ANTI-FRAUD GUIDELINES

Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY)

National Health Agency
Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
(PMJAY)

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National Health Agency
Ministry of Health and Family Welfare
Government of India

Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana endeavours to offer health coverage of Rs. 5,00,000 to more than 10 crore beneficiary families, that is more than 40 percent of the country's population. This unprecedented effort of the Government of India is likely to have a significant impact on the poor and vulnerable population's access to secondary and tertiary hospital care.

Global experience shows that integrity violations in health insurance programmes are high. Fraud in such programmes not only result in financial losses but have a much greater impact on people's health. The ultimate responsibility to effectively prevent, detect, and deter fraud lies with the State Health Agencies (SHA). Strong anti-fraud efforts are important not only from the perspective of reducing the adverse impact on scheme finances and for safeguarding beneficiary health but also to mitigate any reputational risk faced by the SHA, state and the scheme resulting from fraud.

Hence, SHA's anti-fraud efforts are key for ensuring effective implementation of PMJAY and it is critical that a "zero tolerance" approach to fraud be internalized and permeate all aspects of management of the scheme.

With this spirit, the National Health Agency is sharing the National Anti-Fraud Guidelines for the PMJAY and look forward to feedback from stakeholders for strengthening this. We sincerely hope that state governments participating in PMJAY will use these guidelines to strengthen the governance and management of PMJAY in their respective states.

Dr. Indu Bhushan
Chief Executive Officer

Acronyms

AF	Anti-fraud
CEO	Chief Executive Officer
CRC	Claims Review Committee
CVO	Chief Vigilance Officer
DVO	District Vigilance Officer
FIR	First Information Report
HFS	High Focus State
ICU	Intensive Care Unit
IEC	Information, Education, and Communication
ISA	Implementation Support Agency
IT	Information Technology
LOS	Length of Stay
M&E	Monitoring and Evaluation
MMRC	Mortality and Morbidity Review Committee
NE	North Eastern States
NHA	National Health Agency
OPD	Out Patient Department
PMAM	Pradhan Mantri Arogya Mitra
PMJAY	Pradhan Mantri Jan Arogya Yojana
SHA	State Health Agency
SMS	Short Message Service
SOP	Standard Operating Procedure
TPA	Third Party Administrator
UT	Union Territories

ANTI-FRAUD GUIDELINES

Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY)

Section 1. Purpose and Scope

1.1 **Anti-Fraud Guidelines** for the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY) is aimed at assisting state governments in designing and managing a robust anti-fraud system in PMJAY.

1.2 The scope of Anti-Fraud Guidelines cover 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-authorisation
Detection	- Claims management - Monitoring - Audits
Deterrence	- Contract management - Enforcement of contractual provisions

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

1.4 For the purpose of the Anti-Fraud Guidelines, State Health Agency or the SHA means and refers to the agency or a unit set up by the state government to administer PMJAY in a state, irrespective of whether such entity is registered as a Society or a Trust or is a cell/unit/division within the Health Department of the state government.

Section 2. Health Insurance Fraud under the PMJAY

2.1 Principles

2.1.1 Any form of fraud under PMJAY is a violation of patients' right to health and misuse of public resources.

2.1.2 PMJAY is governed based on a zero-tolerance approach to any kind of fraud and aims at developing an anti-fraud culture that permeates all aspects of the scheme's governance. The approach to anti-fraud efforts shall be based on five founding principles: *Transparency*, *Accountability*, *Responsibility*, *Independence,* and *Reasonability*.

Understanding the terms:

i. *Transparency* shall mean public disclosure in decision making and in disclosing information as necessary in relation to PMJAY fraud.
ii. *Accountability* shall mean clear functions, structures, systems, and accountability for services for effective management.
iii. *Responsibility* shall mean management's conformity or compliance with sound organizational principles for PMJAY anti-fraud efforts.
iv. *Independence* shall mean a condition where the SHA is managed professionally without conflict of interest and under no compulsion or pressure from any party.
v. *Reasonability* shall mean fair and equal treatment to fulfil stakeholders' rights arising from agreements in PMJAY anti-fraud efforts.

2.2 Definition of fraud under PMJAY:

2.2.1 Fraud under the PMJAY shall mean and include *any* ***intentional deception, manipulation of facts and / or documents or misrepresentation made by a person or organization with the knowledge that the deception could result in unauthorized financial or other benefit to herself/himself or some other person or organisation. It includes any act that may constitute fraud under any applicable law in India***.

2.2.2 In addition to the above, any act (indicative list below) that is recognised by different provisions of the Indian Penal Code as *fraud* shall be deemed to be *fraud* under the PMJAY:

a. Impersonation
b. Counterfeiting
c. Misappropriation
d. Criminal breach of trust
e. Cheating
f. Forgery
g. Falsification
h. Concealment

Indian Contract Act 1972, Section 17:

"Fraud" means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agent, with intent to deceive another party thereto of his agent, or to induce him to enter into the contract:

1. the suggestion, as a fact, of that which is not true, by one who does not believe it to be true;
2. the active concealment of a fact by one having knowledge or belief of the fact;
3. a promise made without any intention of performing it;
4. any other act fitted to deceive;
5. any such act or omission as the law specially declares to be fraudulent.

2.2.3 Human errors and waste are not included in the definition of fraud[1].

[1] '**Errors**' are un-intention mistakes during the process of healthcare delivery (like prescribing wrong medications to a patient). '**Waste**' refers to unintentional inadvertent use of resources (prescribing high cost medicines when generic versions are available). '**Abuse**' refers to those provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the PMJAY, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the PMJAY. Whereas **fraud** is wilful and deliberate, involves financial gain, is done under false pretence and is illegal, **abuse** generally fails to meet one or more of these criteria. The main purpose of both fraud and abuse is financial and non-financial gain. Few examples of common health insurance abuse would be - excessive diagnostic tests, extended length of stay and conversion of day procedure to overnight admission.

2.3 Types of fraud under PMJAY and who may conduct fraud

Fraud under PMJAY may be conducted by either a beneficiary, a payer or a provider. Each type of fraud is described in the table below and illustrative examples for each type of fraud are listed in Annex 1.

Fraud type	Description
Beneficiary fraud	Fraud conducted by an eligible beneficiary of PMJAY or an individual impersonating as a beneficiary.
Payer fraud	Fraud conducted by a staff or consultant of NHA or SHA or personnel employed by any of the agencies contracted by the NHA or the SHA directly or indirectly involved with PMJAY. This could include but is not limited to Insurance Companies, Third Party Administrators, Implementation Support Agencies, IT solutions provider, and management, monitoring or audit agencies.
Provider fraud	Fraud conducted by any private or public health service provider empanelled for providing services under PMJAY.

Section 3. Responsibilities of National and State Health Agencies

3.1 Responsibilities of the National Health Agency

3.1.1 **Develop anti-fraud framework, guidelines and policies:** The NHA shall be responsible for developing national anti-fraud framework, policies, tools and guidelines to design and streamline anti-fraud efforts under the PMJAY. This responsibility shall include, among others:

a. Developing anti-fraud framework and guidelines which include this document and any other amendments or new guidelines that the NHA may issue from time to time;
b. Developing guidelines and standard operating procedures for different aspects of PMJAY such as beneficiary identification, provider empanelment, claims processing and management, monitoring and verification and audits.

3.1.2 **Provide broad oversight**: The NHA shall be responsible for providing broad oversight of PMJAY and for developing and implementing effective oversight plans to ensure that resources under PMJAY are used only for legitimate purposes. As part of this responsibility, the NHA shall:

a. Ensure that resources from all stakeholders are used as efficiently as possible to prevent and detect fraud and abuse;
b. Ensure that States have effective programme integrity systems in place, including the collection and validation of sufficient service delivery data to assess utilization and quality of care;
c. Develop effective communication framework for anti-fraud public messaging campaigns;
d. As required review current laws and regulations and develop legislative proposals to encourage appropriate statutes to support effective control of fraudulent activities;
e. Provide whistle blower mechanism for confidential reporting of fraud.

3.1.3 **Design IT infrastructure and protocols for advanced data analytics for fraud detection**: Specific tasks shall include but not be limited to:

a. Developing IT system design;
b. Integrating comprehensive list of fraud triggers into the IT system design;
c. Develop data standards and guidelines for data consolidation, mining and advanced analytics using predictive modelling, machine-learning models, regression techniques and social network analysis. Over a period of time, the NHA may integrate artificial intelligence and machine learning algorithms into the IT system for state-of-art fraud detection platform.

3.1.4 **Provide technical assistance to states**: The NHA shall provide need-based technical assistance to States in strengthening their anti-fraud efforts which may include but not be limited to:

a. Developing robust model contracts with fraud management clauses, punitive action and claw-back provisions;
b. Institutionalising effective internal control methods;
c. Developing specifications for IT-platform for the states;
d. Advanced data mining and analytics support including analysing inter-state anomalies;
e. Training on fraud management and programme integrity issues and, developing certification courses for district vigilance officers, field investigators, claim auditors;
f. Promote best practices through knowledge sharing;
g. Innovative techniques and mechanisms to stay ahead of perpetrators;
h. Sharing the list of suspect/black listed empanelled hospitals.

3.2 Responsibilities of the State Health Agency

3.2.1 **Develop institutional structures:** The SHA shall be responsible for developing institutional structures and operationalising them as per the guidelines set forth in Section 4 of the *NHA Anti-Fraud Guidelines*. It is recommended that appropriate government orders be issued by the State Governments to lend legitimacy to the structures and ensure that they are empowered to optimally perform their functions.

3.2.2 **Adapt and approve state anti-fraud policies and guidelines:** The SHA shall be responsible for adapting, wherever required, and adopting the NHA Anti-Fraud Guidelines to the implementation needs of PMJAY in their respective states. During adaptation the states may exercise freedom to align the provisions of these guidelines to their state-specific anti-fraud guidelines and/or practices, if they are already in place, while ensuring that the principles and the intent of the NHA Anti-Fraud Guidelines are not diluted in any manner and standard data sets are not tampered with.

3.2.3 **Recruit, deploy, train and manage anti-fraud human resources:** The SHA shall undertake the following tasks to ensure adequate human resource and capacity for anti-fraud efforts within the state:

a. Develop anti-fraud human resource plan on the lines indicated in Section 4 of the NHA Anti-Fraud Guidelines and seek appropriate approvals;
b. Ensure recruitment of required personnel as per the indicative skills and competencies set forth in Section 4;
c. Ensure training of all staff on PMJAY and on the state Anti-Fraud Guidelines.

3.2.4 **Develop IT system:** The SHA shall develop a state-specific IT platform which will include but not be limited to:

a. Transaction management software including claims management software that allows for submission, verification and approvals of pre-authorisations and claims;
b. Inter-operability to handle portability claims;
c. Develop comprehensive list of fraud triggers (see Annex 2) and embed the same in IT system, at relevant stages from beneficiary identification to payment and feedback;
d. Analyse data for trends, utilization patterns, outlier cases at individual level or for organised rackets/fraud rings;
e. Share data with the NHA for support in advanced fraud analytics.

However, SHAs shall have the flexibility to use the NHA IT platform if they so desire.

3.2.5 **Conduct anti-fraud awareness:**

a. Design and implement strategies for beneficiary awareness on possible episodes of fraud under the PMJAY. Awareness may include understanding types of fraud, its impact on beneficiaries, preventing measures that the beneficiaries could take and whom to report.
b. Beneficiary awareness on fraud may use mass media and interpersonal communication at the point of service. The Pradhan Mantri Arogya Mitras at the point of service could provide the beneficiaries a list of potential provider fraud along with the contact details for reporting episodes of fraud.
c. Design and implement strategies for medical community and provider awareness on what constitutes fraud under PMJAY, anti-fraud efforts under the PMJAY and implications of provider fraud and unethical practices.

3.2.6 **Develop and implement mechanisms for preventing and detecting all kinds of fraud under PMJAY including but not limited to beneficiary fraud, empanelment related fraud and claims related fraud.**

a. Adapt and adopt the NHA Anti-Fraud Guidelines including all other the relevant guidelines issued and amended by the NHA from time to time.
b. Ensure compliance to the guidelines approved by the state.

3.2.7 **Data analytics**

a. Set up mechanisms for data analytics for fraud detection. It essential for each state to have at least basic rule-based and outlier-based analytics and a comprehensive list of fraud triggers embedded within the IT system.
b. For advanced fraud-analytics, SHAs may seek the support of NHA.

3.2.8 **Contract design, management and enforcement:** The SHA shall be responsible for developing and managing contracts and providing oversight of all contracts issued by it. The contracts developed by the SHA shall have a clear definition of fraud, description and illustration of fraudulent practices, incentives and disincentives for anti-fraud efforts and the enforcement mechanisms. Contract management shall include monitoring of all contractual provisions and reporting obligations. The SHA shall develop compliance management tools and capacity to ensure time detection of gaps and implement corrective actions.

Contracted agencies of the SHA, like the Insurance Companies and TPAs / ISAs, shall set up their own anti-fraud units, develop their own fraud management systems and processes and deploy required personnel as a part of their contractual obligation to the SHA. This does not substitute the fraud management efforts and oversight responsibility of the SHA and it is recommended that SHAs set up their own fraud management systems as per these Anti-Fraud Guidelines.

Section 4. Institutional Arrangements for Anti-Fraud Efforts

4.1 Dedicated Anti-Fraud Cell at the national level

4.1.1 **Mandate and functions**: The NHA shall constitute a dedicated Anti-fraud cell (National Anti-Fraud Cell) at the national level. The mandate of the National Anti-Fraud Cell shall be to:

a. Provide leadership stewardship to the national anti-fraud efforts under PMJAY;
b. Develop, review and update the national anti-fraud framework and guidelines based on emerging trends;
c. Provide mentoring support to states in setting up and institutionalising the in-state anti-fraud efforts;
d. Capacity building of states on anti-fraud measures under PMJAY;
e. Liaise with the national IT team / agency to ensure that the IT platform is periodically updated with fraud triggers based on review of trends;
f. Liaise with the monitoring unit of the NHA for triangulating fraud related data analytics with the overall service utilisation trends emerging under PMJAY;
g. Provide evidence-based insights to states on trends emerging from state-specific fraud data analytics;
h. Handle all fraud related complaints that the NHA may receive directly and liaise with the states from any complaints specific to states as per Anti- Fraud Guidelines and Grievance Redressal Guidelines of PMJAY;
i. Take *Suo moto* action based on prima facie evidence as deemed appropriate;
j. Establish whistle blower mechanism, public disclosure guidelines, and other deterrent measures.

4.1.2 **Location and structure of the National Anti-Fraud cell**: The National Anti-Fraud Cell should:

a. Be an independent unit in the NHA reporting directly to the CEO of the NHA;
b. Be headed by an officer not less than the rank of Director in the Ministry of Health and Family Welfare, Government of India, who shall have the designation of Executive Director (Anti-Fraud Cell). If possible, it is recommended that the National Anti-Fraud Cell head may be an expert with background in medical forensics.
c. Have three senior officials as General Manager / Deputy General Manager for each of the following three disciplines: Medical, Data Analytics and Legal & Vigilance.
d. Have at least 6 full time anti-fraud officers under the Anti-Fraud Cell Head responsible for the following category of states:

State Category	States included	No. of full time anti-fraud officers
HFS (NE) *8 states*	Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura	1
HFS (non-NE) *10 states*	Bihar, Chhattisgarh, Himachal Pradesh, Jammu Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, Uttarakhand	2
Non-HFS (large) *11 states*	Andhra Pradesh, Goa, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana, West Bengal	2
Non-HFS (small & UTs) *7 states*	Andaman & Nicobar Islands, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, Delhi, Lakshadweep & Pondicherry	1

e. Alternately, NHA may deploy Anti-Fraud Officers based on geographical cluster of states preferably with not more than 5 large states assigned to each officer.
f. The 6 Anti-Fraud Officers should be selected to offer complementary skills sets and competencies (for example, medicine, data analytics, clinical audit, field investigation, legal, etc.) while having distinct state responsibilities.
g. Anti-Fraud Officers responsibilities may include but not be limited to:
    i. Assessing fraud management capacity needs of assigned states;
    ii. Liaising with the Anti-Fraud Cells in the SHAs and provide mentoring support;
    iii. State-specific fraud-episode profiling and analysis with the support of the IT team;
    iv. Develop evidence-based state-specific recommendations for strengthening state-level anti-fraud efforts;
    v. Visit states as required;
    vi. Provide recommendations for course-correction in the PMJAY design based on anti-fraud data analytics.

Refer to Annex 3 for organogram of the Anti-Fraud Cell in the NHA and indicative terms of reference for various positions.

4.2 Dedicated Anti-Fraud Cell in states

4.2.1 **Mandate and functions**: The SHA shall constitute a dedicated Anti-Fraud cell at the state level. The mandate of the Anti-Fraud Cell shall be to:

a. Provide stewardship to the state level anti-fraud efforts under PMJAY;
b. Develop, review and update the state anti-fraud framework and guidelines based on emerging trends for service utilisation and monitoring data;
c. Ensure that the state Anti-Fraud Guidelines are consistent with the national Anti-Fraud Guidelines issued by the NHA from to time;
d. Capacity building of the state PMJAY team on anti-fraud measures under PMJAY including field verification and investigations;
e. Liaise with the IT team / agency to ensure that the IT platform is periodically updated with fraud triggers based on review of trends;
f. Liaise with the monitoring unit of the SHA for triangulating fraud related data analytics with the overall service utilisation trends emerging under PMJAY;
g. Provide evidence-based insights to the SHA on trends emerging from state-specific fraud data analytics;

h. Handle all fraud related complaints that the SHA may receive and liaise with other departments of the SHA, specially the monitoring and the audits departments;
i. Take *Suo moto* action based on prima facie evidence as deemed appropriate;
j. Undertake fraud investigations as required, prepare investigation reports that can stand legal scrutiny if needed, file First Information Reports with the police as needed, navigate the legal system, pursue recovery and all other tasks related fraud investigation and follow up actions, including if required notice to treating doctors, etc.
k. Incentivising internal team/outsourced agency involved in fraud management based on performance;
l. Publish data on utilization, claim rejection, suspension, dis-empanelment, etc.

4.2.2 **Location and structure of the anti-fraud cell**: The state Anti-Fraud Cell should:

a. Be an independent unit in the SHA reporting directly to the CEO of the SHA;
b. Be headed by an officer not less than the rank of Director in the Department of Health and Family Welfare of the state government, who reports directly to the CEO of the SHA. If possible, it is recommended that the state Anti-Fraud Cell head may be headed an expert with background in medical forensics.
c. Recommended staffing pattern for the Anti-Fraud Cell under the Insurance, Assurance, and mixed (both insurance and assurance) modes:

	Insurance Mode	Assurance and Mixed Mode
State level Anti-Fraud staff		
Head	1	1
Officers	1	1 for every 10 districts
District & facility level staff		
District Vigilance & Investigation Officers	1 in each district	1 in each district
Pradhan Mantri Arogya Mitras (PMAM)	Minimum 1 PMAM to be available 24&7 in each empanelled provider	Minimum 1 PMAM to be available 24&7 in each empanelled provider

d. To avoid possibilities of collusion, it is recommended that the District Vigilance & Investigation Officers be directly recruited by the SHA.
e. To ensure adequate capacity and skills, it is recommended that all anti-fraud staff be recruited from among ex-servicemen.
f. To avoid collusion, if possible, the SHA should try and rotate Pradhan Mantri Arogya Mitras every 3-6 months preferably within the same city / town.

Refer to Annex 3 for organogram of the Anti-Fraud Cell in the SHA and indicative terms of reference for various positions.

4.3 Core competencies in the Anti-Fraud Cells

The Anti-Fraud Cell should have the following minimum core competencies and skills:

a. Legal skills
b. Case investigation skills
c. Claims processing
d. Medical specialist
e. Medical audit

f. Medical forensics

4.4 Other committees at the state

4.4.1 **Claims Review Committee (state level)**:

a. A Claims Review Committee (CRC) is recommended at the State level within the SHA.
b. Constitution of the CRC:
    i. The CRC may be headed by the Medical Management and Quality Manager of the SHA;
    ii. Other members may include a panel of experts from the insurance / TPA industry and medical specialists from apex government medical institutions and medical colleges.
c. Functions of the CRC:
    i. Review 100 percent claims that are rejected by the Insurer / TPA / ISA / SHA and appealed by the provider;
    ii. Randomly review / audit at least 2 percent of the pre-authorisations and 3 percent of the claims of each provider each quarter.

4.4.2 Mortality and Morbidity Review Committee (state level)

a. A Mortality and Morbidity Review Committee (MMRC) is recommended at the state level within the SHA.

b. Constitution of the MMRC:
    i. The MMRC may be headed by the Medical Management and Quality Manager of the SHA;
    ii. Other members may include medical specialists as required from apex government medical institutions and medical colleges.

c. Functions of the MMRC:
    i. The scope of MMRC review shall include assessment of line of treatment, review of medical and patient progress records, prescription practices and determine whether the treatment provided is in line with good clinical practices;
    ii. Review 100 percent of mortality claims;
    iii. Undertake fraud-trigger based review and audit of cases as recommended by the medical audit team or the claims processing team;
    iv. Review high value/complex surgical/uncommon procedure code claims.

4.5 Role of existing health department structures in strengthening anti-fraud oversight

4.5.1 It is important to integrate and institutionalise anti-fraud efforts within the state health department and health systems at the state and sub-state levels.

4.5.2 At the state level, each state may develop mechanisms for involving the Health Directorate in anti-fraud oversight.

4.5.3 A large number of states have administrative structures and set up at the regional / divisional level. Each divisional / regional unit is responsible for monitoring of health department operations in a cluster of districts. The feasibility of engaging these regional / divisional units in monitoring and anti-fraud oversight of PMJAY is recommended.

4.5.4 At the district level, existing governance and monitoring structures such as the District Health Societies or the Zilla Parishads (in states where the local self-government structures at the district level are strong), may be leveraged upon.

4.5.5 States that may have set up community-based monitoring mechanisms may consider leveraging upon such structures to Involve local communities for reporting unethical / fraudulent practices / behaviour.

4.6 Operations and management of the anti-fraud cell at the state level

4.6.1 **Nodal responsibility**: The Head of the Anti-Fraud Cell shall be the nodal person responsible for all anti-fraud efforts within the state.

4.6.2 **Annual plan and budget**: The Anti-Fraud Cell shall develop an annual anti-fraud response plan which may include but not be limited to:

a. Statement detailing detecting fraud cases with like the agency / individual committing fraud, type of fraud, time taken for detecting and proving the fraud, update on action-taken reports filed and pending and relevant other details;
b. Typology of fraud detected in the last financial year and disaggregation of cases by types of fraud;
c. Any new strategies that may need to be adopted based on the analysis of last year's fraud data;
d. Additional capacity need, if any;
e. Budget (all activities related to anti-fraud efforts as per the plan to be budgeted).

The anti-fraud action plan and budget needs to be approved by the Executive Committee or the Governing Board of the SHA and funds should be made available to the SHA.

4.6.3 **Review of anti-fraud efforts**: Apart from review meetings as and when required, the Anti-Fraud Cell shall ensure at least a quarterly structured anti-fraud meeting with the SHA management team. Alternately, anti-fraud efforts review could feature as a part of the ongoing review meetings of the SHA. All discussions and decisions thereof should be minuted and the head of the Anti-Fraud Cell shall ensure follow-up actions as per decisions taken.

Section 5. Guidelines for Anti-Fraud Measures

5.1 Guidelines for fraud prevention

5.1.1 **Develop anti-fraud policies and guidelines**: Based on the national Anti-Fraud Guidelines, it is recommended that the states develop their own anti-fraud framework and policies/ guidelines for PMJAY to account for the implementation-specificities of their respective states. The Governing Body of the SHA should approve the state Anti-Fraud Guidelines prior to implementing the PMJAY. The SHA should ensure that all staff are trained on the approved state Anti-Fraud Guidelines.

5.1.2 **Develop referral protocols for benefits that are more prone to fraud and abuse**. Procedures or certain benefits under PMJAY that are more prone to fraud may be either reserved only for empanelled public providers or can be availed only on referral from a public provider. The SHA should issue appropriate orders to this effect.

5.1.3 **Ensure that all contracts signed by the SHA with any party (Insurer, ISA, TPA, provider, IT agency, etc.) have adequate anti-fraud provisions that are enforceable.** The SHA should ensure that all model contracts available on PMJAY website that are adapted by the states have a clear definition of abuse and fraud, what constitutes abuse and fraud and what are their consequences. Liabilities of different parties concerned should be clearly spelt out in the contract. The SHA should ensure that the contracts have adequate disincentives and penalties for abuse and fraud.

5.1.4 **Preventing empanelment fraud:** The SHA shall ensure strict compliance to the NHA guidelines for empanelment of providers. In addition, to further reduce empanelment related fraud, the SHA may publish hospital-wise empanelment assessment scores on PMJAY website of the state to allow any third party to report false capacity representation made by any provider. Annual assessment / audit of all empanelled providers by an independent agency with relevant experience is recommended to ensure compliance to the minimum empanelment criteria. Extra caution should be exercised during initial and follow up providers assessments especially in those states that have provisions of awarding assessment grades and have differential grade-based tariff.

5.1.5 **Beneficiary identification / verification:** The SHA shall ensure strict compliance to NHA guidelines for beneficiary verification. For beneficiary fraud prevention, the Anti-Fraud Cell shall track the conversion of beneficiary records from 'silver' to 'gold', which indicates that the beneficiary details are verified. When a beneficiary reports to an empanelled provider for treatment, the Arogya Mitra enters the beneficiary details on the Beneficiary Identification System of the transaction software. After the beneficiary verification is complete, the record is inserted into the system as a 'Silver' record, which gets converted to 'Golden Record' after further verification and approval by the designated authorities. For further details, refer to the NHA guidelines on 'Arogya Mitras' and 'Guidelines on Process of Beneficiary Identification' available on the NHA website.

5.1.6 **Pre-authorisation**: The SHA shall ensure strict compliance to NHA guidelines for pre-authorisation. In addition, to further strengthen the efforts to pre-authorisation fraud, the SHA shall:

a. Develop detailed pre-authorisation protocols and automate the process including mandatory submissions into the claims management software as an automated workflow process;
b. Ensure SMS updates to beneficiaries on pre-authorisation decision and amount blocked procedure proposed to be carried out etc in local language and another SMS at the time of discharge;
c. Ensure auto-cancellation of pre-authorisation approvals if services are not sought and records are not updated on the transaction platform by the provider within 30 days of issuing the pre-authorisation.

5.1.7 **More important for states going through the Assurance mode**: Financial risks to the state government on account of fraud is significantly higher in assurance mode than in the Insurance mode, where the Insurer bears the risk and the outgo of the state government is limited to the premium paid. Therefore, it is recommended that the SHA, especially for states implementing PMJAY though the Assurance mode (even the states following the Insurance route may adopt these practice), may set up a separate committee(s) of senior government

staff for high-value pre-authorisation requests for different threshold levels (states may set up their own thresholds for high value pre-authorisation requests).

5.2 Guidelines for fraud detection

5.2.1 Claims management

a. The SHA shall ensure strict compliance to NHA guidelines for claims management.
b. Claim data analysis for early detection of fraud shall be conducted fortnightly by the Anti-Fraud Cell.
c. Such claim data analysis shall be conducted through the following approaches:
    i. Identifying data anomalies trigger based and rule-based analysis;
    ii. Advanced algorithms for fraud detection, predictive / regression based and machine learning models and other advanced data analytics reports received by the SHA from the NHA or as requested by the SHA to the NHA, provided the SHA makes all claims data available to the NHA for analysis.

d. In conducting claim data analysis, the Anti-Fraud Cell may coordinate with the medical audit team of the SHA, claims processors and adjudicators in the TPA / ISA or the CRC or the MMRC (refer to Section 4.4) and other parties as necessary.

5.2.2 Fraud detection during routine monitoring and verification: The key to an effective anti-fraud and abuse programme is to gather information on provider performance. The Anti-Fraud Cell within the SHA should combine the following techniques to detect fraud:

a. Data analysis comparing providers on such indices as utilization, performance, outcomes, referrals, disenrollment, followed by focused reviews on areas of aberrancy;
b. Routine reviews on particular problem areas;
c. Routine validation of provider data;
d. Random reviews and beneficiary interviews;
e. Unannounced site visits; and
f. Use of feedback and quality improvement.

5.2.3 **Comparative analysis:** The Anti-Fraud Cell may elect to perform a comparison of empanelled providers within districts or state-wide. Individual patterns of providers may not be significantly unusual but the cumulative pattern within a provider may require further review. It is recommended that the SHA's data systems be used to identify benefit utilization patterns that may assist in the case development and in the review.

5.2.4 **Routine reviews on problem areas:** As part of its fraud and abuse strategy, the Anti-Fraud Cell may identify areas of a focus that will receive special attention during routine monitoring of provider activities. These areas should be identified through systematic risk assessment, and could include, but not be limited to, items such as:

a. ensuring that providers within networks are eligible to participate in PMJAY;
b. ensuring that beneficiaries claimed as enrolled are in fact enrolled;
c. ensuring that provider employees understand PMJAY guidelines, can define fraud, and know where, how, and when to report it.

5.2.5 **Random reviews and beneficiary interviews:** The SHA should plan for a minimum level of random reviews, in which a selected universe of beneficiaries are contacted for interviews. Medical records should also be reviewed to identify any possible errors or evidence of abuse and/or fraud. All such reviews shall be as per the guidelines issued by the NHA from time to time.

5.2.6 **Unannounced site visits:** SHA monitoring plans should include unannounced provider visits, particularly to those providers for which some significant concerns exist. During unannounced provider visits, reviewers can observe encounters, interview beneficiaries or employees, confirm the accuracy of facility-based information, and/or review records.

5.2.7 **Use of feedback and quality improvement:** The results of reviews (including feedback from local communities, health workers) and investigations should be used to improve PMJAY implementation systems. The goal is to prevent the same fraud and abuse from recurring. This use of feedback is integral to PMJAY quality improvement.

5.2.8 Recommended minimum sample for audits:

Audit Type	Sample for Insurer / TPA audit	Sample for SHA audit
Medical audit	5% of total cases hospitalised	2% direct audits + 2% of audits done by the Insurer / TPA /ISA
Death audit	100%	100%
Hospital audit	Each empanelled hospital at least twice each year	Each empanelled hospital at least twice a year
Beneficiary audit (during hospitalisation)	10% of total cases hospitalised	5% direct audits + 10% of audits done by the Insurer/TPA /ISA
Beneficiary audit (post discharge – through telephone)	10% of total cases hospitalised	5% direct audits + 10% of audits done by the Insurer/TPA /ISA
Beneficiary audit (post discharge – through home visit)	5% total cases hospitalised	2% direct audits + 2% of audits done by the Insurer /TPA /ISA
Pre-authorisation audit	10% of total pre-authorisations across disease specialties	2% of audits done by the Insurer / TPA /ISA for Insurance mode) 10% of audits done by the TPA /ISA (for Assurance mode)
Claims audit (approved claims)	10% of total claims	3% of audits done by the Insurer /TPA /ISA for Insurance mode) 10% of audits done by the TPA /ISA (for Assurance mode)
Claims audit (rejected claims)	-	100%

5.3 Guidelines for deterrence

5.3.1 Sound contracts, strong contract management, prompt action, speedy adjudication and strict enforcement of penalties and contractual provisions act as strong deterrence for fraud.

5.3.2 To enable the SHA to take firm actions against fraud including dis-empanelment and delisting of providers, it is recommended that a panel of providers be shortlisted and a waiting-list of to-be empanelled providers prepared.

5.3.3 However, in geographical locations with limited provider presence, the SHA may be constrained to dis-empanel or delist providers. In such situations, that SHA may consider more stringent penalties and firm disciplinary actions.

5.3.4 Public disclosure of providers who have engaged in fraudulent activities may act as a deterrent.

5.3.5 The SHA may demand the providers to take firm action including issuing warnings and show cause notices to treating doctors found indulging in unethical practices under the provisions of the Medical Council of India.

5.4 Monitoring effectiveness of anti-fraud measures

5.4.1 Periodic review of anti-fraud measures is required to improve the quality of the measures and to ensure that the anti-fraud efforts remain responsive and robust. A set of illustrative indicators for measuring the effectiveness of anti-fraud measures is provided in Annex 4. The SHA is at liberty to add more indicators as per its need.

5.4.2 The Anti-Fraud Cell may set up mechanisms of quarterly reporting against these indicators and recommend corrective measures to the SHA as required.

Section 6. Use of IT in Anti-Fraud Efforts

6.1 IT infrastructure for detecting fraud: The SHA should set up an IT infrastructure for seamless management of the PMJAY process that include:

a. beneficiary identification and verification module;
b. hospital transaction module;
c. pre-authorisation module;
d. claims processing module;
e. grievance redressal module;
f. hotline module.

6.2 Fraud triggers: The IT infrastructure should have a comprehensive fraud triggers based on which for automated alerts based on basic outlier analysis and rule-based analysis could be generated. A list of illustrative fraud triggers in provided in Annex 2. It is recommended that the Anti-Fraud Cell should constantly review the list of triggers in coordination with the Monitoring and Evaluation unit and the audit unit of the SHA and the IT platform be constantly updated with new triggers as needed.

6.3 **Data mining and analytics**: The IT infrastructure set up by the SHA is expected to have at least the basic fraud data analytics that allows for rule-based and outlier-based analysis. The NHA shall set up a centralised IT architecture for advanced analytics that may include predictive modelling, regression techniques and use of social network analysis. It is expected that the SHA shall allow NHA complete access to its transaction data for the NHA to provide fraud-analytics support to the SHA. Data analytics shall include retrospective and prospective analysis approaches. Whereas retrospective analysis will help identify patterns of fraudulent behaviour based on historical information, prospective analysis will analyse current data on a case-by-case basis to determine the legitimacy of claims.

6.4 **Automated tools to assist in fraud management**: The IT platform shall have automated security layers and tools to detect fraud. Security within data processing systems, segregation of responsibilities to prevent conflict of interest and ensure internal checks and balances, password and confidentiality policy are important to prevent fraud. This also includes development and use of a unique provider identification mechanism through which claims submitted electronically may be traced to their origin.

Section 7. Managing fraud complaints

7.1 Fraud under PMJAY may either be detected internally by the PMJAY staff lead by the Anti-Fraud Cell or be externally reported. Sources of information and mechanism of reporting are provided in the table below:

Internal detection sources	External reporting
- Audit reports (internal and external) - Monitoring reports - Filed visit reports - Routine validation of provider data - Random reviews and beneficiary interviews - Unannounced site visits - Use of feedback and quality improvement - Data analytics dashboard – including comparing providers on such indices as utilization, performance, outcomes, referrals, disenrollment, followed by focused reviews on areas of aberrancy	- From any individual or agency irrespective of whether they are engaged with or are beneficiaries of PMJAY or not - In writing through email / fax / letter to the SHA or the NHA or the grievance redressal cells that may be set up by the state government directly under the supervision of the Chief Minister - On PMJAY national or state helplines/call centre - On grievance redressal helplines, if any, set up under the Chief Minister's office

7.2 Subject to provisions under law, the SHA shall ensure that the identity of those filing grievances filed related to suspected fraud shall be kept confidential until the investigation is completed and it is ascertained that fraud has been committed.

7.3 On receipt of any complaint related to suspected fraud, the Anti-Fraud Cell shall promptly initiate action as follows:

a. Designate a nodal person to lead the enquiry and management of the case.
b. Within 48 hours, undertake preliminary examination to make a prima facie assessment. For a prima facie assessment, the Anti-Fraud Cell should analyse available data to create a hypothesis and test it against available facts to arrive at a reasonably certain prima facie conclusion that an act of fraud may have been conducted.
c. If there is prima facie evidence of fraud, the Anti-Fraud Cell shall take all measures required to initiate detailed investigation.
d. For detailed investigation, the Anti-Fraud Cell shall constitute an investigation team that will be headed by the concerned District Vigilance Officer. The head of the investigation team shall report to the Chief Vigilance Officer (CVO) of the SHA. Other members of the investigation team may include members of the medical audit team, monitoring and evaluation team, district level staff as the CVO of the SHA may deem appropriate. The CVO may, at her / his sole discretion, decide on the inclusion of staff from the ISA / TPA in the investigation team.
e. The investigation team shall undertake a thorough assessment which may include but not be limited to on-site enquiry, verification of original records, oral examination of concerned individuals, and submit a detailed investigation report to the CVO within 7 working days. The investigation report shall at the minimum include all details of the ooccurrence of fraud found; recommendations to prevent similar future reoccurrence; and recommendations to impose sanctions on fraud actors.
f. If the investigation report confirms fraud, the SHA shall, through appropriate levels within the SHA, issue a show-cause notice to the accused entity providing it with 3 days' time to respond to the allegations and present its defence.
g. Following the principles of Natural Justice, the Anti-Fraud Cell shall, within 2 weeks of receiving the response from the accused, communicate its final decision in the matter.
h. If the final decisions are related to suspension or dis-empanelment of an empanelled provider, the SHA shall abide by the detailed guidelines for disciplinary proceedings and dis-empanelment set forth in the NHA Guidelines on "Process for Empanelment of Hospitals" and the provisions of the provider contract.

Annex 1 Types of Fraud – Some examples

Beneficiary fraud:

a. Making a false statement of eligibility to access health services;
b. Knowingly allowing impersonation / identity theft in own name by another person to access health services;
c. Using their rights to access unnecessary services by falsifying their health conditions;
d. Giving gratifications / bribes to service providers for receiving benefits that are excluded/uncovered under PMJAY;
e. Engaging in a conspiracy with service providers to submit false claims;
f. Knowingly receiving prescribed medicines and/or medical devices for resale.

Payer fraud:

a. Engaging in a conspiracy with health facilities to falsify information with the aim of meeting empanelment criteria/becoming empanelled under the PMJAY;
b. Engaging in a conspiracy with beneficiaries and/or service providers to submit false claims for reimbursement;
c. Manipulating beneficiary list/covered members list;
d. Manipulating uncovered benefits into covered benefits;
e. Withholding legitimate claims payments to service providers to take personal advantage;
f. Not taking action against complaints of fraud received against provider(s).

Note: Reference to 'any of the agencies contracted by the NHA or the SHA directly or indirectly involved with PMJAY' in this para include but are not limited to Insurance Companies, Third Party Administrators, Implementation Support Agencies, IT solutions provider, management consultants / agencies, and monitoring and audit agencies.

Provider fraud:

a. Getting empanelled through manipulation of records or service/facilities etc.;
b. Manipulating / fudging claims for services covered under other state schemes and interventions and paid out of state budget;
c. Staff of public providers receiving some payment/commission/referral fees from private empanelled providers for referring beneficiaries;
d. Delays in scheduling treatment in anticipation of financial gain from beneficiaries or luring beneficiaries of preferential and early treatment in lieu of bribes;
e. Collecting unauthorized fees from beneficiaries;
f. Giving beneficiaries an inappropriate referral in order to gain a particular advantage;
g. Staff in empanelled public provider referring beneficiaries to private providers in exchange for financial considerations from the private providers;
h. Diagnosis upcoding (change of diagnosis code and/or procedure to a code of higher rate) and procedure code substitution;
i. Cloning of claims from other patients (duplication of claims from other patients' claims);
j. Phantom visit (claim for patients' false visit);

k. Phantom procedures (claim for procedures never performed);
l. Phantom billing (claim for services never provided);
m. Services unbundling or fragmentation (claim for two or more diagnoses and/or procedures that should be in one service package in the same episode or separate claims for a procedure that should be submitted in one service package in order to produce a larger amount of claims in one episode);
n. Duplicate/repeated billing (claim repeated for the same case);
o. Cancelled services (claim for services that are cancelled);
p. Measures of no medical value (claim for measures taken inconsistent with medical needs or indications);
q. Unnecessary treatment and/or medically inappropriate treatment;
r. Readmissions diagnoses and/or measures for one episode claimed for more than one time, as if for more than one episode;
s. Provision of counterfeit medicines;
t. Indulging or conniving to indulge in unethical practices not permissible under guidelines of Medical Council of India/State Medical Council for medical practitioners or Clinical Establishment Act or under any other law of land or established medical norms, whether leading to patient harm, future health endangerment of member or not;
u. Arogya Mitras colluding to refer patients to a competing empanelled provider.

Annex 2 Fraud Triggers

Claim History Triggers

1. Impersonation.
2. Mismatch of in house document with submitted documents.
3. Claims without signature of the beneficiary on pre-authorisation form.
4. Second claim in the same year for an acute medical illness/surgical.
5. Claims from multiple hospitals with same owner.
6. Claims from a hospital located far away from beneficiary's residence, pharmacy bills away from hospital/residence.
7. Claims for hospitalization at a hospital already identified on a "watch" list or black listed hospital.
8. Claims from members with no claim free years, i.e. regular claim history.
9. Same beneficiary claimed in multiple places at the same time.
10. Excessive utilization by a specific member belonging to the beneficiary Family Unit.
11. Deliberate blocking of higher-priced package rates to claim higher amounts.
12. Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
13. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
14. Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the beneficiary family unit and different hospitals for other members of the beneficiary family unit,
15. Multiple claims towards the end of policy cover period, close proximity of claims.

Admissions Specific Triggers

16. Members of the same beneficiary family getting admitted and discharged together.
17. High number of admissions.
18. Repeated admissions.
19. Repeated admissions of members of the same beneficiary family unit.
20. High number of admission in odd hours.
21. High number of admission in weekends/ holidays.
22. Admission beyond capacity of hospital.
23. Average admission is beyond bed capacity of the provider in a month.
24. Excessive ICU (Intensive Care Unit) admission.
25. High number of admission at the end of the Policy Cover Period.
26. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
27. Claims with Length of Stay (LOS) which is in significant variance with the average LoS for a particular ailment.

Diagnosis Specific Triggers

28. Diagnosis and treatment contradict each other.
29. Diagnostic and treatment in different geographic locations.
30. Claims for acute medical Illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
31. Ailment and gender mismatch.
32. Ailment and age mismatch.
33. Multiple procedures for same beneficiary – blocking of multiple packages even though not required.

34. One-time procedure reported many times.
35. Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
36. Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
37. Part of the expenses collected from beneficiary for medicines and screening in addition to amounts received by the Insurer.
38. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of critical illnesses.
39. Overall medical management exceeds more than 5 days, other than in the case of critical illness.
40. High number of cases treated on an out-of-pocket payment basis at a given provider, post consumption of financial limit.

Billing and Tariff based Triggers

41. Claims without supporting pre/ post hospitalisation papers/ bills.
42. Multiple specialty consultations in a single bill.
43. Claims where the cost of treatment is much higher than expected for underlying etiology.
44. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
45. Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
46. Claims submitted that cause suspicion due to format or content that looks "too perfect" in order. Pharmacy bills in chronological/running serial number or claim documents with colour photocopies. Perfect claim file with all criteria fulfilled with no deficiencies.
47. Claims with visible tempering of documents, overwriting in diagnosis/ treatment papers, discharge summary, bills etc. Same handwriting and flow in all documents from first prescription to admission to discharge. X-ray plates without date and side printed. Bills generated on a "Word" document or documents without proper signature, name and stamp.

General

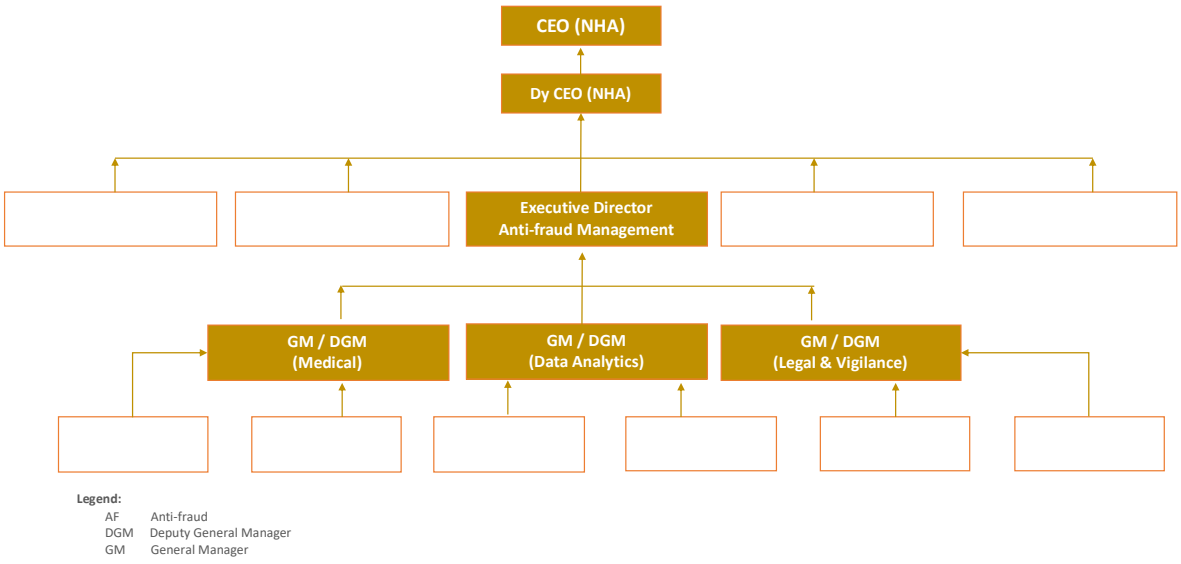
48. Qualification of practitioner doesn't match treatment.
49. Specialty not available in hospital.
50. Delayed information of claim details to the Insurer.
51. Conversion of out-patient to in-patient cases (compare with historical data).
52. Non-payment of transportation allowance.
53. Not dispensing post-hospitalization medication to beneficiaries.

Annex 3 Anti-Fraud Cell – Structure and Composition

At the National Health Agency (NHA)

It is proposed to establish an Anti-Fraud Management Cell as an independent vertical in NHA, headed by an Executive Director, reporting to Chief Executive Officer (NHA). Some of the roles/responsibilities may have some overlap with presently planned functions of Medical audit, grievance and vigilance teams, however it is felt that an independent anti-fraud vertical is critical for focused efforts and results in this area. The overlapping roles/functions, will be reviewed and streamlined to ensure synergies, avoid duplication of effort, and, for greater efficiency.

ORGANOGRAM OF THE ANTI-FRAUD CELL (NHA)



Positions, skills and key responsibilities:

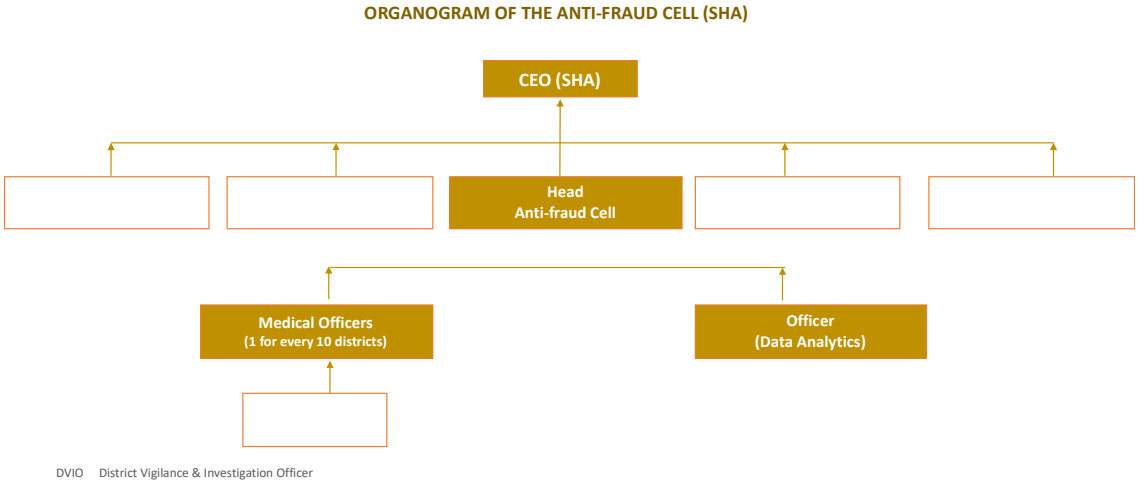
Position	Education and skill set	Key responsibilities
ED Anti – fraud management	- Post graduate in medicine, management, legal, IT or equivalent discipline. - 10 years relevant experience in health insurance or 3-5 years' experience, in government administered health insurance scheme in key positions. - Director or equivalent level if in Govt job, others from private sector with 10 years' experience in leadership position.	- To develop vision, strategy, guidelines and implementation road map for robust fraud management under PMJAY from prevention, detection to deterrence, public awareness, whistle blower facilitation, etc. - To work with IT team for system integration, deployment of tools, advanced analytics etc. for fraud management. - To oversee SHA performance with regard to fraud management, guide, mentor and support capacity building in SHAs,

Position	Education and skill set	Key responsibilities
	- Leadership, communication, analytics, vigilance and medical forensics capability preferred.	standard training and certification programmes. - To work with legal, regulatory and industry bodies for standard contracts, punitive action, search, seizure, other deterrence measures/guidelines etc. - To develop strong zero tolerance anti-fraud culture in all aspects of the Scheme.
GM/DGM Medical	- Post graduate in medicine (recognized by MCI). - 10 years' experience, health insurance/schemes claims management/audit preferred. - Knowledge of medical protocols, standard treatment guidelines. - Presentation and communication skills.	- To work with IT team for embedding fraud triggers, medical protocols, guidelines and medical audit capabilities (concurrent & post facto) in the system. - To develop medical audit and check lists for SHA team, post audit action closure. - To analyze data, trends and ensure field investigations through vigilance team for outlier cases. - To guide, mentor, support SHA Medical team & oversee performance. - To carry out surprise field visits.
GM/DGM Analytics	- Post graduate in IT, statistics, management or equivalent. - 10 years' relevant experience - Knowledge of data mining, data consolidation, Big data, analytical tools and soft wares e.g. R, Weka, Tableau. - Strong analytical capability for large database behaviour, trends, predictive modelling etc. - Presentation and communication skills.	- To manage, organize and analyze transactions data - To manage, organize and analyze transactions data. - To work with IT team and develop dashboards for trend and behaviour, outlier cases. - To work with IT team for developing dynamic rule engines, triggers and predictive modelling. - To manage and update trigger list, publish the same for other teams and SHA's use. - To publish daily MIS and reports relating to anti-fraud management in coordination with Medical audit team for subsequent timely action. - To guide, mentor and support SHA Analytics team. - To work with Capacity Building team and Communications & Grievance Redressal Team to support development relevant

Position	Education and skill set	Key responsibilities
		training materials and IEC materials for SHAs.
GM/DGM Legal & Vigilance	- Post graduate, law degree. - 10 years' experience. - Criminal prosecution law back ground preferred. - Ex-servicemen preferred. - Strong investigative capabilities, communication skills.	- To lay guidelines, SOP and check lists for vigilance, field verification, investigation, conclusive evidence collection, etc. - To establish whistle blower mechanism at NHA level. - To develop strong vigilance and investigation capacity in the SHA team, develop training programmes. - To carry out surprise visits based on grievances, claims data, trends, M & E team inputs etc. - To develop a network of informal/extended community for discrete intelligence inputs and local issues. - To develop guidelines and SOPs for suitable action for dealing with fraud – contracts, legal and punitive action, prosecution, search, seizure, claw back recoveries etc. - To develop framework for deterrence measures guidelines. - To ensure compliance with anti-fraud guidelines as regards penalties and action. - To develop and deploy public awareness and social messaging guidelines/content for anti-fraud issues in consultation with IEC team including establishing social audits. - To guide, mentor and support SHA team.

At the State Health Agency (SHA)

For SHA, it is proposed to have a combined unit for Anti-fraud, medical audit and vigilance at the state level and to have Vigilance and Investigation Officers at district level. In case SHA is implementing scheme under insurance model or through Implementing Support Agency (ISA), the District Vigilance and Investigation Officer may be requisitioned from such insurance company or ISA as part of service level agreement, the positions need not be duplicated, however the structure in SHA is proposed to remain same.



Positions, skills and key responsibilities:

Position	Education and skill set	Key responsibilities
Chief Manager – Anti fraud, vigilance and legal	- Graduate, preferably law or forensics. - 10 years' experience. - Ex-servicemen/senior officials engaged in health insurance schemes implementation/hospital/social schemes implementation. - Good communication skills, analytical, investigative and forensics capabilities. - To carry out action – penalty, de-empanelment, prosecution, and other deterrence measures as per anti-fraud guidelines.	- To implement anti-fraud management guidelines laid down by NHA and additionally design/implement state specific guidelines, enforce contracts. - To guide, mentor and oversee District Vigilance officers, conduct training programmes. - To work with medical audit and analytics team for ensuring prompt and effective investigation of all suspect cases with collection of documentary evidence. - To develop anti-fraud messaging and public awareness campaigns in local languages along with the communication team, liaise with other state level regulatory bodies for

Position	Education and skill set	Key responsibilities
		concerted action, local officials, communities for intelligence. - To establish whistle blower mechanism. - To carry out surprise inspection. - To carry out action – penalty, de-empanelment, prosecution, and other deterrence measures, etc. as per guidelines against fraudsters.
Medical Officers (about 1 per 10 districts)	- Medical graduate. - 5-7 years' experience in health claims processing/audit. - Knowledge of medical protocols, clinical pathways and standard treatment guidelines. - Operational knowledge of hospital functioning and billing practices.	- To carry out medical audit as per guidelines incorporating state specific practices - To analyze transactions data from medical perspective and highlight. outlier/suspect/variant cases for further investigation. - To support investigation team for appropriate probing of suspect cases.
Data Analytics Officer	- Graduate, preferably Computer Science. - 5-7 years, preferably in MIS, reporting in volume business industry/health schemes. - Knowledge of data and query management, advanced analytics. - MIS and reporting.	- To apply fraud triggers to all transactions on daily basis and share report with Medical audit and Vigilance team. - Update triggers in the system based on new information. - To manage, organize and analyze state level data, compare utilization, average movement, length of stay, outlier cases etc. across providers, districts at micro and macro level. - To publish dashboard pertaining to anti-fraud work.

District Level

Position	Education and skill set	Key responsibilities
District Vigilance and Investigation Officer	- Graduate. - 3-5 years, preferably investigation related field jobs, ex-servicemen preferred. - Good communication skills, sharp and investigative mindset. - Knowledge of hospital billing practices desirable.	- To carry out field investigation of assigned cases within timeline, collecting documentary evidence. - To collect market intelligence reports discretely. - To carry out any other assigned tasks relating to anti-fraud management.

Annex 4 Measuring Effectiveness of Anti-Fraud Efforts

1. Share of pre-authorization rejected
2. Emergency pre-authorization as a share of total pre-authorisation requests
3. Share of pre-authorization and claims audited
4. Claim repudiation/denial/ disallowance ratio
5. Reduction in number of enhancements requested per 100 claims
6. Number of providers dis-empanelled
7. Share of combined/multiple-procedures per 100,000 procedures
8. Instances of single disease dominating a geographical area are reduced
9. Disease utilization rates correlate more with the community incidence
10. Share of households physically visited by PMJAY functionary
11. Reduction in utilization of high-end procedure
12. Number of enquiry reports against hospitals
13. Number of enquiry reports against own staff
14. Number of FIRs filed
15. Conviction rate of detected fraud
16. Number of cases discussed in Empanelment and Disciplinary Committee
17. Per cent of pre-authorisations audited
18. Per cent of post-payment claims audited
19. Fraudulent claims as a share of total claims processed
20. Number of staff removed or replaced due to confirmed fraud
21. Number of actions taken against hospitals in a given time period
22. Amount recovered as a share of total claims paid
23. Frequency of hospital inspection in a given time period in a defined geographical area
24. Share of red flag cases per 100 claims
25. Inter-district trends in incidence and utilisation rates
26. Number of fraud reported on helplines
27. Movement of averages: claim size, length of stay, etc.