Schedules to Insurance Contract

for

Selection of Insurance Company
for the implementation of
Ayushman Bharat Pradhan Mantri Jan Arogya Yojna
Chief Minister's Health Insurance Scheme
(AB PM-JAY CMHIS)

Volume 3
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Schedule 1: Details of the Scheme and Beneficiaries

The name of the Scheme is **Ayushman Bharat Pradhan Mantri Jan Arogya Yojna Chief Minister's Health Insurance Scheme (AB PM-JAY CMHIS) ,** a converged scheme of the **Chief Minister's Health Insurance Scheme (CMHIS) launched by the Government of Nagaland (GoN) in the State and AB PM-JAY.** This Schedule lays down the key elements of the design and implementation of the proposed Scheme.

1. Objective of the scheme

1.1 **AB PM-JAY CMHIS** aims to protect against catastrophic health expenditure and reduce out-of-pocket expenditure by providing Insurance Coverage for hospital care to all residents of the State as defined in Section 2 of this Schedule 1 below.

1.2 The **AB PM-JAY CMHIS** is a step towards fulfilling the Nagaland Sustainable Development Goal Vision 2030, launched by the Hon'ble Chief Minister of Nagaland in August 2021, which states that by 2030, Nagaland will **ensure healthy lives and promote well-being for all ages** by providing **equitable, affordable,** and **quality healthcare services** to the people of the state.

1.3 The **AB PM-JAY CMHIS** will strengthen health systems and service delivery by increasing efficiencies, reducing fragmentation in existing health protection schemes, and improving service delivery and user experience.

2. Eligibility for coverage

2.1. The unit of enrolment shall be a Beneficiary Family as follows:

2.1.1.Beneficiaries Covered under AB PM-JAY

a. Families entitled for benefits under the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY);
b. Additional categories who have been extended benefits of the AB PM-JAY by the Government of India (GoI): e.g., Building and other Construction Workers (BoCW);

2.1.2. Beneficiaries Covered under CMHIS

a. GoN employees and other officials, and their dependents entitled for benefits under the existing Medical Reimbursement Scheme of the GoN, and serving Parliamentarians/Legislators;
b. GoN pensioners and ex- Parliamentarians/Legislators; and
c. Any uncovered households with a valid Ration Card/ Permanent Resident Certificate (PRC) or Indigenous Inhabitant Certificate (IIC).

2.2. All enrolments under the AB PM-JAY CMHIS shall be on a 'family' or 'Household' basis without limit to the number and age of members in the family/household, provided the dependency criteria dependency criteria for employees and pensioners as defined in the table under Section 2.4 of this Schedule 1 is met.

2.3. To administer the AB PM-JAY CMHIS , the population of Nagaland eligible for the AB PM-JAY CMHIS shall be divided into the five categories mentioned in table under section 2.4 of this Schedule 1 below.

2.4. For AB PM-JAY CMHIS, the GoN shall adopt the following definitions for a "Family," which shall be either dependency based on family-based depending on the Category of the beneficiary:

Category	BENEFITS Category CODE	Beneficiary Family Unit definition
Category 1: AB PM-JAY	CMHIS (GEN)	Family-based as defined under the Government of India's AB PM-JAY scheme.
Category 2: Additional AB PM-JAY	CMHIS (GEN)	Same as Category 1
Category 3: GoN employees and other officials, and serving Parliamentarians/ Legislators	CMHIS (EP)	Dependency-based: definition of a family shall be as per the Central Services (Medical Attendance) Rules 1944 – a Government employee's wife or husband, and parents, sisters, widowed sisters, widowed daughters, minor brothers, children, stepchildren, divorced/ separated daughters, and stepmother wholly dependent upon the Government servant and usually are residing with the Government employee.
Category 4: GoN pensioners and ex Parliamentarians/Legislators	CMHIS (EP)	Same as Category 3
Category 5: General population	CMHIS (GEN)	Same as Category 1

Note: CMHIS (GEN) *and* ***CMHIS (EP)*** *- code "GEN" refers to "General" and "EP" refers to GoN employees and pensioners*

2.5. For enrolment under the AB PM-JAY CMHIS , family members shall be considered as per the family members listed on the issued ration cards on the NFSA database for Nagaland.

2.6. For those not having a ration card, a self-certified list of household members countersigned by local authority shall be required for defining family members. The GoN shall undertake intensive audits of such declarations, and deterrent measures, including criminal liability for fraud, shall be undertaken for any false declarations made by individuals.

'Family' in common parlance connotes a group of persons united by the ties of marriage, blood, or adoption, constituting a single household and interacting with each other in their respective social positions, usually those of spouses, parents, children, and siblings.

3. Annual Risk Cover

3.1 All beneficiaries of AB PM-JAY CMHIS , from Categories 1 to 5 shall be eligible for a Basic Risk Cover of Rs 500,000 (Rupees five lakhs only) per annum on a family floater basis offered through the insurance mode.

3.2 In addition to the Basic Risk Cover as specified in Section 3.1 above, all beneficiaries under Category 3 (GoN employees and other government Officials and serving Parliamentarians/Legislators) and Category 4 (GoN pensioners and ex-Parliamentarians/Legislators) shall be eligible for additional top up cover of Rs. 5,00,000(Rupees Five Lakhs Only)/Rs. 15,00,000(Rupees Fifteen Lakh Only)<to be edited after bid opening> .

4. Nagaland Health Benefits Package 2022 (N-HBP2022)

4.1 The AB PM-JAY CMHIS has two types of Health Benefits Packages (N-HBP 2022) for different population categories. Henceforth, these will be referred to as **CMHIS (GEN)** and **CMHIS (EP)** when the code "GEN" refers to "General" and "EP" refers to GoN employees and pensioners.

4.2 Beneficiaries under Category 1 (AB PM-JAY), Category 2 (Additional AB PM-JAY), and Category 5 (General Population) shall be eligible for HBP under **CMHIS (GEN)**.

4.3 Beneficiaries under Category 3 (GoN employees and other officials, and serving Parliamentarians/Legislators) and Category 4 (GoN pensioners and ex Parliamentarians/Legislators) shall be eligible for HBP under **CMHIS (EP)**.

4.4 **HBP under CMHIS (GEN) for Category 1 (AB PM-JAY), Category 2 (Additional AB PM-JAY), and Category 5 (General Population)**:

a. The HBP under CMHIS(GEN) shall hereafter be referred to as "**N-HBP 2022 for CMHIS (GEN)**".

b. Procedures: The AB PM-JAY CMHIS will cover approximately 1950 in-patient procedures across 27 major clinical specialties. The procedures will include both surgical and medical procedures and limited day-care packages. Based on the feedback and suggestions received from stakeholders, the procedure list may undergo revisions, additions, and deletions as the AB PM-JAY CMHIS progresses.

c. Bundled package costs: The package cost shall be "bundled," implying that it will be an all-inclusive cost payable for a particular procedure (including medical management cases); the cost of Implants, high-end drugs, and diagnostics may be additional in a matter of few specific procedures. *Refer Schedule 3 and Schedule 4 of this Insurance Contract for components of the package, inclusions, and exclusions.*

d. Package prices: The package prices have been fixed by the Department of Health and Family Welfare, GoN in consultation with relevant experts and providers, also taking the help of national guidelines laid down by the National Health Authority (NHA), and as modified and applicable to Nagaland. The package prices shall be reviewed by the SHA at regular intervals.

e. Standard Treatment Guidelines (STG): As per the World Health Organization, STGs 'assist practitioners and patients in making decisions about appropriate health care for specific clinical circumstances. Thus, the procedure packages shall follow the STGs developed by the NHA for most utilized packages to the extent feasible. The mandatory documents specified in STGs shall also help empaneled hospitals submit uniform set documents in support of procedures booked for treating a patient, thereby increasing the operational efficiencies.

4.5 N-HBP 2022 under CMHIS (EP) for Category 3 (GoN employees and other Officials, and serving Parliamentarians/Legislators) and Category 4 (GoN pensioners)

a. Benefit for CMHIS (EP) shall be as per the CGHS package construct.

b. Beneficiary Categories that are eligible for CMHIS(EP) cover shall be entitled to in-patient care with differential room entitlement as per employee Pay Level or Pay Level at which the employee retired as specified in Clause 5.4.3.

c. For the purposes of room entitlement as provided in Clause 5.4.2, employees of GoN shall be entitled to treatment as per the room entitlement given in the table below:

Employee classification as per Pay Level	Room entitlement	Maximum Room Rate (Per day)
Pay Level 15 and above	Private ward	3000
Pay Level 10-14	Semi-private ward	2000
Pay Level 9 and below	General Ward	1000
All levels	Day Care (6-8 hours)	500

i. Room rent is applicable only where prescribed treatment package rates are not available. Room rent includes charges for occupation of bed, diet for patient, charges for electricity and water supply, linen charges, nursing charges and routine up keeping.

ii. For patients availing bundled health benefit packages (surgical packages), no separate room rent will be admissible if the patient is treated in ICU/ICCU.

iii. Private ward, semi-private ward, and general ward are as per the definitions given by CGHS. Entitlement to rooms and exceptions in case of non-availability of entitled category accommodation, admission to higher or lower category of accommodation, etc., shall be as per extant CGHS guideline.

d. For the purposes of room entitlement as provided in Clause 5.4.1, all pensioners of GoN shall be entitled to avail of care with room upgrade as per the room entitlement given in Clause 1.7.2.1 above based on the employee classification level at which they retired from service with the GoN.

e. The Insurer shall ensure that all beneficiaries under Beneficiary Category 3: all employees and other officials of GoN, and serving parliamentarians/Legislators shall be allowed to avail of care with room upgrade per their room entitlement provisions set forth in Clause 5.4.3.

f. The Insurer shall ensure that all beneficiaries under Category 4: GoN pensioners and ex-parliamentarians/Legislators shall be allowed to avail of care with room upgrade as per their room entitlement provisions set forth in Clause 5.4.4 based on the employee classification level at which they retired from service with the GoN.

g. The benefits under the CMHIS (EP) shall be organized on a cashless basis at empanelled hospitals.

h. For treatment within Nagaland of Beneficiaries eligible for CMHIS (EP), shall follow the following construct as per prescribed rates detailed out in N-HBP 2022 for CMHIS(EP) in Schedule 3B :

i. The prescribed package rates are for semi-private ward. If the beneficiary is entitled for general ward there will be a decrease of 10% in the rates. For private ward entitlement there will be an increase of 15%. However, the rates shall be the same for investigation irrespective of entitlement.

ii. Package rate includes all the expenses for in-patient treatment, and specific daycare procedures. Beneficiaries are permitted by the competent authority or for treatment under emergency from the time of admission to the time of discharge, including (but not limited to):

- Registration charges
- Admission charges
- Accommodation charges
- Diet charges
- Operation charges
- Injection charges
- Dressing charges
- Doctor consultant charges
- ICU/ICCU charges
- Monitoring charges
- Transfusion charges
- Anesthesia charges
- Operation theatre charges
- Procedural charges
- Surgeon fee
- Surgical disposables cost
- Medicines cost
- Physiotherapy charges
- Nursing charges

iii. For implants, stents, grafts, consumables, drugs, not specifically mentioned in the NHBP 2022 for CMHIS (EP) list, the lower of the rates as per PMJAY (Gen) rates or CGHS or NPPA (National Pharmaceutical Pricing Authority) ceiling rates shall be applicable. If no prescribed ceiling rates are available, the cost shall be paid as per actual.

i. For treatment outside Nagaland of Beneficiaries eligible for CMHIS (EP), CMHIS (EP) Beneficiaries can access care at any CGHS empaneled hospital (on CGHS rates

applicable for that city) across India with room category as per their room entitlement as per the provisions of Clause 5.4.3 and Clause 5.4.5;

1.2 The Insurer shall provide cashless benefits as per the Benefit Packages furnished in Schedule 3: 'N-HBP 2022 and Packages Rates' and its sub-schedules subject to exclusions set forth in Schedule 4: 'Exclusions to the Policy'.

1.3 The Insurer shall ensure pre-authorisation of pre-defined cases within the prescribed turn-around time for availing select treatment in any empanelled hospitals.

1.4 Except for exclusions listed in Schedule 4, treatment/procedures will also be allowed , in addition to the procedures listed in Schedules 3A and 3B, of up to the limit of Insurance Cover **(called 'Unspecified Procedure')** to all AB PM-JAY CMHIS Beneficiaries within the overall limit of Rs. 5,00,000 for CMHIS (GEN) and with an additional top up cover of Rs. 5,00,000/Rs. 15,00,000 for CMHIS (EP). <relevant amount to be retained after premium discovery> Operations pertaining to Unspecified Procedure are to be governed as per Unspecified Package Guidelines provided under Schedule 3C.

5. Identification and Enrolment of beneficiaries

5.1 The AB PM-JAY CMHIS is an entitlement-based Scheme wherein all Beneficiaries meeting the eligibility criteria in Section 2.1 of Schedule 1 shall be eligible for coverage under the Scheme. A covered family member can avail of treatment at any of the empaneled hospitals at any time after due identification.

5.2 **Beneficiary identification:** An essential aspect of AB PM-JAY CMHIS is the proper identification of beneficiaries of the Scheme.

a. For this purpose, the beneficiaries shall provide identification documents to substantiate individual ID and family ID. To ensure the uniqueness of each beneficiary ID, Aadhaar ID shall be a mandatory identification document along with other individual and family level identification documents as per table below:

Category		Required individual ID document	Required family document
Cat 1	AB PM-JAY	Documents needed as the AB PM-JAY scheme guidelines for those eligible but not yet enrolled	As per GOI definition / Ration Card / Prescribed format from Village

			Council / Ward Authority
Cat 2	Additional AB PM-JAY	Same as Category 1+BoCW or any other identifying Category ID	Same as Category 1
Cat 3	GoN Regular employees and other officials, serving Parliamentarian/Legislators	5.1.1.1. Aadhaar card 5.1.1.2. GoN issued Photo ID card which includes PIMS number/Employee Code	Self declared list and approved by P&AR Department
Cat 4	GoN pensioners and ex-Parliamentarian/Legislators	1. Aadhaar card 2. GoN issued Photo ID card/ Pension Payment Order(PPO)	Self-declared list and approved by P&AR Department
Cat 5a:	NFSA ration card holder who do not fall under categories 1-4 above	Aadhaar card	Same as Category 2
Cat 5b:	General - all other residents	1. Aadhaar card 2. Any one of the following: valid Permanent Residency Certificate (PRC) **OR** Certificate or Indigenous Inhabitant Certificate(IIC)	Self-Certified list and countersigned by local authority

b. The unit of coverage under AB PM-JAY CMHIS is based on 'family' or 'household', thus, family or household documents also form part of identification documents to be submitted by beneficiaries for enrollment under the CMHIS. A detailed list of individual and family identification documents for different groups of beneficiaries is provided in the table above.

5.3 **Beneficiary enrolment drive**: To promote awareness of the scheme and to streamline the covered beneficiary database on a 'family'/'household' basis for the efficient rollout of the scheme, it is proposed to carry out an enrolment process on an ongoing basis during the first one to two years of the scheme till the time all citizens of Nagaland are enrolled with a

unique individual and family identification document specific to the CMHIS. The entitled beneficiaries shall be enrolled under AB PM-JAY CMHIS following due process of identification, and a unique ID for AB PM-JAY CMHIS shall be generated.

a. Enrolment of eligible beneficiaries is expected to be completed within 1-2 years of the launch of the CMHIS, and only additions/deletions may be carried out after that.
b. For the beneficiaries who already have an AB PM-JAY ID, their existing card shall continue to be valid. Special enrolment drive/card delivery campaigns shall be held for Government employees and pensioners close to their place of work or another suitable location.
c. All other categories of beneficiaries shall get enrolled through enrolment drives and other appropriate mechanisms as organized by the GoN, and obtain their unique AB PM-JAY CMHIS ID. All empaneled hospitals shall also have a beneficiary enrolment facility so that no beneficiary is denied treatment due to lack of enrolment under the Scheme.
d. All beneficiaries shall receive an AB PM-JAY CMHIS card after enrolment, and the card shall be valid in perpetuity so that a new card is not required to be issued yearly. The beneficiaries who are already enrolled under AB PM-JAY and have received an Ayushman card will not be issued another card as their existing Ayushman card shall be valid for CMHIS.
e. In case the AB PM-JAY card is not linked to Aadhaar, the beneficiary shall be advised to have it linked, in any case, before utilizing benefits.

6. Provider (empaneled hospital) network

6.1 The AB PM-JAY CMHIS shall empanel both public and private hospitals so that an appropriate level of care is accessible to the beneficiaries on a cashless basis without difficulty.

6.2 The AB PM-JAY CMHIS shall also ensure portability of benefits outside Nagaland so that beneficiaries traveling/residing outside the State can also avail of benefits on a cashless basis.

6.3 Hospital network under CMHIS (GEN):

a. The hospitals desirous of empanelment under the AB PM-JAY CMHIS shall need to comply with the minimum criteria as set out in Schedule 6 of this Insurance Contract.
b. Hospitals shall apply for empanelment online on a dedicated government portal, and the overall time for completion of the end-to-end process from submission of

application to physical/virtual inspection, approval of an application to allocation of Hospital ID, and launch of operations shall be maximum one month.

c. All hospitals presently empaneled by the State Health Agency (SHA), GoN under AB-AB PM-JAY shall be deemed empaneled under the CMHIS (GEN), and no additional registration or empanelment shall be required.

d. The SHA shall hold consultations and approach all private hospitals not part of the AB PM-JAY network to be a part of the CMHIS.

e. The empaneled hospitals shall be reimbursed for the cost of treatment as per N-HBP 2022 rates for the booked 'package' and shall not be allowed to charge patients for any costs related to treatment, food, etc.

6.4 **Hospital network under CMHIS (EP)**:

a. Within Nagaland: Category 3 (GoN employees and other officials and serving Parliamentarians/Legislators) and Category 4 (GoN pensioners and ex-Parliamentarians/Legislators) beneficiaries covered under CMHIS(EP) shall have access to the network of empaneled hospitals covered under CMHIS(GEN) within Nagaland. All such private hospitals within Nagaland will be onboarded through an empanelment process. This will be the primary responsibility of the Insurance Company.

b. Outside Nagaland: CMHIS(EP) beneficiaries can avail treatment in all CGHS empaneled hospitals across the country. For CGHS empaneled hospitals offering treatment to CMHIS (EP) beneficiaries, the CGHS rates applicable for the booked procedure/package shall be used to reimburse claims. They shall not be allowed to charge patients for any costs related to treatment, consumables, and components included in the packages.

6.5 If a hospital is empaneled for both CMHIS (GEN) and CMHIS (EP), the hospital will admit the patient under the scheme of entitlement of the beneficiary, i.e., AB PM-JAY for CMHIS(GEN) and CGHS for CMHIS(EP).

6.6 The empaneled hospitals shall be reimbursed for the cost of treatment as per N-HBP 2022 rates for CMHIS (EP) and shall not be allowed to charge patients for any costs related to treatment, food, etc., unless the beneficiary chooses to seek services in upgraded room, in which case the Beneficiary shall pay the difference between the package price as per their entitlement and the services actually sought.

6.7 The CGHS hospitals shall be empaneled through NHA Convergence platform and Insurance company shall be responsible for providing on-ground/field level support for onboarding the hospitals, supported by SHA, GON as required.

7. Administration of AB PM-JAY CMHIS

7.1 **Registration of the SHA**: For administration and implementation of AB PM-JAY CMHIS , the GoN shall register a non-profit entity under the Society's Registration Act. The newly registered Society shall exercise all the required authority and powers to take policy decisions, design, manage and administer the AB PM-JAY CMHIS as per the provisions of its Memorandum of Association.

7.2 **Functions and capacity of the SHA**: Some of the key functions that the SHA is expected to perform are – to develop an overall policy framework and guidelines for implementation of AB PM-JAY CMHIS for all beneficiaries (including AB PM-JAY), estimate budget and provisioning of funds, hold consultations with stakeholders, contract with healthcare providers and other implementation agencies such as insurance companies, ISA, IEC agencies, etc., establish operational processes, monitoring mechanisms, supervise the implementation and all other activities to achieve the objectives of the program efficiently. The SHA shall be staffed adequately with experienced staff in key scheme implementation and monitoring areas. At the district level, the District Implementation Unit shall comprise Dy. Commissioner and Chief Medical Officer/Dy. Chief Medical Officer, supported by District Program Manager (DPM) and/or other staffs as required.

7.3 **Mode of administering the AB PM-JAY CMHIS** : The AB PM-JAY CMHIS shall be administered through an Insurance mode upto the Insurance cover. Refer to the table below.

The Insurance Company shall bear the financial risk, and the State Government's liability will be limited to the agreed premium per Beneficiary Family Unit (BFU). The Insurance Company shall 'underwrite' the risk and perform all functions in consideration of the 'premium' paid for all covered families. The Insurance Company shall bear the liability, empanel hospitals, process transactions, settle and pay claims, manage grievances, etc.

Category		Basic Cover up to Rs 5 lakhs per annum	Top-up cover More than Rs 5 lakhs – Rs 15 lakhs per annum
Category 1	AB PM-JAY	Insurance mode	Not applicable
Category 2	Additional AB PM-JAY	Insurance mode	Not applicable

Category 3	GoN employees GoN employees and other officials, and serving Parliamentarians/Legislators	Insurance mode	Insurance mode
Category 4	GoN pensioners ex-Parliamentarians/Legislators	Insurance mode	Insurance mode
Category 5	General population	Insurance mode	Not applicable

7.4 **24X7 call center for handling beneficiary queries and stakeholder grievances**: It is proposed that a call center will be set up for the beneficiaries. The call center shall have the following salient features:

a. The call center shall operate 24 hours a day, seven days a week.

b. The call center operations and management, including recruitment of staff, and licensing of the software, and any Technology Upgradation shall be the responsibility of the Insurance Company. This shall be a specific deliverable and included in the tender document, and the Insurance Company shall be expected to factor this while quoting their premium.

c. The toll-free number, space and one time Procurement of IT shall be arranged and owned by the GoN to ensure continuity of the helpline number even if Insurance Companies change over time.

d. At the end of the term of the Insurance Company, the Insurance Company shall unconditionally hand over all the call center data, infrastructure, technology, licenses, and software along with their copyrights to the GoN.

Schedule 2: Enrolment of AB PM-JAY CMHIS Beneficiary Family Units (BFU)

1. The SHA shall, either itself or through other agencies hired by it, carry out enrolment process on an ongoing basis for the first two years of the Scheme or until such time that all families eligible for AB PM-JAY CMHIS benefits are enrolled with a unique individual and family identification number.

2. The SHA shall create a Master Beneficiary Database for the AB PM-JAY CMHIS through various existing sources as detailed below:

Beneficiary Category	Category description	Source of Data
1	AB PM-JAY beneficiaries	PM-JAY database
2	Additional AB PM-JAY beneficiaries (Building & Other Construction Workers – BOCW)	Nagaland Building and Other Construction Workers' Welfare Board
3	Government Employees	Personnel and Administrative Reforms, GoN
4	Pensioners	Personnel and Administrative Reforms, GoN, Finance Department GoN
5a	NFSA ration card holder who do not fall under categories 1-4 above	NFSA data base from the Department of Food and Civil Supplies, GoN
5b	All other residents	Through enrolment drive

3. Specifically for the AB PM-JAY Beneficiaries, all the AB PM-JAY Beneficiary Family Units, as defined under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (in rural areas) and broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of Nagaland (as updated from time to time) along with the existing Rashtriya Swasthya Bima Yojana (RSBY) Beneficiary Families not figuring in the SECC 2011 Database which are resident in Nagaland and fall under one or more of the categories shall be considered as eligible for benefits under the Scheme and be automatically covered under the AB PM-JAY.

Beneficiary Identification

4. The identification documents as provided in Schedule 1 Section 5.2 a shall be considered as valid for substantiating individual eligibility and family identity under the AB PM-JAY CMHIS
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5. For ensuring uniqueness of each beneficiary ID, Aadhaar ID shall be mandatory identification document along with other individual and family level identification

documents listed under Section 4 of this Schedule 2. In case Aadhaar is not available then other defined Government recognized ID will be used for this purpose. State Government shall share with the insurance company within 7 days of signing the agreement a list of defined Government IDs.

Beneficiary Enrolment

6. The eligible Beneficiaries of AB PM-JAY CMHIS shall be enrolled under the Scheme following due process of identification, and a unique ID for AB PM-JAY CMHIS shall be generated.

7. At the time of enrolment:

    a. A Beneficiary must produce an identification document as per the details provided under Section 5.2 a of Schedule 1.
    b. The operator from the card generating/enrolment agency shall undertake an online search of the Beneficiary Identification System (BIS) to determine if the person is covered.
    c. Search can be performed by Name and Location, Household ID, Employee ID, PPO No, Ration Card No or Mobile number (collected during data drive) or ID printed on the letter sent to family or RSBY URN
    d. The operator will capture 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.
    e. If the beneficiary's name is found in the Beneficiary Identification System (BIS) of the Scheme, Aadhaar (or an alternative government ID) and Ration Card (or an alternative family ID) as per Section 4 of this Schedule 2 is collected against the Name / Family.
    f. The operator shall send the linked record for approval to the Insurance Company / Trust. The beneficiary will be advised to wait for approval from the Insurer or other card approving agencies deployed by the SHA.
    g. The Insurer will setup a Beneficiary approval team that works on fixed service level agreements on turnaround time.
    h. 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

8. The enrolment system shall have the provision of additions/deletions to the Beneficiary Master Database as per the Scheme eligibility criteria.

9. Special enrolment drive/card delivery campaigns shall be held for Government employees and pensioners close to their place of work or another suitable location.

10. All other categories of beneficiaries shall visit the enrolment facilitation centers established for AB PM-JAY CMHIS , get enrolled, and obtain their unique AB PM-JAY CMHIS ID.

11. All empaneled hospitals shall also have a beneficiary enrolment facility so that no beneficiary is denied treatment due to lack of enrolment under the Scheme.

12. All beneficiaries shall receive an AB PM-JAY CMHIS card after enrolment, and the card shall be valid in perpetuity so that a new card is not required to be issued yearly.

13. The beneficiaries who are already enrolled under AB PM-JAY and have received an Ayushman card will not be issued another card as their existing Ayushman card shall be valid for AB PM-JAY CMHIS .

Schedule 3: Nagaland Health Benefits Package 2022 (N-HBP 2022) and Package Rates

Schedule 3A: N-HBP 2022 for CMHIS (GEN)

Schedule 3A may be accessed at :
https://cmhis.nagaland.gov.in/docs/N-HBP%202022%20for%20CMHIS%20(GEN).pdf

Schedule 3B: N-HBP 2022 for CMHIS (EP)

Schedule 3B may be accessed at:
https://cmhis.nagaland.gov.in/docs/N-HBP%202022%20for%20CMHIS%20(EP).pdf

Schedule 3C: Guidelines for Unspecified Packages

1. **All unspecified packages:** To ensure that beneficiaries are not denied care, for treatments/procedures that do not feature in the listed interventions, there is an exclusive provision that has been enabled in the TMS (transaction management system) for blocking such treatments, subject to satisfying certain defined criteria (as mentioned).

2. Unspecified Surgical packages can be booked under the following circumstances:

    a. Only for surgical treatments.
    b. Compulsory pre-authorization is in-built while selecting this code for blocking treatments.
    c. Cannot be raised under multiple package selection. Not applicable for medical management cases.
    d. Government reserved packages cannot be availed by private hospitals under this code.
    e. Preauthorization Panel Doctor (PPD)/ Claims Panel Doctor (PPD) may reject such claims on these grounds. In addition, the SHA may circulate Government reserved packages to all hospitals. Further, States need to establish suitable mechanisms to refer such cases to the public system – to avoid denial of care.
    f. Cannot be booked for removal of implants, which were inserted under the same Policy. Exceptions where removal of implants is not covered under any other package, to be approved by State Health Agencies
    g. In the event of portability, the home state approval team may either reject if a government reserved package of the home state is selected by a private hospital in the treating state or consider on grounds of ‘emergency’.

h. Aesthetic treatments of any nature cannot be availed under this code or as such under any other listed codes. Only medically necessary with functional purpose/ indications can be covered. The procedure should result in improving/restoring bodily function or to correct significant deformity resulting from accidental injury, trauma or to address congenital anomalies that have resulted in significant functional impairment.
i. Individual drugs or diagnostics cannot be availed under this code. Only LISTED drugs and diagnostics with fixed price schedules, listed under the drop down of respective specialties, are included for blocking treatments.

3. None of the treatments that fall under the exclusion list can be availed viz. individual diagnostics for evaluation, out-patient care except otherwise listed out in the N-HBP 2022, drug rehabilitation, cosmetic/ aesthetic treatments, vaccination, hormone replacement therapy for sex change or any treatment related to sex change, any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalization for treatment etc.

4. However, for life threatening cases e.g., of suicide attempt or accident due to excess consumption of alcohol, treatment shall be provided by the hospital till the patient's condition stabilizes.

5. In case the State is getting multiple requests for the same unspecified package from multiple hospitals or for multiple patients, then the same should be taken up with the Medical Committee for inclusion in the package master for that State within a defined time frame as per the State.

6. For deciding on the approval amount, the PPD may consider the rate of closest match of the requested surgery, in listed packages. It should be noted that the amount approved by the PPD would be sacrosanct, to be communicated to the hospital, and the CPD would not be able to deduct any amount or approve partial payment for that claim.

7. Unspecified package above Rs 1 lakh to Rs 5 lakh: For State to utilize the unspecified package above Rs 1 lakh, it is to be ensured that the same is approved only in (a) exceptional circumstances and / or (b) for life saving conditions.

8. Exceptional circumstances may include:
    a. Rare disease conditions or rare surgeries.
    b. Procedure available under N-HBP 2022 in a different specialty but not available in the treating specialty.

c. Procedure available under N-HBP 2022 in a specialty for which the hospital is not empaneled.
d. Other conditions / treatments which are not excluded under the AB PM-JAY CMHIS but not listed in N-HBP 2022.
e. Life-saving conditions may include Emergencies or life-threatening conditions

9. A Standing Medical Committee (SMC) will be constituted by the CEO of the SHA to provide inputs on requests received for unspecified surgical packages among their other deliverables.

10. While it is difficult to define all the situations where unspecified surgical package may be used or the upper limit for booking the package, but it can be allowed if it is approved by medical committee of the SHA comprising of experts from public hospitals. Condition for booking such package should also be mentioned as described above. The broad SoP for processing the requests for booking of Unspecified Surgical Packages(USP) shall be as follows:
    a. Every USP, before being put up to the competent authority, shall be examined by the medical cell of the SHA.
    b. The request for approving USP along with the opinion of the medical cell shall be placed before the competent authority for approval. The competent authority for approving such requests shall be:
        (i) Chief Executive Officer, SHA: For USPs upto Rs. 1 lakh
        (ii) Addl. Chief Secretary/ Principal Secretary/ Secretary (Health& Family Welfare) of respective State/UT: For USPs between Rs. 1 lakh to Rs. 5 lakh

    c. Approval shall be done after taking inputs from the SMC, with details of treatment and pricing that is duly negotiated with the EHCP. This recommendation should have Insurance Company's concurrence, wherever applicable.

    d. The price should be based on the principle of case-based lump-sum rate that includes all investigations, procedure cost, consumables, post-op care and applicable incentive to the hospital included – preferably citing rates as ceiling from any government purchasing scheme like CGHS etc., if available.

    e. The turnaround time for the entire activity shall be 48 hours to ensure that the beneficiary is provided prompt treatment.

Schedule 3D: Differential package pricing guidelines for EHCPs

**These differential package pricing shall not be applicable for N-HBP 2022 for CMHIS (EP) , ie., treatment of Government Employees/Pensioners/ex-Legislators/other Government Officials shall only be claimed by EHCPs at the published N-HBP 2022 for CMHIS (EP) with no additional incentives as defined below , which will be applicable on for AB PM-JAY and general Category Beneficiary categories using the N-HBP 2022 for CMHIS (GEN). However any applicable Incentives under CGHS shall apply for CGHS-Network Hospitals outside the state. **

EHCPs fulfilling the criteria set forth in the table below shall be eligible for incentives which is a percentage mark up on the base package price:

S. No.	Criteria	Incentive (Over and above base procedure rate)
1	AB PM-JAY Bronze certification	5%
2	Entry level NABH / AB PM-JAY Silver certification	10%
3	Full NABH / JCI accreditation/ NQAS certification/ AB PM-JAY Silver certification	15%
4	Situated in Delhi or some other Metro*	10%
5	Aspirational district	10%
5	Running PG / DNB course in the empaneled specialty	10%

*Classification of Metro Cities:

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

These percentage incentives are added by compounding. However, Hospitals eligible for both NABH and NQAS related incentive will be incentivized under NQAS only.

Schedule 3E: Quality Certification of Empanelled Health Care Providers

a. The SHA, through Insurance Company, shall ensure the quality of service provided to the beneficiaries in EHCP.
b. EHCP has to monthly submit the online Self – Assessment checklist to District Empanelment Committee and SHA shall focus on low performing hospitals for further improvement.
c. EHCP will be encouraged by Insurer to attain quality milestones by attaining AB PM-JAY Quality Certification (Bronze, Silver and Gold).
d. Bronze Quality Certification is pre-entry level certificate in AB PM-JAY Quality Certification. EHCP which do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate.
e. Bronze Quality Certified EHCP can apply for AB PM-JAY Silver Quality Certification after completion of 6 months from the date of receiving bronze certification. This certification is also benchmarked with NABH Entry Level / NQAS certification and EHCP with these certifications can directly apply for Silver Quality Certification without getting Bronze Quality Certification with simplified process.
f. Silver Quality Certified EHCP can apply for AB PM-JAY Gold Quality Certification after completion of 6 months from the date of receiving silver certification. This certification is benchmarked with NABH full/ JCI accreditation and EHCP with these certifications can directly apply for Gold Quality Certification without getting Silver or Bronze Quality Certification with simplified process.

Schedule 4: Exclusions to the Benefits under the Policy

Ayushman Bharat PM-JAY shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

a. Condition that does not require hospitalization and can be treated under Out Patient Care, unless featuring in the N-HBP 2022.

b. Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.

c. Any dental treatment or surgery which is corrective, prosthetic, cosmetic procedure, filling of tooth cavity, root canal including wear and tear of teeth, periodontal diseases, dental implants etc. are excluded. Exception to the above would be treatment needs arising from trauma / injury, neoplasia / tumour / cyst requiring hospitalisation for bone treatment.

d. Any assisted reproductive techniques, or infertility related procedures, unless featuring in the N-HBP 2022.

e. Vaccination and immunization

f. Surgeries related to ageing face & body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc

g. Circumcision for children less than 2 years of age shall be excluded (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident)

h. Persistent Vegetative State: a condition in which a medical patient is completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function, being kept alive only by medical intervention.

Schedule 5: AB PM-JAY CMHIS Copayment guidelines

All AB PM-JAY CMHIS beneficiaries shall have the option to use other sources of funding over and above AB PM-JAY CMHIS wallet (if required) for availing healthcare services as provided in Schedule 5.

a. through self-contribution in case the beneficiary wallet has insufficient balance for availing any package listed under AB PM-JAY CMHIS ;
b. topping the beneficiary wallet by availing beneficiary entitlement under some other scheme i.e. Rashtriya Arogya Nidhi (RAN) / Health Ministers' Discretionary Grant (HMDG) or other Central or State sponsored scheme.
c. through self-contribution in case of such packages where the cost of package itself is higher than Rs. 5 lakhs e.g., lungs transplant.

To avoid any abuse of co-payment provision, following checks and balances are being put in place:

a. All such requests should be processed on AB PM-JAY IT platform.
b. Copayment shall be triggered only in cases where the beneficiary wallet is insufficient for booking any package and there is a willingness on part of beneficiary to make the additional payments or it can be topped up through some other Central/ State scheme wallet.
c. For availing co-payment option, beneficiary consent shall be mandatory, which shall have to be recorded in writing duly signed by the beneficiary or his/her guardian. Such consent must be uploaded on IT platform and preserved for audit purpose. NHA shall shortly share the standard formats for recording the consent.
d. CEO, SHA shall be the competent authority to approve any request for availing funding from other sources including from beneficiary pocket. In case of using other scheme wallet, decision of CEO, SHA has to be subsequently concurred by the concerned authority (if any) responsible for approvals under another scheme.
e. Co-payment option will not be available for unspecified procedures or for packages under exclusion category of NHA/ SHA.
f. All such cases will be mandatorily audited by NAFU. Details of such audit report must be presented during the subsequent Executive Committee/Governing Board meetings of NHA and respective SHA.
g. Punitive action will be taken as per guidelines against EHCPs found to have coerced beneficiary for co-payment or misused the option of availing additional co-funding from another scheme.

a. Additionally, all expenditure related to the treatment of families belonging to Category 3 (GoN employees and other Officials, and serving Parliamentarians/Legislators) over and above the sum insured shall be paid directly by the beneficiary to the hospital and they will seek reimbursement from the state government as per its extant policies.

Schedule 6: Guidelines for Empanelment of Health Care Providers and Other Related Issues

The empaneled hospital network is the backbone of a healthcare scheme. AB PM-JAY CMHIS shall empanel both public and private hospitals so that appropriate level of care is accessible to the beneficiaries on cashless basis without difficulty. The Scheme shall also ensure portability of benefits outside the Nagaland so that beneficiaries travelling/residing outside the State can also avail benefits on cashless basis.

1. PURPOSE AND SCOPE

1.1. The guidelines on empanelment have been developed for AB PM-JAY CMHIS based on three years of experience of implementing PMJAY scheme and basis the feedback provided by various stakeholders during pre-launch consultations for AB PM-JAY CMHIS , with the objective of providing quality services to AB PM-JAY CMHIS beneficiaries and also to increase empanelment and participation of healthcare providers

1.2. This document aims to provide a framework to Nagaland SHA under which the empanelment of healthcare service providers may be undertaken for AB PM-JAY CMHIS . It provides guidelines for processes that may be undertaken by SHA to empanel a healthcare service provider and also to undertake any disciplinary proceedings, including suspension and de-empanelment of healthcare service providers wherever needed.

1.3. All hospitals presently empanelled by the State Health Agency (SHA), GoN under AB PM-JAY shall be deemed empanelled under AB PM-JAY CMHIS, and no additional registration or empanelment shall be required. All new healthcare service providers, including public hospitals which are deemed empaneled (if more than 5 beds) must mandatorily adhere to registration process on a web-based platform called 'Hospital Empanelment Module' (HEM) portal using URL https://hospitals.pmjay.gov.in to become a part of AB PM-JAY CMHIS Provider network, called Empaneled Health Care Providers (EHCPs)"

1.4. In addition to AB PM-JAY CMHIS network of hospitals for treatment in Nagaland, AB PM-JAY CMHIS (EP) beneficiaries going outside Nagaland for treatment will have access to CGHS empanelled hospitals on CGHS rates, across India with room category as per their room entitlement. Since the empanelment process for these 2 types of hospital networks (AB PM-JAY CMHIS network and CGHS network) are different, this empanelment guideline document describes the empanelment processes separately, starting with AB PM-JAY CMHIS hospitals empanelment followed by CGHS empanelment process.

2. GUIDELINES FOR EMPANELMENT FOR AB PM-JAY CMHIS NETWORK

2.1. SHA shall in addition to empanelment of private healthcare providers in the State of Nagaland for AB PM-JAY CMHIS , will empanel all public facilities, having 5 beds or more, providing inpatient services or those covering daycare packages (along with any in-patient or day care services outsourced by the public healthcare facility). If SHA determines the need to empanel healthcare service providers outside Nagaland under AB PM-JAY CMHIS , it shall approach NHA with the specific request and rationale for the same.

2.2. If public healthcare provider facility is below Community Health Center (CHC) level, it should raise at least 1 preauthorization within 6 months of empanelment, otherwise, it will be moved to 'invalid public hospital bucket'

2.3. Public Hospitals under other schemes/government bodies including Employee State Insurance Corporation (ESIC) and CGHS hospitals are eligible for empanelment under AB PM-JAY CMHIS , if they meet the minimum eligibility requirement. These hospitals will have to fill in the application on the web portal to get empanelled under AB PM-JAY CMHIS.

2.4. Private hospitals are encouraged to provide ROHINI ID provided by Insurance Information Bureau (IIB) and public hospitals are encouraged to have National Identification Number (NIN) provided by MoHFW at the time of empanelment.

2.5. Healthcare service providers are encouraged to attain quality milestones by attaining PM-JAY Certification i.e., Bronze, Silver and Gold or get accreditation with National Accreditation Board for Hospitals & Healthcare Providers (NABH) (full / entry level)/ National Quality Assurance Standards (NQAS). These quality certifications would also provide incentive in terms of higher price for health benefit packages to the healthcare service providers under the scheme.

2.6. For the healthcare service providers which were empanelled based on Quality Certification/ accreditation, healthcare service providers will undergo a renewal process, once every 3 years or till the expiry of validity of PM-JAY Bronze/NABH/ NQAS certification whichever is earlier; to determine compliance to minimum standards

2.7. There will be no restriction on the number of healthcare providers that can be empaneled under the scheme in a district/ state.

2.8. In case a private hospital chooses to withdraw from the network of AB PM-JAY CMHIS , a minimum advance notice of 30 days should be provided by the hospital to SHA, and it will only be permitted to re-enter/get re-empaneled after 6 months. After serving the notice period, the hospital should be allowed to withdraw provided the decisions to withdraw is not triggered by an action against the hospital initiated by any government instrumentality, including AB PM-JAY CMHIS .

3. CRITERIA FOR EMPANELMENT FOR AB PM-JAY CMHIS

3.1 **MINIMUM CRITERIA**: Healthcare providers should meet the basic minimum eligibility requirements as detailed in Annexure 1. As these are minimum standards, no exceptions can be provided on these. Exemption for minimum number of ten beds however may be given for dental and day-care procedure hospitals like Eye, ENT, and Standalone Dialysis Centres, etc.

3.2 **EMPANELMENT IN ASPIRATIONAL DISTRICTS**: For empanelment of hospitals in aspirational districts, the norms for empanelment has been relaxed to encourage greater participation of the hospitals e.g. number of minimum beds has been reduced from ten to five. Details are provided in Annexure 1

3.3 **ADVANCED CRITERIA**: Additionally, specialty specific eligibility criteria have been defined for healthcare providers offering specific specialties, e.g., Oncology, Neurology etc. This is applicable over and above the basic minimum criteria and is also detailed in Annexure 1.

**SHA has the flexibility to revise/relax the empanelment criteria (barring the minimum requirements as highlighted in Annexure 1), based on experience, local context, availability of providers, and the need to balance quality and access, with prior approval from National Health Authority (NHA).*

4. INSTITUTIONAL STRUCTURE FOR EMPANELMENT IN NAGALAND FOR AB PM-JAY CMHIS

4.1 **STATE HEALTH AGENCY (SHA)**: It plays a key role in the approval flow for the submitted applications. The final decision to approve/reject the application of the healthcare service provider rests with SHA. The decision on relaxation to be given to any healthcare service provider based on the recommendation of the District Empanelment Committee (DEC) will also rest with SHA

4.2 **STATE EMPANELMENT COMMITTEE (SEC)**: It will be established in Nagaland to monitor the overall empanelment process and undertake disciplinary proceedings against errant health service providers in the state. The role of the SEC would be to supervise the work of DEC and to ensure timely empanelment of healthcare service providers, as well as handle matters pertaining to rejection or pendency of hospital applications at the SHA level.

4.3 **DISTRICT EMPANELMENT COMMITTEE (DEC)**: It is formed at the district level

which will assist SEC/SHA in the empanelment process and disciplinary proceedings for healthcare providers at the district level. It will be responsible for conducting the following:

- Validation and scrutiny of the uploaded documents by the hospital for completeness and accuracy.
- Conducting field and desktop-based verification of hospitals both during empanelment and in case of any complaints related to infrastructure.
- Submission of the verification reports to the SHA through the online empanelment portal with a recommended decision to approve or reject with clear reasons for rejection.
- Recommending any relaxation in empanelment criteria, if needed (with justification for relaxation

** If additional support is required for the empanelment process, SHA can hire a third-party empanelment agency (TPEA) or additional resource as deputed by SHA. These will be responsible to facilitate verification of healthcare providers (both physical as well desk-top verification). The third-party agency hired should not be the current Implementation Support Agency (ISA) of the State. The composition and functions of TPEA will be similar as DEC.*

5. PROCESS OF EMPANELMENT FOR AB PM-JAY CMHIS

5.1 Option 1: Desktop and Physical Verification within 15 working days

Healthcare service providers desirous of getting themselves empanelled have to register themselves on a web-based platform called 'Hospital Empanelment Module' (HEM) portal using URL https://hospitals.pmjay.gov.in for which they have to fill in basic information to create an account which will provide an exclusive hospital reference number and password to the hospital on their registered mobile number. Using the credentials, a detailed application form will have to be filled.

The application will be scrutinized by DEC and processed completely within 15 working days of receipt of the application. It will include document verification and physical inspection / verification. If any deficiencies are found, hospital will modify the application form and resubmit for DEC verification.

In case during physical inspection, it is found that hospital has applied for specialties, that do not conform to minimum requirements under AB PM-JAY CMHIS , the hospital will only be empanelled for specialties that conform to PMJAY norms.

The DEC will submit its final inspection report to SHA within 15 working days from receipt of the application request and can either recommend for approval or recommend for rejection, after due diligence of the documents and physical inspection / verification

DEC may also recommend for approval, with relaxation in empanelment criteria (above the minimum empanelment criteria) to ensure that an adequate number of empanelled facilities are available in the district. All such relaxations need to be approved by NSHA with due rationale clearly documented

SHA will review the reports submitted by DEC along with its recommendation to approve or reject the empanelment application, and accord its final decision, which should be completed withing 30 working days of receiving the application from healthcare provider.

If the application is rejected, healthcare providers will have the right to file a review against the rejection with the State Empanelment Committee (SEC) within 15 working days of rejection. In case the request for empanelment is rejected by the SEC, the healthcare providers can approach the competent authority as defined in the Grievance Redressal Mechanism for remedy.

5.2 OPTION 2: Fast Track Empanelment of Quality Council of India (QCI) recommended/State empanelled hospital without physical verification

SHA may choose to auto-approve already empanelled hospitals under a state scheme, if they meet the minimum eligibility criteria prescribed under AB PM-JAY CMHIS . The healthcare provider will have to submit their Hospital ID during the application process to facilitate auto empanelment

Additionally, healthcare providers which are PMJAY Bronze Certified/NABH accredited/ NABH certified/CGHS empanelled/ECHS empanelled will be auto-approved; provided they have submitted the application on web portal and meet the minimum criteria

The DEC will conduct a desktop-based verification based on PMJAY Bronze Certificate/NABH certificate/QCI recommended document for CGHS/ECHS empanelment (as applicable) uploaded by the healthcare providers

5.3 OPTION 3: Fast track-empanelment for non QCI healthcare providers with physical verification within 3 months

This option may be undertaken during exceptional circumstance wherein relaxation for online- empanelment may be provided for those districts that have limited number of empanelled hospitals or any other exceptional situation as the SHA may deem fit. The reason for availing this option should be documented by the SHA

6. ON-BOARDING PROCESSES AFTER APPROVAL FOR AB PM-JAY CMHIS

6.1 Once the application is approved, EHCP will be assigned a unique national hospital registration number under the scheme. Additionally, SHA will ensure

that the status of the application is updated on the PMJAY portal. EHCP is informed about the decision through email/SMS on the registered phone number within 3 working days.

6.2 SHA and EHCP will sign an MoU within 7 working days of updating the decision on the portal. A prefilled contract copy as defined in the MoU will be sent by the system to the healthcare provider. The contract will be printed on a non-judicial stamp paper of INR 100 value by EHCP and physically signed with two original copies (one for each party). If the insurance company is involved, a tripartite agreement will be made including IC as one of the members. A copy of the signed contract will be uploaded on the HEM portal within 3 working days of signing.

6.3 EHCP will have to designate a nodal officer as a focal point for the scheme. Once the hospital is empaneled, a user admin login will be created for the healthcare service provider.

6.4 SHA will ensure automatic creation of Beneficiary Identification System (BIS) / Transaction Management System (TMS) login through the system within 5 working days of MoU signing. A link for access to training videos will also be shared simultaneously.

6.5 SHA will also ensure that training on systems and processes like beneficiary identification system, transaction management system, health benefit package, standard treatment guidelines, claim settlement process is provided within 15 working days of MoU signing.

6.6 It will be the responsibility of EHCP to update changes in Hospital Basic information, infrastructure or manpower on HEM as soon as possible and update 'Nil' change in HEM system at the end of every month in case of no change

7. MINIMUM CRITERIA

A hospital would be empanelled as a network private hospital with the approval of the State Health Agency if it adheres with the following minimum criteria:

a) Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms:
   i. Exemption may be given for dental and day-care procedure hospitals like Eye, ENT, and Standalone Dialysis Centres, etc.
   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

b) It should have adequate and qualified medical and nursing staff (doctors[4] & nurses[5]), physically in charge round the clock; (necessary certificates to be produced during empanelment). The state should have specific guidelines on the number of hospitals a doctor can work.

c) Fully equipped and engaged in providing medical and surgical services, commensurate to the scope of service/available specialties 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 Anesthetist where maternity services are offered
   iii. Round-the-clock availability of specialists (or on-call) in the concerned specialties having enough experience where such services are offered (e.g., Orthopaedics, ENT, Ophthalmology, Dental, general surgery (including endoscopy) etc.)

d) Hospital should have adequate arrangements for 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 (mandatory for providing surgical packages), X-ray facility etc., either 'in-house' or with 'outsourcing arrangements' with appropriate agreements and in nearby vicinity.

e) Separate male and female wards with toilet and other basic amenities.

f) 24 hours emergency services managed by technically qualified staff wherever emergency services are offered or a minimum first aid/emergency medicine/oxygen availability:
   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.
   ii. Round the clock ambulance services (own or tie-up).

g) 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.

h) Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (for medical/surgical ICU/HDU) with requisite staff:
   i. The unit is to be situated in proximity of operation theatre, acute care

medical and surgical ward units.

ii. Suction, oxygen supply and compressed air should be provided for each bed.

iii. Further High Dependency Unit (HDU) - where such packages are mandated should have the following equipment:

1. Piped gases
2. Multi-sign monitoring equipment
3. Infusion of ionotropic support
4. Equipment for maintenance of body temperature
5. Weighing scale
6. Manpower for 24x7 monitoring
7. Emergency cash cart
8. Defibrillator
9. Equipment for ventilation
10. In case there is common Pediatric ICU then Pediatric equipments, e.g.: Pediatric ventilator, Pediatric probes, medicines, and equipment for resuscitation to be available

iv. HDU should also be equipped with all the equipment and manpower as per HDU norms.

i) Records maintenance: Maintain complete records as required on day-to-day basis and can 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 CMHIS cases must have complete records maintained.
iii. Share data with designated authorities for information as mandated.
iv. Patient level cost data when needed.

j) Legal requirements as applicable by the local/state health authority.

k) Adherence to Standard Treatment Guidelines/Clinical Pathways for procedures as mandated by NHA from time to time.

l) Registration with the Income Tax department.

m) NEFT enabled bank account.

n) Telephone/fax/internet.

o) Safe drinking water facilities.

p) Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.

q) Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act.

r) Appropriate fire-safety measures.

s) Provide space for a separate kiosk for AB PM-JAY CMHIS beneficiary

management (AB PM-JAY CMHIS non- medical coordinator) at the hospital reception; with required office supplies and computer/ camera/scanner/printer/other accessories as required.

t) Ensure a designated medical officer to work as a medical[7] coordinator towards AB PMJAY beneficiary management (including records for follow-up care as prescribed).

u) Ensure appropriate promotion of AB PM-JAY CMHIS 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 CMHIS team.

v) IT hardware requirements (desktop/laptop with internet, printer, webcam, scanner/fax, bio-metric device etc.) as mandated by SHA

1. Qualified doctors are those having at least a MBBS degree approved as per the Clinical Establishment Act/ National Medical Commission/ State government rules & regulations as applicable from time to time.
2. 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.
3. 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).
4. 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

8. CRITERION FOR ASPIRATIONAL DISTRICTS

All the criteria remain the same for Aspirational Districts as mentioned above apart from the following:

i. Minimum number of inpatient beds required for empanelment, should have 5 inpatient beds with adequate spacing and supporting staff as per norms unless providing day-care packages covered under AB PM-JAY CMHIS
ii. Minimum number of doctors and nursing staff required for empanelment, Doctor-1 (minimum Qualification MBBS).
iii. Requirements of licenses and certificates – Hospital registration certificate as per state law is mandatory, if applicable.
iv. Requirement of equipment according to the defined scope of services - Hospital needs to be fully equipped.

v. Requirement of equipment and services in emergency- life saving and resuscitation equipment as required by facility.
vi. Position of the ICU/HDU -The unit is to be situated in the same building or referral linkage with hospitals where ICU/HDU facility is available (mandatory self-declaration) through an MoU or tie up.
vii. Requirement of space for AB PM-JAY CMHIS kiosk - Provide space for a working desk for AB PM-JAY CMHIS beneficiary management (AB PM-JAY CMHIS non-medical coordinator) at the hospital main entrance area.
viii. Criteria for dialysis services for nephrology and urology surgery facility - dialysis unit either inhouse or tie-up.
ix. Criteria for OT Services with staff requirement- Fully equipped Operation Theatre of its own with qualified nursing staff (Minimum qualification - ANM Course) under its employment round the clock.
x. Casualty should be equipped with minimum Emergency Tray

9. ADVANCED CRITERIA

Over and above the essential criteria required to provide basic services under AB PM-JAY CMHIS (as mentioned in Category 1) those facilities undertaking defined specialty packages (as indicated in the benefit package for specialties mandated to qualify for advanced criteria) should have the following:

a) These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Neonatal/Paediatric Surgery, Urology etc.
b) A hospital could be empanelled for one or more specialties subject to it qualifying to the concerned specialty criteria.
c) 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.
d) 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 with an advanced qualification 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.
e) Indicative specialty specific criteria are as under:

9.1. SPECIFIC CRITERIA FOR CARDIOLOGY/CVTS

a) CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.).
b) Post-op with ventilator support.
c) ICU facility with cardiac monitoring and ventilator support.
d) Hospital should facilitate round the clock cardiologist services.
e) Availability of support specialty of General Physician & Pediatricians.
f) Fully equipped Catheterization Laboratory Unit with qualified and trained paramedics.

9.2. SPECIFIC CRITERIA FOR CANCER CARE

a) 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). Tumour board should consist of a qualified team of Surgical, Radiation and Medical Oncologist to ensure the most appropriate treatment for the patient.
b) Relapse/recurrence may sometimes occur during/after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/Pediatrics Oncologist/tumour board with prior approval and pre-authorization of treatment.
c) For extending the treatment of chemotherapy and radiotherapy the hospital should have the requisite infrastructure for radiotherapy treatment viz. for cobalt therapy, linear accelerator radiation treatment and brachytherapy available in-house or through "outsourced facility". In case of outsourced facility, the empanelled hospital for radiotherapy treatment and even for chemotherapy, 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. A tie up in the form of MoU with an outsourced facility should be available with the EHCP.
d) Further hospitals should have infrastructure capable for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/therapy.
    i. Treatment machines which can deliver SRS/SRT
    ii. Associated treatment planning system
    iii. Associated Dosimetry system

9.3. SPECIFIC CRITERIA FOR NEUROSURGERY

a) Well-equipped theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with head holding frame (horseshoe, may field/sagittal or equivalent frame).
b) Neuro ICU facility.
c) Post-op with ventilator support.
d) Facilitation for round the clock MRI, CT, and other support bio-chemical investigations.

9.4. SPECIFIC CRITERIA FOR BURNS, PLASTIC & RECONSTRUCTIVE SURGERY

a) 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.
b) Isolation ward having monitor, defibrillator, central oxygen line and all OT equipment.
c) Well-equipped theatre.
d) Surgical Intensive Care Unit.
e) Post-op with ventilator support.
f) Trained paramedics.
g) Post-op rehab/Physiotherapy support/Phycology support.

9.5. SPECIFIC CRITERIA FOR PEDIATRIC SURGERY

a) The hospital should have full time/on call services of Paediatric surgeons/plastic surgeons/ urologist surgeons related to congenital malformation in the Paediatric age group.
b) Well-equipped theatre.
c) Paediatric and Neonatal ICU support.
d) Support services of Paediatrician.
e) Availability of mother rooms and feeding area.
f) Availability of radiological/fluoroscopy services (including IITV), laboratory services and blood bank.

9.6. SPECIFIC CRITERIA FOR SPECIALIZED NEW-BORN CARE

a) The hospital should have well developed and equipped neonatal nursery/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms.
b) 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/bolometer/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.

c) For Advanced Care and Critical Care Packages, in addition to point b above: parenteral nutrition, laminar flow bench, invasive monitoring, in-house USG. Ophthalmologist on call.
d) Trained nurses 24x7 as per norms.
e) Trained Paediatrician(s) round the clock
f) 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.
g) Provision for post-discharge follow up visits for counselling for feeding, growth/development assessment and early stimulation, ROP checks, hearing tests etc.

9.7. SPECIFIC CRITERIA FOR POLYTRAUMA

a) Shall have Emergency Room setup with round the clock dedicated duty doctors.
b) Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and Anaesthetist services.
c) 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.
d) Shall have dedicated round the clock Emergency Theatre with C-Arm facility, Surgical ICU, post-op setup with qualified staff.
e) Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

9.8. SPECIFIC CRITERIA FOR NEPHROLOGY AND UROLOGY SURGERY

a) Dialysis unit
b) Well-equipped operation theatre with C-ARM
c) Endoscopy investigation support
d) Post-op ICU care with ventilator support
e) Sew lithotripsy equipment either “in-house” or through outsourced facility

9.9. SPECIFIC CRITERIA FOR STANDALONE/OUTSOURCED DIALYSIS CENTERS

In addition to existing guideline the medical institutions sought to be empaneled under “Dialysis Single Speciality Centre” should be as follows:

a) Standalone Centre should be a separate physical and legal entity and should

not be associated with or not be a part of any other multispecialty hospitals/medical college/government hospitals. A self-declaration for the same as per Annexure 5 is mandatory for the dialysis centres to submit a signed and scanned copy of the same on the institutes letter head at the time of submission of application.

b) Dialysis Centre associated (outsourced/PPP) with:
   i. Government hospitals - deemed empanelled if the hospital is empanelled under AB PM-JAY CMHIS.
   ii. Private Empanelled HCPs - the HCPs can apply for enhancement of specialities.
   iii. Non-empanelled private HCPs - The outsourced dialysis centre can get empanelled under AB PMJAY.

   The outsourced dialysis centre should have separate parent company and legal entity. A self-declaration for the same as per Annexure 6 is mandatory for the dialysis centres to submit a signed and scanned copy of the same on the institutes letter head at the time of submission of application

c) Shall be registered under Nursing Home Act/Medical Establishment Act/State Authority and having necessary licenses as per state laws/regulations.

d) Space and facility requirement:
   Haemodialysis area:
   i. Each unit requires at least 11 x 10 ft (100 to 110 sq. feet).
   ii. Facility for monitoring ECG and other vitals like Blood Pressure and Heart Rate.
   iii. Each machine should be easily observed from the nursing station.
   iv. Head end of each bed should have a stable electric supply, oxygen supply, vacuum outlet, treated water inlet and drainage facility.
   v. Air conditioning to achieve 70 to 72-degree Fahrenheit temperature and 55 to 60% humidity.
   vi. Patients having viral diseases (HIV/HBV/HCV) should be separated from those patients not having any viral infections and separate machines must be used for their treatment.
   vii. Facilities for hand washing/hand rub; sterillium or alcohol-based hand rub/sterilant dispensers must be available in each patient area.
   viii. Shall have build-up area of 175 Sq. Mtr for Haemodialysis units with Registration Area (Reception, Waiting and Public Utilities) of 30 Sq. Mtr, Treatment Room (Procedure room, Staff Change room, Dirty Utility Room, Clean Utility, Dialyzer cleaning area, Toilet, Storeroom, CAPD training area, Store and Pharmacy) of 80 Sq. Mtr, Administrative Department (Account's office, medical office) of 20 Sq. Mtr, Water

Treatment Area (RO Plant, Water Pump) of 20 Sq. Mtr and Generator Area of 5 Sq. Mtr.

e) Machinery/Physical facilities:
   i. Minimum 5 dialysis units should be available to empanel any standalone centre not associated with any hospital. However, depending on the requirement of and situation in the state, the SHA may change the criteria by recording reasons in writing.
   ii. All precautions required to prevent infection including infections from HIV, HBV and HCV should be taken.
   iii. Preparation, storage and work area.
   iv. Independent area for reprocessing the dialyzers.
   v. Two storage areas, one for storage of new supplies and one for reprocessed dialyzers.
   vi. Consulting room for doctor in-charge of the unit.
   vii. Office area for nurses and technicians.
   viii. Storage facility for individual patients' belongings.
   ix. Space for a water treatment unit.
   x. Patient and patient attendant waiting area.

f) Human Resource requirements:
   i. Qualified Nephrologist having DM or DNB in nephrology or MD/DNB Medicine with 2 years training in Nephrology from a recognized centre on full time or part time basis. Qualified Nephrologist shall be the head of the centre. In areas where there is no Qualified Nephrologist, a certified trained dialysis physician (as per local law and regulation) shall be the head of the centre.
   ii. Dialysis doctor (at least 1 in each shift)
      - M.B.B.S. with a valid registration in each shift.
      - One-year house job.
      - Certified in advanced cardiac life support (ACLS).
      - Experience in central line placement.
      - Experience in critical care management.
      - To be trained under the care of a nephrologist for a period of 6 months or more
      - To report to a nephrologist in the same institute or in case of a standalone unit- to a covering visiting nephrologist from the nearest facility.
   iii. Dialysis technician (Full time)
      One year or longer certificate course in dialysis technology (after high school) certified by a government authority or have sufficient verifiable hands-on experience.

iv. Dialysis nurses (full time)

The centre shall have qualified and/or trained nursing staff as per the scope of service provided and the nursing care shall be provided as per the requirements of professional and regulatory bodies.

v. Dietician (optional), social worker (optional), dialysis attendants (full time) and housekeeping service (full time).

g) Should have following equipments:

i. Emergency equipments:

Resuscitation equipment including Laryngoscope, endotracheal tubes, suction equipment, xylocaine spray, oropharyngeal and nasopharyngeal airways, ambo bag - adult & pediatric (neonatal if indicated)

Oxygen cylinders with flow meter/tubing/catheter/face mask/nasal prongs

Suction apparatus

Defibrillator with accessories

Equipment for dressing/bandaging/suturing

Basic diagnostic equipment- blood pressure apparatus, stethoscope, weighing machine, thermometer

ECG machine

Pulse Oximeter

Nebulizer with accessories

ii. Other equipment's for regular use:

Stethoscope

Sphygmomanometer

Examining light

Oxygen unit with gauge

Minor surgical instrument set

Instrument table

Goose neck lamp

Standby rechargeable light

ECG machine

Suction machine

Defibrillator with cardiac monitor

Stretcher

Wheelchair

Haemodialysis equipment

Haemodialysis set

Monitor

Pulse Oximeter

iii. Machine and Dialyzer:

HD machines
Peritoneal Dialysis machine (if applicable)
CRRT machine (optional)
Dialyzers

iv. Reverse osmosis (RO) water plant/RO system components:
Feed water temperature control
Backflow preventer
Multimedia depth filter
Water softener
Brine tank
Ultraviolet irradiators (optional)
Carbon filter tanks

10. PROCESS OF EMPANELMENT FOR CGHS NETWORK

Central Government Health Scheme (CGHS) is a health care facility scheme providing Comprehensive medical care to Central Government employees and pensioners enrolled under the scheme across India.

The Insurer shall be responsible for onboarding all CGHS empanelled hospitals across the country for offering services for the CMHIS (EP) Beneficiaries.

CGHS considers either NABH accredited Health Care Organizations (HCOs) or Quality Council of India (QCI) recommended HCOs only for empanelment under CGHS subject to fulfillment of other prescribed eligibility criteria. Pre-accreditation entry-level NABH certificate is not a valid eligibility criterion for consideration of empanelment of private HCOs under CGHS.

CGHS in order to ensure quality Healthcare services to all its beneficiaries has entrusted National Accreditation Board for Hospitals & Healthcare Providers (NABH), a constituent board of Quality Council of India (QCI) for assessment of hospitals as per set criteria for empanelment of Hospitals under CGHS. HCOs have to use application format specified for empanelment under CGHS and submit the completely filled application form along with covering letter on their letter head to NABH office. Based on the assessment, NABH-QCI will submit its recommendations to the CGHS and also display on website at www.nabh.co

In Dec 2021, NABH-QCI has digitised the process of QCI inspections for ECHS & CGHS empanelment. HCOs will now be able to apply for and pay fee for empanelment through an online portal. Applicants desirous of getting their facilities assessed for CGHS / ECHS Empanelment are encouraged to apply online for prompt processing

Note:SHA may amend/adapt the empanelment and Deempanelment guidelines based on new guidelines issued by NHA , a draft of which is provided in this link <Link to latest NHA guideline on Hospital empanelment and Deempanelment:

https://nha.gov.in/img/resources/OM-Revised-Empanelment-and-De-empanelment-Guideline.pdf >

Schedule 7: List of hospitals currently empaneled under

a. AB PM-JAY
https://hospitals.pmjay.gov.in/Search/

b. CGHS
https://cghs.nic.in/reports/view_hospital.jsp

Schedule 8: List of hospitals currently empaneled by the GoN for medical reimbursement scheme.

https://nagahealth.nagaland.gov.in/assets/images/documents/Empaneled_Hospitals_for_MR.pdf

Schedule 9: Draft Provider Service Agreement

Draft Agreement

For Implementation of
Chief Minister's Health Insurance Scheme (CMHIS)
In the State of Nagaland

August 2022

Between

[Insert Name of the Empanelled Health Care Provider]

Nagaland Health Protection Society, Nagaland
and

[Insert Name of the Insurance Company]

This Agreement (Hereinafter referred to as “Agreement”) made at _____ on this _____ day of _____ 20__.

BETWEEN

_____(Empaneled Health Care Provider or EHCP) an institution located in _____, having their registered office at _____ (here in after referred to as “EHCP”, which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include it's successors and permitted assigns) as party of the FIRST PART

AND

_____ Nagaland Health Protection Society, a Society/ Trust registered by the State Government of Nagaland and having its registered office _____ (hereinafter referred to as “SHA” which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors, affiliate and assigns) as party of the SECOND PART.

AND

_____ Insurance Company Limited, a Company registered under the provisions of the Companies Act, 1956 and having its registered office _____ (hereinafter referred to as “Insurer” which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include it's successors, affiliate and assigns) as party of the THIRD PART.

The EHCP, SHA and Insurer are individually referred to as a "Party” or “party" and collectively as "Parties” or “parties")

WHEREAS

1. EHCP is a health care provider duly recognized and authorized by appropriate authorities to impart heath care services to the public at large.
2. SHA is State Health Agency that has been set-up/identified by the State Government for implementation of CMHIS in the State of Nagaland.
3. Insurer is registered with Insurance Regulatory and Development Authority. Insurer has entered into an agreement with the Government of Nagaland wherein it has agreed to provide the health insurance/ implementation support services to identified Beneficiary families covered under Chief Minister’s Health Insurance Scheme (CMHIS)
4. EHCP has expressed its desire to join CMHIS’s network of EHCPs and has represented that it has requisite facilities to extend medical facilities and treatment to beneficiaries as covered under CMHIS on terms and conditions herein agreed.

5. Insurer after approval of SHA and on the basis of desire expressed by the EHCP and on its representation/application has accepted the provisional empanelment for rendering health services as per the specified clinical specialities.

In this **AGREEMENT**, unless the context otherwise requires:

1. Natural persons include created entities (corporate or incorporate) and vice-versa.
2. Marginal notes or headings to clauses are for reference purposes only and do not bear upon the interpretation of this **AGREEMENT**.
3. Should any condition contained herein, contain a substantive condition, then such substantive condition shall be valid and binding on the **PARTIES** notwithstanding the fact that it is embodied in the definition clause.

In this **AGREEMENT** unless inconsistent with, or otherwise indicated by the context, the following terms shall have the meanings assigned to them hereunder, namely:

Definitions

1. **Appellate Authority** shall mean the authority designated by the State Health Agency which has the powers to accept and adjudicate on appeals by the aggrieved party against the decisions of any Grievance Redressal Committee set up pursuant to the Insurance Contract between the State Health Agency and the Insurer.
2. Beneficiary means all people who are domicile residents of the state.
3. Beneficiary Family Unit 'Family means father, mother, husband, wife, brother, sister, son, daughter and includes grand-father, grand-mother, grand-child, adoptive father or mother, adopted son or daughter. As regards government servants and government retirees, the definition of family shall be as per the Central Services (Medial Attendance) Rules 1944 – a government servant's wife or husband, and parents, sisters widowed sisters, widowed daughters, minor brothers, children, stepchildren, divorced/separated daughters, and stepmother wholly dependent upon the government servant and are normally residing with the government servant.
4. Benefit Risk Cover or Benefit Cover refers to the annual basic cashless hospitalisation coverage of Rs. 5,00,000/- (Rupees five lakhs only) on a family floater basis, that all the insured families would receive under the CMHIS. In addition, beneficiaries belonging to the category CMHIS (EP) i.e., Employees and Pensioners of the Government of Nagaland shall be eligible for unlimited cover, which will be managed through one of the following two options: Option A: Entirely directly administered by the SHA; Option B: A top up insurance cover of Rs. 5,00,000/- (Rupees five lakhs only) over and above basic cover and all expenses above the top up cover to be administered directly by the SHA.

5. **Claim** shall mean a claim that is received by the Insurer from an Empanelled Health Care Provider, either online or through alternate mechanism in absence of internet connectivity.
6. **Claim Payment** shall mean the payment of eligible Claim received by an Empanelled Health Care Provider from the Insurer in respect of benefits under the Risk Cover made available to a Beneficiary.
7. **Days** shall be interpreted as calendar days unless otherwise specified.
8. **Fraud** under the CMHIS shall refer to, mean, and include any intentional deception, manipulation of facts and / or documents or misrepresentation made by the EHCP or by any person or organization appointed employed / contracted by the EHCP with the knowledge that the deception could result in unauthorized financial or other benefit to herself/himself or some other person or the organisation itself. It includes any act that may constitute fraud under any applicable law in India.
9. **Health Services** shall mean all services necessary or required to be rendered by the Institution under an agreement with an insurer in connection with "health insurance business" or "health cover" but does not include the business of an insurer and or an insurance intermediary or an insurance agent.
10. **Hospitalization** shall mean any Medical Treatment or Surgical Procedure which requires the Beneficiary to stay at the premises of an Empanelled Health Care Provider for 24 hours or more including day care treatment as defined
11. **ICU or Intensive Care Unit** shall mean an identified section, ward or wing of an Empanelled Health Care Provider which is under the constant supervision of dedicated Medical Practitioners, and which is specially equipped for the continuous monitoring and treatment of patients who are in critical condition, require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the general ward.
12. **Institution** shall for all purpose mean an EHCP.
13. **Insurer** shall mean an Insurance Company registered with IRDAI which has been selected pursuant to bidding process and has signed the Insurance Contract with the State Government in insurance mode of implementation of CMHIS.
14. **Medical Treatment** shall mean any medical treatment of an illness, disease, or injury, including diagnosis and treatment of symptoms thereof, relief of suffering and prolongation of life, provided by a Medical Practitioner, but that is not a Surgical Procedure. Medical Treatments include but not limited to bacterial meningitis, bronchitis-bacterial/viral, chicken pox, dengue fever, diphtheria, dysentery, epilepsy, filariasis, food poisoning, hepatitis, malaria, measles, meningitis, plague, pneumonia, septicaemia, tuberculosis (extra pulmonary, pulmonary etc.), tetanus, typhoid, viral fever, urinary tract infection, lower respiratory tract infection and other such diseases requiring Hospitalization.
15. **Medically Necessary Treatment** under CMHIS shall mean any medical treatment, surgical procedure, day-care treatment, or follow-up care, which:
    i. is required for the medical management of the illness, disease or injury suffered by the Beneficiary.

ii. does not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity.
iii. has been prescribed by a Medical Practitioner; and
iv. conforms to the professional standards widely accepted in international medical practice or by the medical community in India.

16. **MoHFW** shall mean the Ministry of Health and Family Welfare, Government of India.
17. **Package Rate** shall mean the fixed maximum charges for a Medical Treatment or Surgical Procedure or for any Follow-up Care that will be paid by the Insurer under Cover, which shall be determined in accordance with the rates provided in this Contract.
18. **Policy Cover Period** shall mean the standard period of 12 calendar months from the date of start of the Policy Cover or lesser period as stipulated by SHA from time to time.
19. Risk Cover shall have the same meaning as Benefit Risk Cover or Benefit Cover
20. **Service Area** refers to all the districts in the State of Nagaland covered and included under this Tender Document for the implementation of the Scheme
21. **State Health Agency (SHA)** refers to the agency/ body set up by the Department of Health and Family Welfare, Government of Nagaland for the purpose of coordinating and implementing the CMHIS the State of Nagaland.
22. **Scheme** shall refer to and mean the Nagaland Chief Minister's Health Insurance Scheme (CMHIS), managed, and administered by the Nagaland Health Protection Society/State Health Agency in Nagaland.
23. **Turn-around Time** shall mean the time taken by the Insurer in processing a Claim received from an Empanelled Health Care Provider and Insurer making a Claim Payment including investigating such Claim or rejection of such Claim.

NOW IT IS HEREBY AGREED AS FOLLOWS:

Section 1: Term

This Agreement shall be for a period of 3 years. However, it is understood and agreed between the Parties that the term of this agreement may be renewed periodically upon mutual consent of the Parties in writing, either by execution of a Supplementary Agreement or by exchange of letters.

Section 2: Scope of services

2.1. The EHCP undertakes to provide the services to beneficiaries in a precise, reliable, and professional manner to the satisfaction of SHA/Insurer and in accordance with additional instructions issued by Insurer in writing from time to time.

2.2. The EHCP will treat the beneficiaries according to good business practice.

2.3. The EHCP will extend priority admission facilities to the beneficiaries, whenever possible.

2.4. The EHCP shall provide treatment/interventions to beneficiary as per specified packages as per the rates mentioned in **Annexure 3**. The following is agreed among the parties regarding the packages:

i. The treatment/interventions to CMHIS beneficiaries shall be provided in a complete cashless manner. Cashless means that for the required treatment/interventions as per package rates and no payment shall need to be done by the CMHIS beneficiary undergoing treatment/intervention or any of its family member till such time there is balance amount left in sum insured.

ii. The various benefits under CMHIS which EHCP can provide include,
   - hospitalisation expense benefits
   - Day care treatment benefits (as applicable)
   - Pre and post hospitalisation expense benefits
   - New-born/children care benefit (as applicable)

iii. An EHCP can provide these benefits subject to exclusions mentioned in Annexure 1 and subject to availability of sum insured/remaining available cover balance and subject to pre-authorisation for selected procedures by Insurer.

iv. However, the EHCP (include the name of the hospital) is eligible to provide treatment/interventions to beneficiaries only for those clinical specialties for which it has been empanelled, namely

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2.5. The EHCP agrees that in future if it adds or foregoes any clinical specialty to its services, the information regarding the same shall be provided to the SHA and IC in written, who then shall update the empanelment status of the EHCP after due process.

2.6. The charges payable to EHCP for medical/ day care/surgical procedures/ interventions under the Benefit package will be no more than the package rate agreed by the Parties, for that particular year. The EHCP shall be paid for the treatment/intervention provided to the beneficiary based on package rates determined as below-

a. If the Package Rate for a medical treatment or surgical procedure requiring Hospitalisation or Day Care Treatment (as applicable) is fixed as in **Annexure 3,** then it shall apply.
b. If the Package Rate for any surgical procedure requiring Hospitalisation or Day Care Treatment (as applicable) is not listed in Annexure 3, then the Insurer may pre-authorise an appropriate amount up to a limit of Rs. 1,00,000 to an eligible CMHIS beneficiary as per guidelines for unspecified treatment.
c. If the Package Rate for a medical treatment requiring Hospitalisation is not listed in **Annexure 3,** the flat daily Package Rates for medical packages specified in Annexure 3 shall apply subject to pre-authorisation from Insurer.
d. In case of CMHIS Beneficiary is required to undertake multiple surgical treatment, then the highest Package Rate shall be taken at 100%, thereupon the 2nd treatment package shall be taken as 50% of Package Rate and 3rd treatment package shall be at 50% of the Package Rate as configured in the transaction management software.
e. Surgical and Medical packages will not be allowed to be availed at the same time.
f. Certain packages may be reserved for Public EHCPs as may be decided by the SHA. They can be availed in Private EHCPs only after a referral from a Public EHCP is made.

2.7. These Package Rates (in case of surgical or defined day care benefits) will include:

a. Registration Charges
b. Bed charges (General Ward in case of surgical)
c. Nursing and Boarding charges
d. Surgeons, Anaesthetists, Medical Practitioner, Consultants fees etc.
e. Anaesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
f. Medicines and Drugs
g. Cost of Prosthetic Devices, implants
h. Pathology and radiology tests: radiology to include but not be limited to X-ray, MRI, CT-Scan, etc. (as applicable)
i. Food to patient
j. Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests, and medicines before the admission of the patient in the same

hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

k. Any other expenses related to the treatment of the patient in the EHCP.

2.8. If the treatment cost is more than the benefit coverage amount available with the beneficiary families then the remaining treatment cost will be borne by the CMHIS beneficiary family as per the package rates defined in Annexure 3. Beneficiary will need to be clearly communicated in advance about the additional payment by the treating EHCP.

2.9. The follow up care prescription for identified packages are set out in **Annexure 3.**

2.10. The EHCP shall ensure that medical treatment/facility under this agreement should be provided with all due care and accepted standards is extended to the beneficiary.

2.11. EHCP agrees to provide treatment to all eligible beneficiaries subject to sum insured available and as per agreed Package Rate from all over India. The EHCP shall be paid at the Package Rates applicable in the EHCP State and not as per the package rates applicable in the beneficiary State. The EHCP agrees not to discriminate between the beneficiaries on any basis.

2.12. The EHCP shall allow SHA and/ or Insurance Company official to visit the beneficiary while s/he is admitted in the EHCP. SHA and/ or Insurer shall not interfere with the medical team of the EHCP, however SHA and/ or Insurer reserve the right to discuss the treatment plan with treating doctor. Further access to medical treatment records and bills prepared in the EHCP will be allowed to SHA/ Insurer on a case-to-case basis with prior appointment from the EHCP.

2.13. The EHCP shall also endeavour to comply with future requirements of SHA and Insurer to facilitate better services to beneficiaries e.g., providing for standardized billing, ICD coding or implementation of Standard Clinical and Treatment Protocols and if mandatory by statutory requirement both parties agree to review the same.

2.14. The EHCP agrees to have bills audited on a case-to-case basis as and when necessary, through Insurer/SHA audit team. This will be done on a pre-agreed date and time and on a regular basis. The SHA shall have the right to undertake spot checks without any prior intimation and the EHCP agrees to provide full cooperation regarding the same.

2.15. The EHCP will convey to its medical consultants to keep the beneficiary only for the required number of days of treatment and carry only the required investigation &

treatment for the ailment, which s/he is admitted. Any other incidental investigation required by the patient on their own request needs to be approved separately by SHA/Insurer and if it is not covered under the policy will not be paid by SHA/Insurer and the EHCP needs to recover it from the patient.

Section 3: Identification of Beneficiaries

3.1. The beneficiaries presenting themselves to the EHCP will be identified by the EHCP on the basis of a Beneficiary Identification System (BIS). The details of BIS have been provided in **Annexure 4**. The EHCP agrees to conform to the following for effective implementation of BIS.

3.2. The EHCP will set up a helpdesk for beneficiaries within 7 days of signing of this agreement. The helpdesk must be situated in the facility of the EHCP in such a way that it is easily visible, easily accessible to the beneficiaries.

3.3. The help desk will be equipped with all the necessary hardware and software as well as internet connectivity as required by BIS to establish the identity of the CMHIS beneficiary.

3.4. The help desk shall be manned by an Arogya Mitra (AM) for facilitating the beneficiary in accessing the benefits. Arogya Mitra will need to be hired by the private EHCP at their own cost and they should get them trained before starting the operations. The guidelines for engagement of Arogya Mitra's are provided in Annex 2.

3.5. The EHCP shall ensure that if the Arogya Mitra's or any other personnel of EHCP suspects or detects any beneficiary fraud, it shall be incumbent upon them to immediate inform the SHA in writing with all particulars of the beneficiary and reasons for suspecting fraud.

3.6. The EHCP hereby agrees that is shall be obliged to ensure that beneficiary identification is done with adequate due diligence by the Arogya Mitra's employed by the EHCP so that only eligible beneficiaries are admitted for services and cashless treatment under the Scheme and to rule out errors/omissions or mala-fide actions like impersonation etc. with or without connivance of various parties. If at a later date it is found that an ineligible person was extended treatment under the scheme, whether pre-authorization obtained or not, the SHA shall not be liable to reimburse claims of such beneficiaries; and if such claim has been paid by the SHA, the SHA shall have the right to seek recovery from the EHCP through means available under this Agreement and under Applicable Laws.

Section 4: EHCP Services- Admission Procedure

4.1. The EHCP shall be required to follow the process as described in **Annex 5**. CMHIS operation manual for EHCP for detailed verification, pre-authorisation, and claims procedures. The SHA may issue revisions to these guidelines from time to time. The EHCP agrees to constantly update itself on these guidelines and follow the same.

4.2. Pre-authorisation

i. All procedures in **Annexure 3** that are earmarked for pre-authorisation shall be subject to mandatory pre-authorisation. In addition, in case of Inter-State portability, all procedures shall be subject to mandatory pre-authorisation irrespective of the pre-authorisation status in **Annexure 3**

ii. Also, all such hospitalisation procedures which are required to be undertaken but are not included in Annexure 3 need to be pre-authorised (subject to exclusion) by the Insurer within an overall limit of Rs. 1,00,000.

iii. No EHCP shall, under any circumstances whatsoever, undertake any such earmarked procedure without pre-authorisation unless under emergency. Process for emergency approval will be followed as per guidelines laid down by SHA.

iv. The EHCP agrees to provide a minimum set of documents for pre-authorisation to Insurer through online submission so as to enable the Insurer to decide the merit of the case.

4.3. Regular or planned admission

The process to be followed for regular or planned/elective procedures is set in **Annex 5**.

4.4. Emergency admission

In case of emergency the hospital shall follow the standard guidelines of the medical treatment. Meanwhile the EHCP will get the TPIN (Telephonic Patient Identification Number) from the Insurer and same will be recorded. Government Photo ID proof need not be insisted in case of emergency. Once the patient gets stable the EHCP has to follow the normal guidelines of registration and admission under the scheme for claim payment.

Section 5: The Discharge and Claim Procedure

5.1. Original discharge summary, counterfoil generated at the time of discharge, original investigation reports, all original prescription & pharmacy receipt etc. must be kept with the EHCP for records. These are to be forwarded to billing department of the EHCP who will compile and keep the same with the EHCP. A copy of these documents may be given to the patient.

5.2. EHCPs shall be obliged to submit their claims online within 24 hours of discharge in the format prescribed. EHCP is also required to constantly monitor the progress on claim generation, submission and claim payments. Any delays or discrepancies must be brought to the notice of SHA by EHCP.

5.3. The Insurer shall be responsible for settling all claims **within 15 days after receiving all the required information/ documents**. However, it is the primary responsibility of the EHCP to furnish all the details at the time of discharge and thereafter as may be necessary so as to enable the claim processing on time.

5.4. The details of raising a claim, claims processing, handling of claim query, stipulated time, documentation requirements and related details shall be provided to the EHCP in an CMHIS transaction manual for EHCP. The EHCP agrees to follow these guidelines as detailed in Annexure 5. The SHA may issue revisions to these guidelines from time to time. The EHCP agrees to constantly update itself on these guidelines and follow the same.

Section 6: Payment terms

6.1. EHCP will submit claims online in accordance with the process described in **Annex 5**.

6.2. The Insurer will have to take a decision and settle the Claim within 15 days from requiring all the necessary documents/information. If required, Insurer can visit EHCP to gather further documents related to treatment to process the case.

6.3. However, the Insurer must note that requirements for such information are assessed by the Insurer at once and the same be intimated to the EHCP. The information must not be sought in bits and instalments or in a piecemeal method.

6.4. In case the Insurer decides to reject the claim then that decision also will need to be taken within 15 days.

6.5. In case of inter-operability claim arising from patient visiting from other States the decision on claim settlement and actual payment has to be done within 30 days by the Insurer from the State to which beneficiary belongs.

6.6. If claim payment to the EHCP is delayed beyond defined period of 15 days (30 days for inter-State claims), the Insurer is liable to pay an interest of 1% for every seven days of delays to EHCP in addition to the claim amount.

6.7. The EHCP must ensure that the required documents are in place.

6.8. Payment will be done by Electronic Fund Transfer as far as possible.

6.9. The Insurer shall have the right to initiate recovery actions against the EHCP for any financial fraud or financial dues to the Insurer on account of acts of fraud by the EHCP which may include, adjusting payments against future claims or any other remedies to recover funds available to SHA under Applicable Laws.

Section 7: Declarations and undertakings of an EHCP

7.1. The EHCP undertakes that they have obtained all the registrations/ licenses/ approvals required by law to provide the services pursuant to this agreement and that they have the skills, knowledge and experience required to provide the services as required in this agreement.

7.2. The EHCP undertakes to uphold all requirement of law in so far as these apply to him and in accordance to the provisions of the law and the regulations enacted from time to time, by the local bodies or by the central or the state govt. The EHCP declares that it has never committed a criminal offence which prevents it from practicing medicines and no criminal charge has been established against it by a court of competent jurisdiction.

7.3. The EHCP hereby declares that it has not been blacklisted from another government scheme or by any government body or by a licenced insurer/TPA or under the provisions of any law of the land.

Section 8: General responsibilities & obligations of the EHCP

8.1. Ensure that no confidential information is shared or made available by the EHCP, or any person associated with it to any person or entity not related to the EHCP without prior written consent of SHA.

8.2. The EHCP shall provide cashless facility to the beneficiary in strict adherence to the provisions of the agreement.

8.3. The EHCP may have their facility covered by proper indemnity policy including errors, omission and professional indemnity insurance and agrees to keep such policies in force during entire tenure of the Agreement. The cost/ premium of such policy shall be borne solely by the EHCP.

8.4. The EHCP shall provide the best of the available medical facilities to the beneficiary.

8.5. The EHCP will hire a dedicated person called Arogya Mitra to manage the help desk and facilitate the beneficiary in accessing the benefits under CMHIS. The cost of the Arogya Mitra's will need to be entirely borne by the Private EHCP. SHA may support Public EHCPs.

8.6. The EHCP shall also have two contact persons nominated for all matters related to CMHIS; one person from clinical team (a doctor who is actively engaged in the treatment of the patients) and one officer in the administration department assigned for CMHIS. These officers will eventually be required to make themselves trained with the processes described in CMHIS.

8.7. The EHCP shall endeavour to make their team including Arogya Mitra's and contact persons actively participate in all CMHIS trainings and workshops to be organised by SHA /Insurer from time to time. SHA and/or Insurer will organise trainings for Arogya Mitra's and other contact persons of EHCP. In addition, the EHCP may also be required to conduct trainings for its staff regarding CMHIS at their premise with the help of SHA and Insurer. The cost of attending such trainings and organising trainings shall be borne by the EHCP unless otherwise agreed with SHA.

8.8. SHA may decide, if the EHCP has received NABH entry-level certification, it will receive an additional 10% over the listed package rates, while if EHCP has qualified for full accreditation of NABH, it will receive an additional 15%. If the EHCP is based in one of the aspirational districts it will receive an additional 10%. Additionally, if the EHCP is a teaching hospital running PG/ DNB courses, it would receive further an additional 10% over the listed package rate.

However these incentives shall not be applicable on the N-HBP 2022 CMHIS(EP) rates for Government Employees/Pensioners/ex-Legislators and other officials under CMHIS(EP)

8.9. For such EHCP that is not NABH accredited, it agrees to get at least NABH entry level certification within a reasonable period of time.

8.10. The EHCP agrees that it shall display their status of preferred service provider of CMHIS at their main gate, reception/ admission desks along with the display and other materials supplied by SHA/Insurer whenever possible for the ease of the beneficiaries. Format, design, and other details related to these signages as provided by SHA shall be used.

8.11. The EHCP hereby agrees that it shall unconditionally comply with all the provisions of the Anti-Fraud Guidelines issued by the SHA including all its amendments from time to time.

8.12. The EHCP further agrees and acknowledges that lack of compliance the Anti-Fraud Guidelines shall be deemed as a material breach of this contract and in such a situation the SHA may, at its sole discretion, initiate disciplinary proceedings as per the provisions of this contract, which may lead to termination and / or if the situation so demands seeking recourse to civil or criminal remedies available under Applicable Laws.

Section 9: Fraud management

9.1. EHCP hereby agrees that under the Scheme, fraud shall be defined as any intentional deception, manipulation of facts and / or documents or misrepresentation made by the EHCP or by any person or organization appointed employed / contracted by the EHCP with the knowledge that the deception could result in unauthorized financial or other benefit to herself/himself or some other person or the organisation itself. It includes any act that may constitute fraud under any applicable law in India.

9.2. Pursuant to any trigger alert related to possible fraud at the level of the EHCP, the SHA or its authorised representatives shall have the liberty to undertake investigation of the case.

9.3. The SHA shall on an ongoing basis measure the effectiveness of anti-fraud measures in the through a set of indicators.

9.4. In the event that the EHCP or any of its employee or consultant or contractor undertakes any fraudulent activity and if the fraud is proven through investigation, the SHA shall:

i. refuse to honour a fraudulent Claim or Claim arising out of fraudulent activity or reclaim all benefits paid in respect of a fraudulent claim or any fraudulent activity relating to a claim from the EHCP; and/or
ii. de-empanel or delist the EHCP, with the procedure specified in Annex 6; and/or
iii. terminate this services agreement with the EHCP and if deemed appropriate initiate civil and / or criminal proceedings as per Applicable Laws.

9.5. For fraudulent activities by any of its employee or consultant or contractor, the vicarious liability shall vest with the EHCP and the EHCP shall be obliged to initiate action against such employee or consultant or contractor as per the directions of the SHA which may include but not be limited to (a) disciplinary actions; and / or (b) termination of services / contract; and / or (c) debarring engagement / employment with another provider under CMHIS; and / or (d) civil and / or criminal proceedings as per Applicable Laws.

Section 10: General responsibilities of SHA, Insurer/ ISA

10.1. SHA, Insurer has a right to avail similar services as contemplated herein from other institution for the health services covered under this agreement.

Section 11: Monitoring and verification

11.1. The SHA shall, either directly or through the Insurer / ISA / TPA or any of its authorised representatives, shall have the right to conduct monitoring visits and random audits of any or all cases of hospitalisation and any or all claims submitted by the EHCP.

11.2. Monitoring of EHCPs shall include but not be limited to:

i. Overall performance and conduct of the EHCP
ii. Beneficiary registration process
iii. Pre-authorisation and claims submission process
iv. EHCP facility and infrastructure.

11.3. The scope of medical audit of services provided by the EHCP shall focus on ensuring comprehensiveness of medical records and shall include but not be limited to:

i. Completeness of the medical records file
ii. Evidence of patient history and current illness
iii. Operation report (if surgery is done)
iv. Patient progress notes from admission to discharge
v. Pathology and radiology reports.

11.4. If at any point in time the SHA issues Standard Treatment Guidelines for all or some of the medical/ surgical procedures, assessing compliance to Standard Treatment Guidelines shall be within the scope of the medical audit.

11.5. The SHA/Insurer shall conduct the medical audit through on-site visits to the EHCP facility for inspection of records, discussions with the nursing and medical staff.

11.6. The SHA/Insurer shall conduct hospital audit of the EHCP that will focus on compliance to minimum empanelment criteria including but not limited to facilities, infrastructure, human resources, medical record keeping system and EHCP's obligations like operational help desk, appropriate signage of the Scheme prominently displayed.

11.7. The EHCP shall be obliged to provide unconditional support to the Insurer or any of its authorised representatives in all their monitoring activities which shall include but not be limited to providing access to the hospital facility, patients and record for planned and unplanned supervision visits, providing copies of all medical records of CMHIS beneficiaries as required for purposes of audit or otherwise and any other cooperation and support that may be required under the provisions of this Agreement.

Section 12: Relationship of the Parties

12.1. Nothing contained herein shall be deemed to create between the Parties any partnership, joint venture or relationship of principal and agent or master and servant or employer and employee or any affiliate or subsidiaries thereof. Each of the Parties hereto agrees not to hold itself or allow its directors employees/agents/representatives to hold out to be a principal or an agent, employee or any subsidiary or affiliate of the other.

Section 13: Reporting

13.1. In the first week of each month, beginning from the first month of the commencement of this Agreement, the EHCP and SHA and Insurer shall exchange information on their experiences during the month and review the functioning of the process and make suitable changes whenever required. However, all such changes have to be in writing and by way of suitable supplementary agreements or by way of exchange of letters.
13.2. All official correspondence, reporting, etc. pertaining to this Agreement shall be conducted with SHA and Insurer at its corporate offices at the address _____.

Section 14: Termination

14.1. SHA and Insurer reserves the right to terminate this agreement in case of material breach of this Agreement, material breach of the Anti-Fraud Guidelines issued by the SHA and any fraudulent activity of the EHCP that has been investigated and proven as fraud, and as per the guidelines issued by SHA as given in Annex 6.
14.2. This Agreement may be terminated by either party by giving one month's prior written notice by means of registered letter or a letter delivered at the office and duly acknowledged by the other, provided that this Agreement shall remain effective thereafter with respect to all rights and obligations incurred or committed by the parties hereto prior to such termination.
14.3. Either party reserves the right to inform public at large along with the reasons of termination of the agreement by the method which they deem fit.

Section 15: Confidentiality

This clause shall survive the termination/expiry of this Agreement.

15.1. Each party shall maintain confidentiality relating to all matters and issues dealt with by the parties in the course of the business contemplated by and relating to this agreement. The EHCP shall not disclose to any third party and shall use its best efforts to ensure that its, officers, employees, keep secret all information disclosed, including without limitation, document marked confidential, medical reports, personal information relating to insured, and other unpublished information except as maybe authorized in

writing by SHA/ Insurer. SHA/ Insurer shall not disclose to any third party and shall use its best efforts to ensure that its directors, officers, employees, sub-contractors, and affiliates keep secret all information relating to the EHCP including without limitation to the EHCP's proprietary information, process flows, and other required details.

15.2. In particular, the EHCP agrees to:

Maintain confidentiality and endeavour to maintain confidentiality of any persons directly employed or associated with health services under this agreement of all information received by the EHCP or such other medical practitioner or such other person by virtue of this agreement or otherwise, including Insurer's proprietary information, confidential information relating to insured, medicals test reports whether created/ handled/ delivered by the EHCP. Any personal information relating to an Insured received by the EHCP shall be used only for the purpose of inclusion/preparation/finalisation of medical reports/ test reports for transmission to Insurer only and shall not give or make available such information/ any documents to any third party whatsoever.

- Keep confidential and endeavour to maintain confidentiality by its medical officer, employees, medical staff, or such other persons, of medical reports relating to Insured, and that the information contained in these reports remains confidential and the reports or any part of report is not disclosed/ informed to the Insurance Agent / Advisor under any circumstances.

- Keep confidential and endeavour to maintain confidentiality of any information relating to Insured and shall not use the said confidential information for research, creating comparative database, statistical analysis, or any other studies without appropriate previous authorisation from Insurer and through Insurer from the Insured.

Section 16: Indemnities and other provisions

16.1. SHA, Insurer will not interfere in the treatment and medical care provided to its beneficiaries. SHA and/ or Insurer will not be in any way held responsible for the outcome of treatment or quality of care provided by the provider.

16.2. SHA and/ or / Insurer shall not be liable or responsible for any acts, omission or commission of the Doctors and other medical staff of the EHCP and the EHCP shall obtain professional indemnity policy on its own cost for this purpose. The EHCP agrees that it shall be responsible in any manner whatsoever for the claims, arising from any deficiency in the services or any failure to provide identified service.

16.3. Notwithstanding anything to the contrary in this agreement no Parties shall be liable by reason of failure or delay in the performance of its duties and obligations under this agreement if such failure or delay is caused by acts of God, Strikes, lockouts, embargoes,

war, riots civil commotion, any orders of governmental, quasi-governmental or local authorities, or any other similar cause beyond its control and without its fault or negligence.

16.4. The EHCP will indemnify, defend, and hold harmless the SHA and Insurer against any claims, demands, proceedings, actions, damages, costs, and expenses which the company may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the EHCP or any of its employees or doctors or medical staff.

16.5. SHA will not have legal obligations towards claim settlement amount in the cases where an insurance company has been hired by SHA to implement CMHIS.

Section 17: Force Majeure

17.1. Notwithstanding anything to the contrary in this agreement no Parties shall be liable by reason of failure or delay in the performance of its duties and obligations under this agreement if such failure or delay is caused by acts of God, Strikes, lockouts, embargoes, war, riots civil commotion, any orders of governmental, quasi-governmental or local authorities, or any other similar cause beyond its control and without its fault or negligence.

Section 18: Notices

18.1. All notices, demands or other communications to be given or delivered under or by reason of the provisions of this Agreement will be in writing and delivered to the other Party:

A. By registered mail.
B. By courier.
C. By facsimile.

18.2. In the absence of evidence of earlier receipt, a demand or other communication to the other Party is deemed given

- If sent by registered mail, seven working days after posting it: and
- If sent by courier, seven working days after posting it: and
- If sent by facsimile, two working days after transmission. In this case, further confirmation has to be done via telephone and e-mail.

18.3. The notices shall be sent to the other Party to the above addresses (or to the addresses which may be provided by way of notices made in the above said manner):

If to the EHCP:

Attn: ……
Tel: …….
Fax: ……

If to Insurance company

_____ Insurance Company Limited/ TPA Limited
_____
_____
_____

If to the SHA

Section 19: Miscellaneous

19.1. This Agreement together with the clauses specified in the tender document floated for selection of Insurance Company and any Annexure attached hereto constitutes the entire Agreement between the parties and supersedes, with respect to the matters regulated herein, and all other mutual understandings, accord and agreements, irrespective of their form between the parties. Any annexure shall constitute an integral part of the Agreement.

19.2. Except as otherwise provided herein, no modification, amendment, or waiver of any provision of this Agreement will be effective unless such modification, amendment or waiver is approved in writing by the parties hereto.

19.3. Should specifically provision of this Agreement be wholly or partially not legally effective or unenforceable or later lose their legal effectiveness or enforceability, the validity of the remaining provisions of this Agreement shall not be affected thereby.

19.4. The EHCP may not assign, transfer, encumber or otherwise dispose of this Agreement or any interest herein without the prior written consent of SHA and Insurer, provided whereas that the SHA/Insurer may assign this Agreement or any rights, title, or interest herein to an Affiliate without requiring the consent of the EHCP.

19.5. The failure of any of the parties to insist, in any one or more instances, upon a strict performance of any of the provisions of this Agreement or to exercise any option herein

contained, shall not be construed as a waiver or relinquishment of such provision, but the same shall continue and remain in full force and effect.

19.6. The EHCP will indemnify, defend, and hold harmless the SHA /Insurer against any claims, demands, proceedings, actions, damages, costs, and expenses which the latter may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the EHCP or any of its employees/doctors/other medical staff.

19.7. Law and Arbitration

i. The provisions of this Agreement shall be governed by and construed in accordance with Indian law.
ii. Any dispute, controversy or claims arising out of or relation to this Agreement or the breach, termination, or invalidity thereof, shall be settled by arbitration in accordance with the provisions of the (Indian) Arbitration and Conciliation Act, 1996.
iii. The arbitral tribunal shall be composed of three arbitrators, one arbitrator appointed by each Party and one another arbitrator appointed by the mutual consent of the arbitrators so appointed.
iv. The place of arbitration shall be _____ and any award whether interim or final, shall be made, and shall be deemed for all purposes between the parties to be made, in _____.
v. The arbitral procedure shall be conducted in the English language and any award or awards shall be rendered in English. The procedural law of the arbitration shall be Indian law.
vi. The award of the arbitrator shall be final and conclusive and binding upon the Parties, and the Parties shall be entitled (but not obliged) to enter judgement thereon in any one or more of the highest courts having jurisdiction.
vii. The rights and obligations of the Parties under, or pursuant to, this Clause including the arbitration agreement in this Clause, shall be governed by and subject to Indian law.
viii. The cost of the arbitration proceeding would be borne by the parties on equal sharing basis.

19.8. NON – EXCLUSIVITY: SHA and/ or Insurer reserves the right to appoint any other health care provider for implementing the packages envisaged herein and the EHCP shall have no objection for the same.

19.9. Severability: The invalidity or unenforceability of any provisions of this Agreement in any jurisdiction shall not affect the validity, legality, or enforceability of the remainder of this Agreement in such jurisdiction or the validity, legality, or enforceability of this Agreement, including any such provision, in any other jurisdiction, it being intended that all rights and obligations of the Parties hereunder shall be enforceable to the fullest extent permitted by law.

19.10. Captions: The captions herein are included for convenience of reference only and shall be ignored in the construction or interpretation hereof.

SIGNED AND DELIVERED BY

the EHCP. - the within named_____, by the Hand of _____ its Authorized Signatory

In the presence of:

1 SIGNED AND DELIVERED BY _____, Government of ……. the within named _____, by the hand of _____ its Authorised Signatory

In the presence of:

2 SIGNED AND DELIVERED BY _____, Government of ……. the within named _____, by the hand of _____ its Authorised Signatory

In the presence of:

Annex 1 – Exclusions to the Policy

The Insurance Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

POLICY EXCLUSIONS:

- Condition that does not require hospitalization and can be treated under Outpatient Care.
- Except those expenses covered under pre and post hospitalization expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc. unless forming part of treatment for injury or disease as certified by the attending physician.
- Any dental treatment or surgery which is corrective, prosthetic, cosmetic procedure, filling of tooth cavity, root canal including wear and tear of teeth, periodontal diseases, dental implants etc. are excluded. Exception to the above would be treatment needs arising from trauma / injury, neoplasia / tumour / cyst requiring hospitalization for bone treatment.
- Any assisted reproductive techniques, or infertility related procedures, unless featuring in the National Health Benefit Package list.
- Vaccination and immunization.
- Surgeries related to ageing face and body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc.
- Circumcision for children less than 2 years of age shall be excluded (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident)
- Persistent Vegetative State: a condition in which a medical patient is completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function, being kept alive only by medical intervention.

Annex 2: Arogya Mitra Under CMHIS

Arogya Mitra (AM) will need to be hired by Private EHCP for managing the help desk. Public EHCP to follow the final guidelines issued by SHA for AMs. This help desk will need to be set up exclusively for CMHIS. Indicative role of AM is as follows:

A. Receive beneficiary at the EHCP
B. Guide beneficiary regarding CMHIS and process to be followed in the EHCP for taking the treatment
C. Carry out the process of Beneficiary Identification for such persons who are beneficiaries of CMHIS
D. Take photograph of the beneficiary
E. Carry out the Aadhaar based identification for such beneficiaries who are carrying Aadhaar
F. If the person is not carrying Aadhaar carry out the identification through other defined Government issued ID
G. Scan the identification documents as per the guidelines and upload through the software
H. Send the result of beneficiary identification process to Insurer for approval
I. After getting confirmation from Insurer regarding identification of the beneficiary, issue e-card to the beneficiary
J. Refer the patient to doctor for consultation
K. Check the balance of CMHIS Beneficiary family in her/ his CMHIS Cover amount.
L. Upon advice of the doctor admit the patient in the EHCP
M. Take the pre-authorisation as and when required as per the guidelines
N. Enter all the relevant details of package and other information as provided by the doctor and required by the CMHIS software
O. At the time of discharge again enter all the relevant details and discharge summary in the software
P. Carry out any other task as defined by the EHCP related to CMHIS

Detailed guidelines for Arogya Mitra's issued by States to be inserted here

Annex 3 – Packages and Rates

Health Benefit Packages

3.0. The Health Benefit Package (HBP) for Nagaland shall be called the N-HBP 2022. The N-HBP 2022 will be divided in the following two categories for different population categories. Henceforth, these will be referred to as NHBP 2022 for **CMHIS (GEN)** and NHBP 2022 for **CMHIS (EP)** when the code "GEN" refers to "General" and "EP" refers to GoN employees and pensioners.

3.1. Beneficiaries under Category 1 (AB-PMJAY), Category 2 (Additional AB-PMJAY), and Category 5 (General Population) shall be eligible for HBP under **CMHIS (GEN)**.

3.2. Beneficiaries under Category 3 (GoN employees) and Category 4 (GoN pensioners) shall be eligible for NHBP 2022 under **CMHIS (EP)**.

3.3. **NHBP under CMHIS (GEN) for Category 1 (AB-PMJAY), Category 2 (Additional AB-PMJAY), and Category 5 (General Population)**:

a. The HBP under CMHIS(GEN) shall hereafter be referred to as "Nagaland Health Benefits Package" or "**N-HBP 2022**".

b. Procedures: The CMHIS will cover approximately 1950 in-patient procedures across 27 major clinical specialties. The procedures will include both surgical and medical procedures and limited day-care packages. Based on the feedback and suggestions received from stakeholders, the procedure list may undergo revisions, additions, and deletions as the CMHIS progresses.

c. Bundled package costs: The package cost shall be "bundled," implying that it will be an all-inclusive cost payable for a particular procedure (including medical management cases); the cost of Implants, high-end drugs, and diagnostics may be additional in a matter of few specific procedures.

d. Package prices: The package prices shall be fixed by the Department of Health and Family Welfare, GoN) in consultation with relevant experts and providers, also taking the help of national guidelines laid down by the National Health Authority (NHA), and as modified and applicable to Nagaland. The package prices shall be reviewed at regular intervals.

e. Standard Treatment Guidelines (STG): As per the World Health Organization, STGs 'assist practitioners and patients in making decisions about appropriate health care for specific clinical circumstances. Thus, the procedure packages shall follow the STGs developed by the NHA for most utilized packages to the extent feasible. The mandatory documents specified in STGs shall also help empanelled hospitals submit uniform set documents in support of procedures booked for treating a patient, thereby increasing the operational efficiencies.

3.4. HBP under CMHIS (EP) for Category 3 (GoN employees) and Category 4 (GoN pensioners)

1.5 **N-HBP 2022 for CMHIS(EP):** The N-HBP 2022 for the Beneficiary Categories that are eligible for CMHIS(EP) cover shall cover and include:

a. Benefit for CMHIS (EP) shall be as per the CGHS package construct.

b. Beneficiary Categories that are eligible for CMHIS(EP) cover shall be entitled to in-patient care with differential room entitlement as per employee Pay Level or Pay Level at which the employee retired as specified in Clause 5.4.3.

c. For the purposes of room entitlement as provided in Clause 5.4.2, employees of GoN shall be entitled to treatment as per the room entitlement given in the table below:

Employee classification as per Pay Level	Room entitlement	Maximum Room Rate (Per day)
Pay Level 15 and above	Private ward	3000
Pay Level 10-14	Semi-private ward	2000
Pay Level 9 and below	General Ward	1000
All levels	Day Care (6-8 hours)	500

i. Room rent is applicable only where prescribed treatment package rates are not available. Room rent includes charges for occupation of bed, diet for patient, charges for electricity and water supply, linen charges, nursing charges and routine up keeping.

ii. For patients availing bundled health benefit packages (surgical packages), no separate room rent will be admissible if the patient is treated in ICU/ICCU.

iii. Private ward, semi-private ward, and general ward are as per the definitions given by CGHS. Entitlement to rooms and exceptions in case of non-availability of entitled category accommodation, admission to higher or lower category of accommodation, etc., shall be as per extant CGHS guideline.

d. For the purposes of room entitlement as provided in Clause 5.4.1, all pensioners of GoN shall be entitled to avail of care with room upgrade as per the room entitlement given in Clause 1.7.2.1 above based on the employee classification level at which they retired from service with the GoN.

e. The Insurer shall ensure that all beneficiaries under Beneficiary Category 3: all employees and other officials of GoN, and serving parliamentarians/Legislators shall be allowed to avail of care with room upgrade per their room entitlement provisions set forth in Clause 5.4.3.

f. The Insurer shall ensure that all beneficiaries under Category 4: GoN pensioners and ex-parliamentarians/Legislators shall be allowed to avail of care with room upgrade as per their room entitlement provisions set forth in Clause 5.4.4 based on the employee classification level at which they retired from service with the GoN.

g. The benefits under the CMHIS (EP) shall be organized on a cashless basis at empanelled hospitals.

h. For treatment within Nagaland of Beneficiaries eligible for CMHIS (EP), shall follow the following construct as per prescribed rates detailed out in N-HBP 2022 for CMHIS(EP) in Schedule 3B :

i. The prescribed package rates are for semi-private ward. If the beneficiary is entitled for general ward there will be a decrease of 10% in the rates. For private ward entitlement there will be an increase of 15%. However, the rates shall be the same for investigation irrespective of entitlement.

ii. Package rate includes all the expenses for in-patient treatment, and specific daycare procedures. Beneficiaries are permitted by the competent authority or for treatment under emergency from the time of admission to the time of discharge, including (but not limited to):

- Registration charges
- Admission charges
- Accommodation charges
- Diet charges
- Operation charges
- Injection charges
- Dressing charges
- Doctor consultant charges
- ICU/ICCU charges
- Monitoring charges
- Transfusion charges
- Anesthesia charges
- Operation theatre charges
- Procedural charges
- Surgeon fee
- Surgical disposables cost
- Medicines cost
- Physiotherapy charges
- Nursing charges

iii. For implants, stents, grafts, consumables, drugs, not specifically mentioned in the NHBP 2022 for CMHIS (EP) list, the lower of the rates as per PMJAY (Gen) rates or CGHS or NPPA (National Pharmaceutical Pricing Authority) ceiling rates shall be applicable. If no prescribed ceiling rates are available, the cost shall be paid as per actual.

i. For treatment outside Nagaland of Beneficiaries eligible for CMHIS (EP), CMHIS (EP) Beneficiaries can access care at any CGHS empaneled hospital (on CGHS rates applicable for that city) across India with room category as per their room entitlement as per the provisions of Clause 5.4.3 and Clause 5.4.5;

Standard Treatment Guidelines (STG): STGs, as applicable for CMHIS (GEN) – refer to Section 4.4d above, shall be applicable for the CMHIS (EP) as well.

a. Annexure 3 (a) CMHIS HBP
(Insert CMHISHBP Packages)

b. Annexure 3 (b)

HBP PACKAGE INCLUSIONS:

- Registration charges
- Bed charges
- Nursing and boarding charges
- Surgeons, anaesthetists, medical practitioner, consultant's fees etc.
- Anaesthesia, blood transfusion, oxygen, O.T. charges, cost of surgical appliances etc.
- Medicines and drugs
- Cost of prosthetic devices, implants etc.
- Pathology and radiology tests:
- **Medical procedures** include basic radiological imaging and diagnostic tests such as X-ray, USG, haematology, pathology etc. However, high end radiological diagnostic and high-end histopathology (biopsies) and advanced serology investigations packages can be booked as a separate 'Add-on procedure', if required.
- **Surgical packages** are all inclusive and do not permit addition of other diagnostic packages.
- Food to patient
- Pre and post hospitalization expenses: Expenses incurred for consultation, diagnostic tests, and medicines prior to admission of the patient in the same hospital

and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.

- Any other expenses related to the treatment of the patient in the hospital.

c. Annexure 3 (c): Guidelines for Unspecified Surgical Packages

3.c.i. All unspecified packages: To ensure that beneficiaries are not denied care, for treatments/procedures that do not feature in the listed interventions, there is an exclusive provision that has been enabled in the TMS (transaction management system) for blocking such treatments, subject to satisfying certain defined criteria (as mentioned)

When can Unspecified Surgical be booked/ criteria for treatments that can be availed:

j. Only for surgical treatments.
k. Compulsory pre-authorization is in-built while selecting this code for blocking treatments.
l. Cannot be raised under multiple package selection. Not applicable for medical management cases.
m. Government reserved packages cannot be availed by private hospitals under this code. PPD/ CPD may reject such claims on these grounds. In addition, SHA may circulate Government reserved packages to all hospitals. Further, States need to establish suitable mechanisms to refer such cases to the public system – to avoid denial of care.
n. Cannot be booked for removal of implants, which were inserted under the same policy. Exceptions where removal of implants is not covered under any other package, to be approved by State Health Agencies
o. In the event of portability, the home state approval team may either reject if a government reserved package of the home state is selected by a private hospital in the treating state or consider on grounds of 'emergency'.
p. Aesthetic treatments of any nature cannot be availed under this code or as such under any other listed codes. Only medically necessary with functional purpose/ indications can be covered. The procedure should result in improving/restoring bodily function or to correct significant deformity resulting from accidental injury, trauma or to address congenital anomalies that have resulted in significant functional impairment.
q. Individual drugs or diagnostics cannot be availed under this code. Only LISTED drugs and diagnostics with fixed price Annexures, listed under the drop down of respective specialties, are included for blocking treatments.

3.c. ii. None of the treatments that fall under the exclusion list can be availed viz. individual diagnostics for evaluation, out-patient care, drug rehabilitation, cosmetic/ aesthetic treatments, vaccination, hormone replacement therapy for sex change or any treatment related to sex change, any dental treatment or surgery which is corrective,

cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalization for treatment etc.

r. However, for life threatening cases e.g., of suicide attempt or accident due to excess consumption of alcohol, treatment shall be provided by the hospital till the patient's condition stabilizes.
s. In case the State is getting multiple requests for the same unspecified package from multiple hospitals or for multiple patients, then the same should be taken up with the Medical Committee for inclusion in the package master for that State within a defined time frame as per the State.

3.c.iii. For deciding on the approval amount, the PPD may consider the rate of closest match of the requested surgery, in listed packages. It should be noted that the amount approved by the PPD would be sacrosanct, to be communicated to the hospital, and the CPD would not be able to deduct any amount or approve partial payment for that claim.

3.c. iv. Unspecified package above 1 lakh to 5 lakh: For State to utilize the unspecified package above 1 lakh, it is to be ensured that the same is approved only in (a) exceptional circumstances and / or (b) for life saving conditions.

Exceptional circumstances may include:

f. Rare disease conditions or rare surgeries.
g. Procedure available under HBP in a different specialty but not available in the treating specialty.
h. Procedure available under HBP in a specialty for which the hospital is not empanelled.
i. Other conditions / treatments which are not excluded under CMHIS but not listed in HBP.

Life-saving conditions may include:

i. Emergencies or life-threatening conditions

3.c.v. While it is difficult to define all the situations where unspecified surgical package may be used or the upper limit for booking the package, but it can be allowed if it is approved by medical committee of SHA comprising of experts from public hospitals. Condition for booking such package should also be mentioned as described above. The following process to be adhered:

- A standing medical committee will be constituted by CEO of each SHA to provides inputs on requests received for unspecified surgical packages among their other deliverables.

- CEO, SHA will recommend every case for approval after taking inputs from the standing medical committee (wherever committee is yet to be constituted, opinion of 2 medical experts will suffice as recommendation in the interim period), with details of treatment and pricing that is duly negotiated with the provider. This recommendation should have insurance company concurrence, wherever applicable.
- The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, consumables, post-op care and applicable incentive to the hospital included – preferably citing rates as ceiling from any government purchasing scheme like CGHS etc., if available.
- A letter or request from the SHA.
- The turnaround time for the entire activity shall be 48 hours to ensure that the beneficiary is provided prompt treatment.

Annexure 3 (d): Differential Pricing Guidelines

CMHIS provides additional incentive on the procedure rate based on following criteria's:

**These differential package pricing shall not be applicable for N-HBP 2022 for CMHIS (EP) , ie., treatment of Government Employees/Pensioners/ex-Legislators/other Government Officials shall only be claimed by EHCPs at the published N-HBP 2022 for CMHIS (EP) with no additional incentives as defined below , which will be applicable on for AB PM-JAY and general Category Beneficiary categories using the N-HBP 2022 for CMHIS (GEN). However any applicable Incentives under CGHS shall apply for CGHS-Network Hospitals outside the state. **

S. No.	Criteria	Incentive (Over and above base procedure rate)
1	PM-JAY Bronze Certification	5%
2	Entry level NABH / NQAS certification	10%
3	Full NABH / JCI accreditation	15%
4	Situated in Delhi or some other Metro*	10%
5	Aspirational district	10%
6	Running PG / DNB course in the empaneled specialty	10%

*Classification of Metro Cities:

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

7. Chennai
8. Ahmedabad

These percentage incentives are added by compounding.

Annexure 3 (e): Quality Assurance of Empanelled Health Care Providers

g. The SHA, through Insurance Company, shall ensure the quality of service provided to the beneficiaries in EHCP.
h. EHCP has to monthly submit the online Self – Assessment checklist to District Empanelment Committee and SHA shall focus on low performing hospitals for further improvement.
i. EHCP will be encouraged by Insurer to attain quality milestones by attaining AB PMJAY Quality Certification (Bronze, Silver and Gold).
j. Bronze Quality Certification is pre-entry level certificate in AB PMJAY Quality Certification. EHCP which do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate.
k. Bronze Quality Certified EHCP can apply for AB PMJAY Silver Quality Certification after completion of 6 months from the date of receiving bronze certification. This certification is also benchmarked with NABH Entry Level / NQAS certification and EHCP with these certifications can directly apply for Silver Quality Certification without getting Bronze Quality Certification with simplified process.
l. Silver Quality Certified EHCP can apply for AB PMJAY Gold Quality Certification after completion of 6 months from the date of receiving silver certification. This certification is benchmarked with NABH full/ JCI accreditation and EHCP with these certifications can directly apply for Gold Quality Certification without getting Silver or Bronze Quality Certification with simplified process.

Annex 4: Beneficiary Identification System

This needs to be finalised based on the decision of the SHA on individual and family ID and alignment of IT software.

The CMHIS is an entitlement-based scheme wherein all domicile residents of Nagaland shall be eligible for coverage under the scheme and a member of covered family can avail treatment at any of the empaneled hospitals at any time after due identification. However, to promote awareness of the scheme and to streamline covered beneficiary database on 'family' /'household' basis for purpose of efficient roll out of the scheme, it is proposed to carry out enrolment process ongoing basis during first two years of the scheme till the time all citizens of Nagaland are enrolled with a unique individual and family id. The process shall have 3 key components as explained below.

4.2. *Master data base creation:* The total number of beneficiary families in Nagaland under all categories is estimated to be 4.91 lakhs. Brief table for different sources of data for different Groups of beneficiaries is given below which shall be merged to form CMHIS beneficiary Master database. The data may be pulled through APIs or shared manually.

4.3. Beneficiary Identification

4.3.1. An important aspect of CMHIS is proper identification of beneficiaries of the Scheme. For this purpose, the beneficiaries shall provide identification documents to substantiate individual ID as well as family ID. For ensuring uniqueness of each beneficiary ID, Aadhaar ID shall be mandatory identification document along with other individual and family level identification documents.

4.3.2. If the 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

4.3.3. The family member does not have an Aadhaar card, and the contact point is a hospital or place of treatment then:

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

a. The beneficiary must produce an ID document from the list of approved ids by the State
b. 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.
c. A scan of the ID produced is uploaded into the system for verification.
d. A photo of the beneficiary is taken.

e. The information from this alternate ID is used instead of Aadhaar for matching against the CMHIS record.

4.3.4. Different groups of beneficiaries shall provide suitable/relevant documents in support of their individual identity. Govt employees and pensioners are issued Govt ID. Ration card holders have NFSA ID. Beneficiaries who are already enrolled under PMJAY have PMJAY ID. The unit of coverage under CMHIS is based on 'family' or 'household', thus family or household document also form part of identification documents to be submitted by beneficiaries for enrolment under the scheme.

4.3.5. Detailed list of individual and family identification documents for different groups of beneficiaries is as follows:
- To be finalized in consultation with SHA

4.4. *Beneficiary Enrolment:* To promote awareness of the scheme and to streamline the covered beneficiary database on a 'family'/'household' basis for the efficient rollout of the scheme, it is proposed to carry out an enrolment process ongoing basis during the first one to two years of the scheme till the time all citizens of Nagaland are enrolled with a unique individual and family identification document specific to the CMHIS. The entitled beneficiaries shall be enrolled under CMHIS following due process of identification, and a unique ID for CMHIS shall be generated.

f. Enrolment of eligible beneficiaries is expected to be completed within 1-2 years of the launch of the CMHIS, and only additions/deletions may be carried out after that.

g. For the beneficiaries who already have a PMJAY ID or have a Government employee/pensioner ID linked to Aadhaar, their data shall be uploaded in Beneficiary Identification System (BIS) from back end, and a unique ID under CMHIS shall be generated, mapped to their Aadhaar and PMJAY or Government employee ID. Special enrolment drive/card delivery campaigns shall be held for Government employees and pensioners close to their place of work or another suitable location.

h. All other categories of beneficiaries shall visit the enrolment facilitation centres established for CMHIS, get enrolled, and obtain their unique CMHIS ID. All empanelled hospitals shall also have a beneficiary enrolment facility so that no beneficiary is denied treatment due to lack of enrolment under the Scheme.

i. All beneficiaries shall receive a CMHIS card after enrolment, and the card shall be valid in perpetuity so that a new card is not required to

j. be issued yearly. The beneficiaries who are already enrolled under PMJAY and have received an Ayushman card will not be issued another card as their existing Ayushman card, if linked to Aadhaar, shall be valid for CMHIS.

Annex 5: Process of Delivery of Benefits, Claim reporting and Submission

1 Cashless Access of Services

A. The CMHIS beneficiaries shall be provided treatment free of cost for all such ailments covered under the Scheme within the limits/ sub-limits and sum insured, i.e., not specifically excluded under the Scheme.

B. The EHCP shall be reimbursed as per the package cost specified in the Tender Document agreed for specified packages or as pre-authorised amount in case of unspecified packages.

C. The Insurer shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the CMHIS Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique Family ID on the CMHIS Card and ascertain the balance available under the CMHIS Cover provided by the Insurer.

D. The SHA/ Insurer shall provide each EHCP with a transaction manual describing in detail the verification, pre-authorisation and claims procedures.

E. The SHA / Insurer shall train Arogya Mitra's that will be deputed in each EHCP that will be responsible for the administration of the CMHIS on the use of the Hospital IT infrastructure for making Claims electronically and providing Cashless Access Services.

F. The EHCP shall establish the identity of the member of CMHIS Beneficiary Family Unit by Aadhaar Based Identification System (No person shall be denied the benefit in the absence of Aadhaar Card) and ensure:
   i. That the patient is admitted for a covered procedure and package for such an intervention is available.
   ii. CMHIS Beneficiary has balance in her/ his CMHIS Cover amount.
   iii. Provisional entry shall be made on the server using the CMHIS ID of the patient. It has to be ensured that no procedure is carried out unless provisional entry is completed through blocking of claim amount.
   iv. At the time of discharge, the final entry shall be made on the patient account after completion of Aadhaar Card Identification Systems verification, or any other recognised system of identification adopted by the SHA to complete the transaction.

2 Pre-authorisation of Procedures

A. All procedures that are earmarked for pre-authorisation shall be subject to mandatory pre-authorisation. In addition, in case of Inter-State portability, all procedures shall be subject to mandatory pre-authorisation irrespective of the pre-authorisation status.

B. No EHCP shall, under any circumstances whatsoever, undertake any such earmarked procedure without pre-authorisation unless under emergency. Process for emergency approval will be followed as per guidelines laid down under CMHIS

C. Request for hospitalisation shall be forwarded by the EHCP after obtaining due details from the treating doctor, i.e., “request for authorisation letter” (RAL). The RAL needs to be submitted online through the Scheme portal and in the event of any IT related problem on the portal, then through email or fax as per defined process. The medical team of Insurer would get in touch with the treating doctor, if necessary.

D. The Insurer shall ensure that in all cases pre-authorisation request related decisions are communicated to the EHCP within 6 hours for all normal cases and within 1 hours for emergencies. If there is no response from the Insurer within 6 hours of an EHCP filing the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised.

E. The SHA/ Insurer shall not be liable to honour any claims from the EHCP for defined procedures for which the EHCP does not have a pre-authorisation, if prescribed.

F. Reimbursement of all claims for procedures in package rate list shall be as per the limits prescribed for each such procedure unless stated otherwise in the pre-authorisation letter/communication.

G. The RAL form should be dully filled with clearly mentioned Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.

H. The Insurer guarantees payment only after receipt of RAL and the necessary medical details.

I. In case the ailment is not covered, or the medical data provided is not sufficient for the medical team of the authorisation department to confirm the eligibility, the insurer can deny the authorisation or seek further clarification/ information.

J. The Insurer needs to file a report to the SHA explaining reasons for denial of every such pre-authorisation request.

K. Denial of authorisation (DAL)/ guarantee of payment is by no means denial of treatment by the EHCP. The EHCP shall deal with such case as per their normal rules and regulations.

L. Authorisation letter (AL) will mention the authorisation number and the amount authorized as a package rate for such procedure for which package has not been fixed earlier. The EHCP must see that these rules are strictly followed.

M. The authorisation is given only for the necessary treatment cost of the ailment covered and mentioned in the RAL for hospitalisation.

N. The entry on the web portal for claim amount blocking at discharge would record the authorisation number as well as package amount agreed upon by the EHCP and the Insurer.

O. In case the balance sum available is less than the specified amount for the Package, the EHCP should follow its norms of deposit/running bills etc. However, the EHCP shall only charge the balance amount against the package from the CMHIS beneficiary. The Insurer upon receipt of the bills and documents would release the authorized amount.

P. The Insurer will not be liable for payments in case the information provided in the RAL and subsequent documents during the course of authorisation is found to be incorrect or not fully disclosed.

Q. In cases where the CMHIS beneficiary is admitted in the EHCP during the current Policy Cover Period but is discharged after the end of the Policy Cover Period, the claim has to be paid by the Insurer from the Policy which was operating during the period in which the CMHIS beneficiary was admitted.

3 Claims Management

A. All EHCPs shall be obliged to submit their claims within 24 hours of discharge in the format prescribed. However, in case of Public EHCPs this time may be relaxed as defined by SHA.

B. The Insurer shall be responsible for settling all claims **within 15 days after receiving all the required information/ documents**.

4 Process for Beneficiary identification, issuance of CMHIS e-card and transaction for service delivery

A. Beneficiary Verification & Authentication

These details are yet to be finalised based on the list of state government approved family ID and individual IDs finalised for the implementation of the scheme and the IT configuration for the same.

Annex 6: Process for Empanelment and Disciplinary Proceedings and De-Empanelment

The empaneled hospital network is the backbone of a healthcare scheme. CMHIS shall empanel both public and private hospitals so that appropriate level of care is accessible to the beneficiaries on cashless basis without difficulty. The Scheme shall also ensure portability of benefits outside the Nagaland so that beneficiaries travelling/residing outside the State can also avail benefits on cashless basis.

6.1. Hospital network under CMHIS(GEN)

a. The hospitals desirous of empanelment under the scheme shall need to comply with minimum criteria as below:
   - 10 beds
   - OT
   - 24 hours emergency care
   - Compliance with local regulations
   - Hardware and internet

   Detailed General criteria and Specialty criteria is as below:

   General criteria for hospital empanelment under CMHIS(GEN):

   1. Qualified Doctor with MBBS Degree & Nurse
   2. At least 10 inpatient beds with adequate spacing and supporting staff as per norms.
   3. Adequate and qualified medical and nursing staff (Doctors - 2 & Nurses- 3), physically in charge round the clock
   4. Fully equipped and engaged in providing Medical and Surgical services, commensurate to the scope of service/ available specialties and number of beds
   5. Round-the-clock Ambulance facilities (own or tie-up).
   6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
   7. Casualty ward 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.
   8. Mandatory for hospitals wherever surgical procedures is offered:
      - Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
      - Post-op ward with ventilator and other required facilities.

9. Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU) with requisite staff
    1. The unit is to be situated in proximity of operation theatre, acute care medical and surgical ward units.
    2. Suction, oxygen supply and compressed air should be provided for each bed.
    3. Further High Dependency Unit (HDU) - where such packages are mandated should have the following equipment:
        i. Piped gases
        ii. Multi-sign Monitoring equipment
        iii. Infusion of ionotropic support
        iv. Equipment for maintenance of body temperature
        v. Weighing scale
        vi. Manpower for 24x7 monitoring
    4. ICU should also be equipped with all the equipment and manpower as per HDU norms, plus pediatric ventilator(s).
10. Maintain complete records as required on day-to-day basis and can provide necessary records of hospital / patients to the Society/Insurer or his representative as and when required.
11. Wherever automated systems are used it should comply with GON guidelines (as and when they are enforced and updated)
12. Maintain complete records of all the CMHIS cases
13. Legal requirements as applicable by the local/state health authority.
14. Adherence to Standard treatment guidelines/ Clinical Pathways for procedures as mandated by NHA from time to time.
15. Registration with the Income Tax Department.
16. NEFT enabled bank account
17. Telephone/Fax
18. Safe drinking water facilities.
19. Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
20. Waste management support services (General and Bio Medical) – in compliance with the bio- medical waste management Act
21. Appropriate fire-safety measures.
22. Provide space for a separate kiosk for CMHIS beneficiary management (CMHIS non-medical coordinator) at the hospital reception. 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)

23. Ensure a dedicated medical officer to work as a medical coordinator towards CMHIS beneficiary management (including records for follow-up care as prescribed). 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.
24. Ensure appropriate promotion of CMHIS in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the SHA/ district level team.
25. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio- metric device etc.) as mandated by the SHA

Specialty criteria

Over and above the essential criteria required to provide basic services under CMHIS (as mentioned in Minimum Criteria) those facilities undertaking defined specialty packages (as indicated in the benefit package for specialties mandated to qualify for advance criteria) should have the following:

1. These empaneled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Neonatal/ Pediatric Surgery, Urology etc.
2. A hospital could be empaneled for one or more specialties subject to it qualifying to the concerned specialty criteria.
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.
5. The Hospital should have sufficient experienced specialists with an advanced qualification in the specific identified fields for which the Hospital is empaneled as per the requirements of professional and regulatory bodies/ as specified in the clinical establishment act/ State regulations.
6. The Hospital should have sufficient diagnostic equipment and support services in the specific identified fields for which the Hospital is empaneled as per the requirements specified in the clinical establishment act/ State regulations.

b. Hospitals shall apply for empanelment online on dedicated portal of the Govt and the overall time for completion of end-to-end process from submission of application to

physical/virtual inspection, approval of application to allocation of Hospital ID and launch of operations shall be maximum one month.

c. All hospitals presently empanelled under PM-JAY shall be deemed empanelled under the CMHIS (GEN), no further registration or empanelment shall be required.

d. The SHA shall hold consultations and approach all private hospitals which are presently not part of PMJAY network to be part of CMHIS scheme. It is likely that there would be a significant fall in number of patients paying in cash from pocket after launch of CMHIS since the Scheme shall cover every citizen of Nagaland.

e. The empanelled hospitals shall be reimbursed for cost of treatment as per HBP 2022 rates for the booked 'package' and shall not be allowed to charge patients for any costs related to treatment, food etc.

6.2. The institution structures established for empanelment will also be responsible for processes leading up to disciplinary proceedings/de-empanelment. SHA, SEC and DEC at the state and district level will form the key institutions in enforcing this mechanism.

6.1.1. SHA and ICs authorized representatives will conduct ongoing analytics to identify aberrant cases/suspect EHCPs. This will be followed by desk audits, field medical audits and EHCPs visits of the suspicious cases, followed by submission of report within 10 working days of flagging the case.

6.1.2. Additionally, any complaint received about the EHCP from the patient or any third party or reported in the grievance cell may be put under the watch list by SHA.

6.1.3. Based on the investigation report received, if the SHA or IC observes that there is sufficient evidence/suspicion of EHCP indulging in malpractices, a show cause-notice shall be issued to the EHCP within 7 working days from receipt of investigation report.

6.1.4. EHCP shall within 5 working days from the date of receipt respond to the show-cause notice along with supporting evidence. In case, the EHCPs response to the show-cause notice is satisfactory, it will continue to function as usual. In case, the response is not received within 5 working days, or the response is unsatisfactory, the EHCP will be suspended for a specified time frame not exceeding 6 months or till a decision has been taken on the proceedings. The notification of suspension will be sent through email and registered speed post.

6.1.5. During the period of suspension, EHCP operations will be blocked under CMHIS through its web portal, so that no new pre-authorizations can be raised by the

EHCP. However, the treatment of existing patients will continue as usual till they are discharged.

6.1.6. A detailed investigation will be carried by the SHA in case the EHCP is suspended due to the reasons mentioned above or if a serious complaint has been filed by the beneficiary. A detailed investigation may include field visits to the EHCP, examination of case papers, talking with the beneficiaries (if needed), examination of hospital records etc.

6.1.7. If the detailed investigation reveals that the report/complaint/allegation against the hospital is not valid and no malpractices are detected, suspension will be revoked and operations as usual will be initiated. All attempts will be made by SHA to revoke the suspension within 5 working days of the investigation report submitted.

6.1.8. If the detailed investigation reveals that the suspicion/alleged malpractice on the part of EHCP are valid and further new cases are detected, SHA may recommend suspension for a specified time, not exceeding 6 months.

6.1.9. Once the EHCP is suspended (or de-empanelled), cases of the EHCP shall be managed as below:

I. **Suspicious cases**: All the paid and unpaid cases where trigger/suspicion flag has been raised shall be promptly investigated within 15 working days of suspension/de-empanelment, confirmed as fraud or not fraud and recovery shall be finalized for confirmed fraudulent cases which are already paid, and the unpaid fraudulent cases shall be rejected.

II. **Unpaid cases (non-triggered) with a high-risk score** as determined by SHA algorithm (i.e., more than 60): These shall be mandatorily audited within 15 days of suspension/de-empanelment. The audit shall be completed before payment and payment shall be based on clearance by audit and adjudication on merit.

III. **Unpaid cases (non-triggered) with a low-risk score**: At least 20% of such cases shall be audited (with a minimum of 10 cases and maximum of 100 cases) before payment and payment shall be based on audit findings. In case any fraudulent case is found during audit of these cases, then 100% of remaining unpaid cases shall be also audited. All such audits shall be completed within 30 days of suspension/de-empanelment.

6.1.10. SHA/Insurance company will ensure that the payment of all unpaid claims is released only after making the recoveries already imposed and recovery of penalties as required to be levied.

6.1.11. A Final Settlement Letter clearly mentioning the recovery and/or penalty and its adjustment from pending claims shall be sent to the suspended/de-empanelled EHCP by the SHA.

6.1.12. If it is a hospital chain, only the branch will get de-empanelled while the other

hospitals will continue to function.

6.1.13. If a hospital is blacklisted or de-empanelled for a defined period, it can be permitted to re- apply at the end of the blacklisting/de-empanelment period or revocation of the blacklisting/ de-empanelment order, whichever is earlier; provided all other changes directed by SEC were completed.

6.2. ***Hospital network under CMHIS(EP)***

The employees/pensioners shall have access to network of empaneled hospitals covered under CMHIS(GEN) within Nagaland along with PMJAY and CGHS empaneled hospitals outside Nagaland. Following process shall be followed as regards CGHS empaneled hospitals for inclusion under CMHIS(EP).

- The already empanelled hospitals for CGHS (in Nagaland or outside Nagaland) shall be onboarded to accept and treat CMHIS(EP) beneficiaries at par with CGHS beneficiaries. This will be the primary responsibility of the Insurance company and SHA will facilitate the process.

- If a hospital is empanelled under both the schemes (PM-JAY and CGHS), hospital will admit the patient under the scheme of entitlement of the beneficiary i.e., PM-JAY for CMHIS(GEN) and CGHS for CMHIS(EP).

- For the hospitals empanelled under CGHS in Nagaland, CGHS rates for state of Nagaland will be applicable. For CGHS hospitals outside Nagaland, CGHS rates of the respective location will be applicable.

- The empanelled hospitals shall be reimbursed for cost of treatment as per CGHS rates for the booked 'package' and shall not be allowed to charge patients for any costs related to treatment, consumables and components included in the packages.

For detailed guidelines on CGHS empanelment criteria, process of empanelment/de-empanelment, refer to https://cghs.gov.in/CghsGovIn/faces/ViewPage.xhtml

Schedule 10: De-empanelment guidelines

Disciplinary proceedings/de-empanelment processes have been introduced primarily as a deterrence and control mechanism in the scheme to ensure that medically appropriate quality treatment is provided to beneficiaries at all times and all wasteful and unnecessary expenditure is curtailed. The institution structures established for empanelment will also be responsible for processes leading up to disciplinary proceedings/de-empanelment. SHA, SEC and DEC at the state and district level will form the key institutions in enforcing this mechanism. The steps are:

1. INVESTIGATION OF SUSPECT CLAIMS/HOSPITALS

1.1. SHA/IC/NHA or any of their authorized representatives will conduct ongoing analytics to identify aberrant cases/suspect EHCPs.

1.2. This will be followed by desk audits, field medical audits and EHCPs visits of the suspicious cases, followed by submission of report within 10 working days of flagging the case.

1.3. Additionally, any complaint received about the EHCP from the patient or any third party or reported in the grievance cell may be put under the watch list by SHA.

2. SHOW-CAUSE NOTICE TO EHCP

2.1. Based on the investigation report received, if the SHA/IC/NHA observes that there is sufficient evidence/suspicion of EHCP indulging in malpractices, a show cause-notice shall be issued to the EHCP within 7 working days from receipt of investigation report.

2.2. In the show cause notice sent to the EHCP, it should be explicitly communicated to not contact the beneficiaries in question as this would lead to tampering of evidence, as per the applicable laws. In case any such tampering is found, legal action may be taken accordingly.

2.3. The show-cause notice will be sent both to the EHCP's registered email ID provided at the time of empanelment or the most current one available/updated with SHA and a hard copy will be sent via speed post or delivered by hand through district coordinator to the EHCP's notified address.

2.4. If there is no documentary evidence to suggest that the show cause notice was received or the EHCP denies having received the show cause notice, the SHA may share the notice again either through physical delivery or registered email ID and receive an acknowledgement of the receipt. EHCP will have to respond within 3 working days from the date of receipt of the show-cause notice

2.5. The show-cause notice will mention email ID of SHA where the response to the show-cause needs to be sent by the EHCP. The receipt of the registered speed post or acknowledgement of receipt by EHCP (in case delivered by hand) should be kept securely as proof by the SHA/IC. The show-cause notice will also be updated in the online portal used by EHCP.

2.6. EHCP shall within 5 working days from the date of receipt respond to the show-cause notice along with supporting evidence. In case, the EHCPs response to the show-cause notice is satisfactory, it will continue to function as usual. In case, the response is not received within 5 working days, or the response is unsatisfactory, the EHCP will be suspended for a specified time frame not exceeding 6 months or till a decision has been taken on the proceedings. The notification of suspension will be sent through email and registered speed post.

2.7. During the period of suspension, EHCP operations will be blocked under PMJAY through its web portal, so that no new pre-authorizations can be raised by the EHCP. However, the treatment of existing patients will continue as usual till they are discharged.

3. DETAILED INVESTIGATION OF EHCP

3.1. A detailed investigation will be carried in case the EHCP is suspended due to the reasons mentioned above or if a serious complaint has been filed by the beneficiary. A detailed investigation may include field visits to the EHCP, examination of case papers, talking with the beneficiaries (if needed), examination of hospital records etc.

3.2. All attempts will be made to complete the investigation and submit the report within 10 working days of show-cause issued.

3.3. All statements of the beneficiaries will be recorded in writing in the language known to the beneficiary and ensured that the said statement is read over to the beneficiary for confirmation. The statement will be self-attested by the beneficiary via signature or thumb impression for use as evidence. Wherever possible, video recording will be taken and if possible, a copy of photo identity proof of such beneficiary will be maintained.

3.4. If the detailed investigation reveals that the report/complaint/allegation against the hospital is not valid and no malpractices are detected, suspension will be revoked and operations as usual will be initiated. All attempts will be made by SHA/IC to revoke the suspension within 5 working days of the investigation report submitted.

3.5. If the detailed investigation reveals that the suspicion/alleged malpractice on the part of EHCP are valid and further new cases are detected, IC/SHA may recommend suspension for a specified time, not exceeding 6 months.

4. SUSPENSION OF EHCP

4.1. Suspension after show cause notice: For EHCPs where adequate evidence of malpractices is present and the EHCP is not able to provide satisfactory justification, the SHA may suspend the hospital for a specified time, not exceeding a period 6 months.

4.2. Suspension due to no response to show cause notice: In case, the EHCP does not provide any response to the show-cause notice within the stipulated time as outlined above, the EHCP may be suspended for a specified time, not exceeding 6 months. If the response is received during suspension period, the SHA may review the response, if found satisfactory then the suspension may be revoked.

4.3. Direct suspension along with show-cause: If the SHA/IC obtains irrefutable evidence that the actions of the EHCP have or may cause grievous harm to the patients' health

or life, SHA may immediately suspend the EHCP for a specified time, not exceeding 6 months. The suspension must be accompanied with a show-cause notice, allowing EHCP time of 5 working days to respond to it. SHA will share the notice along with detailed justification/reason for suspension with NHA and Secretary – Department of Health. The SHA will also conduct a detailed investigation in such cases as outlined above.

4.4. Suspension due to non-payment of fine: If the penalty is levied on the EHCP for an offence and it fails to submit the penalty amount within the stipulated time, SHA may adjust the fine with the pending payment to the EHCP. If the pending amount after the adjustment of dues is not paid by the SHA, a reminder may be sent to the EHCP. Upon no response, the SHA may decide to suspend the EHCP till the amount is recovered.

4.5. Notification of suspension will be sent through email and registered speed post within 3 working days of decision.

4.6. Once the EHCP is suspended (or de-empaneled), cases of the EHCP shall be managed as below:

4.7. Suspicious cases: All the paid and unpaid cases where trigger/suspicion flag has been raised shall be promptly investigated within 15 working days of suspension/de-empanelment, confirmed as fraud or not fraud and recovery shall be finalized for confirmed fraudulent cases which are already paid and the unpaid fraudulent cases shall be rejected.

4.8. Unpaid cases (non-triggered) with a high-risk score as determined by SHA/NHA algorithm (i.e., more than 60): These shall be mandatorily audited within 15 days of suspension/de-empanelment. The audit shall be completed before payment and payment shall be based on clearance by audit and adjudication on merit.

4.9. Unpaid cases (non-triggered) with a low-risk score: At least 20% of such cases shall be audited (with a minimum of 10 cases and maximum of 100 cases) before payment and payment shall be based on audit findings. In case any fraudulent case is found during audit of these cases, then 100% of remaining unpaid cases shall be also audited. All such audits shall be completed within 30 days of suspension/de-empanelment.

4.10. SHA/Insurance company will ensure that the payment of all unpaid claims is released only after making the recoveries already imposed and recovery of penalties as required to be levied.

4.11. A Final Settlement Letter clearly mentioning the recovery and/or penalty and its adjustment from pending claims shall be sent to the suspended/de-empanelled EHCP.

4.12. If the matter of suspension or de-empanelment has been taken to court by the EHCP or is sub- judice, the claims under sub-judice case jurisdiction shall not be considered for above guidelines till the matter is finally concluded in court of law.

4.13. The EHCP may file an appeal against suspension to review the order along with the submission of necessary evidence and an undertaking of not repeating similar instances of malpractices within 30 working days of suspension. The SHA may decide to

revoke the suspension after examining the evidence and undertaking submitted by EHCP

5. PRESENTATION OF CASE TO SEC AND DE-EMPANELMENT

5.1. Presentation of case for de-empanelment may be initiated by SHA after conducting proper disciplinary proceedings as outlined above. All relevant documents including the detailed investigation report will be submitted to the SEC. The SEC must ensure that the EHCP has been issued a show-cause notice seeking an explanation for the alleged malpractice. Both parties (SHA and EHCP) will be provided a fair opportunity to present their case with necessary evidence at the meeting conducted by SEC.

5.2. If the SEC finds that the complaint/allegation against the EHCP is valid, it will order de-empanelment of the EHCP based on appropriate legal advice along with additional disciplinary actions like penalties, FIR etc. as it may deem fit.

5.3. In case the SEC does not find adequate supporting evidence against the EHCP, it may revoke the suspension of the EHCP or reverse/modify any other disciplinary action taken by SHA against the EHCP, while making clear observations and reasons underlying the final decision.

5.4. All attempts shall be made to take final decision within 30 working days of 1st SEC meeting.

5.5. If either party is not satisfied by the decision of SEC, they can approach competent authority as per the grievance redressal guidelines.

6. ACTIONS TO BE TAKEN AFTER DE-EMPANELMENT

6.1. Once the hospital has been de-empaneled, a letter/email will be sent to the EHCP regarding the decision at registered address/registered email ID/of the EHCP within 3 working days of the decision. Once de-empaneled, new preauthorization will be disabled. However, the existing pre-authorizations/ treatment will have to be completed.

6.2. A decision may be taken by the SEC to ask the SHA/IC to either lodge an FIR in case there is suspicion of criminal activity or take permissible legal action under applicable laws of India.

6.3. In case of confirmed act of professional misconduct and violation of medical ethics, the appropriate professional medical bodies/council at the national/state level should be informed of the details of the case, the treating doctor and the hospital involved. The Medical Council and Sate Medical Council should take it up and take appropriate action as per the Code of Medical Ethics Regulation, 2002 and/ or such necessary action as may be required as per the applicable laws. This information will be sent to other Insurance Companies, ESIC, CGHS, IRDAI and other relevant regulatory bodies and to NHA

6.4. A list of de-empaneled hospitals will be enlisted on NHA and SHA website. The list should be prominently displayed and easily accessible on the website to ensure beneficiary awareness. SHA may notify in the local media about the entities where

malpractice is confirmed, and the action taken against the EHCP engaging in malpractices.

6.5. The period of de-empanelment would be for 1 year, unless stated otherwise. Once de-empaneled, the EHCP cannot seek for re-empanelment until completion of 1 year from the date of such de-empanelment. Healthcare service providers will not be allowed to change their names and re-apply. In case SHA/SEC decides to re-empanel an EHCP within a period of 1 year, the same may be flagged in the system through HEM portal. The reason for re-empanelment of EHCP will also be documented in the HEM web portal.

6.6. Based on the severity of the offence, SEC may de-empanel the EHCP for more than 2 years or may blacklist an EHCP. In such cases, the SHA/SEC will inform NHA and PS/AS-Health and Family Welfare Department of Nagaland of its decision along with a detailed explanation/ recorded reason for the same

6.7. If it is a hospital chain, only the branch will get de-empaneled while the other hospitals will continue to function.

6.8. If a hospital is blacklisted or de-empaneled for a defined period, it can be permitted to re- apply at the end of the blacklisting/de-empanelment period or revocation of the blacklisting/ de-empanelment order, whichever is earlier; provided all other changes directed by SEC were completed.

7. GRADATION OF OFFENCES AND PENALTIES FOR AB PM-JAY CMHIS

8.1 Based on the investigation report/field audits, gradation of penalties given in Table 1 below may be levied by the SEC. However, this tabulation is intended to be as guidelines rather than mandatory rules

8.2 These penalties are recommendatory in nature and SHA may inflict larger or smaller penalties depending on the severity/regularity/scale/intentionality on a case-to-case basis. If any hospital is found add is to be involved in unethical practices/malpractices/severe offence, then legal action may also be taken by SHA.

8.3 Table 2 gives the timelines during which the disciplinary action and suspension / de-empanelment of hospital has to be completed.

TABLE 1: PENALTIES FOR OFFENCES BY THE HOSPITAL

Penalties for Offences by the Hospital			
Case Issue	**First Offence**	**Second Offence**	**Third Offence**
Illegal cash payments by beneficiary	Full refund and penalty 5 times of illegal payment to be paid to the SHA by the hospital within 7 working days of the receipt of notice. SHA shall thereafter transfer money to the beneficiary, charged in- actual, within 7 working	In addition to actions as mentioned for first offence, rejection of claim for the case, suspension of hospital	De-empanelment/ blacklisting

	days		
Billing for services not provided	Rejection of claim and penalty 5 times the amount claimed for services not provided, to IC/SHA	Rejection of claim and penalty of 10 times the amount claimed for services not provided, to IC/SHA, suspension of hospital	De-empanelment/ blacklisting
Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of up to 10 times the excess amount claimed due to up coding/unbundling/ unnecessary procedures, to IC/SHA SHA may decide the amount based on the severity of the breach	Rejection of claim and penalty of up to 20 times the excess amount claimed due to up coding/unbundling/ unnecessary procedures, to IC/SHA, suspension of hospital	De-empanelment/ blacklisting
Wrongful beneficiary identification	Rejection of claim and penalty of up to 5 times the amount claimed for wrongful beneficiary identification to IC/SHA if hospital is found to be in connivance SHA may decide the amount based on the severity of the breach	Rejection of claim and penalty of up to 10 times the amount claimed for wrongful beneficiary to SHA/IC if the hospital is found to be in connivance, suspension of hospital	De-empanelment/ blacklisting
Non-adherence to minimum criteria for empanelment, quality and service standards as laid under PMJAY	In case of minor gaps: Show cause notice with compliance period of 2 weeks for rectification and rejection of claims related to gaps In case major gaps and willful suppression/misrepresentation of facts: Show cause notice with compliance period of 2 weeks for rectification, suspended if not rectified after 2 weeks and rejection of claims related to gaps and penalty up to 3 times of all cases related to gaps observed Suspension of services until rectification of gaps and validation by DEC	Penalty of up to 5 times of all the approved claims related to the gaps observed and suspension until rectification of gaps and validation by DEC	De-empanelment and penalty of up to 5 times of all the approved claims related to the gaps observed

TABLE 2: TIMELINE FOR DISCIPLINARY PROCEEDINGS AND DE-EMPANELMENT

Timeline for Disciplinary Proceedings and De-empanelment	
Investigation of suspect claims	10 working days of flagging the cause
Show-cause Notice Issuance	7 working days of submission of investigation report
Response to Show-cause Notice by EHCP	Within 5 working days
Clarification of the Response from EHCP	Within 3 working days
Issuance of Show-cause Notice post Decision	Within 2 working days
Detailed Investigation along with submission of Investigation Report	Within 10 working days
Response to Suspension by EHCP	Within 5 working days
EHCP can file an appeal against suspension	Within 30 working days
Final decision to suspend/suspend with fine/ revoke suspension/de-empanelment	Within 30 working days of the 1st SEC meeting

Note:SHA may amend/adapt the empanelment and Deempanelment guidelines based on new guidelines issued by NHA , a draft of which is provided in this link <Link to latest NHA guideline on Hospital empanelment and Deempanelment>

Schedule 11: Premium Payment Guidelines for Beneficiary Category 1 and Beneficiary Category 2

1. The State Government shall release the premium for implementation of AB PM-JAY CMHIS into a designated escrow account.

2. Stages 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, pay the Premium for the Cover to the Insurer in accordance with the following schedule:

2.1 First instalment of Premium - 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 have been identified or based on the minimum commitment of the SHA as per Clause 3.3 of the Insurance Contract, whichever is more. Thereupon, the State shall upfront release 45% of their respective share viz, on the number of eligible families that have been identified and the data for whom has been shared with Insurance Company along with their share of administrative expense into the designated account of the Insurance Company.

2.2 Second instalment for States: 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 that are identified. The State within 15 days upon the receipt of invoice from the insurance company, shall release their 2nd instalment of premium i.e., 45% of their respective share into the designated Insurance Company account.

2.3 Third Instalment for the state: Upon completion of 10 Months of Policy, the Insurer shall submit a self certified Claim Settlement Report of the first 9(nine) months of the policy period along with the invoice for the last instalment of the Premium payable for the Beneficiary Family Units under Beneficiary Category 1 and Category 2. The SHA, upon receipt of the Claim Settlement report from the Insurer and verification against Data available with it and due satisfaction of permissible claim settlement ratio, release the remaining due premium of 10% or the proportionate premium based upon the claim settlement scenario, as the case may be into the escrow account. Thereupon, within 15 days of the 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 Insurer

3. 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.

Schedule 12: Portability guidelines

1. An EHCP under the AB PM-JAY CMHIS in Nagaland should provide services as per AB PM-JAY CMHIS guidelines to beneficiaries from any other states participating in AB PM-JAY under portability feature of the Scheme.

2. Similarly, all the AB PM-JAY CMHIS beneficiaries irrespective of their categories will be eligible to get treatment outside the state at PM-JAY empaneled hospitals.

3. Any empaneled hospital under the CMHIS (GEN) will not be allowed to deny services to any AB PM-JAY beneficiary. All interoperability cases shall be mandatorily under pre-authorization mode and pre-authorization guidelines of the treatment delivery state in case of AB PM-JAY implementing States or indicative pre-authorization guidelines as issued by the NHA, shall be applicable.

4. Portability for non AB PM-JAY beneficiaries under CMHIS (GEN) category will have the same rules applicable as for AB PM-JAY beneficiaries under portability.

5. **For CMHIS(EP) beneficiaries outside the state:** They can avail treatment in all CGHS empaneled hospitals across the country. For CGHS empaneled hospitals offering treatment to the CMHIS (EP) beneficiaries, the CGHS rates applicable for the booked procedure/package shall be used to reimburse claims. They shall not be allowed to charge patients for any cost related to treatment, consumables, and components included in the packages.

6. If a hospital is empaneled for both CMHIS (GEN) and CMHIS (EP), the hospital will admit the patient under the Scheme of entitlement of the beneficiary.

7. The CGHS hospitals shall be empaneled through NHA Convergence platform and Insurance Company shall be responsible for providing on-ground/field level support for onboarding the hospitals, supported by the SHA as required.

8. For portability, the following key aspects will be applicable:

8.1 Empaneled hospitals: The Empaneled Hospital shall have to sign a tripartite contract with its insurance company and State Health Agency (in case of Insurance Model) which explicitly agrees to provide AB PM-JAY CMHIS services to CMHIS & AB PM-JAY beneficiaries from both inside and outside the state and the Insurance Company agrees to pay to the EHCP through the inter-agency claim settlement process, the claims raised for AB PM-JAY CMHIS

beneficiaries that access care outside the state in AB PM-JAY empaneled healthcare provider network.

8.2 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. 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 the Home State IC/Trust.

8.3 Fraud Detection: Portability related cases will be scrutinized separately for suspicious transactions, fraud, and misuse. Data for the same shall be shared with the IC for necessary action. The IC shall also be responsible for fraud prevention and investigation and will have a dedicated team for conducting real time checks and audits on such flagged cases with due diligence.

8.4 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.

a. 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.
b. 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.
c. The empaneled 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.
d. If 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

8.5 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 provides a centralized balance check facility.

8.6 Claim Settlement: A claim raised by the empaneled 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 (three) 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 honor the decision of the Treatment State during the time of interagency settlement.

8.7 Fraud Management: In case the Trust/Insurer of the home State of beneficiary has identified fraudulent practices by the empaneled 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.

8.8 Expansion of Beneficiary Set: The above process for portability will follow for all categories of beneficiaries of the Home State i.e., State of Nagaland.

8.9 Modifications: The above guidelines will be detailed/updated by the SHA which will be binding on the insurer. The guidelines may be updated from time to time by the SHA.

Schedule 13: Key Performance Indicators (KPIs)

1. The Insurer is obliged to maintain its performance and obligations under this Insurance Contract to the SHA. The Insurer hereby agrees that the SHA shall measure and monitor its performance against a set of Key Performance Indicators (KPI).

2. The SHA shall use four types of KPIs for performance monitoring of the Insurer. These shall be known as **Initial Setting up KPIs** (presented as Schedule 13A), **Performance KPIs** (presented as Schedule 13B), **Audit related KPIs** (presented as Schedule 13C), and **Payment KPIs** (presented as Schedule 13D).

3. Each of the Schedules 13A, 13B, 13C, and 13D contain detailed instructions on how the performance will be measured, how KPIs values shall be calculated and all other relevant details. The Insurer hereby agrees that the SHA shall use the methodology and the approach.

Schedule 13A: Initial Setting up KPIs

No.	Performance aspect covered	KPI	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
KPI 1	**State Project Office (SPO) and staff**	Fully functional SPO of the Insurer set up in the capital city of Kohima within 30 (thirty) days of signing this Insurance Contract.	Setting up of the SPO shall be defined as: 1. Availability of physical office space that is functional. 2. Appointment of State Project Head and other staff as per the details in Schedule 19. 3. For those Insurers who already have a branch office in Kohima and meet the staffing requirement as per the details in Schedule 19, this KPI shall be deemed to fulfilled.	1. A sworn undertaking of fulfilment of this KPI to the CEO-SHA. 2. Curriculum Vitae and redacted appointment letters of all such appointed staffs.	Rs. 25,000 per week of delay or part thereof in setting up of the fully functional SPO.	No. of Calendar days of delay: **D** **Penalty amount** = (D/7)*25000
KPI 2	**District staff**	One District Coordinator recruited by the Insurer in each existing district in Nagaland within 30 (thirty) days of signing this Insurance Contract.	1. The District Coordinator shall be recruited full time for the Scheme. 2. The District Coordinator shall be based at the district headquarter.	1. Letter issued by the District Nodal Officer under the district Implementation Unit(DIU) certifying that the District Coordinator has been	Rs. 5,000 per week of delay or part thereof in appointment of every single District Coordinator.	1. Calculation to be done independently for each District Coordinator. 2. Delay to be calculated from

No.	Performance aspect covered	KPI	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
				appointed and is based in the district. 2. Curriculum Vitae and redacted appointment letters of all such appointed staffs.		30th day from the date of singing of the Insurance Contract **Calculation:** No. of calendar days of delay: **D** **Penalty amount** for each District Coordinator whose appointment is delayed = (D/7)*5000
KPI 3	**District staff**	One District Coordinator recruited by the Insurer in each newly-formed district in Nagaland within 60 days of the GoN notifying the formation of such a district.	1. **This KPI shall be applicable only for** such new districts that are notified by the GoN at least 9 (nine) months prior to either the end of any Policy Period. 2. The District Coordinator shall be recruited full time for the Scheme.	1. Letter issued by the District Nodal Officer under the district Implementation Unit(DIU) certifying that the District Coordinator has been appointed and is based in the district.	Rs. 5,000 per week of delay or part thereof in appointment of every single District Coordinator.	1. Calculation to be done independently for each District Coordinator. 2. Delay to be calculated from 60th day from the date of the GoN

No.	Performance aspect covered	KPI	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
			3. The District Coordinator shall be based at the district headquarter.	3. Curriculum Vitae and redacted appointment letters of all such appointed staffs.	*Calculation to be done independently for each District Coordinator.*	notifying the formation of such a district. **Calculation:** No. of calendar days of delay: **D** **Penalty amount** for each District Coordinator whose appointment is delayed = (D/7)*5000

Schedule 13B: Performance KPIs

No.	Performance aspect covered	KPI	Turn-around time (TAT) / KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
KPI 4	**E-card verification and approval**	At least 95% of the AB PM-JAY CMHIS E-cards have been verified/approved by the Insurer within the prescribed TAT threshold	30 minutes of its receipt on the BIS Portal	The SHA shall measure this KPI each month, and penalties, if any, shall be payable by the SHA within 7 (seven) days of receiving the Penalty Notice.	Data generated from the BIS /State Data Warehouse. All transactions in the BIS module is time stamped and this shall be used for generating the performance report on this indicator.	Rs 100 of each card delayed beyond TAT indicated in the KPI.	**Penalty amount** = No. of verifications/approvals that were issued after the TAT X Rs 100.
KPI 5	**E-card verification and approval**	% of E-cards correctly approved by the Insurer as per the AB PM-JAY CMHIS guidelines.	100%	Correctly approved implies that no individual who is not eligible for AB PM-JAY CMHIS as per the criteria set forth in Clause 3.2 and Clause 3.3 of the Insurance Contract.	Data generated from the BIS module/State Data Warehouse/TMS	In case any claim is adjudicated out of wrongly approved BIS card by IC then penalty of three times over and above the claim amount.	**Penalty amount** = 3 X Claim amount paid against wrongly approved eCard

No.	Performance aspect covered	KPI	Turn-around time (TAT) / KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
KPI 6	**Pre-authorization**	% of pre-authorization requests on which the Insurer has acted upon as per Scheme guidelines within the prescribed 6 (six) hours. (6 hours threshold as per the Transaction Management System)	95%	(For calculation, monthly delayed preauthorization amount shall be the amount for delayed pre-authorizations for the admissions in that month. Penalty shall be calculated on this amount and Insurer shall pay the penalty as per Penalty Notice per quarter)	TMS	If the performance is 95% or more, NO PENALTY. **If the performance is**: 1. **90% or more and less than 95%**: 5% of the sum total of all preauthorization requested amount that were delayed beyond the TAT. 2. **85% or more and less than 90%:** 10% of the sum total of all preauthorization requested amount that were delayed beyond the TAT. 3. **Below 85%:** 20% of the sum total of all preauthorization requested amount	*Illustration:* If the IC handled 100 preauthorization in the month and failed to meet TAT for 16 cases, 20% preauthorization amount of only these 16 cases will be charged as penalty. Even if the preauthorization is rejected, not meeting the TAT will invite the penalty. *Examples:* In case of claims processing, TAT will be determined as days during which claim is with IC (Excluding the days claim is pending at EHCPs end) *Example: 1* *The day EHCP raises claim will be treated as Day 1*

No.	Performance aspect covered	KPI	Turn-around time (TAT) / KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
						that were delayed beyond the TAT.	*If IC raises query on Day 4, and EHCP complies with query on Day 10,* *IC acts (accepting or rejection of claim) on Day 12* *Payment on Day 15* *in this case (4-1=3) days + (15-10=5) days, hence TAT determined is 3+5=8 days* *<u>Example 2</u>:* *The day EHCP raises claim will be treated as Day 1* *If IC raises query on Day 4, and EHCP complies with query on Day 10,* *IC raises another query on Day 11* *EHCP complies with second query on Day 14* *EHCP accepts approves the claim on Day 16*

No.	Performance aspect covered	KPI	Turn-around time (TAT) / KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
							Payment on Day 17 *In this case (4-1=3) days + (11-10=1) days+ (17-14=3) days, hence TAT determined is 3+1+3=7 days*
KPI 7	**Pre-authorization**	% of pre-authorizations correctly approved by the Insurer as per the AB PM-JAY CMHIS guidelines.	100%	Correctly approved pre-authorizations implies pre-authorization approval strictly as per the AB PM-JAY CMHIS guidelines for the eligible benefits/packages for eligible AB PM-JAY CMHIS beneficiaries as per the overall terms if this Insurance Contract.	TMS	In case any pre-authorization request is wrongly approved by the Insurer, then the penalty shall be three times over and above the claim amount.	**Penalty =** Amount for all the wrongly pre-authorised requests X 4 times
KPI 8	**Scrutiny, Claim processing**	% of claims processed and paid within 15 (fifteen)	100%	**APPLICABILITY**: Not applicable if the delay in payment is on	TMS	Insurer shall be liable to pay a penal interest to the EHCP at the rate of	*Illustration*: If the IC processed 100 claims in the month and failed to

No.	Performance aspect covered	KPI	Turn-around time (TAT) / KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
	and payment of the claims	days of claims submission for claims within the state; and 30 (thirty) days for portability claims.		account of delays in payment of premium by the SHA to the Insurer. However , Insurer shall calculate the amount of penalty due to delay in claim payment to the EHCP, and submit monthly.		0.1% for each claim amount for every day of delay or the part thereof on every claim delayed beyond the prescribed timeline.	meet TAT for 16 claims, it will be liable to pay penalty of 0.1% for each claim per day of these 16 claims to EHCPs.
KPI 9	**Scrutiny, Claim processing and payment of the claims**	% of claims correctly processed and correctly approved that are as per AB PM-JAY CMHIS guidelines and are not wrongful.	100%	Correctly processed and approved claims means all claims scrutinised strictly as per the AB PM-JAY CMHIS guidelines and actioned upon or paid as per the overall terms if this Insurance Contract.	TMS	**If such claims have not been paid by the SHA and the SHA has not suffered any wrongful loss:** Rs 10,000 per claim wrongly processed by the Insurer. **If such claims have been paid by the SHA and the SHA has suffered wrongful loss:**	-

No.	Performance aspect covered	KPI	Turn-around time (TAT) / KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA	Calculation
						Penalty of three times over and above the claim amount	
KPI 10	**Delays in compliance to orders of the Grievance Redressal Committee (GRC)**	% of GRC orders that have not been complied with by the Insurer within 30 (thirty) days of the date of such GRC orders.	100%	-	1. GRC order date 2. Date on which the Insurer intimates the SHA with an Action Taken Report on the GRC order	Rs 25,000 per week of delay per GRC order or part thereof.	**Penalty amount per GRC order where there is a delay in compliance** = (D/7)*5000, Where, D = no. of days of delay in compliance

Schedule 13C: Audit related KPIs

No.	Performance aspect covered	KPI	Minimum KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA
KPI 11	**Pre-authorization audit**	% of pre-authorizations that have been audited by the Insurer in the preceding quarter.	5%	Sample of 5% pre-authorization audits selected in each quarter shall be across disease specialities from which pre-authorization requests were generated.	Sampling strategy & plan which should be a part of the audit reports submitted by the Insurer.	Rs. 50,000 per missing audit report.
KPI 12	**Approved claims audit**	% of approved claims that have been audited by the Insurer in the preceding quarter.	5%	Sample of 5% pre-approved claims selected in each quarter shall be across disease specialities from which claims were submitted.	Sampling strategy & plan which should be a part of the audit reports submitted by the Insurer as per the template in Schedule 22.	Rs. 50,000 per missing audit report.
KPI 13	**Medical Audits**	% of total hospitalization cases audited by the Insurer in the preceding quarter.	5%	Sample of 5% pre-approved claims selected in each quarter shall be across disease specialities from which claims were submitted.	Sampling strategy & plan which should be a part of the audit reports submitted by the Insurer. Audit reports submitted as per the template in Schedule 14.	Rs. 50,000 per missing audit report.
KPI 14	**Death Audits**	% of total deaths of AB PM-JAY CMHIS beneficiaries while hospitalised in an EHCP as a AB PM-JAY CMHIS beneficiary audited by the Insurer in the preceding quarter.	100%	-	Audit reports submitted by the Insurer.	Rs. 50,000 per missing audit report.

No.	Performance aspect covered	KPI	Minimum KPI threshold	Explanation for measuring KPIs	Data source/evidence	Penalty to be paid by the Insured to the SHA
KPI 15	**Beneficiary Audit**	% of AB PM-JAY CMHIS beneficiaries audited during hospitalization by the Insurer in the preceding quarter.	2%		Audit reports submitted by the Insurer.	Rs. 50,000 per missing audit report.
KPI 16	**Beneficiary Audit (phone)**	% of AB PM-JAY CMHIS beneficiaries audited on phone during hospitalization by the Insurer in the preceding quarter.	5%	-	Audit reports submitted by the Insurer.	Rs. 50,000 per missing audit report.
KPI 17	**Beneficiary Audit (home visit)**	% of AB PM-JAY CMHIS beneficiaries audited at their place of residence post discharge by the Insurer in the preceding quarter.	1%	-	Audit reports submitted by the Insurer.	Rs. 50,000 per missing audit report.
KPI 18	**Hospital Audit**	% of Private EHCPs within Nagaland that have been audited twice in a Policy Period by the Insurer as per the Hospital Audit guidelines issued by the SHA.	100%	The Insurer shall audit each Private EHCP twice : the first round of audit shall be at the end of 3(three) months of the start of the policy period; and the second round of audit shall be at the end of 9 months of the start of the policy period.	Audit reports submitted by the Insurer as per the template provided in Schedule 15.	Rs. 50,000 per missing audit report.

Note to Schedule 12C

1. While conducting the audit, IC shall ensure not more than 20% of sample size of overlapping of beneficiaries across audits except SN. 4.
2. Sample size shall be equally distributed across all the districts in the state and ensuring coverage of all suspect entities
3. For the purpose of computing above audit percentages, cases from public hospitals shall be excluded. SHA may give directions regarding inclusion of cases from public hospitals for the audits.

4. If submitted audit report dues do not mention required sample size or details, it will be treated as non-submission of audit report
5. Audit reports shall contain details as required in Anti-Fraud Guidelines
6. Insurer shall ensure audits to be conducted as prescribed by Anti-Fraud Guidelines, however penalty is only applicable on above audit reports.

Schedule 13D: Payment related KPIs

No.	Performance aspect covered	KPI	Minimum KPI threshold	Penalty to be paid by the Insured to the SHA
KPI 19	**Premium payment by the SHA**	Payment of premium by the SHA to the Insurer as per the schedule provided in Clause 13	For beneficiary Category 1, Payment to be made within the minimum number of days as per Schedule 11. For all other category of beneficiaries, payment to be made within 21 days of the receipt of the invoice by the SHA.	Interest @ 1% on due premium amount for every 30 days' delay beyond KPI threshold or part thereof shall be paid by the SHA to the Insurer
KPI 20	**Premium refund by the Insurer**	Refund of premium by the Insurer to the SHA as per the Premium Refund Notice issued by the SHA to the Insurer	Payment to be made within 30 days of the receipt of the Premium Refund Notice by the Insurer.	1.5% penal interest for every month of delay or part thereof if not received from IC by SHA within 30 days Return of Premium clause will be applicable as mentioned in the contract
KPI 21	**Payment of penalties by the Insurer**	Payment of penalties by the Insurer to the SHA as per the quarterly payment notice issued by the SHA to the Insurer.	1. Within 15 (fifteen) days from date of receiving the quarterly payment notice by the Insurer in case non contested payment. 2. Within 30 (thirty) days from date of receiving the quarterly payment notice by the Insurer in case the Insurer contests the levied penalty.	Interest @ 1.5% on due penalty amount for every 30 days delay or part thereof shall be paid as penal interest by the Insurer to SHA.

Schedule 14: Template for Medical Audit

Template for Medical Audit

AB PM-JAY CMHIS ID		Hospital ID	
Patient Name		Hospital Name	
Case No.		Hospital Contact No.	
Date of Admission		Date of Discharge	
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	**Does each medical record file contain?**			
a.	Is discharge summary included?			
b.	Are significant findings recorded?			
c.	Are details of procedures performed recorded?			
d.	Is treatment given mentioned?			
e.	Is patient's condition on discharge mentioned?			
f.	Is final diagnosis recorded with main and other conditions?			
g.	Are instructions for follow up provided?			
2.	**Patient history and evidence of physical examination is evident.**			
a.	Is the chief complaint recorded?			
b.	Are details of present illness mentioned?			
c.	Are relevant medical history of family members present?			
d.	Body system review?			
e.	Is a report on physical examination available?			
f.	Are details of provisional diagnosis mentioned?			
3.	**Does an operation report available? (Only if surgical procedure done)**			
a.	Does the report include pre-operative diagnosis?			
b.	Does the report include post-operative diagnosis?			
c.	Are the findings of the diagnosis specified?			
d.	Is the surgeon's signature available on records?			
e.	Is the date of procedure mentioned?			

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

Overall observations of the Auditor:

Significant findings:

Recommendations:

_____

Signature of the Auditor

Date:

Schedule 15: Template for Hospital Audit

Template for Hospital Audit

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

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Was there power cut during the audit?			
2.	If yes, what was the time taken for the power back to resume electric supply?			
3.	Was a AB PM-JAY CMHIS kiosk present in the reception area with proper IEC material?			
4.	Was any AB PM-JAY CMHIS trained staff present at the kiosk?			
5.	Did you see the AB PM-JAY CMHIS Empanelled Hospital Board with scope of services displayed near the kiosk in the reception and other prominent areas?			
6.	Was the kiosk prominently visible?			
7.	Was the kiosk operational in local language?			
8.	Were AB PM-JAY CMHIS brochures available at the kiosk?			
9.	Were the toilets in the OPD and IPD areas clean?			

10.	Was drinking water available in the OPD and IPD areas for patients?			
11	Were sanctioned beds/functional beds available as per the claimed beds by hospital during empanelment?			
12	Was qualified manpower (full time/part time) as per the scope of services?			
13	Was the basic physical infrastructure of hospital clean and intact?			
14	Were diagnostic facilities (inhouse/outsourced*) as per the scope of services?			
15	Was functional ambulance (inhouse/outsourced*) available during visit?			
* For outsources services – check signed MoU				

Overall observations of the Auditor:

Significant findings:

Recommendations:

_____

Signature of the Auditor

Date:

Schedule 16: Format of Actuarial Certificate for Determining Refund of Premium

[***On the letterhead of the Insurer/Insurer's Appointed Actuary***]

From:

[*Name of Appointed Actuary*]
[*Designation of Appointed Actuary*]
[*Address of Insurer/Appointed Actuary*]

Date: [●]

To:

Mr. [●]
CEO, State Health Agency

[***Insert Address***]

Dear Sir,

Sub: Actuarial Certificate in respect of Pure Claim Ratio of [*insert name of Insurer*] for Policy Cover Period [●] to [●]

I/We, [*insert name of actuary*], are/am a/an registered actuary under the laws of India and are/is licensed to provide actuarial services.

[*Insert name of Insurer*] (the **Insurer**) is an insurance company engaged in the business of providing general insurance (including health insurance) services in India for the last [●] years. I/We have been appointed by the Insurer as its Appointed Actuary in accordance with the IRDA (Appointed Actuary) Regulations, 2000.

The Insurer has executed a contract dated [●] with the State Health Agency for the implementation of the AB PM-JAY CMHIS (the **Insurance Contract**). The Premium payable by the State Health Agency under the Insurance Contract for the Policy Cover Period from [●] to [●] (**Previous Policy Cover Period**) is ₹ [●] (Rupees [*insert sum in words*] only).

In accordance with the Insurance Contract, we are required to certify the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period for all the districts within the Service Area.

I, [*insert name*] designated as [*insert title*] at [*insert location*] of [*insert name of actuary*] do hereby certify that:

(a) We have read the Insurance Contract and the terms and conditions contained therein.

(b) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period has been determined by us in accordance with the formula below:

$$\textbf{Pure Claim Ratio} = \frac{C}{P_T} \times 100$$

= [*insert calculation*]
= [*insert result*] %

For the purposes of the formula above:

$\mathbf{P_T}$ is the total Premium collected by the Insurer in the Previous Policy Cover Period for all the Beneficiary Family Units covered by it. It is calculated as the product of the Premium per Beneficiary Family Unit in the Current Policy Cover Period and the total number of Beneficiary Family Units covered by the Insurer in the Current Policy Cover Period, i.e., Rs. [●] (Rupees [*insert sum in words*] only).

C is the total Claims paid by the Insurer to the Empanelled Health Care Providers in the full 12 months of the Previous Policy Cover Period, i.e., Rs. [●] (Rupees [*insert sum in words*] only).

(c) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio of the Insurer in respect of all the districts within the Service Area in the full 12 months of the Previous Policy Cover Period is [●]% ([*insert sum in words*] percentage).

At [*insert place*]
Date: [*insert date*]

On behalf of [*insert name of Appointed Actuary*]
[*Name*]
[*title*]

Name and Counter Signature of Principal Officer of Appointed Actuary, along with Appointed Actuary's name and seal

On behalf of [*insert name of Appointed Actuary*]
[*Name*]
[*title*]

[*Note. This counter signature is only required if the Appointed Actuary is an external actuarial firm.*]

A. For claim submission after discharge by the EHCP, the following guidelines will apply:
    a. All claims are to be submitted by EHCP within 7 days from the actual date of discharge of the beneficiary from EHCP.
    b. Any delay in claim submission will invite nonstandard settlement of the claim with the reduction in claim payable amount by 0-1% per day for each day of delay beyond 7 days from the date of discharge subjected to a maximum of 9% of the value of the claim payable
    c. The EHCP shall be provided a dashboard for easy tracking of its claim management.
    d. Claim will be automatically closed if it's not settled within 90 days of claim submission, which can be reopened at the request of EHCP through an evidence mechanism.

    For response to Claim processing Doctor query by EHCP, the following will apply:

    a. The response to the query should be submitted in 7 days from the date of query raised.
    b. Delay beyond 7 days will similarly attract penalty as above at 0.05% of the value of claims payable for each day of delay.
    c. This penalty will be subjected to a maximum of 4.5% of the value of the claims payable
    d. The empanelled EHCP shall be made available a dashboard for easy tracking of its queries overdue for submission
    e. Automatic closure of the claims will be done if there is a delay beyond 90 days which can be reopened at the request of the EHCP though a grievance mechanism.

    EHCP will more than 20% of the cases falling in the delayed category on monthly basis, shall be issued a warning and if there is no improvement after 2 warnings, further disciplinary actions like show cause notice, suspension, de-empanelment shall be initiated.

    Above guidelines notwithstanding, insurance company shall not penalise EHCPs or deny claims on flimsy grounds. It shall further make all efforts for capacity building and dissemination of guidelines to all ECHPs and ensure their understanding and compliance.

Schedule 17: Indicative Fraud Triggers

Claim History Triggers

1. Impersonation.
2. Mismatch of in-house document with submitted documents.
3. Claims without signature of the AB PM-JAY CMHIS Beneficiary on pre-authorisation form.
4. Second claim in the same year for an acute medical illness/surgical.
5. Claims from multiple hospitals with same owner.
6. Claims from a hospital located far away from AB PM-JAY CMHIS Beneficiary's residence, pharmacy bills away from hospital/residence.
7. Claims for hospitalization at a hospital already identified on a "watch" list or blacklisted hospital.
8. Claims from members with no claim free years, i.e., regular claim history.
9. Same AB PM-JAY CMHIS Beneficiary claimed in multiple places at the same time.
10. Excessive utilization by a specific member belonging to the AB PM-JAY CMHIS Beneficiary Family Unit.
11. Deliberate blocking of higher-priced Package Rates to claim higher amounts.
12. Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
13. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
14. Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the AB PM-JAY CMHIS Beneficiary Family Unit and different hospitals for other members of the AB PM-JAY CMHIS Beneficiary Family Unit), multiple claims towards the end of Policy Cover Period, proximity of claims.

Admissions Specific Triggers

15. Members of the same AB PM-JAY CMHIS Beneficiary Family Unit getting admitted and discharged together.
16. High number of admissions.
17. Repeated admissions.
18. Repeated admissions of members of the AB PM-JAY CMHIS Beneficiary Family Unit.
19. High number of admissions in odd hours.
20. High number of admissions in weekends/ holidays.
21. Admission beyond capacity of hospital.
22. Average admission is beyond bed capacity of the EHCP in a month.
23. Excessive ICU admission.

24. High number of admissions at the end of the Policy Cover Period.
25. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
26. Claims with Length of Stay (LoS) which is in significant variance with the average LoS for a particular ailment.

Diagnosis Specific Triggers

27. Diagnosis and treatment contradict each other.
28. Diagnostic and treatment in different geographic locations.
29. Claims for acute medical Illness which are uncommon e.g., encephalitis, cerebral malaria, monkey bite, snake bite etc.
30. Ailment and gender mismatch.
31. Ailment and age mismatch.
32. Multiple procedures for same AB PM-JAY CMHIS Beneficiary – blocking of multiple packages even though not required.
33. One-time procedure reported many times.
34. Treatment of diseases, illnesses, or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
35. Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
36. Part of the expenses collected from AB PM-JAY CMHIS Beneficiary for medicines and screening in addition to amounts received by the Insurer.
37. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of Critical Illness.
38. Overall medical management exceeds more than 5 days, other than in the case of Critical Illness.
39. High number of cases treated on an OOP basis at a given provider, post consumption of financial limit.

Billing and Tariff based Triggers

40. Claims without supporting pre/ post hospitalisation papers/ bills.
41. Multiple specialty consultations in a single bill.
42. Claims where the cost of treatment is much higher than expected for underlying etiology.
43. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
44. Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.

45. Claims submitted that cause suspicion due to format or content that looks "too perfect" in order. Pharmacy bills in chronological/running serial number or claim documents with colour photocopies. Perfect claim file with all criteria fulfilled with no deficiencies.
46. Claims with visible tempering of documents, overwriting in diagnosis/ treatment papers, discharge summary, bills etc. Same handwriting and flow in all documents from first prescription to admission to discharge. X-ray plates without date and side printed. Bills generated on a "Word" document or documents without proper signature, name, and stamp.

General

47. Qualification of practitioner doesn't match treatment.
48. Specialty not available in hospital.
49. Delayed information of claim details to the Insurer.
50. Conversion of OP to IP cases (compare with historical data).
51. Non-payment of transportation allowance.
52. Not dispensing post-hospitalization medication to AB PM-JAY CMHIS Beneficiaries.

Schedule 18: Indicators to Measure Effectiveness of Anti-Fraud Measures

1. Monitoring the number of grievances per 1,00,000 AB PM-JAY CMHIS Beneficiaries.
2. Proportion of Emergency pre-authorisation requests.
3. Percent of conviction of detected fraud.
4. Share of pre-authorisation and claims audited.
5. Claim repudiation/ denial/ disallowance ratio.
6. Number of dis-empanelment/ number of investigations.
7. Share of AB PM-JAY CMHIS Beneficiary Family Units physically visited by Scheme functionaries.
8. Share of pre-authorisation rejected.
9. Reduction in utilization of high-end procedures.
10. AB PM-JAY CMHIS Beneficiary satisfaction.
11. Share of combined/ multiple procedures investigated.
12. Share of combined/ multiple procedures per 1,00,000 procedures.
13. Pre-authorisation pendency rate and Claim pendency rate per 100 cases decided OR percent of pre-authorisation decided after additional observation being attended + correlated with frauds detected as a consequence of this effort.
14. Instances of single disease dominating a geographical area/Service area are reduced.
15. Disease utilization rates correlate more with the community incidence.
16. Number of FIRs filed.
17. Number of enquiry reports against hospitals.
18. Number of enquiry reports against Insurer or SHA staff.
19. Number of charge sheets filed.
20. Number of judgments received.
21. Number of cases discussed in Empanelment and Disciplinary Committee.
22. Reduction in number of enhancements requested per 100 claims.
23. Impact on utilization.
24. Percent of pre-audit done for pre-authorisation and claims.
25. Percent of post-audit done for pre-authorisation and claims.
26. Number of staff removed or replaced due to confirmed fraud.
27. Number of actions taken against hospitals in a given time period.
28. Number of adverse press reports in a given time period.
29. Frequency of hospital inspection in a given time period in a defined geographical area.
30. Reduction in share of red flag cases per 100 claims.

Schedule 19: Human Resource Requirements

The Insurer is obliged to deploy Human Resource as per the provisions of Schedule 19A, Schedule 19B and Schedule 19A.

Schedule 19A: Minimum Human Resource Requirements

1. Minimum manpower required:

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

Table 1: Qualification for the manpower

S. No.	Designation	Number	Location	Minimum Qualification and experience	Brief Roles and Responsibilities
1	State Project Manager	1	SPO of IC	• At least Management diploma or MA/MS/M Com with at least 4 years of experience of managing a public insurance programme at the state level	• Overall coordinator of ICs operations in the state • Single contact point for SHA for any coordination purpose
2	State Medical Manager	1	SPO of IC	• MBBS with at least 5 years of work experience of managing a public insurance scheme	• Overall supervision and guidance to be provided to CPDs and PPDs
3	State Operations/ Technical Coordinator	1	SPO of IC	• A bachelor's degree in science, arts, or commerce	• Overall responsibility of the operations of the scheme

				with experience of working in public insurance projects	
4	District Coordinator	1 each district	Office of District Nodal Officer	• A graduate degree with the experience of working in the insurance sector for 3 years	• To coordinate and ensure smooth implementation of the Scheme in the district. • To follow up with the EHCP to ensure that the IT infrastructure installed is always fully functional. • Liaise with the district officials of the SHA to addressing operational issues as and when they arise. Liaise with the District Grievance Redressal Cell for resolving all complaints.
5	PPD	Minimum required to meet the TAT as per Schedule 13B	SPO of IC/Centrally located	• Medical Professional with the experience of insurance sector for 2 years	• Approve/assign/reject pre-auth request • Raise query/send for clarification to hosp. • Trigger investigation
6	CEX	Minimum required to meet the TAT	SPO of IC/Centrally located	• A bachelor's degree along with the	• Verification on non-technical documents,

		as per Schedule 13B		experience in the insurance sector for 3 years	reports, dates verification • Forward case to CPD for processing with inputs
7	CPD	Minimum required to meet the TAT as per Schedule 13B	SPO of IC/Centrally located	• Medical Professional with the experience of insurance sector for 2 years	• Verification of technical information e.g., Diagnosis, clinical treatment, notes, evidence, etc. • Approve/assign/reject a claim • Raise query/as for clarification • Trigger investigation
8	Fulltime medical Auditors cum Fraud Investigator	1 per each 6 zone	6 zones in the state under - Phek/Kiphire, Kohima/Wokha/tseminyu, Dimapur/Peren/Niuland/Chumoukedima, Mokokchung/Zunheboto/Longleng, Tuensang/Noklak, Mon/Shamator	• MBBS / BDS	• Coordinate and conduct required periodical audit • Finalize and submit audit report for the district/cluster to the state headquarter for finalization of state wise periodical audit • Fraud investigation
9	Empaneled medical auditors	As per requirement	NA	• MBBS degree with the experience of working in the insurance sector for 2 years	• Support conducting medical audits

10	Empaneled Hospital Auditors	As per requirement	NA	• MBBS degree with the experience of working in the insurance sector for 2 years	• Support conducting hospital audits

Schedule 19B: Additional Manpower Requirement within the organisation

In addition to the personnel mentioned in Schedule 19A, the Insurer shall recruit or employ experienced and qualified personnel for each of the *following role within its organisation* exclusively for the purpose of the implementation of the Scheme:

a. To undertake Information Technology related functions which will include, among other things, collating and sharing claims related data with the SHA and running of the website at the State level and updating data at regular intervals on the website. The website shall have information on AB PM-JAY CMHIS in the local language and English with functionality for claims settlement and account information access for the AB PM-JAY CMHIS Beneficiaries and the EHCP.
b. The AB PM-JAY CMHIS website should have a separate login ID for Beneficiary family Unit where the Beneficiary Family Unit profile could be accessible along with information like claim history, options for raising queries/complaints and other features as agreed upon with the SHA.
c. To implement the grievance redressal mechanism and to participate in the grievance redressal proceedings provided that such persons shall not carry out any other functions simultaneously if such functioning will affect their independence as members of the grievance redressal committees at different levels.
d. To coordinate the Insurer's State level obligations with the State level administration of the SHA.

Schedule 19C: Additional Manpower Requirement at State/district level

In addition to the personnel mentioned in Schedule 19A and Schedule 19AB, the Insurer shall recruit and employ experienced and qualified personnel for each of the *following role within its organisation at the State/district level*, exclusively for the purpose of the implementation of the Scheme:

a. To undertake the Management Information System (MIS) functions, which include creating a MIS dashboard with real time updates on the claims and BIS updates in the state and collecting, collating, and reporting data.
b. To generate reports in formats prescribed by the SHA from time to time or as specified in the Scheme Guidelines, at monthly intervals.
c. Processing and approval of beneficiary identity verification requests, received from Ayushman Mitra's at the hospitals, as per the process defined in the Scheme.
d. Scrutiny and approval of beneficiary identity verification requests if all the conditions are fulfilled, within 30 minutes of receiving the requests from Ayushman Mitra's at the network hospital.
e. To undertake feedback functions which include designing feedback formats, collecting data based on those formats from different stakeholders like AB PM-JAY CMHIS beneficiaries, the EHCPs etc., analysing the feedback data and recommending appropriate actions.

Schedule 20: Non-Disclosure Agreement

NON-DISCLOSURE AGREEMENT

This Non- Disclosure Agreement **("Agreement")** is entered into on this … day of _____, 2020**("Effective Date")** by and between:

State Health Agency,_____represented by the _____, having its office located at _____which expression shall, unless repugnant to the context, include its successors and assigns (hereinafter referred to **as "SHA")**

And

M/s. _____ a company registered under the Companies Act 1956 and having its registered office at _____ represented by Mr. _____ which expression shall, unless repugnant to the context include its successors (hereinafter referred as "**the Insurer**")

SHA and Insurer shall hereinafter be referred individually as Party/ as specified hereinabove and jointly as "**Parties**".

Whereas:

A. SHA is constituted with an objective of _____.
B. The Insurer is carrying on business of_____.
C. SHA is [contemplating engaging the services of the Insurer*)* for [specify Purpose] (the "Purpose") and for this Purpose, the Insurer shall come into contact with certain confidential information.
D. SHA desires to ensure that strict confidentiality is maintained by the Insurer regarding its relationship with SHA and regarding the confidential information which comes to the knowledge of Insurer in connection with the Purpose.
E. The Parties desire to set forth their rights and obligations with respect to the use, dissemination and protection of the confidential information accessed by the Insurer.

NOW THEREFORE, in consideration of the mutual covenants and agreements set forth below, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, it is understood and agreed as follows:

1. **Definitions**

In this Agreement, the following terms shall have the following meanings:

"Confidential Information" shall include all information or data, whether electronic, written or oral, relating to AB PM-JAY CMHIS Scheme , SHA 's business, operations, financials, services, facilities, processes, methodologies, technologies, intellectual property, trade secrets, research and development, trade names, Personal Data, Sensitive Personal Data, methods and procedures of operation, business or marketing plans, licensed document know-how, ideas, concepts, designs, drawings, flow charts, diagrams, quality manuals, checklists, guidelines, processes, formulae, source code materials, specifications, programs, software packages/ codes, clients and suppliers, partners, principals, employees, consultants and authorized agents and any information which is of a manifestly confidential nature, that is supplied by SHA to the Insurer or otherwise acquired/ accessed by the Insurer during the course of dealings between the Parties or otherwise in connection with the Purpose. Confidential Information may also include the Confidential Information related to AB PM-JAY CMHIS Scheme, SHA 's/ other SHA's clients, licensors, alliances, contractors and advisors.

"Personal Data" and "Sensitive Personal Data" shall have the meanings as assigned to them under applicable law of India.

2. **Supply and Use of Confidential Information**

(a) The Insurer shall use Confidential Information only for the Purpose or in relation to the definitive written agreement between the Parties (if any or is subsequently entered) in connection with the Purpose, pursuant to which a given item of Confidential Information was disclosed. Upon the completion of the business objective relating to the Purpose or the termination/ expiry of such definitive written agreement in connection with the Purpose, and upon the written request of SHA, an authorized officer of the Insurer shall promptly, at the option of SHA, either return to SHA or destroy all Confidential Information in the Insurer's possession or control and shall certify to SHA as to such return or destruction.

(b) The Insurer shall not disclose the Confidential Information to any third party without SHA 's prior written consent. The Insurer may disclose the Confidential Information to its employees, on a strict need to know basis in connection with the Purpose provided such employees are bound under confidentiality agreements which are at least as restrictive as this Agreement.

(c) The Insurer shall exercise the same degree of care with respect to SHA 's Confidential Information as the Insurer takes to safeguard and preserve its own confidential and/or proprietary information provided that in no event shall the degree of care be less than a reasonable degree of care. Upon discovery of any prohibited use or disclosure of the Confidential Information, the Insurer shall immediately notify SHA in writing and shall make its best efforts to prevent any further prohibited use or disclosure; however, such remedial actions shall in no manner relieve the Insurer's obligations or liabilities for breach hereunder.

(d) The Insurer shall ensure that all appropriate confidentiality obligations and technical and organizational security measures are in place, within the Insurer's organization, to prevent any unauthorized or unlawful disclosure or processing of Confidential Information and the accidental loss or destruction of or damage to such Confidential Information. The Insurer will comply with applicable data protection and privacy legislation in this regard.

(e) To the extent it is a transferee of Personal Data from SHA, the Insurer shall be under and shall assume identical and/or similar obligations that of SHA under the applicable data protection and privacy legislation in this regard relating to such Personal Data.

(f) The Insurer shall notify SHA forthwith from the time it comes to the attention of the Insurer that Confidential Information (including Personal Data) transferred by SHA to it has been the subject of accidental or unlawful destruction or accidental loss, alteration, unauthorized disclosure or access, or any other unlawful forms of processing. The obligation contained above shall survive any termination/expiration of the Agreement.

3. **Limitations**:
   This Agreement shall not restrict disclosure of information that, the Insurer can evidence through sufficient documentation:

(a) was, at the time of receipt, otherwise known to the Insurer without restrictions as to use or disclosure; or

(b) was in the public domain at the time of disclosure or thereafter enters into the public domain through no breach of this Agreement by the Insurer.

4. **Exclusion:**

The Insurer may disclose Confidential Information, strictly to the extent such disclosure is compulsorily required under applicable law (including court order), to a regulatory authority or a court of law with competent jurisdiction over the Insurer, provided that the Insurer will first have provided SHA with immediate written notice of such required disclosure and will take reasonable steps to allow SHA to seek a protective order with respect to the Confidential Information required to be disclosed. The Insurer will promptly cooperate with and assist SHA in connection with obtaining such protective order.

5. **No Warranty:**
   SHA HEREBY DISCLAIMS ALL WARRANTIES, WHETHER EXPRESS OR IMPLIED, WITH RESPECT TO THE CONFIDENTIAL INFORMATION.
6. **No License:**
   No license or conveyance of any rights held by SHA under any discoveries, inventions, patents, trade secrets, copyrights, or other form of intellectual property is granted or

implied by this Agreement or by the disclosure of any Confidential Information pursuant to this Agreement.

7. No Formal Business Obligations:

This Agreement shall not constitute, create, give effect to, or otherwise imply (i) a joint venture, pooling arrangement, partnership, or formal business organization of any kind, or (ii) any obligation or commitment on SHA to submit a proposal or to enter a further contract or business relationship with the Insurer, or (iii) any obligation on SHA to disclose, supply or otherwise communicate any information, general or specific, to the Insurer. Nothing herein shall be construed as providing for the sharing of profits or losses arising out of efforts of either or both Parties.

8. Confidentiality and Intellectual Property Notices:

The Insurer shall not (nor shall it permit or assist others to) alter or remove any confidentiality label, proprietary label, patent marking, copyright notice or other legend (singularly or collectively, "Notices") placed on the Confidential Information, and shall maintain and place any such Notices on applicable Confidential Information or copies thereof.

9. Governing Law and Jurisdiction:

This Agreement shall be governed by and construed in accordance with the laws of India. Any dispute arising out of the Agreement shall be referred to the nominated senior representatives of both the Parties for resolution through negotiations. In case, any such difference or dispute is not amicably resolved within forty-five (45) days of such referral, it shall be resolved through Arbitration, in India, in accordance with the provisions of Arbitration and Conciliation Act 1996 and _____ shall be considered as sole Arbitrator to adjudicate the dispute between the Parties as per the Arbitration and Conciliation Act as amended from time to time. Arbitration shall be held in English and the venue of the Arbitration same shall be in Kohima. The award of the Arbitrator shall be final and binding on the Parties. The proceedings of arbitration, including arbitral award, shall be kept confidential. Subject always to the foregoing provisions of this paragraph, the competent High courts of Gauhati, Kohima bench shall have jurisdiction in relation to any dispute between the Parties under this Agreement.

10. Injunctive Relief and Damages:

The Insurer acknowledges that use or disclosure of any confidential and proprietary information in a manner inconsistent with this Agreement will give rise to irreparable injury for which damages would not be an adequate remedy. Accordingly, in addition to any other legal remedies which may be available at law or in equity, the SHA shall be entitled to equitable or injunctive relief against the unauthorized use or disclosure of confidential and proprietary information. The SHA shall be entitled to pursue any other legally permissible remedy available because of such breach, including but not limited to damages, both direct and consequential. Additionally, the Insurer agrees to keep SHA indemnified against any losses or damages

(including reasonable attorneys' fees) arising due to the breach of this Agreement by the Insurer.

11. Miscellaneous:

- **Amendment:** This Agreement may be amended or modified only by a written agreement signed by both Parties.
- **Relationship:** The Parties to this Agreement are independent contractors. Neither Party is an agent, representative, or partner of the other Party. Neither Party shall have any right, power, or authority to enter into any agreement for, or on behalf of, or incur any obligation or liability of, or to otherwise bind, the other Party. No joint venture, partnership or agency relationship exists between the Insurer, the SHA or any third-party because of this Agreement.
- **Assignment:** Neither Party may assign its rights or delegate its duties under this Agreement without the other Party's prior written consent.
- **Severability:** If any provision of this Agreement is held to be invalid, illegal, or unenforceable in whole or in part, the remaining provisions shall not be affected and shall continue to be valid, legal, and enforceable as though the invalid, illegal or unenforceable parts had not been included in this Agreement.
- **Waiver:** Neither Party will be charged with any waiver of any provision of this Agreement, unless such waiver is evidenced by a writing signed by the Party and any such waiver will be limited to the terms of such writing.

12. Termination and Survival:

This Agreement shall commence as of the date written above and shall remain in effect for a period 3 unless terminated earlier by SHA by (i) giving fourteen (14) days' written notice of termination to the Insurer at any time, or (ii) giving notice effective immediately following a breach by the Insurer. Notwithstanding the foregoing, any obligations imposed on the Insurer under this Agreement, including confidentiality obligations, that by their very nature survive the termination or expiry of this Agreement shall so survive the termination or expiry of this Agreement.

13. No Publicity:

No press release, advertisement, marketing materials or other releases for public consumption concerning or otherwise referring to the terms, conditions or existence of this Agreement shall be published by the Insurer. The Insurer shall not promote or otherwise disclose the existence of the relationship between the Parties evidenced by this Agreement or any other agreement between the Parties for purposes of soliciting or procuring sales, clients, investors, or other business engagements.

14. **Non-Solicitation:**

Except as may be otherwise agreed in writing between the Parties, during the term of this Agreement and for twelve (12) months thereafter, neither the Insurer nor any of its affiliates, shall offer employment to or employ any person employed (then or within the preceding twelve (12) months) by SHA if such person had interacted with the Insurer or its

affiliates, directly or indirectly, in relation to the Purpose or was involved in performing responsibilities in relation to the Purpose.

15. **No Conflict:**
    The Insurer represents and warrants that the performance of its obligations hereunder does not, and shall not, conflict with any of its other agreement or obligation to which it is bound.
16. **Entire Agreement; Counterparts:**
    This Agreement together with any other definitive written agreement executed or to be executed between the Parties relating to the Purpose constitutes the entire agreement between the Parties with respect to the subject matter hereof. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same instrument.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives and made effective from the Effective Date first written above.

SIGNED for and on behalf of **SHA** By _____ Title _____ (authorized signatory) Date _____	SIGNED for and on behalf of **Insurer** By _____ Title_____ (authorized signatory) Date _____

Schedule 21: Individual Confidentiality Undertaking

UNDERTAKING

I, [*Insert Name*], the undersigned, acknowledge that as an employee/ staff of _____ ("**Insurer**"), I will be working as a team member of the company project team which is providing, or shall provide, certain services to State Health Agency (SHA) as per the terms and conditions of the Agreement dated _____.

In this regard, I confirm that I have fully read and understood all the terms and conditions of the Agreement executed between SHA and Insurer, to the contents below. With effect from _____], I undertake to strictly abide by this undertaking and the Agreement.

To the extent not defined in this undertaking itself, the capitalized terms contained in this letter shall have the meaning attributed to them under the Agreement.

Without prejudice to the generality of the foregoing paragraphs, I agree to the following:

1. I shall not discuss/ disclose, at any time during my work on the Services or at any time thereafter, any Confidential Information with/ to any third party or any employee or partner of Insurer or other Insurer Firms, other than those working or advising on the Services or those who need to access such information on a strict need to know basis.

2. If approached by any third party or Insurer employee/staff (where such employee/ staff do not require access to the Confidential Information on a need-to-know basis) to provide any Confidential Information relating to the Services, I shall immediately inform the Insurer and/or SHA and shall not disclose any such information unless approved.

3. I shall not remove or destroy any documents, data, files or working papers in whatsoever form (including but not restricted to any in electronic form) in respect of the Services, without the written consent of Insurer.

4. If I leave the employment of Insurer or my association with Insurer gets terminated, I shall not discuss/ disclose thereafter any Confidential Information with/ to any other party.

5. I voluntarily waive all my rights and disclaim my ownership on any work and/or deliverables to be performed while deployed at Insurer/ SHA for the purposes of Agreement.

I understand that strict compliance with this undertaking and the Agreement is a condition of my involvement with the Services and a breach hereof may be regarded as an infringement of my terms of employment/ association with Insurer. I acknowledge that I will be personally liable for any breach of this undertaking and/or the Agreement and that the confidentiality obligations hereinunder shall survive the tenure of my employment/ association with Insurer.

Signature: _____

Name (in block letters): _____
Mother's/Father's name:……..
Address: ……..
Aadhaar: ……..

Telephone #: _____

Date: _____
Attach : Self-attested copy of the Aadhaar Card + 1 more government issued ID

Schedule 22: Template for Claims Adjudication Audit

Case ID	Hospital Name	Package name	Package Cost	Date of Admission	Date of Discharge	Types of findings	Comments

Claims adjudication audit reporting format

Name of the IC/ISA/TPA		
Month and year of Audit		
Total number of claims audited		
Total number of errors found during audit	Financial	Non-financial
No of Hospitals found suspected during audit		
Action plan against suspected hospitals		
Major type of errors found during audit		
Executive summary of audit		

Claims adjudication audit manual checklist

Case number	
Hospital name and District	
Package booked (Diagnosis)	
Package amount	

Date of admission			
Date of Discharge			
Type of package medical/Surgical			
Particulars	Yes	No	Remarks
History checked			
Are all mandatory documents required at the time of pre-Auth uploaded			
Validate Length of stay - DOA/DOD			
Are symptoms matching with the diagnosis			
Is the package booked matching with the diagnosis			
Are Investigation reports supporting diagnosis available			
Are Post op photos showing scar available in surgical cases			
Investigation reports signed by doctor with registration no			
Are pre op and post op x-rays available in ortho cases			
Discharge summary in proper format			
Complete ICP available from the day of admission till discharge			
ICP in same handwriting			
Is referral letter from government hospital available (State specific)			
Death Summary in case of death			

Schedule 23: Call Centre Operations -Service Levels and KPIs

The Service Levels mentioned in this section define the levels of service which shall be delivered by the ISA as part of the Call Centre Service for the duration of the contract and shall be applicable on the Insurer from the date of start of the Contract Period.

The penalties on individual service levels would be applied individually. However, if the total penalties exceeds by 10% of the billed amount, the aggregated penalty would be capped at 10% of the billed amount.

The Call Centre Service Provider will be required to submit weekly and monthly reports on all service levels as defined herein to SHA.

1. Service level

Applicability	Inbound voice calls.
Definition	This is the percentage of calls that are answered by the call center agents within a specified time period
Formulae	Calls Answered within a threshold of 10 seconds across all languages/ (Total Calls offered across all languages - Abandoned calls with less than or equal to 5 seconds queue time across all languages)

Measurement Interval	**Reporting period**	**Target**	**Penalty**
Daily	Quarterly	>80%	Nil
		>=75% and <80%	1% of invoice billed value
		>=70% and <75%	2% of invoice billed value
		<70%	5% of invoice billed value

2. Call abandoned rate-

Applicability	Inbound voice calls.
Definition	The % of inbound voice calls that are requested for an agent but got disconnected before being answered by the agent. (Only calls that get disconnected after 10 seconds after being transferred from IVRS to agent's queue will be considered for computation of this service level).

Formulae	(Total Abandoned calls across all languages – Abandoned calls with less than or equal to 5 seconds queue time across all languages)/Total Calls Offered across all languages.

Measurement Interval	Reporting period	Target	Penalty
Daily	Quarterly	<=3%	Nil
		>=3% and <5%	3% of invoice billed value
		>=5% and <10%	5% of invoice billed value
		>10%	10% of invoice billed value

3. **Call Quality Score**

Applicability	Inbound voice calls
Definition	Call quality audit score is a method of scoring agent's calls against predefined parameters to ensure that the agents are adhering to the quality standards defined by SHA.

Measurement Interval	Reporting period	Target	Penalty
Daily	Quarterly	>85%	Nil
		Between 80% to 85%	1% of invoice billed value
		Between 75% to 80%	2% of invoice billed value
		<75%	5% of invoice billed value

4. **Caller's Satisfaction**

Applicability	Inbound voice calls.

Definition	This is the measure of caller's satisfaction with the way their query/complaint has been handled by the agent. The Call Centre Service Provider shall be responsible for maintaining a minimum level of Caller satisfaction based on the criteria defined by SHA. The satisfaction level of callers shall be collected on a five pointer scale of 5: "Very satisfied", 4: "Satisfied" 3: "Average", 2:"Dissatisfied" and 1: "Very Dissatisfied"
Formulae	(Sum of- 5: "Very satisfied", 4: "Satisfied")/Total number of surveys

Measurement Interval	**Reporting period**	**Target**	**Penalty**
Daily	Quarterly	>=85%	Nil
		>=80% but <85%	2% of invoice billed value
		>=75% but <80%	5% of invoice billed value

5. **Average Handle Time (AHT)**

Applicability	Inbound voice calls.
Definition	It is the average amount of time an agent spends either talking on a call or average amount of time an agent places a call on hold or average amount of time spend on after call work in relation to an inbound call.
Formulae	**For Inbound Calls-** [(Sum of Talk Time + Sum of Hold Time + Sum of Wrap Time)/Sum of calls handled] across all languages.

Measurement Interval	**Reporting period**	**Target**	**Penalty**
Daily	Quarterly	<=240 seconds	Nil
		>240 seconds and <=270 seconds	2% of invoice billed value
		>270 seconds and <=300 seconds	3% of invoice billed value
		>300 seconds	5% of invoice billed value

6. Agent Productivity

Definition	This is defined as the percentage of time an agent is productive for PM-JAY process against the total duration he/she is connected using his/her login ID to Call Centre Service Provider (as the case may be) Automatic Call Distribution (ACD) system in any mode pre-defined in the Automatic Call Distribution (ACD) system.
Formulae	[{(Talk Time + Hold Time + After Call Work Time+ Available Time + Other productive Auxiliary Time) – nonproductive Auxiliary Time} / Total Staffed Time] *100 Where, Talk Time: - Length of time spent by an agent talking to an inbound call or outbound call. Hold Time: - Length of time spent by an agent with an inbound or \outbound call on hold. After Call Work Time: - Length of time spent by an agent in ACW mode. Available Time: - Length of time spent by an agent in available mode waiting for calls from split/skill.

Measurement Interval	Reporting period	Target	Penalty
Daily	Quarterly	>=85%	Nil
		>=80% but <85%	2% of invoice billed value
		>=75% but <80%	5% of invoice billed value
		>=75%	10% of invoice billed value

Where,
Talk Time: - Length of time spent by an agent talking to an inbound call or outbound call.
Hold Time: - Length of time spent by an agent with an inbound or outbound call on hold.
After Call Work Time: - Length of time spent by an agent in ACW mode.
Available Time: - Length of time spent by an agent in available mode waiting for calls from split/skill.
Other productive Auxiliary time: - Length of time spent by an agent on productive Auxiliary time on SHA's ACD system.
Productive Auxiliary time are: -

- On-Job training
- Quality Feedback
- E-mail Support
- Briefing
- Re-Fresher Training
- Outbound

Non Productive Aux Time: - Length of time spent by an agent on nonproductive Auxiliary time.
Non-productive Auxiliary time are: -

- 15 Minutes Break.
- 30 Minutes Lunch / Dinner Break.
- Meeting/Vendor
- Headset/Desktop Issue

7. Average Response Time for Email

Applicability	E-Mail interactions.
Definition	The average response time for an email is a measurement of the number of hours it takes to provide a response/attend to an email-based inquiry.
Formulae	Sum of Response Times/ Total Number of Email Inquiry

Measurement Interval	Reporting period	Target	Penalty
Daily	Quarterly	<=24 hours	Nil
		>24 hours and <=30 hours	2% of invoice billed value
		>30 hours and <=36 hours	3% of invoice billed value
		>36 hours	5% of invoice billed value

8. Count Incorrect Email Responses-

Applicability	E-Mail
Definition	To measure number of incorrect e-mails replied by Call Centre Service Provider.
Formulae	Count of incorrect e-mails replied by Call Centre Service Provider.

Measurement Interval	Reporting period	Target	Penalty
Daily	Quarterly	Zero	Nil

Measurement Interval	Reporting period	Target	Penalty
		For every count of incorrect reply of e-mail	₹ 1000 per e-mail.

9. **First Time Resolution (FTR)**

Applicability	Inbound Phone and E-mail.
Definition	This refers to the percentage of calls/e-mails resolved at first line, without the need for escalation to other support groups. The Call Centre Service Provider's agent is expected to resolve the issue or answer the question during the first contact.
Formulae	Count of FTR cases /Count of cases created

Measurement Interval	Reporting period	Target	Penalty
Daily	Quarterly	>80%	0.5% of the monthly bill value for every 2.5% actual FTR below

10. **Accuracy of complaint logging by Agents**

Applicability	Inbound voice calls
Definition	To measure the accuracy with which Agent register interactions to ensure that not more than a small percentage of complaints are incorrectly captured. This is the percentage of interactions that have been captured incorrectly by the Agent making it difficult to resolve the same.
Formulae	The interactions that have been wrongly captured shall be used to calculate the % of incorrect interactions logged by Agent using the following formulae: Total number of wrongly tagged interactions / Total interactions logged for the month.

Measurement Interval	Reporting period	Target	Penalty
Weekly	Quarterly	<=15%	Nil
		<15% but <=20%	2% of invoice billed value
		>20% but <=25%	3% of invoice billed value
		>25%	5% of invoice billed value

11. **Interactions of Record Percentage**

Applicability	Inbound voice calls
Definition	To measure percentage of interactions recorded in CRM system.
Formulae	Number of cases created or modified in CRM system/Number of Interactions

Measurement Interval	Reporting period	Target	Penalty
Weekly	Quarterly	>=95%	Nil
		>=90% but <95%	2% of invoice billed value
		>85% but <=90%	3% of invoice billed value
		<85%	5% of invoice billed value

12. **Average Hold Time**

Applicability	Inbound voice calls.
Definition	This is measured as the average time a call was put on hold by the Agent
Formulae	Total Hold Time (Inbound + Outbound)/(Sum of Inbound Calls Handled + Sum of Outbound Calls)

Measurement Interval	Reporting period	Target	Penalty
Weekly	Quarterly	<=20 seconds	Nil

Measurement Interval	Reporting period	Target	Penalty
		>20 seconds but <=30 seconds	2% of invoice billed value
		>30 seconds but <=35 seconds	3% of invoice billed value
		>35 seconds	5% of invoice billed value

13. **Average wrap time**

Applicability	Inbound voice calls.
Definition	This is measured as the average time spent by the Agent in wrap mode.
Formulae	Total wrap Time/(Sum of Inbound Calls Handled + Sum of Outbound Calls)

Measurement Interval	Reporting period	Target	Penalty
Weekly	Quarterly	<=5 seconds	Nil
		>5 seconds but <=10 seconds	2% of invoice billed value
		>10 seconds but <=15 seconds	3% of invoice billed value
		>15 seconds	5% of invoice billed value

14. **Deployment of Resources at the request of SHA**

Applicability	Inbound/outbound voice calls.
Definition	Deployment of Resources/agents on the project at the request of SHA
Target	Within 15 days of request by SHA/as per work order issued by SHA

Measurement Interval	Reporting period	Target	Penalty
Weekly	Quarterly	<=15 days	Nil
		>15 days but <=21 days	2% of invoice billed value
		>21 days but <=28 days	3% of invoice billed value
		>28 days	5% of invoice billed value