Operational Guidelines

AYUSHMAN BHARAT – PRADHAN MANTRI JAN AROGYA YOJANA (AB PM-JAY)

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Introduction and Salient Features of the AB PM-JAY

Salient features of the Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana for families belonging to poor, vulnerable and disadvantage sections of populations are as below:

1. Cashless and paperless access to services for the beneficiary at the point of service in any (both public and private) empanelled hospitals across India.
2. The benefit coverage of AB PM-JAY will be Rs. 5,00,000/- covering over 10 Crore beneficiary families (identified through SECC database).
3. No restriction on family size, ensuring all members of designated families specifically girl child and senior citizens get coverage. It is suggested that a female member of the household is preferably made the head of the family.
4. This scheme is on entitlement basis. Every family figuring in defined Socio-Economic Caste Census 2011 database will be entitled to claim benefit under the scheme. The beneficiaries will be encouraged to bring Aadhaar for the purpose of identification. However, no person will be denied benefits under the scheme in the absence of Aadhaar.
5. Implementation Arrangement –States would have the option to use an existing Trust/ Society/ Not for Profit Company [SNA] or set up a new Trust/ Society/ Not for Profit Company [State Health Protection Mission Agency] to implement the scheme. With respect to implementation, the States will be free to choose the modalities for implementation. They can implement the scheme through insurance company or directly through the Trust/ Society or mixed model.
6. A well-defined Complaint and Public Grievance Redressal Mechanism, actively utilising electronic, mobile platform, internet as well as social media, will be put in place through which complaints/ grievances will be registered, acknowledged, escalated for relevant action, resolved and monitored.
7. While ensuring user convenience, AB PM-JAY would create robust safeguards to prevent misuse/ fraud/ abuse by providers and users. Pre-Authorisation will be made mandatory for all tertiary care and selected secondary care packages.

Guidelines on Constitution of State Health Agency (SHA)

In order to facilitate the effective implementation of the scheme, the State Government shall set up the State Health Agency (SHA) or designate this function under any existing agency/ trust/ society designated for this purpose, such as the state nodal agency for RSBY or a trust/ society set up for a state insurance program. SHA can either implement the scheme directly (Trust/ Society mode) or it can use an insurance company to implement the scheme. The SHA shall be responsible for delivery of the services under AB PM-JAY at the State level.

Similar to the National Health Authority (NHA) at the central level, the day-to-day operations of the SHA will be administered by a Chief Executive Officer (CEO) appointed by the State Government. The CEO will look after all the operational aspects of the implementation of the scheme in the State and shall be supported by a team of specialists (dealing with specific functions). The CEO/ operations team will be counselled and overseen by a governing council set up at the State level.

1. Roles and Responsibilities of SHA

All key functions relating to delivery of services under AB PM-JAY shall be performed by the SHA viz. data sharing, verification/validation of families and members, awareness generation, monitoring etc. The SHA shall perform following activities through staff of SHA/Implementation Support Agency (ISA):

- Policy related issues of State Health Protection/ Insurance scheme and its linkage to AB PM-JAY
- Convergence of State scheme with AB PM-JAY
- Selection of Insurance Company through tendering process (if implementing AB PM-JAY through Insurance Companies)
- Selection of Implementation Support Agencies (in Trust/ society mode) if needed
- Awareness generation and Demand creation
- Aadhaar seeding and issuing print out of E-card to validated AB PM-JAY beneficiaries
- Empanelment of network hospitals which meet the criteria
- Monitoring of services provided by health care providers
- Fraud and abuse Control
- Punitive actions against the providers
- Monitoring of pre-authorizations which are already approved by Insurer/ ISA
- Administration of hospital claims which are already approved by Insurer/ ISA
- Package price revisions or adaptation of AB PM-JAY list

- Adapting AB PM-JAY treatment protocols for listed therapies to state needs, as needed
- Adapting operational guidelines in consultation with NHA, where necessary
- Forming grievance redressal committees and overseeing the grievance redressal function
- Capacity development planning and undertaking capacity development initiatives
- Development of proposals for policy changes –e.g. incentive systems for public providers and implementation thereof
- Management of funds through the Escrow account set up for purposes of premium release to Insurance Company under AB PM-JAY
- Data management
- Evaluation through independent agencies
- Convergence of AB PM-JAY with State funded health insurance/ protection scheme (s)
- Alliance of State scheme with AB PM-JAY
- Setting up district level offices and hiring of staff for district
- Oversee district level offices
- Preparation of periodic reports based on scheme data and implementation status
- Implementing incentive systems for ASHA workers & public providers in line with national guidance

2. Constitution of SHA/Governing Council

The suggested composition of SHA is as follows:

S. No.	Name / Designation	Position
1	Chief Secretary	Chairperson, ex officio
2	Principal Secretary to Government, Health & Family Welfare Department	Vice-Chairperson, ex officio
3	Secretary, Finance Department	Member, ex officio
4	Secretary, Department of Rural Development	Member, ex officio
5	Secretary, Department of Housing and Urban Affairs	Member, ex officio
6	Secretary, Department of IT	Member, ex officio
7	Secretary, Department of Labour	Member, ex officio
8	MD, NHM or Commissioner, Health Department	Member, ex officio
9	Director of Medical Education or his/her nominee	Member, ex officio
10	Director of Health Services or his/her nominee	Member, ex officio
11	CEO (SHA)	Member Secretary, ex officio
12	Representative of NHA	Special Invitee
13	1 Subject matter expert as nominated by the State Government	Special Invitee

3. Operational Core Team of SHA

The Chief Executive Officer (CEO) will look after all the operational aspects of the implementation of the scheme and shall be supported by a team of specialists (dealing with specific functions). The SHA should hire the following team to support the Chief Executive Officer in discharge of different functions:

Position	Responsibility	No. in Category A State	No. in Category B State
Operations Manager (s)	• Pre-authorization process • Claims management • Finalization of Packages & Pricing	2	3
Monitoring & Evaluation Manager	• Monitoring & evaluation of functioning of key vendors including any insurers, ISA, hospitals, Field personnel, monitoring achievement of goals of the scheme	2	4
Policy	• Designing policy for State Schemes and convergence thereof with AB PM-JAY	1	2
IT Support cum Data Manager	• Data availability, integrity and security • MIS coordination • Management of IT hardware & software	2	3
Beneficiary verification	• Co-ordination for smooth beneficiary verification process • Manage issues related to beneficiary verification	1	2
Grievance Redressal Manager	• Oversee Grievance redressal mechanisms • Undertake beneficiary communications. • Local grievance redressal	1	2
Medical Management & Quality Manager	• Designing standard packages and hospitals empanelment criterion for additionalities like State schemes such that they are complimentary to AB PM-JAY • Empanelment of Hospital • Quality & Patient safety	2	4

	• Punitive action against hospitals		
IEC Manager	• Strategic communication planning and execution	1	2
Capacity Development Manager	• Training & capacity building planning and organization	1	2
Finance Manager	• Fund management • Managing initial corpus & funding of trust • Managing finance & admin processes • Claim settlement • Payments • Budgeting & accounting • Internal and external audit	2	3
Accounts Assistant	• Assisting Accounts manager in finance & admin processes	1	1
Administrative Officer	• General administration of the programme	1	1

**States have been categorized based on AB PM-JAY target population size as below, in two groups, where group B may need more than one official for the same role.*

Category A States/ UTs	Arunachal Pradesh, Goa, Himachal Pradesh, Jammu and Kashmir, Manipur, Meghalaya, Mizoram, Nagaland, NCT Delhi, Sikkim, Tripura, Uttarakhand and 6 Union Territories (Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Puducherry)
Category B States	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal

4. Structure at District Level

In addition to the state level posts, a District Implementation Unit (DIU) will also be required to support the implementation in every district included under the scheme. This team will be in addition to the team deployed by Insurance Company/ ISA. A DIU shall be created which would be chaired by the Deputy Commissioner/ District Magistrate/ Collector/ of the district. This Unit is to coordinate with the Implementing Agency (ISA/ Insurer) and the Network Hospitals to ensure effective implementation and also send review reports periodically. DIU will also work closely and coordinate with District Chief Medical officer and his/ her team.

Proposed staffing pattern of the DIU as follows:

Post	Qualification	Status	Number
District Nodal Officer (AB PM-JAY)	Program Officer designated by the State. Regular state official and responsible for the AB PM-JAY implementation in the district.	Regular state official, may be part-time role	1 per district
District Program Coordinator	Staff hired with experience in medical management/ health insurance industry overseeing grievance redressal, Aadhaar seeding, validation of beneficiaries, awareness, monitoring, spot checks, and capacity building.	Contractual, full time	1 per district
District Information Systems Manager	Staff hired with experience in IT hardware and hospital software functionality helping hospitals and implementing agencies (insurer/ISA) with use of the information system, troubleshooting, report-generation and ensuring uptime of system functionality across the National Health Network.	Contractual, full time	1 per district
District Grievance Manager	Staff hired with experience in grievance management for managing complaint and grievances at the district level. Also responsible for organizing meetings of District Grievance Committees	Contractual, full time	1 per district

Guidelines on Process of Beneficiary Identification

1. Brief Process Flow

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

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

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

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

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

i. AB PM-JAY Additional Data Collection drive at Gram Sabha's across India took place on 30th April. MoHFW in collaboration with Ministry of Rural Development (MoRD) will drive collection of Ration Card, Mobile Number for each AB PM-JAY household. Similar exercise was carried out for urban beneficiaries in May 2018

ii. Government of India will send a personalised letter via mass mail to each targeted family through postal department in states launching AB PM-JAY. This letter will include details about the scheme, toll free helpline number and family details and their ID under AB PM-JAY
iii. States which are primarily covering AB PM-JAY beneficiaries are encouraged to create multiple service locations where beneficiaries can check if they are covered. These include
   - Contact points or kiosks set up at CSCs, PHCs, Gram Panchayat, etc.
   - Empaneled Hospital
   - Self-check via mobile or web
   - Or any other contact point as deemed fit by States

D Beneficiary identification will include the following broad steps:

i. The operator searches through the AB PM-JAY list to determine if the person is covered.
ii. Search can be performed by Name and Location, Ration Card No or Mobile number (collected during data drive) or ID printed on the letter sent to family or RSBY URN
iii. If the beneficiary's name is found in the AB PM-JAY list, Aadhaar (or an alternative government ID) and Ration Card (or an alternative family ID) is collected against the Name / Family.
iv. The system determines a confidence score (threshold score defined by the system but not visible to operator/Pradhan Mantri Arogya Mitra) for the link based on how close the name / location / family members between the AB PM-JAY record and documents is provided.
v. The operator sends the linked record for approval to the Insurance Company / Trust. The patient will be advised to wait for approval from the insurance company/ trust
vi. The insurance company / Trust will setup a Beneficiary approval team that works on fixed service level agreements on turnaround time. The AB PM-JAY details and the information from the ID is presented to the verifier. The insurance company / Trust can either approve or recommend a case for rejection with reason.
vii. All cases recommended for rejection will be scrutinised by a State team that works on fixed service level agreements on turnaround time. The state team will either accept rejection or approve with reason.
viii. The e-card will be printed with the unique ID under AB PM-JAY and handed over to the beneficiary to serve as a proof for verification for future reference.
   - The beneficiary will also be provided with a booklet/ pamphlet with details about AB PM-JAY and process for availing services.
   - Presentation of this e-card (appendix 2: draft sample design) will not be mandatory for availing services. However, the e-card may serve as a tool for reinforcement of entitlement to the beneficiary and faster registration process at the hospital when needed.

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

i. Name of the new member is in the family ration card or State defined family card of the identified family member
ii. A marriage certificate to identified family member is available
iii. A birth certificate to identified family member is available.

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

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

The main steps for the above exercise are as follows:

A Preparatory Activities for State/ UT's:

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

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

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

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

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

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

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

B Preparation of AB PM-JAY target data

Responsibility of – MoHFW
Timeline – Preparation of SECC data by 15th March

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

For Rural

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

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

Automatically included-

Households without shelter

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

For Urban

Occupational Categories of Workers

- Rag picker
- Beggar
- Domestic worker
- Street vendor/ Cobbler/hawker / Other service provider working on streets

- Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and another head-load worker
- Sweeper/ Sanitation worker / Mali
- Home-based worker/ Artisan/ Handicrafts worker / Tailor
- Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller
- Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery assistant / Attendant/ Waiter
- Electrician/ Mechanic/ Assembler/ Repair worker
- Washer-man/ Chowkidar

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

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

Example:

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

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

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

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

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

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

C Informing Beneficiaries on what to bring for Identification

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

- Aadhaar
- Any other valid government id(s) decided by the State if they do not have an Aadhaar
- Ration Card or any other family id decided by the State.

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

D Beneficiary identification Contact Points – Infrastructure and Locations

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

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

Only Hardware and software as prescribed by MoHFW/NHA shall only be used. Detailed specifications will be provided in a separate document. Beneficiary identification will be available as a web and mobile application. Availability as a mobile app will make it easy to be deployed at larger number of contact points. The DNO shall be responsible for choosing the locations for contact centres within each village/ward area that is easily accessible to a maximum number of beneficiary families including the following:

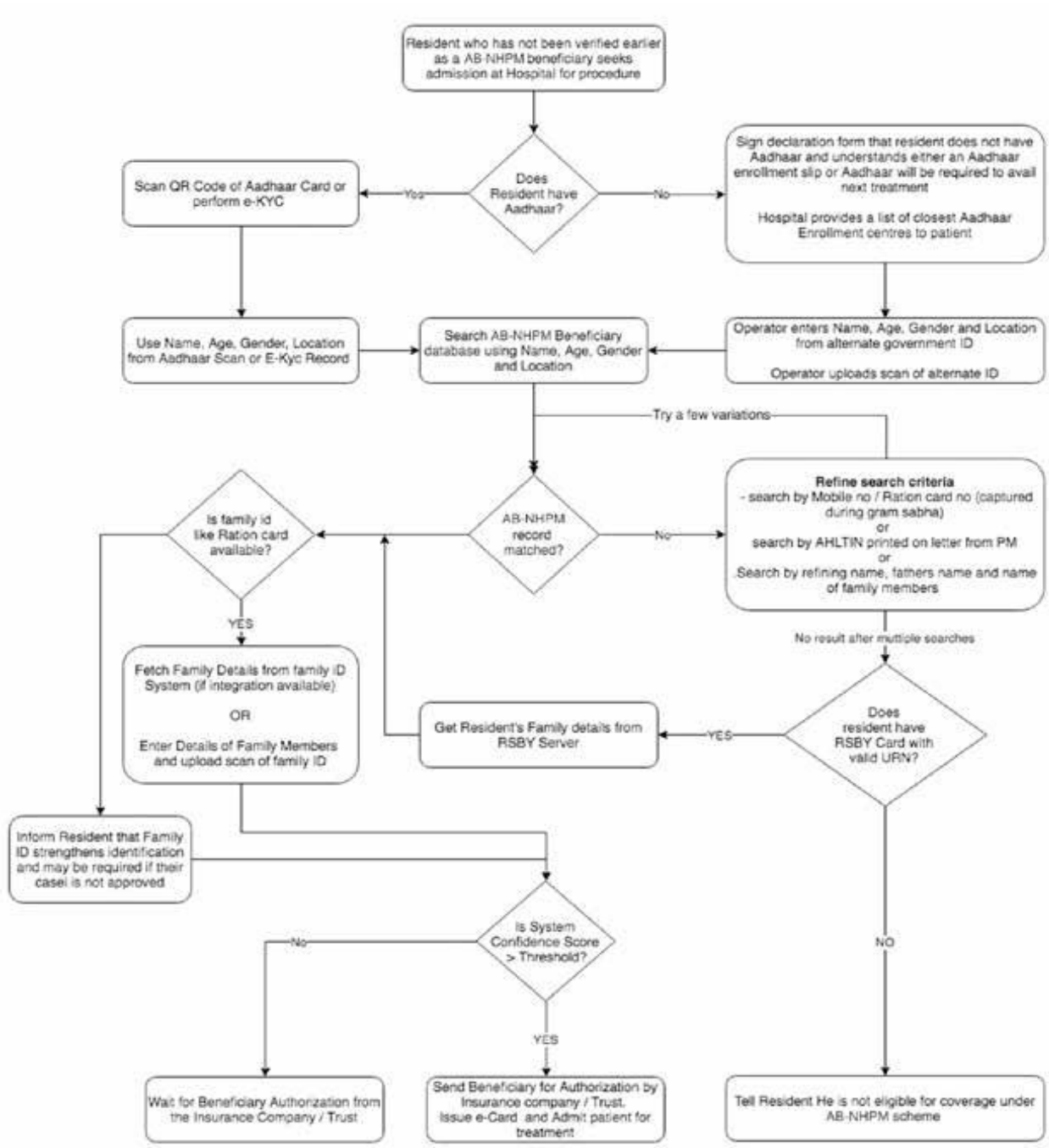
- CSC
- PHCs
- Gram Panchayat Office
- Empanelled Hospital

- Or any other contact point as deemed fit by States/UTs

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

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

3. Process Flow Chart for Beneficiary Identification



4. Identity Document for a Family Member

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

If the AB PM-JAY family member does not have an Aadhaar card and the contact point is a location where no treatment is provided, the operator will inform the beneficiary that he is eligible and can get treatment only once without an Aadhaar or an Aadhaar enrolment slip. They may be requested to apply for an Aadhaar as quickly as possible. A list of the closest Aadhaar enrolment centres is provided to the beneficiary

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

A A signed declaration is taken from the Beneficiary that he does not possess an Aadhaar card and understands he will need to produce an Aadhaar or an Aadhaar enrolment slip prior to the next treatment

B The beneficiary must produce an ID document from the list of approved ids by the State

C The operator captures the type of ID and the fields as printed on the ID including the Name, Father's Name (if available), Age, Gender and Address fields.

D A scan of the ID produced is uploaded into the system for verification.

E A photo of the beneficiary is taken

F The information from this alternate ID is used instead of Aadhaar for matching against the AB PM-JAY record.

5. Searching the AB PM-JAY Database

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

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

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

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

A Search by Ration Card and Mobile No (Information captured during the Additional Data Collection Drive)

B Search using the ID printed on the letter sent by post to Beneficiaries (AHL_HH_ID)

C Reduce some of the parameters like Age, Gender, Sub district, etc and trial with variation in the spelling of the Name if there are no matching results

D Try adding the name of the father or family members if there are too many results.

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

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

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

7. Linking Family Identification document with the AB PM-JAY Family

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

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

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

Linking the family identification document will be mandatory ONLY if the same document (Ration Card) is also the ID used by the state to cover a larger base. Operators are encouraged to upload the family document if the name match confidence score is low, but they believe the 2 records are the same

Integration with an online family card database is recommended. In this scenario, the operator will enter the Family ID No (Ration Card No) and will be able to fetch the names of the family members from the online database.

If an integration is not possible, the operator will enter the names of the family members as written in the ID card and upload a scan of the ID card for verification.

8. Approval by Insurance Company/Trust

The State can appoint either the Insurance company or Trust to perform the verification of the data of identified beneficiaries. The team needs to work with a strong Service Level Agreements (SLA) on turnaround time. Approvals are expected to be provided within 30 minutes back to the operator on a 24x7 basis.

The Approver is presented the Beneficiary Identity Document and the AB PM-JAY (or RSBY) record side by side for validation along with the confidence score. The lowest confidence score records are presented first.

If the operator has uploaded the Family Identity document, it is also displayed along with the Confidence Score.

The Approver has only 2 choices for each case – *Approve* or *Recommend for Rejection* with Reason

The System maintains a track of which Operator is Approving / Recommending for rejection. The Insurance Company/Trust can analyze the approval or rejection pattern of each of the operators.

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

The State should setup a team that reviews all the cases recommended for Rejection. The team reviews the data provided and the reason it has been recommended for rejection. If the State agrees with the Insurer, it can reject the case.

If the State disagrees with the Insurer, it can approve the case. The person in the state making the decision is also tracked in the system. The State review role is also SLA based and a turnaround is expected in 24 hours on working hour basis.

B Addition of Family Members

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

To add the additional member the family must produce:

- The name of the additional member in a State approved family document like Ration Card OR

- A birth certificate linking the member to the family OR
- A marriage certificate linking the member to the family.

In order to add a family member, at least one of the existing family members needs to be verified and the identity document used for the verification must be Aadhaar.

C Monitoring of Beneficiary identification and e-card printing process

Responsibility of – State Government/ SHA
Timeline – Continuous

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

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

Guidelines on Process for Empanelment of Hospitals

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/UTs as per these guidelines.

The states are free to decide the mode of verification of empanelment application, conducting the physical verification either through District Empanelment Committee (DEC) or using the selected Insurance Company (Insurance Model), under the broad mandate of the instructions provided in these guidelines.

2. Institutional Set-Up for Empanelment

A. State Empanelment Committee (SEC) will constitute of following members:

i. CEO, State Health Agency – Chairperson;
ii. Medical Officer not less than the level Director, preferably Director In Charge for Implementation of Clinical Establishment Regulation Act – Member;
iii. Two State government officials nominated by the Department – Members;
iv. In case of Insurance Model, Insurance Company to nominate a representative not below Additional General Manager or equivalent;

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

Alternatively, the State/SHA may continue with any existing institution under the respective state schemes that may be vested with the powers and responsibilities of SEC as per these guidelines.

The SHAs through State Empanelment Committee (SEC) shall ensure:

- Ensuring empanelment within the stipulated timeline for quick implementation of the programme;
- The empanelled provider meets the minimum criteria as defined by the guidelines for general or specialty care facilities;
- Empanelment and de-empanelment process transparency;
- Time-bound processing of all applications; and

- Time-bound escalation of appeals.

It is prescribed that at the district level, a similar committee, District Empanelment Committee (DEC) will be formed which will be responsible for hospital empanelment related activities at the district level and to assist the SEC in empanelment and disciplinary proceedings with regards to network providers in their districts.

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

i. Chief Medical Officer of the district
ii. District Program Manager – State Health Agency
iii. In case of Insurance Model, Insurance Company representative

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

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

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

The DEC will be responsible for:

i. Getting the field verification done along with the submission of the verification reports to the SEC through the online empanelment portal.
ii. 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.
iii. Final approval of relaxation will lie with SEC
   - The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return to the hospital the empanelment request.

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 PM-JAY. For such states where AB PM-JAY 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 PM-JAY. 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 PM-JAY.

iv Employee State Insurance Corporation (ESIC) hospitals will also be eligible for empanelment in AB PM-JAY, 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 empanelled 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 PM-JAY for providing general care have to meet the minimum criteria established under the Mission detailed in	Hospitals would need to be empanelled separately for certain tertiary care packages authorized for one or more specialties (like Cardiology, Oncology, Neurosurgery etc.). This

Annex 1. No exceptions will be made for any hospital at any cost.	would only be applicable for those hospitals who meet the general criteria for the AB PM-JAY.

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 Authority. The same will have to be incorporated in the web-portal for online empanelment of hospitals.

Hospitals will undergo a renewal process for empanelment once every **3 years or till the expiry of validity of NABH/ NQAS certification whichever is earlier** to determine compliance to minimum standards.

National Health Authority may revise the empanelment criteria at any point during the programme, if required and the states will have to undertake any required re-assessments for the same.

4. Awareness Generation and Facilitation

The state government shall ensure that maximum number of eligible hospitals participate in the AB PM-JAY, 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 PM-JAY. The SHA shall organize a district workshop to discuss the details of the Mission (including empanelment criteria, packages and processes) with the hospitals and address any query that they may have about the mission.

Representatives of both public and private hospitals (both managerial and operational persons) including officials from Insurance Company will be invited to participate in this workshop.

5. Online Empanelment

A. A web-based platform is being provided for empanelment of hospitals for AB PM-JAY.
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 PM-JAY.
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.abnhpm.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.abnhpm.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)

6. Role of DEC

A. After the empanelment request by a hospital is filed, the application should be scrutinized by the DEC and processed completely within 15 days of receipt of application.

B. A login account for a nodal officer from DEC will be created by SEC. This login ID will be used to download the application of hospitals and upload the inspection report.

C. As a first step, the documents uploaded have to be correlated with physical -verification of original documents produced by the hospital. In case any documents are found wanting, the DEC may return the application to the hospital for rectifying any errors in the documents.

D. After the verification of documents, the DEC will physically inspect the premises of the hospital and verify the physical presence of the details entered in the empanelment application, including but not limited to equipment, human resources, service standards and quality and submit a report in a said format through the portal along with supporting pictures/videos/document scans.

E. DEC will ensure the visits are conducted for the physical verification of the hospital. The verification team will have at least one qualified medical doctor (minimum MBBS).

F. The team will verify the information provided by the hospitals on the web-portal and will also verify that hospitals have applied for empanelment for all specialties as available in the hospital.

G. In case during inspection, it is found that hospital has not applied for one or more specialties but the same facilities are available, then the hospital will be instructed to apply for the missing specialties within a stipulated a timeline (i.e. 7 days from the inspection date).

   i In this case, the hospital will need to fill the application form again on the web portal. However, all the previously filled information by the hospital will be pre-populated and hospital will be expected to enter the new information.

   ii If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.

H. In case during inspection, it is found that hospital has applied for multiple specialties, but all do not conform to minimum requirements under AB PM-JAY then the hospital will only be empanelled for specialties that conform to AB PM-JAY 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.

7. Role of SEC

A. The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return back to the hospital the empanelment request.

B. In case of refusal, the SEC will record in writing the reasons for refusal and either direct the hospital to remedy the deficiencies, or in case of egregious emissions from the empanelment request, either based on documentary or physical verification, direct the hospital to submit a fresh request for empanelment on the online portal.

C. The SEC will also consider recommendations for relaxation of criteria of empanelment received from DEC or from the SHA and approve them to ensure that sufficient number and specialties of empanelled facilities are available in the states.

D. Hospital will be intimated as soon as a decision is taken regarding its empanelment and the same will be updated on the AB PM-JAY 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 PM-JAY.

E. If the application is rejected, the hospital will be intimated of the reasons on the basis of which the application was not accepted and comments supporting the decision will be provided on the AB PM-JAY 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 PM-JAY, it will only be permitted to re-enter/ get re-empanelled under AB PM-JAY after a period of 6 months.

G. If a hospital is blacklisted for a defined period due to fraud, 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 PM-JAY in a district.

I. Final decision on request of a Hospital for empanelment under AB PM-JAY, shall be completed within 30 days of receiving such an application.

8. Fast Track Approvals

A. In order to fast track the empanelment process, hospitals which are NABH/ NQAS accredited shall be auto-empanelled 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 PM-JAY.

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 PM-JAY 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.

9. Signing of Contract

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

B. If Insurance Company is involved in implementing the scheme in the State, they will also be part of this agreement, i.e. tripartite agreement will be made between the IC, SHA and the hospital.

C. Each empanelled hospital will need to provide a name of a nodal officers who will be the focal point for the AB PM-JAY 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.

10. Process for Disciplinary Proceedings and De-Empanelment

A. Institutional Mechanism

i De-empanelment process can be initiated by Insurance Company/SHA after conducting proper disciplinary proceedings against empanelled hospitals on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries.

ii Hospital can contest the action of de-empanelment by Insurance Company with SEC/SHA. If hospital is aggrieved with actions of SEC/SHA, the former can approach the SHA to review its

decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.

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 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 If during investigation, it is observed that treating doctor has also connived to commit the fraud with ECHP/beneficiary/insurance company / any other party, a show cause Notice shall be issued by the EHCP to such doctor(s) employed by it for unethical practices under relevant provisions of the Medical Council of India / State Council / Clinical Establishment Act / other laws of land. Similar notice shall be issued by the EHCP to all parties e.g. medical device company, pathology/diagnostic lab, pharma

supplier etc. which are complicit to the fraud(s). The EHCP shall submit to the SEC and the Insurer a copy of such Notice(s) served by it to relevant parties.

iii 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.

iv 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 PM-JAY.

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.

vi The Insurer and the SHA shall ensure that such EHCP shall not be able to initiate any new transaction on the Scheme's transaction software. However, patients already admitted would not be denied treatment and such transactions shall be allowed to be completed and all processes carried out till the discharge of such patients as in a normal course.

vii The name of de-empanelled provider shall be prominently displayed on the website of the Insurer and the SHA along with reason(s) for de-empanelment and state-wise consolidated list of all de-empanelled hospitals shall be displayed on the website of the NHA along with reason(s) for de-empanelment.

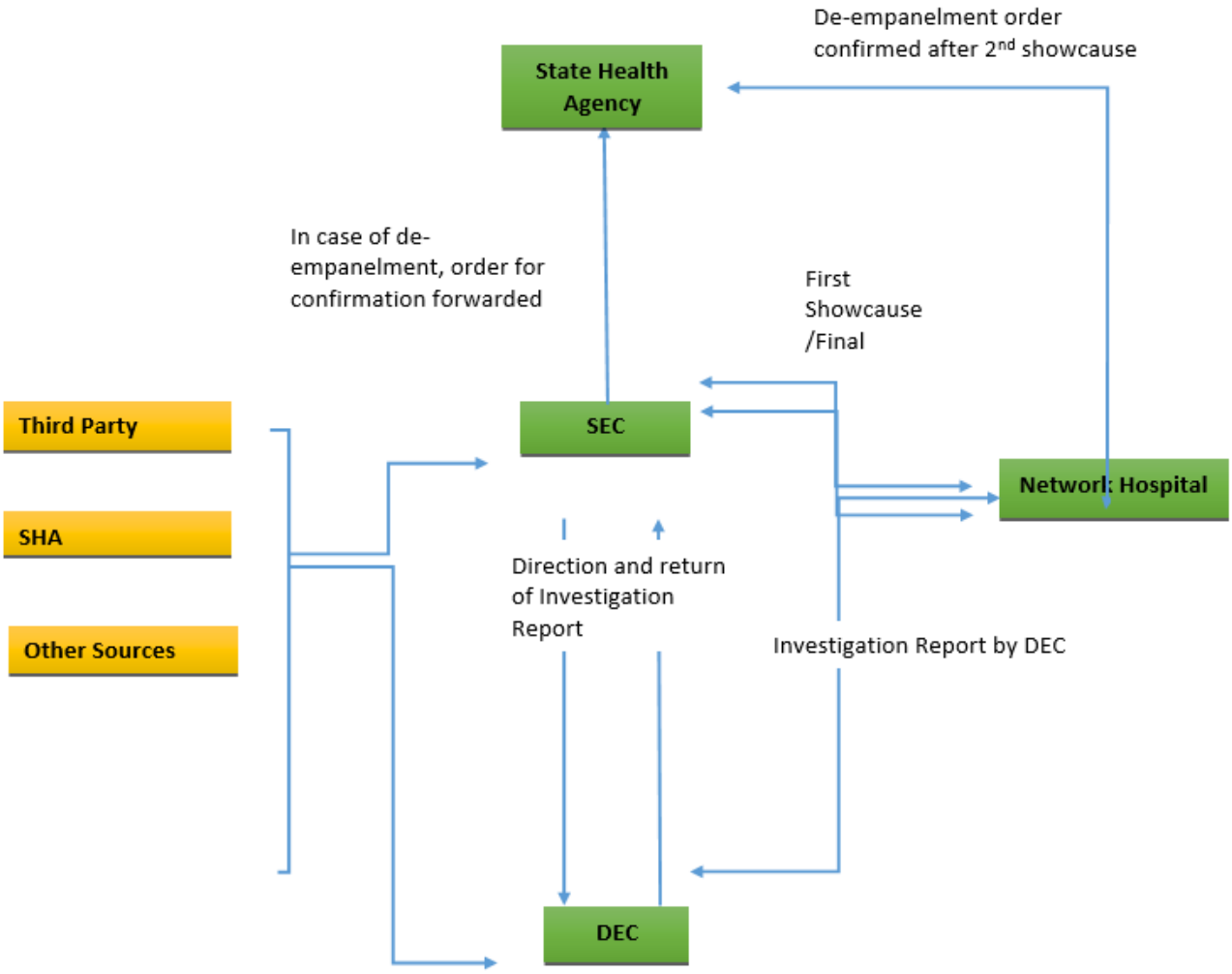
C. Gradation of Offences

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 and compensation 3 times of illegal payment to the beneficiary	In addition to actions as mentioned for first offence, Rejection of claim for the case	De-empanelment/ black-listing
Billing for services not provided	Rejection of claim and penalty of 3 times the amount claimed for services not provided, to Insurance Company /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for services not provided, to Insurance Company /State Health Agency	De-empanelment
Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of 8 times the excess amount claimed due to up coding /unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency. For unnecessary procedure:	Rejection of claim and penalty of 16 times the excess amount claimed due to up coding/unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency	De-empanelment
Wrongful beneficiary Identification	Rejection of claim and penalty of 3 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	De-empanelment
Non-adherence to AB PM-JAY	In case of minor gaps, warning period of 2 weeks for rectification, for	Suspension until rectification of gaps and validation by SEC/ DEC	De-empanelment

quality and service standard	major gaps, Suspension of services until rectification of gaps and validation by SEC/ DEC		

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



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 Authority1 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 (doctors2 & nurses3), physically in charge round the clock; (necessary certificates to be produced during empanelment).

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

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

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

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[1] In order to facilitate the effective implementation of AB PM-JAY, State Governments shall set up the State Health Authority (SHA) or designate this function under any existing agency/ trust designated for this purpose, such as the state nodal agency or a trust set up for the state insurance program.
[2] Qualified doctor is a MBBS approved as per the Clinical Establishment Act/ State government rules & regulations as applicable from time to time.
[3] Qualified nurse per unit per shift shall be available as per requirement laid down by the Nursing Council/ Clinical Establishment Act/ State government rules & regulations as applicable from time to time. Norms vis a vis bed ratio may be spelt out.

6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
   i. Casualty should be equipped with Monitors, Defibrillator, Nebulizer with accessories, Crash Cart, Resuscitation equipment, Oxygen cylinders with flow meter/ tubing/catheter/face mask/nasal prongs, suction apparatus etc. and with attached toilet facility.

7. Mandatory for hospitals wherever surgical procedures are offered:
   i. Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
   ii. Post-op ward with ventilator and other required facilities.

8. Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU/Neonatal ICU) with requisite staff
   i. The unit is to be situated in close proximity of operation theatre, acute care medical, surgical ward units, labour room and maternity room as appropriate.
   ii. Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
   iii. Further ICU- where such packages are mandated should have the following equipment:
      - Piped gases
      - Multi-sign Monitoring equipment
      - Infusion of ionotropic support
      - Equipment for maintenance of body temperature
      - Weighing scale
      - Manpower for 24x7 monitoring
      - Emergency cash cart
      - Defibrillator.
      - Equipment for ventilation.
      - In case there is common Paediatric ICU then Paediatric equipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.
   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 PM-JAY 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 PM-JAY beneficiary management (AB PM-JAY non-medical[4] coordinator) at the hospital reception.

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

21. Ensure appropriate promotion of AB PM-JAY in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the SHA/ district level AB PM-JAY team.
22. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the NHA.

[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).
[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.

Category 2: Advanced Criteria

Over and above the essential criteria required to provide basic services under AB PM-JAY (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, Pediatric 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.

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 Pediatrician(s) round the clock
6. Arrangement for 24x7 stay of the Mother – to enable her to provide supervised care, breastfeeding and KMC to the baby in the nursery/NICU and upon transfer therefrom; provision of bedside KMC chairs.
7. Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

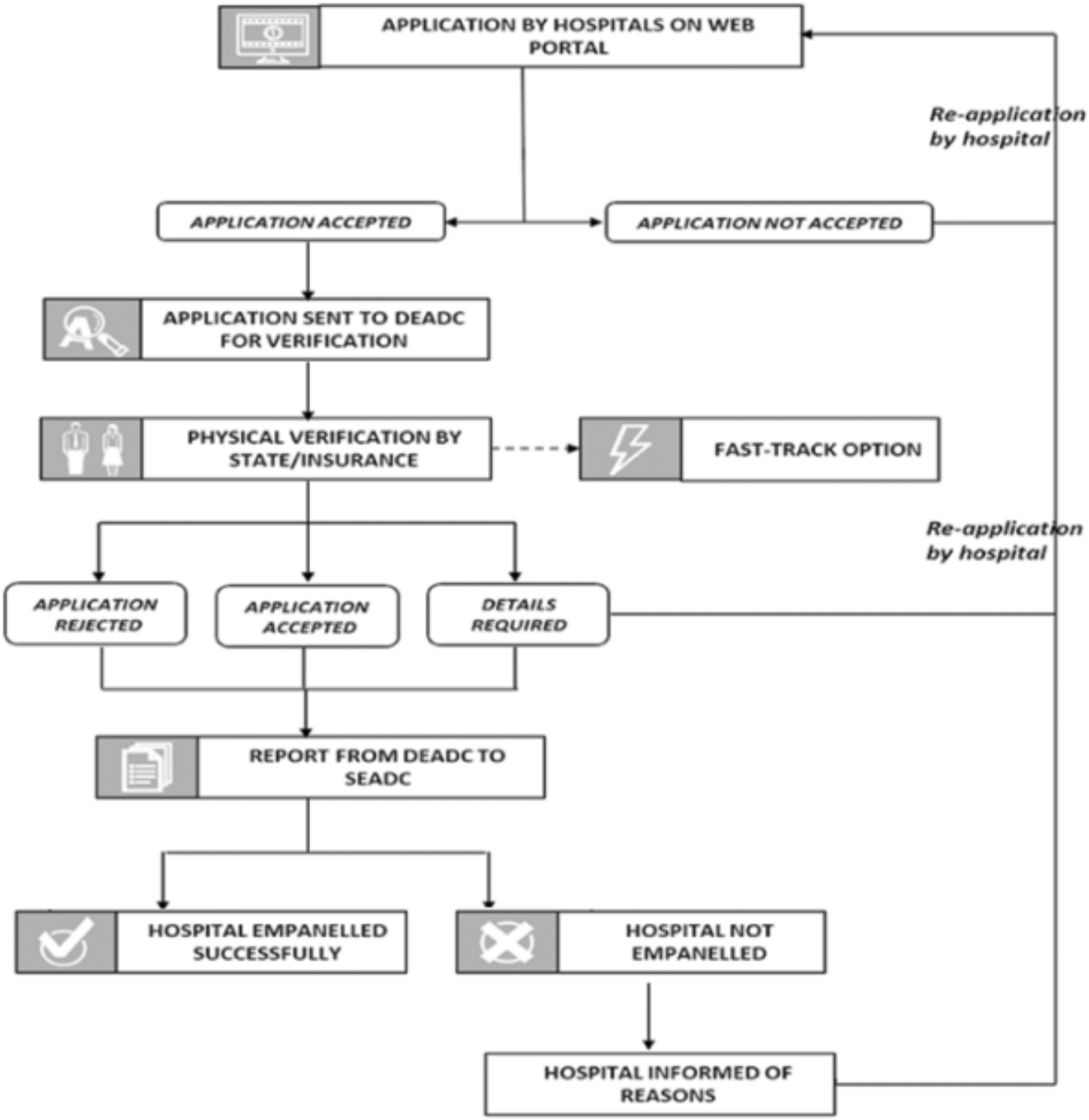
G. Specific criteria for Polytrauma

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

H. Specific criteria for Nephrology and Urology Surgery

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

Annex 2: Process Flow for the Empanelment



Guidelines on Process for Hospital Transaction

AB PM-JAY would be cashless & paperless at any of the empanelled hospitals. The beneficiaries shall not be required to pay any charge for the hospitalization expenses. The benefit also includes pre- and post-hospitalisation expenses. The scheme is an entitlement based and entitlement of the beneficiary is decided on the basis of family being figured in SECC database.

The core principle for finalising the Balance Check and providing treatment at empanelled hospital guidelines for AB PM-JAY is to construct a broad framework as guiding posts for simplifying the service delivery under the ambit of the policy and the technology.

1. Decision on IT Platform to be Used for AB PM-JAY

Responsibility of – State Government

IT platform for identification of beneficiaries and transactions at the Empanelled Health Care Provider (EHCP) will be provided by MoHFW/NHA.

For ease of convergence and on boarding, States which have their own IT systems under their own health insurance/ assurance scheme may be allowed to continue to use their own IT platform. However, these States will need to map their scheme ID with AB PM-JAY ID (AHL TIN) at the point of care and will need to share real time defined transaction data through API with the Central server with respect to AB PM-JAY beneficiaries. States will need to also ensure that no family eligible as per SECC criteria of AB PM-JAY is denied services under the scheme and will need to provide undertaking that eligibility under their schemes covers AB PM-JAY targeted families as per SECC.

2. Preparatory Activities for State/ UT's:

Responsibility of – State Government

Timeline – within a period of 30 days, after approval of empanelment of health care provider

The State will need to:

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

B Ensure that a Medical Officer as Nodal Officer at EHCP for AB PM-JAY has been nominated.
C Ensure appointment of Pradhan Mantri Arogya Mitra for the EHCP
D Ensure that a dedicated helpdesk for AB PM-JAY at a prominent place at the EHCP
E Availability of printed booklets, in abundant quantities at the helpdesk, which will be given to beneficiaries along with the AB PM-JAY e-cards, if beneficiary has not been issued the AB PM-JAY e-card earlier.
F State/ State Health Agency (SHA) shall identify and set-up team(s) which shall have the capacities to handle hardware and basic software support, troubleshooting etc.
G Training of EHCP staff and Pradhan Mantri Arogya Mitras by the SHA/ Insurer.

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

3. Process for Beneficiary Identification, Issuance of AB PM-JAY e-card and Transaction for Service Delivery

Responsibility of – EHCP through Pradhan Mantri Arogya Mitra or another authorised person

Timeline – Ongoing

A Beneficiary Verification & Authentication

i. Member may bring the following to the AB PM-JAY helpdesk:
- Letter from MoHFW/NHA
- RSBY Card
- Any other defined document as prescribed by the State Government

ii. Pradhan Mantri Arogya Mitra/Operator will check if AB PM-JAY e-Card/ AB PM-JAY ID/ Aadhaar Number is available with the beneficiary

iii. In case Internet connectivity is available at hospital:
- Operator/Pradhan Mantri Arogya Mitra identifies the beneficiary's eligibility and verification status from AB PM-JAY Central Server
- If beneficiary is eligible and verified under AB PM-JAY, server will show the details of the members of the family with photo of each verified member
- If found OK then beneficiary can be registered for getting the cashless treatment.
- If patient is eligible but not verified then patient will be asked to produce Aadhaar Card/Number/ Ration Card for verification (in absence of Aadhaar)
- Beneficiary mobile number will be captured.
- If Aadhaar Card/Number is available and authenticated online then patient will be verified under scheme (as per the parameters defined in the software) and will be issued a AB PM-JAY e-Card for getting the cashless treatment.

- Beneficiary gender and year of birth will be captured with Aadhaar eKYC or Ration Card
- If Aadhaar Card/Number is not available then beneficiary will advised to get the Aadhaar Card/number within stipulated time.

iv. In case Internet connectivity is not available at hospital:
- AB PM-JAY Registration Desk at Hospital will call Central Helpline and using IVRS enters AB PM-JAY ID or Aadhaar number of the patient. IVRS will speak out the details of all beneficiaries in the family and hospital will choose the beneficiary who has come for treatment. It will also inform the verification status of the beneficiary
- If eligible and verified, then beneficiary will be registered for getting treatment by sending an OTP on the mobile number of the beneficiary
- In case beneficiary is eligible but not verified then she/he can be verified using Aadhaar OTP authentication and can get registered for getting cashless treatment

v. In case of emergency or in case person does not show AB PM-JAY e-Card/ID or Aadhaar Card/Number and claims to be AB PM-JAY beneficiary and show some photo ID proof issued by Government, then beneficiary may get the treatment after getting TPIN (Telephonic Patient Identification Number) from the call centre and same will be recorded. Government Photo ID proof need not be insisted in case of emergency. In all such cases, relevant AB PM-JAY beneficiary proof will be supplied within specified time before discharge otherwise beneficiary will pay for the treatment to the Hospital.

vi. If eligibility, verification and authentication are successful, beneficiary should be allowed for treatment

These details captured will be available at SHA/ Insurance Company/ Trust level for their approval. Once approved, the beneficiary will be considered as successfully identified and verified under AB PM-JAY.

4. Package Selection

A The operator will check for the specialty for which the hospital is empanelled. Hospitals will only be allowed to view and apply treatment package for the specialty for which they are empanelled.

B Based on diagnosis sheet provided by doctor, operator should be able to block Surgical or Non-Surgical benefit package(s) using AB PM-JAY IT system.

C Both surgical and non-surgical packages cannot be blocked together, either of the type can only be blocked.

D As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.

E The operator can block more than one package for the beneficiary. A logic will be built in for multiple package selection, such that reduced payment is made in case of multiple packages being blocked in the same hospitalization event.

F Certain packages as mentioned will only be reserved for Public EHCPs as decided by the SHA. They can be availed in Private EHCPs only after a referral from a Public EHCP is made.

G Packages as indicated may have differential pricing for NABH/ NQAS and Non-NABH/ NQAS, for Hospitals running PG/ DNB Course, for rural and urban EHCPs and for EHCPs in aspirational districts as identified by NITI Aayog.

H If a registered mobile number of beneficiary family is available, an SMS alert will be sent to the beneficiary notifying him of the packages blocked for him.

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

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

5. Pre-authorisation

A There would be defined packages which will require pre-authorization from the insurance company/ trust. In case any inpatient treatment is not available in the packages defined, then hospital will be able to provide that treatment up to Rs. 50,000 to the beneficiary only after the same gets approved by the Insurance company/ trust and will be reflected as unspecified package. Under both scenarios, the operator should be able to initiate a request to the insurance company/trust for pre-authorization using the web application.

B The hospital operator will send all documents required for pre-authorization to the insurance company/trust using the Centralized AB PM-JAY/ States transaction management application.

C The documents exchanged will not be stored on the AB PM-JAY server permanently. Only the information about pre-authorization request and response received will be stored on the central server. It is the responsibility of the insurance company/ Trust to maintain the documents at their end.

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

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

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

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

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

I In case of emergency, insurance company/ trust will provide the pre-authorization code generated through the algorithm/ utility provided by MoHFW/NHA-NIC.

J Pre-authorization code provided by the Insurer/ Trust will be entered by the operator and will be verified by the system.

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

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

6. Balance Check, Treatment, Discharge and Claim Request

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

B States using their own IT system for hospital transaction will be able to check and update balance from Central AB PM-JAY server using API

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

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

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

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

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

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

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

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

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

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

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

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

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

P Once the claim is processed and the hospital gets the payment, the above-mentioned information along with payment transaction ID will be updated on central AB PM-JAY system by the insurance company/trust for each claim separately.

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

R Upon discharge, beneficiary will receive a feedback call from the Call centre where he can share his feedback about his/her hospitalisation experience. Beneficiary can also provide the feedback through “mera hospital” or similar application.

S Hospital will have the responsibility to inform DHA and SHA in writing if they deny services to the beneficiary along with the reason for denying the services.

7. Monitoring of Transaction Process at EHCP

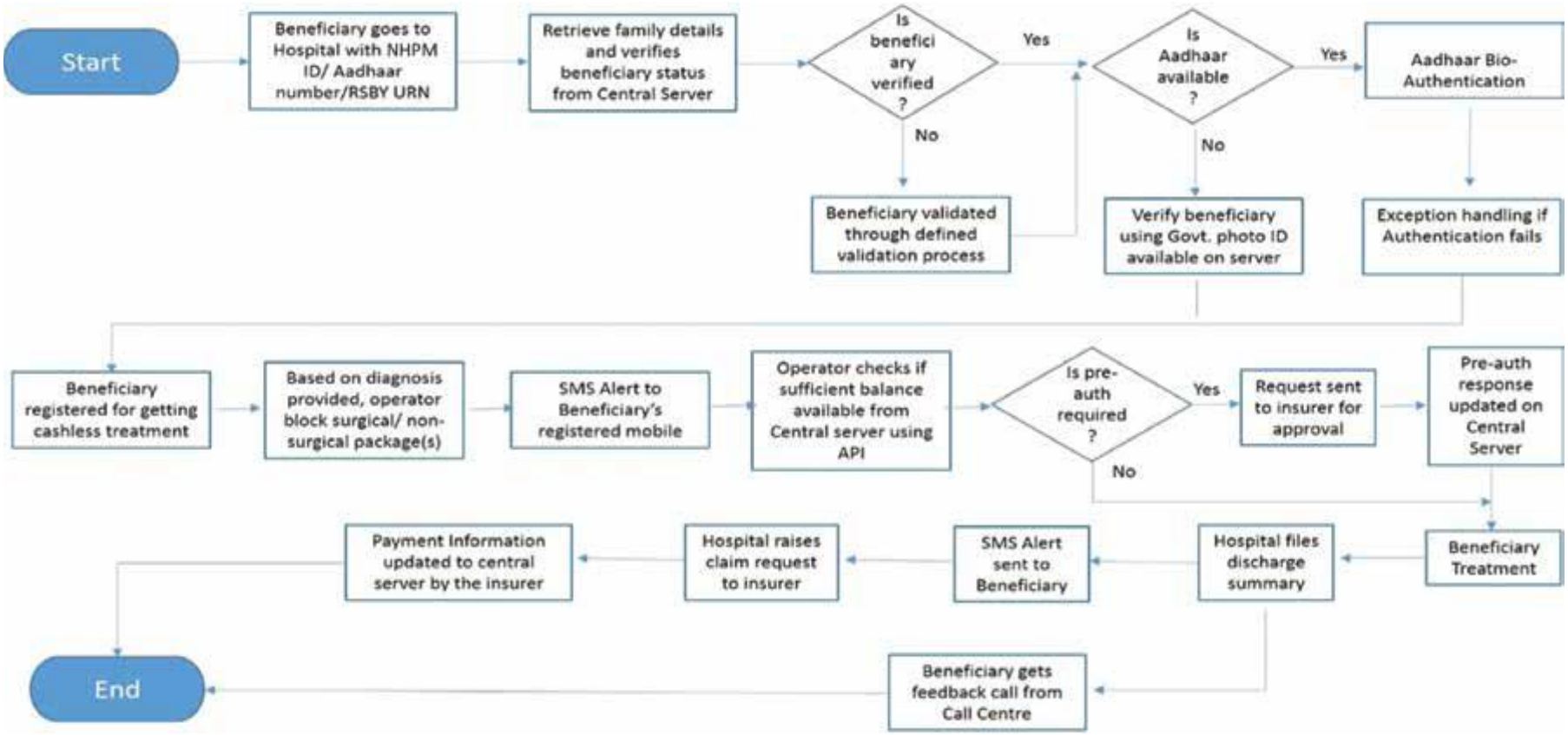
Responsibility of – SHA and Insurance Company/ Trust

Timeline – Continuous

SHA and Insurance Company/ Trust will need to have very close monitoring of the process in order to ascertain challenges, if any, being faced and resolution of the same. Some examples of the parameters on which monitoring may be based are as follows:

A Number of EHCP and Pradhan Mantri Arogya Mitras
B Time taken for verification and issuance of e-card of each member
C Time taken for approval of verification of beneficiaries
D Percentage of families with at least one member having issued e-card out of total eligible families in SECC
E Number of admissions per family
F Grievances received against Pradhan Mantri Arogya Mitras or EHCP
G Proportion of Emergency pre-authorisation requests
H Percent of conviction of detected fraud.
I Share of pre-authorisation and claims audited
J Claim repudiation/ denial/ disallowance ratio
K AB PM-JAY Beneficiary satisfaction

8. Transaction Process Flow



Guidelines on Claim Settlement Process

All Empanelled Health Care Providers (EHCP) will make use of IT system of AB PM-JAY to manage the claims related transactions. IT system of AB PM-JAY 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 AB PM-JAY strives to make the entire claim management paperless that is at any stage of claim registration, intimation, payment, investigation by EHCP or by the Trust/Insurer 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, Insurer (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 Trust/Insurance Companies regarding claim settlement:

1. Claim Payments and Turn-around Time

The Trust/Insurer shall follow the following process regarding the processing of claims received from the EHCP:

A. The Trust/Insurer or the agency (IRDAI compliant only) appointed by it shall decide on the acceptance or rejection of any claim received from an EHCP. Any rejection notice issued by the Trust/Insurer or the agency to EHCP shall clearly state that rejection is subject to the EHCP's right to appeal against rejection of the claim.
B. If a claim is not rejected, the Trust/Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.
C. The process specified in clause a and b above (rejection or payment/investigation) in relation to claim shall be carried out in such a manner that it is completed (Turn-around Time, TAT) shall be no longer than 15 calendar days (irrespective of the number of working days). For claims outside the State, a time of 30 calendar days will be provided.
D. The EHCP is expected to upload all claim related documents within 24 hours of discharge of the beneficiary.
E. The counting of days for TAT shall start from the date on which all the claim documents are accessible by the Trust/Insurer or its agency.
F. The Trust/Insurer shall make claim payments to each EHCP against payable claims on a weekly basis through electronic transfer to such EHCP's designated bank account. Insurer is then also

required to provide the details of such payments against each paid claim on the online portal (IT System of AB PM-JAY).

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 Trust/Insurer 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 Trust/Insurer'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, the Trust/Insurance Company can ensure that the treatment was in conformity to the Standard Treatment Guidelines, if implemented.

H. The Trust/Insurer will need to update the details on online portal (IT system of AB PM-JAY) of:
   i. All claims that are under investigation on a fortnightly basis for review; and
   ii. Every claim that is pending beyond 15 days, along with its reasons for delay in processing such Claim.
   iii. The Trust/Insurer may collect at its own cost, complete Claim papers (including diagnostic reports) from the EHCP, if required for audit purposes for claims under investigation. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

2. Penalty on Delay in Settlement of Claims

There will be a penalty for delay in settlement of claims by the Trust/Insurance Companies beyond the turnaround time of 15 days. A penalty of 1 % of claimed amount per week for delay beyond 15 days to be paid directly to the hospitals by the Trust/Insurance Companies. In case of Inter-State claims with respect to portability of benefits, penalty of 1 % of claimed amount per week for delay beyond 30 days to be paid directly to the hospitals by the Trust/Insurance Companies.

3. Update of Claim Settlement

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

4. Right of Appeal and Reopening of Claims

A. The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the Trust/Insurer, if the Empanelled 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).

B. The Trust/Insurer and/or the DGC can re-open the Claim if the Empanelled Health Care Provider submits the proper and relevant Claim documents that are required by the Trust/Insurer.
C. The DGC may suo moto review any claim and direct either or both the Trust/Insurer and the health care provider to produce any records or make any deposition as it deems fit.
D. The Trust/Insurer 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
F. If the DGC (if there is no appeal) or SGC directs the Trust/Insurer to pay a claim amount, the Trust/Insurer shall pay the amount within 15 days. Any failure to pay the amount shall attract an interest on the delayed payment @ 1% for every week or part thereof. If the Trust/Insurer does not pay the amount within 2 months they shall pay a fine of Rs. 25,000/- for each decision of DGC not carried out and Rs. 50,000 for each non-compliance of decision of SGC. This amount shall be remitted to the State Health Agency.

Guidelines on Grievance Redressal

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

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

District Grievance Redressal Committee (DGRC)

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

- The District Magistrate or an officer of the rank of Addl. District Magistrate, who shall be the Chairperson of the DGRC.
- The CMO/ CMOH/ DM&HO/ DHO or equivalent rank officer shall be the Convenor of the DGRC.
- Representatives from the district level offices of the Departments of Rural Development.
- The District Coordinator of the Insurer.
- The District Grievance Nodal Officer (DGNO)
- The DGRC may invite other experts for their inputs for specific cases.

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

State Grievance Redressal Committee (SGRC)

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

- CEO of State Health Authority / State Nodal Agency shall be the Chairperson of the SGRC.

- Representatives of the Departments of Rural Development, Women & Child Development, Labour, Tribal Welfare.
- Director Health Services.
- Medical Superintendent of the leading state level government hospital.
- The State Grievance Nodal Officer (SGNO) of the SHA shall be the Convenor of SGRC.
- The SGRC may invite other experts for their inputs on specific cases.

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

National Grievance Redressal Committee (NGRC)

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

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

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

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

NGRC will consider:

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

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

1. Grievance Settlement of Stakeholders

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

A. Grievance of a Beneficiary

i. Grievance against insurance company, hospital, their representatives or any functionary

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

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

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

ii. Grievance against district authorities

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

B. Grievance of a Health Care Provider

i. Grievance against beneficiary, insurance company, their representatives or any other functionary

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

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

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

C. Grievance of insurance company

i. Grievance against district authorities/ health care provider

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

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

2. Functions of Grievance Redressal Committees

A. Functions of the DGRC

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

i. Review grievance records.
ii. Call for additional information as required either directly from the Complainant or from the concerned agencies which could be the Insurer or an EHCP or the SHA or any other agency/ individual directly or indirectly associated with the Scheme.
iii. Conduct grievance redressal proceedings as required.
iv. If required, call for hearings and representations from the parties concerned while determining the merits and demerits of a case.
v. Adjudicate and issue final orders on grievances.

vi. In case of grievances that need urgent redressal, develop internal mechanisms for redressing the grievances within the shortest possible time, which could include but not be limited to convening special meetings of the Committee.
vii. Monitor the grievance database to ensure that all grievances are resolved within 30 days.

B. Functions of the SGRC:

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

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

C. Functions of the NGRC:

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

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

3. Lodging of Grievances/ Complaints

A. If any stakeholder has a complaint (complainant) against any other stakeholder during the subsistence of the Policy Cover Period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of the Insurance Contract between the Insurer and the SHA or a Policy or of the terms of their agreement (for example, the Services Agreement between the Insurer and an Empanelled Health Care Provider), then such complainant may lodge a complaint by online grievance redressal portal or letter or e-mail.
B. For this purpose, a stakeholder includes: any AB PM-JAY Beneficiary; an empanelled health care provider (EHCP); a De-empanelled Health Care Provider; the Insurer or its employees; the SHA or its employees or nominated functionaries for implementation of the Scheme (DNOs, State Nodal Officer, etc.); and any other person having an interest or participating in the implementation of the Scheme or entitled to benefits under the AB PM-JAY Cover.

C. A complainant may lodge a complaint in the following manner:
   i. directly with the DGNO of the district where such stakeholder is located or where such complaint has arisen and if the stakeholder is located outside the Service Area, then with any DGNO located in the Service Area; or
   ii. with the SHA: If a complaint has been lodged with the SHA, they shall forward such complaint to the concerned DGNO.

D. Upon a complaint being received by the DGNO, the DGNO shall decide whether the substance of the complaint is a matter that can be addressed by the stakeholder against whom the complaint is lodged or whether such matter requires to be dealt with under the grievance redressal mechanism.

E. If the DGNO decides that the complaint must be dealt with under the grievance redressal mechanism, the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee.

F. If the DGNO decides that the complaint need not be dealt with under the grievance redressal mechanism, then the procedures set out in various process/guidelines shall apply.

4. Redressal of Complaints

A. The DGNO shall enter the particulars of the complaint on the Web-based Central Complaints and Grievance Management System (CCGMS) established by the MoHFW.

B. The CCGMS will automatically: (i) generate a Unique Complaint Number (UCN); (ii) categorize the nature of the complaint; and (iii) an e-mail or letter to be sent to the appropriate stakeholder to which such category of complaint is to be referred (including updating on phone).

C. Once the UCN is generated, the DGNO shall send or cause to be sent an acknowledgement email/phone call to the complainant and provide the complainant with the UCN. Upon receipt of the UCN, the complainant will have the ability to track the progress of complaint resolution online through CCGMS and use the same at the time of calling the helpline for allowing easy retrieval of the specific complaint data.

D. The stakeholder against whom a complaint has been lodged must send its comments/ response to the complainant and copy to the DGNO within 15 days. If the complaint is not addressed within such 15-day period, the DGNO shall send a reminder to such stakeholder for redressal within a time period specified by the DGNO.

E. If the DGNO is satisfied that the comments/ response received from the stakeholder will addresses the complaint, then the DGNO shall communicate this to the complainant by e-mail and update the CCGMS.

F. If the DGNO is not satisfied with the comments/ response received or if no comments/ responses are received from the stakeholder despite a reminder, then the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee depending on the nature of the complaint after which the procedures set out shall apply.

5. Grievance Redressal Mechanism

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

A. The DGNO/SGRC shall update the CCGMS to change the status of the complaint to a grievance, after which the CCGMS shall categorize the grievance and automatically refer it to the Convenor of the relevant Grievance Redressal Committee by way of e-mail.
B. The Convenor of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at its next meeting.
C. Each grievance shall be addressed by the relevant Grievance Redressal Committee within a period of 30 days of receipt of the grievance. For this purpose, each Grievance Redressal Committee shall be convened at least once every 30 days to ensure that all grievances are addressed within this time frame. Depending on the urgency of the case, the Grievance Redressal Committee may decide to meet earlier for a speedier resolution of the grievance.
D. The relevant Grievance Redressal Committee shall arrive at a reasoned decision within 30 days of receipt of the grievance. The decision of the relevant Grievance Redressal Committee shall be taken by majority vote of its members present. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard.
E. If any party to a grievance is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the relevant Grievance Redressal Committee or other authority having powers of appeal.
F. If an appeal is not filed within such 30-day period, the decision of the original Grievance Redressal Committee shall be final and binding.
G. A Grievance Redressal Committee or other authority having powers of appeal shall dispose of an appeal within 30 days of receipt of the appeal. The decision of the Grievance Redressal Committee or other authority with powers of appeal shall be taken by majority vote of its members. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard. The decision of the Grievance Redressal Committee or other authority having powers of appeal shall be final and binding.

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

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

A. Compliance with the Orders of the Grievance Redressal Committees

i. The Insurer shall ensure that all orders of the Grievance Redressal Committees by which it is bound are complied with within 30 days of the issuance of the order, unless such order has been stayed on appeal.

ii. If the Insurer fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the Insurer shall be liable to pay a penalty of Rs. 25,000 per month for the first month of such non-compliance and Rs. 50,000 per month thereafter until the order of such Grievance Redressal Committee is complied with. The Insurer shall be liable to pay such penalty to the SHA within 15 days of receiving a written notice.

iii. On failure to pay such penalty, the Insurer shall incur an additional interest at the rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid.

B. Complaints/ Suggestions received through Social Media/Call Centre

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

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

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

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
AB PM-JAY Beneficiary	• Denied treatment • Money sought for treatment, despite Sum Insured under AB PM-JAY Cover being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB PM-JAY Cover is insufficient or exhausted • AB PM-JAY Card retained by Empanelled Health Care Provider • Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO
Empanelled Health Care Provider	• Claims rejected by Insurer or full Claim amount not paid • Suspension or de-empanelment of Empanelled Health Care Provider • Hospital IT Infrastructure not functioning Insurer not assisting in solving issue or not accepting manual transaction	Insurer/ SHA	DGNO
Insurer	• No space provided for District Office	DNO	SGNO
	• AB PM-JAY Beneficiary Database not updated for renewal Policy Cover Period • Premium not received within time prescribed.	SHA	SGRC
Inter State/UT (Portability issues)			
AB PM-JAY Beneficiary	• Denied treatment • Money sought for treatment, despite Sum Insured under AB PM-JAY Cover being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB PM-JAY Cover is insufficient or exhausted	Hospital	DGNO of the State/UT where Beneficiary is applying/availing benefits of AB PM-JAY (other than parent State/UT)

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
	• Medicines not provided against OPD Benefits or follow-up care		
Empanelled Health Care Provider	• Claims rejected by Insurer or full Claim amount not paid	Insurer/ SHA	SGRC of both parent State/UT and State/UT where the claim is raised State/UT

Guidelines on Release of Premium/Grant in Aid

1. Financing

A. The maximum ceiling of the estimated grant-in-aid payable for the implementation of Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana will be decided by the Government of India and this would be shared as per the sharing pattern ratio guidelines issued by Ministry of Finance in vogue, from time to time. The existing sharing pattern is of 60:40 sharing pattern ratio basis between the Central Government and the States Government / Union Territories, for States and Union Territories which are other than North-Eastern & Three Himalayan States and Union Territories, which does have Legislation;

B. For North-Eastern and Three Himalayan states (viz. Jammu and Kashmir, Himachal Pradesh and Uttarakhand), the sharing pattern ratio between the Central and State Governments will be 90:10;

C. For Union Territories, without Legislation, the Central Government may provide upto 100% of Grant-in-Aid on a case to case basis.

The Central & State Government / UT shall open two separate designated escrow account viz. Premium / Grant-in-Aid and Administrative Expense. In addition, out of the annual administrative expense component of Rs. 50 per family, the Central Government will also pay it's respective share based upon the sharing pattern ratio applicable for that particular States / UTs.

In case the State is implementing, AB PM-JAY, the Central Government's Share of Administrative Expenses will be paid separately in addition to the grant-in-aid / premium payment by the Central Government in advance through the separate designated escrow account opened for this purpose, after the State Government / Union Territory has released their share of administrative expenses into the separate designated escrow account also opened by the States / UTs for this purpose.

2. Implementation under Insurance Mode

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

i. A flat premium per family, irrespective of the number of members under AB PM-JAY in that family, will be determined through open tendering process.

ii. The State Government / Union Territories shall upfront release their respective share of premium (grant-in-aid) for the eligible beneficiary families considered for the implementation of AB PM-JAY into the separate designated escrow account, from where it shall be paid to the

Insurance Company on a per family basis. Upon releasing of States' / UT's share, the States / UTs shall send the proposal to the Central Government for release of respective Central Government's Share of Premium (Grant-in-Aid) along with prescribed documents.

iii. The modalities that will be adhered for release of premium for the implementation of AB PM-JAY will be as under:

I. Number of Eligible Beneficiary Families

The targeted beneficiary families as per the eligibility criteria of AB PM-JAY based on the SECC Database or the number of beneficiary families mapped with the SECC Database (in case a different database, other than SECC Database is used by the States / UTs), as the case may be, shall be considered for the purpose of release of premium by the Central Government.

II. Stage of Release of Premium:

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

i. **First instalment of Premium for all States and UTs:** The Insurer, upon the issue of policy, shall raise an invoice for the first instalment of the Premium payable for the Beneficiary Family Units that are targeted or identified by the SHA. Thereupon, the State / UT shall upfront release 45% of their respective share viz. (out of 10% / 40%) of premium within 15 working days from the receipt of invoice from insurance company, depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA and the data for whom has been shared with Insurance Company along with their respective administrative expense share into a separate designated escrow account opened by the States / UTs for the implementation of AB PM-JAY.

Thereafter, within 15 working days from the release of their respective share, the State / UT shall raise the proposal for release of proportionate share of Central Government's Share of Premium along with the proposal, documentary proof for release of State's / UT's Share of Premium and requisite documentary evidences & compliance of applicable financial provisions. The Central Government will release 45% of its respective share depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA within 21 working days from the receipt of duly completed proposal from the State / UT.

However, in case of Union Territories without legislation, where the Central Government has to bear 100% premium, the Central Government shall pay 45% of its respective share of premium (viz. out of 100%] through the designated escrow account into the designated Escrow Account of the State / UT within 21 working days from the receipt of duly completed proposal (including and not limited to all information / clarifications demanded by Central Government).

Illustration: Rs. 500/- Annual Premium / Family decided in open tendering process. The calculation of premium per family for 1st instalment shall be done as under:

A. In case of North Eastern and 3 Himalayan States

1st Instalment of State Government's Share of Premium:
Rs. 500/- X 45% (Out of total 10% Share i.e. Rs. 50.00) = Rs. 22.50

1st Instalment of Central Government's Share of Premium:
Rs. 500/- X 45% (Out of total 90% Share i.e. Rs. 450.00) = Rs. 202.50

Total 1st instalment = Rs. 22.50 + Rs. 202.50 = Rs. 225.00 (paid through State's / UT's Escrow Account to the Insurance Company)

B. In case of Other States and Union Territories with Legislation

1st Instalment of State Government's / UT's Share of Premium:
Rs. 500/- X 45% (Out of total 40% Share i.e. Rs. 200.00) = Rs. 90.00

1st Instalment of Central Government's Share of Premium:
Rs. 500/- X 45% (Out of total 60% Share i.e. Rs. 300.00) = Rs. 135.00

Total 1st instalment = Rs. 90.00 + Rs. 135.00 = Rs. 225.00 (paid through State's / UT's Escrow Account to the Insurance Company)

C. In case of Union Territories without Legislation (#)

1st Instalment of Central Government's Share of Premium:
Rs. 500/- X 45% (Out of total 100% Share i.e. Rs. 500.00) = Rs. 225.00
(Paid through UT's Escrow Account to the Insurance Company)

(#) 100% of Premium and Administrative Cost is borne by Central Government.

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

ii. **Second instalment for all States and UTs**: The Insurer upon the completion of 2nd quarter shall raise an invoice for the second instalment of the Premium payable for the Beneficiary Family Units for which first instalment was released earlier. The State / UT (with Legislature), within 15 working days upon the receipt of invoice from the insurance company, shall release their 2nd instalment of premium i.e. 45% of their respective share viz. (out of 10% / 40%) into the designated escrow account. Thereafter, within 15 working days from the release of their respective share, the State / UT shall raise the proposal for release of proportionate share of Central Government's Share of Premium along with the proposal, documentary proof for release of State's / UT's Share of Premium (Grant-in-Aid) and requisite documentary evidences & compliance of applicable financial provisions. The Central Government will release 45% of its respective share depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA within 21 working days from the receipt of duly completed proposal from the State / UT.

Illustration: Rs. 500/- Annual Premium / Family decided in open tendering process. The calculation of premium per family for 2nd Instalment shall be done as under:

A. In case of North Eastern and 3 Himalayan States

2nd Instalment of State Government's Share of Premium:
Rs. 500/- X 45% (Out of total 10% Share i.e. Rs. 50.00) = Rs. 22.50

2nd Instalment of Central Government's Share of Premium:
Rs. 500/- X 45% (Out of total 90% Share i.e. Rs. 450.00) = Rs. 202.50

Total 2nd instalment = Rs. 22.50 + Rs. 202.50 = Rs. 225.00 (paid through State's / UT's Escrow Account to the Insurance Company)

B. In case of Other States and Union Territories with Legislation

2nd Instalment of State Government's / UT's Share of Premium:
Rs. 500/- X 45% (Out of total 40% Share i.e. Rs. 200.00) = Rs. 90.00

2nd Instalment of Central Government's Share of Premium:
Rs. 500/- X 45% (Out of total 60% Share i.e. Rs. 300.00) = Rs. 135.00

Total 2nd instalment = Rs. 90.00 + Rs. 135.00 = Rs. 225.00 (paid through State's / UT's Escrow Account to the Insurance Company)

C. In case of Union Territories without Legislation (#)

2nd Instalment of Central Government's Share of Premium:
Rs. 500/- X 45% (Out of total 100% Share i.e. Rs. 500.00) = Rs. 225.00 (paid through UT's Escrow Account to the Insurance Company)

(#) 100% of Premium and Administrative Cost is borne by Central Government.

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

iii. **Third Instalment for all States and UTs:** Upon completion of 10 Months of Policy, the Insurer shall submit the Claim Settlement Report along with the invoice for the last instalment of the Premium payable for the Beneficiary Family Units for which the first and second instalment was released earlier. The State / UT (with Legislative) Government shall, upon receipt of the Claim Settlement report from the Insurance Company / Real Time Data available with States / UTs and upon due satisfaction of permissible claim settlement ratio, release the remaining due premium of 10% or demand for the refund of premium from the insurance company or release the proportionate States / UTs Share of premium based upon the claim settlement scenario, as the case may be, within 15 working days into the escrow account. Thereupon, within 15 working days of their release of premium, shall raise the proposal to the Central Government for the release of 10% of Premium or the proportionate premium based upon the claim settlement scenario, as the case may be into the escrow account as last tranche of premium to the Insurance Company.

The Central Government will release the due proportionate respective share of premium depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA within 21 working days from the receipt of duly completed proposal from the State / UT.

Illustration: Rs. 500/- Annual Premium / Family decided in open tendering process. The calculation of premium per family for 3rd Instalment shall be done as under:

A. In case of North Eastern and 3 Himalayan States

3rd Instalment of State Government's Share of Premium:
Rs. 500/- X 10% (Out of total 10% Share i.e. Rs. 50.00) = Rs. 5.00

3rd Instalment of Central Government's Share of Premium:
Rs. 500/- X 10% (Out of total 90% Share i.e. Rs. 450.00) = Rs. 45.00

Total 3rd instalment = Rs. 5.00 + Rs. 45.00 = Rs. 50.00 (paid through State's / UT's Escrow Account to the Insurance Company)

B. In case of Other States and Union Territories with Legislation

3rd Instalment of State Government's / UT's Share of Premium:
Rs. 500/- X 10% (Out of total 40% Share i.e. Rs. 200.00) = Rs. 20.00

3rd Instalment of Central Government's Share of Premium:
Rs. 500/- X 10% (Out of total 60% Share i.e. Rs. 300.00) = Rs. 30.00

Total 3rd instalment = Rs. 20.00 + Rs. 30.00 = Rs. 50.00 (paid through State's / UT's Escrow Account to the Insurance Company)

C. In case of Union Territories without Legislation (#)

3rd Instalment of Central Government's Share of Premium:
Rs. 500/- X 10% (Out of total 100% Share i.e. Rs. 500.00) = Rs. 50.00 (paid through UT's Escrow Account to the Insurance Company)

(#) 100% of Premium and Administrative Cost is borne by Central Government.

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

iv. If in case, the State / UT is has not deposited its due share of premium into the escrow account, then a penal interest would be levied @ 1% per week for the number of week delay and part thereof on the State / UT. Similarly, penal interest provision shall also be applicable on the Central Government. The counter Government viz. State or Central / UT shall have the right to own such penal interest amount for adjusting in their future payable respective share of premium.

v. If in case, if any interest is earned by SHA on Central Government's Share of Premium released into the Escrow account, the Central Government shall have the first right of claim on such interest earned amount and shall have to be transferred back to the Central Government / adjusted in future payment of the Central Government, as the case may be. Similarly, interest provision shall also be applicable for the State Government too.

vi. The State Health Agency shall send the proposal to the Central Government for the release of Central Government's Share of Premium within 15 (Fifteen) working days of receipt of the Insurer's invoice along & release of their share of premium, along with requisite documents (viz. Details of Eligible Identified Beneficiary Families, Documentary Proof for release of State Government's Share, etc] and compliance of Applicable Financial Rules.

vii. In case the insurance company is not paid the premium from the escrow account within the stipulated time of 7 (seven) Business Days, then for such unwarranted delay, the States / UTs shall be solely liable to pay a penal interest of 1% per week to the Insurance Company starting from after 15 days.

B. Refund of Premium / Grant-in-Aid

The Insurer will be required to refund premium as stipulated below if they fail to reach the claim ratio specified in comparison with the premium paid (excluding GST & Other taxes / Duties) below in the full period of insurance policy period. The premium refund shall be as per the formula below:

a. The SHA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 24/36 months of Policy Cover Period (depending on renewal for third year) for the State/UT. In the letter, the SHA shall indicate the amount of premium that the Insurer shall be obliged to refund. The amount of premium to be refunded shall be calculated based on the provisions as mentioned below.
b. After adjusting a defined percent for expenses of management (including all costs excluding only GST and any cess, if applicable) and after settling all claims, if there is surplus: 100 percent of leftover surplus should be refunded by the Insurer to the SHA within 30 days. The percentage that will need to be refunded will be as per the following:

- In category A States:
  i. Administrative cost allowed 10% if claim ratio less than 60%.
  ii. Administrative cost allowed 15% if claim ratio between 60-70%.
  iii. Administrative cost allowed 20% if claim ratio between 70-80%.

- In Category B States:
  i. Administrative cost allowed 10% if claim ratio less than 60%.
  ii. Administrative cost allowed 12% if claim ratio between 60-70%.
  iii. Administrative cost allowed 15% if claim ratio between 70- 85%.

c. The entire surplus as determined through formula mentioned above should be refunded by the insurer to the SHA within 30 days.
d. If the Insurer delays payment of or fails to pay the refund amount within 30 days from the date of communication by SHA, then the Insurer shall be liable to pay interest at the rate of one percent of the refund amount payable to the SHA for every 7 days of delay beyond such 30-day period.
e. If the Insurer fails to refund the Premium within such 90-day period and/ or the default interest thereon, the SHA shall be entitled to recover such amount as a debt due from the Insurer through legal remedial procedures.

Note: List of Category A and Category B:

Category A States/ UTs	Arunachal Pradesh, Goa, Himachal Pradesh, Jammu and Kashmir, Manipur, Meghalaya, Mizoram, Nagaland, NCT Delhi, Sikkim, Tripura, Uttarakhand and 6 Union Territories (Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Puducherry)
Category B States	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal

C. Sharing of Excess Claim Settlement Amount

This Clause shall be applicable only in case the claim settlement ratio exceeds 120%, in case of category A States (115% in case of Category B States) in any policy period. Under such instance, the excess amount over and above 120% (or 115%) shall be initially shared in equal proportion between the insurance company and State Government / Union Territory.

Thereupon, out of the excess burden amount, which the State Government / Union Territory has borne, the Central Government shall share the burden in line with the sharing pattern ratio. However, the total contribution of the Central Government along with the premium share and excess burden amount of

claim shall not exceed the maximum ceiling amount of Share of Central Government, applicable for that particular States / UTs, respectively.

Any amount over and above the Central and State Government's contribution amount shall have to be borne by the Insurance Company, respectively.

D. Penalty Provision on Delay of Premium

If in case, the State / UT has not deposited its due share of premium into the escrow account, then a penal interest would be levied @ 1% per week for the number of week delay and part thereof on the State / UT. Similarly, penal interest provision shall also be applicable on the Central Government. The counter Government Viz. State or Central / UT shall have the right to own such penal interest amount for adjusting in their future payable respective share of premium.

In case the insurance company is not paid the premium from the escrow account within the stipulated time of 7 (seven) Business Days, then for such unwarranted delay, the States / UTs shall be solely liable to pay a penal interest of 1% per week to the Insurance Company starting from after 15 days.

E. Submission and Approval of Proposal

Before the start of implementation of AB PM-JAY, the States / UTS will have will have to send their proposal to the Central Government and execute the Memorandum of Understanding with the Central Government indicating their modus operandi for the implementation of AB PM-JAY. Further, for States / UTs, who are implementing through Insurance Mode, shall also upon the completion of the tendering process, send their proposal for the approval of Central Government in order to enable them to execute the insurance contract with the selected insurance company.

F. Compliance with Section 64VB of Insurance Act

The Insurer hereby acknowledges, confirms and undertakes that the Premium payment mechanism as mentioned above is acceptable to them / in compliances with Section 64VB of the Insurance Act.

G. No Separate Fees, Charges or Premium

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

3. Implementation under Assurance (Trust) Mode

A. Release of Grant-in-Aid

i. The Central Government's Share of Grant-in-Aid will be paid in the same ratio as mentioned in Section 7.1 for the total actual expenditure incurred towards the treatment of AB PM-JAY Beneficiary Families, subject to the maximum annual permissible ceiling share of Central Government decided by Government of India, whichever is less.

ii. The proposal for release of Central Government's Share of Grant-in-Aid shall be made by the State Government, upon release of its matching share of contribution, along with the certified expenditure statement for the treatment cost and other requisite document s as specified under General Financial Rules, 2017.

iii. The grant-in-aid for the implementation of AB PM-JAY will be decided as under:

- In 1st Year: The first tranche of grant-in-aid of 50% out of the annual maximum ceiling of Central Government's Share of Grant-in-Aid, shall be released as advance through Escrow Account for the total targeted beneficiary families as per the SECC Database or the number of beneficiary families mapped with the SECC Database, as the case may be. The second tranche of 25% will be also be paid as advance by the end of second quarter, subject to the submission of documentary proof of utilisation of at least 75% of the earlier released first installment to the SHA. Further, the last tranche of grant-in-aid as full and final release shall be made upon receipt of the Utilisation Certificate of the earlier released tranches in the last quarter and actual amount of certified expenditure incurred by the States/UT.
- For 2nd Year and onwards: The first tranche of grant-in-aid of 50%, out of the total Central Government's Share of Grant-in-Aid, shall be released as advance through Escrow Account based upon the actual total actual expenditure incurred in the previous year towards the treatment of AB PM-JAY Beneficiary Families, subject to the maximum annual permissible ceiling decided by Government of India, whichever is less, as the case may be. The second tranche of 25% will be also be paid as advance by the end of second quarter, subject to the submission of documentary proof of utilisation of at least 75% of the earlier released first installment to the SHA. Further, the last tranche of grant-in-aid as full and final release shall be made upon receipt of the Utilisation Certificate of the earlier released tranches in the last quarter.

B. Submission and Approval of Proposal

Before the start of implementation of AB PM-JAY, the States / UTS will have will have to send their proposal to the Central Government and execute the Memorandum of Understanding with the Central Government indicating their modus operandi for the implementation of AB PM-JAY.

4. Incentivizing States / Union Territories for Cost Saving effectiveness[6]

This Clause shall be applicable only in case the where the gross annual effective cost for implementation of AB PM-JAY (pertaining to eligible AB PM-JAY's beneficiary families] is coming under the maximum ceiling limit as decided by Government of India, in any of the mode of implementation viz. trust mode or insurance mode or mixed model.

Under such instance, 100% of the cost savings attained of Central Government's Share of Premium shall be additionally paid to the State Government / Union Territories, which shall be mandatorily used for the development / improvement of Health Infrastructure Facilities. This incentive will be provided only if State Government will be able to ensure that at least 30% of claim amount comes back to the Government hospitals from second year of the implementation of the scheme. If, it is observed that the cost saving incentive amount is utilized for any other purpose then the purpose of development / improvement of Health Infrastructure Facilities, then a penal interest @ 1% per week or part thereof, shall be levied until the period such amount is refunded back to the Central Government by the State / UT.

[6] This clause is subject to approval of the National Governing Council of AB PM-JAY

Guidelines for the Use of Claim Amount by Public Hospitals

1. Background

All such public hospitals empanelled under AB PM-JAY to provide inpatient services to the eligible beneficiary families will be reimbursed by the insurance companies/trusts for the services rendered by them as per package rates under AB PM-JAY as claim amount.

The claim amount earned by public hospitals under AB PM-JAY shall be retained locally at the hospital level. The hospital level Chikitsa Prabandhan Samiti (CPS) / Hospital Management Committee (HMC) / Rogi Kalyan Samiti (RKS) shall be responsible for utilization of this claim amount. In principle, the amount has to be spent on improvement of the infrastructure and services in the hospital itself whereby improving the overall infrastructure and quality of care.

2. Guidelines for the Use of Claim Amount by Public Hospitals

1. Respective empanelled AB PM-JAY public hospital shall maintain a dedicated bank account and books for the amount accrued as claim under the scheme. The bank account opening and maintenance shall be as per the general applicable rules in this matter and shall not require any special approval.
2. All the withdrawals and reimbursements from the account for all AB PM-JAY related matters shall be done by approved banking instrument (Cheque/draft/bank order, etc) only. Cash payments should not be done.
3. Upto 25% of the total claim amount can be earmarked for payment of incentive to the hospital staff.
4. The remaining claim can used for improving the overall infrastructure (critical gap funding), functioning of the hospital, quality of services and delivery of services.
5. This claim amount can be used for the following but not limited to the following:
   a. Payment of remuneration of Arogya Mitra.
   b. Local purchase of consumables and medicines which is not available at the State health department stores department supply/State Medical Services Corporation supply but as per the overall guidelines of the State in regard to procurement of the medicines (to the extent possible only the generic medicines should be prescribed and procured).
   c. Local purchasing of services related to diagnostics and investigations which are not available in the hospital.
   d. Hiring of services of clinical specialists and non-clinical man power such as technicians, computer operators, etc.
   e. Any other clinical or non-clinical services of patient centric nature.

All local purchasing must be done by entering into well negotiated rates with the supplier as per the applicable rules in this matter. All hiring should be done as per the NHM rules as far as possible.

The State Health Agency (SHA can modify and add to the guidelines for specific use of the utilisation of the claim amount.

6. The State Health Agency shall formulate specific guidelines for utilisation of amount for payment of incentive to hospital staff. An indicative list for the team of clinical and non-clinical specialist that shall be rewarded with incentive for service delivery under AB PM-JAY is as below-
   a. Surgeon/Medical Specialist / Physician, the principal person treating the patient.
   b. Assistant Surgeon / other medical specialist involved (such as paediatrician in delivery cases).
   c. Anaesthetists / Other specialists which are involved in the care
   d. On call / on roster physician
   e. Staff nurse and nursing assistants
   f. Lab technicians or technicians of imaging or rehabilitative departments
   g. Others (such as involved in ancillary patient care).

   SHA may like to formulate a state specific guideline for distribution of incentive amount based on their local condition. Any specific issues that may arise with respect to distribution of incentive amount or utilisation of this claim amount by public hospitals be presented before the SHA for their resolution.

Guidelines on Portability of Benefits

An Empanelled Health Care Provider (EHCP) under AB PM-JAY in any state should provide services as per AB PM-JAY guidelines to beneficiaries from any other state also participating in AB PM-JAY. 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 PM-JAY will not be allowed to deny services to any AB PM-JAY beneficiary. All interoperability cases shall be mandatorily under pre-authorisation mode and pre-authorisation guidelines of the treatment delivery state in case of AB PM-JAY implementing States / UTs or indicative pre-authorisation guidelines as issued by NHA, shall be applicable.

1. 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 PM-JAY will sign MoU with Central Government which will allow all any the hospital empanelled hospitals by that state under AB PM-JAY to provide services to eligible beneficiaries of other States from across the country. Moreover, the state shall also be assured that its AB PM-JAY beneficiaries will be able to access services at all AB PM-JAY 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 PM-JAY services to AB PM-JAY 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 PM-JAY beneficiaries that access care outside the state in AB PM-JAY empanelled healthcare provider network.

C. **Insurance companies/Trusts**: The Insurance Company (IC) signs a contract with all other IC's and Trusts in the States / UTs under AB PM-JAY 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.

2. Implementation Arrangements of Portability

A. **Packages and Package Rates**: The Package list for portability will be the list of mandatory AB PM-JAY 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 PM-JAY 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 PM-JAY state, any AB PM-JAY state can separately empanel such facilities. Such EHCP shall become a member of provider

network for all AB PM-JAY implementing States. NHA can also empanel a CGHS empanelled provider for AB PM-JAY in non-AB PM-JAY 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 PM-JAY and any State Scheme or AB PM-JAY 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 PM-JAY.

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

Structure and Tasks of State Health Agency for Implementing AB PM-JAY in Assurance Mode

In order to facilitate the effective implementation of the PMRSSM, the State Government shall set up the State Health Agency (SHA) or designate this function under any existing agency/ trust/ society designated for this purpose, such as the state nodal agency for RSBY or a trust/ society set up for a health insurance program. SHA can either implement the scheme directly (Trust/ Society mode) or it can use an insurance company to implement the scheme.

The SHA shall be responsible for delivery of the services under PMRSSM at the State level. For such States that want to implement the PMRSSM directly through a Trust/ Society without intermediation of an insurance company, the scope and tasks of SHA are much wider. The State Health Agency is responsible for complete implementation of the PMRSSM in the State.

1. Tasks of the State Health Agency

All key functions relating to delivery of services under PMRSSM shall be performed by the SHA viz. data sharing, verification/validation of families and members, awareness generation, monitoring etc. The SHA shall perform following activities through staff of SHA or by hiring an Implementation Support Agency (ISA):

- Policy related issues of State Health Protection/ Insurance scheme and its linkage to PMRSSM
- Selection of ISA, if needed
- Awareness generation and Demand creation
- Aadhaar seeding and issuing print out of E-card to validated PMRSSM beneficiaries
- Empanelment of network hospitals which meet the criteria including field verification
- Monitoring of services provided by health care providers
- Fraud and abuse control
- Punitive actions against the providers
- Pre-authorisation of claims or monitoring of pre-authorizations which are approved by ISA
- Administration of hospital claims
- Payment of claims
- Carrying out medical and claims audits
- Package price revisions or adaptation of PMRSSM list
- Adapting PMRSSM treatment protocols for listed therapies to state needs, as needed
- Adapting operational guidelines in consultation with NHA, where necessary
- Forming grievance redressal committees and overseeing the grievance redressal function

- Capacity development planning and undertaking capacity development initiatives
- Development of proposals for policy changes –e.g. incentive systems for public providers and implementation thereof
- Management of funds through the escrow account set up for releasing grant-in-aid under PMRSSM
- Data analytics
- Evaluation through independent agencies
- Convergence of PMRSSM with State funded health insurance/ protection scheme (s)
- Alliance of State scheme with PMRSSM
- Setting up district level offices and hiring of staff for district
- Oversee district level offices
- Preparation of periodic reports based on scheme data and implementation status
- Implementing incentive systems for field functionaries & public providers in line with national guidance
- Any other such activity required for effective functioning of PMRSSM in the State.

2. Additional Tasks in Trust Mode

In addition to the tasks to be done by State Health Agency in the insurance company mode, following additional tasks will need to be done by the SHA in the Trust/ Society mode:

A. **Field Verification of Hospitals for Empanelment** – Once the interested hospitals apply for hospital empanelment through the online portal, a field verification needs to be done to check the veracity of the information provided by the hospitals. SHA, through their district team will need to get this field verification done.

B. **Claim Management and Audits** – This involves receiving the claims from the hospital, analysing the claims, taking a decision on accepting or rejecting the claims and finally making payments of claims to the hospitals. It will also involve carrying out claims and medical audit either after receiving the claims or concurrently at the hospital itself. This can be done in two ways:

   I. **Option 1: Through internal team** – SHA can have an internal team of experts for carrying out all the tasks related to claims management.
      a. Team of 4-6 persons for claim management with relevant experience
      b. Team of 3-5 doctors to work together with claim management team

   II. **Option 2: Through external agency** – SHA can also hire an external agency called ISA for claim management process and related activities. For this purpose, SHA will need to carry out a tendering process to hire such agency. The model tender document for hiring of ISA shall be provided separately. The ISA selected for this purpose must be IRDAI compliant. The SHA will sign a contract with the ISA detailing clear key performance indicators. ISA will provide a dedicated team for carrying out the claim management process. ISA will also provide a team for carrying out claims and medical audit either after receiving the claims from the hospitals or concurrently at the hospital.

3. Constitution of SHA

The day-to-day operations of the SHA will be administered by a Chief Executive Officer appointed by the State Government. The CEO will look after all the operational aspects of the implementation of the scheme in the State and shall be supported by a team of specialists (dealing with specific functions). The CEO/ operations team will be counselled and overseen by a governing council set up at the State level. The suggested composition of Governing Council is as follows:

S. No.	Name/ Designation	Position
1.	Chief Secretary	Chairperson, ex officio
2.	Principal Secretary to Government, Health & Family Welfare Department	Vice Chairperson, ex officio
3.	Secretary, Finance Department	Member, ex officio
4.	Secretary, Department of Rural Development	Member, ex officio
5.	Secretary, Department of Housing and Urban Affairs	Member, ex officio
6.	Secretary, Department of IT	Member, ex officio
7.	Secretary, Department of Labour	Member, ex officio
8.	MD, NHM or Commissioner, Health Department	Member, ex officio
9.	Director of Medical Education	Member, ex officio
10.	Director of Health Services	Member, ex officio
11.	CEO (SHA)	Member Secretary, ex officio
12.	Representative of NHA	Special Invitee
13.	1 Subject matter experts as nominated by the State Government	Special Invitee

4. Operational Core Team for SHA including additional staff in Trust mode

The Chief Executive Officer (CEO) will look after all the operational aspects of the implementation of the scheme and shall be supported by a team of specialists (dealing with specific functions). The SHA should hire a core team to support the Chief Executive Officer in discharge of different functions.

For States implementing the scheme in Trust/ Society mode, they have two options, as mentioned above.

A. **Option 1** – They can hire the same number of staff as the States with insurance mode, additionally staff for beneficiary identity verification. For rest of the functions they can hire an ISA.
B. **Option 2** – Instead of hiring an ISA, they can hire additional staff in the team itself to carry out the additional functions. For option 2, the following additional staff will need to be hired in the team:

Position	Responsibility	No. in Category A State		No. in Category B State	
		Insurance Mode	Trust Mode	Insurance Mode	Trust Mode
Claim Management Team	• Pre-authorization process • Claims management • Ensuring payment of claims to the hospitals	1	6	2	8
Audit Team	• Carrying out medical audit • Carrying out claims audit	0	3	0	6
Operations Management Team	• Field operations under the scheme • Programme management	2	4	3	6
Monitoring & Evaluation Team		2	4	4	6

	• Monitoring & evaluation of scheme • Monitoring functioning of key vendors including hospitals, Field personnel, • Monitoring achievement of goals of the scheme				
Policy Team	• Designing policy for State Schemes and convergence thereof with PMRSSM	1	2	1	2
IT Support, Data and Fraud Control Team	• Data availability, integrity and security • MIS coordination • Management of IT hardware & software	2	5	3	8
Beneficiary verification Team	• Co-ordination for smooth beneficiary verification process • Manage issues related to beneficiary verification		2		4
Grievance Redressal Team	• Oversee Grievance redressal mechanisms • Undertake beneficiary communications.	1	2	2	4

	• Local grievance redressal				
Medical Management & Quality Team	• Designing standard packages and hospitals empanelment criterion for additionalities like State schemes such that they are complimentary to PMRSSM • Empanelment of Hospital • Quality & Patient safety • Punitive action against hospitals	2	6	4	8
IEC Team	• Strategic communication planning and execution	1	2	2	4
Capacity Development Team	• Training & capacity building planning and organization	1	3	2	6
Finance Management Team	• Fund management • Managing initial corpus & funding of trust • Managing finance & admin processes • Claim settlement • Payments • Budgeting & accounting	2	6	5	9

	• Internal and external audit				
Administrative Team	• General administration of the programme	1	3	2	6

**States have been categorized based on PMRSSM target population size as below, in two groups, where group B may need more than one official for the same role.*

Category A States/ UTs	Arunachal Pradesh, Goa, Himachal Pradesh, Jammu and Kashmir, Manipur, Meghalaya, Mizoram, Nagaland, NCT Delhi, Sikkim, Tripura, Uttarakhand and 6 Union Territories (Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Puducherry)
Category B States	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal

5. Structure at District Level

In addition to the state level posts, a District implementation unit (DIU) will also be required to support the implementation in every district included under the scheme. A DIU shall be created which would be chaired by the Deputy Commissioner/ District Magistrate/ Collector of the district. This Unit is to coordinate with the Implementing Agency (ISA/ Insurer) and the Network Hospitals to ensure effective implementation and also send review reports periodically. DIU will also work closely and coordinate with District Chief Medical officer and his/ her team.

Proposed staffing pattern of the DIU as follows:

Post	Role	Status	No.
District Nodal Officer (PMRSSM)	Program Officer designated by the State. Regular state official and responsible for the PMRSSM implementation in the district.	Regular State official, may be part time role	1 per district

District Program Coordinator	Responsible for monitoring the implementation of the scheme Aadhaar seeding, validation of beneficiaries, awareness, spot checks, and capacity building.	Contractual, full time	1 per district
District Information Systems Manager	Supporting hospitals and implementing agencies (ISA) with use of the information system, troubleshooting, report-generation and ensuring uptime of system functionality.	Contractual, full time	1 per district
District Grievance Manager	Managing complaint and grievances at the district level. Also responsible for organising meetings of District Grievance Committees	Contractual, full time	1 per district

In addition to the additional staff at the State level, at the district level also additional staff will need to be hired by the SHA in option 2 without ISA.

Post	**Role**	**Status**	**No.**
District Coordinator	Person responsible for implementation of the Scheme in each of the districts.	Contractual, full time	1 per district
District medical officer	Responsible for medical audits, fraud control etc.	Contractual, full time	1 per district

Note: State Nodal Agency may combine more than one of the above tasks in the TORs of the same individual as per its requirements.