AB PM-JAY - KASP

Schedules to Service Contract

Tender Document Vol – III

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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 and 2019-20 not figuring in the SECC Database. These eligible AB-PMJAY beneficiary families will be proviced coverage for secondary, tertiary and day care procedures (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP).

1.2. 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 and 2019-20 not figuring in the SECC Database which are resident in the Service 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
- 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

Schedule 2: Exclusions to the Policy

The Trust 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.
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

3.1. Schedule 3 (a) HBP 2.1

Will be enclosed as additional document

3.2. Schedule 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.
- No incentives under ABPMJAY KASP will be provided.
- The Diagnosis and Treatment should be mentioned clearly during the time of PPD. Wrongly entering the Treatment details will be rejected on the same grounds of misinformation.
- Compulsory pre-authorization is in-built while selecting this code for blocking treatments.
- The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, consumables, post-op care and applicable incentive to the hospital included — preferably citing rates as ceiling from any govt. purchasing scheme like CGHS etc., if available.
- Cannot be raised under multiple package selection. But if 2 Surgeries are to be done, one in HBP 2.1 and one not then a clubbed case may be raised under Unspecified package. This will also follow 100-50-25 rule.
- 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.
- 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 SHA.
- 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. 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.

For deciding on the approval amount, the PPD may consider the rate of closest match of the requested surgery, in listed PM-JAY packages. CPD will be able to deduct any amount or approve partial payment for the claim as per supporting documents during claim adjudication.

3.3. Schedule 3 (c): Differential Pricing Guidelines:

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

Sl. 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%

*Classification of Metro Cities:

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

These percentage incentives are added by compounding.

3.4. 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 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

4.1. Brief Process Flow

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 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.

Schedule 5: Guidelines for Empanelment of Health Care Providers

5.1. 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.

5.2. 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. At present, the current role of DEC is performed by District Project Coordinator (DPC) posted by the State Health Agency (SHA), Kerala

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.

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

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

1.1. 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 TPA will be invited to participate in this workshop.

1.2. 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 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

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)

1.3. 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.

1.4. 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***.**

1.5. 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.

1.6. 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.

1.7. 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 DECs 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.

Penalties for Offences by the Hospital			
Case Issue	**First Offence**	**Second Offence**	**Third Offence**
Illegal cash payments by beneficiary	Full Refund to the Beneficiary and compensation 3 times of Claimed amount or illegal payment made, whichever is higher to SHA.	Full Refund to the Beneficiary and compensation 10 times of Claimed amount or illegal payment made, whichever is higher to SHA.	Suspension of EHCP for 6 months/ De-empanelment/ black-listing (based on the severity of the offense)
Billing for services not provided	Rejection of claim and penalty of 3 times the claimed amount or the amount claimed for services not provided, whichever is higher to State Health Agency	Rejection of claim and penalty of 10 times the claimed amount or the amount claimed for services not provided, whichever is higher to 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/ 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[1] 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[2] & nurses[3]), 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).

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:

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[1] 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.

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

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

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[4] coordinator) at the hospital reception.

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

20. Ensure a dedicated medical officer to work as a medical[5] co-ordinator towards AB-PMJAY beneficiary management (including records for follow-up care as prescribed)
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.
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.

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

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 nursey/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

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://sha.kerala.gov.in/list-of-empanelled-hospitals/

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:

8.1. 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 shall clearly state that reason for rejection and 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 shall be responsible for processing the claim (rejection or approval including investigation) at the earliest but not beyond 10 days of submission of claim in TMS so that SHA can settle the claim within the next 5 days.
D. All EHCPs shall be obliged to submit their claims in TMS at the earliest but not later than 15 days of discharge.
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 through electronic transfer to such EHCP's designated bank account.

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.

8.2. 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 0.1% of claimed amount per day for delay in claim processing beyond 10 days to be paid to SHA by the TPA/ISA. This penalty will become due after 20 days in case of Inter-State claims or portability of benefits.

8.3. 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

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.

<u>Implementation Arrangements of Portability</u>

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

Format to be provided by SHA

Schedule 11: Template for Hospital Audit

Format to be provided by SHA

Schedule 12: Key Performance Indicators (KPI)

Sl. No.	Summary of Key Performance Indicators (KPI)
12.1.	Initial Setting up – KPIs
12.2.	Claim Processing Related – KPIs
12.3.	Audit Related – KPIs
12.4.	Productivity - KPIs

12.1. Initial Setting up – KPIs

SN	KPI	Timeline	Measure and Explanation	Penalty
1.	**Setting up of a State Project Office (SPO) and Appointment of Project Head and other Staff at SPO for co-ordination and Scheme implementation**	Up to 30 days after signing of Contract.	Within 30 days of signing of the contract, TPA shall establish SPO with required staff and submit the sworn undertaking of the same to ED-SHA • Establishment of the State Project Office • Appointment of CMO • Appointment of other required staff	Rs. 25,000 per week 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: (will be detailed out in Model Tender Document)				

12.2. Claim Processing Related – KPIs

SN	KPI	Timeline	Baseline KPI Measure	Penalty
1.	**Pre-authorisation**	Action within 6 * hours: of raising preauthorization request (all auto approvals beyond 6 hours will be considered non-compliance)	95% Compliance	• Compliance from compliance below 95% upto 90% then penalty of 5% of the monthly total delayed preauthorization amount • Compliance below 90% upto 85% then penalty of 10% of the monthly total delayed preauthorization amount • Compliance below 85% then penalty of 20% of the monthly total delayed preauthorization amount with one instance of triggering of SPD** (for calculation, monthly delayed preauthorization amount shall be the amount for delayed pre-authorizations for the admissions in that month. Penalty shall be calculated on this amount and shall be recovered from the ISA every quarter, please see Clause 23.5) *Example: if the ISA handled 100 preauthorization in the month and failed to meet TAT for 16 cases, 20% preauthorization amount of only these 16 cases will be charged as penalty from next instalment of the premium. Even if the preauthorization is rejected, not meeting the TAT will invite the penalty*
2.	**Scrutiny, Claim processing and payment of the claims**	Action within 10 days of claim submission for claims within state and 20 days for claims from outside state (Portability cases). (This is applicable if the TPA fails to process	100% Compliance	If the TPA fails to process within Turn Around Time (TAT)***, then the TPA shall be liable to pay a penal interest to the SHA at the rate of 0.1% for each claim amount for every day of delay or the part thereof on every delayed claim, up to a maximum 10%. • If the compliance in the month falls below 85% of number

		within a Turn-around Time of 10 days / 20 days for a reason other than delay on the part of SHA, if any)		claims, it will be treated as one instance of SPD trigger *Example: if the TPA processed 100 claims in the month and failed to meet TAT for 16 claims, it will be liable to pay penalty of 0.1% for each claim per day of these 16 claims to SHA. It will also be treated as one instance of triggering of SPD.*
			100% Compliance	In case any claim is adjudicated wrongly, then penalty of three times over and above the claim amount. If the wrong adjudication is identified by TPA, and if the amount is recovered then SHA may waive the penalty for wrong adjudication in such cases.

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

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

- Penalty amount for Claim Processing KPIs shall be calculated each quarter and TPA shall pay all penalties imposed by the SHA within 30 days of receipt of Penalty Notice from SHA.

- At any point during term of contract, if penalty amount is 10% of the total contract value, contract shall be liable to be terminated
- *** in case of claims processing, TAT will be determined as days during which claim is with TPA (Excluding the days claim is pending at EHCPs end)

  Example: 1
  The day EHCP raises claim will be treated as Day 1
  If TPA raises query on Day 4,
  and EHCP complies with query on Day 10,
  TPA takes action (accepting or rejection of claim) on Day 12
  in this case (4-1=3) days + (12-10=2) days, hence TAT determined is 3+2=5 days

  Example 2:

The day EHCP raises claim will be treated as Day 1
If TPA raises query on Day 4,
and EHCP complies with query on Day 10,
TPA raises another query on Day 11
EHCP complies with second query on Day 14
TPA approves the claim on Day 16
in this case (4-1=3) days + (11-10=1) days+ (16-14=2) days, hence TAT determined is 3+1+2=6 days

Example 3:
The day EHCP raises claim will be treated as Day 1
If TPA raises query on Day 3,
and EHCP complies with query on Day 13,
TPA raises another query on Day 19
EHCP complies with second query on Day 24
TPA approves the claim on Day 30
in this case (3-1=2) days + (19-13=6) days+ (30-24=6) days, hence TAT determined is 2+6+6=14 days.
In this case, TPA is liable to pay 0.4% of the claim value as penalty to SHA (i.e. 0.1% of claim value for 4 days that exceeded TAT)

12.3. Audit Related – KPIs

SN	KPIs	Sample	Baseline KPI Measure	Penalty
1.	**Claims Audit (Approved Claims)**	5% of total claims of the quarter	100% compliance	Rs. 50,000 per missing audit report per quarter If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
2.	**Hospital Audits**	25% of all EHCPs per quarter ***Furthermore, TPA personnel must visit any EHCP as directed by SHA.	100% compliance	Rs. 50,000 per missing audit report per quarter If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
3.	**Death Audits**	100%	100% compliance	Rs. 50,000 Per missing death audit report per quarter If ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers

- Sample size shall be equally distributed across all the districts in the state and also ensuring coverage of all suspect entities.
- If submitted audit report dues do not mention required sample size or details, it will be treated as non-submission of audit report.
- Audit reports shall contain details as required in Anti-Fraud Guidelines published by NHA.
- TPA shall ensure audits to be conducted as prescribed by Anti-Fraud Guidelines, however penalty is only applicable on above audit reports

12.4. Productivity KPIs for Key Staff of TPA – KPIs

SN	Designation	Benchmark	Location	Brief Roles and Responsibilities
1	**PPD**	100-120 Pre-authorization request per person per day	SPO / Central Office of ISA	• Approve/assign/reject pre-auth request • Raise query/send for clarification to hosp. • Trigger investigation
2	**CEX**	100-120 claims processing per person per day	SPO / Central Office of ISA	• Verification on non technical documents, reports, dates verification • Forward case to CPD for processing with inputs
3	**CPD**	70-100 claims per person per day	SPO / Central Office of ISA	• Verification of technical information eg. Diagnosis, clinical treatment, notes, evidences, etc. • Approve/assign/reject a claim • Raise query/as for clarification • Trigger investigation

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: Minimum Manpower Requirements

The TPA shall ensure that it shall at all times during the Tenure of the Contract, maintain at a minimum, the following number of Personnel having, at a minimum, the prescribed qualifications and experience:

SN	Designation	Number	Location	Brief Roles and Responsibilities
1	State Project Manager	1	SPO of TPA	• Overall coordinator of TPA's operations in the state • Single contact point for SHA for any coordination purpose
2	State Medical Manager / CMO	1	SPO of TPA	• Overall supervision and guidance to be provided to CPDs, PPDs, Medical Auditors *(State Medical manager / CMO should be MBBS qualified with valid Medical Council registration)*
3	Regional Project Coordinators	3 in the state	Corresponding Zonal offices / districts	• Overall coordination of TPA's operations in the region / districts • Assistance to State Project Manager
4	PPD	100-120 Pre-authorization request per day per person	SPO of TPA / Centrally located	• Approve / assign / reject pre-auth request • Raise query / send for clarification to hosp. • Trigger investigation
5	CEX	100-120 per claims processing per person	SPO of TPA / Centrally located	• Verification on non technical documents, reports, dates verification • Forward case to CPD for processing with inputs
6	CPD	70-100 claims per person per day	SPO of TPA / Centrally located	• Verification of technical information eg. Diagnosis, clinical treatment, notes, evidences, etc. • Approve / assign / reject a claim • Raise query / ask for clarification • Trigger investigation
7	Medical Auditors	to complete tasks as per Audit Related KPI mentioned in Schedule 12.3	SPO of TPA / Centrally located	• Conduct required hospital / claim audit • To support in Pre-DGRC and CRC activities • To audit cases assigned to TPA - SAFU *(Medical Auditors should be MBBS qualified with valid Medical Council registration)*

Schedule 16: Guidelines and Details of Grievance Redressal Mechanisms

Grievance Division of State Health Agency (SHA) is manned by resources to address the grievances pertaining to the AB PM-JAY-KASP from time to time. The District authorities shall act as a frontline for the redressal of Beneficiaries'/ Providers'/ other Stakeholder's grievance. The District authorities shall also attempt to solve the grievance at their end. The grievance 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.

The major objective of the Grievance Redressal Mechanism is to ensure that grievances of all stakeholders are redressed within the time frame mentioned in the Grievance Guidelines up to the satisfaction of the aggrieved party based on the principles of natural justice while ensuring that cashless access to timely and quality care to remains uncompromised.

1. GRIEVANCE REDRESSAL STRUCTURE AND AUTHORITIES

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

a) 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 / Addl. District Magistrate / Sub-Collector or District Development Commissioner, who shall be the Chairperson of the DGRC.
- The DMO or equivalent rank officer - Member.
- The District Programme Manager, National Health Mission – 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.

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) <u>State Grievance Redressal Committee (SGRC)</u>

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) representative - Member
- The SGRC may invite other experts for their inputs on specific cases.

If any party is not satisfied with the decision of DGRC, then they may approach the SGRC against the decision of DGRC.

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. Call for additional information as required either directly from an aggrieved party or from the concerned agencies / individuals
iv. Perform all tasks necessary to decide on all such appeals within 30 days of receiving such appeal.
v. Adjudicate and issue final orders on grievances.

vi. Nominate District Grievance Officer (DGO) at each District.
vii. Direct the concerned Third-Party Administrator to appoint District Nodal Officer of each district.
viii. Ensure compliance to the Grievance Redressal Guideline of AB PM-JAY-KASP.

c) <u>State Appellate Authority (SAA)</u>

NHA brought in revision to the conventional Grievance Redressal Committee in terms of introduction of a State Appellate Authority in the State for appeal against the orders of the SGRC. The Principal Secretary to Government, Health & Family Welfare Department, Government of Kerala shall act as the SAA.

Functions of SAA

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

i. Act as an Appellate Authority for appeal against the orders of the SGRC
ii. Redressal of all grievances referred to it, following the principles of natural justice
iii. Call for additional information as required either directly from an aggrieved party or from the concerned agencies / individuals
iv. Oversee grievance redressal functions of the SGRC including but not limited to monitoring the turnaround time for grievance redressal
v. Perform all tasks necessary to decide on all appeals received within 30 days
vi. Adjudicate and issue final orders on grievances
vii. For any appeal escalated to the SAA, the SAA may at its sole discretion assign the task of investigation of the grievance to the independent agency or any official if need be
viii. The decision of SAA shall be final and binding wherein SHA and Insurance Company/ISA/TPA are the aggrieved parties

Complaints/grievances/appeals received against the orders of State Empanelment Committee as regards empanelment/de-empanelment shall be referred to State Appellate Authority for further action and disposal. These types of appeals/ representations/etc. should be filed directly to State Appellate Authority.

Also, complaints/grievances received against any of the officials of the SHA or State/UT Government shall be referred to the State Appellate Authority.

The appeals against the disputes between the SHA and the insurance company/TPA/ISA alone will be taken in the National Grievance Redressal Committee and the SAA will be final authority for all other appeals against SGRC.

d) National Grievance Redressal Committee (NGRC)

The National Grievance Redressal Committee (NGRC) shall be formed by the Chief Executive Officer, National Health Authority at the national level. The constitution of the NGRC shall be determined by the NHA in accordance with the Guidelines from time to time. Members for NGRC are:

- Deputy CEO of National Health Agency (NHA) - Chairperson
- Head Beneficiary Engagement Division (NHA) - Convener
- Representative of Finance Division (NHA)
- Representative of IRDAI/Member of General Insurance Corporation
- Other experts for specific cases as determined by the Chairperson or the Convener on behalf of the Chairperson.

Functions of the NGRC:

The NGRC shall act as the apex Authority and shall

i. Review state-wise performance of the Grievance Redressal. Review may include but not be limited to analysis of monthly reports from the SHA and field visits for monitoring, evaluation and make suggestions for improvement in the system
ii. Provide need-based mentoring and capacity building support to the SGRCs
iii. Issue specific recommendations to the states/SHAs for corrective actions and process improvement based on state-wise review of grievance redressal data
iv. Issue amendments to the national grievance redressal guidelines as and when required
v. NGRC shall ensure adequate and effective settlement of disputes only between Insurance Company / ISA / TPA and SHA, with respect to any deviation from 'Terms & Conditions' of the contract and NHA guidelines between the two parties or any act of omission or commission with respect to the contractual provision.

Grievances wherein EHCP or beneficiary are the one of the parties shall not be entertained by NGRC and decision of SAA shall be final and binding.

The meetings of the NGRC shall be convened as per the cases received by it for consideration or as per the convenience of the Chairman, NGRC.

For any appeal escalated to the NHA, the NHA may at its sole discretion assign the task of investigation of the grievance to the independent agency or relevant official if need be.

2. Grievance Officer

a) District Grievance Nodal Officer (DGNO)

DGNO is a person who is nominated by SGRC to resolve the grievances at district level under AB PM-JAY-KASP. The roles and responsibilities of DGNO are as listed below:

i. Addressing grievances of stakeholders directly or through DGRC within the timeframe defined

ii. Ratifying the actions taken against the grievances by placing in the DGRC from time to time
iii. Enter the particulars of the grievance on the CGRMS portal received directly, telephonically, through letter, email or social media and updating the status in CGRMS
iv. Initiating enquiries wherever felt necessary with the approval of District Medical Officer/District Health Officer/Civil Surgeon or any other officer nominated
v. Referring grievances to convener of DGRC
vi. Forwarding grievances to concerned DGNO/SGNO in case the grievance doesn't fall under his/her jurisdiction
vii. Submitting reports and records

b) State Grievance Nodal Officer (SGNO)

SGNO is a person who is nominated by SHA to address the grievances at state level under AB PM-JAY-KASP. The roles and responsibilities of the SGNO are as listed below:

i. Addressing grievances of stakeholders directly or through SGRC within the timeframe defined
ii. Giving priority to the grievances that are emergent nature
iii. Ratifying the actions taken against the grievances by placing them in the SGRC from time to time
iv. Forwarding the grievances which are received at state level to concerned DGNO for further actions
v. Referring grievances to convener of SGRC
vi. Forwarding grievances to concerned SGNO in case the grievance doesn't fall under his/her jurisdiction
vii. Monitoring of the grievances and ensuring grievances are resolved within the time frame at State & District Level
viii. Submitting reports and records

c) National Grievance Nodal Officer (NGNO)

NGNO is a person who is nominated by NHA to address the grievances at National level under PM-JAY The roles and responsibilities of the NGNO are as listed below

i. Forwarding the grievances received at national level to concerned SGNO for the action
ii. Referring grievances to convener of NGRC
iii. Monitoring of the grievances and ensuring grievances are resolved as per the time frame,
iv. Submitting reports and records

3. Meeting Schedule of Committees

The DGRC & SGRC meeting should be conducted every month on a specific day on regular basis. State can decide a particular date/day based on the convenience and availability of the members of the committee.
SAA meetings shall be convened within one week of receiving the grievances before SAA.

For inter-state / Union Territory (Portability) cases:

a. All grievances of beneficiaries against the hospital shall be referred to the DGNO of the State/UT where beneficiary is availing benefits of PM-JAY
b. Inter-state beneficiary cases should be solved jointly by the concerned DGRC and SGRC of two respective states/ UTs. They shall coordinate amongst themselves, if required, to redress the grievance
c. All Empaneled Health Care Provider grievances against the Insurer / SHA shall be referred to the SGRC of both parent State/UT and State/UT where the claim is raised by State/UT. The SGRCs of both the states shall coordinate amongst them, if required, to redress the grievance

4. LODGING AND REGISTRATION OF GRIEVANCES

Any grievance under AB PM-JAY can be raised through following means:

Online Mode

Through online grievance redressal portal – CGRMS of AB PM-JAY
(https://cgrms.pmjay.gov.in)

Offline Mode

- AB PM-JAY Call Centre helpline no. 14555
- SHA call centre no. 104/1056
- Through letter, telephone, e-mail, and fax to the official addresses of the SHA or the NHA
- Directly with the DGNO of the district where such stakeholder is located or where such grievance has arisen

Details of all complaints shall be entered in CGRMS portal by the concerned officer.

a. For all grievances received by the call center, call center executives shall register the details of the grievance in the CGRMS portal as per defined format. The grievance will appear in the login of concerned Grievance Nodal Officer.
b. The DGNO shall enter the particulars of the grievances which are received in the form of letter, telephonic, fax or direct walk-in cases on the CGRMS portal established by the NHA.
c. The CGRMS will automatically generate a Unique Grievance Number (UGN), categorize the nature of the grievance and an auto SMS sent to the stakeholder as per the Grievance Redressal Matrix (Annexure 1)

Special powers of the authorities: The SHA, SGRC and/ or the SAA shall have the authority to initiate Suo moto proceedings and file a grievance on behalf of itself and / or AB PM-JAY-KASP Beneficiaries under the Scheme. They can also take cognizance of reports in social media and other public forums for further investigation and redressal.

5. GRIEVANCE REDRESSAL MECHANISMS

Upon receipt of a grievance, the DGNO/SGNO shall try to resolve the same directly through his/her own efforts and coordination with concerned parties. However, if he/she is unable to resolve the grievance at his/her level, the same may be put up before the concerned Grievance redressal committee.

For ease of conduct of the Grievance Committee, the claims disputed by the EHCPs are first reviewed by the TPAs through Pre-DGRC process wherein the cases are reviewed for any genuineness as per the remarks by the EHCP. The cases which are found to be payable are cleared at this Pre-DGRC level itself before passing on the rest of the cases for the DGRCs.

Each grievance irrespective of the mode of receipt shall be first registered on the CGRMS portal with a unique grievance number for tracking till closure. Following process shall be followed:

a) Process for Redressal directly by DGNO/SGNO

While redressing the grievances,

i. The grievance officer should analyze the case and seek explanation from the stakeholder/s against whom the grievance is being lodged by sending a show cause notice

ii. The stakeholder against whom a grievance has been lodged must send its comments/ response to the aggrieved party with copy to the DGNO/SGNO within 7 days. If the grievance is not addressed within such 7 days period, the DGNO/SGNO shall send a reminder for redressal within a time specified by the DGNO/SGNO

iii. The DGNO/SGNO shall try to resolve the grievance by forwarding the same to Action Taking Authority (ATA). If the grievance is not resolved or comments are not received within 15 days of the grievance, then the matter may be referred to relevant Grievance Redressal Committee

iv. If the DGNO/SGNO is satisfied that the comments/ response received from the stakeholder satisfactorily addresses the grievance(s), then the DGNO/SGNO shall communicate this to the aggrieved party by Letter/e-mail/SMS/telephone and update on the CGRMS portal.

v. If the DGNO/SGNO is not satisfied with the comments/ response received or if no comment/ response is received from the stakeholder despite a reminder, then the DGNO/SGNO shall refer such grievance to the Convener of the relevant Grievance Redressal Committee

b) Process of Review of claims of EHCPs through Claims Review Committee

Since the District Project Coordinator, State Health Agency is the only nodal person and the District Grievance Nodal Officer, for the entire scheme activities in the District, Government have constituted a Claims review committee comprising of the following members for addressing the medical merits of the disputed claims raised in the DGRCs.

i. District Medical Officer or nominee.
ii. District Programme Manager, NHM.
iii. District Project Coordinator, State Health Agency.

The Claims Review Committee review the huge volume of disputed claims of the EHCPs and recommend the cases for approval/rejection considering the medical merit and scheme guidelines. The cases wherever physical verification is required for deciding the genuineness are handled by the CRCs. CRCs form part of the pre-DGRC and post-DGRC process wherever the decisions are to be taken based on expert opinion to assist the Grievance Redressal Committees.

c) Process of Redressal through the Relevant Grievance Committee

All the cases which are appealed against the orders of grievance officer must be placed before the concerned grievance redressal committee.

i. The Convener of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at its next meeting
ii. Each grievance shall be addressed by the relevant Grievance Redressal Committee within a period of 30 days of the receipt of the grievance. Depending on the urgency of the case, the Grievance Redressal Committee may decide to meet earlier for a speedier resolution of the grievance
iii. The relevant Grievance Redressal Committee shall arrive at a logical decision within30 days of receipt of the grievance. All such decisions shall be based on the principles of natural justice (including giving the parties a reasonable opportunity to be heard) and be taken by majority vote of its members present
iv. 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 higher Grievance Redressal Committee or other authority having powers of appeal
v. If an appeal is not filed within 30-day period, the aggrieved party shall lose its right to appeal, and the decision of the original Grievance Redressal Committee shall be final and binding
vi. A Grievance Redressal Committee or any other authority having powers of appeal shall dispose of an appeal within 30 days of receipt of the appeal. 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. COMPLIANCE WITH ORDERS OF GRIEVANCE REDRESSAL COMMITTEES

a) Parties against whom an order has been issued by any Grievance Redressal Committee, shall ensure that all orders are fully complied with and executed within not more than 30 calendar days of the issuance of the order unless such order has been stayed on appeal

b) If the party against whom such orders have been issued, fails to comply with the order within 30-day period or a time set forth in the Grievance Redressal Committee Order, the defaulting party shall be liable to pay penalty as described under the contract between the parties

c) The defaulting party shall be liable to pay the levied penalty to the SHA within 15 days of receiving a written notice from the SHA. All such payments must be made by the defaulting party in the manner as specified by the SHA in the notice issued

d) On failure to pay penalty, the defaulting party shall be liable to pay a penal interest at the rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid

e) For delays in compliance to the order beyond three months of the date of its issue, the SHA/ NHA shall have the right to seek recourse to available legal remedies all costs of which shall be borne by the defaulting party

7. Mode of Communication

The decision made by the grievance officer, or the grievance committee must be communicated to all the parties as soon as possible in writing and in addition, if possible, by e-mail. In addition, a phone call should also be made to a beneficiary informing him about the redressal of the grievance.

*System generated SMS shall be automatically sent to aggrieved party through CGRMS portal about the status of the grievance.

8. AUTO-ESCALATION OF GRIEVANCES

The grievances which are not resolved within the prescribed TAT or if no action is taken by the concerned officer, then such cases will be automatically escalated to the higher authority. E.g., if DGNO has not taken any action within 15 days, the case will be escalated to the SGNO.

9. REPORTING

a) CGRMS portal generates various reports like total grievance count, age wise pendency, closure report, SOS Grievances
b) Such reports may be utilized by grievance redressal officials in planning and decision making

10. MONITORING

a) The SHA shall be responsible for monitoring the functioning of the CGRMS within the state
b) Some of the key indicators for tracking the efficiency of GRS system shall be:

i. Resolution turn-around time ratio

Indicator	Resolution turn-around time ratio
Description	Grievances that are resolved within the prescribedtime frame
Numerator (N)	Number of grievances resolved within the prescribed time frame
Denominator (D)	Total number of grievances registered
Calculation	(N /D) *100
Frequency of measurement	Monthly
Acceptable Threshold (benchmark)	98% or more

Table 1 Turn Around Ratio

ii. Escalation ratio

Indicator	Escalation ratio
Description	Grievances that needed escalation
Numerator (N)	Number of GRC orders that were appealed against
Denominator (D)	Total number of GRC orders issued
Calculation	(N /D)*100
Frequency of measurement	Monthly
Acceptable Threshold (benchmark)	10 % or less

Table 2 Escalation Ratio

c) These indicators are illustrative and may evolve and be amended by the NHA and / or the SHA from time to time.
d) The NHA shall provide overall supervision and monitoring of the implementation of the CGRMS across all states. This may include site visits, and internal and third-party process audits.

e) Monitoring of time series grievance data may also provide insights into the overallperformance of the AB PM-JAY. Some of these indicators could be:
   - **i.** Percentage of grievances resolved through **Direct Channel**
   - **ii.** Percentage of grievances related to **out-of-pocket payments**
   - **iii.** Percentage of grievances related to **quality of services**
   - **iv.** Percentage of grievances related to **denial of services**
   - **v.** Percentage of beneficiary grievances related to **delays in receiving services**
   - **vi.** Percentage of grievances from empaneled providers related to **delays in receiving claims reimbursements**
   - **vii.** Number of grievances related to **portability benefits**
   - **viii.** Percentage of provider grievances related to **portability claims**

Analyses of these grievance related indicators over time and across states (may be even across districts) is likely to provide useful insights for course corrections and strengtheningthe implementation mechanisms under the AB PM-JAY.

GRIEVANCE REDRESSAL MATRIX

Sl. No	Aggrieved party	Grievance against	Indicative nature of grievances	Approach authority	Turn- around time	Grievance escalated to Committees (if either party is not satisfied)
1	Beneficiary	Empanelled Healthcare providers	**SOS (Emergency) Grievances (Grievances Registered during the period of hospitalization)** Denied treatment under AB PM-JAY-KASP by empanelled healthcare provider **at the time of admission** Demanding money for the services which are available for free in the scheme Not returning AB PM-JAY-KASP card at the time of discharge Prescribed medicines and diagnostics from outside, which are available for free in the scheme Non-availability of Arogya Mitra Non-Cooperation by Arogya Mitra. Misconduct by Hospital Staff	SGNO	6 working hours (if the case is not resolved within TAT, CEO of SHA will be alerted through system generated Email)	SGRC decision shall be final & binding

2	Beneficiary	Empaneled Healthcare providers	**Non-SOS (Non-Emergency) Grievances (Grievances Registered before admission or after discharge of the patient)** Denied treatment under AB PM-JAY-KASP Money sought for treatment, despite sum insured under AB PM- JAY-KASP cover being available Demanding more than Package Rate/ Pre-Authorized Amount AB PM-JAY Ayushman Card retained by Empaneled Health Care Provider Free medicines & Consultation not provided during follow-up Ayushman Card not provided despite eligibility Poor Quality of Treatment Poor facilities Charge money for printing Ayushman card. Non-availability of Arogya Mitra Non-Cooperation of Arogya Mitra Misconduct by Hospital Staff	DGNO	15 days (If no response received by stakeholder within 7 days of show cause notice, DGNO should send reminder)	DGRC (Within 30 days of the DGNO decision) If either party is not satisfied with DGRC decision, then they can appeal to SGRC within 30 days SGRC shall have 30 days to resolve the grievance. SGRC decision shall be final & binding

3	Beneficiary	Insurance company / TPA	Demanding money for approval of pre-authorization Misconduct by IC/ISA/TPA representative	DGNO / SGNO	15 days of receipt of grievance for DGNO/SGNO 30 days of receipt of grievance for DGRC	If grievance is not resolved by DGNO/SGNO within 15 days, case shall be referred to DGRC/SGRC. If either party is not satisfied with DGNO's/SGNO's decision, then they can appeal to DGRC/SGRC within 30 days of the DGNO/SGNO order DGRC/SGRC shall have 30 days to resolve the grievance. If either party is not satisfied with DGRC decision, then they can appeal to SGRC within 30 days SGRC shall have 30 days to resolve the grievance. SGRC decision shall be final and binding
4	Beneficiary	District authorities	Grievance not addressed by the concerned officer	SGNO	15 days of receipt of grievance for SGNO 30 days of receipt of grievance for SGRC	If either party is not satisfied with DGRC order, they shall approach the SGRC Decision of SGRC on such cases shall be final and binding.
5	Health Care Provider	Beneficiary	Misconduct or harassment by the beneficiary Any other	DGNO	15 days of receipt of grievance for DGNO 30 days of receipt of grievance for DGRC	If grievance is not resolved by DGNO within 15 days, case shall be referred to DGRC. If either party is not satisfied with DGNO's decision, then they can appeal to DGRC within 30 days of the DGNO order DGRC shall have 30 days to resolve the grievance. If either party is not satisfied with DGRC decision, then they can appeal to SGRC within 30 days SGRC shall have 30 days to resolve the grievance Decision of the SGRC shall be final and binding.

6	Health Care Provider	Insurance Company / ISA / TPA /SHA	Claims rejected by Insurer/SHA in full or partial claim amount not paid Demanding Money for Claim Settlement Misconduct by ISA/TPA/ SHA Representatives Non-cooperation by Insurer/ISA/ SHA Delay in claim payment	DGNO / SGNO / SAA	15 days of receipt of grievance for DGNO/SGNO /SAA 30 days of receipt of grievance for DGRC 30 days of receipt of grievance for SAA	If either party is not satisfied with DGNO's decision, then they can appeal to DGRC within 30 days of the DGNO order DGRC shall have 30 days to resolve the grievance. If either party is not satisfied with DGRC decision, then they can appeal to SGRC within 30 days SGRC shall have 30 days to resolve the grievance If either party is not satisfied with SGRC order, they shall approach the SAA within 30 days of the SGRC order. The decision of SAA shall be final and binding. (*For claims related grievance first Pre-DGRC procedure to be completed to raise grievance in CGRMS portal)*
7	Health Care Provider	Insurer / ISA / DPC	Demanding money for empanelment Not empaneled despite meeting all the criteria	SGRC	30 days of receipt of grievance	SGRC shall have 30 days to resolve the grievance If either party is not satisfied with SGRC order, they shall approach SAA within 30 days of the SGRC order. The decision of SAA shall be final and binding.
8	Health Care Provider	State Empanelment Committee	Empanelment/ Suspension/ De-empanelment	SGRC	30 days of receipt of grievance	SGRC shall have 30 days to resolve the grievance If either party is not satisfied with the SGRC order, they shall approach the SAA within 30 days of the SGRC order. Decision of the SAA shall be final and binding.
9	Insurance Company / ISA / TPA	SHA	Premium not received within time prescribed Fees for Service not paid as per the MOU AB PM-JAY-KASP Beneficiary Database not updated	SGRC	30 days of receipt of grievance	If either party is not satisfied with SGRC order, they shall approach the SAA within 30 days of the SGRC order. If either party is not satisfied with SAA order, they shall approach NGRC within 30 days of the SAA order. Decision of the NGRC shall be final and binding.