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Guidelines for Utilisation of Claim Revenues by Government Hospitals Under Ayushman Bharat PM-JAY

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List of Abbreviations

AHU	Air Handling Unit
CCU	Cardiac Care Unit
ETP	Effluent Treatment Plant
HLC	High Level Committee
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IT	Information Technology
MEDCO	Medical Coordinator
NHM	National Health Mission
NICU	Neonatal Intensive Care Unit
OT	Operation Theatre
SICU	Surgical Intensive Care Unit
SNCU	Sick Newborn Care Unit
PICU	Pediatric Intensive Care Unit
PM-JAY	Pradhan Mantri Jan Arogya Yojana
RKS	Rogi Kalyan Samiti
SECC	Socio-Economic Caste Census
SHA	State Health Agency
UHC	Universal Health Coverage

Guidelines for Utilisation of Claim Revenues by Government Hospitals Under Ayushman Bharat PM-JAY

1 Introduction

1.1 The Government of India launched the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) in September 2018. The core aim of this scheme is to reduce the severe financial burden on the poor and vulnerable communities and ensure their access to quality health services, to accelerate India's progress towards achievement of Universal Health Coverage (UHC). PM-JAY covers bottom 40 percent of poor and vulnerable population or about 10.74 crore households. The inclusion of households is based on the deprivation and occupational criteria of the Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas, respectively. PM-JAY covers hospitalisation costs of up to Rs. 5,00,000 per entitled family per year for secondary and tertiary care, provided through a network of public and empanelled private hospitals.

1.2 The service provider network under PM-JAY includes government hospitals having 10 or more beds and large numbers of empanelled private hospitals across states where PM-JAY is implemented. Deemed empanelment under the PM-JAY provides government hospitals an unprecedented opportunity to mobilise and independently manage revenues earned through claims for treatment provided to PM-JAY beneficiaries (hereinafter referred to as "Claim Revenues").

1.3 Claim revenues earned under PM-JAY by government hospitals are credited directly into the bank accounts of the hospital (whether the Rogi Kalyan Samiti (RKS) or Hospital Development Societies/Committees or other specific hospital-level entities tasked with this role, hereafter referred to generally as the RKS), are likely to be substantial as the PM-JAY matures and service utilisation increases.

1.4 Claim revenues are the most flexible source of funds that government hospitals have. These revenues can be used exclusively for patient medical benefits and hospital improvement. The flexible nature of earnings through claim revenues makes it the most important pool of resource for government hospitals in-charges/superintendents as this flexibility is generally not available under other hospital financing sources.[1]

1 World Bank. 2020. Government Hospitals and Insurance Revenues: Documenting Experiences in Chhattisgarh, Kerala, Meghalaya, and Tamil Nadu © World Bank."

2 Purpose and Scope of this Document

2.1 This document aims to provide a national framework and guidance to the State Health Agencies (SHA) to ensure that PM-JAY claim revenues earned are optimally used by government hospitals for improving patients' experience of seeking quality care and for hospital improvement.

2.2 It is expected that this framework shall enable states to make informed decisions on different aspects of fund utilisation and, as required, develop their comprehensive guidelines, and issue a Government Order for the same. In so doing, it can help ensure that states do not forego significant potential claim revenues (including co-financing from Government of India) for strengthening government hospitals.

3 Revenue Sharing Model between SHA and Government Hospitals

3.1 SHAs have two options to choose from, regarding sharing PM-JAY claim revenues:

Option 1: *Transfer 100% of eligible PM-JAY claims amount to the respective government hospital.*

Option 2: *Deduct a certain percentage (20% or less) of these revenues at source to set up a state-level corpus fund directly administered by the SHA.*

3.2 States that chose Option 2 and set up the state corpus may determine the purposes for which such corpus fund may be used. Some of the areas that states may consider are listed in Section 11.

3.3 It may be noted that if states opt to retain a portion of PM-JAY claim revenues, it is equivalent to a policy of differential pricing for the public and private sectors (e.g., if 20% is retained, package prices paid to government hospitals will be 20% less than private hospitals). This may be justified for policy reasons (e.g., in recognition of the fact that government hospitals receive substantial supply-side funding; or absorptive capacity considerations).

3.4 It may also be noted that the establishment of a state corpus fund for state-wide upgradation of hospitals can help achieve a more equal resource allocation by partially offsetting the link between hospital footfall and earnings.

3.5 For further guidelines related to setting up the state corpus and its usage, refer to Section 11.

4 Application of Funds and Expenditure Categories

4.1 The government hospital may use the PM-JAY claim revenues as per the indicative categories and allocation shares mentioned in Table 1 below and are subject to modifications based on the provisions of Section 4.2.

Table 1: Indicative items where PM-JAY claim revenues may be used

Indicative items where PM-JAY claim revenues may be used (expenditure categories)	Allocation shares
1. Staff incentives	15%
2. Human Resources: Salaries for personnel recruited primarily for PM-JAY in the hospital	15%
3. Medicines, consumables, and pathology/radiology tests	40%
4. Hospital upgradation & Quality Improvement	20%
5. Administrative expenses	10%

SHAs have the flexibility to determine their expenditure categories and allocation shares as per their requirements. States may opt for anywhere from 3 to 7 expenditure categories, with fewer categories implying greater flexibility but potentially less clarity for hospitals. It may be noted that salaries for administrative personnel for PM-JAY may "pay for themselves" by ensuring that claim submission processes function smoothly and maximum revenues are received.

4.2 SHAs may exercise the following flexibility with the purpose of improving procurement efficiency and value for money, provided the SHA or other state agencies have the capacity to manage such tasks better than individual government hospitals. While exercising this flexibility, SHA may bear in mind that the ease and timeliness of availability of resources at the hospital level should not be compromised due to either lack of capacity or procedural delays at the state level:

a. **Recruitment:** SHA may decide that personnel for a particular position shall be centrally recruited and deployed (for example Pradhan Mantri Arogya Mitras or Data Entry Operators). *Such costs may be proportionately recovered from their allocation share under the Human Resources expenditure category as provided in Table 1.*

b. **Medicines:** SHA may decide to procure certain commonly required medicines for a procedure or set of procedures under PM-JAY, medicines which are not included in the Essential Drug List of the state. Such supplies may be procured at better rates by the state agency, and supplied only to those government hospitals that frequently require under the said procedures. *Such costs may be proportionately recovered from hospitals allocation share under the Medicines and Consumables expenditure category as provided in Table 1.* The suppliers may continue to supply such medicines directly to the hospitals using their existing distribution and retail network.

c. **Upgradation works:** SHA may decide to undertake certain works uniformly across all government hospitals – for example: setting up of kiosks, PM-JAY patient digital display board, dedicated waiting area for PM-JAY patient attendants, or any other hospital upgradation tasks as per these Guidelines that may be uniformly required across government hospitals. Such tasks may be more efficient if the SHA centrally commissions the concerned state agency (public or private).

Such costs may be proportionately recovered from their allocation share under the Hospital Upgradation expenditure category as provided in Table 1.

***Note:** While exercising the flexibility provided under Section 4.2 above, the SHAs should ensure that significant flexible funds are available at the disposal of hospital authorities to respond to urgent and emergency needs in the interest of the beneficiaries. PM-JAY's intention of zero out-of-pocket expenditure for treatments covered under the PM-JAY should not get compromised due to this flexibility.*

4.3 SHAs shall exercise the flexibility provided under Section 4.2 and adjust/recover such costs from government hospitals claim revenues, only if the SHA does not have any other source of funds under its existing budgets including corpus funds.

4.4 SHAs may provide flexibility to the government hospital to use unspent balances from one expenditure category for another, *ensuring that the first priority for expenditure should be on expenditure categories "medicines and consumables" followed by "salaries for personnel recruited specially for PM-JAY in the hospital".* Such flexibility shall, however, be subject to the following two conditions:

a. Provisions for such flexibility shall be incorporated in state-specific guidelines approved by the SHA or appropriate government order; and

b. RKS passes a prior resolution to that effect and provide ex-ante approvals for such expenditure.

4.5 ***Apart from other restrictions on the use of PM-JAY claim revenues that may be there in other sections of this Guideline, claim revenues shall not, under any circumstance whatsoever, be used for the following:***

a. Substitute state share under any centrally sponsored scheme/programme.

b. Transfers, either in full or part, to any state scheme.

c. Provide medical reimbursements for any state/central scheme other than the PM-JAY.

d. Deposits in the state treasury.

4.6 All expenditure decisions shall be documented ex-ante with clear rationale that shall be within the framework of these guidelines and as per state policies, following the approval procedures as set forth in such approved guidelines. Greater clarity of guidelines can serve to improve utilisation rates of PM-JAY claim revenues by giving hospitals the assurance that funds may legitimately be used for a variety of purposes.

5 Expenditure on Staff Incentives

5.1 Under the expenditure category "*Staff Incentives*", a government hospital may use the allocations for staff incentives (as outlined in section 4.1) to incentivise medical and paramedical personnel of the patient treating team in the government hospital. Such incentives shall be additional to the salaries they are getting and shall be subject to tax deductions at source as per existing income tax rules.

5.2 It is clarified that the distribution of such staff incentives are not a right of employees. Award of incentives is at the discretion of the SHA. The SHA or the RKS may, at its sole

discretion, decide to divert either in full or part of the allocations for staff incentives for relatively higher priority areas like '*Medicines and consumables for patients' or 'Salaries for personnel recruited especially for PM-JAY in the hospital*'.

5.3 To account for the differences in staffing pattern in medical college hospitals and other government hospitals, illustrative allocation patterns are indicated in Table 2 and Table 3 below. However, SHAs may exercise discretion in modifying the staff categories and/or the suggested allocations for different staff categories based on their staffing pattern and designations. The Government Order pertaining to the use of PM-JAY incentives should also include the details relating the incentives.

Table 2: Allocations for staff incentives in government hospitals other than government medical college hospitals

Staff category	Allocation
Treating doctors team including supporting doctors[2]	55%
Nursing and paramedical staff[3]	30%
Other support staff[4]	10%
Nodal Officer	1%
Counsellor	4%

Table 3: Allocations for staff incentives in empanelled government medical college hospitals

Staff category	Allocation
Head of the Department	2%
Professor	4%
Associate Professor	8%
Assistant Professor	12%
Senior Registrar/Senior Resident Medical Officer	16%
Junior Registrar/Junior Resident Medical Officer	8%
Nursing staff and paramedical technicians	30%
PM-JAY Nodal Officer	2%
Clerk/Computer Operator	3%
Class IV employees	15%

2 If only one doctor, 100 percent of this amount could be paid to the doctor. If there is a junior doctor, the senior could get 40% of the allocated amount and the remaining 15 percent to the junior doctor.

3 Of this 30 percent, 40 percent could be allocated for the nurse; 30 percent for the support nurse and the remaining 30 percent for OT and other technicians.

4 Of this 10 percent, 70 percent could be allocated to ward boys and sweepers, 20 percent for the Hospital Consultant/BPM and the remaining 10 percent for the computer operator.

6 Expenditure on Human Resource

6.1 Under the expenditure category "*Human Resources*", a government hospital may use the allocations for paying staff salaries (as set forth in section 4.1).

6.2 Decisions related to the type of personnel to recruit (e.g. the Pradhan Mantri Arogya Mitras, Medical Coordinators (MEDCO), Data Entry Operators, etc.) shall be as per the NHA guidelines and SHA's own policy. This may also include medical specialists on call to attend to specific clinical needs of PM-JAY patients.

6.3 SHAs may consider providing flexibility to the RKS to recruit additional personnel provided they are engaged full time for tasks related to PM-JAY and provided their salaries/fee can be paid out of the allocation for salaries as set forth in section 4.1.

6.4 SHAs may decide a fixed salary or a combination of fixed salary and incentives for such positions (or decentralise such decisions to the hospitals).

6.5 All such recruitments shall be as per SHA's own policies, subject to all statutory compliances, if any, and deduction of applicable income tax at source. Terms of reference for all such positions shall be approved by the SHA and uniformly used by all hospitals.

6.6 SHAs may exercise the liberty to centrally recruit and manage the payroll (directly or indirectly) of certain cadres of staff/personnel/consultants, for which the SHAs shall abide by the guidance set forth in Section 4.2 (a) and Section 4.3 above.

7 Expenditure on Medicines, Diagnostics, and Consumables

7.1 Under the expenditure category "*Medicines, Diagnostics and Consumables*", a government hospital may use the allocations (as set forth in section 4.1) for ensuring that PM-JAY beneficiaries do not incur any out-of-pocket expenses on these heads during treatment at the hospital. SHAs shall ensure that no PM-JAY beneficiary should have to make any out-of-pocket medical expenditure for seeking treatment. Out-of-pocket medical expenditure includes expenditure on account for consultations, patient food during hospitalisation, medicines, laboratory tests and radiology investigations and any other expenditure directly related to treatment.

7.2 SHAs may introduce a concept of e-vouchers for high-end diagnostics, based on the guidelines that may be issued by the NHA in this regard.

7.3 SHAs/government hospitals should use funds allocated under this category for supplying medicines/consumables to only PM-JAY beneficiaries.

7.4 SHAs may exercise the liberty to centrally procure certain medicines for patients on behalf of government hospitals, for which the SHAs shall abide by the guidance set forth in Section 4.2 (b) and Section 4.3 above.

7.5 Allowable expenditure under this category shall include:

a. Medicines as required for the treatment of PM-JAY patients.

b. Medical and surgical supplies as needed for the treatment of PM-JAY patients.

c. Payments for pathology tests and radiology investigations (x-ray, ultrasound, CT scan, etc.) for PM-JAY patients if such tests/investigations are not available within the government hospital and therefore are done from outside the concerned government hospital (this could be at another government hospital which has such facilities or from a nearby private provider). In all such cases, rates at which such services can be procured from other government hospitals and private providers should ideally be equal to or less than CGHS rates for such tests/investigations applicable for that city.

d. Arrangement of a free ambulance in case of a road traffic accident, disaster, or any other case when the patient is alone.

7.6 The RKS may be allowed to undertake local procurement of medicines and consumables, provided the same cannot be supplied by the state machinery (through its central stores or the state level corporation responsible for procurement and supply chain of medicines).

7.7 The SHAs may consider setting up an expedited mechanism for seeking a no-objection certificate by the government hospital from the state corporation/agency responsible for all procurement.

7.8 SHAs should ensure that all government hospitals create and maintain minimum documentation related to the procurement of medicines and consumables, that may include but not be limited to:

a. Minutes of all RKS decisions related to procurement.

b. Procurement committee meeting minutes.

c. Separate stock register for medicines and consumables procured under PM-JAY.

8 Expenditure on Hospital Upgradation and Quality Improvement

8.1 Under the expenditure category "*Hospital Upgradation and quality improvement*", a government hospital may use the allocations for (as set forth in Section 4.1) to improve the hospital's infrastructure and equipment that have a direct relationship with patients' treatment outcomes and experience of seeking care in the hospital.

8.2 **Where funds can be used:** An indicative list of areas where such funds can be used are provided below:

a. **Minor repairs and civil works:** Patchwork on walls and floors, flooring/tiling wherever required, whitewashing/distempering, fixing and painting of grill/gates/windows, animal traps at an appropriate places, renovation/repairing of a toilet(s), partition wall wherever required, false ceiling of the roof, water tanks, etc.

b. **Minor mechanical, electrical and plumbing works:** Includes fixing basins/surgical basins, water tap, motor pump, water tank/overhead tanks, pipe connection, new electrical connection, change/repair of wiring, replacement of switchboards, switches, creating new light posts, etc.

c. **Minor medical equipment:** up to a specific financial threshold that the state could decide – this may include but not be limited to patient examination table, delivery table, fowler and semi fowler beds, haemoglobin meter, instrument tray, baby tray, adult/neonatal Ambu bag, weighing scale, surgical instruments, stethoscope, BP apparatus, attendant's stool, instrument cabinet, baby mucus sucker, IV stand, thermometer, setting central oxygen and suction system, operation theatre light, focused lamp, infusion pump, multipara monitor, defibrillator, nebulizer, phototherapy unit, radiant warmer, saline stand, bedside curtains, wheelchairs, stretcher, bins for biomedical waste, hub cutter, effluent treatment plant (ETP), air handling unit (AHU), positive air pressure machine, crash cart, air condition for OT, labour room, wards, ICU, SNCU, CCU, SICU, NICU, PICU, laboratory, blood bank, any other clinical/patient care area, etc.

d. **Repair and maintenance of medical equipment**

e. **Additional medical facilities:** Setting up additional medical facilities that are not funded under existing national or state schemes like burns ward, cath labs, etc.

f. **Other upgradation works:** Kitchen for dietary services, shed for ambulance parking, cycle/motorcycle stand, toilet, waiting area/attendant's rest shed, breastfeeding room/corner, ramp, general and biomedical waste storage area/ room, washroom for differently abled, signages, electronic display boards for patients, public announcement system, water dispenser/purifier, room heaters, upgradation in patient waiting areas, security solutions and equipment, etc.

g. **Administrative infrastructure:** Computer and printer for the use of Pradhan Mantri Aarogya Mitras or Data Entry Operators who are 100% dedicated to PM-JAY operations in the hospital.

h. **Quality of care improvement:** Expenses related to process of achieving PM-JAY recommended quality certification and upgradation of facility in terms of quality standards.

i. **Procurement of innovations/new technology:** Expenses under the following indicative areas shall be subject to prior approval from the SHA or any other relevant state authority.

- Here, innovations refer to the new and novel technologies which can impact operational efficiency, affordability, accessibility, and quality of care at the hospitals.
- Innovations procured by the hospitals can be products or services that fall into following categories (but not limited to):

    i. Biomedical devices, products and services aimed towards diagnostics and treatment that may be using new and novel technologies or processes, potentially improving areas such as better clinical outcomes, reducing turn-around time, increasing ease of usage, reducing cost, etc.

    ii. Digital innovative enterprise level innovations such as virtual clinical solutions (for training, diagnostics, treatment etc), data management and analytics platform and other operational streamlining solutions.

    iii. Other innovative emerging technology solutions.

iv. In terms of hospitals identifying the innovations to procure, NHA through its Market Access Programme is actively working on selecting the innovations which have been clinically validated. Further, these innovations will be listed on the Government E-Marketplace (GeM) such that the public hospitals can access the procurement on these innovations in a streamlined manner. This can be one of the pathways for a hospital to identify and procure innovations. Further, the hospitals can also explore other mechanisms to procure innovations.

- Any other clinical or non-clinical services of patient centric nature.

8.3 **Upgradation work where PM-JAY funds are not permitted to be used:** List of areas where allocations for hospital upgradation cannot be used are provided below:

a. Civil works, major equipment purchase, repair and maintenance for which funds are or could have routinely been made available under other financing streams like the state budget or the National Health Mission budget. This can help ensure that PM-JAY claim revenues are truly additional and do not crowd out other resource streams.

b. Office equipment and furniture, including air conditioners for administrative offices.

c. Computers and printers for the use of overall hospital administration purposes.

d. Purchase or renting of vehicles for office/hospital works.

8.4 Under this section, state guidelines may set down the rules for expenditure decisions, approval process, delegation of financial powers within the existing RKS, ensuring transparency and fairness.

8.5 SHAs may exercise the liberty to centrally procure and undertake certain hospital upgradation works, for which the SHAs shall abide by the guidance set forth in Section 4.2 (c) and Section 4.3 above.

9 Expenditure on Administrative Expenses and Innovations

9.1 Under the expenditure category "*Administrative Expenses*", a government hospital may use the allocations (as set forth in Section 4.1) for administrative expenses which may include but not be limited to:

a. Routine office supplies and consumables for the administration of PM-JAY.

b. Maintenance of IT hardware and software related to PM-JAY operations.

c. Bank charges.

d. Any innovations aimed at improving patient care and patient safety including setting up teleconsultation services, more particularly for specialist consultations in rural areas.

9.2 All such expenses may be approved as per existing RKS guidelines or any other guidelines that the SHA may desire to put in place.

10 Expenditure for Emergency Purposes

10.1 Emergencies may include natural calamities and disaster, disease outbreaks, pandemics and any other situation that is declared as a medical emergency at the sole discretion of the state Health Departments. Expenditure incurred shall only be on account on either hospital-based or community-based medical treatment or medical relief under such emergency situations, including preparedness and mock drills.

10.2 All guidelines using funds generated from PM-JAY claim revenues for the emergency purpose, shall be developed by the state Health Departments and approved by the Principal Secretary of the Health Department.

11 State Corpus

11.1 If the SHA chooses to set up a state corpus through at-source deduction of funds from eligible PM-JAY claim amounts of government hospitals as per the provisions set forth in Section 3, SHA shall constitute a High Level Committee (HLC) for governance and oversight of the Corpus Fund.

11.2 **High-Level Committee:** The HLC may be chaired by the state Health Minister or the Principal Secretary of the state Health Department or the CEO of the SHA, as deemed appropriate by the SHA/state. States shall have the liberty to determine the constitution and other committee members. It is recommended to have state Mission Director NHM, and the head of the state infrastructure development corporation or any other agency responsible for civil construction/upgradation and medical equipment procurement works for health facilities in the state as members of the HLC.

11.3 **Responsibilities of the HLC:** The HLC shall be responsible for:

a. Approving the corpus fund utilisation guidelines, including updating as and when required.

b. Approving the eligibility criteria for (as applicable based on state guidelines):

   i. The government hospitals to access corpus funds for hospital upgradation.

   ii. Individuals seeking benefits for high-cost medical treatment that are either not covered under the PM-JAY benefits package or the cost of treatment is beyond the annual risk cover provided under the PM-JAY.

   iii. Any other usage of the corpus fund as deemed appropriate by the HLC.

c. Evaluation of applications for seeking funds/benefits from the corpus fund and all related decisions thereof.

d. Ensuring oversight on fund utilisation and accountability as per approved guidelines.

e. Any other function related to the corpus fund that the SHA may deem appropriate.

11.4 **Application of corpus funds:** Corpus funds may be used by the SHA for one or more of the following areas:

a. **Infrastructure upgradation:** Common infrastructure upgradation/patient amenities/facilitation services that may be required in most or all of the government hospitals: like PM-JAY kiosks, patient waiting areas upgradation, digital display boards at PM-JAY kiosks or touch-panel digital information kiosk at the PM-JAY desk for increased patient interaction and interface, etc.

b. **IEC activities:** State-wide communication campaigns, special drives for enrolment/empanelment; outreach camps through third party organisation (say NGOs).

c. **Staff recruitment:** Centralised recruitment of all PMAMs, DEOs or other PM-JAY staff for all government hospitals (in which case 15% allocation for salaries mentioned in Section 4.1 could be retained by the SHA).

d. **Centralised medicine procurement:** The SHA may collaborate with the agency that procures drugs for the state health department to purchase medicines commonly required for certain PM-JAY procedures that were not a part of the State Essential Drug List or not commonly procured in adequate quantities by the state health department. The list of such medicines and quantities could be furnished by the SHA based on prescription audit of at least selected high end procedures – and quantities supplied to hospitals as required.

e. **Using corpus fund for incentivising beneficiary enrolment:** SHAs may consider providing incentives to front-line workers for enrolling each new beneficiary to increase coverage of the scheme. In addition, special incentives may be announced by SHAs for front line workers that achieve more than 80% coverage of eligible beneficiaries in their respective geographical areas. All such incentives can be paid out of the state corpus. States shall develop an IT-based robust system for tracking front-line workers efforts and an automated system for determining the incentives eligible for each frontline worker. All eligible payments shall be transferred directly by the SHA into the bank accounts of beneficiaries every 15 days without front-line workers having to undertake any paper documentation.

f. Audit of all hospital accounts related to PM-JAY.

11.5 For any other purpose for which corpus funds may be used as determined by the HLC, the SHA shall develop appropriate guidelines and seek approval from the HLC.

12 Procurement using PM-JAY Claim Revenues

12.1 Each government hospital shall set up a procurement committee for procuring goods and services using PM-JAY claim revenues. Alternately, if a government hospital already has a functional procurement committee, the same committee may handle all procurement using PM-JAY claim revenues.

12.2 Existing procurement guidelines/practices of SHAs or government hospitals may be followed, provided:

a. Such guidelines are documented and approved by a competent state/district authority as per state guidelines.

b. The guidelines include different types of procurement (sole source, limited tender, open tender, etc.) and financial threshold values for each type of procurement.

c. Clear segregation of duties and authorities to prevent conflict of interest and ensure transparent and efficient procurement.

13 Fund Management and Accounting

13.1 **Bank account:**

a. Each government hospital shall set up a dedicated bank account for all transactions related to PM-JAY claim revenues.

b. SHA may set up a separate single bank account for managing the following fund streams if applicable for any state: (a) state corpus funds; (b) refund of funds not utilised by the hospitals; (c) funds retained or asked for by the SHAs from government hospitals in lieu of any centralised procurement/supply that the SHA may uniformly intend to do as per these guidelines.

13.2 Alternately, SHA may want its government hospital to use the main RKS bank account for all PM-JAY claim revenue transactions, provided:

a. separate books of accounts are maintained for PM-JAY claim revenues;

b. expenditure monitoring and tracking system shall ensure that claim revenues are not used for purposes other than those set forth under these guidelines; and

c. the accounting system within the hospital shall generate claim revenue specific receipt and expenditure statements as and when required by the SHA/health department.

13.3 **Signatories to the bank account:** Minimum of two signatories shall be there on the bank account. The state shall ensure that the signatories should be so designated that they are readily available for signatures.

13.4 **Financial powers and authorities:** State guidelines shall set forth financial powers for authorising expenditure in a manner that enables quick expenditure decisions.

a. States may follow existing RKS guidelines/practices unless states think that the existing delegation of powers may not hinder speedy expenditure decisions.

b. The government hospital in-charge/Superintendent should have adequate autonomy and significant devolution of financial powers at the operational level for taking quick expenditure decisions and undertake timely transactions, especially for the expenditure category "*medicines, diagnostics and consumables*". This is important to ensure that patients' medical needs during hospitalisation are met real-time without any out-of-pocket expenditure for the PM-JAY patient.

13.5 **Accounting system and platform:** The government hospital shall follow, and SHAs shall ensure that the accounting system and standards of accounting are followed in compliance with state government rules and statutory requirements:

a. Accrual system of accounting shall be followed.

b. All books of accounts to be maintained on accounting software.

c. Records for all funds transacted out of the bank account referred to in Para 13.1(b) above shall be maintained in a manner that allows for independent tracking of funds by source through separate ledgers/entries on the accounting software.

d. Petty cash limits and usage guidelines shall be developed as per SHA's existing rules.

14 Reporting

14.1 All government hospitals shall submit quarterly financial reports to the SHA within the 5th working day the month after the end of the quarter.

14.2 Financial report shall include:

a. Statement of PM-JAY claims submitted by volume and value and reimbursements received from the SHA, including outstanding dues and rejected claims.

b. Statement of total receipts and expenditure.

c. Detailed expenditure statement by expenditure categories set forth in Section 4.1 of this guideline.

d. Quarterly bank reconciliation statement (BRS) including BRS for the bank account referred to in Section 13.1(b) above.

14.3 SHAs shall set up a web-based expenditure reporting module specifically for this purpose or integrate reporting against PM-JAY claim revenues into their existing expenditure reporting module if any.

14.4 SHAs shall provide feedback to those government hospitals that consistently report low expenditure and follow up with corrective actions to ensure optimal fund utilisation.

15 Refund of Underutilised Funds

15.1 Claim revenues are generally the most flexible pool of funds available to government hospitals that should be used as per the needs and discretion of the hospital authorities to improve quality of care and overall hospital improvement.

15.2 The government hospitals shall have to refund to SHA all unspent amounts if the aggregate utilisation against PM-JAY claim revenues received by a government hospital is less than 80% for two consecutive financial years.

15.3 The amounts so refunded by the government hospital shall be credited into the state corpus account (refer to Section 13.1(b))and used as per the guidelines set forth for the state corpus fund or used for any other purposes related to patient care and hospital improvement as deemed appropriate by the state Health Department.

16 Audits

16.1 Each government hospital shall ensure annual statutory audits of PM-JAY claim funds at the disposal of the government hospitals.

16.2 Annual statutory audits of the SHA shall include a separate schedule showing audited receipt and expenditure statement for the funds transacted through the bank account referred to in Para 13.1(b).

16.3 Such audits shall be completed and report available within 180 days of the end of the financial year.

16.4 SHAs may consider including audit of PM-JAY claim revenue funds within the scope of existing concurrent/internal auditors and statutory auditors of NHM or set up mechanisms for hiring separate auditors.

16.5 If any reason whatsoever, SHA decides to hire separate auditors, it shall centrally procure and empanel the audit firm(s) and negotiate audit fees that are either lumpsum or slab-based depending on the volume of funds to be audited.

16.6 SHAs may choose one of the following options regarding contracting and payment of auditors:

a. ***Option 1:*** The government hospital may empanel the auditor(s) and declare volume-based audit fee slabs. Hospitals directly issue work orders at negotiated rates and pays the auditor directly from their allocations under administrative expenses.

b. ***Option 2:*** SHA may issue the work order centrally for audit of all government hospitals and pay centrally. The audit fee paid by the SHA may be recovered from the future PM-JAY claims of government hospital after apportioning the total audit fee paid to each government hospital based on the proportion of funds audited for each government hospital.