national health authority

सत्यमेव जयते

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

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Guidelines for portability services under AB PM-JAY

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Purpose & Scope

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana offers a unique feature of portability to its beneficiaries which allows them to avail health care services (as per the defined package) across the country through empaneled public and private healthcare service providers. The portability guidelines for AB PM-JAY are aimed at assisting State governments in implementing the portability services effectively. They further provide clarity on hospital empanelment, health benefit packages, IT applications, pre-authorization and claims payment & adjudication, fraud management etc. in context with portability feature.

Implementation of portability services

The State where beneficiaries name is registered, in the database of entitled families, will be recognized as the 'Home State' and the State where the beneficiary avails the treatment i.e. where the treating hospital is located will be called 'Hospital State'. For the purpose of this document, State would mean States and Union Territories (UTs).

1. Enabling portability (Memorandum of Understanding (MoU) & agreements)

a. States which are onboard for providing services under AB PM-JAY and who have signed an MoU with National Health Agency (NHA) will provide services under portability to eligible beneficiaries of other States through their empaneled hospitals.
b. All AB PM-JAY (SECC/RSBY) beneficiaries by default are eligible for portability services i.e. eligible beneficiaries can avail health care services at all empaneled across the country.
c. States may extend portability services to State scheme beneficiaries. NHA would provide all necessary support for roll out of services on request of individual States.
d. SHAs should ensure that the MoU/contract signed with the empaneled Hospital shall explicitly mandate the provision of healthcare services under portability feature to AB PM-JAY beneficiaries from outside the State.

2. Beneficiary Identification Process (BIS) in portability

The steps for beneficiary identification process under portability will be as follows-

a. The treating hospital will select the Home State in the BIS
b. 'Beneficiary Search' is performed on either SECC, RSBY or State entitled databases integrated with BIS to find the entitled beneficiary record.
c. ID proof of the beneficiary – individual and family IDs are captured and uploaded into BIS. This is sent to the Home State for validation directly.
d. The Home State shall validate the e-Card creation request within the defined service level agreements.
e. A feature for validation has also been added for Hospital State. The 'State Auditor' in BIS will now be able to view AB PM-JAY e- Card details for outside State beneficiaries.

3. Empanelment of Hospitals under portability

a. The respective State Health Agencies (SHA) shall be responsible for empaneling hospitals within their own States/UTs. This responsibility shall include the physical verification of facilities, medical audits, post procedure audits etc.

b. In exceptional scenarios if any State/UT feels that neighboring State has not empaneled enough hospitals, and hospitals in certain cities/districts (in other State) are required to be empaneled for portability cases, it may be brought to the notice of neighboring State for empanelment with intimation to NHA. In case of any disagreement between the two States, NHA will take a final decision on reference being made by the Home State.

c. In case the neighboring State is not implementing PM-JAY, the empanelment will be done by NHA. As a policy, NHA does not encourage the practice of one State empaneling hospitals in other States as that may create confusion in implementation of the scheme. However, in exceptional circumstances, States may be allowed to empanel one or more of hospitals in the non-participating State with prior intimation to NHA. In both the above cases the National Package master will be applicable.

4. Transaction Management System (TMS) in portability

a. All empaneled hospitals in the country will use NHA's BIS and TMS applications for catering to portability cases. States may use their own IT system for intrastate transactions.

b. Logins for all SHAs and their Insurers/ ISAs can be created by raising a ticket. TMS will also provide logins for all empaneled hospitals across the country. Hospitals, ISA and Insurers must be trained in using the BIS and TMS system.

c. The process of beneficiary identification will have to be completed by the Hospital State. NHA will support integration of State beneficiary database if maintained on a non NHA IT platform.

d. In case of beneficiaries that have been already verified by the Home State (i.e. Golden Record created in BIS post approval), the Beneficiary record can be directly searched in the TMS system and the treating hospital can immediately apply for pre-authorization. If the beneficiary has not yet been verified, then treating Empaneled Health Care Provider (EHCP) shall first conduct a beneficiary identity verification and admit the patient as per the case.

5. Health Benefit Packages (HBP) in portability

a. National portability will be permitted on the packages already existing in the National master. A total of 1,393 packages in HBP 1.0 and 872 packages (1,578 procedures) of HBP 2.0 will be used for portability. Portability of services will also be allowed for the "unspecified surgical package".

b. Hospitals can request for authorization for packages / procedures not available in the HBP master list using the "unspecified surgical package" option in case the portability beneficiaries hail from States having greater number of than present in the National master.
c. Package mapping between HBP 1.0 and HBP 2.0 is available. In case the HBP versions of the Home State and the Hospital State are different, the package mapping will be used at the backend to identify a suitable package.
d. The hospital will be paid at the HBP rates agreed to in the MoU/contract entered with the empaneling State. In case of hospitals that are directly empanelled with NHA, National master as per HBP 2.0 will be applicable. Subsequent revisions will be intimated to the concerned stakeholders.
e. All portability cases will require a mandatory pre-auth to be approved by the Home State. The rules related to auto approval due to delay in authorization will be applicable as per the Home State.
f. Regarding reservation of packages for public facilities, the rules of reservation of Home State shall apply. However, in exceptional cases, with the approval of Home State, relaxation can be provided.
g. Home State specific thresholds with respect to utilization of wallets for secondary, tertiary and unspecified packages, if any, will be applicable. It will be the responsibility of the 'Home State' to check whether these thresholds are being breached at the time of pre-authorization.
h. Package specific documents, as mandated by the Home State shall be required to be submitted by the treating hospital at the time of raising a pre-auth request, as well as at the time of claim submission.

6. Patient facilitation

Each SHA will identify a Single Point of Contact(s) (SPoC) to provide support to ensure the timely response to BIS, pre-auth approvals, claims payment and grievances. A list of State-wise SPoCs will be circulated to all States to facilitate the issues pertaining to portability services.

7. Claims adjudication for portability services

a. Wallet management of beneficiary will be the responsibility of the 'Home State'
b. A claim raised by the empaneled hospital through TMS will be received directly by the Trust/Insurer of the Home State. The Home State IC/Trust shall settle the claim with the hospital within 30 days of receipt of claim along with the required documents.
c. If a Hospital State has a policy whereby it allocates/deducts certain percentage of approved claim amount payable to their public hospitals and wants it to be applicable for portability cases in their hospitals also, then NHA should be informed to configure the same in the TMS. For this to be implemented, the Hospital state should mandatorily provide a separate bank account for deductions.

d. Home State shall honor claims raised for the cases wherein the pre-authorization has been completed either manually or by the system subject to uploading of requisite treatment documents or in case the treatment hospital has been found to be involved in fraudulent practices.

e. The timelines for processing of claim and payment along with other components of the claims adjudication (pre-authorization, CPD/PPD query resolution etc.) shall be as per table in Annexure1. Latest claims adjudication guidelines are available at https://www.pmjay.gov.in.

f. Portability claims payment: Following scenarios may be applicable in case the scheme implementation is on insurance or mixed mode in the 'Home State'. The scenario 1 is applicable for all the States drafting their Model Tender Document to select an Insurer.

   i. Insurance company will have to carry out due diligence and actuarial analysis based on the existing portability data to account for portability cases and possibility of paying different rates when 'Home State' patients go to other Hospital States to avail services. Quoted premium will account for portability cases and ICs will reimburse the hospitals at the rates applicable in the Hospital State. No separate payment/recovery will be made to or from insurance company on the account of differential rates in other States.

   ii. States already implementing the AB PM-JAY scheme in the insurance/mixed mode and currently have no provision in their existing contract with the IC as mentioned in the point f.(i) then, difference in the package rate of the Hospital State with respect to the Home State may be adjusted by the Insurance company with the SHA of Home State at a mutually agreed interval. However, portability feature should be incorporated as a part of the fresh tender document to select the insurer once the existing arrangement is over and has to be accounted for while insurer does the costing exercise as stated in f.(i) above. Such States/UTs may request NHA to make necessary changes in the IT system for calculation of the liability of SHA /Insurance company related to the portability cases.

Example:

Scenario			Maharashtra - Home State			Gujarat - Treatment State		Process
1	MH Patient goes to Gujarat - Home state Package is greater than Treatment State		Maharashtra Package for X Disease.	15000	→	Gujarat Package for X Disease.	12000	IC of MH will pay Guj Hos 12000, IC of MH will pay SHA MH - 3000
2	MH Patient goes to Gujarat - Treatment state Package is greater than home state.		Maharashtra Package for X Disease.	12000	→	Gujarat Package for X Disease.	15000	IC of MH will pay 15000 to Guj Hos, SHA MH will pay - 3000 to IC

Note: New Model Tender Document have also been developed as modular document and once the portability guidelines are revised, they become automatically applicable to Insurer/ISA.

8. Redressal of portability grievances

a) All beneficiaries' grievances against the hospital shall be referred to the District Grievance Nodal Officer (DGNO) of the Hospital State where beneficiary is applying/availing benefits of PM-JAY (other than Home State/UT)

b) Inter-State beneficiary cases should be solved by concerned District Grievance Redressal Committee (DGRC) and State Grievance Redressal Committee (SGRC) of the Hospital State. The SGRCs of both the States shall coordinate between themselves, if required, to redress the grievance.

c) All EHCP grievances against the Insurance company/ SHA shall be referred to the SGRC of both Home & Hospital State/UT. The SGRCs of both the States shall co-ordinate between them, if required, to redress the grievance.

d) Latest grievance redressal guidelines shall be referred for additional details in this regard.

9. Anti-fraud measures in portability cases

a. BIS Audits- Card of a beneficiary being created by PMAM/CSC of another State

1. Beneficiary Investigations for suspect BIS cards shall be conducted by Home State.
2. The investigation shall include BIS desk audits and visiting the beneficiary, verifying the information and collecting evidences.
3. If, during the investigation, it is established that the BIS records (silver/golden) submitted are incorrect or manipulated, the Home State shall share the findings with the State where the PMAM/CSC/Card issuer belongs to for further due diligence. A copy of such communication should be marked to NHA.
4. The State where the Card issuer (PMAM/CSC) is located shall conduct the investigation on the Card issuer and his connivance with other entities and act against the entities under their jurisdiction (Errant Card issuer/ Impersonator/ Hospital (if found to be in connivance) as per the BIS anti-fraud guidelines.
5. The Home State shall initiate investigation against the Card approver (if E-card is generated) and if collusion is confirmed, shall take appropriate action against the card approver as well.

b. Medical Audits of suspected Pre-auths/ Claims

Beneficiary availing treatment in hospital outside of 'Home State'. Medical audit will entail investigation of suspect transactions either in the form of desk or field audits. Desk audits can be conducted remotely by examining medical documents submitted by EHCP at the time of pre-auth/ claims, while field audit requires an in-person visit to the hospital/ beneficiary.

In case a claim needs to be investigated where beneficiary has gone out of Home State for treatment, the following methodology will be followed:

1. Desk audits

i. Desk audit of documents submitted by the EHCP for suspect cases shall be done by the beneficiary State.

ii. If adequate evidence is found during desk audit, it may be decided by the Home State, whether further field medical audit is required to be conducted by the Hospital State.
iii. Home State may decide if beneficiary audits are needed and carry them out accordingly.

2. **Field Audits**
i. If field medical audit of the hospital is needed, the outcome of desk audit shall be shared with Hospital State by Home State and the former shall conduct the field medical audit. Home State's officials may accompany on field medical audit, if feasible and considered appropriate.
ii. During the field medical audit, the Hospital State shall review case documents at the EHCP premises, collect relevant evidences and make observations on the cases.
iii. The Hospital State officials shall share the field audit report with outcomes with the Home State for the final decision on claims approval and payment. A copy of such communication should be marked to NHA.
iv. In case it is confirmed that the hospital has engaged in malpractices, then the Hospital State officials must initiate further action against the errant provider. The Home State may initiate action against the ISA if it is found to be in connivance with the hospital.

c. Payment of claims and Disciplinary Actions

1. In case of BIS fraud- if the fraud is confirmed, but there is no evidence of the EHCP being in connivance, in such cases the claims must be processed/ cleared provided that the services were rendered and EHCP provided treatment assuming the beneficiary was genuine, as per the anti-fraud guidelines.
2. In case of TMS fraud - if the outcomes of medical audit indicate evidences of malpractices, disciplinary action against EHCP (Show cause notice, suspension, penalty, de-empanelment, FIR, etc.) shall be initiated by the Hospital State.
3. In case other entities are also found to be in collusion to perpetrate the fraud, action will be initiated by the State which has agreement/contract with the entity, as per the anti-fraud guidelines.

Annexure 1: Turnaround time for the different operational activities

SN	Activities	Activity by	TAT	Proposed Action
1	**Pre-auth initiation after Patient Registration**	EHCP	24 hours post registration	• Auto rejection after 24 hrs. • New registration shall be initiated once rejection due to non-initiation pre-authorizations
2	**TAT for Pre-authorization Request**	Claims Adjudication Agency	6 hours (as per threshold set in TMS)	Auto approved after 6 hours (working hours)
3	**Response on PPD Query**	EHCP	24 hours	• Reminders after 24th hour, 48 hours, Auto reject after 72 hours due to non-submission of PPD Query. • The rejected claim can be revoked by SHA on receiving proper justification from EHCP post 72 hours. Reference shall be updated for Claims Adjudication manual in EHCP contract
4	**Claim submission after Discharge**	EHCP	To submit ASAP but not later than 7 days post discharge, above 7 up to 21 days with SHAs written approval, beyond 21 days not admissible	• First auto Reminders would be sent after 1st day & 3rd day and final auto reminder would be sent after 5th day of Discharge. • Claim beyond 7 days will move to SHA bucket. For reconsideration upto 21 days, medco shall raise reconsideration request quoting reasons for delay • SHA will approve or reject reconsideration request
5	**Response on CPD Query**	EHCP	7 days	• First Auto reminder after 1 day, 3 days and Auto reject after 7 days due to non-submission of response to CPD Query. • The rejected claim can be revoked by SHA after receiving proper justification from EHCP post 7 days.
6	**TAT for Claim payment**	Claims Adjudication Agency/SHA	30 days for inter-State portability	NA