Schedules to Insurance Contract

_____2021

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Schedule 1: Details of the scheme and Beneficieries

1.1 Name and Objective of the of the Scheme

The name of the scheme is 'Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana' (AB-PMJAY). The objective of AB-PM JAY is to reduce catastrophic health expenditure, improve access to quality health care, reduce unmet needs and reduce out of pocket healthcare expenditures of poor and vulnerable families falling under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category and broadly 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the State/ UT along with the estimated existing RSBY Beneficiary Families not figuring in the SECC Database. These eligible AB-PMJAY beneficiary families will be proviced coverage for secondary, tertiary and day care procedures (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP).

1.2 Beneficieries

All AB-PMJAY Beneficiary Family Units, as defined under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (in rural areas) and broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the State/ UT (as updated from time to time) along with the existing RSBY Beneficiary Families not figuring in the SECC Database which are resident in the Service Area (State or cluster of States for which this Tender Document is issued) shall be considered as **eligible** for benefits under the Scheme and be automatically covered under the Scheme.

For Rural

Total deprived Households targeted for AB-PMJAY who belong to one of the six deprivation criteria amongst D1, D2, D3, D4, D5 and D7:

- Only one room with kucha walls and kucha roof (D1)
- No adult member between age 16 to 59 (D2)
- Female headed households with no adult male member between age 16 to 59 (D3)
- Disabled member and no able-bodied adult member (D4)
- SC/ST households (D5)
- Landless households deriving major part of their income from manual casual labour (D7)

Automatically included-

Households without shelter

- Destitute/ living on alms
- Manual scavenger families
- Primitive tribal groups
- Legally released bonded labour

For Urban

Occupational Categories of Workers

- Rag picker
- Beggar
- Domestic worker
- Street vendor/ Cobbler/hawker / Other service provider working on streets
- Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and another head-load worker

- Sweeper/ Sanitation worker / Mali
- Home-based worker/ Artisan/ Handicrafts worker / Tailor
- Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller
- Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery assistant / Attendant/ Waiter
- Electrician/ Mechanic/ Assembler/ Repair worker
- Washer-man/ Chowkidar

1.2.1 Unit of Coverage

Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB-PMJAY Beneficiary Family Unit, which will comprise all members in that family. Any addition in the family will be allowed only in case of marriage and/or birth/ adoption.

1.2.2 District Wise SECC Beneficieries

Districts	Number of eligible families in SECC Data			Number of families currently enrolled in RSBY	Total Number of eligible families for PMJAY (benchmarked against RSBY)
	Rural	Urban	Total		
1. Dimapur	13,190	9,585	22,775	44,033	44,033
2. Longleng	6,528	239	6,767	6,188	6,188
3. Kiphire	15,449	5,036	20,485	16,822	16,822
4. Kohima	10,700	422	11,122	16,292	16,292
5. Mokokchung	17,840	2,331	20,171	26,632	26,632
6. Mon	27,698	1,193	28,891	24,904	24,904
7. Peren	11,084	505	11,589	15,298	15,298
8. Phek	22,645	503	23,148	16,788	16,788
9. Tuensang	23,922	670	24,592	19,206	19,206
10. Wokha	16,956	612	17,568	25,096	25,096
11. Zunheboto	14,627	535	15,162	22,069	22,069
G/ Total	**1,80,639**	**21,631**	**2,02,270**	**2,33,328**	**2,33,328**

*Noklak district being a new district is included under Tuensang district as per SECC 2011.

Schedule 2: Exclusions to the Policy

**Note:As per latest exclusion policy issued by NHA and/or SHA and revised from time to time*

Ayushman Bharat PM-JAY shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

- Conditions that do not require hospitalization: Condition that do not require hospitalization and can be treated under Outpatient Care. Outpatient Diagnostic, Medical and Surgical

procedures or treatments unless necessary for treatment of a disease covered under day care procedures (as applicable) will not be covered.

- Except those expenses covered under pre and post hospitalization expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.

- Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalization for treatment.

- Congenital external diseases: Congenital external diseases or defects or anomalies, Convalescence, general debility, "run down" condition or rest cure.

- Fertility related procedures: Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.

- Drugs and Alcohol Induced illness: Diseases, illness or injury due to or arising from use, misuse or abuse of drugs or alcohol or use of intoxicating substances, or such abuse or addiction. In case of trauma or life threatening this clause may be exempted.

Schedule 3: HBP and Quality

a. Schedule 3 (a) HBP 2.0

The HBP 2.0 specific to Nagaland is available at nagahealth.nagaland.gov.in

b. Schdule 3 (b): Guidelines for Unspecified Surgical Packages

All unspecified packages:

To ensure that PM-JAY beneficiaries are not denied care, for treatments/procedures that do not feature in the listed interventions, there is an exclusive provision that has been enabled in the TMS (transaction management system) for blocking such treatments, subject to satisfying certain defined criteria (as mentioned)

When can Unspecified Surgical be booked/ criteria for treatments that can be availed:

- Only for surgical treatments.
- Compulsory pre-authorization is in-built while selecting this code for blocking treatments.
- Cannot be raised under multiple package selection. Not applicable for medical management cases.
- Government reserved packages cannot be availed by private hospitals under this code. PPD/ CPD may reject such claims on these grounds. In addition, SHA may circulate Government reserved packages to all hospitals. Further, States need to establish suitable mechanisms to refer such cases to the public system – as a means to avoid denial of care.
- Cannot be booked for removal of implants, which were inserted under the same policy. Exceptions where removal of implants is not covered under any other package, to be approved by State Health Agencies or National Health Authority.
- In the event of portability, the home state approval team may either reject if a Government reserved package of the home state is selected by a private hospital in the treating state or consider on grounds of 'emergency'.
- Aesthetic treatments of any nature cannot be availed under this code or as such under any other listed codes under PM-JAY. Only medically necessary with functional purpose/ indications can be covered. The procedure should result in improving/restoring bodily function or to correct significant deformity resulting from accidental injury, trauma or to address congenital anomalies that have resulted in significant functional impairment.
- Individual drugs or diagnostics cannot be availed under this code. Only LISTED drugs and diagnostics with fixed price schedules, listed under the drop down of respective specialties, are included for blocking treatments.
- None of the treatments that fall under the exclusion list of PM-JAY can be availed viz. individual diagnostics for evaluation, out-patient care, drug rehabilitation, cosmetic/ aesthetic treatments, vaccination, hormone replacement therapy for sex change or any treatment related to sex change, any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalization for treatment etc.
- However, for life threatening cases e.g. of suicide attempt or accident due to excess consumption of alcohol, treatment shall be provided by the hospital till the patient's condition stabilizes.
- In case the State/UT is getting multiple requests for the same unspecified package from multiple hospitals or for multiple patients, then the same should be taken up with

the Medical Committee for inclusion in the package master for that State/UT within a defined time frame as per the State/UT.

- The same should also be shared with NHA for consideration to include such packages in national package master

For deciding on the approval amount, the PPD may consider the rate of closest match of the requested surgery, in listed PM-JAY packages. It should be noted that the amount approved by the PPD would be sacrosanct, to be communicated to the hospital, and the CPD would not be able to deduct any amount or approve partial payment for that claim.

Unspecified package above 1 lakh: For any State/UT to utilize the unspecified package above 1 lakh, it is to be ensured that the same is approved **only in (a) exceptional circumstances and / or (b) for life saving conditions.**
The following process to be adhered:

For Public Hospitals:

1. A standing Medical committee will be constituted by CEO of each state to provide inputs on unspecified packages among their other deliverables.
2. CEO, SHA will approve every case after recommendation from the standing medical committee (wherever committee is yet to be constituted, opinion of 2 medical experts will suffice as recommendation in the interim period), with details of treatment and pricing that is duly negotiated with the provider. This approval should have insurance company concurrence, wherever applicable.
3. The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, consumables and post-op care included – preferably citing rates as ceiling from any govt. purchasing scheme like CGHS etc. if available.
4. A letter or request from the SHA with approval of competent authority may be sent to NHA as an intimation of their approval and requesting technical support for backend change of amount via ticket (including an intimation via mail); TMS will permit to block the unspecified package ≥ Rs. 1 lakh.
5. Upon request of State Coordinator at NHA, technical team will carry out backend change.

For Private Hospitals:

1. A standing Medical committee will be constituted by CEO of each state to provide inputs on unspecified packages among their other deliverables.
2. CEO, SHA will approve every case after recommendation from the standing medical committee (wherever committee is yet to be constituted, opinion of 2 medical experts will suffice as recommendation in the interim period), with details of treatment and pricing that is duly negotiated with the provider. **Justification for the case not being carried out at a public hospital will be required to be highlighted in the approval.** This approval should have insurance company concurrence, wherever applicable.

3. The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, consumables and post-op care included – preferably citing rates as ceiling from any govt. purchasing scheme like CGHS etc. if available.
4. A letter or request from the SHA with approval of competent authority may be sent to NHA for approval along with request for technical support for backend change of amount via ticket (including an intimation via mail); TMS will permit to block the unspecified package ≥ Rs. 1 lakh.
5. **The case upon recommendation of ED (HNW&QA) will be assessed on its merit for approval.** Once approved, it will be shared by State Coordinator with technical team for backend change.

c. Schedule 3 (c)

Diffrential Pricing Guidelines:

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-Jay) provides additional incentive on the procedure rate based on following criteria's:

S. No.	Criteria	Incentive (Over and above base procedure rate)
1	Entry level NABH / NQAS certification	10%
2	Full NABH / JCI accreditation	15%
3	Situated in Delhi or some other Metro*	10%
4	Aspirational district	10%
5	Running PG / DNB course in the empanelled specialty	10%
6	Private or public autonomous hospitals situated in Nagaland state	10%

*Classification of Metro Cities:

1. Delhi (including Faridabad, Ghaziabad, Noida and Gurgaon)
2. Greater Mumbai
3. Kolkata
4. Bangalore/Bengaluru
5. Pune
6. Hyderabad
7. Cheenai
8. Ahemdabad

These percentage incentives are added by compounding.

b. Schedule 3 (d): Quality Assurance of Empaneled Health Care Providers

a. The SHA, through Insuance Company, shall ensure the quality of sevice provided to the benificiaries in EHCP.

b. EHCP has to monthly submit the online Self – Assesment checklist which can be accessed in HEM web portal portal in www. pmjay.gov.in to DEC and SHA shall focus on low performing hospitals for further improvement.

c. EHCP will be encouraged by Insurer to attain quality milestones by attaning AB PMJAY Quality Certification (Bronze, Silver and Gold).

d. Bronze Quality Certification is pre-entry level certificate in AB PMJAY Quality Certification. EHCP which do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate.

e. Bronze Quality Certified EHCP can apply for AB PMJAY Silver Quality Certification after completion of 6 months from the date of receiving Bronze certification. This certification is also benchmarked with NABH Entry Level / NQAS certification and EHCP with these certifications can directly apply for Silver Quality Certification without getting Bronze Quality Certification with simplified process.

f. Silver Quality Certified EHCP can apply for AB PMJAY Gold Quality Certification after completion of 6 months from the date of receiving Silver certification. This certification is benchmarked with NABH full/ JCI accreditation and EHCP with these certifications can directly apply for Gold Quality Certification without getting Silver or Bronze Quality Certification with simplified process

Schedule 4: Guidelines for Identification of AB-PM JAY Beneficiary Family Units

Brief Process Flow

The core principle for finalizing the operational guidelines for proposed AB PM-JAY is to construct a broad framework as guiding posts for simplifying the implementation of the Mission under the ambit of the policy and the technology while providing requisite flexibility to the States to optimally chalk out the activities related to implementation in light of the peculiarities of their own State/UT, as ownership of implementation of scheme lies with them.

A. AB PM-JAY will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data, both rural and urban. Additionally, all such enrolled families under RSBY that do not feature in the targeted groups as per SECC data will be included as well.

B. States covering a much larger population than the AB PM-JAY beneficiary list will need to:

   i. Provide a declaration that their eligibility criteria cover AB PM-JAY beneficiaries.
   ii. Setup a process to ensure any family in AB PM-JAY list who may be missed under the State's criteria is covered when they seek care.
   iii. Beneficiaries obtaining treatment should be tagged if they are AB PM-JAY beneficiaries. Reports to MoHFW/ NHA will need to be provided for these beneficiaries.
   iv. Link all AB PM-JAY beneficiaries with the State's Scheme ID and Aadhaar in a defined time period.

C. State/UT will be responsible for carrying out Information, Education and Communication (IEC) activities amongst targeted families such that they are aware of their entitlement, benefit cover, empanelled hospitals and process to avail the services under AB PM-JAY. This will include leveraging village health and nutrition days, making available beneficiary family list at Panchayat office, visit of ASHA workers to each target family and educating them about the scheme, Mass media, etc. among other activities. The following 2 IEC activities are designed to aid in Beneficiary Identification

   i. AB PM-JAY Additional Data Collection drive at Gram Sabha's across India took place on 30th April. MoHFW in collaboration with Ministry of Rural Development (MoRD) will drive collection of Ration Card, Mobile Number for each AB PM-JAY household. Similar exercise was carried out for urban beneficiaries in May 2018.
   ii. Government of India will send a personalised letter via mass mail to each targeted family through NHA vendors in states launching AB PM-JAY. The Asha network will be leveraged for distribution of these letters at the village level. This letter will include details about the scheme, toll free helpline number and family details and their ID under AB PM-JAY.
   iii. States which are primarily covering AB PM-JAY beneficiaries are encouraged to create multiple service locations where beneficiaries can check if they are covered. These include:
      - Contact points or kiosks set up at CSCs, PHCs, Gram Panchayat, etc

- Empanelled Hospital
- Self-check via mobile or web
- Or any other contact point as deemed fit by States

D. Beneficiary identification will include the following broad steps:

i. The operator searches through the AB PM-JAY list to determine if the person is covered.

ii. Search can be performed by Name and Location, Ration Card No or Mobile number (collected during data drive) or ID printed on the letter sent to family or RSBY URN

iii. If the beneficiary's name is found in the AB PM-JAY list, Aadhaar (or an alternative government ID) and Ration Card (or an alternative family ID) is collected against the Name / Family. Other family IDs include the following options:

- Government certified list of members
- RSBY Card: Document image (RSBY Card) to be uploaded
- PM Letter: Document image (PM Letter) to be uploaded
- State Specific Requirement

In case of unavailability of either of the above mentioned family IDs, the state can decide to accept an Individual ID mentioning at least father/ mother/ spouse's name as a family ID. This will be accepted only in such cases where both individual's name and father/ mother/ spouse's name match as that in SECC/ RSBY/ State Scheme data.

iv. The system determines a confidence score (threshold score defined by the system but not visible to operator/Pradhan Mantri Arogya Mitra) for the link based on how close the name / location / family members between the AB PM-JAY record and documents is provided.

v. The operator sends the linked record for approval to the Insurance Company / Trust. The beneficiary will be advised to wait for approval from the insurance company/ trust.

vi. The insurance company / Trust will setup a Beneficiary approval team that works on fixed service level agreements on turnaround time. The AB PM-JAY details and the information from the ID is presented to the verifier. The insurance company / Trust can either approve or recommend a case for rejection with reason.

vii. All cases recommended for rejection will be scrutinised by a State team that works on fixed service level agreements on turnaround time. The state team will either accept rejection or approve with reason.

viii. The e-card will be printed with the unique ID under AB PM-JAY and handed over to the beneficiary to serve as a proof for verification for future reference.

- The beneficiary will also be provided with a booklet/ pamphlet with details about AB PM-JAY and process for availing services.
- Presentation of this e-card (appendix 2: draft sample design) will not be mandatory for availing services. However, the e-card may serve as a tool for reinforcement of entitlement to the beneficiary and faster registration process at the hospital when needed.

E. Addition of new family members will be allowed. This requires at least one other family member has been approved by the Insurance Company/Trust. Proof of being part of the same family is required in the form of:

i. Name of the new member is in the family ration card or State defined family card of the identified family member
ii. A marriage certificate to identified family member is available (Husband/Wife)
iii. A birth certificate to identified family member is available
iv. An Adoption certificate to identified family member is available

Note:
Any family member can be added in existing SECC family in-spite of his/her date of birth is after or before 2011 and addition of members is not limited only to new born and newly married, any member can be added to existing SECC family provided member can establish relation with a PMJAY verified beneficiary in conformity with the guidelines for beneficiary identification issued by the NHA and/or SHA from time to time.

F. National Portability has been released. PMAM'S can now search the beneficiary from any state other than their Home State and do their KYC. For this, a dropdown list is provided, which gets activated on clicking the" CHANGE STATE" button.
   i) Having selected the state, an alert dialog box will appear to check if user wants to change the state.
   ii) Upon confirming, the state is changed, and another dialog box will appear to confirm the change of state.

Detailed Steps for Beneficiary Identification and Issuance of e-card

AB PM-JAY will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data, both rural and urban. Additionally, all such enrolled families under RSBY that do not feature in the targeted groups as per SECC data will be included as well.
The main steps for the above exercise are as follows:

A. Preparatory Activities for State/ UT's:

Responsibility of – State Government
Timeline – within a period of 15 days, after receiving the approval from MoHFW/NHA, the State/UT may complete the preparatory activities to initiate the implementation and beneficiary identification process.
The State will need to:

i. Ensure the availability of requisite hardware, software and allied infrastructure required for beneficiary identification and AB PM-JAY e-card printing. Beneficiary Identification Software/ Application/ platform will be provided free of cost by MoHFW/NHA. Specifications for these will be provided by MoHFW/NHA.

ii. Availability of printed booklets, in abundant quantities at each Contact point, which will be given to beneficiaries along with the AB PM-JAY e-cards after verification. The booklet/pamphlet shall provide the following details:

- Details about the AB PM-JAY benefits
- Process of taking the benefits under AB PM-JAY and policy period
- List of the empanelled network hospitals in the district along with address and contact details (if available)
- The names and details of the key contact person/persons in the district
- Toll-free number of AB PM-JAY call centre (if available)
- Details of DNO for any further contact

iii. State/State Health Agency (SHA) shall identify and set-up team(s) which shall have the capacities to handle hardware and basic software support, troubleshooting etc.

iv. Training of trainers for this purpose will be organised by MoHFW/NHA.

The State shall ensure availability of above, in order to carry out all the activities laid down in this guideline.

B. Preparation of AB PM-JAY target data

Responsibility of – MoHFW
Timeline – Preparation of SECC data by 15th March
MoHFW has decided to use latest Socio-Economic Caste Census (SECC) data as a source/base data for validation of beneficiary families under the AB PM-JAY. Based on SECC data, number of families in each State, that will be eligible for central subsidy under the AB PM-JAY, will be identified. The categories in rural and urban that will be covered under AB PM-JAY are given as follows:

For Rural

Total deprived Households targeted for AB PM-JAY who belong to one of the six deprivation criteria amongst D1, D2, D3, D4, D5 and D7:

- Only one room with kucha walls and kucha roof (D1)
- No adult member between age 16 to 59 (D2)
- Female headed households with no adult male member between age 16 to 59 (D3)
- Disabled member and no able-bodied adult member (D4)
- SC/ST households (D5)
- Landless households deriving major part of their income from manual casual labour (D7)

Automatically included-

Households without shelter

- Destitute/ living on alms
- Manual scavenger families
- Primitive tribal groups
- Legally released bonded labour

For Urban

Occupational Categories of Workers

- Rag picker
- Beggar
- Domestic worker
- Street vendor/ Cobbler/hawker / Other service provider working on streets
- Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and another head-load worker
- Sweeper/ Sanitation worker / Mali
- Home-based worker/ Artisan/ Handicrafts worker / Tailor
- Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller
- Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery assistant / Attendant/ Waiter
- Electrician/ Mechanic/ Assembler/ Repair worker
- Washer-man/ Chowkidar

The following activities will be carried out for identifying target families for AB PM-JAY:

i. AB PM-JAY data in defined format by applying inclusion and exclusion criteria shall be prepared.
ii. Preparation of Rashtriya Swasthya Bima Yojana (RSBY) beneficiary family list (based on existing RSBY enrolled families) for such families where premium has been paid by Government of India and data finalized by MoHFW with inputs of States.
iii. AHL_HH_ID will be considered as Family ID for AB PM-JAY targeted families.
iv. Final data will be accessible in a secure manner to only authorised users who will be allowed to access it online and use it for beneficiary verification.

Example:

A. State implementing RSBY –the scenario could be as follows:

- **Number of eligible families in SECC Data = 50 lakhs**
- **Number of families currently enrolled in RSBY = 52 lakhs**
- **Total Number of eligible families for AB PM-JAY = 52 lakhs**

B. State/ UT not implementing RSBY - the scenario could be as follows:

- **Number of eligible families in SECC data = 50 lakhs**
- **Total number of eligible families for AB PM-JAY = 50 lakhs**

C. State implementing their own scheme – the scenario could be as follows:

- **Number of eligible families in SECC Data = 50 lakhs**
- **Number of families currently covered in State Scheme = 75 lakhs**
- **Total Number of eligible families for AB PM-JAY = 50 lakhs**

C. Informing Beneficiaries on what to bring for Identification

Responsibility of – SHA
Timeline – Ongoing
The process requires that Beneficiaries bring:

- Aadhaar
- Any other valid government id(s) decided by the State if they do not have an Aadhaar
- Ration Card or any other family ID from the following:
    - Government certified list of members
    - RSBY Card: Document image (RSBY Card) to be uploaded
    - PM Letter: Document image (PM Letter) to be uploaded
    - State Specific Requirement

    In case of unavailability of either of the abovementioned family IDs, the state can decide to accept an Individual ID mentioning at least father/ mother/ spouse's name as a family ID. This will be accepted only in such cases where both individual's name and father/ mother/ spouse's name match as that in SECC/ RSBY/ State Scheme data.

All IEC activities (see detailed IEC guidelines) must work towards education of the above to ensure it is easy for the beneficiaries to receive care.

D. Beneficiary identification Contact Points – Infrastructure and Locations

Any resident must be able to easily find out if they are covered under the scheme. This is especially critical in States that are launching only on the basis of AB PM-JAY list (SECC + RSBY). These states are encouraged to create a large number of resident contact points where they can easily check if they are eligible and obtain an e-card.
The Beneficiary identification contact point will require:

- A computer with the latest browser
- A QR code scanner
- A document scanner to scan requisite documents
- A printer to print the e-Card
- A web camera for photos
- Internet connectivity
- Aadhaar registered device for fingerprint and iris biometrics (only at Hospital Contact Points)

Only Hardware and software as prescribed by MoHFW/NHA shall only be used. Detailed specifications will be provided in a separate document. Beneficiary identification will be available as a web and mobile application. Availability as a mobile app will make it easy to be

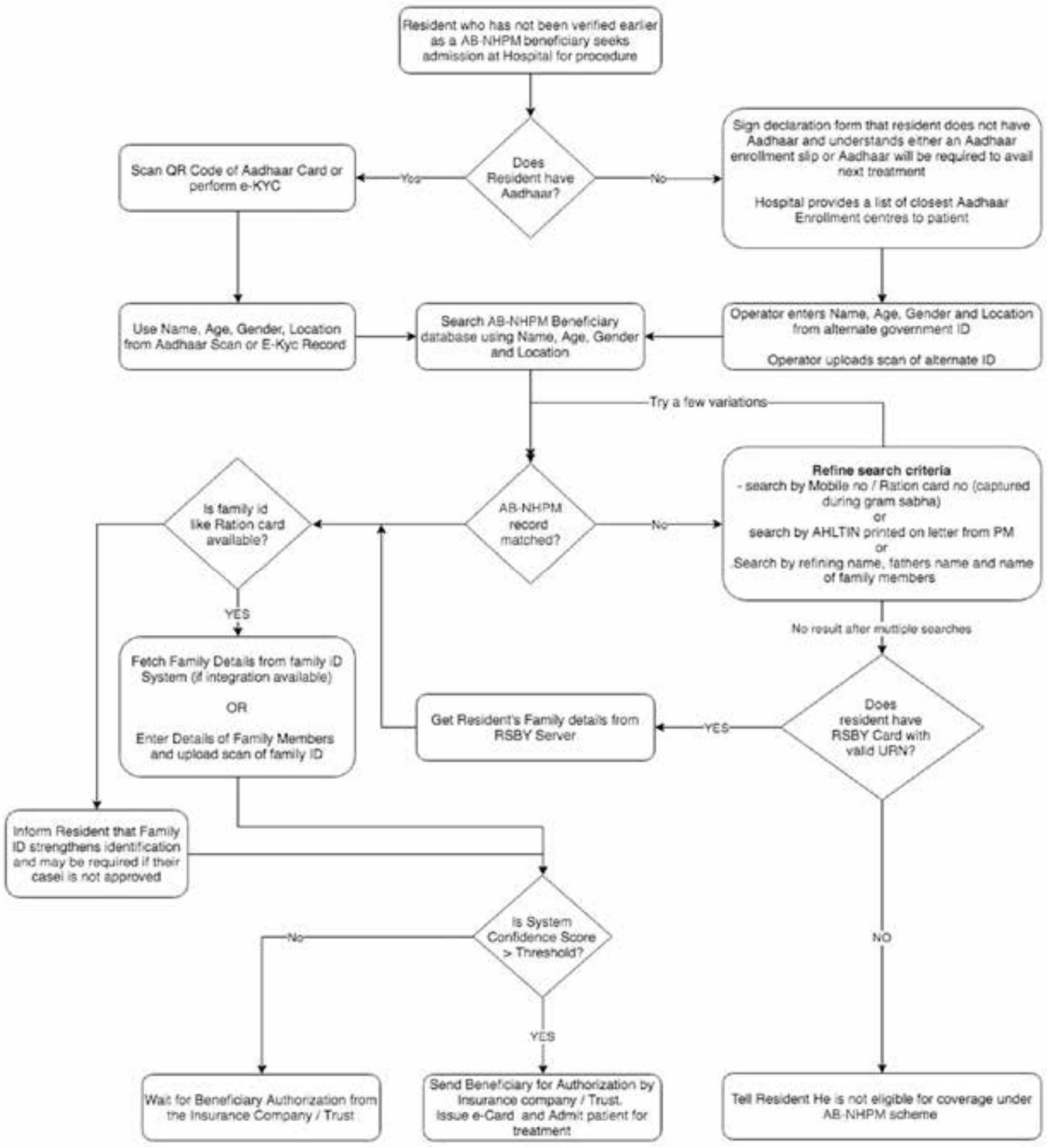
deployed at larger number of contact points. The DNO shall be responsible for choosing the locations for contact centres within each village/ward area that is easily accessible to a maximum number of beneficiary families including the following:

- CSC
- PHCs
- Gram Panchayat Office
- Empanelled Hospital
- Or any other contact point as deemed fit by States/UTs

Required hardware and software must be setup in these contact points which will be authorized to perform Beneficiary identification and issue e-cards.

SHA/ District Nodal Agency will organize training sessions for the operators so that they are trained in the Beneficiary identification, Aadhaar seeding and AB PM-JAY e-card printing process. Operators are registered entities in the system. All beneficiary verification requests are tagged to the operator that initiated the request. If the insurer (Insurance Company/ Trust) rejects multiple requests from a single operator – the system will bar the operator till further training / remedial measures can be undertaken.

Process Flow Chart for Beneficiary Identification


Resident who has not been verified earlier as a AB-NHPM beneficiary seeks admission at Hospital for procedure
Does Resident have Aadhaar?
Yes
No
Scan QR Code of Aadhaar Card or perform e-KYC
Sign declaration form that resident does not have Aadhaar and understands either an Aadhaar enrollment slip or Aadhaar will be required to avail next treatment
Hospital provides a list of closest Aadhaar Enrollment centres to patient
Use Name, Age, Gender, Location from Aadhaar Scan or E-Kyc Record
Search AB-NHPM Beneficiary database using Name, Age, Gender and Location
Operator enters Name, Age, Gender and Location from alternate government ID
Operator uploads scan of alternate ID
Try a few variations
AB-NHPM record matched?
No
Refine search criteria
- search by Mobile no / Ration card no (captured during gram sabha)
or
search by AHLTIN printed on letter from PM
or
Search by refining name, fathers name and name of family members
Is family id like Ration card available?
YES
No result after multiple searches
Fetch Family Details from family ID System (if integration available)
OR
Enter Details of Family Members and upload scan of family ID
Get Resident's Family details from RSBY Server
YES
Does resident have RSBY Card with valid URN?
Inform Resident that Family ID strengthens identification and may be required if their casei is not approved
Is System Confidence Score > Threshold?
No
YES
NO
Wait for Beneficiary Authorization from the Insurance Company / Trust
Send Beneficiary for Authorization by Insurance company / Trust. Issue e-Card and Admit patient for treatment
Tell Resident He is not eligible for coverage under AB-NHPM scheme

Identity Document for a Family Member

Aadhaar will be primary identity document for a family member that has to be produced under the AB PM-JAY scheme. When the beneficiary comes to a contact point, the QR code on the Aadhaar card is scanned (or an e-KYC is performed) to capture all the details of the Aadhaar. A demographic authentication is performed with UIDAI to ensure the information captured is authentic. A live photograph of the member is taken to be printed on the e-card.

If the AB PM-JAY 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 he is 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 list of the closest Aadhaar enrolment centres is provided to the beneficiary

The AB PM-JAY family member does not have an Aadhaar card and the contact point is a Hospital or place of treatment then:

A. A signed declaration is taken from the Beneficiary that he does not possess an Aadhaar card and understands he will need to produce an Aadhaar or an Aadhaar enrolment slip prior to the next treatment
B. The beneficiary must produce an ID document from the list of approved ids by the State
C. The operator captures the type of ID and the fields as printed on the ID including the Name, Father's Name (if available), Age, Gender and Address fields.
D. A scan of the ID produced is uploaded into the system for verification.
E. A photo of the beneficiary is taken.
F. The information from this alternate ID is used instead of Aadhaar for matching against the AB PM-JAY record.

Searching the AB PM-JAY Database

The AB PM-JAY database will be searched based on the information provided in the Member Identity document. AB PM-JAY is based on SECC and it is likely that spellings for Name, Fathers Name and even towns and villages will be different between the AB PM-JAY record and the identity document. A beneficiary will be eligible for AB PM-JAY if the Name and Location parameters in the beneficiary identity document can be regarded as similar to the Name and Location parameters in the AB PM-JAY record.

The Search system automatically provides a confidence score between the two.

Aadhaar or Other Government ID Beneficiary Identity Document		AB PM-JAY Beneficiary Record	
Name	Geetha Bandhopadhya	**Name**	Gita Banarjee
Age	33	**Age**	40
Gender	F	**Gender**	F
Father's Name	<Not Available>	**Father's Name**	Arghya Banarjee
State	West Bengal	**State:**	West Bengal
District	Malda	**District**	Malda
Town / Village	Dakshin Chandipur	**Town / Village**	Dakshen Chandhipur
NAME MATCH CONFIDENCE SCORE: 94%			

The Search system will provide multiple ways to find the AB PM-JAY beneficiary record. If there are no results based on Name and Location, the operator should:

A Search by Ration Card and Mobile No (Information captured during the Additional Data Collection Drive)
B Search using the ID printed on the letter sent by post to Beneficiaries (AHL_HH_ID)
C Reduce some of the parameters like Age, Gender, Sub district, etc. and trial with variation in the spelling of the Name if there are no matching results
D Try adding the name of the father or family members if there are too many results.

The Search system will show the number of results matched if > 5. The operator is expected to add more information to narrow results. The actual results will be displayed when the number matched is 5 or less. The operator has to select the correct record from the list shown.

Searching the AB PM-JAY Database for Valid RSBY Beneficiaries

The operator is unable to find the person using AB PM-JAY search using Name and other methods described above, then he can search from the valid RSBY database. The RSBY URN printed on the beneficiary card is used to perform the search. The system fetches the record from the RSBY database. The operator is presented with the confidence score between the Beneficiary Identity document and the RSBY record.

Linking Family Identification document with the AB PM-JAY Family

One or more Family Identity Cards can be linked with each AB PM-JAY Family. While Ration cards will be the primary family document, States can define additional family documents that can be used. SECC survey was conducted on the basis of households and there are possibilities where the household could have multiple ration cards.

Linking a family identification document strengthens the beneficiary identification process as we can create a confidence score based on the names in family identification document and AB PM-JAY record.

Ration Card or Other Government Family ID Beneficiary Identity Document	AB PM-JAY Beneficiary Record

Names of family members	RAM, GEETHA, GOVIND, MEENAKUMARI	**Names of family members**	GEETHA, MEENAKUMARI, RAM
FAMILY MATCH CONFIDENCE SCORE: 92%			

Linking the family identification document will be mandatory ONLY if the same document is also the ID used by the state to cover a larger base. Operators are encouraged to upload the family document if the name match confidence score is low, but they believe the 2 records are the same
Integration with an online family card database is recommended. In this scenario, the operator will enter the Family ID No (from the IDs mentioned earlier) and will be able to fetch the names of the family members from the online database.
If an integration is not possible, the operator will enter the names of the family members as written in the ID card and upload a scan of the ID card for verification.

Approval by Insurance Company/Trust

The State can appoint either the Insurance Company or Trust to perform the verification of the data of identified beneficiaries. The team needs to work with a strong Service Level Agreements (SLA) on turnaround time. Approvals are expected to be provided within 30 minutes back to the operator on a 24x7 basis.
The Approver is presented the Beneficiary Identity Document and the AB PM-JAY (or RSBY) record side by side for validation along with the confidence score. The lowest confidence score records are presented first.
If the operator has uploaded the Family Identity document, it is also displayed along with the Confidence Score.
The approver must ensure that there exists at least a two member overlap between source family members and members mentioned in the produced family document (e.g. Ration card etc.)
The Approver has only 2 choices for each case – Approve or Recommend for Rejection with Reason
The System maintains a track of which Operator is Approving / Recommending for rejection. The Insurance Company/Trust can analyze the approval or rejection pattern of each of the operators.

A Acceptance of Rejection Request by State (applicable only in case of Insurance Company mode of implementation)

The State should setup a team that reviews all the cases recommended for Rejection. The team reviews the data provided and the reason it has been recommended for rejection. If the State agrees with the Insurer, it can reject the case.
If the State disagrees with the Insurer, it can approve the case. The person in the state making the decision is also tracked in the system. The State review role is also SLA based and a turnaround is expected in 24 hours on working hour basis.

B Addition of Family Members

The AB PM-JAY scheme allows addition of new family members if they became part of the family either due to marriage or by birth. In order to add a family member, at least one of the existing family members needs to be verified and the identity document used for the verification must be Aadhaar.

To add the additional member, the family must produce:

- The name of the additional member in a State approved family document like Ration Card OR
- A birth certificate linking the member to the family OR
- A marriage certificate linking the member to the family OR
- An Adoption certificate to identified family member is available.

Note: Any family member can be added in existing SECC family in-spite of his/her date of birth is after or before 2011 and addition of members is not limited only to new born and newly married, any member can be added to existing SECC family provided member can establish relation with a PMJAY verified beneficiary and the identity document used for the verification must be Aadhaar.

C Monitoring of Beneficiary identification and e-card printing process

Responsibility of – State Government/ SHA

Timeline – Continuous

SG/ SHA will need to have very close monitoring of the process in order to ascertain challenges, if any, being faced and resolution of the same. Monitoring of verification process may be based on following parameters:

- Number of contact points and manpower deployed/ Number and type of manpower
- Time taken for issuance of e-card of each member
- Percentage of families with at least one member having issued e-card out of total eligible families in AB PM-JAY
- Percentage of members issued e-cards out of total eligible members in AB PM-JAY
- Percentage of families with at least one member verified out of total eligible families in RSBY data (if applicable)
- Percentage of members issued e-card out of total eligible members in RSBY data (if applicable)
- Percentage of total members where Aadhaar was available and captured and percentage of members without Aadhaar number
- Percentage of total members where mobile was available and capture

Schedule 5: Guidelines for Empanelment of Health Care Providers and Other Related Issues

Basic Principles

For providing the benefits envisaged under the Mission, the State Health Agency (SHA) through State Empanelment Committee (SEC) will empanel or cause to empanel private and public health care service providers and facilities in their respective State/UTs as per these guidelines.
The states are free to decide the mode of verification of empanelment application, conducting the physical verification either through District Empanelment Committee (DEC) or using the selected insurance company (Insurance Model), under the broad mandate of the instructions provided in these guidelines.
Institutional Set-Up for Empanelment

State Empanelment Committee (SEC) will constitute of following members:
CEO, State Health Agency – Chairperson;
Medical Officer not less than the level Director, preferably Director In Charge for Implementation of Clinical Establishment Regulation Act – Member;
Two State government officials nominated by the Department – Members;
In case of Insurance Model, Insurance company to nominate a representative not below Additional General Manager or equivalent;

The state government may invite other members to SEC as it may deem fit to assist the Committee in its activities. The State Government may also require the Insurance Company to mandatorily provide a medical representative to assist the SEC in its activities.

Alternatively, the State/SHA may continue with any existing institution under the respective state schemes that may be vested with the powers and responsibilities of SEC as per these guidelines**.**
The SHAs through State Empanelment Committee (SEC) shall ensure:
Ensuring empanelment within the stipulated timeline for quick implementation of the programme;
The empanelled provider meets the minimum criteria as defined by the guidelines for general or specialty care facilities;
Empanelment and de-empanelment process transparency;
Time-bound processing of all applications; and
Time-bound escalation of appeals.

It is prescribed that at the district level, a similar committee, District Empanelment Committee (DEC) will be formed which will be responsible for hospital empanelment related activities at the district level and to assist the SEC in empanelment and disciplinary proceedings with regards to network providers in their districts.
District Empanelment Committee (DEC) will constitute of the following members
Chief Medical Officer of the district
District Program Manager – State Health Agency
In case of Insurance Model, Insurance company representative

The State Government may require the Insurance Company to mandatorily provide a medical representative to assist the DEC in its activities.

The structure of SEC and DEC for the two options are recommended as below:

S.No.	Institutional Option	SEC Recommended Composition	DEC Recommended Composition
1.	Approval of the Empanelment application by the State	Chair: CEO/Officer in Charge of State Health Agency At least 5 membered Committee	Chair: CMO or equivalent At least 3 membered committee At least one other doctor other than CMO
2.	Verification of the Empanelment application by the Insurance Company and approval by State	Chair: CEO/Officer in Charge of State Health Agency SEC may have 1 representative from the insurance company	DEC may have 1 representative from the insurance company

The DEC will be responsible for:
Getting the field verification done along with the submission of the verification reports to the SEC through the online empanelment portal.
The DEC will also be responsible for recommending, if applicable, any relaxation in empanelment criteria that may be required to ensure that sufficient number of empanelled facilities are available in the district.
Final approval of relaxation will lie with SEC
The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return to the hospital the empanelment request.

Process of Empanelment

Empanelment requirements

All States/UTs will be permitted to empanel hospitals only in their own State/UT.
In case State/ UT wants to empanel hospitals in another State/UT, they can only do so till the time that State/ UT is not implementing AB-PMJAY. For such states where AB-PMJAY is not being implemented NHA may directly empanel CGHS empanelled hospitals.
All public facilities with capability of providing inpatient services (Community Health Centre level and above) are deemed empanelled under AB-PMJAY. The State Health Department shall ensure that the enabling infrastructure and guidelines are put in place to enable all public health facilities to provide services under AB-PMJAY.
Employee State Insurance Corporation (ESIC) hospitals will also be eligible for empanelment in AB-PMJAY, based on the approvals.
For private providers and not for profit hospitals, a tiered approach to empanelment will be followed. Empanelment criteria are prepared for various types of hospitals / specialties catered by the hospitals and attached in Annex 1.
Private hospitals will be encouraged to provide ROHINI provided by Insurance Information Bureau (IIB). Similarly public hospitals will be encouraged to have NIN provided by MoHFW.
Hospitals will be encouraged to attain quality milestones by making AB PM-JAY Bronze Certification/ NABH (National Accreditation Board of Health) pre entry level accreditation/ NQAS (National Quality Assurance Standards) mandatory for all the empaneled hospitals to be attained within 1 year with 2 extensions of one year each.

Hospitals with NABH/ NQAS accreditation will be given incentivised payment structures by the states within the flexibility provided by MoHFW/NHA. The hospital with NABH/ NQAS accreditation can be incentivized for higher package rates subject to Procedure and Costing Guidelines.
Hospitals in backwards/rural/naxal areas may be given incentivised payment structures by the states within the flexibility provided by MoHFW/NHA
Criteria for empanelment has been divided into two broad categories as given below.

Category 1: General Criteria	Category 2: Specialty Criteria
All the hospitals empanelled under AB-PMJAY for providing general care have to meet the minimum criteria established under the Mission detailed in Annex 1. No exceptions will be made for any hospital at any cost.	Hospitals would need to be empanelled separately for certain tertiary care packages authorized for one or more specialties (like Cardiology, Oncology, Neurosurgery etc.). This would only be applicable for those hospitals who meet the general criteria for the AB-PMJAY.

Detailed empanelment criteria have been provided as Annex 1.
State Governments will have the flexibility to **revise/relax** the empanelment criteria based, barring minimum requirements of Quality as highlighted in Annex 1, on their local context, availability of providers, and the need to balance quality and access; with prior approval from National Health Agency. The same will have to be incorporated in the web-portal for online empanelment of hospitals.
Hospitals will undergo a renewal process for empanelment once every **3 years or till the expiry of validity of NABH/ NQAS certification whichever is earlier** to determine compliance to minimum standards.
National Health Agency may revise the empanelment criteria at any point during the programme, if required and the states will have to undertake any required re-assessments for the same.

Awareness Generation and Facilitation

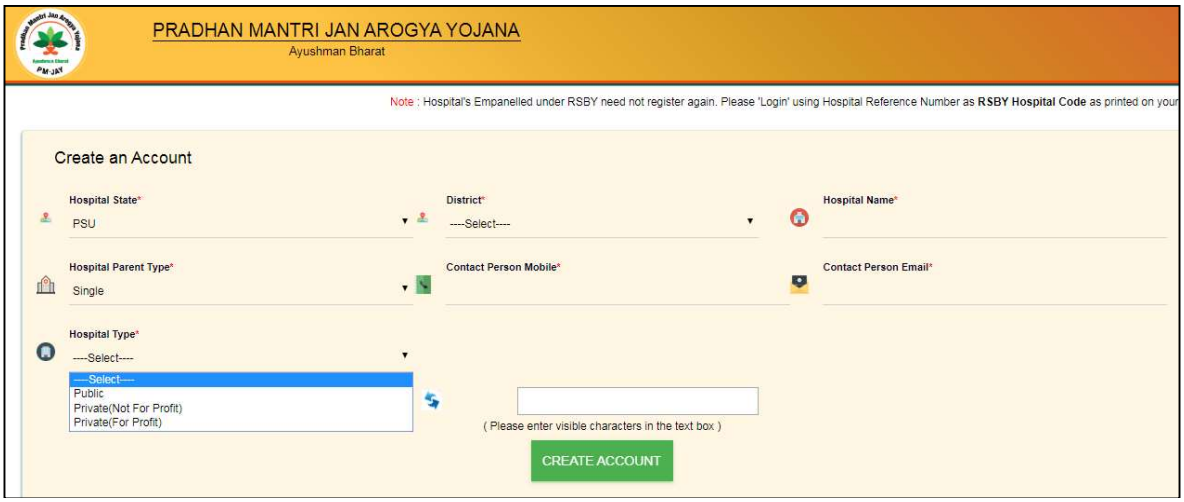
The state government shall ensure that maximum number of eligible hospitals participate in the AB-PMJAY, and this need to be achieved through IEC campaigns, collaboration with and district, sub-district and block level workshops.
The state and district administration should strive to encourage all eligible hospitals in their respective jurisdictions to apply for empanelment under AB-PMJAY. The SHA shall organise a district workshop to discuss the details of the Mission (including empanelment criteria, packages and processes) with the hospitals and address any query that they may have about the mission.
Representatives of both public and private hospitals (both managerial and operational persons) including officials from Insurance Company will be invited to participate in this workshop.

Online Empanelment

A web-based platform Hospital Empanelment Management (HEM) have been developed for registration of a healthcare provider to get empanelled under the PM-JAY. The hospital must apply through this portal as the first step of empanelment as, it is the interface for application. Every hospital needs to visit the web portal and create an account for themselves.

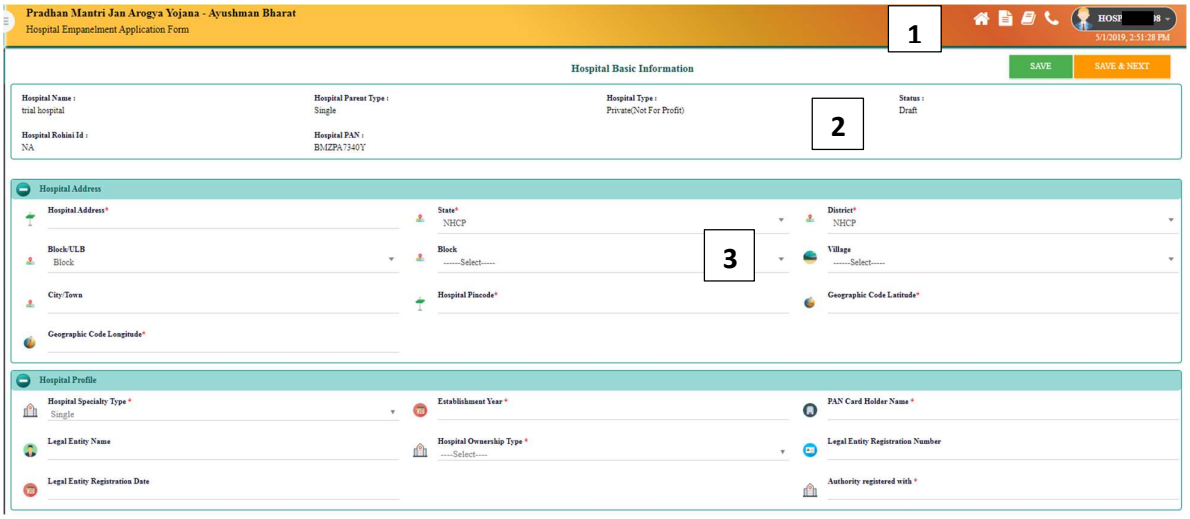
The hospital/healthcare provider must show willingness to empanel the hospital under PM-JAY by visiting the web portal using URL https://hospitals.pmjay.gov.in . After agreeing on this section, the system will provide an opportunity to create an account for the hospital. This section includes of the following information to be provided by the hospital:

State of the hospital
District of the hospital
Name of the hospital
Hospital parent type:
Single hospital
Group of hospitals
Hospital type:
Public Hospital
Private (for profit) hospital
Private (not for profit) hospital
Contact person mobile number
Contact person email id



After successful submission of all the relevant information, the system will allow to create an account for the hospital. An exclusive hospital reference number and password will be sent to registered mobile number and email id. Using these credentials, the hospital has to login in to the system to start filling the application form. This will direct the user to the "Home Page" which consists of following components:

User Section: This section displays the "Hospital Reference Number" which is unique for every hospital. "Home Page Icon" which directs the user to the home page. "Eligibility Criteria Icon" which directs the user to the list of mandatory fields need to be filled by the user to complete the form. A link for "User manual" of Hospital Empanelment Management System.

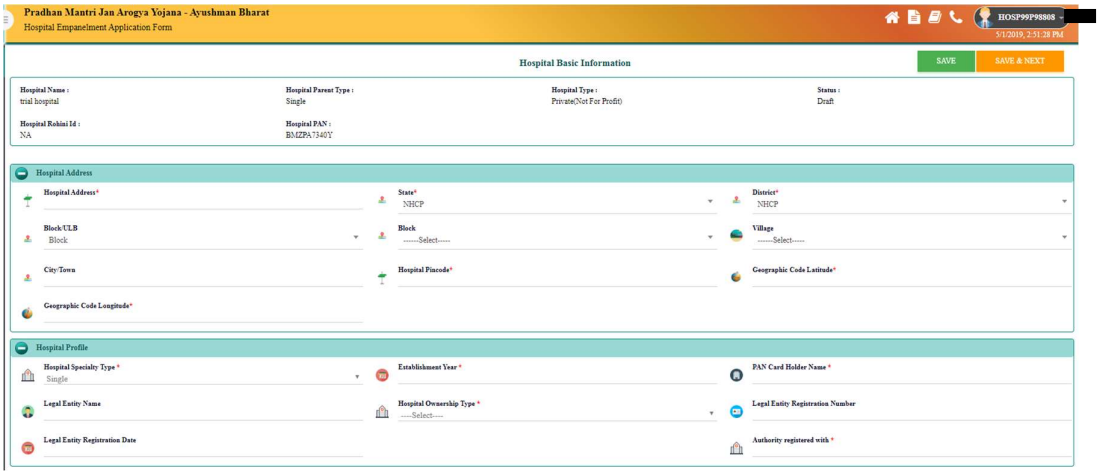


Hospital Basic Information (A): This section includes the information filled by the user at the time of creating the account for the hospital. The user cannot update/edit this section at this point of time.

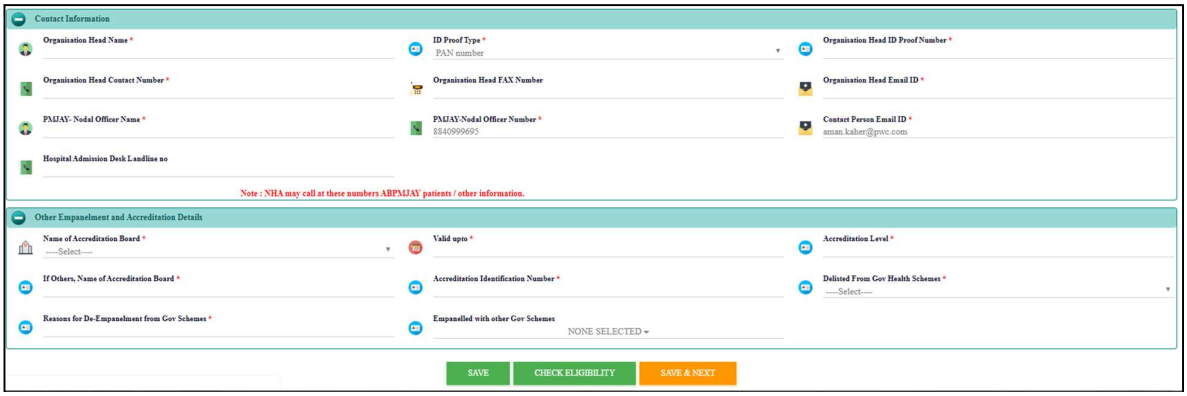
Hospital Basic Information (B): This section allows the user to enter the basic information related to the hospital. The process of application using HEM includes following information to be filled by the user.

Hospital Basic Information
Financial details of the hospital
Specialties offered by the healthcare provider
Licences and Certification of the hospital
Details of civil infrastructure
Details of medical infrastructure
General services
Man-power details
Update / Ugrade Application

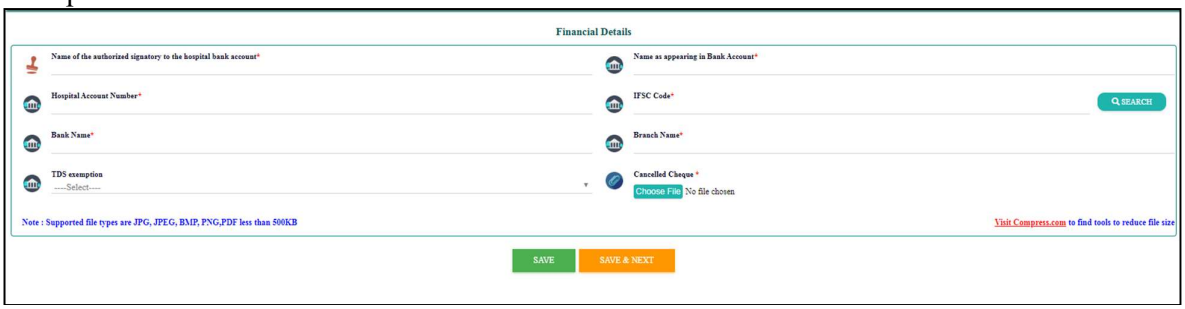
Hospital Basic Information: This section allows the user to enter all the basic information of the hospital which includes hospital address, hospital profile, contact information and other empanelment and accreditation details. The address of the hospital consists of state, district, block, city/town, pin code and geographical code longitude of the hospital. Hospital profile section consists of specialty of the hospital differentiated as single specialty or a multispecialty. Year of the establishment of the hospital. Legal or Registered name, registration number and date of the hospital and the owner ship details of the hospital. The detail of the PAN card associated with the hospital.



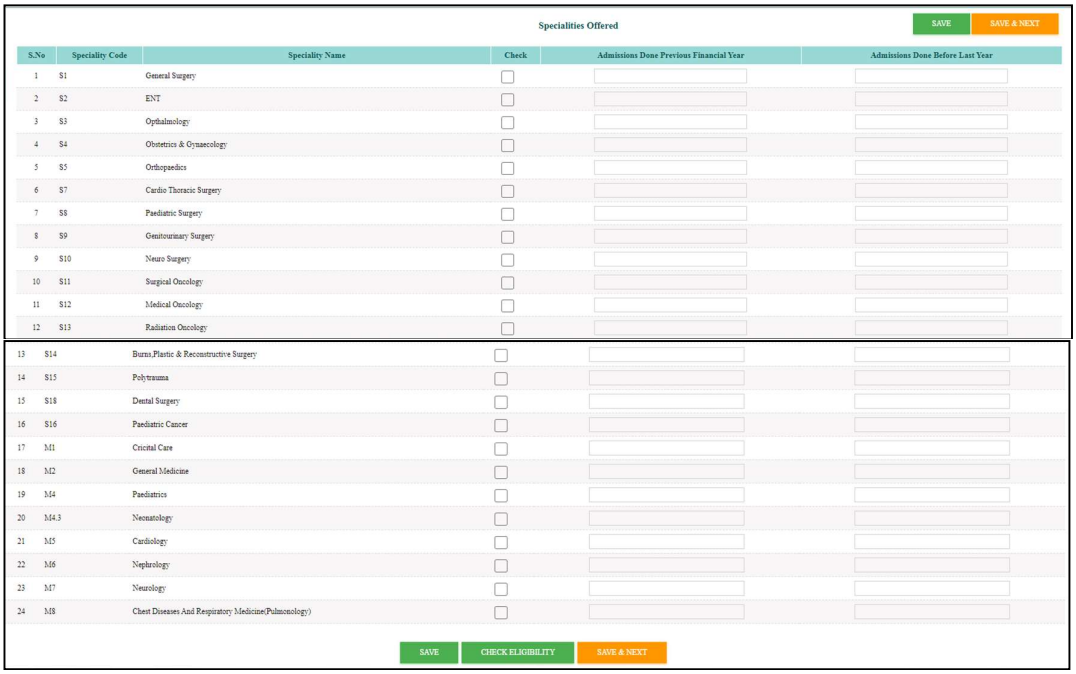
The contact information section comprises of name of the organization head, his/her contact number with ID proof number and email id. PMJAY nodal officer name and contact number and email id. Also, the hospital admission desk landline number. The hospital must choose the ID proof type which is shared with the authority. Other empanelment and accreditation details that are need to be added by the hospitals are name of the accreditation board, level of accreditation and its validity.



Financial Details: The hospital is requested to fill the financial details of the hospital in this section. The financial details of the hospitals are as follows: Name of the authorized signatory to the hospital bank account, name as appearing in the bank account, hospital account number, Bank name, IFS Code, cancelled cheque and must declare if hospital; comes under TDS exemption.



Specialty offered by hospital: Hospital is mandated to apply for all specialties for which requisite infrastructure and facilities are available with it. Hospitals will not be permitted to choose specific specialties it wants to apply for unless it is a single specialty hospital.



Specialities Offered

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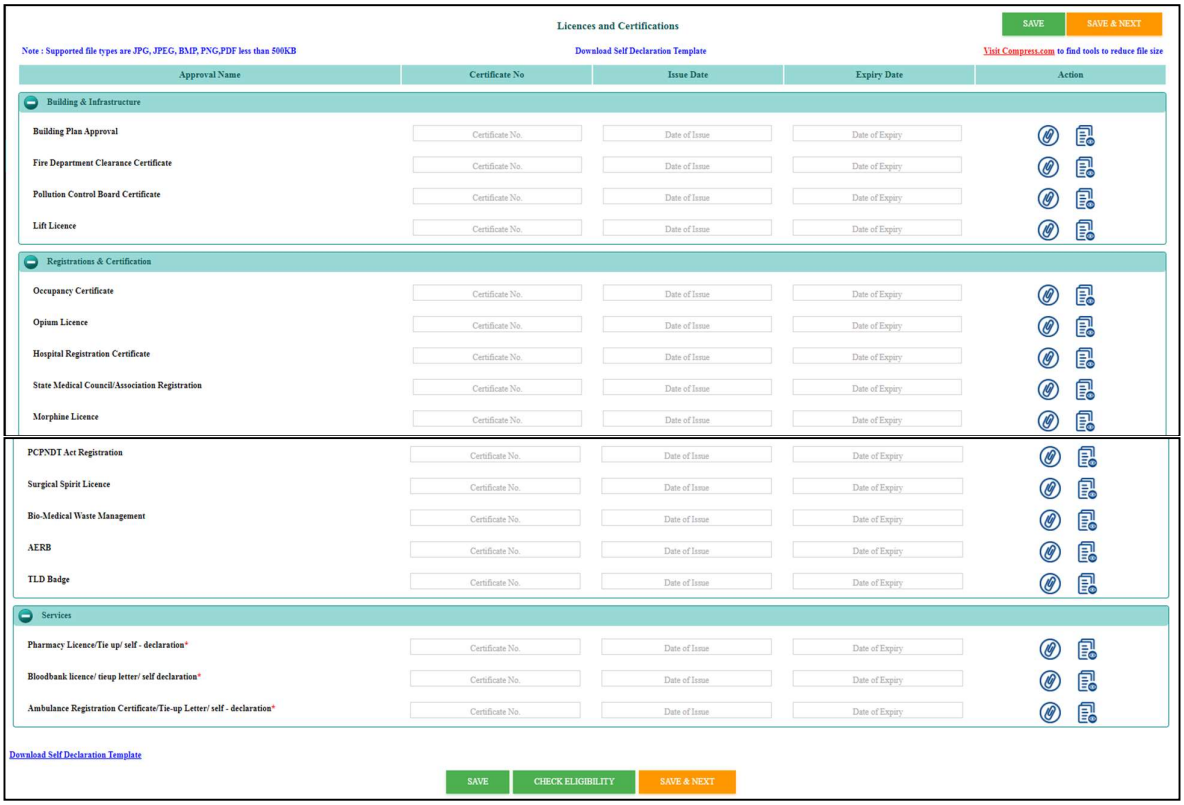
S.No	Speciality Code	Speciality Name	Check	Admissions Done Previous Financial Year	Admissions Done Before Last Year
1	S1	General Surgery			
2	S2	ENT			
3	S3	Opthalmology			
4	S4	Obstetrics & Gynaecology			
5	S5	Orthopaedics			
6	S7	Cardio Thoracic Surgery			
7	S8	Paediatric Surgery			
8	S9	Genitourinary Surgery			
9	S10	Neuro Surgery			
10	S11	Surgical Oncology			
11	S12	Medical Oncology			
12	S13	Radiation Oncology			
13	S14	Burns,Plastic & Reconstructive Surgery			
14	S15	Polytrauma			
15	S18	Dental Surgery			
16	S16	Paediatric Cancer			
17	M1	Cricital Care			
18	M2	General Medicine			
19	M4	Paediatrics			
20	M4.3	Neonatology			
21	M5	Cardiology			
22	M6	Nephrology			
23	M7	Neurology			
24	M8	Chest Diseases And Respiratory Medicine(Pulmonology)			

SAVE | CHECK ELIGIBILITY | SAVE & NEXT

Licenses and Certifications: This licences and certificates are divided into three major categories which are:
Building and Infrastructure
Registrations and certifications
Services
The hospital should upload all the relevant certificates and licences on the portal in this section.



Licences and Certifications

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Note : Supported file types are JPG, JPEG, BMP, PNG,PDF less than 500KB | Download Self Declaration Template | Visit Compress.com to find tools to reduce file size

Approval Name	Certificate No	Issue Date	Expiry Date	Action
Building & Infrastructure				
Building Plan Approval	Certificate No.	Date of Issue	Date of Expiry	
Fire Department Clearance Certificate	Certificate No.	Date of Issue	Date of Expiry	
Pollution Control Board Certificate	Certificate No.	Date of Issue	Date of Expiry	
Lift Licence	Certificate No.	Date of Issue	Date of Expiry	
Registrations & Certification				
Occupancy Certificate	Certificate No.	Date of Issue	Date of Expiry	
Opium Licence	Certificate No.	Date of Issue	Date of Expiry	
Hospital Registration Certificate	Certificate No.	Date of Issue	Date of Expiry	
State Medical Council/Association Registration	Certificate No.	Date of Issue	Date of Expiry	
Morphine Licence	Certificate No.	Date of Issue	Date of Expiry	
PCPNDT Act Registration	Certificate No.	Date of Issue	Date of Expiry	
Surgical Spirit Licence	Certificate No.	Date of Issue	Date of Expiry	
Bio-Medical Waste Management	Certificate No.	Date of Issue	Date of Expiry	
AERB	Certificate No.	Date of Issue	Date of Expiry	
TLD Badge	Certificate No.	Date of Issue	Date of Expiry	
Services				
Pharmacy Licence/Tie up/ self - declaration*	Certificate No.	Date of Issue	Date of Expiry	
Bloodbank licence/ tieup letter/ self declaration*	Certificate No.	Date of Issue	Date of Expiry	
Ambulance Registration Certificate/Tie-up Letter/ self - declaration*	Certificate No.	Date of Issue	Date of Expiry	

Download Self Declaration Template

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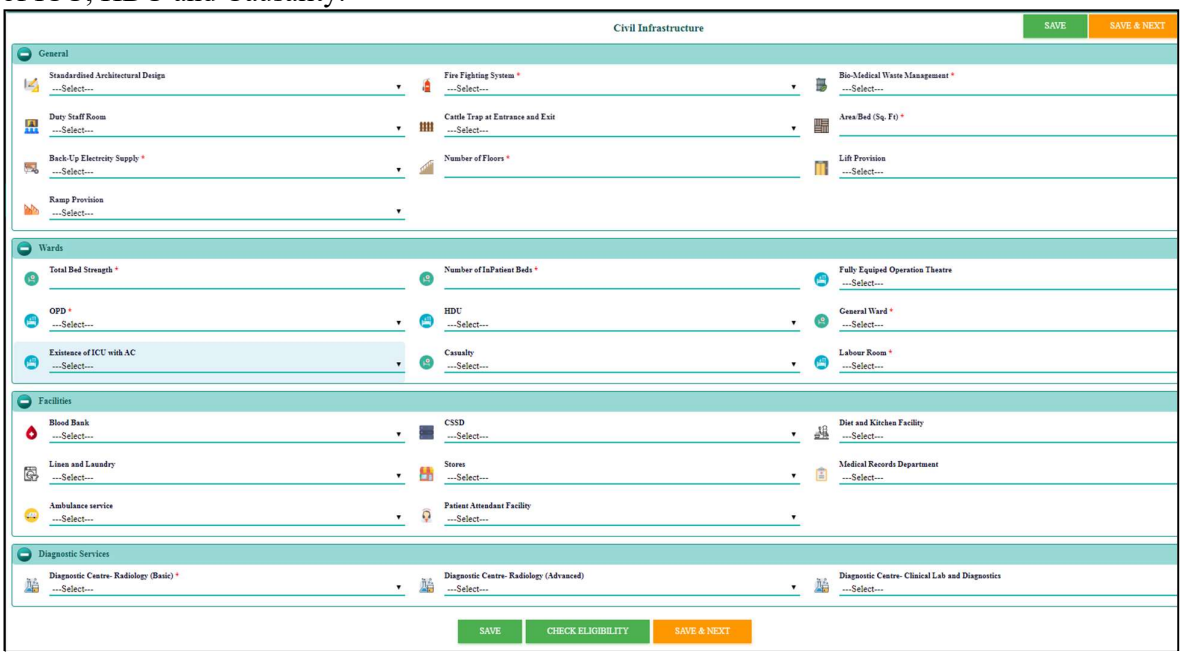
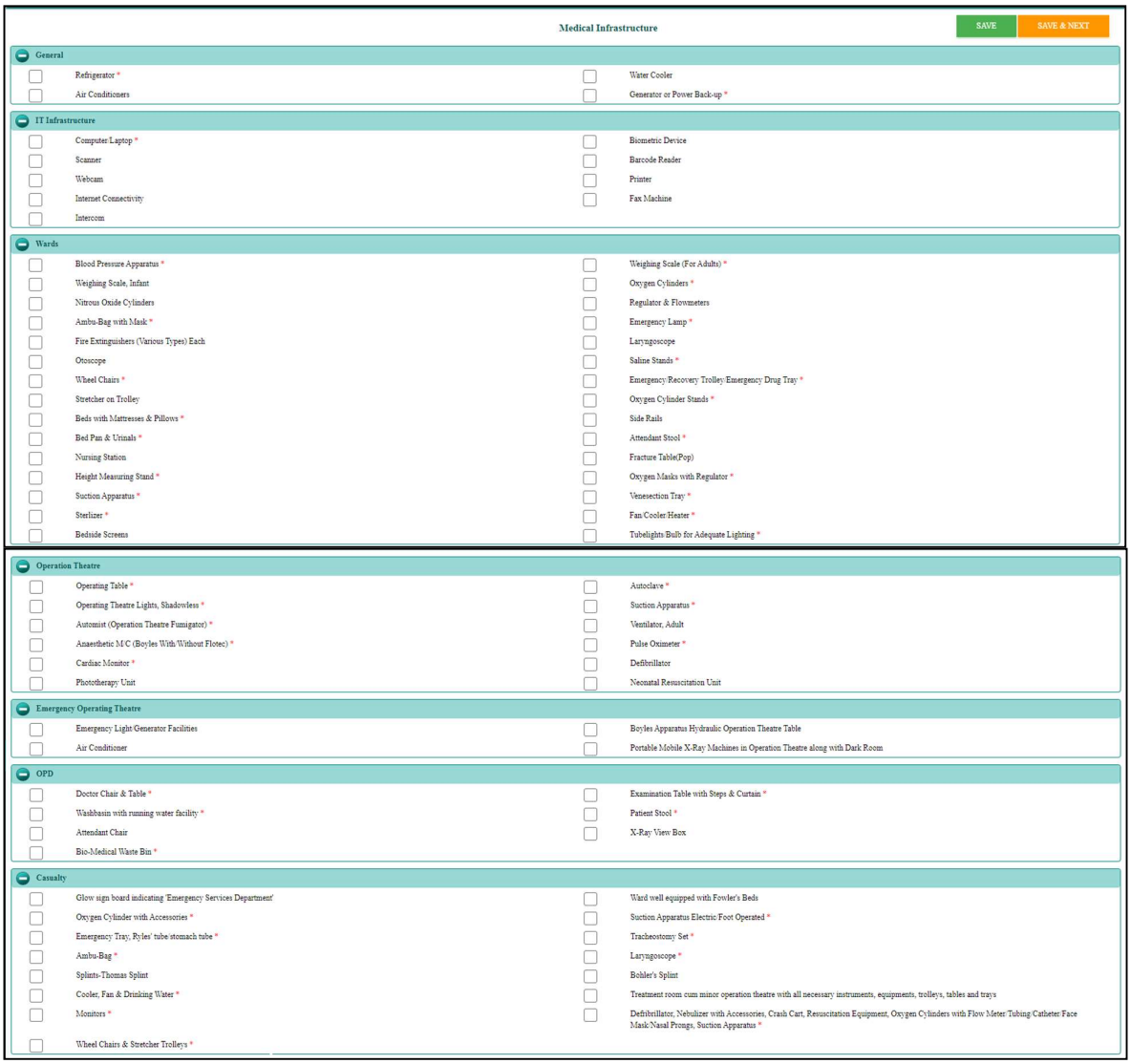
Civil Infrastructure: It is advised to the hospital to update al the necessary infrastructure of the hospital. The section is divided into following major sub sections:
General infrastructure
Wards
Facilities
The general Infrastructure includes of information on the basic architecturial design of the hospital, number of floors, licence of firefighting system, provision of electricity backup, Bio medical waste management, total area and availability of ramp for patient transport. The hospital also must provide the information of the total in-patient bed, OPD details, existence of ICU, HDU and Causality.



Also, the hospital should update the various availability of all allied facilities in or outsourced by the hospital.

Medical Infrastructure: The updated medical infrastructure of the hospital is required to be updated in this section. The fields are divided into following major sections:
General Medical Infrastructure
IT infrastructure
Wards
Operation Theater
Emergency Operation Theater
OPD
Causality



Medical Infrastructure

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General

- Refrigerator *
- Air Conditioners
- Water Cooler
- Generator or Power Back-up *

IT Infrastructure

- Computer/Laptop *
- Scanner
- Webcam
- Internet Connectivity
- Intercom
- Biometric Device
- Barcode Reader
- Printer
- Fax Machine

Wards

- Blood Pressure Apparatus *
- Weighing Scale, Infant
- Nitrous Oxide Cylinders
- Ambu-Bag with Mask *
- Fire Extinguishers (Various Types) Each
- Otoscope
- Wheel Chairs *
- Stretcher on Trolley
- Beds with Mattresses & Pillows *
- Bed Pan & Urinals *
- Nursing Station
- Height Measuring Stand *
- Suction Apparatus *
- Sterlizer *
- Bedside Screens
- Weighing Scale (For Adults) *
- Oxygen Cylinders *
- Regulator & Flowmeters
- Emergency Lamp *
- Laryngoscope
- Saline Stands *
- Emergency/Recovery Trolley/Emergency Drug Tray *
- Oxygen Cylinder Stands *
- Side Rails
- Attendant Stool *
- Fracture Table(Pop)
- Oxygen Masks with Regulator *
- Venesection Tray *
- Fan/Cooler/Heater *
- Tubelights/Bulb for Adequate Lighting *

Operation Theatre

- Operating Table *
- Operating Theatre Lights, Shadowless *
- Automist (Operation Theatre Fumigator) *
- Anaesthetic M/C (Boyles With/Without Flotec) *
- Cardiac Monitor *
- Phototherapy Unit
- Autoclave *
- Suction Apparatus *
- Ventilator, Adult
- Pulse Oximeter *
- Defibrillator
- Neonatal Resuscitation Unit

Emergency Operating Theatre

- Emergency Light/Generator Facilities
- Air Conditioner
- Boyles Apparatus Hydraulic Operation Theatre Table
- Portable/Mobile X-Ray Machines in Operation Theatre along with Dark Room

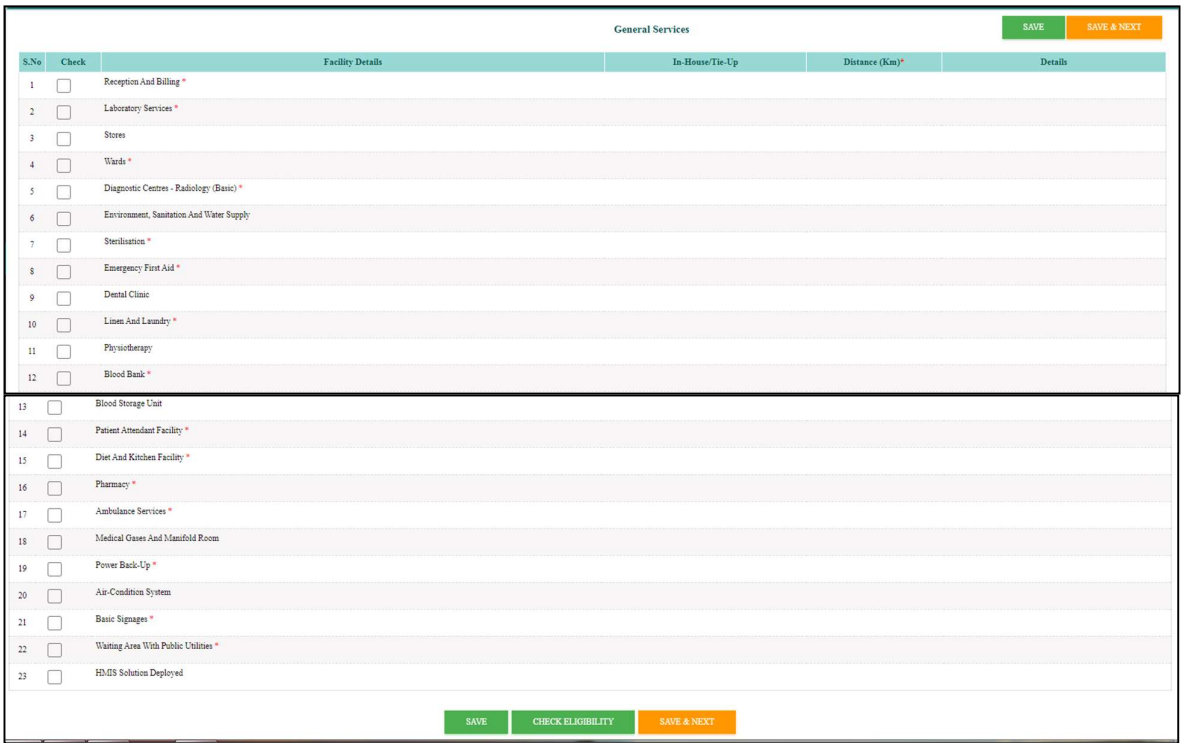
OPD

- Doctor Chair & Table *
- Washbasin with running water facility *
- Attendant Chair
- Bio-Medical Waste Bin *
- Examination Table with Steps & Curtain *
- Patient Stool *
- X-Ray View Box

Casualty

- Glow sign board indicating 'Emergency Services Department'
- Oxygen Cylinder with Accessories *
- Emergency Tray, Ryles' tube/stomach tube *
- Ambu-Bag *
- Splints-Thomas Splint
- Cooler, Fan & Drinking Water *
- Monitors *
- Wheel Chairs & Stretcher Trolleys *
- Ward well equipped with Fowler's Beds
- Suction Apparatus Electric/Foot Operated *
- Tracheostomy Set *
- Laryngoscope *
- Bohler's Splint
- Treatment room cum minor operation theatre with all necessary instruments, equipments, trolleys, tables and trays
- Defibrillator, Nebulizer with Accessories, Crash Cart, Resuscitation Equipment, Oxygen Cylinders with Flow Meter/Tubing/Catheter/Face Mask/Nasal Prongs, Suction Apparatus *

General Services: This includes basic services provided by the hospital such as reception and billing, Laboratory services, diagnostic services, pharmacy, blood bank and others. The hospital should provide the details of the abovementioned services.



General Services

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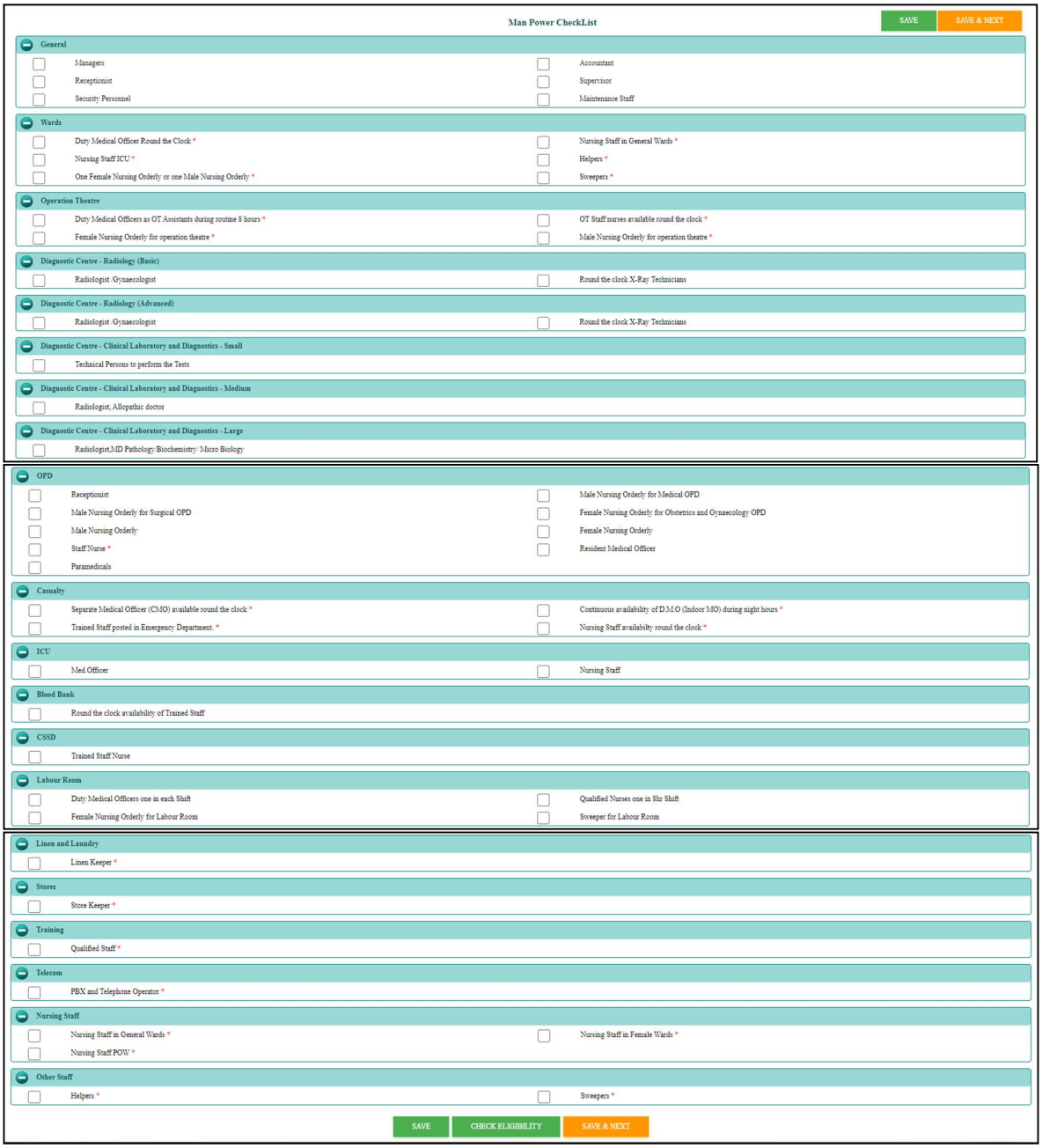
S.No	Check	Facility Details	In-House/Tie-Up	Distance (Km)*	Details
1	☐	Reception And Billing *			
2	☐	Laboratory Services *			
3	☐	Stores			
4	☐	Wards *			
5	☐	Diagnostic Centres - Radiology (Basic) *			
6	☐	Environment, Sanitation And Water Supply			
7	☐	Sterilisation *			
8	☐	Emergency First Aid *			
9	☐	Dental Clinic			
10	☐	Linen And Laundry *			
11	☐	Physiotherapy			
12	☐	Blood Bank *			
13	☐	Blood Storage Unit			
14	☐	Patient Attendant Facility *			
15	☐	Diet And Kitchen Facility *			
16	☐	Pharmacy *			
17	☐	Ambulance Services *			
18	☐	Medical Gases And Manifold Room			
19	☐	Power Back-Up *			
20	☐	Air-Condition System			
21	☐	Basic Signages *			
22	☐	Waiting Area With Public Utilities *			
23	☐	HMIS Solution Deployed			

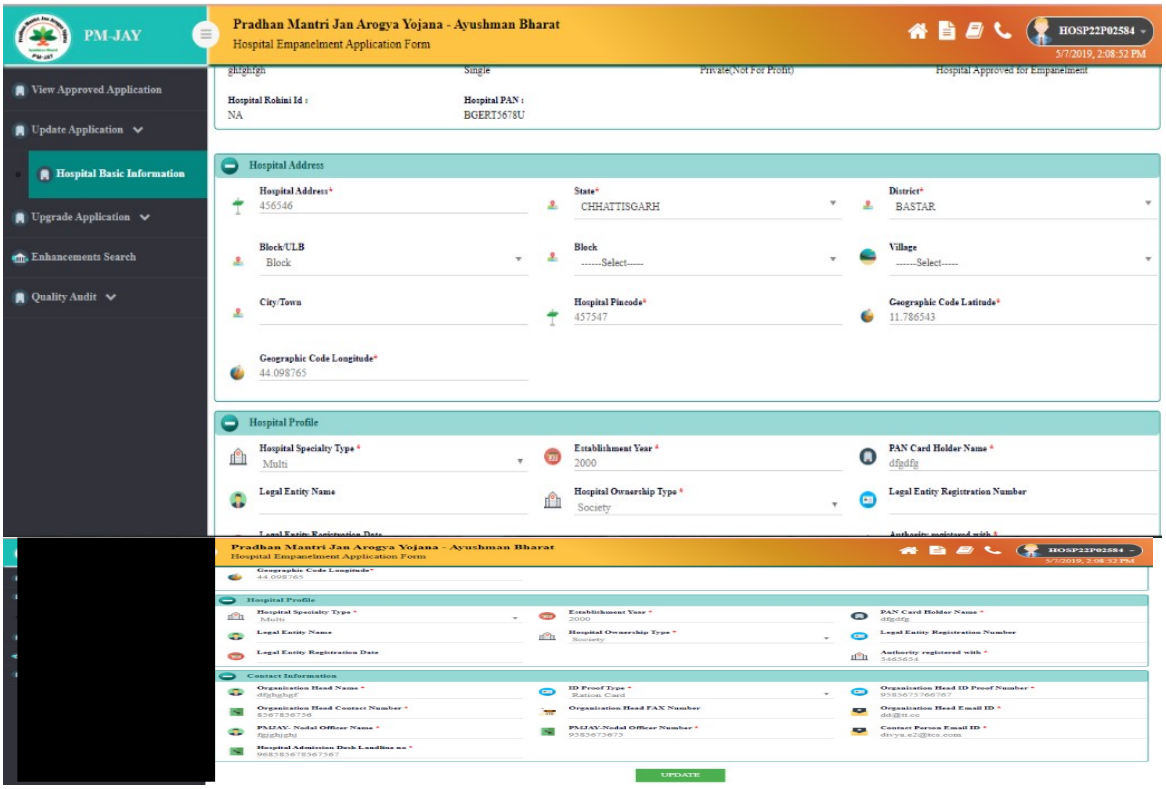
SAVE | CHECK ELIGIBILITY | SAVE & NEXT

Man-Power Details: The human resources currently placed at the hospitals should be filled in this section. The checklist of the possible man-power is clubbed under following sub-sections:
General Human resource
Human resource associated with Wards, Operation Theatre, diagnostic center (basic and advance), OPD, ICU, Causality, Blood Bank, CSSD, Labour Room.
Staff placed at Laundry, stores, training department, telecom and nursing staff.

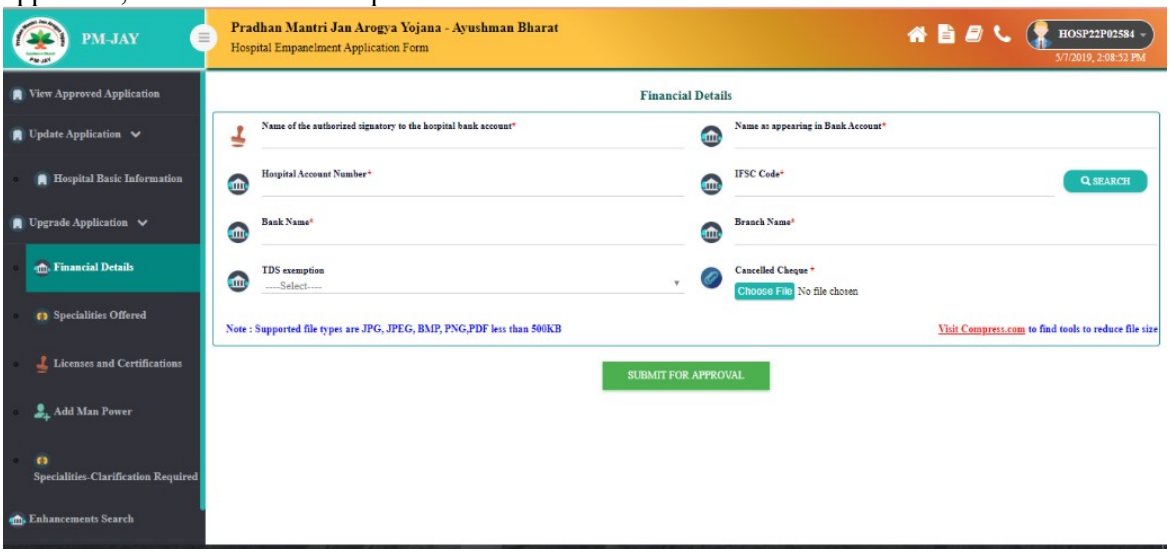


Update / Upgrade Application: This is an inbuilt feature allows the user to update the basic information related to the hospital post approval. This do not require any approval from the administration. This section consists of the following:

Hospital Address
Hospital Profile
Contact Information



Certain information of the hospital requires administrative approvals to upgrade the status of the hospital, such as:
Financial Details
Specialities offered
Licences and Certifications
Adding Man – Power
The user must fill the desired changes in this section and submit it for approval. Once the request is received clarification can be asked for from the approver. After proper resolution and approvals, the details will be updated in this section.



After registering on the web-portal, the hospital user will be able to check the status of their application. At any point, the application shall fall into one of the following categories:
Hospital registered but application submission pending
Application submitted but document verification pending
Application submitted with documents verified and under scrutiny by DEC/SEC
Application sent back to hospital for correction
Application sent for field inspection
Inspection report submitted by DEC and decision pending at SEC level
Application approved and contract pending
Hospital empanelled
Application rejected
Hospital de-empanelled
Hospital blacklisted (2 years)

Role of DEC

After the empanelment request by a hospital is filed, the application should be scrutinized by the DEC and processed completely within 15 days of receipt of application.
A login account for a nodal officer from DEC will be created by SEC. This login ID will be used to download the application of hospitals and upload the inspection report.
As a first step, the documents uploaded have to be correlated with physical -verification of original documents produced by the hospital. In case any documents are found wanting, the DEC may return the application to the hospital for rectifying any errors in the documents.
After the verification of documents, the DEC will physically inspect the premises of the hospital and verify the physical presence of the details entered in the empanelment application, including but not limited to equipment, human resources, service standards and quality and submit a report in a said format through the portal along with supporting pictures/videos/document scans.
DEC will ensure the visits are conducted for the physical verification of the hospital. The verification team will have at least one qualified medical doctor (minimum MBBS).
The team will verify the information provided by the hospitals on the web-portal and will also verify that hospitals have applied for empanelment for all specialties as available in the hospital.
In case during inspection, it is found that 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 a timeline (i.e. 7 days from the inspection date).
In this case, the hospital will need to fill the application form again on the web portal. However, all the previously filled information by the hospital will be pre-populated and hospital will be expected to enter the new information.
If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.
In case during inspection, it is found that hospital has applied for multiple specialties, but all do not conform to minimum requirements under AB-PMJAY then the hospital will only be empanelled for specialties that conform to AB-PMJAY norms.
The team will recommend whether hospital should be empanelled or not based on their field-based inspection/verification report.
DEC team will submit its final inspection report to the state. The district nodal officer has to upload the reports through the portal login assigned to him/her.
The DEC will then forward the application along with its recommendation to the SEC.

Role of SEC

The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return back to the hospital the empanelment request.
In case of refusal, the SEC will record in writing the reasons for refusal and either direct the hospital to remedy the deficiencies, or in case of egregious emissions from the empanelment request, either based on documentary or physical verification, direct the hospital to submit a fresh request for empanelment on the online portal.
The SEC will also consider recommendations for relaxation of criteria of empanelment received from DEC or from the SHA and approve them to ensure that sufficient number and specialties of empanelled facilities are available in the states.
Hospital will be intimated as soon as a decision is taken regarding its empanelment and the same will be updated on the AB-PMJAY web portal. The hospital will also be notified through SMS/email of the final decision. If the application is approved, the hospital will be assigned a unique national hospital registration number under AB-PMJAY.
If the application is rejected, the hospital will be intimated of the reasons on the basis of which the application was not accepted and comments supporting the decision will be provided on the AB-PMJAY web portal. Such hospitals shall have the right to file a review against the rejection with the State Health Agency within 15 days of rejection through the portal. In case the request for empanelment is rejected by the SHA in review, the hospitals can approach the Grievance Redressal Mechanism for remedy.
In case the hospital chooses to withdraw from AB-PMJAY, it will only be permitted to re-enter/ get re-empanelled under AB-PMJAY after a period of 6 months.
If a hospital is blacklisted for a defined period due to fraud/abuse, after following due process by the State Empanelment Committee, it can be permitted to re-apply after cessation of the blacklisting period or revocation of the blacklisting order, whichever is earlier.
There shall be no restriction on the number of hospitals that can be empanelled under AB-PMJAY in a district.
Final decision on request of a Hospital for empanelment under AB-PMJAY, shall be completed within 30 days of receiving such an application.

Fast Track Approvals

In order to fast track the empanelment process, hospitals which are NABH/ NQAS accredited shall be auto-empaneled provided they have submitted the application on web portal and meet the minimum criteria.
In order to fast track the empanelment process, the states may choose to auto-approve the already empanelled hospitals under an active RSBY scheme or any other state scheme; provided that they meet the minimum eligibility criteria prescribed under AB-PMJAY.
If already empanelled, under this route, should the state allow the auto-approval mode, the hospital should submit their RSBY government empanelment ID or State empanelment ID during the application process on the web portal to facilitate on-boarding of such service providers.
The SEC shall ensure that all hospitals provided empanelment under Fast Track Approval shall undergo the physical verification process within 3 months of approval. If a hospital is found to have wrongfully empanelled under AB-PMJAY under any category, such an empanelment shall be revoked to the extent necessary and disciplinary action shall be taken against such an errant medical facility.

Signing of Contract

Within 7 days of approval of empanelment request by SEC, the State Government will sign a contract with the empanelled hospitals as per the template defined in the tender document.

If insurance company is involved in implementing the scheme in the State, they will also be part of this agreement, i.e. tripartite agreement will be made between the IC, SHA and the hospital.
Each empanelled hospital will need to provide a name of a nodal officers who will be the focal point for the AB-PMJAY for administrative and medical purposes.
Once the hospital is empanelled, a separate admin user for the hospital will be created to carry out transactions for providing treatment to the beneficiaries.

Process for Disciplinary Proceedings and De-Empanelment

Institutional Mechanism

De-empanelment process can be initiated by Insurance Company/SHA after conducting proper disciplinary proceedings against empanelled hospitals on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries.
Hospital can contest the action of de-empanelment by Insurance Company with SEC/SHA. If hospital is aggrieved with actions of SEC/SHA, the former can approach the SHA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.
In case of implementation through the insurance mode, the SEC and DEC will mandatorily include a representative of the Insurance Company when deliberating and deciding on disciplinary proceedings under the scheme.
The SEC may also initiate disciplinary proceedings based on field audit reports/survey reports/feedback reports/ complaints filed with them/ complaints.
For disciplinary proceedings, the DEC may consider submissions made by the beneficiaries (through call centre/ mera hospital or any other application/ written submissions/Emails etc.) or directions from SEC or information from other sources to investigate a claim of fraud by a hospital.
On taking up such a case for fraud, after following the procedure defined, the DEC will forward its report to the SEC along with its recommendation for action to be taken based on the investigation.
The SEC will consider all such reports from the DECs and pass an order detailing the case and the penalty provisions levied on the hospital.
Any disciplinary proceeding so initiated shall have to be completed within 30 days.

Steps for Disciplinary Proceedings
Step 1 - Putting the provider on “Watch-list”
Based on the claims, data analysis and/or the provider visits, if there is any doubt on the performance of a Provider, the SEC on the request of the IC or the SHA or on its own findings or on the findings of the DEC, can put that hospital on the watch list. The data of such hospital shall be analysed very closely on a daily basis by the SHA/SEC for patterns, trends and anomalies and flagged events/patterns will be brought to the scrutiny of the DEC and the SEC as the case may be.
The IC shall notify such service provider that it has been put on the watch-list and the reasons for the same.
Step 2 – Issuing show-cause notice to the hospital

Based on the activities of the hospital if the insurer/ trust believes that there are clear grounds of hospital indulging in wrong practices, a showcause notice shall be issued to the hospital. Hospital will need to respond to the notice within 7 days of receiving it.

Step 3 - Suspension of the hospital

A Provider can be temporarily suspended in the following cases:

For the Providers which are on the "Watch-list" or have been issued showcause notice if the SEC observes continuous patterns or strong evidence of irregularity based on either claims data or field visit of the hospital or in case of unsatisfactory reply of the hospital to the showcause notice, the hospital may be suspended from providing services to beneficiaries under the scheme and a formal investigation shall be instituted.

If a Provider is not in the "Watch-list", but the SEC observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical Practice/ is not adhering to the major clauses of the contract with the Insurance Company / Involved in financial fraud related to health insurance patients, it may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.

A formal letter shall be send to the concerned hospital regarding its suspension with mentioning the time frame within which the formal investigation will be completed.

Step 4 - Detailed Investigation

The detailed investigation shall be undertaken for verification of issues raised in disciplinary proceedings and may include field visits to the providers (with qualified allopathic doctor as part of the team), examination of case papers, talking with the beneficiary/ policyholders/insured (if needed), examination of provider records etc. If the investigation reveals that the report/ complaint/ allegation against the provider is not substantiated, the Insurance Company/SHA would immediately revoke the suspension (in case of suspension) on the direction of the SEC. A letter regarding revocation of suspension shall be sent to the provider within 24 hours of that decision.

Step 5 – Presentation of Evidence to the SEC

The detailed investigation report should be presented to the SEC and the detailed investigation should be carried out in stipulated time period of not more than 7 days**.** The insurance company (Insurance mode)/SHA (Trust Mode) will present the findings of the detailed investigation. If the investigation reveals that the complaint/allegation against the provider is correct, then the following procedure shall be followed:

The hospital must be issued a "show-cause" notice seeking an explanation for the aberration.

In case the proceedings are under the SEC, after receipt of the explanation and its examination, the charges may be dropped or modified or an action can be taken as per the guidelines depending on the severity of the malafide/error. In cases of de-empanelment, a second show cause shall be issued to the hospital to make a representation against the order and after considering the reply to the second showcause, the SEC can pass a final order on de-empanelment. If the hospital is aggrieved with actions of SEC/SHA, the former can approach the SHA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.

In case the preliminary proceedings are under the DEC, the DEC will have to forward the report to the SEC along with its findings and recommendations for a final decision. The SEC may ask for any additional material/investigation to be brought on record and to consider all the material at hand before issuing a final order for the same.

The entire process should be completed within 30 days from the date of suspension. The disciplinary proceedings shall also be undertaken through the online portal only.

Step 6 - Actions to be taken after De- empanelment

Once the hospital has been de-empanelled, following steps shall be taken:

A letter shall be sent to the hospital regarding this decision.

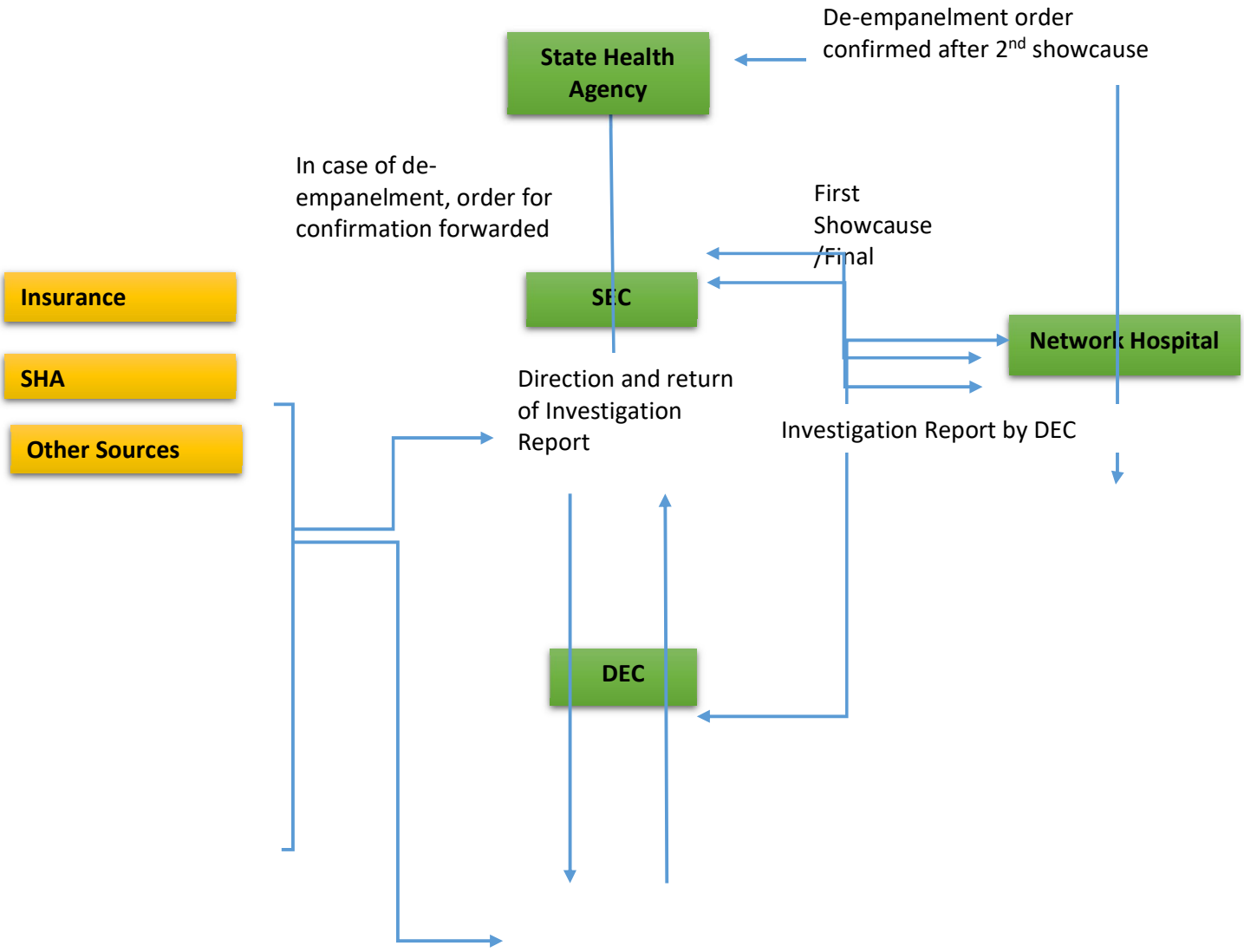
A decision may be taken by the SEC to ask the SHA/Insurance Company to lodge an FIR in case there is suspicion of criminal activity.
This information shall be sent to all the other Insurance Companies as well as other regulatory bodies and the MoHFW/ NHA.
The SHA may be advised to notify the same in the local media, informing all policyholders/insured about the de-empanelment ensuring that the beneficiaries are aware that the said hospital will not be providing services under AB-PMJAY.
A de-empanelled hospital cannot re-apply for empanelment for at least 2 years after de-empanelment. However, if the order for de-empanelment mentions a longer period, such a period shall apply for such a hospital.

Gradation of Offences
On the basis of the investigation report/field audits, the following charges may be found to be reasonably proved and a gradation of penalties may be levied by the SEC. However, this tabulation is intended to be as guidelines rather than mandatory rules and the SEC may take a final call on the severity and quantum of punishment on a case to case basis.

Penalties for Offences by the Hospital			
Case Issue	**First Offence**	**Second Offence**	**Third Offence**
Illegal cash payments by beneficiary	Full Refund and compensation 3 times of illegal payment to the beneficiary	In addition to actions as mentioned for first offence, Rejection of claim for the case	De-empanelment/ black-listing
Billing for services not provided	Rejection of claim and penalty of 3 times the amount claimed for services not provided, to Insurance Company /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for services not provided, to Insurance Company /State Health Agency	De-empanelment
Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of 8 times the excess amount claimed due to up coding /unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency. For unnecessary procedure:	Rejection of claim and penalty of 16 times the excess amount claimed due to up coding/unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency	De-empanelment
Wrongful beneficiary Identification	Rejection of claim and penalty of 3 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	De-empanelment
Non-adherence to AB-PMJAY quality and	In case of minor gaps, warning period of 2 weeks for rectification, for major gaps, Suspension of services	Suspension until rectification of gaps and validation by SEC/ DEC	De-empanelment

service standard	until rectification of gaps and validation by SEC/ DEC		

All these penalties are recommendatory and the SEC may inflict larger or smaller penalties depending on the severity/regularity/scale/intentionality on a case to case basis with reasons mentioned clearly in a speaking order.


De-empanelment order confirmed after 2nd showcause
State Health Agency
In case of de-empanelment, order for confirmation forwarded
First Showcause /Final
Insurance
SHA
Other Sources
SEC
Network Hospital
Direction and return of Investigation Report
Investigation Report by DEC
DEC

Annex 1: Detailed Empanelment Criteria

Category 1: Essential criteria:

A Hospital would be empanelled as a network private hospital with the approval of the respective State Health Authority[1] if it adheres with the following minimum criteria:
Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms. Exemption may be given for single-specialty hospitals like Eye and ENT.
General ward - @80sq ft per bed, or more in a Room with Basic amenities- bed, mattress, linen, water, electricity, cleanliness, patient friendly common washroom etc. Non-AC but with fan/Cooler and heater in winter.

It should have adequate and qualified medical and nursing staff (doctors[2] & nurses[3]), physically in charge round the clock; (necessary certificates to be produced during empanelment).

Fully equipped and engaged in providing Medical /Surgical services, commensurate to the scope of service/ available specialities and number of beds.
Round-the-clock availability (or on-call) of a Surgeon and Anaesthetist where surgical services/ day care treatments are offered.
Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anaesthetist where maternity services are offered.
Round-the-clock availability of specialists (or on-call) in the concerned specialties having sufficient experience where such services are offered (e.g. Orthopaedics, ENT, Ophthalmology, Dental, general surgery (including endoscopy) etc.)

Round-the-clock support systems required for the above services like Pharmacy, Blood Bank, Laboratory, Dialysis unit, Endoscopy investigation support, Post op ICU care with ventilator support, X-ray facility (mandatory) etc., either 'In-House' or with 'Outsourcing arrangements', preferably with NABL accredited laboratories, with appropriate agreements and in nearby vicinity.

Round-the-clock Ambulance facilities (own or tie-up).

24 hours emergency services managed by technically qualified staff wherever emergency services are offered
Casualty should be equipped with Monitors, Defibrillator, Nebulizer with accessories, Crash Cart, Resuscitation equipment, Oxygen cylinders with flow meter/ tubing/catheter/face mask/nasal prongs, suction apparatus etc. and with attached toilet facility.
Mandatory for hospitals wherever surgical procedures are offered:

[1] In order to facilitate the effective implementation of AB-PMJAY, State Governments shall set up the State Health Authority (SHA) or designate this function under any existing agency/ trust designated for this purpose, such as the state nodal agency or a trust set up for the state insurance program.

[2] Qualified doctor is a MBBS approved as per the Clinical Establishment Act/ State government rules & regulations as applicable from time to time.

[3] Qualified nurse per unit per shift shall be available as per requirement laid down by the Nursing Council/ Clinical Establishment Act/ State government rules & regulations as applicable from time to time. Norms vis a vis bed ratio may be spelt out.

Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
Post-op ward with ventilator and other required facilities.
Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU/Neonatal ICU) with requisite staff
The unit is to be situated in close proximity of operation theatre, acute care medical, surgical ward units, labour room and maternity room as appropriate.
Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
Further ICU- where such packages are mandated should have the following equipment:
Piped gases
Multi-sign Monitoring equipment
Infusion of ionotropic support
Equipment for maintenance of body temperature
Weighing scale
Manpower for 24x7 monitoring
Emergency cash cart
Defibrillator.
Equipment for ventilation.
In case there is common Paediatric ICU then Paediatric equipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.
HDU (high dependency unit) should also be equipped with all the equipment and manpower as per HDU norms.

Records Maintenance: Maintain complete records as required on day-to-day basis and is able to provide necessary records of hospital / patients to the Society/Insurer or his representative as and when required.
Wherever automated systems are used it should comply with MoHFW/ NHA EHR guidelines (as and when they are enforced)
All AB-PMJAY cases must have complete records maintained
Share data with designated authorities for information as mandated.
Legal requirements as applicable by the local/state health authority.
Adherence to Standard treatment guidelines/ Clinical Pathways for procedures as mandated by NHA from time to time.
Registration with the Income Tax Department.
NEFT enabled bank account
Telephone/Fax
Safe drinking water facilities/Patient care waiting area
Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act.
Appropriate fire-safety measures.
Provide space for a separate kiosk for AB-PMJAY beneficiary management (AB-PMJAY non-medical[4] coordinator) at the hospital reception.

[4] The non-medical coordinator will do a concierge and helpdesk role for the patients visiting the hospital, acting as a facilitator for beneficiaries and are the face of interaction for the beneficiaries. Their role will include helping in preauthorization, claim settlement, follow-up and Kiosk-management (including proper communication of the scheme).

Ensure a dedicated medical officer to work as a medical[5] co-ordinator towards AB-PMJAY beneficiary management (including records for follow-up care as prescribed)
Ensure appropriate promotion of AB-PMJAY in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the SHA/ district level AB-PMJAY team.
IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the NHA.

Category 2: Advanced criteria:

mentioned in Category 1) those facilities undertaking defined speciality packages (as indicated in the benefit package for specialities mandated to qualify for advanced criteria) should have the following:
These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Paediatric Surgery, Neonatal intensive care etc.
A hospital could be empanelled for one or more specialities subject to it qualifying to the concerned speciality criteria for respective packages
Such hospitals should be fully equipped with ICCU/SICU/ NICU/ relevant Intensive Care Unit in addition to and in support of the OT facilities that they have.
Such facilities should be of adequate capacity and numbers so that they can handle all the patients operated in emergencies.
The Hospital should have sufficient experienced specialists in the specific identified fields for which the Hospital is empanelled as per the requirements of professional and regulatory bodies/ as specified in the clinical establishment act/ State regulations.
The Hospital should have sufficient diagnostic equipment and support services in the specific identified fields for which the Hospital is empanelled as per the requirements specified in the clinical establishment act/ State regulations.
Indicative domain specific criteria are as under:
Specific criteria for Cardiology/ CTVS
CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.)
Post-op with ventilator support
ICU Facility with cardiac monitoring and ventilator support
Hospital should facilitate round the clock cardiologist services.
Availability of support speciality of General Physician & Paediatrician
Fully equipped Catheterization Laboratory Unit with qualified and trained Paramedics.
Specific criteria for Cancer Care
For empanelment of Cancer treatment, the facility should have a Tumour Board which decides a comprehensive plan towards multi-modal treatment of the patient or if not then appropriate linkage mechanisms need to be established to the nearest regional cancer centre (RCC). Tumor Board should consist of a qualified team of Surgical, Radiation and Medical /Paediatric Oncologist in order to ensure the most appropriate treatment for the patient.
Relapse/recurrence may sometimes occur during/ after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/ Paediatric Oncologist/ Tumor Board with prior approval and pre-authorization of treatment.

[5] The medical coordinator will be an identified doctor in the hospital who will facilitate submission of online pre-authorization and claims requests, follow up for meeting any deficiencies and coordinating necessary and appropriate treatment in the hospital.

For extending the treatment of chemotherapy and radiotherapy the hospital should have the requisite Pathology/ Haematology services/ infrastructure for radiotherapy treatment viz. for cobalt therapy, linear accelerator radiation treatment and brachytherapy available in-house. In case such facilities are not available in the empanelled hospital for radiotherapy treatment and even for chemotherapy, the hospital shall not perform the approved surgical procedure alone but refer the patients to other centres for follow-up treatments requiring chemotherapy and radiotherapy treatments. This should be indicated where appropriate in the treatment approval plan.

Further hospitals should have following infrastructure for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/ therapy.

Treatment machines which are capable of delivering SRS/SRT

Associated Treatment planning system

Associated Dosimetry systems

Specific criteria for Neurosurgery

Well Equipped Theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with head holding frame (horse shoe, may field / sugita or equivalent frame).

ICU facility

Post-op with ventilator support

Facilitation for round the clock MRI, CT and other support bio-chemical investigations.

Specific criteria for Burns, Plastic & Reconstructive surgery

The Hospital should have full time / on - call services of qualified plastic surgeon and support staff with requisite infrastructure for corrective surgeries for post burn contractures.

Isolation ward having monitor, defibrillator, central oxygen line and all OT equipment.

Well Equipped Theatre

Intensive Care Unit.

Post-op with ventilator support

Trained Paramedics

Post-op rehab/ Physiotherapy support/ Phycology support.

Specific criteria for /Paediatric Surgery

The Hospital should have full time/on call services of paediatric surgeons

Well-equipped theatre

ICU support

Support services of paediatrician

Availability of mother rooms and feeding area.

Availability of radiological/ fluoroscopy services (including IITV), Laboratory services and Blood bank.

Specific criteria for specialized new born care.

The hospital should have well developed and equipped neonatal nursey/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms

Availability of radiant warmer/ incubator/ pulse oximeter/ photo therapy/ weighing scale/ infusion pump/ ventilators/ CPAP/ monitoring systems/ oxygen supply / suction / infusion pumps/ resuscitation equipment/ breast pumps/ bilimeter/ KMC (Kangaroo Mother Care) chairs and transport incubator - in enough numbers and in functional state; access to hematological, biochemistry tests, imaging and blood gases, using minimal sampling, as required for the service packages

For Advanced Care and Critical Care Packages, in addition to 2. above: parenteral nutrition, laminar flow bench, invasive monitoring, in-house USG. Ophthalmologist on call.

Trained nurses 24x7 as per norms

Trained Paediatrician(s) round the clock

Arrangement for 24x7 stay of the Mother – to enable her to provide supervised care, breastfeeding and KMC to the baby in the nursery/NICU and upon transfer therefrom; provision of bedside KMC chairs.

Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

Specific criteria for Polytrauma

Shall have Emergency Room Setup with round the clock dedicated duty doctors.

Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and anaesthetist services.

The Hospital shall provide round the clock services of Neurosurgeon, Orthopaedic Surgeon, CT Surgeon, General Surgeon, Vascular Surgeon and other support specialists as and when required based on the need.

Shall have dedicated round the clock Emergency theatre with C-Arm facility, Surgical ICU, Post-Op Setup with qualified staff.

Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

Specific criteria for Nephrology and Urology Surgery

Dialysis unit

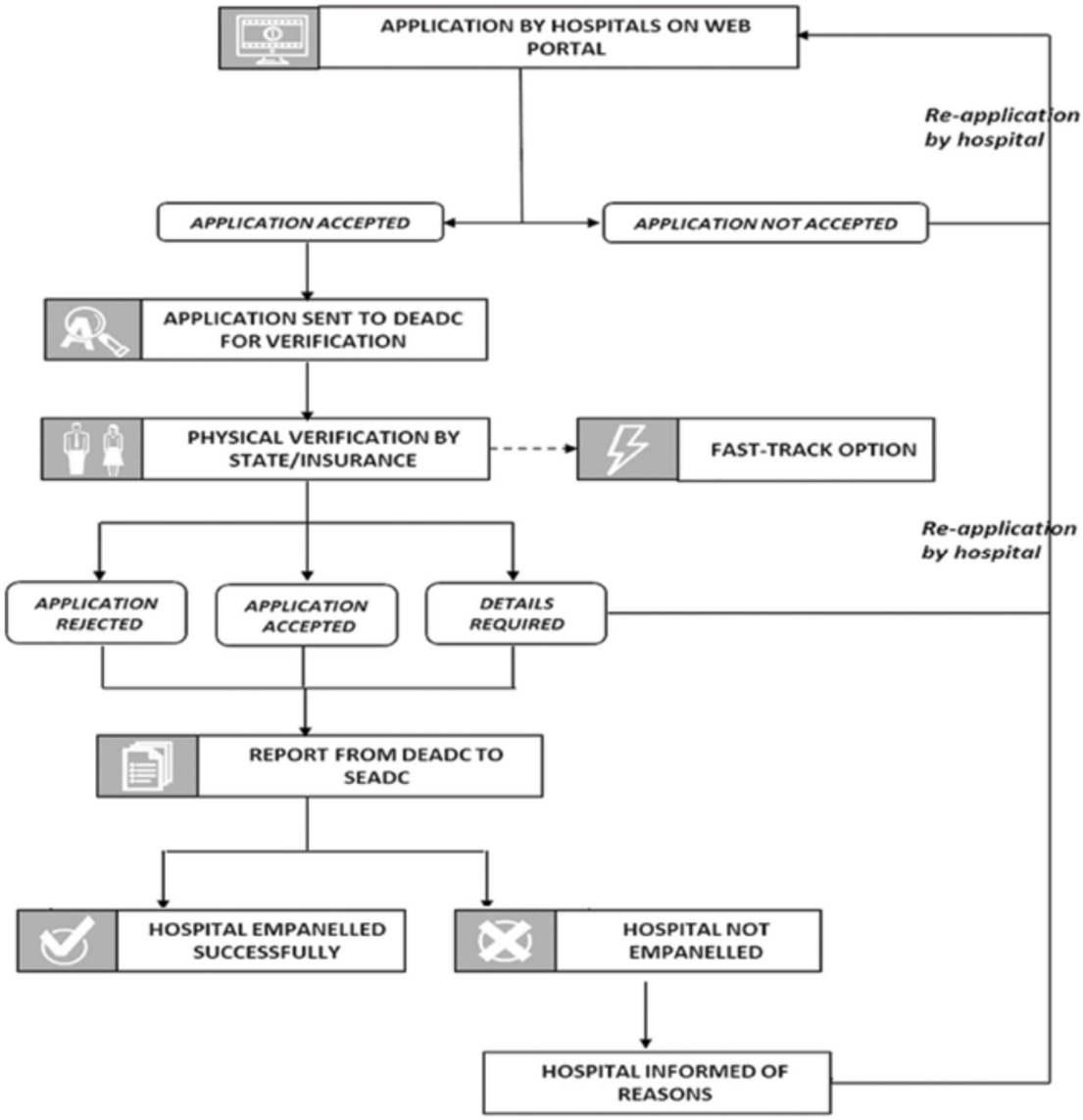
Well-equipped operation theatre with C-ARM

Endoscopy investigation support

Post op ICU care with ventilator support

Sew lithotripsy equipment

Annex 2: Process Flow for the Empanelment



Schedule 6: Service Agreement with Empaneled Health Care Providers

State Specific to be provided by state

Sample Service Agreement of Empaneled Health Care Providers with National Health Authotity is as below

Memorandum of Understanding (MoU)
Between

National Health Authority, Government of India, hereinafter called the NHA

And

[Name of Medical Establishment] hereinafter called the National Health Care Provider (NHCP) / Empanelled Health care Provider (EHCP)
For providing services under
Ayushman Bharat Pradhan Mantri - Jan Arogya Yojana (AB PM-JAY)

This Memorandum of Understanding (MoU) made at _____on this _____ day of -_____2018

Between

National Health Authority and the National Health Care Provider, who is willing to join the AB PM-JAY provider network and is agreed to extend cashless medical facilities for surgical/ medical management procedures as per "AB PM-JAY benefit cover for secondary and tertiary care hospitalizations only in the specialties which are available in the NHCP to all eligible AB PM-JAY families on family floater basis". No OPD treatment / care will be covered under AB PM-JAY.

STANDARD DEFINITIONS & INTERPRETATIONS

AB PM-JAY shall refer to Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB PM-JAY)

NHA shall mean the National Health Authority, the apex body for setting policy, design and roll-out of AB PM-JAY.

SUM INSURED shall mean the sum of Rs. 5,00,000/- (INR Five lakhs only) per AB PM-JAY Beneficiary Family Unit per annum or any other coverage as determined by the Government of India from time to time under AB PM-JAY.

BENEFICIARY FAMILY UNIT refers to those families including all its members figuring in the Socio-Economic Caste Census (SECC), 2011 database under the deprivation criteria specified or any additional categories as may be decided by Government of India from time to time under AB PM-JAY. This includes members added in the identified families as per provisions under PM-JAY.

BENEFIT COVER refers to the treatment package i.e care requiring inpatient hospitalization and specific day care conditions that the insured families would receive under the AB PM-JAY as may be decided by Government of India from time to time.

NATIONAL HEALTHCARE PROVIDER (NHCP) shall refer to establishments/ institutions of national significance under the administration of the Government of India/ Central Government Ministries) that have been empaneled by NHA across the country under AB PM-JAY.

EMPENELLED HEALTHCARE PROVIDER (EHCP) shall refer to Empaneled Health Care Provider, that is, private that have been empaneled by NHA across the country under AB PM-JAY.

National Transactional Management System (NTMS) refers to National TMS portal for providing services for outside state beneficiaries.

Day care treatment refer to the treatment requiring less then 24hrs of hospitalization.

Home State refers to the State from where AB PM-JAY beneficiaries belongs.

State Health Agency (SHA) refers to the agency which are set up by State Governments for implementing and managing AB PM-JAY in their respective states

PAYER shall mean SHA or other entity responsible for the actual payment for Covered Services rendered to AB PM-JAY beneficiaries. Payers may also include intermediaries hired by SHA such as Insurance companies.

BENEFIT PACKAGE & RATES: Each benefit/ hospitalization package is standardized that includes all benefits required during the entire episode of care in respect to the identified ailment, such as

Medical examination, treatment, and consultation

Medicine and medical consumables

Non-intensive and intensive care services

Diagnostic and laboratory investigations

Medical implant(s) (where necessary)

Accommodation benefits for the patient

Food services for beneficiary admitted

Administrative services

Expenses incurred for diagnostic test and medicines before the admission of the patient leading to the package

At discharge, diagnostic tests and medicines required for recovery from the same ailment/ surgery up to a limit of 15 days shall be provided by the treating health facility.

In the case of cancer treatments, preliminary investigations done towards approval of the appropriate clinical treatment approach to be included in the approved treatment package.

Investigations not available in NHCP / EHCP shall be done by referring to outside facility, payment to which shall be made by the NHCP /EHCP.

In case of non-availability of required treatment facilities or implants, the patient will be referred to some other empaneled hospital with those facilities. Health Services shall mean all services necessary or required to be rendered by the Institution under an agreement with an insurer/ ISA in connection with "health insurance business" or "health cover" but does not include the business of an insurer and or an insurance intermediary or an insurance agent.

BACKGROUND

As part of the comprehensive health care vision of the Government of India, the Ayushman Bharat Pradhan Mantri-Jan Arogya Yojana (AB PM-JAY) provides financial coverage related to hospitalization up to five lakh rupees to more than 10 crore poor and vulnerable households (approx. 50 crore beneficiaries). With the choice of accessing services at both public and private providers across the country, this ambitious mission aids in protecting beneficiary households against health-related contingencies across the life cycle. To operationalize the scheme at the National level, and to rollout the scheme in coordination with the various State Governments, the NHA has been established.

Ensuring access to and delivery of safe, quality health services to its beneficiaries is core to the vision of AB PM-JAY. Health care services under AB PM-JAY will be provided through a network of public hospitals and empaneled private healthcare providers. The government is committed to developing a strategic partnership with providers so that the vision of AB PM-JAY becomes a reality. Empanelment of health care providers and institutions is a key aspect of this partnership.

In the above regard, it has been decided to bring all medical establishments having inpatient hospitalizations under MoHFW, PSU hospitals situated in different states, and other medical establishments as decided by NHA from time to time.

PURPOSE

The purpose of this document is to specify the specific agreements the NHA and the NHCP will adopt to implement collaboration for strengthening service delivery under AB PM-JAY. This document lays down a broad road map for the proposed technical collaboration between the parties and identifies areas of cooperation on a long-term basis.

SCOPE OF SERVICES

The NHCP / EHCP undertakes to provide the health services to beneficiaries in a precise, reliable and professional manner to the satisfaction of NHA and in accordance with additional instructions issued by respective State Health Agency/Insurer in writing from time to time.

The NHCP / EHCP will treat the beneficiaries as per the prevailing standard healthcare practices.

The NHCP / EHCP will extend priority admission facilities to the beneficiaries, whenever possible.

The NHCP / EHCP shall provide treatment/interventions to beneficiary as per specified packages and rates mentioned in Annex 2. The following is agreed among the parties regarding the packages:

The treatment/interventions to AB PM-JAY beneficiaries shall be provided in a complete cashless manner. Cashless means that for the required treatment/interventions the payment shall be made by the concerned SHA as per package rates and no payment shall need to be done by the AB PM-JAY beneficiary undergoing treatment/intervention or any of his/her family member till such time there is balance amount left in sum insured.

The various benefits under AB PM-JAY which NHCP / EHCP shall provide include,

hospitalization

Day care treatment (as applicable)

Pre and post hospitalization

New born/children care (as applicable)

An NHCP / EHCP can provide these benefits subject to exclusions mentioned in **Annex 1** and subject to availability of sum insured/remaining available cover balance and subject to pre-authorization for selected procedures by NHA.

However, the NHCP / EHCP is eligible to provide treatment/interventions to beneficiaries only for those clinical specialties for which it has been empaneled.

The NHCP / EHCP agrees that in future if it adds or foregoes any clinical specialty to its services, the information regarding the same shall be provided to the NHA in written, or through the hospital empanelment portal, NHA then shall update the empanelment status of the NHCP / EHCP after due process.

The charges payable to NHCP / EHCP for medical/ day care/surgical procedures/ interventions under the Benefit package will be no more than the package rate agreed by the Parties, as per the latest arrangement. The NHCP / EHCP shall be paid for the treatment/intervention provided to the beneficiary based on package rates determined as below-

If the Package Rate for a medical treatment or surgical procedure requiring Hospitalisation or Day Care Treatment (as applicable) is fixed as in **Annex 2** then it shall apply.

If the Package Rate for any surgical procedure requiring Hospitalisation or Day Care Treatment (as applicable) is not listed in **Annex 2**, then the SHA/Insurer, or ISA on their behalf, may pre-authorise an appropriate amount up to a limit of Rs. 1,00,000 to an eligible AB PM – JAY beneficiary

In case an AB PM-JAY Beneficiary is required to undergo multiple surgical treatment, then preauth can be raised for a set of 2 or more procedure. At the time of payment the highest Package Rate shall be reimbursed at 100%, thereupon the 2nd treatment package shall be reimbursed at 50% of Package Rate and 3rd treatment package shall be at 25% of the Package Pate as configured in the transaction management software.

Surgical and Medical packages will not be allowed to be availed at the same time.

Certain packages as mentioned in **Annex 2** will only be reserved for Public NHCPs as decided by the SHA. They can be availed in Private EHCPs only after a referral from an empanelled Public Hospital/ NHCP / EHCP is made.

These Package Rates (in case of surgical or defined day care benefits) will include:

Registration Charges

Bed charges (General Ward in case of surgical),

Nursing and Boarding charges,

Surgeons, Anesthetists, Medical Practitioner, Consultants fees etc.

Anesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.,

Medicines and Drugs,

Cost of Prosthetic Devices, implants,

Pathology and radiology tests: radiology to include but not be limited to X-ray, MRI, CT Scan, etc. (as applicable)

Food to patient

Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

Any other expenses related to the treatment of the patient in the NHCP / EHCP.

If the treatment cost is more than the benefit coverage amount available with the beneficiary families then the remaining treatment cost will be borne by the AB PM-JAY beneficiary family as per the package rates defined in this document. Beneficiary will need to be clearly communicated in advance about the additional payment. The follow up care prescription for identified packages are set out in **Annex 2**. The NHCP / EHCP shall ensure that medical treatment/facility under this agreement should be provided with all due care and accepted standards is extended to the beneficiary. NHCP / EHCP agrees to provide treatment to all eligible beneficiaries subject to sum insured available and as per agreed Package Rate from all over the India. The NHCP / EHCP shall be paid as per the National Package Rates and not as per the package rates applicable in the beneficiary State. The NHCP / EHCP agrees not to discriminate between the beneficiaries on any basis. The NHCP / EHCP shall allow NHA/SHA state officials to visit the beneficiary while s/he is admitted in the NHCP / EHCP. NHA shall not interfere with the medical team of the NHCP / / EHCP, however NHA reserve the right to discuss the treatment plan with treating doctor. Further access to medical treatment records and bills prepared in the NHCP / / EHCP will be allowed to NHA on a case to case basis with prior appointment from the NHCP. The NHCP / EHCP shall also endeavor to comply with future requirements of NHA to facilitate better services to beneficiaries e.g. providing for standardized billing, ICD coding or implementation of Standard Clinical and Treatment Protocols and if mandated by statutory requirement both parties agree to review the same. The NHCP / EHCP agrees to have claims audited on a case to case basis as and when necessary through SHA/NHA audit team. This will be done on a pre-agreed date and time and on a regular basis. The NHCP / EHCP will convey to its medical consultants to keep the beneficiary only for the required number of days of treatment and carry only the required investigation & treatment for the ailment, which she/he is admitted.

Any other incidental investigation required by the patient on their own request needs to be approved separately through TMS and if it is not covered under the policy will not be paid by SHA and the NHCP / / EHCP, if required, needs to recover it from the patient

Declarations and Undertakings of NHCP

1. The NHCP / EHCP undertakes that they have obtained all the registrations/ licenses/ approvals required by law in order to provide the services pursuant to this agreement and that they have the skills, knowledge and experience required to provide the services as required in this agreement.

2. The NHCP / EHCP undertakes to uphold all requirement of law in so far as these apply to it and in accordance to the provisions of the law and the regulations enacted from time to time, by the local bodies or by the central or the state govt. The NHCP / EHCP declares that it has never committed a criminal offence which prevents it from practicing medicine and no criminal charge has been established against it by a court of competent jurisdiction.

General responsibilities & obligations of the NHCP

Ensure that no confidential information is shared or made available by the NHCP / EHCP or any person associated with it to any person or entity not related to the NHCP / EHCP without prior written consent of NHA/SHA

The NHCP / EHCP shall provide cashless facility to the beneficiary in strict adherence to the provisions of the agreement.

The NHCP / EHCP may have their facility covered by proper indemnity policy including errors, omission and professional indemnity insurance and agrees to keep such policies current during entire tenure of the Agreement. The cost/ premium of such policy shall be borne solely by the NHCP / EHCP.

The NHCP / EHCP shall provide the best of the available medical facilities to the beneficiary.

The NHCP / EHCP will hire dedicated person(s) called Pradhan Mantri Arogya Mitra to manage the help desk and facilitate the ABPM-JAY beneficiaries in accessing the benefits under AB PM – JAY as per the guidelines of NHA. The cost of engaging the Pradhan Mantri Arogya Mitras will need to be entirely borne by the NHCP / EHCP (Private/Public).

The NHCP / EHCP shall also have atleast two contact persons nominated for all matters related to AB PM – JAY; one person from clinical team (a doctor who is actively engaged in the treatment of the patients) and one officer in the administration department assigned for AB PM-JAY. These officers will eventually be required to make themselves trained with the processes described in AB PM-JAY.

The NHCP/ EHCP shall endeavor to make their team including Arogya Mitras and contact persons actively participate in all AB PM-JAY trainings and workshops to be organized by NHA from time to time. NHA will organize trainings for Arogya Mitras and other contact persons of NHCP/ EHCP. In addition, the NHCP/ EHCP may also be required to conduct trainings for its staff regarding AB PM-JAY at their premise with the help of NHA. The cost of attending such trainings and organizing trainings shall be borne by the NHCP/ EHCP unless otherwise agreed with NHA.

NHA has decided, additional 10% on base package rates (means base package + 10%) = A for all private EHCP hospitals in Delhi empanelled by NHA. Additionally, the following performance-based incentive criteria may be applicable:

If the EHCP has received NABH entry-level certification, it will receive an additional 10% over A (it means (Base package+10%) + 10%=B

If EHCP has qualified for full accreditation of NABH, it will receive an additional 15% over A it means (Base package+10%) + 15%. =C

If the EHCP is a teaching hospital running PG/ DNB courses, it would receive an additional 10% over the payment due to it. If without NABH certificate / accreditation than A + 10%, if entry level than B +10%, if full accreditation than criteria C +1 0%.

The EHCP agrees that it shall display their status of preferred service provider of AB PM-JAY at their main gate, reception/ admission desks along with the display as per the standard template designed by the NHA whenever possible for the ease of the beneficiaries. Format, design and other details related to these sinages as published on the https://pmjay.gov.in/iec-materials

PROVISIONS

Registration into the AB PM-JAY provider network: NHCP/ EHCP will be providing treatment to patients from all over the country. NHCP/ EHCP needs to provide information about the establishment online at the nation-wide empanelment interface to be registered into the AB PM-JAY provider network.
Cashless service provision: AB PM-JAY beneficiaries shall be provided treatment free of cost for all such ailments covered under AB PM-JAY within the limits/ sub-limits and sum insured. The NHCP/ EHCP shall be reimbursed as per the package cost applicable specified in the 'AB PM-JAY benefits manual' for such treatments and pre-authorized amount in case of unspecified packages.
Under no circumstances shall NHCP/ EHCP charge any money extra within the treatment period of package.
Identification of beneficiaries: Beneficiaries will be identified using Aadhaar and/or Ration Card and/ or any other specified identification document produced by the beneficiary at the point of contact. This would undergo pre-authorization from the Home State of the AB PM-JAY beneficiary online. The requisite process, training to personnel and guidelines will be imparted/communicated by NHA.
Pre-Authorization: All procedures shall be subject to mandatory pre-authorization by the Home State of beneficiary. Approval for pre-authorization will be coordinated online.
Human Resource Requirements: NHCP/ EHCP needs to appoint a Medical Coordinator (Part time) & a Non-Medical Coordinator (Full time) to facilitate beneficiary management.
The non-medical coordinator called PM Arogya Mitra will manage the helpdesk established within the premise of NHCP/ EHCP for the patients visiting the hospital, acting as a facilitator for beneficiaries and are the face of the scheme for the beneficiaries. Their role will include helping in beneficiary identification & verification at reception, preauthorization, claim settlement, follow-up and Kiosk-management (including proper scheme IEC).
The medical coordinator will be an identified doctor(s) in the hospital who will facilitate submission of online pre-authorization and claims requests, follow up for meeting any deficiencies and coordinating necessary and appropriate treatment in the hospital
Structural Requirements: NHCP/ EHCP **will** provide space for a kiosk for AB PM-JAY beneficiary management at the hospital reception.
These kiosks need to be equipped with IT Hardware requirements such as desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc. as mandated by the NHA from time to time.
Ensure appropriate promotion of AB PM-JAY in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the NHA team.
Input for setting up the above infrastructure and services can be extended by the NHA. (Training, Capacity building, Technical support, Technical specification and design for material)
Guidelines of AB PM-JAY kiosk management will be shared by NHA.
National Portability: The NHA has laid down the process and terms for extending portability of benefits to all AB PM-JAY beneficiaries across the NHCP/ EHCP network in India. The will be applicable to all empanelled hospitals across India.
IT System and Technical Support: The NHA shall provide an IT platform with functional modules for identification of eligible beneficiaries, transaction and claim management and provision of all services under AB PM-JAY, through NTMS (National Transaction Management System). The NHA will also support in requisite training for the assigned personal within the NHCP/ EHCP for the same.
Information, Education and Communication (IEC) materials: The NHA shall provide standard template for IEC & branding material to ensure uniformity (https://pmjay.gov.in/iec-materials)
Training and Capacity Building: The NHA shall provide standard training manuals and help in organizing orientation cum sensitization workshops for AB PM-JAY NHCP/ EHCP staff.
Grievance Redressal: Complaints and grievance redressal management system for NHCP/ EHCP will be handled by the home state of beneficiaries, if NHCP/ EHCP is not satisfied with the SHA resolution, the complaint or grievance shall be escalated to NHA, and NHA will be the final decision-making authority. NHA would establish a specific pathway for grievance redressal for NHCPs/ EHCP which the authority to would have not only immediately redress the grievance but also recommend action to be undertaken within a stipulated time period. A major change will be affected with the introduction of a National Call Center. Complaints from various stakeholders including hospital authorities and beneficiaries will be logged at the call center and the call center shall direct these complaints to the intended authorities. Each complaint/grievance shall be closely monitored by a dedicated team at NHA

to check resolution timelines and intervene when unresolved. Guidelines on the same will be communicated by NHA including the channels through which complaints/ grievances can be registered, acknowledged, monitored and resolved at various levels.

Collaborating Centers: As knowledge hubs for generating evidence and informing policy inputs for AB PM-JAY, NHCPs/ EHCP play an important role in the generation of knowledge to improve the quality of health care in the regions they cover. Research capacities at such premier institutes of national excellence may prove to be an invaluable asset in generating evidence to inform policy decisions for AB PM-JAY and provide examples/ proof of concept for organization and development of service delivery. For e.g. priority setting, costing surveillance, designing monitory & quality protocols, research on medical necessity of care, promoting conservative management practices etc. Such areas of engagement may be decided mutually by both parties from time to time.

Undertaking: NHCP/ EHCP undertakes that it will ensure availability of all the required facilities for performing the enlisted surgeries / procedures / therapies as specified under the 'Benefits manual of AB PM-JAY', subject to availability.

PAYMENT TERMS & CONDITIONS

Package rates: Reimbursements shall be based on National rates set by the NHA and the process of reimbursements shall be made based on the various implementation mechanisms present in AB PM-JAY. States/ UTs, are referred to as the PAYERS.

NHA has decided, additional 10% on base package rates (means base package + 10%) = A for all private EHCP hospitals in Delhi empanelled by NHA.

If the home state has implemented the scheme through a trust, the SHA shall directly reimburse the cost as per package rates approved by NHA.

If it's through an intermediary, insurance companies assigned by SHA of beneficiary home state shall reimburse as per National package rates

The home State of the AB PM-JAY beneficiary shall be responsible for payments for care accessed in a NHCP/ EHCP through electronic payment gateway. Refer to AB PM-JAY website for detailed guidelines.

In addition, NHCP/ EHCP are eligible to avail performance-linked incentives such as

If the EHCP has received NABH entry-level certification, it will receive an additional 10% over A (it means (Base package+10%) + 10%=B

If EHCP has qualified for full accreditation of NABH, it will receive an additional 15% over A it means (Base package+10%) + 15%. =C

If the EHCP is a teaching hospital running PG/ DNB courses, it would receive an additional 10% over the payment due to it. If without NABH certificate / accreditation than A + 10%, if entry level than B +10%, if full accreditation than criteria C +1 0%. These additional incentives will be applied in a compounded manner.

If EHCP is a private/or public autonomous hospital situated in Nagaland state, it will receive an additional 10% over and above the base package rate.

Billing & Payment cycle: NHCP/ EHCP shall be obliged to submit their claims in the formats prescribed through NTMS.

The PAYER shall be responsible for settling all claims within 30 days after receiving all the required information/ documents in the claim is raised by NCHP / EHCP.

Guidelines for submission of claims, claims processing, and handling of claim queries, dealing with fraudulent claims and all other related details will be communicated by the NHA.

Indemnities and other Provisions

NHA will not interfere in the treatment and medical care provided to its beneficiaries. NHA will not be in any way held responsible for the outcome of treatment or quality of care provided by the provider.

NHA shall not be liable or responsible for any acts, omission or commission of the Doctors and other medical staff of the NHCP/ EHCP and the NHCP/ EHCP shall obtain professional indemnity policy on its own cost for this purpose. The NHCP / EHCP agrees that it shall be responsible in any manner whatsoever for the claims, arising from any deficiency in the services or any failure to provide identified service

Notwithstanding anything to the contrary in this agreement no Parties shall be liable by reason of failure or delay in the performance of its duties and obligations under this agreement if such failure or delay is caused by acts of God, Strikes, lock-outs, embargoes, war, riots civil commotion, any orders of governmental, quasi-governmental or local authorities, or any other similar cause beyond its control and without its fault or negligence.
The NHCP / EHCP will indemnify, defend and hold harmless the NHA against any claims, demands, proceedings, actions, damages, costs, and expenses which the Hospital may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the NHCP / EHCP or any of its employees or doctors or medical staff.
NHA shall not have legal obligations towards claim settlement amount in any case.

Notices
All notices, demands or other communications to be given or delivered under or by reason of the provisions of this Agreement will be in writing and delivered to the other Party:
By registered mail;
By courier;
By facsimile;
In the absence of evidence of earlier receipt, a demand or other communication to the other Party is deemed given
If sent by registered mail, seven working days after posting it; and
If sent by courier, seven working days after posting it; and
If sent by facsimile, two working days after transmission. In this case, further confirmation has to be done via telephone and e-mail.
The notices shall be sent to the other Party to the above addresses (or to the addresses which may be provided by way of notices made in the above said manner):
If to the NHCP: / EHCP
Attn: ……
Tel…
Fax:

If to NHA
Miscellaneous
Except as otherwise provided herein, no modification, amendment or waiver of any provision of this Agreement will be effective unless such modification, amendment or waiver is approved in writing by the parties hereto.
Should specific provision of this Agreement be wholly or partially not legally effective or unenforceable or later lose their legal effectiveness or enforceability, the validity of the remaining provisions of this Agreement shall not be affected thereby.
The NHCP / EHCP shall not assign, transfer, encumber or otherwise dispose of this Agreement or any interest herein without the prior written consent of NHA, provided whereas that the NHA may assign this Agreement or any rights, title or interest herein to an Affiliate without requiring the consent of the NHCP / EHCP.
The failure of any of the parties to insist, in any one or more instances, upon a strict performance of any of the provisions of this Agreement or to exercise any option herein contained, shall not be construed as a waiver or relinquishment of such provision, but the same shall continue and remain in full force and effect.
The NHCP / EHCP will indemnify, defend and hold harmless the NHA against any claims, demands, proceedings, actions, damages, costs, and expenses which the latter may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the NHCP / EHCP or any of its employees/doctors/other medical staff

12. **RELATIONSHIP OF THE PARTIES**
Nothing contained herein shall be deemed to create between the Parties any partnership, joint venture or relationship of principal and agent or master and servant or employer and employee or any affiliate or

subsidiaries thereof. Each of the Parties hereto agrees not to hold itself or allow its directors/employees/agents/representatives to hold out to be a principal or an agent, employee or any subsidiary or affiliate of the other.

13. **LAW AND ARBITRATION**

13.1 The provisions of this MoU shall be governed by and construed in accordance with Law of the country.

13.2 Any dispute, controversy or claims arising out of or in relation to this MoU or the breach, termination or invalidity thereof, shall be settled by arbitration in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

13.3 The arbitral tribunal shall be composed of three arbitrators, one arbitrator appointed by each Party and one another arbitrator appointed by the mutual consent of the arbitrators so appointed.

13.4 The place of arbitration shall be in Delhi and any award whether interim or final, shall be made, and shall be deemed for all purposes between the parties to be made in _____.

13.5 The arbitral procedure shall be conducted in the English language and any award or awards shall be rendered in English. The procedural law of the arbitration shall be Indian Law.

13.6 The award of the arbitrator shall be final and conclusive and binding upon the Parties, and the Parties shall be entitled (but not obliged) to enter judgment thereon in any one or more of the highest courts having jurisdiction.

13.7 The rights and obligations of the Parties under, or pursuant to, this Clause including the arbitration agreement in this Clause, shall be governed by and subject to Indian Law.

13.8 The cost of the arbitration proceeding would be borne by the parties on equal sharing basis.

MISCELLANEOUS

Term, renewal and termination: The term of this MOU is three (3) years commencing on _____. This MoU shall be reviewed periodically, but at least every three years or upon written request by either party and may be amended by the written consent of the authorized representatives.

Notwithstanding the foregoing, this Agreement may be terminated by either party for any reason after the expiration of the first two years of the term hereof by giving 180 days prior written notice citing reasons to the other party of its intention to withdraw from this Agreement and by ensuring the continuity of care to AB PM-JAY beneficiaries/ patients who already are involved in the treatment process and during the transition process. The Parties shall conduct as many coordination and conciliation meetings as possible during this period to explore ways to continue the MoU, if needed.

Confidentiality: The NHCP / EHCP shall maintain the confidentiality of all patient health information and medical records in accordance with applicable guidelines set by the NHA from time to time.

Severability: The invalidity or unenforceability of any provision of this MoU in any jurisdiction shall not affect the validity, legality or enforceability of the reminder of this MoU in such jurisdiction or the validity, legality or enforceability of this MoU, including any such provision, in any other jurisdiction, it being intended that all rights and obligations of the Parties hereunder shall be enforceable to the fullest extent permitted by law.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

For NHA (Authorized signatory) (Signature & Date)	For NHCP / EHCP (Authorized signatory) (Signature & Date)

Annex I – Exclusions to the Policy

As per latest exclusion policy issued by NHA and/or SHA and revised from time to time

Ayushman Bharat PM-JAY shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

• Condition that does not require hospitalization and can be treated under Out Patient Care

• Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.

• Any dental treatment or surgery which is corrective, prosthetic, cosmetic procedure, filling of tooth cavity, root canal including wear and tear of teeth, periodontal diseases, dental implants etc. are excluded. Exception to the above would be treatment needs arising from trauma / injury, neoplasia / tumour / cyst requiring hospitalisation for bone treatment.

• Any assisted reproductive techniques, or infertility related procedures, unless featuring in the National Health Benefit Package list.

• Vaccination and immunization

• Surgeries related to ageing face & body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc.

• Circumcision for children less than 2 years of age shall be excluded (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident)

• Persistent Vegetative State: a condition in which a medical patient is completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function, being kept alive only by medical intervention.

Annex 2 – Packages and Rates

Available at nagahealth.nagaland.gov.in

Annex 3: Beneficiary Identification System

The core principle for finalizing the operational guidelines for proposed AB PM–JAY is to construct a broad framework as guiding posts for simplifying the implementation of the Mission under the ambit of the policy and the technology while providing requisite flexibility to the States to optimally chalk out the activities related to implementation in light of the peculiarities of their own State/UT, as ownership of implementation of scheme lies with them.

AB PM-JAY will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the Socio-Economic Caste Census (SECC) data, 2011, both rural and urban. Additionally, all such enrolled families under RSBY that do not feature in the targeted groups as per SECC data will be included as well.

Empaneled hospital shall render healthcare services to all the AB PM-JAY beneficiaries. List of all the states who have signed the MOU with the NHA is attached.

NHA/SHA shall be responsible for carrying out Information, Education and Communication (IEC) activities amongst targeted families such that they are aware of their entitlement, benefit cover, empaneled hospitals and process to avail the services under AB PM-JAY.

Detailed guidelines and user manuals for Beneficiary identification process can be referred to AB PM-JAY website.

Addition of new family members will be allowed. This requires to be approved by the respective state Insurance Company/Trust. Proof of being part of the same family is required in the form of

Name of the new member is in the family ration card or State defined family card

A marriage certificate relating to marriage to a family member existing in the family

A birth certificate relating to a birth to a family member existing in the family is available.

Specification of Hardware and Software

Annex 4: Ayushman Mitra under AB PM-JAY

Arogya Mitra (AM) will need to be identified by NHCP / EHCP for managing the help desk. This help desk will need to be set up exclusively for AB PM-JAY. Indicative role of AM is as follows:

Receive beneficiary at the NHCP / EHCP

Guide beneficiary regarding AB PM-JAY and process to be followed in the NHCP/ EHCP for taking the treatment

Carry out the process of Beneficiary Identification for such persons who are beneficiaries of AB PM-JAY

Take photograph of the beneficiary

Carry out the Aadhaar based identification for such beneficiaries who are carrying Aadhaar

If the person is not carrying Aadhaar carry out the identification through other defined Government issued ID

Scan the identification documents as per the guidelines and upload through the software

Send the result of beneficiary identification process to the respective state Insurer/ ISA for approval

After getting confirmation from the beneficiary home state Insurer/ ISA or SHA regarding identification of the beneficiary, issue e-card to the beneficiary

Refer the patient to doctor for consultation

Check the balance of AB PM-JAY Beneficiary family in her/ his AB PM-JAY Cover amount.

Upon advice of the doctor admit the patient in the NHCP/ EHCP

Take the pre-authorization as and when required as per the guidelines

Enter all the relevant details of package and other information as provided by the doctor and required by the AB PM-JAY software

At the time of discharge again enter all the relevant details and discharge summary in the AB PM-JAY software

Detailed guidelines for Arogya Mitras

Annex 5: Process of Delivery of Benefits, Claim reporting and Submission

Cashless Access of Services

The AB PM-JAY beneficiaries shall be provided treatment free of cost for all such ailments covered under the Scheme within the limits/ sub-limits and sum insured, i.e., not specifically excluded under the Scheme.

The NHCP / EHCP shall be reimbursed as per the package cost specified in the National Package Master or as pre-authorised amount in case of unspecified packages.

The NHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB PM-JAY Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB PM-JAY Family ID on the AB PM-JAY Card and also ascertain the balance available under the AB PM-JAY Cover.

The NHA shall provide NHCP / EHCP with a transaction manual describing in detail the verification, pre-authorisation and claims procedures.

The NHA shall train Arogya Mitras that will be deputed in NHCP / EHCP that will be responsible for the administration of the AB PM-JAY on the use of the Hospital IT infrastructure for making Claims electronically and providing Cashless Access Services.

The NHCP / EHCP shall establish the identity of the member of a AB PM-JAY Beneficiary Family Unit by Aadhaar Based Identification System (No person shall be denied the benefit in the absence of Aadhaar Card) and ensure:

That the patient is admitted for a covered procedure and package for such an intervention is available.

AB PM-JAY Beneficiary has balance in her/ his AB PM-JAY Cover amount.

Provisional entry shall be made on the server using the AB PM-JAY ID of the patient. It has to be ensured that no procedure is carried out unless provisional entry is completed through blocking of claim amount.

Pre-authorization of Procedures

All procedures in **Annex 2** that are earmarked for pre-authorisation shall be subject to mandatory pre-authorisation. No NHCP / EHCP shall, under any circumstances whatsoever, undertake any such

earmarked procedure without pre-authorisation unless under emergency. Process for emergency approval will be followed as per guidelines laid down under AB PM-JAY.

Request for hospitalisation shall be forwarded by the NHCP after obtaining due details from the treating doctor, i.e. "request for authorisation letter" (RAL). The RAL needs to be submitted online through the Scheme portal and in the event of any IT related problem on the portal, then through email or fax as per defined process. The medical team of the beneficiary home state SHA/ Insurance company/Trust would get in touch with the treating doctor, if necessary.

The beneficiary hometown SHA/ Insurer/ ISA shall ensure that in all cases pre-authorisation request related decisions are communicated to the NHCP / EHCP within 6 hours for all normal cases and within 1 hours for emergencies. If there is no response from the beneficiary hometown SHA/ Insurer/ ISA within 6 hours of an NHCP filing the pre-authorisation request, the request of the NHCP / EHCP shall be deemed to be automatically authorised.

The beneficiary hometown SHA/ Insurer shall not be liable to honour any claims from the NHCP / EHCP for defined procedures for which the NHCP/ EHCP does not have a pre-authorisation, if prescribed.

Reimbursement of all claims for procedures in package rate list shall be as per the limits prescribed for each such procedure unless stated otherwise in the pre-authorisation letter/communication.

The RAL form should be dully filled with clearly mentioned Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.

The beneficiary hometown SHA/ Insurer guarantees payment only after receipt of RAL and the necessary medical details.

In case the ailment is not covered or the medical data provided is not sufficient for the medical team of the authorisation department to confirm the eligibility, the beneficiary hometown SHA/ Insurer can deny the authorisation or seek further clarification/ information.

Denial of authorisation (DAL)/ guarantee of payment is by no means denial of treatment by the NHCP / EHCP. The NHCP/ EHCP shall deal with such case as per their normal rules and regulations.

Authorisation letter (AL) will mention the authorisation number and the amount authorized as a package rate for such procedure for which package has not been fixed earlier. The NHCP / EHCP must see that these rules are strictly followed.

The authorisation is given only for the necessary treatment cost of the ailment covered and mentioned in the RAL for hospitalisation.

The entry on the AB PM-JAY portal for claim amount blocking as well at discharge would record the authorisation number as well as package amount agreed upon by the NHCP / EHCP and the Insurer.

In case the balance sum available is less than the specified amount for the Package, the NHCP / EHCP should follow its norms of deposit/running bills etc. However, the NHCP/ EHCP shall only charge the balance amount against the package from the AB PM-JAY beneficiary. The beneficiary home state/Insurance company/trust upon receipt of the bills and documents would release the authorized amount.

The beneficiary hometown Insurer/ISA will not be liable for payments in case the information provided in the RAL and subsequent documents during the course of authorisation is found to be incorrect or not fully disclosed.

In cases where the AB PM-JAY beneficiary is admitted in the NHCP/ EHCP during the current Policy Cover Period but is discharged after the end of the Policy Cover Period, the claim has to be paid by the Insurance company/trust from the Policy which was operating during the period in which the AB PM-JAY beneficiary was admitted.

Claims Management

All NHCPs / EHCPs shall be obliged to submit their claims within 24 hours of discharge in the format prescribed. The beneficiary hometown SHA (recommended by ISA) / Insurer shall be responsible for settling all claims **within 30 days after receiving all the required information/ documents**.

Process for Beneficiary identification, issuance of AB PM-JAY e-card and transaction for service delivery

Beneficiary Verification & Authentication

Beneficiary may bring the following to the AB PM-JAY helpdesk:

Letter from PM

RSBY Card

Any other defined document as prescribed by the State Government

Ayushman Mitra/Operator will check if AB PM-JAY e-Card/ AB PM-JAY ID/ Aadhaar Number is available with the beneficiary
In case Internet connectivity is available at hospital
Operator/Ayushman Mitra identifies the beneficiary's eligibility and verification status from AB PM-JAY Central Server
If beneficiary is eligible and verified under AB PM-JAY, server will show the details of the members of the family with photo of each verified member
If found OK then beneficiary can be registered for getting the cashless treatment.
If patient is eligible but not verified then patient will be asked to produce Aadhaar Card/Number/ Ration Card for verification (in absence of Aadhaar)
Beneficiary mobile number will be captured.
If Aadhaar Card/Number is available and authenticated online then patient will be verified under scheme (as prescribed by the software) and will be issued an AB PM-JAY e-Card for getting the cashless treatment.
Beneficiary gender and year of birth will be captured with Aadhaar eKYC or Ration Card
If Aadhaar Card/Number is not available then beneficiary will advised to get the Aadhaar Card/number within stipulated time.
In case Internet connectivity is not available at hospital
Ayushman Mitra at AB PM-JAY Registration Desk at Hospital will call Central Helpline and using IVRS enters AB PM-JAY ID or Aadhaar number of the patient. IVRS will speak out the details of all beneficiaries in the family and hospital will choose the beneficiary who has come for treatment. It will also inform the verification status of the beneficiary
If eligible and verified then beneficiary will be registered for getting treatment by sending an OTP on the mobile number of the beneficiary
In case beneficiary is eligible but not verified then she/he can be verified using Aadhaar OTP authentication and can get registered for getting cashless treatment
In case of emergency or in case person does not show AB PM-JAY e-Card/ID or Aadhaar Card/Number and claims to be AB PM-JAY beneficiary and show some photo ID proof issued by Government, then beneficiary may get the treatment after getting TPIN (Telephonic Patient Identification Number) from the call centre and same will be recorded. Government Photo ID proof need not be insisted in case of emergency. In all such cases, relevant AB PM-JAY beneficiary proof will be supplied within specified time before discharge otherwise beneficiary will pay for the treatment to the Hospital.
If eligibility, verification and authentication are successful, beneficiary should be allowed for treatment
These details captured will be available at NHA/SHA level for their approval. Once approved, the beneficiary will be considered as successfully identified and verified under AB PM-JAY.

Package Selection

The operator will check for the specialty for which the hospital is empaneled. Hospitals will only be allowed to view and apply treatment package for the specialty for which they are empaneled.
Based on diagnosis sheet provided by doctor, operator should be able to block surgical or Non-Surgical benefit package(s) using AB PM-JAY IT system. The doctors may be requested to mention the relevant package no. so that AM is able to block the right package without any confusion.
Both surgical and non-surgical packages cannot be blocked together, either of the type can only be blocked.
As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.
Some packages will be reserved for blocking only in public hospitals.
The operator can block more than one package for the beneficiary. A logic will be built in for multiple package selection, such that reduced payment is made in case of multiple packages being blocked in the same hospitalization event (described in detail above).
If a registered mobile number of beneficiary family is available, an SMS alert will be sent to the beneficiary notifying him of the packages blocked for him.
At the same time, a printable registration slip needs to be generated and handed over to the patient or patient's attendant.

If for any reason treatment is not availed for any package, the operator can unblock the package before discharge from hospital.

Pre-authorisation

There would be defined packages which will require pre-authorization from the beneficiary hometown insurance company/ trust. In case any inpatient treatment is not available in the packages defined, then hospital will be able to raise a preauth request to provide that treatment up to Rs. 100,000 to the beneficiary only after the same gets approved by the Insurance company/ trust and will be reflected as unspecified package (Refer AB PM-JAY website for detailed guidelines). Under both scenarios, the operator should be able to initiate a request to the beneficiary hometown insurance company/ISA for pre-authorization using the web application.

The hospital operator will send all documents required for pre-authorization to the beneficiary home state/ insurance company/trust using the Centralized AB PM-JAY/ States transaction management application. The documents exchanged will not be stored on the AB PM-JAY server permanently. Only the information about pre-authorization request and response received will be stored on the central server. It is the responsibility of the beneficiary hometown insurance company/ ISA/ SHA to maintain the documents at their end.

The documents needed may vary from package to package and hence a master list of all documents required for all packages will be available on the server.

The request as well as approval of the form will be done using the AB PM-JAY IT system or using API exposed by AB PM-JAY (Only one option can be adopted by the hospitals or using State's own IT system (if adopted by the State).

In case of no or limited connectivity, the filled form can also be sent to the beneficiary home state/ insurance company/ trust either through fax/ email. However, once internet connectivity is established, the form should also be submitted using online system as described above.

The beneficiary hometown insurance company/ SHA/ ISA will have to approve or reject the request latest by 6 hours. If the insurance company/ SHA/ ISA fails to do so, the request will be considered deemed to be approved after 6 hours by default.

In case of an emergency or delay in getting the response for pre-authorization request due to technical issues, provision will be there to get the pre-authorization code over the phone from Insurance Company/ SHA/ ISA or the call center set up by Insurance Company/ ISA. The documents required for the processing, may be sent using the transaction system within stipulated time.

In case of emergency, the beneficiary hometown insurance company/ SHA/ ISA will provide the pre-authorization code.

Pre-authorization code provided by the beneficiary hometown Insurer/ SHA/ ISA will be entered by the operator and will be verified by the system.

If pre-authorization request is rejected, the beneficiary hometown Insurance Company/ SHA/ ISA will provide the reasons for rejection. Rejection details will be captured and stored in the transaction database.

If the beneficiary or the hospital are not satisfied by the rejection reason, they can appeal through grievance system.

Balance Check, Treatment, Discharge and Claim Request

Based on selection of package(s), the operator will check from the Central AB PM-JAY Server if sufficient balance is available with the beneficiary to avail services.

If balance amount under available covers is not enough for treatment, then remaining amount (treatment cost - available balance), will be paid by beneficiary (OOP expense will also be captured and stored)

The hospital will only know if there is sufficient balance to provide the selected treatment in a yes or no response. The exact amount will not be visible to the hospital.

SMS will be sent to the beneficiary registered mobile about the transaction and available balance

List of diagnostic reports recommended for the blocked package will be made available and upload of all such reports will be mandatory before discharge of beneficiary.

Transaction System would have provision of implementation of Standard Treatment Guidelines for providing the treatment

After the treatment, details will be saved, and beneficiary will be discharged with a summary sheet.

Treatment cost will be deducted from available amount and will be updated on the Central AB PM-JAY Server.

The operator/AM fills the online discharge summary form and the patient will be discharged. In case of mortality, a flag will be raised against the deceased member declaring him as dead or inactive.

At the same time, a printable receipt needs to be generated and handed over to the patient or patient's attendant.

After discharge, beneficiary gets a confirmation and feedback call from the AB PM-JAY call center; response from beneficiary will be stored in the database

Data (Transaction details) should be updated to Central Server and accessible to the beneficiary hometown Insurance Company/ SHA/ ISA for Claim settlement. Claim will be presumed to be raised once the discharge information is available on the Central server and is accessible to the SHA/ ISA/ Insurance Company

SMS will be sent to beneficiary registered mobile about the transaction and available balance

After every discharge, claims would be deemed to be raised to the beneficiary hometown insurance company/ SHA/ ISA. An automated email alert will be sent to the insurance company/ISA specifying patient name, AB PM-JAY ID, registration number & date and discharge date. Details like Registration ID, AB PM-JAY ID, date and amount of claim raised will be accessible to the insurance company/trust on AB PM-JAY System/ State IT system. Also details like Registration-ID, AB PM-JAY-ID, Date and amount of claim raised, date and amount of claim disbursement, reasons for different in claims raised and claims settled (if any), reasons for rejection of claims (if any) will be retrieved from the insurance company/trust through APIs.

Once the claim is processed and the hospital gets the payment, the above-mentioned information along with payment transaction ID will be updated on central AB PM-JAY system by the NHA.

Hospital Transaction Management Module would be able to generate a basic MIS report of beneficiary admitted, treated and claim settled and in process and any other report needed by Hospitals on a regular basis

Upon discharge, beneficiary will receive a feedback call from the Call center where he can share his feedback about his/her hospitalization experience.

Annex 6: Process for Disciplinary Proceedings and De-Empanelment

Institutional Mechanism

In case of any complaints or detection of any malpractice De-empanelment process can be initiated by hospital empanelment committee. After conducting proper investigation against empaneled hospitals by hospital empaneled committee on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, and overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries. Hospital can contest the action of de-empanelment by filling appeal to National Grievance Redressal committee (NGRC) through the Grievance Redressal Mechanism as per guidelines.

Please refer detailed process and criteria for de-empanelment on the AB PM-JAY website.

All these penalties are recommendatory, and the Hospital Empanelment Committee may inflict larger or smaller penalties depending on the severity/regularity/scale/intentionality on a case to case basis with reasons mentioned clearly in a speaking order. The penalties by the hospital shall be paid directly to the respective payor in all the cases.

Schedule 7: List of Empanelled Health Care Providers under the Scheme

Available at https://hospitals.pmjay.gov.in/Search/empnlWorkFlow.htm?actionFlag=ViewRegisteredHosptlsNew

Schedule 8: Premium Payment Guidelines

A. Release of Grant-in-Aid/Premium Payment

i) A flat premium per family, irrespective of the number of members under AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA in that family, will be determined through open tendering process.

ii) The State Government/Union Territories shall upfront release the grant-in-aid / premium for the implementation of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA into a designated escrow account., SHA will release payments to the Insurance companies on a per family basis from this account.

iii) The premium will be based on the targeted beneficiary families as per the eligibility criteria of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA or the number of beneficiary families mapped with the SECC Database (in case a different database, other than SECC Database is used by the States/UTs), as the case may be.

B. Stages of Release of Premium**:**

State Health Agency (SHA) will, on behalf of the Beneficiary Family Units that are targeted/identified by the SHA and covered by the Insurer, pay the Premium for the Cover to the Insurer in accordance with the following schedule:

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% of their respective share viz. (out of 10% / 40%), 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 share of administrative expense into the designated escrow account opened by the States / UTs for the implementation of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA.

Thereafter, within 15 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 and requisite documentary evidences and compliance of applicable financial provisions. The Central Government will release 45% 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 days from the receipt of proposal from the State / UT.

In case of Union Territories without Legislatures, the Central Government shall pay 45% of its respective share of premium (viz. out of 100%) through its designated escrow account into the designated Escrow Account of the UT within 21 days from the receipt of duly completed proposal.

Upon the receipt of Central Government's Share of Premium, the State /UT shall release the first instalment of premium within 7 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 that are targeted or identified by the SHA. The State /UT (with Legislature), within 15 days upon the receipt of invoice from the insurance company, shall release their 2nd instalment of premium i.e. 45% of their respective share viz. (out of 10% / 40%) into the designated escrow account. Thereafter, within 15 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 and requisite documentary evidences and compliance of applicable financial provisions. The Central Government will release 45% 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 days from the receipt of 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 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 that are targeted or identified by the SHA, if applicable. 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% or the proportionate premium based upon the claim settlement scenario, as the case may be into the escrow account. Thereupon, within 15 days of their release of premium, shall raise the proposal to the Central Government for the release of 10% 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.

Thereafter, upon the receipt of Central Government's Share of Premium, the State / UT shall release the second instalment of premium within 7 days through the designated Escrow Account to the Insurance Company under intimation to the Central Government.

A. Penalty Provision on Delay of Premium

If in case, the State / UT has not deposited its due share of premium into the escrow account, then a penal interest would be levied @ 1% per week for the number of week delay and part thereof on the State / UT.

Similarly, penal interest provision shall also be applicable on the Central Government. The concerned Government viz. State or Central / UT shall have the right to own such penal interest amount for adjusting in their future payable respective share of premium.

B. Interest Earned in Escrow Account

Any interest earned by SHA on Central Government's Share of Premium released into the Escrow account, the Central Government shall have the first right of claim on such interest earned amount and shall have to be transferred back to the Central Government Alternatively, it will be adjusted in future payment of the Central Government. Similarly, interest provision shall also be applicable for the State Government too.

The State Health Agency shall send the proposal to the Central Government for the release of Central Government's Share of Premium within 15 (Fifteen) days of receipt of the Insurer's invoice along & release of their share of premium, along with requisite documents (viz. Details of Eligible Identified Beneficiary Families, Documentary Proof for release of State Government's Share, etc] and compliance of Applicable Financial Rules.
In case the insurance company is not paid the premium from the State's escrow account within the stipulated time of 7 (seven) Business Days, then, for such unwarranted delay, the States / UTs shall be solely liable to pay a penal interest of 1% per month to the Insurance Company starting from after one month beyond the mutually agreed date as decided between the SHA and Insurance Company.

C. Submission and Approval of Proposal

Before the start of implementation of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA, the States / UTS will have will have to send their proposal to the Central Government and execute the Memorandum of Understanding with the Central Government indicating their modus operandi for the implementation of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA The approval of National Health Authority will precede and be necessary for signing the contract with the selected Insurance Company.

D. No Separate Fees, Charges or Premium

The Insurer shall not charge any Beneficiary Family Unit or any of the Beneficiaries any separate fees, charges, commission or premium, by whatever name called, for providing the benefits. However, the aforesaid provision shall not be applicable, if the beneficiary is required to take treatment above the amount of benefit cover of Rs. 5,00,000.

Schedule 9: Portability Guidlines

An Empanelled Health Care Provider (EHCP) under AB-PMJAY in any state should provide services as per AB-PMJAY guidelines to beneficiaries from any other state also participating in AB-PMJAY. This means that a beneficiary will be able to get treatment outside the EHCP network of his/her Home State.

Any empanelled hospital under AB-PMJAY will not be allowed to deny services to any AB-PMJAY beneficiary. All interoperability cases shall be mandatorily under pre-authorisation mode and pre-authorisation guidelines of the treatment delivery state in case of AB-PMJAY implementing States / UTs or indicative pre-authorisation guidelines as issued by NHA, shall be applicable.

Enabling Portability

To enable portability under the scheme, the stakeholders need to be prepared with the following:

A. **States**: Each of the States participating in AB-PMJAY will sign MoU with Central Government which will allow all any the hospital empanelled hospitals by that state under AB-PMJAY to provide services to eligible beneficiaries of other States from across the country. Moreover, the state shall also be assured that its AB-PMJAY beneficiaries will be able to access services at all AB-PMJAY empanelled hospitals seamlessly in other states across India.

B. **Empanelled hospitals**: The Empanelled Hospital shall have to sign a tripartite contract with its insurance company and State Health Agency (in case of Insurance Model) or with the Trust which explicitly agrees to provide AB-PMJAY services to AB-PMJAY beneficiaries from both inside and outside the state and the Insurance Company/Trust agrees to pay to the EHCP through the inter-agency claim settlement process, the claims raised for AB-PMJAY beneficiaries that access care outside the state in AB-PMJAY empanelled healthcare provider network.

C. **Insurance companies/Trusts**: The Insurance Company (IC) signs a contract with all other IC's and Trusts in the States / UTs under AB-PMJAY to settle down the interoperability related claims within 30 days settlement so that the final payment is made for a beneficiary by the Insurance Company or Trust of his/her home state.

D. **IT systems:** The IT System will provide a central clearinghouse module where all inter-insurance, inter trust and trust-insurance claims shall be settled on a monthly/bi-monthly basis. The IT System will also maintain a Balance Check Module that will have data pushed on it in real time from all participating entities. The central database shall also be able to raise alerts/triggers based on suspicious activity with respect to the beneficiary medical claim history based on which the treatment state shall take necessary action without delay.

E. **Grievance Redressal:** The Grievance Redressal Mechanism will operate as in normal cases except for disputes between Beneficiary of Home State and EHCP or IC of Treatment State and between Insurance Companies/Trusts of the Home State and Treatment State. In case of dispute between Beneficiary and EHCP or IC, the matter shall be placed before the SHA of the treatment state. In cases of disputes between IC/Trust of the two states, the matter should be taken up by bilateral discussions between the SHAs and in case of non-resolution, brought to the NHA for mediation. The IC/Trusts of Home State should be able to raise real time flags for suspect activities with the Beneficiary State and the Beneficiary State shall be obligated to conduct a basic set of checks as requested by t-he Home State IC/Trust. These clauses have to be built in into the agreement between the ICs and the Trusts. The NHA shall hold monthly mediation meetings for sorting out intra-agency issues as well as sharing portability related data analytics.

F. **Fraud Detection:** Portability related cases will be scrutinized separately by the NHA for suspicious transactions, fraud and misuse. Data for the same shall be shared with the respective agencies for necessary action. The SHAs, on their part, must have a dedicated team for conducting real time checks and audits on such flagged cases with due diligence. The IC working in the State where benefits are delivered shall also be responsible for fraud prevention and investigation.

Implementation Arrangements of Portability

A. **Packages and Package Rates**: The Package list for portability will be the list of mandatory AB-PMJAY packages released by the NHA and package rates as applicable

and modified by the Treatment State will be applicable. The Clause for honouring these rates by all ICs and Trusts shall have to be built into the agreement.

- Clauses for preauthorization requirements and transaction management system shall be as per the treatment state guidelines.
- The beneficiary balance, reservation of procedures for public hospitals as well as segmentation (into secondary/tertiary care or low cost/high cost procedures) shall be as per the home state guidelines.
- Therefore, for a patient from Rajasthan, taking treatment in Tamil Nadu for CTVS in an EHCP – balance check and reservation of procedure check will be as per Rajasthan rules, but TMS and preauthorization requirements shall be as per TN rules. The hospital claim shall be made as per TN rates for CTVS by the TN SHA (through IC or trust) and the same rate shall be settled at the end of every month by the Rajasthan SHA (through IC or trust).

B. **Empanelment of Hospitals:** The SHA of every state in alliance with AB-PMJAY shall be responsible for empanelling hospitals in their territories. This responsibility shall include physical verification of facilities, specialty related empanelment, medical audits, post procedure audits etc.

- For empanelment of medical facilities that are in a non AB-PMJAY state, any AB-PMJAY state can separately empanel such facilities. Such EHCP shall become a member of provider network for all AB-PMJAY implementing States. NHA can also empanel a CGHS empanelled provider for AB-PMJAY in non AB-PMJAY state.
- Each SHA which empanels such a hospital shall be separately and individually responsible for ensuring adherence of all scheme requirements at such a hospital.

C. **Beneficiary Identification:** In case of beneficiaries that have been verified by the home state, the treatment state EHCP shall only conduct an identity verification and admit the patient as per the case.

- In case of beneficiaries that have not been so verified, the treatment EHCP shall conduct the Beneficiary Identification Search Process and the documentation for

family verification (ration card/family card of home state) to the Home State Agency for validation.

- The Home State Agency shall validate and send back a response in priority with a service turnaround time of 30 minutes. In case the home agency does not send a final response (IC/Trust check), deemed verification of the beneficiary shall be undertaken and the record shall be included in the registry. The home state software will create a balance for such a family entry.
- The empanelled hospital will determine beneficiary eligibility and send the linked beneficiary records for approval to the Insurance company/trust of Treatment State which in turn will send the records to the Insurance company/trust in the home State of beneficiary. The beneficiary approval team of the Insurance company/trust in the home State of beneficiary will accept/reject the case and convey the same to the Insurance company/trust in the State of hospital which will then inform the same to the hospital. In case the beneficiary has an E-Card (that is, he/she has already undergone identification earlier), after a KYC check, the beneficiary shall be accepted by the EHCP.
- If the NHA and the SHA agree to provide interoperability benefits to the entire Home State Beneficiary List, the identification module shall also include the Home State Beneficiary Database for validation and identification of eligible beneficiaries.

D. **Balance Check:** After identification and validation of the beneficiary, the balance check for the beneficiary will be done from the home state. The balance in the home state shall be blocked through the necessary API and updated once the claim is processed. The NHA may provide a centralised balance check facility.

E. **Claim Settlement**: A claim raised by the empanelled hospital will first be received by the Trust/Insurer of the Treatment State which shall decide based on its own internal processes. The approval of the claim shall be shared with the Home State Insurance Company/Trust which can raise an objection on any ground within 3 days. In case the Home State raises no objection, the Treatment State IC/Trust shall settle the claim with the hospital. In case the Home State raises an objection, the Treatment State shall settle the claim as it deems fit. However, the objection of the Home State shall only be

recommendatory in nature and the Home State shall have to honour the decision of the Treatment State during the time of interagency settlement.

F. **Fraud Management**: In case the Trust/Insurer of the home State of beneficiary has identified fraudulent practices by the empanelled hospital, the Trust/Insurer should inform the SHA of the Treatment State of EHCP along with the supporting documents/information. The SHA of the Treatment State shall undertake the necessary action on such issues and resolution of such issues shall be mediated by the NHA during the monthly meetings.

G. **Expansion of Beneficiary Set:** In case, there is an alliance between AB-PMJAY and any State Scheme or AB-PMJAY has been expanded in the Home State, the above process for portability may be followed for all beneficiaries of the Home State.

H. **IT Platform:** The states using their own platform shall have to provide interoperability with the central transaction and beneficiary identification system to operationalize guidelines for portability for AB-PMJAY.

I. **Modifications:** The above guidelines may be modified from time to time by the National Health Agency and shall apply on all the states participating in the Pradhan Mantri Jan Arogya Yojana.

Schedule 10: Template for Medical Audit

Template for Medical Audit

AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA ID		Hospital ID	
Patient Name		Hospital Name	
Case No.		Hospital Contact No.	
Date of Admission		Date of Discharge	
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	**Does each medical record file contain:**			
a.	Is discharge summary included?			
b.	Are significant findings recorded?			
c.	Are details of procedures performed recorded?			
d.	Is treatment given mentioned?			
e.	Is patient's condition on discharge mentioned?			
f.	Is final diagnosis recorded with main and other conditions?			
g.	Are instructions for follow up provided?			
2.	**Patient history and evidence of physical examination is evident.**			
a.	Is the chief complaint recorded?			
b.	Are details of present illness mentioned?			
c.	Are relevant medical history of family members present?			
d.	Body system review?			
e.	Is a report on physical examination available?			
f.	Are details of provisional diagnosis mentioned?			
3.	**Is an operation report available? (only if surgical procedure done)**			
a.	Does the report include pre-operative diagnosis?			
b.	Does the report include post-operative diagnosis?			
c.	Are the findings of the diagnosis specified?			
d.	Is the surgeon's signature available on records?			
e.	Is the date of procedure mentioned?			
4.	**Progress notes from admission to discharge**			
a.	Are progress reports recorded daily?			
b.	Are progress reports signed and dated?			
c.	Are progress reports reflective of patient's admission status?			

d.	Are reports of patient's progress filed chronologically?			
e.	Is a final discharge note available?			
5	Are pathology, laboratory, radiology reports available (if ordered)?			
6	Do all entries in medical records contain signatures?			
a.	Are all entries dated?			
b.	Are times of treatment noted?			
c.	Are signed consents for treatment available?			
7	Is patient identification recorded on all pages?			
8	Are all nursing notes signed and dated?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

_____
Signature of the Auditor

Date:

Schedule 11: Template for Hospital Audit

Template for Hospital Audit

Hospital Name		Hospital ID	
Hospital Address			
Hospital Contact No.			
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Was there power cut during the audit?			
2.	If yes, what was the time taken for the power back to resume electric supply?			
3.	Was a AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA kiosk present in the reception area with proper IEC material?			
4.	Was any AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA trained staff present at the kiosk?			
5.	Did you see the AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Empanelled Hospital Board with scope of services displayed near the kiosk in the reception and other prominent areas?			
6.	Was the kiosk prominently visible?			
7.	Was the kiosk operational in local language?			
8.	Were AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA brochures available at the kiosk?			
9.	Were the toilets in the OPD and IPD areas clean?			
10.	Was drinking water available in the OPD and IPD areas for patients?			
11	Were sanctioned beds/functional beds available as per the claimed beds by hospital during empanelment?			
12	Was qualified manpower (full time/part time) as per the scope of services?			
13	Was the basic physical infrastructure of hospital clean and intact?			
14	Were diagnostic facilities (inhouse/outsourced*) as per the scope of services?			
15	Was functional ambulance (inhouse/outsourced*) available during visit?			
* For outsources services – check signed MoU				

Overall observations of the Auditor:

Significant findings:

Recommendations:

_____
Signature of the Auditor

Date:

Schedule 12: Key Performance Indicators

SN	Summary of Key Performance Indicators
A.	Initial Setting up - KPIs
B.	Performance - KPIs
C.	Audit Related - KPIs
D.	Payment - KPIs
E.	Productivity - KPIs

A. Initial Setting up KPIs				
SN	**KPIs**	**Timeline**	**Measure and Explanation**	**Penalty**
1.	**Setting up of a State Project Office (SPO) and Appointment of Project Head and other Staff (As per Schedule F) at SPO for co-ordination and Scheme implementation**	Up to 30 days after signing of Insurance Contract, or in any event, prior to commencement of policy period.	Within 30 days of signing of the contract, IC shall establish SPO with required staff and submit the sworn undertaking of the same to CEO-SHA • Establishment of the State Project Office • Appointment of State Project Head • Appointment of other required staff	Rs. 25,000 per week of delay beyond and part thereof in setting-up* SPO as required
2.	**Appointment of District Coordinator (DC) for each district**	30 days after signing of Insurance Contract, or in any event, 7 days prior to commencement of policy period.	Latest by 30th Day of signing of the contract, IC shall appoint the District Coordinator for each district/cluster. District Nodal Office shall acknowledge the appointment of DC	Rs. 5,000 per week, per district beyond and part thereof
*Setting-up of SPO: Setting up of State Project Office (SPO) includes establishment of the SPO and also putting in place all the staff as per Schedule 18: (will be detailed out in Model Tender Document)				

B. Performance KPIs				
SN	**KPIs**	**Timeline**	**Baseline KPI Measure**	**Penalty**
1.	**E-card verification and approval**	• 30 Mins: Action on Verification Request from hospitals	95% Compliance	• Penalty of Rs 100 of each card delayed beyond given TAT • Penalty of Rs 500 each incorrect verification/approval of e-card by IC
			100% compliance	In case any claim is adjudicated out of wrongly approved BIS card by IC then penalty of three times over and above the claim amount
2.	**Pre-authorisation**	Action within 6 * hours: of raising preauthorization request (all auto approvals beyond 6 hours will be considered non-compliance)	95% Compliance	• Compliance from compliance below 95% upto 90% then penalty of 5% of the monthly total delayed preauthorization amount • Compliance below 90% upto 85% then penalty of 10% of the monthly total delayed preauthorization amount • Compliance below 85% then penalty of 20% of the monthly total delayed preauthorization amount with one instance of triggering of SPD** (for calculation, monthly delayed preauthorization amount shall be the amount for delayed pre-authorizations for the admissions in that month. Penalty shall be calculated on this amount and Insurer shall pay the penalty as per Penlaty Notice per quarter, please see Clause 23.5) *Example: if the IC handled 100 preauthorization in the month and failed to meet TAT for 16 cases, 20% preauthorization amount of only these 16 cases will be charged as penalty. Even if the preauthorization is rejected, not meeting the TAT will invite the penalty*

			100% compliance	In case of wrongful pre-authorization approval, penalty of three times over & above the preauthorization amount
3.	**Scrutiny, Claim processing and payment of the claims**	Action within 15 days of claim submission for claims within state and 30 days & for claims from outside state (Portability cases). (This is applicable if the Insurer fails to make the Claims Payment within a Turn-around Time of 15 days/30 days for a reason other than delay on the part of SHA, if any)	100% Compliance	If the Insurer fails to make the Claim Payment within Turn Around Time (TAT)***, then the Insurer shall be liable to pay a penal interest to the EHCP at the rate of 0.1% for each claim amount for every day of delay or the part thereof on every delayed claim.If the compliance in the month falls below 85% of number claims, it will be treated as one instance of SPD trigger *Example: if the IC processed 100 claims in the month and failed to meet TAT for 16 claims, it will be liable to pay penalty of 0.1% for each claim per day of these 16 claims to EHCPs. It will also be treated as one instance of triggering of SPD*
			100% Compliance	In case any claim is adjudicated wrongly then penalty of three times over and above the claim amount
4.	**Delays in compliance to orders of the Grievance Redressal Committee (GRC)**	Beyond 30 days of the date of the order of the GRC	100% Compliance	Rs. 25,000 per week or part thereof

- *6 hours: As per threshold set in TMS
- ** Service Provider Default (SPD) is special termination clause in the agreement and triggering of which is a failure to meet baseline KPIs and will be considered as Default by IC. Default herein shall occur if SPD trigger
  - Occurs 8 (eight) times during any one year of the agreement

In this event, agreement with IC is liable for termination and IRDAI shall be informed to take stringent actions against IC under relevant rules. However, SPD triggers shall only be applicable from 3rd month of signing of the contract

- Penalty amount for Performance KPIs shall be calculated each month and Insurers shall pay all penalties imposed by the SHA within 7 working days of receipt Penalty Notice from SHA (Clause 23.5).
- At any point during term of contract, if penalty amount is 10% of the total contract value, contract shall be liable to be terminated
- *** in case of claims processing, TAT will be determined as days during which claim is with IC (Excluding the days claim is pending at EHCPs end)

  Example: 1
  The day EHCP raises claim will be treated as Day 1
  If IC raises query on Day 4,
  and EHCP complies with query on Day 10,
  IC takes action (accepting or rejection of claim) on Day 12
  Payment on Day 15
  in this case (4-1=3) days + (15-10=5) days, hence TAT determined is 3+5=8 days

  Example 2:
  The day EHCP raises claim will be treated as Day 1
  If IC raises query on Day 4,
  and EHCP complies with query on Day 10,
  IC raises another query on Day 11
  EHCP complies with second query on Day 14
  EHCP accepts approves the claim on Day 16
  Payment on Day 17
  in this case (4-1=3) days + (11-10=1) days+ (17-14=3) days, hence TAT determined is 3+1+3=7 days

	C. Audit Related KPIs			
SN	**KPIs**	**Sample**	**Baseline KPI Measure**	**Penalty**
1.	**Preauthorization Audits**	5% of total preauthorization's across disease specialities per quarter	100% compliance	Rs. 50,000 per missing audit report per quarter If IC fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
2.	**Claims Audit (Approved Claims)**	5% of total claims of the quarter	100% compliance	Rs. 50,000 per missing audit report per quarter If IC fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
3.	**Medical Audits**	5% of total hospitalization cases per quarter	100% compliance	Rs. 50,000 per missing audit report per quarter If IC fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
4.	**Death Audits**	100%	100% compliance	Rs. 50,000 Per missing death audit report per quarter If IC fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
5	Beneficiary audit (during hospitalization)	2% of total hospitalized beneficiaries in that quarter	100% compliance	Rs. 50,000 per missing beneficiary (on phone) audit report If IC fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers

6.	**Beneficiary Audit-On Phone**	5% of total hospitalized beneficiaries in that quarter	100% compliance	Rs. 50,000 per missing beneficiary (on phone) audit report If IC fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
7.	**Beneficiary Audit-Home Visit**	1% of total hospitalized beneficiaries in that quarter	100% compliance	Per 50,000 per missing beneficiary (on phone) audit report If IC fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers

- While conducting the audit, IC shall ensure not more than 20% of sample size of overlapping of beneficiaries across audits except SN. 4.
- Sample size shall be equally distributed across all the districts in the state and also ensuring coverage of all suspect entities
- For the purpose of computing above audit percentages, cases from public hospitals shall be excluded. SHA may give directions regarding inclusion of cases from public hospitals for the audits.
- If submitted audit report dues not mention required sample size or details, it will be treated as non-submission of audit report
- Audit reports shall contain details as required in Anti-Fraud Guidelines published by NHA
- Insurer shall ensure audits to be conducted as prescribed by Anti-Fraud Guidelines, however penalty is only applicable on above audit reports

D. Payment KPIs			
SN	**Availability KPIs**	**Timeline**	**Penalty**
1.	**Premium Payment by SHA**	Premium payment as per schedule	Interest @ 1% on due premium amount for every 30 days' delay or part thereof shall be paid by the SHA to the Insurer[#]
2.	**Premium Refund by IC**	30 days from the date of notice	1.5% penal interest for every month of delay or part thereof if not received within 30 days
3	**Payment of Penalties by IC**	• 15 days from date or receiving the quarterly payment notice in case non contested payment • 30 days in case IC contests the levied penalty	Interest @ 1.5% on due penalty amount for every 30 days delay or part thereof shall be paid as penal intrest by the Insurer to SHA
#: State government will bear cost of the penalty caused due to delay in premium payment and not to be booked under NHA's share			

E. Productivity* KPIs for Key Staff by IC				
SN	**Designation**	**Benchmark**	**Location**	**Brief Roles and Responsibilities**
1	**PPD**	100-120 Pre-authorization request per person per day	SPO/Central Office of IC *(Instructions to the state: state shall decide about location of the processor)*	• Approve/assign/reject pre-auth request • Raise query/send for clarification to hosp. • Trigger investigation
2	**CEX**	100-120 claims processing per person per day	SPO/Central Office of IC *(Instructions to the state: state shall decide about location of the processor)*	• Verification on non technical documents, reports, dates verification • Forward case to CPD for processing with inputs
3	**CPD**	70-100 claims per person per day	SPO/Central Office of IC *(Instructions to the state: state shall decide about location of the processor)*	• Verification of technical information eg. Diagnosis, clinical treatment, notes, evidences, etc. • Approve/assign/reject a claim • Raise query/as for clarification • Trigger investigation

- * IC shall make the staff available as detailed in Schedule: 16, however productivity KPIs will be applicable on above staff on given parameters.
- IC shall ensure that preauthorization and claim approval and rejection shall be approved by an MBBS doctor

Schedule 13: Indicative Fraud Triggers

Claim History Triggers

1. Impersonation.
2. Mismatch of in house document with submitted documents.
3. Claims without signature of the AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA 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 AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA 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 AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary claimed in multiple places at the same time.
10. Excessive utilization by a specific member belonging to the AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA 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 AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary Family Unit and different hospitals for other members of the AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary Family Unit), multiple claims towards the end of Policy Cover Period, close proximity of claims.

Admissions Specific Triggers

15. Members of the same AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary Family Unit getting admitted and discharged together.
16. High number of admissions.
17. Repeated admissions.
18. Repeated admissions of members of the AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary Family Unit.
19. High number of admission in odd hours.
20. High number of admission in weekends/ holidays.
21. Admission beyond capacity of hospital.
22. Average admission is beyond bed capacity of the EHCP in a month.
23. Excessive ICU admission.
24. High number of admission at the end of the Policy Cover Period.

25. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
26. Claims with Length of Stay (LoS) which is in significant variance with the average LoS for a particular ailment.

Diagnosis Specific Triggers

27. Diagnosis and treatment contradict each other.
28. Diagnostic and treatment in different geographic locations.
29. Claims for acute medical Illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
30. Ailment and gender mismatch.
31. Ailment and age mismatch.
32. Multiple procedures for same AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary – blocking of multiple packages even though not required.
33. One-time procedure reported many times.
34. Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
35. Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
36. Part of the expenses collected from AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary for medicines and screening in addition to amounts received by the Insurer.
37. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of Critical Illness.
38. Overall medical management exceeds more than 5 days, other than in the case of Critical Illness.
39. High number of cases treated on an OOP basis at a given provider, post consumption of financial limit.

Billing and Tariff based Triggers

40. Claims without supporting pre/ post hospitalisation papers/ bills.
41. Multiple specialty consultations in a single bill.
42. Claims where the cost of treatment is much higher than expected for underlying etiology.
43. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
44. Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
45. 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.
46. 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

47. Qualification of practitioner doesn't match treatment.
48. Specialty not available in hospital.
49. Delayed information of claim details to the Insurer.
50. Conversion of OP to IP cases (compare with historical data).
51. Non-payment of transportation allowance.
52. Not dispensing post-hospitalization medication to AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiaries.

Schedule 14: Indicators to Measure Effectiveness of Anti-Fraud Measures

1. Monitoring the number of grievances per 1,00,000 AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiaries.
2. Proportion of Emergency pre-authorisation requests.
3. Percent of conviction of detected fraud.
4. Share of pre-authorisation and claims audited.
5. Claim repudiation/ denial/ disallowance ratio.
6. Number of dis-empanelment/ number of investigations.
7. Share of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary Family Units physically visited by Scheme functionaries.
8. Share of pre-authorisation rejected.
9. Reduction in utilization of high-end procedures.
10. AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA Beneficiary satisfaction.
11. Share of combined/ multiple-procedures investigated.
12. Share of combined/ multiple-procedures per 1,00,000 procedures.
13. Pre-authorisation pendency rate and Claim pendency rate per 100 cases decided OR percent of pre-authorisation decided after additional observation being attended + correlated with frauds detected as a consequence of this effort.
14. Instances of single disease dominating a geographical area/Service area are reduced.
15. Disease utilization rates correlate more with the community incidence.
16. Number of FIRs filed.
17. Number of enquiry reports against hospitals.
18. Number of enquiry reports against Insurer or SHA staff.
19. Number of charge sheets filed.
20. Number of judgments received.
21. Number of cases discussed in Empanelment and Disciplinary Committee.
22. Reduction in number of enhancements requested per 100 claims.
23. Impact on utilization.
24. Percent of pre-audit done for pre-authorisation and claims.
25. Percent of post-audit done for pre-authorisation and claims.
26. Number of staff removed or replaced due to confirmed fraud.
27. Number of actions taken against hospitals in a given time period.
28. Number of adverse press reports in a given time period.
29. Frequency of hospital inspection in a given time period in a defined geographical area.
30. Reduction in share of red flag cases per 100 claims.

Schedule 15: Format of Actuarial Certificate for Determining Refund of Premium

[***On the letterhead of the Insurer/Insurer's Appointed Actuary***]

From:
[*Name of Appointed Actuary*]
[*Designation of Appointed Actuary*]
[*Address of Insurer/Appointed Actuary*]

Date: [●]

To:
Mr. [●]
CEO, State Health Agency
Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA)
[***Insert Address***]

Dear Sir,

Sub: Actuarial Certificate in respect of Pure Claim Ratio of [*insert name of Insurer*] for Policy Cover Period [●] to [●]

I/We, [*insert name of actuary*], are/am a/an registered actuary under the laws of India and are/is licensed to provide actuarial services.

[*Insert name of Insurer*] (the **Insurer**) is an insurance company engaged in the business of providing general insurance (including health insurance) services in India for the last [●] years. I/We have been appointed by the Insurer as its Appointed Actuary in accordance with the IRDA (Appointed Actuary) Regulations, 2000.

The Insurer has executed a contract dated [●] with the State Health Agency for the implementation of the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA) (the **Insurance Contract**). The Premium payable by the State Health Agency under the Insurance Contract for the Policy Cover Period from [●] to [●] (**Previous Policy Cover Period**) is ₹ [●] (Rupees [*insert sum in words*] only).

In accordance with the Insurance Contract, we are required to certify the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period for all the districts within the Service Area.

I, [*insert name*] designated as [*insert title*] at [*insert location*] of [*insert name of actuary*] do hereby certify that:

(a) We have read the Insurance Contract and the terms and conditions contained therein.

(b) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period has been determined by us in accordance with the formula below:

$$\textbf{Pure Claim Ratio} = \frac{C}{P_T} \times 100$$

= [*insert calculation*]
= [*insert result*]%

For the purposes of the formula above:

P_T is the total Premium collected by the Insurer in the Previous Policy Cover Period for all the Beneficiary Family Units covered by it. It is calculated as the product of the Premium per Beneficiary Family Unit in the Current Policy Cover Period and the total number of Beneficiary Family Units covered by the Insurer in the Current Policy Cover Period, i.e., Rs. [●] (Rupees [*insert sum in words*] only).

C is the total Claims paid by the Insurer to the Empanelled Health Care Providers in the full 12 months of the Previous Policy Cover Period, i.e., Rs. [●] (Rupees [*insert sum in words*] only);

(c) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio of the Insurer in respect of all the districts within the Service Area in the full 12 months of the Previous Policy Cover Period is [●]% ([*insert sum in words*] percentage).

At [*insert place*]
Date: [*insert date*]

_____
On behalf of [*insert name of Appointed Actuary*]
[*Name*]
[*title*]

Name and Counter Signature of Principal Officer of Appointed Actuary, along with Appointed Actuary's name and seal

_____
On behalf of [*insert name of Appointed Actuary*]
[*Name*]
[*title*]

[*Note. This counter signature is only required if the Appointed Actuary is an external actuarial firm.*]

Schedule 16: Minimum Manpower Requirements

(instructions to the state: please make chages in this schedule as per specific requirement)
The Insurer shall ensure that it shall at all times during the Tenure of the Contract, maintain at a minimum, the following number of Personnel having, at a minimum, the prescribed qualifications and experience:

SN	Designation	Number	Location	Minimum Qualification and experience *(instrucions to the state to specify)*	Brief Roles and Responsibilities
1	State Project Manager	1	SPO of IC	•	• Overall coordinator of ICs operations in the state • Single contact point for SHA for any coordination purpose
2	State Medical Manager	1	SPO of IC	• MBBS or BDS	• Overall supervision and guidance to be provided to CPDs and PPDs
3	State Operations/technical Coordinator	1	SPO of IC	• Graduate	• coordinate
4	District Coordinator	1 each district	Office of District Nodal Officer PM JAY	• Graduate	<u>Role of District Coordinator</u> • To coordinate and ensure smooth implementation of the Scheme in the district. • To follow up with the EHCP to ensure that the IT infrastructure installed is fully functional at all times. • Liaise with the district officials of the SHA to addressing

					operational issues as and when they arise. Liaise with the District Grievance Redressal Cell for resolving all complaints.
5	PPD	100-120 Pre-authorization request per day per person	SPO of IC/Centrally located	• MBBS	• Approve/assign/reject pre-auth request • Raise query/send for clarification to hosp. • Trigger investigation
6	CEX	100-120 per claims processing per person	SPO of IC/Centrally located	• Graduate	• Verification on non technical documents, reports, dates verification • Forward case to CPD for processing with inputs
7	CPD	70-100 claims per person per day	SPO of IC/Centrally located	• MBBS	• Verification of technical information eg. Diagnosis, clinical treatment, notes, evidences, etc. • Approve/assign/reject a claim • Raise query/as for clarification • Trigger investigation
8	Fulltime medical Auditors cum Fraud Investigator	1 per each 6 zone	6 zones in the state under - Phek/Kiphire, Kohima/Wokha, Dimapur/Peren, Mokokchung/Zunheboto/Longleng, Tuensang/Noklak ,Mon	• MBBS / BDS	• Coordinate and conduct required periodical audit • Finalize and submit audit report for the district/cluster to the state headquarter for

					finalization of state wise periodical audit • Fraud investigation
9	Empaneled medical auditors	As per requirement *(Instruction to state: No need to be on payroll but can be ad hoc staff)*	NA	• MBBS / BDS	• Support conducting medical audits
10	Empaneled Hospital Auditors	As per requirement *(Instruction to state: No need to be on payroll but can be ad hoc staff)*	NA	•	• Support conducting hospital audits

Schedule 17: Non-Disclosure Agreement

NON-DISCLOSURE AGREEMENT

This Non- Disclosure Agreement **("Agreement")** is entered into on this … day of _____, 2020**("Effective Date")** by and between:

State Health Agency, _____represented by the _____, having its office located at _____which expression shall, unless repugnant to the context, include its successors and assigns (hereinafter referred to **as "SHA")**

And

M/s. _____ a company registered under the Companies Act 1956 and having its registered office at _____ represented by Mr. _____ which expression shall, unless repugnant to the context include its successors (hereinafter referred as "**the Insurer**")

SHA and Insurer shall hereinafter be referred individually as Party/ as specified hereinabove and jointly as "**Parties**".

Whereas:

A. SHA is constituted with an objective of _____.
B. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana **(AB PM-JAY)** in alliance with state governments. AB PM-JAY is targeting over 10 crore poor and vulnerable beneficiary families. Thus, SHA is playing a critical role in **fostering linkages as well as convergence of ABPM-JAY** with health and related programs of the Central and State Governments.
C. The Insurer is carrying on business of_____.
D. SHA is [contemplating engaging the services of the Insurer*)* for [specify Purpose] (the "Purpose") and for this Purpose, the Insurer shall come into contact with certain confidential information;
E. SHA desires to ensure that strict confidentiality is maintained by the Insurer regarding its relationship with SHA and also regarding the confidential information which comes to the knowledge of Insurer in connection with the Purpose;
F. The Parties desire to set forth their rights and obligations with respect to the use, dissemination and protection of the confidential information accessed by the Insurer.

NOW THEREFORE, in consideration of the mutual covenants and agreements set forth below, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, it is understood and agreed as follows:

1. **Definitions**

In this Agreement, the following terms shall have the following meanings:

"Confidential Information" shall include all information or data, whether electronic, written or oral, relating to AB- PMJAY Scheme , SHA 's business, operations, financials, services, facilities, processes, methodologies, technologies, intellectual property, trade secrets, research and development, trade names, Personal Data, Sensitive Personal Data, methods and procedures of operation, business or marketing plans, licensed document know-how, ideas, concepts, designs, drawings, flow charts, diagrams, quality manuals, checklists, guidelines, processes, formulae, source code materials, specifications, programs, software packages/ codes, clients and suppliers, partners, principals, employees, consultants and authorized agents and any information which is of a manifestly confidential nature, that is supplied by

SHA to the Insurer or otherwise acquired/ accessed by the Insurer during the course of dealings between the Parties or otherwise in connection with the Purpose. Confidential Information may also include the Confidential Information related to AB PMJAY Scheme, SHA 's/ other SHA's clients, licensors, alliances, contractors and advisors.

"Personal Data" and "Sensitive Personal Data" shall have the meanings as assigned to them under applicable law of India.

2. **Supply and Use of Confidential Information**

(a) The Insurer shall use Confidential Information only for the Purpose or in relation to the definitive written agreement between the Parties (if any or is subsequently entered into) in connection with the Purpose, pursuant to which a given item of Confidential Information was disclosed. Upon the completion of the business objective relating to the Purpose or the termination/ expiry of such definitive written agreement in connection with the Purpose, and upon the written request of SHA, an authorized officer of the Insurer shall promptly, at the option of SHA, either return to SHA or destroy all Confidential Information in the Insurer's possession or control, and shall certify to SHA as to such return or destruction.

(b) The Insurer shall not disclose the Confidential Information to any third party without SHA 's prior written consent. The Insurer may disclose the Confidential Information to its employees, on a strict need to know basis in connection with the Purpose provided such employees are bound under confidentiality agreements which are at least as restrictive as this Agreement.

(c) The Insurer shall exercise the same degree of care with respect to SHA 's Confidential Information as the Insurer takes to safeguard and preserve its own confidential and/or proprietary information provided that in no event shall the degree of care be less than a reasonable degree of care. Upon discovery of any prohibited use or disclosure of the Confidential Information, the Insurer shall immediately notify SHA in writing and shall make its best efforts to prevent any further prohibited use or disclosure; however, such remedial actions shall in no manner relieve the Insurer's obligations or liabilities for breach hereunder.

(d) The Insurer shall ensure that all appropriate confidentiality obligations and technical and organizational security measures are in place, within the Insurer's organization, to prevent any unauthorized or unlawful disclosure or processing of Confidential Information and the accidental loss or destruction of or damage to such Confidential Information. The Insurer will comply with applicable data protection and privacy legislation in this regard.

(e) To the extent it is a transferee of Personal Data from SHA, the Insurer shall be under and shall assume identical and/or similar obligations that of SHA under the applicable data protection and privacy legislation in this regard relating to such Personal Data.

(f) The Insurer shall notify SHA forthwith from the time it comes to the attention of the Insurer that Confidential Information (including Personal Data) transferred by SHA to it has been the subject of accidental or unlawful destruction or accidental loss, alteration, unauthorized disclosure or access, or any other unlawful forms of processing. The obligation contained above shall survive any termination/expiration of the Agreement.

3. **Limitations**:

This Agreement shall not restrict disclosure of information that, the Insurer can evidence through sufficient documentation:

(a) was, at the time of receipt, otherwise known to the Insurer without restrictions as to use or disclosure; or

(b) was in the public domain at the time of disclosure or thereafter enters into the public domain through no breach of this Agreement by the Insurer;

4. **Exclusion:**

The Insurer may disclose Confidential Information, strictly to the extent such disclosure is compulsorily required under applicable law (including court order), to a regulatory authority or a court of law with competent jurisdiction over the Insurer, provided that the Insurer will first have provided SHA with immediate written notice of such required disclosure and will take reasonable steps to allow SHA to seek a protective order with respect to the Confidential Information required to be disclosed. The Insurer will promptly cooperate with and assist SHA in connection with obtaining such protective order.

5. **No Warranty:**

SHA HEREBY DISCLAIMS ALL WARRANTIES, WHETHER EXPRESS OR IMPLIED, WITH RESPECT TO THE CONFIDENTIAL INFORMATION.

6. **No License:**

No license or conveyance of any rights held by SHA under any discoveries, inventions, patents, trade secrets, copyrights, or other form of intellectual property is granted or implied by this Agreement or by the disclosure of any Confidential Information pursuant to this Agreement.

7. No Formal Business Obligations:

This Agreement shall not constitute, create, give effect to or otherwise imply (i) a joint venture, pooling arrangement, partnership or formal business organization of any kind, or (ii) any obligation or commitment on SHA to submit a proposal or to enter into a further contract or business relationship with the Insurer, or (iii) any obligation on SHA to disclose, supply or otherwise communicate any information, general or specific, to the Insurer. Nothing herein shall be construed as providing for the sharing of profits or losses arising out of efforts of either or both Parties.

8. Confidentiality and Intellectual Property Notices:

The Insurer shall not (nor shall it permit or assist others to) alter or remove any confidentiality label, proprietary label, patent marking, copyright notice or other legend (singularly or collectively, "Notices") placed on the Confidential Information, and shall maintain and place any such Notices on applicable Confidential Information or copies thereof.

9. Governing Law and Jurisdiction:

This Agreement shall be governed by and construed in accordance with the laws of India. Any dispute arising out of the Agreement shall be referred to the nominated senior representatives of both the Parties

for resolution through negotiations. In case, any such difference or dispute is not amicably resolved within forty five (45) days of such referral, it shall be resolved through Arbitration, in India, in accordance with the provisions of Arbitration and Conciliation Act 1996 and _____ shall be considered as sole Arbitrator to adjudicate the dispute between the Parties as per the Arbitration and Conciliation Act as amended from time to time. Arbitration shall be held in English and the venue of the Arbitration same shall be in Delhi. The award of the Arbitrator shall be final and binding on the Parties. The proceedings of arbitration, including arbitral award, shall be kept confidential. Subject always to the foregoing provisions of this paragraph, the competent courts of Kohima shall have jurisdiction in relation to any dispute between the Parties under this Agreement.

10. Injunctive Relief and Damages:

The Insurer acknowledges that use or disclosure of any confidential and proprietary information in a manner inconsistent with this Agreement will give rise to irreparable injury for which damages would not be an adequate remedy. Accordingly, in addition to any other legal remedies which may be available at law or in equity, the SHA shall be entitled to equitable or injunctive relief against the unauthorized use or disclosure of confidential and proprietary information. The SHA shall be entitled to pursue any other legally permissible remedy available as a result of such breach, including but not limited to damages, both direct and consequential. Additionally, the Insurer agrees to keep SHA indemnified against any losses or damages (including reasonable attorneys' fees) arising due to the breach of this Agreement by the Insurer.

11. Miscellaneous:

- **Amendment:** This Agreement may be amended or modified only by a written agreement signed by both of the Parties.
- **Relationship:** The Parties to this Agreement are independent contractors. Neither Party is an agent, representative, or partner of the other Party. Neither Party shall have any right, power, or authority to enter into any agreement for, or on behalf of, or incur any obligation or liability of, or to otherwise bind, the other Party. No joint venture, partnership or agency relationship exists between the Insurer, the SHA or any third-party as a result of this Agreement.
- **Assignment:** Neither Party may assign its rights or delegate its duties under this Agreement without the other Party's prior written consent.
- **Severability:** In the event that any provision of this Agreement is held to be invalid, illegal or unenforceable in whole or in part, the remaining provisions shall not be affected and shall continue to be valid, legal and enforceable as though the invalid, illegal or unenforceable parts had not been included in this Agreement.
- **Waiver:** Neither Party will be charged with any waiver of any provision of this Agreement, unless such waiver is evidenced by a writing signed by the Party and any such waiver will be limited to the terms of such writing.

12. Termination and Survival:

This Agreement shall commence as of the date written above and shall remain in effect for a period _____unless terminated earlier by SHA by (i) giving fourteen (14) days' written notice of termination to the Insurer at any time, or (ii) giving notice effective immediately following a breach by the Insurer. Notwithstanding the foregoing, any obligations imposed on the Insurer under this Agreement, including confidentiality obligations, that by their very nature survive the termination or expiry of this Agreement shall so survive the termination or expiry of this Agreement.

13. No Publicity:

No press release, advertisement, marketing materials or other releases for public consumption concerning or otherwise referring to the terms, conditions or existence of this Agreement shall be published by the Insurer. The Insurer shall not promote or otherwise disclose the existence of the relationship between the Parties evidenced by this Agreement or any other agreement between the Parties for purposes of soliciting or procuring sales, clients, investors or other business engagements.

14. **Non-Solicitation:**

Except as may be otherwise agreed in writing between the Parties, during the term of this Agreement and for twelve (12) months thereafter, neither the Insurer nor any of its affiliates, shall offer employment to or employ any person employed (then or within the preceding twelve (12) months) by SHA if such person had interacted with the Insurer or its affiliates, directly or indirectly, in relation to the Purpose or was involved in performing responsibilities in relation to the Purpose.

15. **No Conflict:**

The Insurer represents and warrants that the performance of its obligations hereunder does not, and shall not, conflict with any of its other agreement or obligation to which it is bound.

16. **Entire Agreement; Counterparts:**

This Agreement together with any other definitive written agreement executed or to be executed between the Parties relating to the Purpose constitutes the entire agreement between the Parties with respect to the subject matter hereof. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same instrument.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives and made effective from the Effective Date first written above.

SIGNED for and on behalf of **SHA** By _____ Title _____ (authorized signatory) Date _____	SIGNED for and on behalf of **Insurer** By _____ Title_____ (authorized signatory) Date _____

Schedule 18: Individual Confidentiality Undertaking

UNDERTAKING

I, [*Insert Name*], the undersigned, acknowledge that as an employee/ staff of _____ ("**Insurer**"), I will be working as a team member of the company project team which is providing, or shall provide, certain services to State Health Agency (SHA) as per the terms and conditions of the Agreement dated _____.

In this regard, I confirm that I have fully read and understood all the terms and conditions of the Agreement executed between SHA and Insurer, in particular to the contents below. With effect from _____], I undertake to strictly abide by this undertaking and the Agreement.

To the extent not defined in this undertaking itself, the capitalised terms contained in this letter shall have the meaning attributed to them under the Agreement.

Without prejudice to the generality of the foregoing paragraphs, I agree to the following:

1. I shall not discuss/ disclose, at any time during my work on the Services or at any time thereafter, any Confidential Information with/ to any third party or any employee or partner of Insurer or other Insurer Firms, other than those working or advising on the Services or those who need to access such information on a strict need to know basis.

2. If approached by any third party or Insurer employee/staff (where such employee/ staff do not require access to the Confidential Information on a need to know basis) to provide any Confidential Information relating to the Services, I shall immediately inform the Insurer and/or SHA and shall not disclose any such information unless approved.

3. I shall not remove or destroy any documents, data, files or working papers in whatsoever form (including but not restricted to any in electronic form) in respect of the Services, without the written consent of Insurer.

4. In the event that I leave the employment of Insurer or my association with Insurer gets terminated, I shall not discuss/ disclose thereafter any Confidential Information with/ to any other party.

5. I voluntarily waive all my rights and disclaim my ownership on any work and/or deliverables to be performed while deployed at Insurer/ SHA for the purposes of Agreement.

I understand that strict compliance with this undertaking and the Agreement is a condition of my involvement with the Services and a breach hereof may be regarded as an infringement of my terms of employment/ association with Insurer. I acknowledge that I will be personally liable for any breach of this undertaking and/or the Agreement and that the confidentiality obligations hereinunder shall survive the tenure of my employment/ association with Insurer.

Signature: _____

Name (in block letters):_____

Telephone #: _____

Date:_____

Schedule 19: Template for Claims Adjudication Audit

Case ID	Hospital Name	Package name	Package Cost	Date of Admission	Date of Discharge	Types of findings	Comments

Claims adjudication audit reporting format

Name of the IC/ISA/TPA		
Month and year of Audit		
Total number of claims audited		
Total number of errors found during audit	Financial	Non financial
No of Hospitals found suspected during audit		
Action plan against suspected hospitals		
Major type of errors found during audit		
Executive summary of audit		

Claims adjudication audit manual checklist

Case number	
Hospital name and District	
Package booked (Diagnosis)	
Package amount	

Date of admission			
Date of Discharge			
Type of package medical/Surgical			
Particulars	Yes	No	Remarks
Past history checked			
Are all mandatory documents required at the time of Pre-Auth uploaded			
Validate Length of stay - DOA/DOD			
Are symptoms matching with the diagnosis			
Is the package booked matching with the diagnosis			
Are Investigation reports supporting diagnosis available			
Are Post op photos showing scar available in surgical cases			
Investigation reports signed by doctor with registration no			
Are pre op and post op x-rays available in ortho cases			
Discharge summary in proper format			
Complete ICP available from the day of admission till discharge			
ICP in same handwriting			
Is referral letter from government hospital available(State specific)			
Death Summary in case of death			