AB PM-JAY-KASP 2021-22

Schedules to Service Contract

26/06/2021

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1. Schedule 1: Details of the Scheme and Beneficieries

1.1. Name and Objective of the of the Scheme

The name of the scheme is Ayushman Bharat Pradhan Mantri - Jan Arogya Yojana (AB 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. Those beneficiaries who do not belong to KASP but have annual family income of Rs. 3 lakh or below will be provided the benefits of Karunya Benevolent Fund (KBF) wherein treatment cover would be limited to Rs. 2 lakhs (Rs. 1 lakh additional for Kidney ailments). These eligible AB-PMJAY-KASP beneficiary families will be proviced coverage for secondary, tertiary and day care procedures (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP).

1.2. Beneficieries

All AB-PMJAY-KASP 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 who 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. Those who donot famll under the above categories but with annual family income of Rs. 3 lakh or below as per Ration card get covered under the KBF category as stated earlier.

1.2.1 Unit of Coverage

Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB-PMJAY-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 Outpatient Care. Outpatient 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.*

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 AB 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 – 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 AB 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 AB 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 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 within a defined time frame as per the State.
- 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 AB 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 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 ≥ 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) - Diffrential 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 prodcedure 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.

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

a. The SHA shall ensure the quality of sevice provided to the benificiaries in EHCP.

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

c. EHCP will be encouraged by Insurer to attain quality milestones by attaning AB 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

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. Beneficiaries with annual family income of Rs. 3 lakh or below will be covered under KBF category.

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-KASP. 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 or Ration card number for KBF.
   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 State's SHA team. 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 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 newborn and newly married, any member can be added to existing family provided member can establish relation with a PMJAY verified beneficiary.

E. National Portability - PMAMs can 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.

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;
   - DHS or Nominee of DHS not less than the rank of Deputy Director, Health – Member;
   - DME or Nominee of DME not less than the rank of Deputy Director of Medical Education – Member;
   - District Project Coordinator (DPC) of respective Districts Sate Health Agency (SHA) – Member;

The State Government may invite other members to SEC as it may deem fit to assist the Committee in its activities.

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.

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

S.No.	Institutional Option	SEC Recommended Composition
1.	Approval of the Empanelment application by the State	• Chair: ED of State Health Agency • At least 5 membered Committee
2.	Verification of the Empanelment application and approval by State	• ED, SHA through the officer in charge of HNQA

The DPC 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 DPC 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 DPC 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.

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

Detailed empanelment criteria have been provided in the scheme and SHA website.

State Governments will have the flexibility to **revise/relax** the empanelment criteria based, barring minimum requirements of Quality, on their local context, availability of providers, and the need to balance quality and access; with prior approval from National Health Authority. 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 Authority 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. 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.

1.5. Process for Disciplinary Proceedings and De-Empanelment

A. Institutional Mechanism

i) De-empanelment process can be initiated by 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 DPC 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 DPC 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 DPCs 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 DPC, 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 DPC 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 sent 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 DPC, the DPC 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.

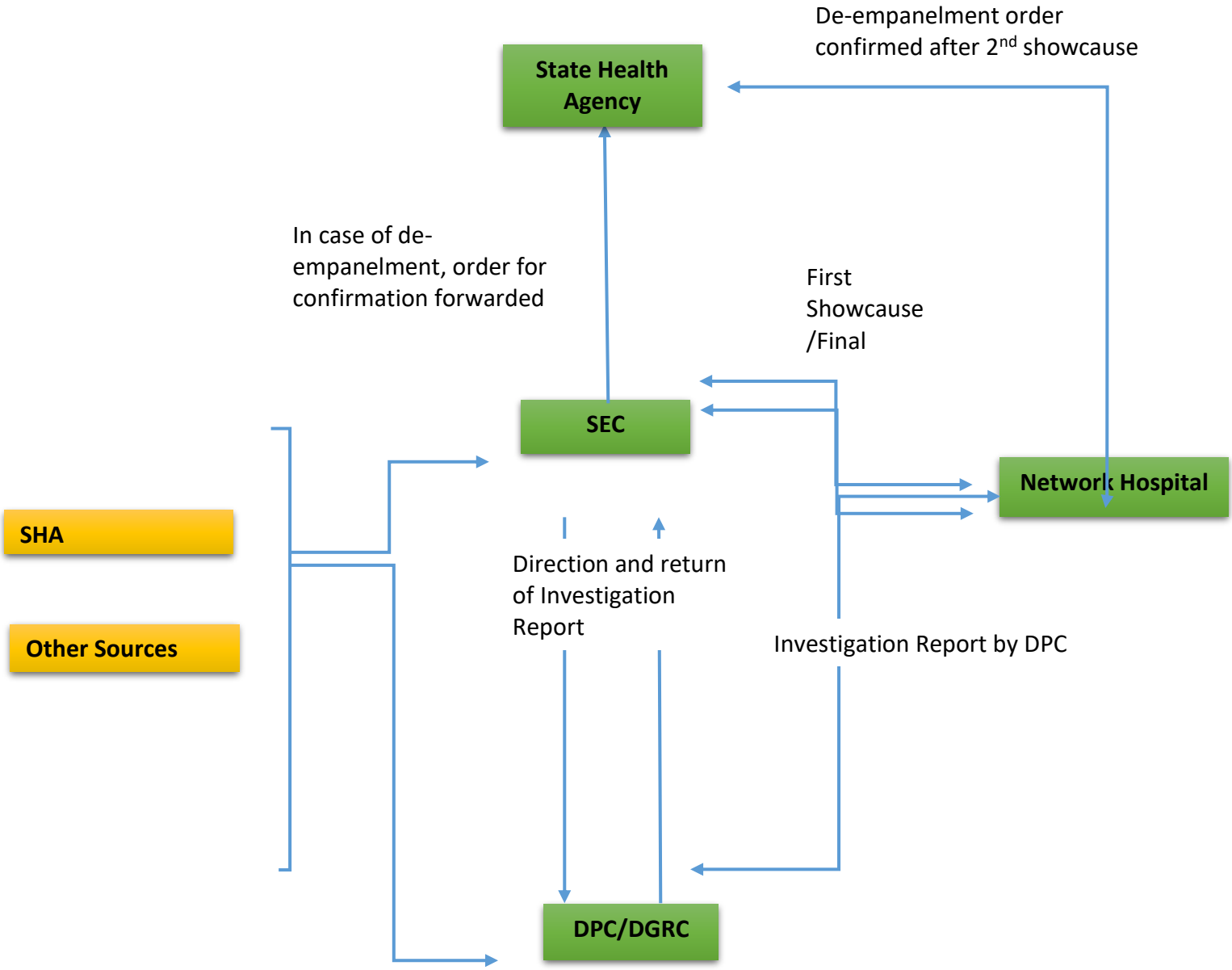
C. Gradation of Offences

Based on 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 or Grievance Committees. However, this tabulation is intended to be as guidelines rather than mandatory rules and the SEC may take a final call on the severity and quantum of punishment on a case-to-case basis.

Penalties for Offences by the Hospital			
Case Issue	**First Offence**	**Second Offence**	**Third Offence**
Illegal cash payments by beneficiary	Full Refund and compensation 3 times of illegal payment to the beneficiary	In addition to actions as mentioned for first offence, Rejection of claim for the case	De-empanelment/ black-listing
Billing for services not provided	Rejection of claim and penalty of 3 times the amount claimed for services not provided, to Insurance Company /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for services not provided, to Insurance Company /State Health Agency	De-empanelment

Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of 8 times the excess amount claimed due to up coding /unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency. For unnecessary procedure:	Rejection of claim and penalty of 16 times the excess amount claimed due to up coding/unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency	De-empanelment
Wrongful beneficiary Identification	Rejection of claim and penalty of 3 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	De-empanelment
Non-adherence to AB-PMJAY quality and service standard	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/ DPC	Suspension until rectification of gaps and validation by SEC/ DPC	De-empanelment

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


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

Schedule 6: Service Agreement with Empaneled Health Care Providers

(Will be provided by SHA)

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

Provided in the scheme and SHA website:

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

www.shakerala.gov.in

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 or as per the revised TAT put forward by SHA/NHA.

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 to the EHCP by the TPA/ISA if the claims payment is delayed beyond 15 days by SHA. This penalty will become due after 30 days in case of Inter-State claims or portability of benefits. For claiming the penalty the EHCP has to raise the disputed claim penalty within 15 days of concerned claim settlement. Either party will not be liable for penalty for reasons beyond the control of the organization.

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 to pay a claim amount, the TPA/ISA shall assist SHA to 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 facilitate the payment 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 must 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
1.	**Does each medical record file contain:**			
a.	Is discharge summary included?			
b.	Are significant findings recorded?			
c.	Are details of procedures performed recorded?			
d.	Is treatment given mentioned?			
e.	Is patient's condition on discharge mentioned?			
f.	Is final diagnosis recorded with main and other conditions?			
g.	Are instructions for follow up provided?			
2.	**Patient history and evidence of physical examination is evident.**			
a.	Is the chief complaint recorded?			
b.	Are details of present illness mentioned?			
c.	Are relevant medical history of family members present?			
d.	Body system review?			
e.	Is a report on physical examination available?			
f.	Are details of provisional diagnosis mentioned?			
3.	**Is an operation report available? (only if surgical procedure done)**			
a.	Does the report include pre-operative diagnosis?			
b.	Does the report include post-operative diagnosis?			
c.	Are the findings of the diagnosis specified?			
d.	Is the surgeon's signature available on records?			

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

Overall observations of the Auditor:

Significant findings:

Recommendations:

_____
Signature of the Auditor

Date:

Schedule 11: Template for Hospital Audit

Template for Hospital Audit

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

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Was there power cut during the audit?			
2.	If yes, what was the time taken for the power back to resume electric supply?			
3.	Was a AYUSHMAN BHARAT PRADHAN MANTRI - JAN AROGYA YOJANA - 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

S. No.	KPIs	Time Frame	Penalty
1.	Setting up of a State Project Office and Appointment of Project Head and other Staff (to be specified by SHA) for co-ordination and Scheme implementation	Within 30 days after signing of TPA/ISA Contract.	Rs. 1 lakh per week of delay and part thereof.
2.	Claims-related Activities:		
	Pre-authorisation	Within 1 hour for emergency cases and 6 hours for all other cases	Automatic approval post 1 and 6 hours for emergency and non-emergency cases, respectively. Rs. 500 per delay of pre-authorisation
	Scrutiny and Claim approval from EHCP	Within 10 days of claim submission for the first time excluding the days when the claim is pending with the network hospital.	If the TPA/ISA fails to push the Claim for Payment/Rejection within a Turn-around Time of 10 days for a reason other than a delay by the SHA in making payment of the Fees or technical issues in the IT platform , then the TPA/ISA at their own cost shall be liable to pay a penal interest to EHCP at the rate of 1% of the Claim amount for every 15 days of delay (30 days for portability claims). EHCP has to raise the disputed claim penalty within 15 days of concerned claim settlement.
3.	Delays in compliance to orders of the Grievance Redressal Committee (GRC)	Beyond 30 days.	Rs. 25,000 for the first month of delay in

			implementing GRC order, Rs. 50,000 per month for every subsequent month thereafter.
4.	Completing minimum audit targets – claims, medical and hospital audits	Specified number of medical, claims and hospital audit reports to be submitted within 5th day of the month following the end of the month	Rs. 10,000 for each audit report not submitted as per plan.
5.	Timely submission of a specified minimum audit reports on a quarterly basis – both claims and medical audits *(To be implemented only when the IT Platform has developed the capability of allowing online filing of these reports)*	Specified number of medical & claims audit reports to be submitted within -7 days of completing the audit.	Rs. 10,000 for each audit report not submitted in time.
6.	If the claims accepted by the TPA/ISA are found to be wrongly recommended by TPA/ISA for payment	Continuous	Three times the value of the claim including interest of 1% for each week of delay to the SHA

Penalty relaxation will be considered only for reasons beyond the control of the organization.

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-authorisation form.
4. Second claim in the same year for an acute medical illness/surgical.
5. Claims from multiple hospitals with same owner.
6. Claims from a hospital located far away from AYUSHMAN BHARAT PRADHAN MANTRI - JAN AROGYA YOJANA - 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 is manned by resources to address the grievances from time to time. 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) is constituted by the State Health Agency (SHA) in each district.

- 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 - Member.
- The District Grievance Nodal Officer (DGNO) — Convener
- Third Party Administrator/Implementation Support Agency/Insurance Company (TPA/ISA/IC) representative - Member
- 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) is constituted by the State Health Agency.

- Executive Director , State Health Agency -Chairperson.
- Director Health Services Nominee of DHS not less than the rank of Deputy Director of Health - Member.
- Director of Medical Education Nominee of DME not less than the rank of Deputy Director of Medical Education – Member.
- The State Grievance Nodal Officer (SGNO) of the SHA shall be the Convenor of SGRC.
- Third Party Administrator/Implementation Support Agency/Insurance

Company (TPA/ISA/IC) respresentative - Member

- 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-KASP related issue against Third Party Administrator, hospital, their representatives or any functionary, the beneficiary can call the DISHA toll free call centre number 1056 and register the complaint. Beneficiary can also approach DGRC through District Project Coordinator (DGNO). 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 Empaneled Health Care Provider (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. Review grievance records.

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 (CGRMS – www.cgrms.pmjay.gov.in) established by the NHA.
B. The portal 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 CGRMS 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 addresses the complaint, then the DGNO shall communicate this to the complainant by e-mail and update the CGRMS.
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 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/SGNO shall update the CGRMS to change the status of the complaint to a grievance, after which the CGRMS shall categorize the grievance.
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:

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
AB-PMJAY-KASP **Beneficiary**	• Denied treatment • Money sought for treatment, despite Sum Assured under AB-PMJAY-KASP Cover being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Assured under AB-PMJAY-KASP Cover is insufficient or exhausted • AB-PMJAY-KASP Card retained by Empanelled Health Care Provider • Medicines not provided as per guidelines	Hospital	DGNO
Empanelled Health Care Provider	• Claims rejected by TPA/ISA/SHA or full Claim amount not paid • Suspension or de-empanelment of Empanelled Health Care Provider	TPA/ISA/ SHA	DGNO
TPA/**ISA**	• Service Fee not received within time prescribed.	SHA	SGRC
Inter State/UT (Portability issues)			

AB-PMJAY Beneficiary	• Denied treatment • Money sought for treatment, despite Sum Insured under AB-PMJAY Cover being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB-PMJAY Cover is insufficient or exhausted • Medicines not provided as per guidelines	Hospital	DGNO of the State/UT where Beneficiary is applying/availing benefits of AB-PMJAY (other than parent State/UT)
Empanelled Health Care Provider	• Claims rejected by TPA/ISA or full Claim amount not paid	TPA/ISA/ SHA	SGRC of both parent State/UT and State/UT where the claim is raised State/UT