implementation	Administrative	1.55	For administrative expenses.
		2018-21	PMJAY administrative grant	State Health Scheme (HIMCARE)	0.64	Payment made to outsourced staff working for State Health Scheme charged to PMJAY.
		2018-21	PMJAY administrative grant	State Health Scheme (HIMCARE)	0.66	
3.	Jharkhand	NA	Implementation (for payment of claims to hospitals)	Payment of premium to NIC	29.60	Grant released by NHA for payment of claims to hospital was diverted towards payment of premium to NIC.
4.	Nagaland	2018-19	PMJAY administrative grant	PMJAY implementation	0.47	State share (1st instalment) of ₹ 46.62 lakh for the policy period ending 22-09-2019 paid from administrative cost released by NHA due to delay in release of State share.
5.	Rajasthan	2019-21	PMJAY administrative grant	Old State Health Scheme (BSBY)	1.56	Expenditure incurred on IEC activities for old State Health Scheme (BSBY) was charged to PMJAY.
6.	Tamil Nadu	2018-19	PMJAY administrative grant	GoTN account	11.61	₹11.61 crore was remitted to GoTN account in two instalment *viz.* ₹ 7.43 crore on

Sl. No.	State/UT	Year	Funds diverted from	Funds diverted to	Amount	Remarks
						30/7/2019 and ₹ 4.18 crore on 16/3/2020.
		2018-19	PMJAY administrative grant	Jt. Director of Health Services of 32 Distt.	4.22	The amount was returned by SHA to Administrative account after one year i.e., on 29.01.2020.
7.	Uttarakhand	2018-19	PMJAY implementation	PMJAY administrative	0.21	For meeting administrative cost.
Total					**50.61**	

Annexure-6.4

(Refer Para-6.6)

Administrative Grants lying unspent with States/UTs

(₹ in crore)

Sl. No.	State/UT	Funds available[$]			Funds utilized (expenditure)			Amount of unspent balance (*percentage*/% w.r.t. funds available)		
		2018-19	2019-20	2020-21	2018-19	2019-20	2020-21	2018-19	2019-20	2020-21
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9 (3-6)**	**10 (4-7)**	**11 (5-8)**
1.	Andaman & Nicobar Islands	0.05	0.46	0.38	0	0.22	0.32	0.05 (100)	0.24 (52)	0.06 (16)
2.	Assam	6.08	10.99	5.24	3.10	7.18	2.23	2.98 (49)	3.81 (35)	3.01 (57)
3.	Bihar	16.34	32.19	17.29	2.40	14.90	14.17	13.94 (85)	17.29 (54)	3.12 (18)
4.	Chandigarh	0.18	0.71	0.57	0	0.14	0.25	0.18 (100)	0.57 (80)	0.32 (56)
5.	Dadra & Nagar Haveli	0.16	0.50	0.33	0	0.17	0.32	0.16 (100)	0.33 (66)	0.01
6.	Daman & Diu	0.05	0.05	0.02	0	0.03	0	0.05 (100)	0.02 (40)	0.02 (100)
7.	Himachal Pradesh	2.25	1.22	3.20	1.03	1.22	1.36	1.22 (54)	0	1.84 (58)
8.	Jammu & Kashmir	1.65	7.10	6.00	0.43	1.54	2.11	1.22 (74)	5.56 (78)	3.89 (65)
9.	Kerala	1.00	1.00	14.50	0	0	3.19	1.00 (100)	1.00 (100)	11.31 (78)
10.	Ladakh	0	0	0.50	0	0	0.09	0	0	0.41 (82)
11.	Madhya Pradesh	30.57	26.90	35.01	3.67	6.32	8.62	26.90 (88)	20.58 (77)	26.39 (75)
12.	Manipur	0.69	3.48	3.17	0.47	0.82	0.54	0.22 (32)	2.66 (76)	2.63 (83)
13.	Meghalaya	18.75	38.36	45.11	1.02	2.27	2.11	17.73 (95)	36.09 (94)	43.00 (95)
14.	Puducherry	0.31	0.19	0.50	0.30	0.19	0.11	0.01	0	0.39 (78)
15.	Punjab	2.24	12.52	12.76	0.04	1.81	2.83	2.20 (98)	10.71 (86)	9.93 (78)
16.	Rajasthan	0	1.42	11.71	0	1.42	8.40	0	0	3.31 (28)
17.	Tamil Nadu	11.65	0	0	0.05	0	0	11.60 (99)	0	0
18.	Tripura	0	5.89	4.31	0	1.58	1.73	0	4.31 (73)	2.58 (60)
19.	Uttar Pradesh	29.50	46.41	48.05	12.39	27.99	22.00	17.11 (58)	18.62 (40)	26.05 (54)
20.	Uttarakhand	2.69	11.54	6.35	0.28	5.20	4.95	2.41 (90)	6.34 (55)	1.40 (22)
Total								**98.98**	**128.13**	**139.67**

([$] Note: Funds available = Central share + State share + last year's closing balance)

Annexure-6.5

(Refer Para-6.7)

Interest earned by SHAs

(₹ in lakh)

Sl. No.	State/UT	Amount of interest			Total	Remarks
		2018-19	2019-20	2020-21		
1.	Andaman & Nicobar Islands	0.08	0.65	0.31	1.04	--
2.	Bihar				927.18	On RSBY funds Year-wise break up not available in State Audit Report
3.	Chandigarh	0.30	0.58	1.59	2.47	--
4.	Jammu & Kashmir	2.27	2.99	3.12	8.38	--
5.	Jharkhand				52.85	From September 2018 to November 2021
6.	Madhya Pradesh	62.05	194.72	138.04	394.81 (-) 257.00 137.81	Out of total interest of ₹ 3.95 crore, ₹ 2.57 crore transferred to NHA
7.	Puducherry				5.87	Since inception till March 2021
8.	Rajasthan	0	0	499.07	499.07	Interest on grant received during 2020-21
9.	Tamil Nadu	0	456.00	96.00	552.00	₹ 4.56 crore and ₹ 0.96 crore on implementation and administration a/c respectively.
10.	Uttarakhand				29.94	NHA share of interest since inception till March 2021
Total					**2216.61**	

Annexure-6.6

(Refer Para-6.8)

Formula for calculation of Claim Settlement Ratio

Guidelines related to release of premium provide that the Insurer will be required to refund premium if they fail to reach the claim ratio specified in comparison with the premium paid (excluding GST & Other taxes/Duties) in the full period of insurance policy period. The premium refund shall be as per the formula elaborated below:

The claim ratio defined with respect to AB-PMJAY will be total pre-authorization approved amount minus rejected and disallowed claims amount divided by total premium payable to insurer in percentage. Total *premium payable = Premium rate per family * number of families* covered. Both the numerator and denominator shall be for the same period of the insurance policy. All Pre-auth with date of admission in the policy period will be accounted.

a. The SHA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 24/36 months of Policy Cover Period (depending on renewal for third year) for the State/UT. In the letter, the SHA shall indicate the amount of premium that the Insurer shall be obliged to refund. The amount of premium to be refunded shall be calculated based on the provisions as mentioned below.

b. After adjusting a defined percent for expenses of management (including all costs excluding only service tax and any cess, if applicable) and after settling all claims, if there is surplus: 100 *percent* of leftover surplus should be refunded by the Insurer to the SHA within 30 days. The percentage that will be needed to be refunded will be as per the following:

- In category A States:
    - i. Administrative cost allowed 10 *per cent* if claim ratio less than 60 *per cent*.
    - ii. Administrative cost allowed 15 *per cent* if claim ratio between 60-70 *per cent*.
    - iii. Administrative cost allowed 20 *per cent* if claim ratio between 70-80 *per cent*.
- In Category B States:
    - i. Administrative cost allowed 10 *per cent* if claim ratio less than 60 *per cent*.
    - ii. Administrative cost allowed 12 *per cent* if claim ratio between 60-70 *per cent*.
    - iii. Administrative cost allowed 15 *per cent* if claim ratio between 70-85 *per cent*.

c. The entire surplus as determined through formula mentioned above should be refunded by the insurer to the SHA within 30 days.

d. If the Insurer delays payment of or fails to pay the refund amount within 30 days from the date of communication by SHA, then the Insurer shall be liable to pay interest at the rate

of one percent of the refund amount payable to the SHA for every 7 days of delay beyond such 30 days period.

e. If the Insurer fails to refund the Premium within such 90-day period and/or the default interest thereon, the SHA shall be entitled to recover such amount as a debt due from the Insurer through legal remedial procedures.

Category A States/ UTs	**Arunachal Pradesh, Goa, Himachal Pradesh, Jammu & Kashmir, Manipur, Meghalaya, Mizoram, Nagaland, NCT Delhi, Sikkim, Tripura, Uttarakhand and six Union Territories (Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Puducherry)**
Category B States/UTs	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal

Annexure-6.7

(Refer Para-6.8)

Non-refund of premium by insurance companies

(₹ in crore)

Sl. No.	State/UT	Name of IC	Policy period	Amount of claim due for recovery from IC	Amount of claim recovered	Remaining recoverable amount
1.	Gujarat	Oriental Insurance Co. Ltd.	01.10.2018 to 30.09.2019	2.12	0	2.12
			01.10.2019 to 30.09.2020	52.83	0	52.83
2.	Jammu and Kashmir	Bajaj Allianz General Insurance Company Ltd.	01.12.2018 to 30.11.2019	17.80	16.85	0.95
3.	Ladakh	Bajaj Allianz General Insurance Company Ltd.	01.03.2020 to 25.12.2020	0.55[4]	0	0.55
4.	Maharashtra	National Insurance Co. Ltd	Till March 2020	214.00	0	214.00
		United India Insurance Co.	April 2020 onwards	265.86	193.55	72.31
5.	Meghalaya	Reliance Gen. Insurance Co.	01.02.2019 to 31.01.2020	36.12	31.51	4.61
6.	Tamil Nadu	United India Insurance Co Ltd.	11.01.2018 to 10.01.2021	110.82	0	110.82[5]
Total				**700.10**	**241.91**	**458.19**

[4] ₹ 0.50 crore (insurance premium) + ₹ 0.05 crore (penal interest) = ₹ 0.55 crore

[5] ₹ 66.49 crore (60 *per cent* NHA portion) + ₹ 44.33 crore (40 *per cent* SHA portion) = ₹ 110.82 crore

Annexure-6.8

(Refer Para-6.10)

Release of grants to SHAs without obtaining audited statements of accounts

(₹ in crore)

Sl. No.	Name of State/UT	No. of UCs received	Year	Amount of grant released		Total	Whether UCs Signed by Head of SHA (Yes/No)
				GIA-Imp	GIA-Admn.		
1.	Andaman and Nicobar Islands	6	2018-19	0.10	0.05	0.15	Yes
			2019-20	0	0.41	0.41	
			2020-21	0.14	0.13	0.27	
2.	Assam	23	2018-19	15	6.08	21.08	Yes
			2019-20	126.03	7.21	133.24	
			2020-21	11.36	0.75	12.11	
3.	Bihar	6	2018-19	71.93	16.34	88.27	Yes
			2019-20	78.07	4.42	82.49	
			2020-21	0	0	0	
4.	Chandigarh	13	2018-19	0.50	0.18	0.68	Yes
			2019-20	3.28	0.53	3.81	
			2020-21	1.84	0	1.84	
5.	Chhattisgarh	15	2018-19	211.84	5.59	217.43	No
			2019-20	274.78	5.59	280.37	
			2020-21	112.62	0	112.62	
6.	Dadra and Nagar Haveli	18	2018-19	3.09	0.16	3.25	Yes
			2019-20	1.69	0.34	2.03	
			2020-21	3.17	0	3.17	
7.	Goa	13	2018-19	0.58	0.60	1.18	Yes
			2019-20	0	0.06	0.06	
			2020-21	0	0.49	0.49	
8.	Gujarat	15	2018-19	70.78	6.73	77.51	No
			2019-20	212.33	0	212.33	
			2020-21	90.53	9.31	99.84	
9.	Jammu and Kashmir	23	2018-19	19.26	1.38	20.64	No
			2019-20	28.88	4.56	33.44	
			2020-21	22.70	0	22.70	
10.	Jharkhand	2	2018-19	165.96	4.21	170.17	No
			2019-20	126.50	0	126.50	
			2020-21	100.32	0	100.32	
11.	Karnataka	1	2018-19	150.00	9.31	159.31	Yes
			2019-20	241.48	12.65	254.13	
			2020-21	145.72	15.13	160.85	
12.	Ladakh	1	2018-19	0	0	0	Yes
			2019-20	0	0	0	
			2020-21	1.12	0.50	1.62	
13.	Manipur	34	2018-19	6.56	0.62	7.18	Yes
			2019-20	14.24	2.87	17.11	
			2020-21	11.45	0	11.45	

Sl. No.	Name of State/UT	No. of UCs received	Year	Amount of grant released		Total	Whether UCs Signed by Head of SHA (Yes/No)
				GIA-Imp	GIA-Admn.		
14.	Puducherry	4	2018-19	1.21	0.31	1.52	Yes
			2019-20	0	0	0	
			2020-21	1.23	0	1.23	
15.	Punjab	11	2018-19	0	2.24	2.24	No (Some UCs signed by CA)
			2019-20	47.90	7.65	55.55	
			2020-21	46.85	0	46.85	
16.	Rajasthan	8	2018-19	0	0	0	No
			2019-20	200.07	0	200.07	
			2020-21	251.71	6.60	258.31	
17.	Sikkim	13	2018-19	0.94	0.09	1.03	Yes
			2019-20	0	0.09	0.09	
			2020-21	1.51	0.34	1.85	
18.	Tamil Nadu	6	2018-19	293.32	11.66	304.98	No
			2019-20	441.77	0	441.77	
			2020-21	359.81	0	359.81	
Total		**212**		**3970.17**	**145.18**	**4115.35**	

Annexure-6.9

(Refer Para-6.10)

Detail of inaccurate/inflated UCs furnished to NHA by SHAs

(₹ in crore)

Sl. No.	State/UT	Head of a/c under which grant received	Period	Amount of UC required to be furnished to NHA	Amount of UC furnished to NHA	UC Inflated by
1	**2**	**3**	**4**	**5**	**6**	**7 (6-5)**
1.	Himachal Pradesh	Implementation	2018-19	2.74	15.67	12.93
2.	Jammu & Kashmir	Implementation	2018-19	21.40	22.30	0.90
			2019-20	32.09	33.71	1.62
		Administrative	2018-19	0.43	1.58	1.15
			2019-20	1.54	5.66	4.12
3.	Madhya Pradesh	Implementation	2019-20	123.57	124.03	0.46
		Administrative	2019-20	1.75	1.85	0.10
			2020-21	4.04	5.85	1.81
4.	Rajasthan	Administrative	2020-21	0.04	0.08	0.04
5.	Tamil Nadu	Administrative	2018-19	0.04	11.65	11.61
6.	Uttarakhand	Implementation	2020-21	3.04	6.36	3.32
		Administrative	2020-21	0.97	1.15	0.18
Total				**191.65**	**229.89**	**38.24**

Annexure-7.1

(Refer Para-7.3.1)

Shortfall in deployed manpower against the sanctioned strength in SHAs

Sl. No.	Name of State/UT	Name of unit	Sanction strength	Men in position	Shortage	Shortfall in per centage
1.	Andaman & Nicobar Islands	SHA	4	1	3	75
2.	Andhra Pradesh	Field unit	230	178	52	22
3.	Assam	Atal Amrit Abhiyan Society	51	15	36	70
4.	Bihar	SHA	183	81	102	56
5.	Chhattisgarh	SNA	81	56	25	31
6.	Dadra & Nagar Haveli and Daman & Diu	SHA	7	3	4	57
7.	Gujarat	SHA	80	41	39	49
8.	Haryana	SHA	279	178	101	36
9.	Jammu & Kashmir	SHA	17	8	9	53
10.	Karnataka	SHA	287	216	71	25
11.	Madhya Pradesh	SHA	78	38	40	51
12.	Manipur	SHA	17	6	11	65
13.	Punjab	SHA	29	11	18	62
14.	Rajasthan	SHA	12	10	2	17
15.	Tripura	SHA	13	11	2	15
16.	Uttarakhand	SHA	74	38	36	49
17.	Uttar Pradesh	SHA	87	51	36	41

Annexure-7.2

(Refer Para-7.11)

Minimum sample for audit by ISA and SHA for each type of audit

Sl. No.	Audit Type	Sample for Insurer/TPA audit	Sample for SHA audit
1	Medical audit	Five *per cent* of total cases hospitalized	*Two per cent* direct audit + two *per cent* of audits done by Insurer/TPA/ISA
2	Death audit	100 *per cent*	100 *per cent*
3	Hospital audit	Each empanelled hospital at least twice each year	Each empanelled hospital at least twice each year
4	Beneficiary audit (during hospitalization)	10 *per cent* of total cases hospitalized	*Five per cent* direct audit + 10 *per cent* of audits done by Insurer/TPA/ISA
5	Beneficiary audit (post discharge – through telephone)	10 *per cent* of total cases hospitalized	*Five per cent* direct audit + 10 *per cent* of audits done by Insurer/TPA/ISA
6	Beneficiary audit (post discharge – through home visit)	*Five per cent* of total cases hospitalized	*Two per cent* direct audit + 2 *per cent* of audits done by Insurer/TPA/ISA
7	Pre-authorization audit	10 *per cent* of total Pre-authorization across disease specialties	*Two per cent* of audits done by Insurer/TPA/ISA (for insurance mode), 10 *per cent* of audits done by Insurer/TPA/ISA (for Assurance mode)
8	Claims audit (approved claims)	10 *per cent* of total claims	*Three per cent* of audits done by Insurer/TPA/ISA (for insurance mode) 10 *per cent* of audits done by the TPA/ISA (for Assurance mode)
9	Claims audit (rejected claims)	-	100 *per cent*

Glossary of Terms and Abbreviations

AB	Ayushman Bharat
ABNHPM	Ayushman Bharat National Health Protection Mission
ADCD	Additional Data Drive Collection
AI	Artificial Intelligence
API	Application Program Interface
ASA	Authentication Service Agency
ASCI	Advertising Standards Council of India
ASHA	Accredited social health activist
AUA	Authentication User Agency
BI	Business intelligence
BIS	Beneficiary Identification System
CAG	Comptroller & Auditor General of India
CEO	Chief Executive Officer
CEX	Claims Executive
CGRMS	Central Grievance Redressal Management System
CHC	Community Health Centres
CPD	Claims Panel Doctor
CPHC	Comprehensive Primary Health Care
CR	Call Recording
CSC	Common Service Centre
DARPG	Department of Administrative Reforms and Public Grievances
DEC	District Empanelment Committee
DHR	Department of Health Research
DIU	District Implementing Unit
DPG	Directorate of Public Grievances
DWH	Data Warehouse
EHCP	Empanelled Health Care Provider
eKYC	Electronic know your customer
FACTS	Fraud Analytical Control and Tracking System
GCC	Government Community Cloud
HBP	Health Benefit Package
HEM	Hospital Empanelment Module
HFM	Health & Family Welfare Minister
HH	House Hold
HHID	Household identification number

HIS	Hospital Information System
HR	Human Resources
HWC	Health and Wellness Centres
IEC	Information, Education & Communication
IHDS	Indian Human Development Survey
IRDAI	Insurance Regulatory and Development Authority of India
ISA	Implementation Support Agency
IT	Information Technology
IVR	Interactive Voice Response
KYC	Know Your customer
LAMA/DAMA	Leave Against Medical Advice/Discharge Against Medical Advice
MEDCO	Medical Coordinator at the hospital
MoHFW	Ministry of Health and Family Welfare
MoRD	Ministry of Rural Development
MoSDE	Ministry for Skill Development & Entrepreneurship
MoU	Memorandum of Understanding
MP	Members of Parliament
NABH	National Accreditation Board for Hospitals & Healthcare Providers
NAFU/SAFU	National Anti-Fraud Unit/State Anti-Fraud Unit
NCD	Non-communicable disease
NCG	National Cancer Grid
NDHM	National Digital Health Mission
NHA	National Health Authority
NHCP	National Health Claims Platform
NHPM	National Health Protection Mission
NHRR	National Health Resource Repository
NHS	National Health Services
NIA	National Innovation Accelerator
NICE	National Institute for Clinical Excellence
NIN	National Identification Number
NPPA	National Pharmaceutical Pricing Authority
NSDC	National Skill Development Corporation
NSSO	National Sample Survey Office
OCR	Optical character recognition/reader
OOPE	Out of Pocket Expenditure
PHC	Primary Health Centre
PII	Personally Identifiable Information
PMAM	Pradhan Mantri Arogya Mitra

PM-JAY	Pradhan Mantri Jan Arogya Yojana
PMO	Prime Minister Office
PMRSSM	Pradhan Mantri Rashtriya Swasthya Suraksha Mission
PPD	Pre-authorization Panel Doctor
PR	Public Relation
PSU	Public Sector Undertaking
QCI	Quality Council of India
RADAR	Risk Assessment, Detection and Analytical Reporting
RSBY	Rashtriya Swasthya Bima Yojana (National Health Insurance Programme)
SC	Sub Centre
SC	Schedule Caste
SCHIS	Senior Citizens Health Insurance Scheme
SDG	Sustainable Development Goals
SEC	State Empanelment Committee
SECC	Socio-Economic Caste Census
SHA	State Health Authority
SI	System Integrator
SMS	Short Message Service
ST	Schedule Tribe
TAT	Turn-around time
TMS	Transaction Management System
TPA	Third Party Administrator
UHC	Universal Health Coverage
UHID	Universal Health Identifier
UIDAI	Unique Identification Authority of India
URN	Unique Request Number
UT	Union Territory
VLE	Village Level Entrepreneur
WHO	World Health Organization

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