I-Proposed Changes in Tender Document (RFP Vol I)			
Sl.No	**Change**	**existing RFP/contract Clause**	**Amendment/addition to RFP/ContractClause**
1	**1.Splitting of Risk Cover for PMJAY & CMHIS (Gen) and Invitation for Separate Financial Bids** **Current Approach: A single risk cover for the entire sum insured of Rs. 5 lakh.** **Proposed Change: Split insurance cover into a base cover of Rs. 3 lakh and an additional Rs. 2 lakh.**	1.5Risk Cover: The Scheme shall provide hospitalization cover up to Rs.5 lakhs per annum on a family floater basis to all eligible beneficiary families of Nagaland. Any member of the covered family can avail treatment within the family 'wallet' of Rs.5 lakhs per annum.	Risk Cover for CMHIS (GEN): The Scheme shall provide hospitalization cover up to Rs.3 lakhs (Rupees three lakhs) per annum on a family floater basis to all CMHIS (GEN) eligible beneficiary families of Nagaland. This shall be known as the Basic Cover for CMHIS (GEN). CMHIS (GEN) beneficiary families are also eligible for a top up cover of Rs. 2 lakhs (Rupees two lakhs only) over and above the basic cover. Any member of the covered family can avail treatment within the family 'wallet' of Rs.5 lakhs per annum.
2		2.5 Quotation Benefit cover Quotation 1Risk Cover (RC) of Rs. 5,00,000 (Rupees Five Lakh only) on a family floater basis per eligible family for hospitalization for the CMHIS (GEN) beneficiaries. Quotation 2Risk Cover (RC) of Rs. 5,00,000 (Rupees Five Lakh only) on family floater basis per eligible family for hospitalization for CMHIS (EP) beneficiaries. Quotation 3In addition to Rs. 5,00,000, a top-up cover of Rs. 15,00,000((Rupees Fifteen Lakh only) per family for CMHIS(EP) beneficiaries. The benefit packages and the prices would remain the same as in Quotation 2.	Quotation Benefit cover Quotation 1Risk Cover (RC) of Rs. 53,00,000 (Rupees FiveThree Lakh only) on a family floater basis per eligible family for hospitalization for the CMHIS (GEN) beneficiaries. Quotation 2Top-up cover of Rs. 2,00,000 (Rupees Two Lakhs only) per family for CMHIS (GEN) beneficiaries. The benefit packages and the prices would remain the same as in Quotation 1. Quotation 3Risk Cover (RC) of Rs. 5,00,000 (Rupees Five Lakh only) on family floater basis per eligible family for hospitalization for CMHIS (EP) beneficiaries. Quotation 4In addition to Rs. 5,00,000, a top-up cover of Rs. 15,00,000((Rupees Fifteen Lakh only) per family for CMHIS(EP) beneficiaries. The benefit packages and the prices would remain the same as in Quotation 23.
3	Added additional non-marking eligibility/qualification criteria	N/A	3.1.4The Bidder shall have gross direct Premium Income from Health Insurance (excluding personal accident or travel cover) of at least Rs. 500 crores in the last three consecutive financial years, immediately preceding Bid Due Date. 3.1.5The Bidder shall have average solvency margin of at least 1.5 for the financial years 2021-22, 2022-23, 2023-24. 3.1.6The Bidder shall have more than 95% claim settlement ratio in health insurance business as on 31st March 2024 3.1.7The Bidder shall have the following claims Settlement Efficiency as on 31st March 2024 a.Turnaround Time (TAT) for Claims (95% settled within 30 days) b.Cashless Pre-authorization Approval (95% within 6 hours) c.Payment to Hospitals within 7 Days of Claim Approval (95%) d.Discharge Summary Processing within 24 Hours (95%) 3.1.8The Bidder shall have grievance Closure Rate (>95% within 30 days) as on 31st March 2024 3.1.9The Bidder shall have a Fraud Detection & Investigation Unit with the following as on 31st March 2024 a.Claims Investigated for Fraud (Minimum 5% of high-cost claims) b.Recovery from Fraudulent Claims (Minimum 60%) c.Reporting of Suspected Fraud to IRDAI (100% compliance) d.Triggered Field Investigations (Minimum 10% of high-cost claims) e.Time taken for Fraud Investigation Closure (Minimum 90% within 30 days) 3.1.10The Bidder shall have experience in any state / government health insurance scheme 3.1.11The Bidder shall have presence in the State of Nagaland. 3.1.12The Bidder shall have AI / ML algorithms that can significantly help control the growth in the healthcare utilisation in the State of Nagaland. The AI / ML algorithms should be capable of

II-Proposed Changes in Draft Contract Document

Sl.	Change	Existing Clause	Amended Clause
1	Added back the loss sharing clause for utilization above 100% gross total premium paid to Insurance Company	N/A	If the Insurer's average Claim Ratio for the full 12 months is in excess of 120 percent then the SHA and Insurance Company shall each bear 50% of additional claim cost in excess of the 120% of the total Premium. The calculation of excess claims shall be done separately for 5 lakh Insurance Coverage beneficiaries and 20 lakh Insurance Coverage beneficiaries.

2	Added clause on tightening procedure for rejections	N/A	16.1.4Every rejection of a claim by the Insurer shall be supported by: (a) A signed note from the Insurer's Medical Officer specifying the reasons for rejection; (b) A clear reference to the applicable policy clause, package guideline, or exclusion invoked for rejection; and (c) A checklist of missing or deficient documents. All rejections below INR 50,000 shall be reviewed at the SHA level. All rejections exceeding INR 50,000 shall be reviewed by a Joint Review Committee (SHA representative, Insurer's Medical Head, and an Independent Medical Expert appointed by SHA). The SHA's decision in case of a deadlock shall be final and binding. 16.1.5All claim rejections citing the ground of "treatment not conforming to standard medical practice" shall automatically trigger an Independent Medical Review by the State Medical Committee. The decision of the State Medical Committee shall be final, binding, and non-appealable on the Insurer.
3	Added Penalty Clause for IC not adhering to prescribed claims adjudication/payment Turn Around Time (TAT)	N/A	16.1.10Claims Adjudication - Turn-Around Time (TAT) and Penalty for Delay The Insurer shall strictly adhere to the Turn-Around Time (TAT) for claim settlement as prescribed under this Contract and its Schedules. Any failure to adhere to the prescribed TAT shall attract a penalty of 0.5% of the claim amount per day of delay, subject to a maximum penalty of 10% of the claim amount for each delayed claim. If more than 10% of total claims processed in any calendar month breach the prescribed TAT, SHA shall have the right to withhold up to 25% of the subsequent premium installment until such claims are settled to SHA's satisfaction. SHA's decision in this regard shall be final and binding.
4	Added detailed guidelines for alleged Fraud and post confirmation of Fraud action	N/A	18.3Investigations pursuant to any such alert shall be concluded by the Insurer within 0714 (seven) days and all final decision related to outcome of the Investigation and consequent penal action, if the fraud is proven, shall vest solely with the SHA., in accordance with the extant guidelines for deempanelment and guidelines on recoveries and other actions post confirmation of fraud and other irregularities issued by the NHA/SHA. 18.4During the investigation period, the Insurer shall submit weekly progress reports to the SHA detailing the status, steps taken, and any preliminary findings. If the fraud investigation exceeds 14 days, the Insurer shall release 75% of the claim amount to the concerned EHCP as an interim payment unless the Insurer submits to the SHA conclusive evidence of fraud, duly vetted and confirmed by the Insurer's legal section.Such conclusive evidence of fraud shall be accompanied by a covering letter issued on the official letterhead of the Insurer, signed by the authorised personnel empowered to issue such notices, explicitly certifying that: The investigation was conducted in compliance with all applicable laws, regulations, and established protocols governing fraud detection and investigation under health insurance contracts; Due process was followed, including providing the concerned EHCP an opportunity to respond to allegations; The fraud has been conclusively established based on documentary evidence, expert opinions (if required), and legal scrutiny. The SHA reserves the right to independently review such fraud findings and seek clarifications or supplementary documentation, where required. If the SHA finds the evidence inconclusive or procedurally deficient, the SHA's decision to overrule the fraud determination shall be final and binding. Additionally, the Insurer shall maintain a Fraud Risk Dashboard, updated in real-time, which shall be fully accessible to the SHA at all times. 18.5No claims payments shall be withheld by the Insurer for more than 14 days on the grounds of suspected Fraud unless conclusively proven and in line with the NHA/SHA guidelines on recoveries and other actions post confirmation of fraud and other irregularities. 18.6Failure to comply with these provisions in clause 18.3 above shall disqualify the Insurer from invoking fraud-related claim denials and shall render such claims payable in full, notwithstanding the pendency of internal investigation by the Insurer.
6	Added Penalty Clause on Insurer for non-compliance with prescribed procedures	N/A	SHA shall impose a penalty of 10% of claim amount for each claim processed deficiently (approved/rejected/paid) including but not limitted to procedural deficiencies committed by the Insurer in addition to revoking the claim for re-processing: •Failure to upload complete documents for claim rejections; •Contradictory or inconsistent rejection reasons; •Such penalties shall be recovered from the next payable premium installment.

7	Added Clause for Monthly Claim Reconciliation by Insurer with the empanelled HealthCare Providers (EHCPs)	N/A	24.1.3 payment reconciliation The Insuer shall mandatoriliy share details of claims payment made to every hospital with a copy to the SHA. Insurer shall undertake a reconciliation exercise with the hospitals at the end of each month and submit monthly payment reconciliation report to the SHA within 5 days of the following month. If unresolved claims exceed 5% of total claims for the month, SHA shall impose a financial penalty of INR 10,00,000 per month and may issue a Show Cause Notice to the IC.
III	Schedules to the Contract-RFP Vol III		
1	Added new Performance KPI to Schedule 11B	N/A	In addition to the existing KPIs, the following shall also apply: 1. Submission of UTR for all payments to hospitals within 24 hours of release, with a copy to SHA . 2. Monthly payment reconciliation with all EHCPs and submission of Action Taken Report (ATR) to SHA by the 5th of each month. 3. Conducting visits to at least 20% of empanelled hospitals every month for handholding and audit, with submission of monthly visit reports to SHA. 4. Monthly TDS deduction and deposit for private EHCPs, with quarterly TDS filing reports submitted to SHA within 5 days of filing. Non-compliance with these above 4 KPIs for two consecutive months shall trigger relevant penalty clause and issuance of a Show Cause Notice.
2	Schedule 3- Health Benefit Package Change		
2.1	Room rent Changes		Align room rent rates with revised CGHS norms, remove Location based incentives on room rates and reduce room rates for public hospitals at only 30% of rate payable for private hospitals.
2.2	Reservation of packages for public hospitals only for PM-JAY and CMHIS(GEN)		4.Normal Vaginal Delivery package to be reserved for public Hospitals only for PMJAY-CMHIS (GEN)
2.3	Revision of packages for some of the existing packages for CMHIS (EP) that were unreasonably low	Procedure NamePresent Existing Base Rates as per CGHS a.Permcath insertion3500 b.Arteriovenous Fistula for Haemodialysis-SI063A3300 c.Retrograde Intrarenal Surgery (RIRS)/ Flexible Ureteroscopy8000	a.Permcath insertion: 35000 b.Arteriovenous Fistula for Haemodialysis-SI063A: 26000 c.Retrograde Intrarenal Surgery (RIRS)/ Flexible Ureteroscopy :45600
2.4	Revision of packages for some of the existing packages for CMHIS (EP) as per revised CGHS Rates	1)Venesection:165 2)Phimosis Under LA:330 3)Suturing of small wounds:440 4)Excision of Axillary Lymph Node:5000 5)Varicose vein surgery-Trendelenburg operation with suturing or ligation:12100 6)Inguinal Hernia - Hernioplasty:19800 7)Resection & Anastomosis of Small Intestine:27940 8)Fistula in Ano - High Fistulectomy:20900 9)Excision of Pilonidal Sinus (open):14300 10)Excision of Pilonidal Sinus with	1)Venesection: 595 2)Phimosis Under LA: 5100 3)Suturing of small wounds: 1060 4)Excision of Axillary Lymph Node: 6715 5)Varicose vein surgery-Trendelenburg operation with suturing or ligation: 19550 6)Inguinal Hernia - Hernioplasty: 27200 7)Resection & Anastomosis of Small Intestine: 40375 8)Fistula in Ano - High Fistulectomy: 29750 9)Excision of Pilonidal Sinus (open): 18700 10)Excision of Pilonidal Sinus with closure: 21250
2.5	Addition of Surgical Packages	N/A	Procedure Name for inclusion under CMHIS (EP)PMJAY rate a.Bi-lateral URSL52575 b.Oesophageal Stenting82700 c.Breast Conserving Surgery Lumpectomy + Axillary surgery61500
2.6	Capping of Immunotherapy/Targetted Therapy	N/A	Per Household, for immunotherapy/targetted Therapy, maximum amount per year will be capped at 10,00,000 annually