

**AB PM-JAY-KASP**  
**Schedules to Service Contract**

24/12/2020

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## 1. Schedule 1: Details of the Scheme and Beneficiaries

### 1.1. Name and Objective of the of the Scheme

The name of the scheme is Ayushman Bharat Pradhan Mantri - Jan Arogya Yojana (AB PM-JAY) - Karunya Arogya Suraksha Padhathi (KASP). The objective of AB-PM JAY - KASP 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 along with the estimated RSBY/CHIS Beneficiary Families who are enrolled during 2018-19 not figuring in the SECC Database. These eligible AB-PMJAY beneficiary families will be provided 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. Beneficiaries

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 RSBY/CHIS Beneficiary Families who are enrolled during 2018-19 not figuring in the SECC Database which are resident in the Service Area area of State of Kerala. Beneficiary Family Unit that is eligible to receive the benefits under the RSBY and CHIS, i.e. those Beneficiary Family Units that fall within any of the following categories: below poverty line (BPL) households listed in the BPL list published for the State of Kerala, MGNREGA households, households of unorganized and the State identified eligible categories under scheme CHIS 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

<ul style="list-style-type: none"> <li>• Legally released bonded labour</li> </ul>
<p>For Urban Occupational Categories of Workers</p> <ul style="list-style-type: none"> <li>• Rag picker</li> <li>• Beggar</li> <li>• Domestic worker</li> <li>• Street vendor/ Cobbler/hawker / Other service provider working on streets</li> <li>• Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and another head-load worker</li> <li>• Sweeper/ Sanitation worker / Mali</li> <li>• Home-based worker/ Artisan/ Handicrafts worker / Tailor</li> <li>• Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller</li> <li>• Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery assistant / Attendant/ Waiter</li> <li>• Electrician/ Mechanic/ Assembler/ Repair worker</li> <li>• Washer-man/ Chowkidar</li> </ul>

#### 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-KASP 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.

#### Schedule 2: Exclusions to the Policy

*The Insurer shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Beneficiary in connection with or in respect of:*

1. **Conditions that do not require hospitalization:** *Condition that do not require hospitalization and can be treated under Out Patient Care. Out Patient Diagnostic, unless necessary for treatment of a disease covered under Medical and Surgical procedures or treatments or day care procedures (as applicable), will not be covered.*
2. *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.*
3. *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, illness or injury and which requires hospitalisation for treatment.*

4. **Congenital external diseases:** *Congenital external diseases or defects or anomalies, Convalescence, general debility, "run down" condition or rest cure unless otherwise treatment packages are available under HBP.*
5. **Fertility related procedures:** *Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.*
6. **Vaccination:** *Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),*
7. **Suicide:** *Intentional self-injury/suicide*
8. *Persistent Vegetative State*

### Schedule 3: HBP and Quality

- a. Schedule 3 (a) HBP 2.0  
*Will be enclosed as additional document*

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

**All unspecified packages:**

To ensure that PM-JAY-KASP 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-KASP. 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-KASP 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 specified limit decided by SHA/NHA: For any State/UT to utilize the unspecified package above the limit, it is to be ensured that the same is approved **only in (a) exceptional circumstances and (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.
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  $\geq$  Specified limit.
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.**

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  $\geq$  Specified limit.
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)

## Differential Pricing Guidelines:

AB PM-JAY-KASP provides additional incentive on the procedure rate based on following criteria's:

## \*Classification of Metro Cities:

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%

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

These percentage incentives are added by compounding.

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

- a. The SHA shall ensure the quality of service provided to the beneficiaries in EHCP.
- b. EHCP has to monthly submit the online Self – Assessment checklist which can be accessed in HEM web portal in [www.pmjay.gov.in](http://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 attaining AB PM-JAY - KASP Quality Certification (Bronze, Silver and Gold).
- d. Bronze Quality Certification is pre-entry level certificate in AB PM-JAY - KASP 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 PM-JAY - KASP 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 PM-JAY - KASP 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 - KASP Beneficiary Family Units

### 1 Brief Process Flow

- A. AB PM-JAY - KASP will target 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 and State scheme CHIS that do not feature in the targeted groups as per SECC data will be included as well.
- B. State 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.
- C. Beneficiary identification will include the following broad steps:
- i. The operator searches through the AB PM-JAY - KASP list to determine if the person is covered.
  - ii. Search can be performed by Name and Location, ID printed on the letter sent to family or RSBY/CHIS URN
  - iii. If the beneficiary's name is found in the AB PM-JAY - KASP 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
- 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 - KASP record and documents is provided.
  - v. The operator sends the linked record for approval to the SHA approval team. The beneficiary will be advised to wait for approval from the team.

- vi. The SHA will setup a Beneficiary approval team that works on fixed service level agreements on turnaround time. The AB PM-JAY - KASP details and the information from the ID is presented to the verifier. The team can either approve or recommend a case for rejection with reason.
  - vii. All cases recommended for rejection will be scrutinised by a State's SHA 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 - KASP 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 - KASP 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.
- D. Addition of new family members will be allowed. This requires at least one other family member has been approved by the SHA. 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
  - v. Other Government approved document for proving relation

Note: Any family member can be added in existing 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 family provided member can establish relation with a PMJAY verified beneficiary.

- E. 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 is 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.

## **2 Detailed Steps for Beneficiary Identification and Issuance of e-card**

AB PM-JAY - KASP will target the left out families/members from about 42 Lakh, deprived rural families and identified occupational category of urban workers' families who are enrolled based on the Socio-Economic Caste Census (SECC)/RSBY and CHIS data, both rural and urban.

The main steps for the above exercise are as follows:

**A. Preparatory Activities for State:**

**Responsibility of – State Government**

**Timeline** – within a period of 15 days, after receiving the approval from MoHFW/NHA, the Statemay 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 - KASP 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 - KASP e-cards after verification. The booklet/pamphlet shall provide the following details:
  - Details about the AB PM-JAY - KASP benefits
  - Process of taking the benefits under AB PM-JAY - KASP 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 - KASP call centre
  - 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 - KASP target data**

**Responsibility of – MoHFW**

**Timeline** – Preparation of SECC data

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 - KASP are given as follows:

#### **For Rural**

Total deprived Households targeted for AB PM-JAY - KASP 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 - KASP 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 - KASP = 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 - KASP = 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 - KASP = 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



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 - KASP list (SECC + RSBY/CHIS). 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:

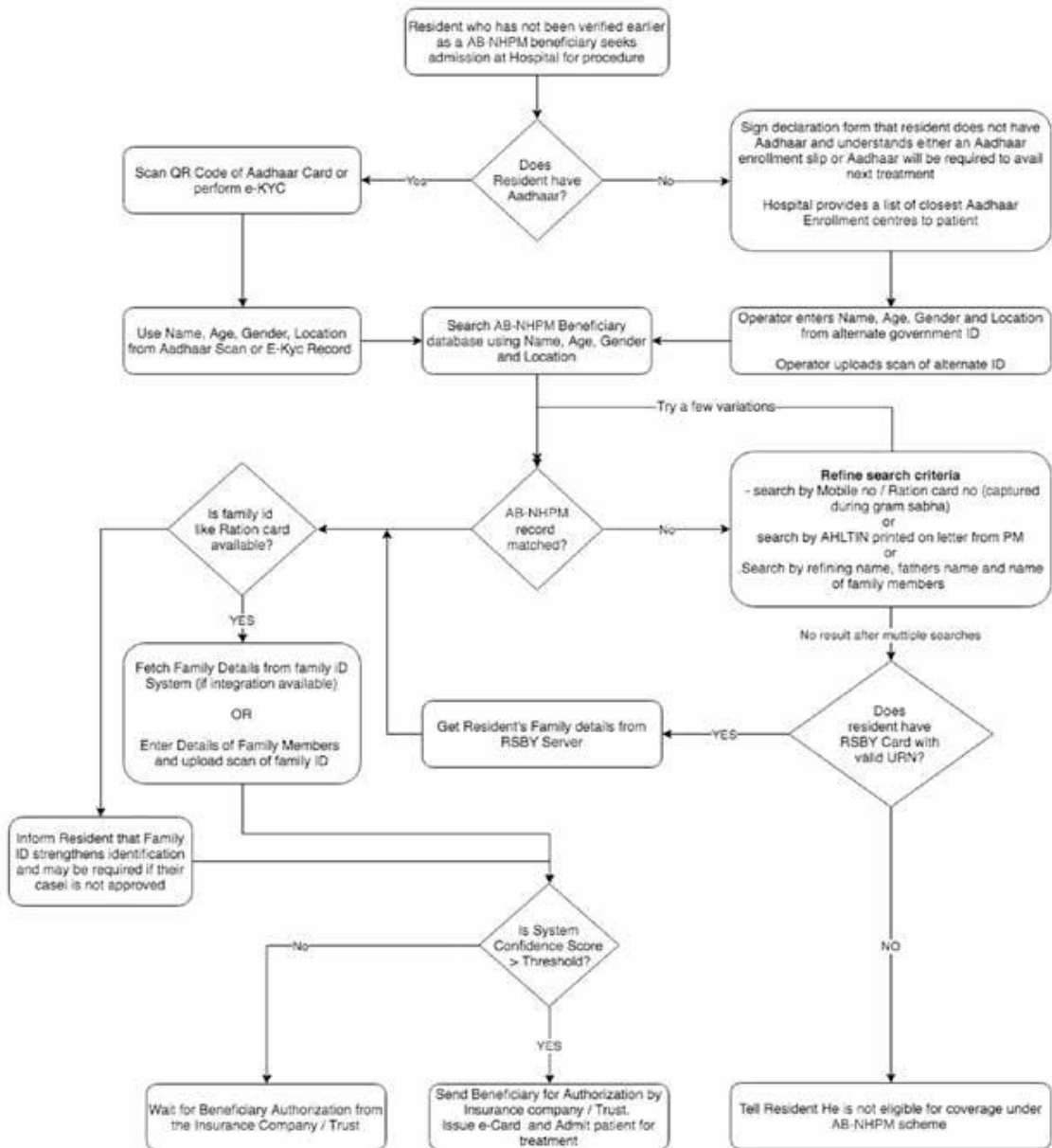
- CSC
- PHCs
- Gram Panchayat Office
- Empanelled Hospital
- Or any other contact point as deemed fit by State

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

SHA will organize training sessions for the operators so that they are trained in the Beneficiary identification, Aadhaar seeding and AB PM-JAY - KASP 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 SHA team rejects multiple requests from a single operator – the system will bar the operator till further training / remedial measures can be undertaken.

### 3 Process Flow Chart for Beneficiary Identification



## 4 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 - KASP 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 - KASP 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 - KASP 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 - KASP record.

## 5 Searching the AB PM-JAY - KASP 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 - KASP Beneficiary Record	
<b>Name</b>	Geetha Bandhopadhya	<b>Name</b>	Gita Banarjee
<b>Age</b>	33	<b>Age</b>	40
<b>Gender</b>	F	<b>Gender</b>	F
<b>Father's Name</b>	<Not Available>	<b>Father's Name</b>	Arghya Banarjee
<b>State</b>	West Bengal	<b>State:</b>	West Bengal
<b>District</b>	Malda	<b>District</b>	Malda
<b>Town / Village</b>	Dakshin Chandipur	<b>Town / Village</b>	Dakshen Chandhipur
<b>NAME MATCH CONFIDENCE SCORE: 94%</b>			

The Search system will provide multiple ways to find the AB PM-JAY - KASP 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 for SECC category. 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.

## 6 Searching the AB PM-JAY - KASP Database for Valid RSBY Beneficiaries

The operator is unable to find the person using AB PM-JAY - KASP 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.

## 7 Linking Family Identification document with the AB PM-JAY - KASP Family

One or more Family Identity Cards can be linked with each AB PM-JAY - KASP 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 - KASP record.

<b>Ration Card or Other Government Family ID Beneficiary Identity Document</b>		<b>AB PM-JAY - KASP Beneficiary Record</b>	
<b>Names of family members</b>	RAM, GEETHA, GOVIND, MEENAKUMARI	<b>Names of family members</b>	GEETHA, MEENAKUMARI, RAM
<b>FAMILY MATCH CONFIDENCE SCORE: 92%</b>			

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.

## 8 Approval by State Approval Team

State Team will 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 - KASP 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 team can analyze the approval or rejection pattern of each of the operators.

## **A Acceptance of Rejection Request by State**

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 Approvers, it can reject the case.

If the State disagrees with the Approvers, 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 - KASP 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.
- Other Government approved document for proving relation

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

### 1.1. 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 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), under the broad mandate of the instructions provided in these guidelines.

### 1.2. Institutional Set-Up for Empanelment

- A. State Empanelment Committee (SEC) will constitute of following members:
- Executive Director, 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.

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.

**B. District Empanelment Committee (DEC) will constitute of the following members**

- District Medical Officer
- District Project Coordinator – State Health Agency
- In case of Insurance Model, Insurance company representative

SHA may invite other members to the Committee.

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	<ul style="list-style-type: none"> <li>• Chair: CEO/Officer in Charge of State Health Agency</li> <li>• At least 5 membered Committee</li> </ul>	<ul style="list-style-type: none"> <li>• Chair: DMO or equivalent</li> <li>• At least 2 membered committee</li> <li>• At least one other doctor other than DMO</li> </ul>
2.	Verification of the Empanelment application and approval by State	<ul style="list-style-type: none"> <li>• Chair: CEO/Officer in Charge of State Health Agency</li> <li>• SEC may have 1 representative from the insurance company</li> </ul>	<ul style="list-style-type: none"> <li>• DEC may have 1 representative from the insurance company</li> </ul>

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, deny, or return to the hospital the empanelment request.

### 1.3. Process of Empanelment

**A. Empanelment requirements**

- i) All States/UTs will be permitted to empanel hospitals only in their own State/UT.
- ii) 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.
- iii) 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.
- iv) Employee State Insurance Corporation (ESIC) hospitals will also be eligible for empanelment in AB-PMJAY, based on the approvals.
- v) 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.
- vi) 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.
- vii) *Hospitals will be encouraged to attain quality milestones by making 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.*
- viii) *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.*
- ix) *Hospitals in backwards/rural/naxal areas may be given incentivised payment structures by the states within the flexibility provided by MoHFW/NHA*
- x) Criteria for empanelment has been divided into two broad categories as given below.

<b>Category 1: General Criteria</b>	<b>Category 2: Specialty Criteria</b>
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<b>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.</b>	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.
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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.

#### **1.4. 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.

#### **1.5. Online Empanelment**

- A. A web-based platform is being provided for empanelment of hospitals for AB-PMJAY.
- B. The hospitals can apply through this portal only, as a first step for getting empanelled in the programme.
- C. This web-based platform will be the interface for application for empanelment of hospitals under AB-PMJAY.
- D. Following the workshop, the hospitals will be encouraged to initiate the process of

empanelment through the web portal. Every hospital willing to get empanelled will need to visit the web portal, [www.pmjay.gov.in](http://www.pmjay.gov.in) and create an account for themselves.

- E. Availability of PAN CARD number (not for public hospitals) and functional mobile number of the hospital will be mandatory for creation of this account / Login ID on the portal for the hospital.
- F. Once the login ID is created, hospital shall apply for empanelment through an online application on the web portal - [www.pmjay.gov.in](http://www.pmjay.gov.in)
- G. Each hospital will have to create a primary and a secondary user ID at the time of registration. This will ensure that the application can be accessed from the secondary user ID, in case the primary user is not available for some reason.
- H. All the required information and documents will need to be uploaded and submitted by the hospital through the web portal.
- I. Hospital will be 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.
- J. 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:
  - i) Hospital registered but application submission pending
  - ii) Application submitted but document verification pending
  - iii) Application submitted with documents verified and under scrutiny by DEC/SEC
  - iv) Application sent back to hospital for correction
  - v) Application sent for field inspection
  - vi) Inspection report submitted by DEC and decision pending at SEC level
  - vii) Application approved and contract pending
  - viii) Hospital empanelled
  - ix) Application rejected
  - x) Hospital de-empanelled
  - xi) Hospital blacklisted (2 years)

#### **1.6. Role of DEC**

- A. 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.
- B. 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.
- C. 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.
  - D. 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.
  - E. 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).
  - F. 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.
  - G. 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).
    - i) 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.
    - ii) If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.
  - H. 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.
  - I. The team will recommend whether hospital should be empanelled or not based on their field-based inspection/verification report.
  - J. 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.
  - K. The DEC will then forward the application along with its recommendation to the SEC.

## **1.7. Role of SEC**

- A. 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.
- B. 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.
- C. 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 State.
- D. 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.
- E. If the application is rejected, the hospital will be intimated of the reasons based on 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.
- F. 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.
- G. 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.
- H. There shall be no restriction on the number of hospitals that can be empanelled under AB-PMJAY in a district.
- I. *Final decision on request of a Hospital for empanelment under AB-PMJAY, shall be completed within 30 days of receiving such an application.*

#### **1.8. Fast Track Approvals**

- A. 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.
- B. 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.

- C. 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.
- D. 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.

### **1.9. Signing of Contract**

- A. 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.
- B. If insurance company/TPA 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/TPA, SHA and the hospital.
- C. Each empanelled hospital will need to provide a name of a nodal officer who will be the focal point for the AB-PMJAY for administrative and medical purposes.
- D. 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.

### **1.10. Process for Disciplinary Proceedings and De-Empanelment**

- A. Institutional Mechanism
  - i) 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, and overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that affect delivery of care to eligible beneficiaries.
  - ii) Hospital can contest the action of de-empanelment 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.



- iii) 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.
- iv) The SEC may also initiate disciplinary proceedings based on field audit reports/survey reports/feedback reports/ complaints filed with them/ complaints.
- v) 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.
- vi) 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.
- vii) The SEC will consider all such reports from the DEC's and pass an order detailing the case and the penalty provisions levied on the hospital.
- viii) Any disciplinary proceeding so initiated shall have to be completed within 30 days.

#### B. 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/TPA/SHA 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:

- i) 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.

- ii) 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:

- i) The hospital must be issued a “show-cause” notice seeking an explanation for the aberration.
- ii) 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.
- iii) 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:

- i) A letter shall be sent to the hospital regarding this decision.
- ii) 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.
- iii) This information shall be sent to all the other Insurance Companies as well as other regulatory bodies and the MoHFW/ NHA.
- iv) 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.
- v) 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.

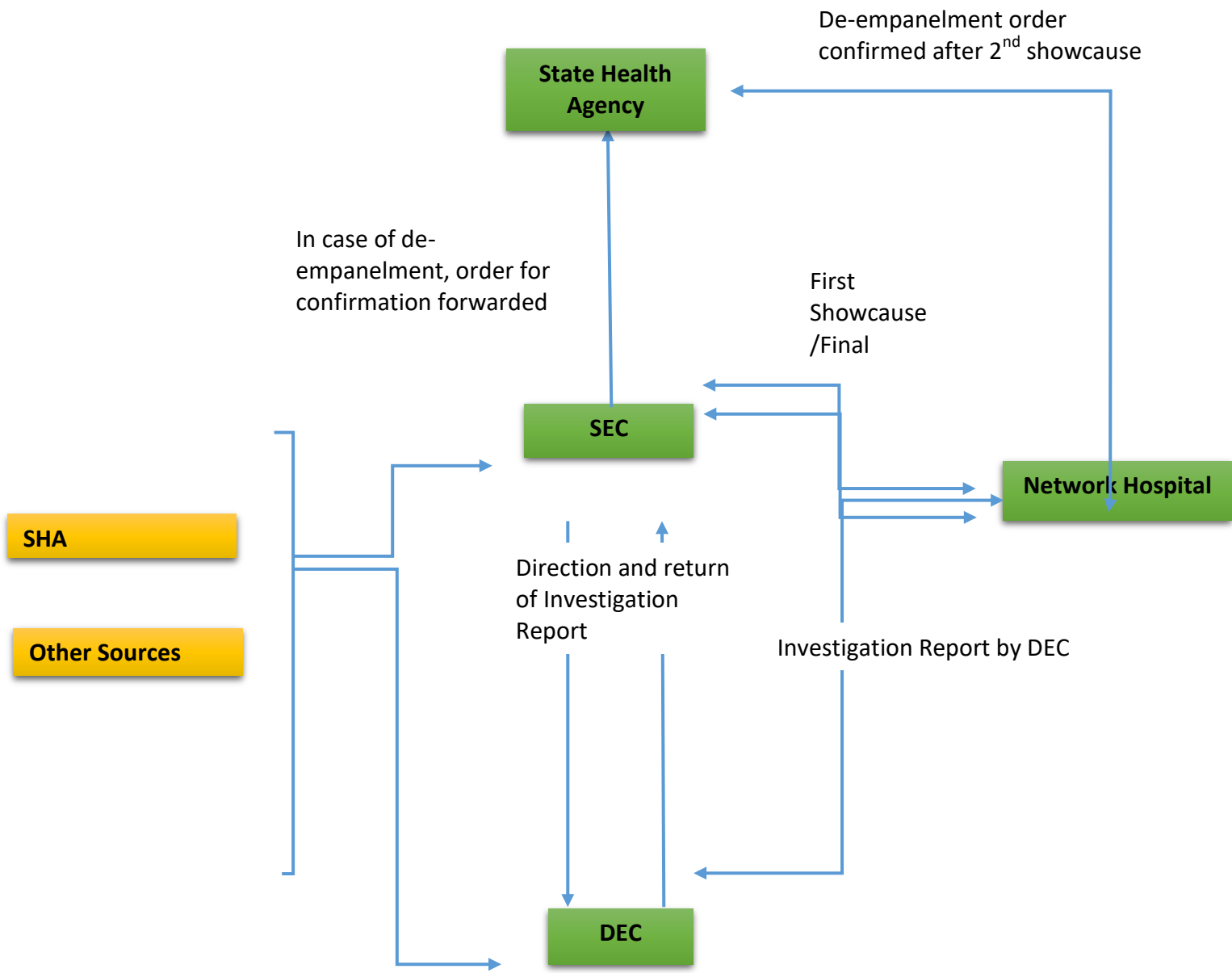
#### C. Gradation of Offences

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.

<b>Penalties for Offences by the Hospital</b>			
<b>Case Issue</b>	<b>First Offence</b>	<b>Second Offence</b>	<b>Third Offence</b>
<b>Illegal cash payments by beneficiary</b>	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
<b>Billing for services not provided</b>	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

<b>Up coding/ Unbundling/ Unnecessary Procedures</b>	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
<b>Wrongful beneficiary Identification</b>	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
<b>Non- adherence to AB-PMJAY quality and service standard</b>	In case of minor gaps, warning period of 2 weeks for rectification, for major gaps, Suspension of services until rectification of gaps and validation by SEC/ DEC	Suspension until rectification of gaps and validation by SEC/ DEC	De- empanelment

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.



## 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 Agency<sup>1</sup> if it adheres with the following minimum criteria:

1. Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms.
  - i. Exemption may be given for single-specialty hospitals like Eye and ENT.
  - ii. 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.
2. It should have adequate and qualified medical and nursing staff (doctors<sup>2</sup> & nurses<sup>3</sup>), physically in charge round the clock; (necessary certificates to be produced during empanelment).
3. Fully equipped and engaged in providing Medical /Surgical services, commensurate to the scope of service/ available specialities and number of beds.
  - i. Round-the-clock availability (or on-call) of a Surgeon and Anaesthetist where surgical services/ day care treatments are offered.
  - ii. Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anaesthetist where maternity services are offered.
  - iii. 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.)
4. 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.
5. Round-the-clock Ambulance facilities (own or tie-up).

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<sup>1</sup> In order to facilitate the effective implementation of AB PM-JAY-KASP, State Governments shall set up the State Health Agency (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.

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

<sup>3</sup> 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.

6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
  - i. 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.
7. Mandatory for hospitals wherever surgical procedures are offered:
  - i. Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
  - ii. Post-op ward with ventilator and other required facilities.
8. 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
  - i. 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.
  - ii. Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
  - iii. Further ICU- where such packages are mandated should have the following equipment:
    - 1) Piped gases
    - 2) Multi-sign Monitoring equipment
    - 3) Infusion of ionotropic support
    - 4) Equipment for maintenance of body temperature
    - 5) Weighing scale
    - 6) Manpower for 24x7 monitoring
    - 7) Emergency cash cart
    - 8) Defibrillator.
    - 9) Equipment for ventilation.
    - 10) In case there is common Paediatric ICU then Paediatric equipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.
  - iv. HDU (high dependency unit) should also be equipped with all the equipment and manpower as per HDU norms.
9. 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.
  - i. Wherever automated systems are used it should comply with MoHFW/ NHA EHR guidelines (as and when they are enforced)
  - ii. All AB-PMJAY cases must have complete records maintained
  - iii. Share data with designated authorities for information as mandated.
10. Legal requirements as applicable by the local/state health authority.
11. Adherence to Standard treatment guidelines/ Clinical Pathways for procedures as mandated by NHA from time to time.
12. Registration with the Income Tax Department.
13. NEFT enabled bank account
14. Telephone/Fax
15. Safe drinking water facilities/Patient care waiting area

16. Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
17. Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act.
18. Appropriate fire-safety measures.
19. Provide space for a separate kiosk for AB-PMJAY beneficiary management (AB-PMJAY non-medical<sup>4</sup> coordinator) at the hospital reception.
20. Ensure a dedicated medical officer to work as a medical<sup>5</sup> co-ordinator towards AB-PMJAY beneficiary management (including records for follow-up care as prescribed)
21. 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.
22. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the NHA.

Category 2: Advanced criteria:

Over and above the essential criteria required to provide basic services under AB-PMJAY (as 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:

1. These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Paediatric Surgery, Neonatal intensive care etc.
2. A hospital could be empanelled for one or more specialities subject to it qualifying to the concerned speciality criteria for respective packages
3. 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.
4. Such facilities should be of adequate capacity and numbers so that they can handle all the patients operated in emergencies.
  - i. 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.
  - ii. 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.

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<sup>4</sup> 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).

<sup>5</sup> 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.



5. Indicative domain specific criteria are as under:

**A. Specific criteria for Cardiology/ CTVS**

1. CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.)
2. Post-op with ventilator support
3. ICU Facility with cardiac monitoring and ventilator support
4. Hospital should facilitate round the clock cardiologist services.
5. Availability of support speciality of General Physician & Paediatrician
6. Fully equipped Catheterization Laboratory Unit with qualified and trained Paramedics.

**B. Specific criteria for Cancer Care**

1. 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.
2. 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.
3. 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.
4. Further hospitals should have following infrastructure for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/ therapy.
  - i. Treatment machines which are capable of delivering SRS/SRT
  - ii. Associated Treatment planning system
  - iii. Associated Dosimetry systems

**C. Specific criteria for Neurosurgery**

1. 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).
2. ICU facility
3. Post-op with ventilator support
4. Facilitation for round the clock MRI, CT and other support bio-chemical investigations.

**D. Specific criteria for Burns, Plastic & Reconstructive surgery**

1. 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.

2. Isolation ward having monitor, defibrillator, central oxygen line and all OT equipment.
3. Well Equipped Theatre
4. Intensive Care Unit.
5. Post-op with ventilator support
6. Trained Paramedics
7. Post-op rehab/ Physiotherapy support/ Phycology support.

**E. Specific criteria for /Paediatric Surgery**

1. The Hospital should have full time/on call services of paediatric surgeons
2. Well-equipped theatre
3. ICU support
4. Support services of paediatrician
5. Availability of mother rooms and feeding area.
6. Availability of radiological/ fluoroscopy services (including IITV), Laboratory services and Blood bank.

**F. Specific criteria for specialized new born care.**

1. The hospital should have well developed and equipped neonatal nurse/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms
2. 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
3. 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.
4. Trained nurses 24x7 as per norms
5. Trained Paediatrician(s) round the clock
6. 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.
7. Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

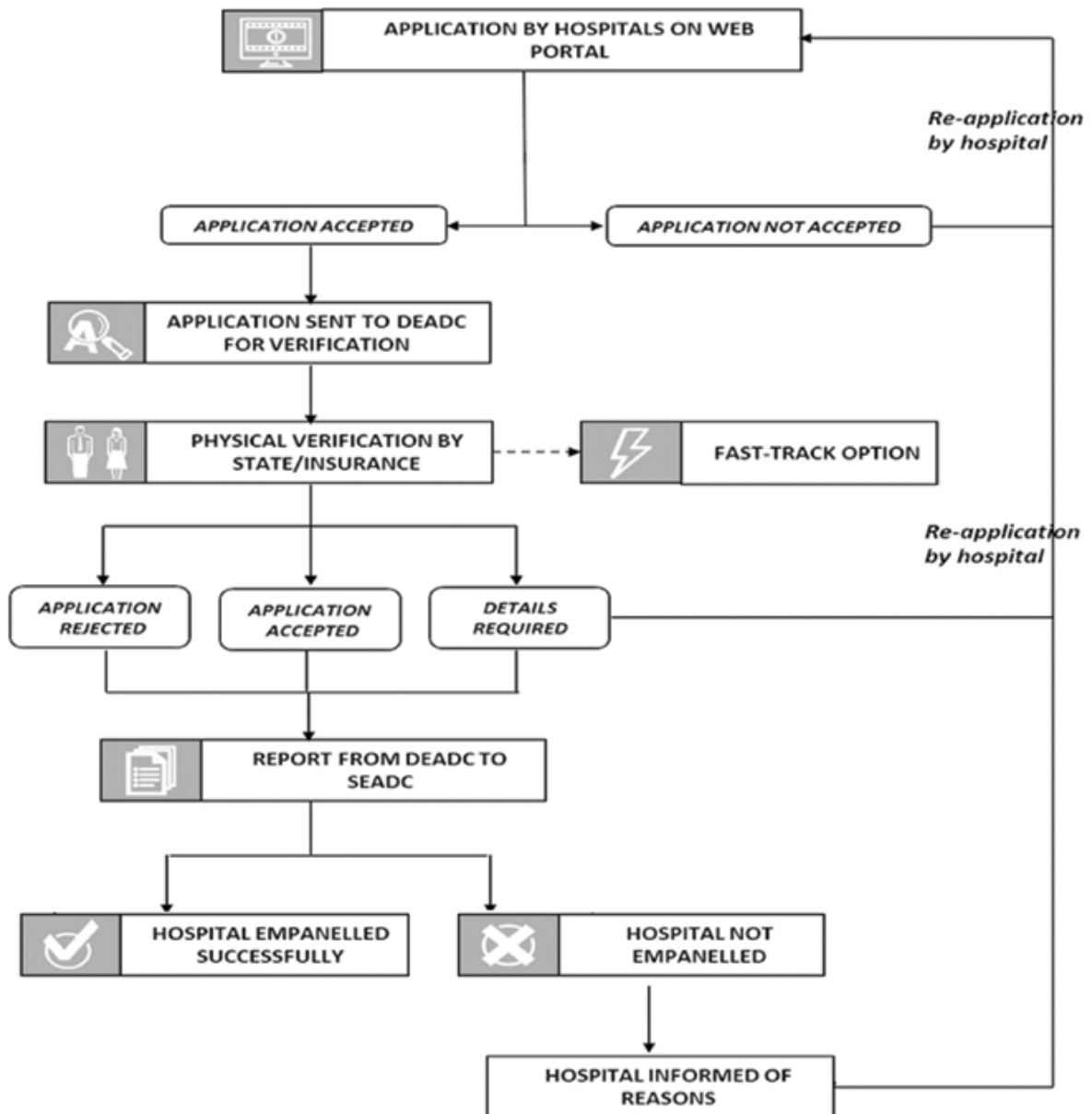
**G. Specific criteria for Polytrauma**

1. Shall have Emergency Room Setup with round the clock dedicated duty doctors.
2. Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and anaesthetist services.
3. 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.
4. Shall have dedicated round the clock Emergency theatre with C-Arm facility, Surgical ICU, Post-Op Setup with qualified staff.
5. Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

**H. Specific criteria for Nephrology and Urology Surgery**

1. Dialysis unit
2. Well-equipped operation theatre with C-ARM
3. Endoscopy investigation support
4. Post op ICU care with ventilator support
5. Sew lithotripsy equipment

## Annex 2: Process Flow for the Empanelment



## Schedule 6: Service Agreement with Empaneled Health Care Providers

*(to be provided)*

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

Provided in the scheme website:

<https://hospitals.pmjay.gov.in/Search/empnlWorkflow.htm?actionFlag=ViewRegisteredHosptlsNew>

## Schedule 8: Claim Management Guidelines

All Empanelled Health Care Providers (EHCP) will make use of IT system of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA to manage the claims related transactions. IT system of AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA has been developed for online transactions and all stakeholders are advised to maintain online transactions preferably to ensure the claim reporting in real time. However, keeping in mind the connectivity constraints faced by some districts an offline arrangement has also been included in the IT system that has to be used only when absolute. The AYUSHMAN BHARAT - PRADHAN MANTRI JAN AROGYA YOJANA-KARUNYA AROGYA SURAKSHA PADHATHI strives to make the entire claim management paperless that is at any stage of claim registration, intimation, payment, investigation by EHCP or by the TPA/ISA the need of submission of a physical paper shall not be required. This mean that this claim data will be sent electronically through IT system to the Central/ State server. The NHA, SHA, TPA/ISA (if applicable), and EHCP shall be able to access this data with respect to their respective transaction data only.

Once a claim has been raised (has hit the Central/State server), the following will need to be adhered to by the TPA/ISA/ SHA regarding claim settlement:

### 1. Claim Payments and Turn-around Time

The SHA through the Third Party Administrator/Implementation Support Agency shall follow the following process regarding the processing of claims received from the EHCP:

- A The SHA or the TPA/ISA (IRDAI compliant only) appointed by it shall decide on the acceptance or rejection of any claim received from an EHCP. Any rejection notice issued by the SHA (on recommendation of TPA/ISA or otherwise) to EHCP shall clearly state that rejection is subject to the EHCP's right to appeal against rejection of the claim.
- B If a claim is not rejected, the SHA shall either make the payment (based on the applicable package rate) or shall conduct further investigation, on its own or through TPA/ISA, into the claim received from EHCP.
- C The process specified in Clause A and B above (rejection or payment including investigation) in relation to claim shall be carried out in such a manner that it is completed (Turn-around Time, TAT) in no longer than 15 calendar days (irrespective of the number of working days). TPA/ISA needs to process the claim within 10 days and the SHA shall settle the claim by payment or rejection within the next 5 days.
- D The EHCP is expected to upload all claim related documents within 24 hours of discharge of the beneficiary.
- E The counting of days for TAT shall start from the date on which all the claim documents are accessible by the SHA and/or the TPA/ISA.
- F The SHA, on recommendation of TPA/ISA or otherwise, shall make claim payments to each EHCP against payable claims on a weekly basis through electronic transfer to such EHCP's

designated bank account. SHA or TPA/ISA is then also required to update the details of such payments against each paid claim on the online portal (IT System of AB-PMJAY

- G All claims investigations shall be undertaken by a qualified and experienced medical staff/team, with at least one MBBS degree holder, appointed by the SHA or its representative, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Agreement and relevant Cover Policy. The SHA's or its representative's medical staff shall not impart any advice on any treatment or medical procedures or provide any guidance related to cure or other care aspects. However, SHA, either own or through its representative, can ensure that the treatment was in conformity to the Standard Treatment Guidelines, if implemented.
- H The TPA/ISA will need to update the details on online portal (IT system of AB-PMJAY) of:
- i. All claims that are under investigation on a fortnightly basis for review; and
  - ii. Every claim that is pending beyond 10 days, along with its reasons for delay in processing such Claim.
  - iii. The TPA/ISA may collect at its own cost, complete Claim papers (including diagnostic reports) from the EHCP, if required for audit purposes for claims under investigation. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

## **2. Penalty on Delay in Settlement of Claims**

There will be a penalty for delay in processing of claims by the TPA/ISA beyond the turnaround time of 10 days so that SHA can make the payment within 15 days. A penalty of 1% of claimed amount per week for delay in claim processing beyond 10 days to be paid directly to the hospitals by the TPA/ISA if the claims payment is delayed beyond 15 days by SHA. This penalty will become due after 20 days in case of Inter-State claims or portability of benefits

## **3. Update of Claim Settlement**

The Third Party Administrator will need to update the claim settlement data on the portal on a daily basis and this data will need to be updated within 24 hours of claims payment. Any claim payment which has not been updated shall be deemed to have been unpaid and the interest, as applicable, shall be charged thereon.

## **4. Right of Appeal and Reopening of Claims**

- A The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the TPA/ISA, if the Empaneled Health Care Provider feels that the Claim is



payable. An appeal may be made within thirty (30) days of the said rejection being intimated to the hospital to the District-level Grievance Committee (DGC). SHA can allow relaxation on this clause on valid grounds.

- B The TPA/ISA and/or the DGC can re-open the Claim, if the Empaneled Health Care Provider submits the proper and relevant Claim documents that are required by the TPA/ISA.
- C The DGC may suo moto review any claim and direct either or both the TPA/ISA and the health care provider to produce any records or make any deposition as it deems fit.
- D The TPA/ISA or the health care provider may refer an appeal with the State-level Grievance Committee (SGC) on the decision of the DGC within thirty days (30) failing which the decision shall be final and binding. The decision of the SGC on such appeal is final and binding.
- E The decisions of the DGC and SGC shall be a speaking order stating the reasons for the decision

If the DGC (if there is no appeal) or SGC directs the TPA/ISA to pay a claim amount, the TPA/ISA shall pay the amount within 15 days. Any failure to pay the amount shall attract an interest on the delayed payment @ 1% for every week or part thereof. If the TPA/ISA does not pay the amount within 2 months they shall pay a fine of Rs. 25,000/- for each decision of DGC not carried out and Rs. 50,000 for each non-compliance of decision of SGC. This amount shall be remitted to the State Health Agency.

## Schedule 9: Portability Guidelines

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 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)/Trust 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 scheme.

## Schedule 10: Template for Medical Audit

### Template for Medical Audit

AYUSHMAN BHARAT PRADHAN MANTRI - JAN AROGYA YOJANA - KARUNYA AROGYA SURAKSHA PADHATHI 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
<b>1.</b>	<b>Does each medical record file contain:</b>			
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?			
<b>2.</b>	<b>Patient history and evidence of physical examination is evident.</b>			
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?			
<b>3.</b>	<b>Is an operation report available? (only if surgical procedure done)</b>			
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?			
<b>4.</b>	<b>Progress notes from admission to discharge</b>			
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:**

Date:

\_\_\_\_\_  
Signature of the Auditor



## 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 - KARUNYA AROGYA SURAKSHA PADHATHI kiosk present in the reception area?			
4.	Was any staff present at the kiosk?			
5.	Did you see the AYUSHMAN BHARAT PRADHAN MANTRI - JAN AROGYA YOJANA - KARUNYA AROGYA SURAKSHA PADHATHI Empanelled Hospital Board displayed near the kiosk in the reception area?			
6.	Was the kiosk prominently visible?			
7.	Was the kiosk operational in local language?			
8.	Were AYUSHMAN BHARAT PRADHAN MANTRI - JAN AROGYA YOJANA - KARUNYA AROGYA SURAKSHA PADHATHI brochures available at the kiosk?			
9.	Were the toilets in the OPD area clean?			
10.	Was drinking water available in the OPD area for patients?			

**Overall observations of the Auditor:**

**Significant findings:**

**Recommendations:**

\_\_\_\_\_  
Signature of the Auditor

Date:

Schedule 12: Key Performance Indicators

A. Initial Setting up KPIs				
SN	KPIs	Timeline	Measure and Explanation	Penalty
1.	<b>Setting up of a State Project Office (SPO) and Appointment of Project Head and other Staff (to be specified by HA) at SPO for co-ordination and Scheme implementation</b>	Up to <b>30 days</b> after signing of Insurance Contract.	Within 30 days of signing of the contract, ISA shall establish SPO with required staff and submit the sworn undertaking of the same to ED-SHA <ul style="list-style-type: none"> <li>• Establishment of the State Project Office</li> <li>• Appointment of State Project Head</li> <li>• Appointment of other required staff</li> </ul>	Rs. <b>100,000 per week</b> of delay beyond and part thereof in setting-up* SPO as required
*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 to be specified by SHA				

B. Performance KPIs				
SN	KPIs	Timeline	Baseline KPI Measure	Penalty
1.	<b>Scrutiny, Claim processing and payment of the claims</b>	Action within <b>10 days</b> of claim submission for claims within state and <b>20 days</b> for claims from outside state (Portability cases).  (This is applicable if the TPA/ISA fails to process within a Turn-around Time of <b>10 days/20 days</b> for a reason other than delay on the part of SHA, if any)	100% Compliance	If the ISA fails to process within Turn Around Time (TAT) of 10 days, then the ISA shall be liable to pay a penal interest to the EHCP at the rate of <b>1% for each claim amount for every day of delay beyond 15 days or the part thereof on every delayed claim.</b> <ul style="list-style-type: none"> <li>• If the compliance in the month falls below 85% of number claims, it will be treated as one instance of SPD trigger</li> </ul> <p><i>Example: if the ISA processed 100 claims in the month and failed to meet TAT for 16 claims, it will be liable to pay penalty of <b>1% for each</b></i></p>

				<b>claim per day of these 16 claims to EHCPS. It will also</b> 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
2.	<b>Delays in compliance to orders of the Grievance Redressal Committee (GRC)</b>	Beyond 30 days of the date of the order of the GRC	100% Compliance	Rs. 25,000 per week or part thereof

C. Audit Related KPIs				
SN	KPIs	Sample	Baseline KPI Measure	Penalty
1.	<b>Claims Audit (Approved Claims)</b>	5% of total claims of the quarter	100% compliance	<b>Rs. 10,000 per missing audit report per quarter</b>  If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
2.	<b>Medical Audits</b>	5% of total hospitalization cases per quarter	100% compliance	<b>Rs. 10,000 per missing audit report per quarter</b>  If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
3.	<b>Death Audits</b>	100%	100% compliance	<b>Rs. 10,000 Per missing death audit report per quarter</b>  If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers

4.	<b>Beneficiary Audit-On Phone</b>	5% of total hospitalized beneficiaries in that quarter	100% compliance	Rs. 10,000 per missing beneficiary (on phone) audit report  If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
5.	<b>Beneficiary Audit-Home Visit</b>	1% of total hospitalized beneficiaries in that quarter	100% compliance	Per 10,000 per missing beneficiary (on phone) audit report  If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
<ul style="list-style-type: none"> <li>• Sample size shall be equally distributed across all the districts in the state and also ensuring coverage of all suspect entities</li> <li>• If submitted audit report does not mention required sample size or details, it will be treated as non-submission of audit report</li> <li>• Audit reports shall contain details as required in Anti-Fraud Guidelines <b>published by NHA</b></li> <li>• ISA shall ensure audits to be conducted as prescribed by Anti-Fraud Guidelines, however penalty is only applicable on above audit reports</li> </ul>				

<b>D. Productivity* KPIs for Key Staff by ISA</b>				
<b>SN</b>	<b>Designation</b>	<b>Benchmark</b>	<b>Location</b>	<b>Brief Roles and Responsibilities</b>
1	CPD	<b>75-100 claims per person per day</b>	SPO/Central Office of ISA <i>(Instructions to the state: state shall decide about location of the processor)</i>	<ul style="list-style-type: none"> <li>• Verification of technical information eg. Diagnosis, clinical treatment, notes, evidences, etc.</li> <li>• Approve/assign/reject a claim</li> <li>• Raise query/as for clarification</li> <li>• Trigger investigation</li> </ul>



### 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 - KARUNYA AROGYA SURAKSHA PADHATHI Beneficiary on pre-authorization 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI Beneficiary Family Unit and different hospitals for other members of the AYUSHMAN BHARAT PRADHAN MANTRI - JAN AROGYA YOJANA - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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 - KARUNYA AROGYA SURAKSHA PADHATHI 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: Guidelines and Details of Grievance Redressal Mechanisms

Grievance Department has to be manned by dedicated resources to address the grievances from time to time as per the instructions of the NHA. The District authorities shall act as a frontline for the redressal of Beneficiaries'/ Providers/ other Stakeholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider with details of the follow-up action taken as regards the grievance as and when the Beneficiaries require it to do so. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication.

Under the Grievance Redressal Mechanism of AB-PMJAY-KASP, following set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels:

### **District Grievance Redressal Committee (DGRC)**

The District Grievance Redressal Committee (DGRC) will be constituted by the State Health Agency (SHA) in each district within 15 days of signing of MoU with the Third-Party Administrator.

- The District Magistrate or an officer of the rank of Addl. District Magistrate, who shall be the Chairperson of the DGRC.
- The DMO or equivalent rank officer shall be the Convenor of the DGRC.
- The District Coordinator of the TPA/ISA.
- The District Grievance Nodal Officer (DGNO)
- The DGRC may invite other experts for their inputs for specific cases.

Note: DGNO shall try to resolve the complaint by forwarding the same to Action Taking Authority (ATA). If the complaint is not resolved or comments are not received over the same within 15 days of the complaint, then the matter may be referred to DGRC.

### **State Grievance Redressal Committee (SGRC)**

The State Grievance Redressal Committee (SGRC) will be constituted by the State Health Agency within 15 days of signing of MoU with the Central Government.

- CEO of State Health Agency / State Nodal Agency shall be the Chairperson of the SGRC.
- Director Health Services.
- Director of Medical Education
- The State Grievance Nodal Officer (SGNO) of the SHA shall be the Convenor of SGRC.
- The SGRC may invite other experts for their inputs on specific cases.

Note: In case of any grievance between SHA and Third-Party Administrator, SGRC will be chaired by the Secretary of Department of Health & Family Welfare of the State. If any party is not agreed with the decision of DGRC, then they may approach the SGRC against the decision of DGRC.

### **National Grievance Redressal Committee (NGRC)**

The NGRC shall be formed by the MoHFW, GoI at the National level. The constitution of the NGRC shall be determined by the MoHFW in accordance with the Scheme Guidelines from time to time.

Proposed members for NGRC are:

1. CEO of National Health Agency (NHA) - Chairperson
2. JS, Ministry of Health & Family Welfare- Member
3. Additional CEO of National Health Agency (NHA)- Member Convenor
4. Executive Director, IEC, Capacity Building and Grievance Redressal
5. NGRC can also invite other experts/ officers for their inputs in specific cases.

*CEO (NHA) may designate Addl. CEO (NHA) to chair the NGRC.*

**Investigation authority for investigation of the grievance may be assigned to Regional Director-CGHS/Director Health Services/ Mission director NHM of the State/UT concerned.**

NGRC will consider:

- a Appeal by the stakeholders against the decisions of the State Grievance Redressal Committees (SGRCs)
- b Also, the petition of any stakeholder aggrieved with the action or the decision of the State Health Agency / State Government
- c Review of State-wise performance based monthly report for monitoring, evaluation and make suggestions for improvement in the Scheme as well as evaluation methodology
- d Any other reference on which report of NGRC is specifically sought by the Competent Authority.

The Meetings of the NGRC will be convened as per the cases received with it for consideration or as per the convenience of the Chairman, NGRC.

## 1. Grievance Settlement of Stakeholders

If any stakeholder has a grievance against another one during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme, it will be settled in the following way by the Grievance Committee:

### A. Grievance of a Beneficiary

#### i. Grievance against Third Party Administrator, hospital, their representatives or any functionary

If a beneficiary has a grievance on issues relating to entitlement, or any other AB-PMJAY related issue against Third Party Administrator, hospital, their representatives or any functionary, the beneficiary can call the toll free call centre number 14555 (or any other defined number by the State) and register the complaint. Beneficiary can also approach DGRC. The complaint of the beneficiary will be forwarded to the relevant person by the call centre as per defined matrix. The DGRC shall take a decision within 30 days of receiving the complaint.

If either of the parties is not satisfied with the decision, they can appeal to the SGRC within 30 days of the decision of the DGRC. The SGRC shall take a decision on the appeal within 30 days of receiving the appeal. The decision of the SGRC on such issues will be final.

**Note: In case of any grievance from beneficiary related to hospitalisation of beneficiary (service related issue of the beneficiary), the timelines for DGRC to take decision is within 24 hours from the receiving of the grievance.**

#### ii. Grievance against district authorities

If the beneficiary has a grievance against the District Authorities or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall take a decision on the matter within 30 days of the receipt of the grievance. The decision of SGRC shall be final.

### B. Grievance of a Health Care Provider

#### i. Grievance against beneficiary, Third Party Administrator, their representatives or any other functionary

If a Health Care Provider has any grievance with respect to beneficiary, Third Party Administrator, their representatives or any other functionary, the Health Care Provider will approach the DGRC. The DGRC should be able to reach a decision within 30 days of receiving the complaint.

**Step I-** If either of the parties is not satisfied with the decision, they can go to the SGRC within 30 days of the decision of the DGRC, which shall take a decision within 30 days of receipt of appeal.

**Step II-** If either of the parties is not satisfied with the decision, they can go to the NGRC within 30 days of the decision of the SGRC, which shall take a decision within 30 days of receipt of appeal. The decision of NGRC shall be final.

## **C. Grievance of Third Party Administrator**

### **i. Grievance against district authorities/ health care provider**

If Third Party Administrator has a grievance against District Authority / Health Care Provider or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall decide the matter within 30 days of the receipt of the grievance.

In case of dissatisfaction with the decision of the SGRC, the affected party can file an appeal before NGRC within 30 days of the decision of the SGRC and NGRC shall take a decision within 30 days of the receipt of appeal after seeking a report from the other party. The decision of NGRC shall be final.

## **2. Functions of Grievance Redressal Committees**

### **A. Functions of the DGRC:**

The DGRC shall perform all functions related to handling and resolution of grievances within their respective Districts. The specific functions will include:

- i. Review grievance records.
- ii. Call for additional information as required either directly from the Complainant or from the concerned agencies, which could be the TPA/ISA or an EHCP or the SHA or any other agency/ individual directly or indirectly associated with the Scheme.
- iii. Conduct grievance redressal proceedings as required.
- iv. If required, call for hearings and representations from the parties concerned while determining the merits and demerits of a case.
- v. Adjudicate and issue final orders on grievances.
- vi. In case of grievances that need urgent redressal, develop internal mechanisms for redressing the grievances within the shortest possible time, which could include but not be limited to convening special meetings of the Committee.
- vii. Monitor the grievance database to ensure that all grievances are resolved within 30 days.

### **B. Functions of the SGRC:**

The SGRC shall perform all functions related to handling and resolution of all grievances received either directly or escalated through the DGRC. The specific functions will include:

- i. Oversee grievance redressal functions of the DGRC including but not limited to monitoring the turnaround time for grievance redressal.
- ii. Act as an Appellate Authority for appealing against the orders of the DGRC.
- iii. Perform all tasks necessary to decide on all such appeals within 30 days of receiving such appeal.
- iv. Adjudicate and issue final orders on grievances.
- v. Nominate District Grievance Officer (DGO) at each District.

- vi. Direct the concerned Third-Party Administrator to appoint District Nodal Officer of each district.

**C. Functions of the NGRC:**

The NGRC shall act as the final Appellate Authority at the National level.

- i. The NGRC shall only accept appeals against the orders of the SGRC of a State.
- ii. The decision of NGRC will be final.

**3. Lodging of Grievances/ Complaints**

- A. If any stakeholder has a complaint (complainant) against any other stakeholder during the subsistence of the Policy Cover Period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of the Implementation Support Contract between the TPA/ISA and the SHA or a Policy or of the terms of their agreement (for example, the Services Agreement between the ISA and an Empanelled Health Care Provider), then such complainant may lodge a complaint by online grievance redressal portal or letter or e-mail.
- B. For this purpose, a stakeholder includes: any AB-PMJAY-KASP Beneficiary; an empanelled health care provider (EHCP); a De-empanelled Health Care Provider; the TPA/ISA or its employees; the SHA or its employees or nominated functionaries for implementation of the Scheme (DNOs, State Nodal Officer, etc.); and any other person having an interest or participating in the implementation of the Scheme or entitled to benefits under the AB-PMJAY-KASP Cover.
- C. A complainant may lodge a complaint in the following manner:
  - i. directly with the DGNO of the district where such stakeholder is located or where such complaint has arisen and if the stakeholder is located outside the Service Area, then with any DGNO located in the Service Area; or
  - ii. with the SHA: If a complaint has been lodged with the SHA, they shall forward such complaint to the concerned DGNO.
- D. Upon a complaint being received by the DGNO, the DGNO shall decide whether the substance of the complaint is a matter that can be addressed by the stakeholder against whom the complaint is lodged or whether such matter requires to be dealt with under the grievance redressal mechanism.
- E. If the DGNO decides that the complaint must be dealt with under the grievance redressal mechanism, the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee.
- F. If the DGNO decides that the complaint need not be dealt with under the grievance redressal mechanism, then the procedures set out in various process/guidelines shall apply.

#### **4. Redressal of Complaints**

- A. The DGNO shall enter the particulars of the complaint on the Web-based Central Complaints and Grievance Management System (CCGMS) established by the MoHFW.
- B. The CCGMS will automatically: (i) generate a Unique Complaint Number (UCN); (ii) categorize the nature of the complaint; and (iii) an e-mail or letter to be sent to the appropriate stakeholder to which such category of complaint is to be referred (including updating on phone).
- C. Once the UCN is generated, the DGNO shall send or cause to be sent an acknowledgement email/phone call to the complainant and provide the complainant with the UCN. Upon receipt of the UCN, the complainant will have the ability to track the progress of complaint resolution online through CCGMS and use the same at the time of calling the helpline for allowing easy retrieval of the specific complaint data.
- D. The stakeholder against whom a complaint has been lodged must send its comments/ response to the complainant and copy to the DGNO within 15 days. If the complaint is not addressed within such 15-day period, the DGNO shall send a reminder to such stakeholder for redressal within a time period specified by the DGNO.
- E. If the DGNO is satisfied that the comments/ response received from the stakeholder will address the complaint, then the DGNO shall communicate this to the complainant by e-mail and update the CCGMS.
- F. If the DGNO is not satisfied with the comments/ response received or if no comments/ response are received from the stakeholder despite a reminder, then the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee depending on the nature of the complaint after which the procedures set out shall apply.

#### **5. Grievance Redressal Mechanism**

Upon escalation of a complaint for grievance redressal the following procedures shall apply:

- A. The DGNO/SGRC shall update the CCGMS to change the status of the complaint to a grievance, after which the CCGMS shall categorize the grievance and automatically refer it to the Convenor of the relevant Grievance Redressal Committee by way of e-mail.
- B. The Convenor of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at its next meeting.
- C. Each grievance shall be addressed by the relevant Grievance Redressal Committee within a period of 30 days of receipt of the grievance. For this purpose, each Grievance Redressal Committee shall be convened at least once every 30 days to ensure that all grievances are addressed within this time frame. Depending on the urgency of the case, the Grievance Redressal Committee may decide to meet earlier for a speedier resolution of the grievance.

- D. The relevant Grievance Redressal Committee shall arrive at a reasoned decision within 30 days of receipt of the grievance. The decision of the relevant Grievance Redressal Committee shall be taken by majority vote of its members present. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard.
- E. If any party to a grievance is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the relevant Grievance Redressal Committee or other authority having powers of appeal.
- F. If an appeal is not filed within such 30-day period, the decision of the original Grievance Redressal Committee shall be final and binding.
- G. A Grievance Redressal Committee or other authority having powers of appeal shall dispose of an appeal within 30 days of receipt of the appeal. The decision of the Grievance Redressal Committee or other authority with powers of appeal shall be taken by majority vote of its members. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard. The decision of the Grievance Redressal Committee or other authority having powers of appeal shall be final and binding.

**6. Proceedings Initiated by the State Health Agency, State Grievance Redressal Committee, the National Health Authority**

The SHA, SGRC and/or the National Health Authority (NHA) shall have the standing to initiate *suo moto* proceedings and to file a complaint on behalf of itself and AB-PMJAY-KASP Beneficiaries under the Scheme.

**A. Compliance with the Orders of the Grievance Redressal Committees**

- i. The TPA/ISA shall ensure that all orders of the Grievance Redressal Committees by which it is bound are complied with within 30 days of the issuance of the order, unless such order has been stayed on appeal.
- ii. If the TPA/ISA fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the TPA/ISA shall be liable to pay a penalty of Rs. 25,000 per month for the first month of such non-compliance and Rs. 50,000 per month thereafter until the order of such Grievance Redressal Committee is complied with. The TPA/ISA shall be liable to pay such penalty to the SHA within 15 days of receiving a written notice.
- iii. On failure to pay such penalty, the TPA/ISA shall incur an additional interest at the rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid.

**B. Complaints/ Suggestions received through Social Media/Call centre**



As Social Media channels will be handled by NHA, hence, the complaints/ suggestions raised through Social Media channels like, Facebook, twitter handles, etc. will be routed to the respective SGNO by NGNO (National Grievance Nodal Officer). SGNO needs to register the same on the Grievance portal and publish a monthly report on the action taken to the NGNO.

Complaint may also be lodged through Call center by beneficiary. Call center need to register the details like complaint details in the defined format and forward the same to State Grievance Nodal Officer of the State concerned. SGNO needs to upload the details of the complaint on the grievance portal and allocate the same to the concerned District. The Complaint / grievance will be redressed as per guidelines.

**Note: Matrix for grievance referral under the Scheme is presented in the table below:**

<b>Aggrieved Party</b>	<b>Indicative Nature of Grievance</b>	<b>Grievance Against</b>	<b>Referred To</b>
<b>AB-PMJAY-KASP Beneficiary</b>	<ul style="list-style-type: none"> <li>Denied treatment</li> <li>Money sought for treatment, despite Sum Assured under AB-PMJAY-KASP Cover being available</li> <li>Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Assured under AB-PMJAY-KASP Cover is insufficient or exhausted</li> <li>AB-PMJAY-KASP Card retained by Empanelled Health Care Provider</li> <li>Medicines not provided as per guidelines</li> </ul>	Hospital	DGNO
<b>Empanelled Health Care Provider</b>	<ul style="list-style-type: none"> <li>Claims rejected by TPA/ISA/SHA or full Claim amount not paid</li> <li>Suspension or de-empanelment of Empanelled Health Care Provider</li> </ul>	TPA/ISA/ SHA	DGNO
<b>TPA/ISA</b>	<ul style="list-style-type: none"> <li>Service Fee not received within time prescribed.</li> </ul>	SHA	SGRC
<b>Inter State/UT (Portability issues)</b>			
<b>AB-PMJAY Beneficiary</b>	<ul style="list-style-type: none"> <li>Denied treatment</li> <li>Money sought for treatment, despite Sum Insured under AB-PMJAY Cover being available</li> <li>Demanding more than Package Rate/ Pre-</li> </ul>	Hospital	DGNO of the State/UT where Beneficiary is applying/availing benefits of AB-PMJAY (other

	<p>Authorized Amount, if Sum Insured under AB-PMJAY Cover is insufficient or exhausted</p> <ul style="list-style-type: none"> <li>Medicines not provided as per guidelines</li> </ul>		than parent State/UT)
<b>Empanelled Health Care Provider</b>	<ul style="list-style-type: none"> <li>Claims rejected by TPA/ISA or full Claim amount not paid</li> </ul>	TPA/ISA/ SHA	SGRC of both parent State/UT and State/UT where the claim is raised State/UT