GUIDELINES ON HOSPITAL EMPANELMENT AND DE-EMPANELMENT

BIJU SWASTHYA KALYAN YOJANA

STATE HEALTH ASSURANCE SOCIETY

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ABBREVIATIONS

BIS	Bureau of Indian Standards
BMW	Bio-Medical Waste
BSKY	Biju Swasthya Kalyan Yojana
CDM&PHO	Chief District Medical and Public Health Officer
CGHS	Central Government Health Scheme
DEC	District Empanelment Committee
EHCP	Empanelled Healthcare Provider
ESIC	Employees State Insurance Corporation
HBP	Health Benefit Packages
HDU	High Dependency Unit
HEM	Hospital Empanelment Module
ICU	Intensive Care Unit
IIB	Insurance Information Bureau
IRDAI	Insurance Regulatory and Development Authority of India
JCI	Joint Commission International
MOEFA	Manually Operated Electronic Fire Alarms
MoU	Memorandum of Understanding
NABH	National Accreditation Board for Hospitals & Healthcare Providers
NBC	National Building Code, 2016
NFSA	National Food Security Act
OPD	Outpatient Department
OSEC	Outside State Empanelment Committee
OT	Operating Theatre
SCN	Show Cause Notice
SEC	State Empanelment Committee
SFSS	State Food Security Scheme
SHAS	State Health Assurance Society
STG	Standard Treatment Guidelines
TMS	Transaction Management System
UHC	Universal Health Coverage

1. INTRODUCTION

1.1. Launched in August 2018, Biju Swasthya Kalyan Yojana (BSKY) is a testament to the Government of Odisha's commitment under the guidance of Hon'ble Chief Minister Shri Naveen Patnaik and his guiding principle "Every Life is Precious". The scheme's primary goal is to provide affordable and accessible quality healthcare to Odisha's residents, mainly focusing on protecting economically vulnerable groups from the burden of catastrophic health expenditures. BSKY plays a significant role in Odisha's journey towards Universal Health Coverage (UHC) and is implemented through two key components, each addressing distinct aspects of healthcare and coverage.

1.2. The first component of BSKY ensures comprehensive cashless healthcare services in State Government Hospitals. It covers the entire cost of health services for every patient, regardless of their income, social or residential status. This component encompasses care delivery at various levels of the state healthcare system, from Sub-Centres to District Hospitals and Government Medical College Hospitals. Its primary aim is to provide universal access to essential healthcare services, aligning with UHC objectives.

1.3. The second component extends cashless healthcare coverage in Empanelled Private Hospitals. It covers approximately 80% of Odisha's population, the economically vulnerable population, identified based on the National Food Security Act (NFSA) and the State Food Security Scheme (SFSS). Under this component, the state government bears healthcare expenses for eligible families in empanelled private hospitals, providing annual coverage of up to INR 5 Lakhs per family and an additional INR 5 Lakhs specifically for female members upon the exhaustion of the initial limit.

1.4. The BSKY scheme includes a vast network of service providers, such as all government healthcare facilities and a considerable number of private hospitals, both within and outside Odisha. Private hospitals empanelled under BSKY are expected to benefit from economies of scale, ensuring efficient service delivery and cost-effectiveness. These hospitals are assured of timely payments for the services provided to BSKY beneficiaries through a streamlined, web-based system designed to expedite the adjudication and settlement of claims. This arrangement allows Empanelled Healthcare Providers (EHCP) to mobilise and effectively manage revenues accrued from BSKY claims. This aspect of the BSKY scheme broadens the scope of available healthcare services for beneficiaries and fosters a sustainable and efficient healthcare delivery system.

2. PURPOSE AND SCOPE

2.1. The empanelment guidelines ensure BSKY beneficiaries have consistent access to quality healthcare services that adhere to established care standards. These guidelines also promote accountability and transparency among EHCPs by establishing clear contractual obligations, performance standards, and monitoring mechanisms. This focus on transparency is vital for maintaining high healthcare delivery standards, enhancing public trust, and minimising the potential for corruption within the system.

2.2. These guidelines have been designed to provide a comprehensive framework for the State Health Assurance Society (SHAS), the administrative entity overseeing the BSKY scheme. The primary aim is to guide SHAS in effectively empanelling healthcare providers and establishing robust procedures for the ongoing oversight of these providers. The guidelines delineate performance standards and monitoring mechanisms to ensure consistent quality of care, patient safety and effective healthcare delivery. It also includes the procedures for disciplinary actions and, if necessary, the de-empanelment of providers. Such measures are imperative for maintaining the integrity and quality of the healthcare services offered under the BSKY scheme.

3. APPROACH FOR EMPANELMENT

3.1. To enhance the healthcare service accessibility and utilisation under BSKY, the SHAS is authorised to empanel Healthcare Providers that meet the eligibility criteria, both within and outside Odisha. These providers must submit their applications through the designated web portal.

3.2. All healthcare providers seeking empanelment under BSKY must complete the mandatory registration process on the web portal.

3.3. Empanelled hospitals are encouraged to obtain and furnish the ROHINI ID, issued by the Insurance Information Bureau (IIB), as part of their credentials to enhance data transparency and coordination.

3.4. Healthcare Providers are incentivised to attain National Accreditation Board for Hospitals & Healthcare Providers (NABH) and/or Joint Commission International (JCI) quality accreditation. Healthcare providers with quality accreditations are eligible for higher reimbursement rates for Health Benefit Packages (HBP) under the scheme.

3.5. For EHCPs empanelled based on quality accreditation, a renewal process is required once every 3 years or on the expiry of the quality accreditation, whichever is earlier, to ensure compliance with minimum standards.

3.6. SHAS reserves the right to revise the empanelment criteria from time to time as needed, requiring EHCPs to undergo reassessments to maintain their empanelment status.

4. CRITERIA FOR EMPANELMENT

4.1. BASIC MINIMUM CRITERIA

4.1.1. This section outlines the basic minimum criteria to be met by all EHCPs. A hospital would be empanelled as a network private hospital with the approval of the SHAS if it adheres to the following minimum criteria:

a. BED CAPACITY:

i. The hospital must have a minimum of 10 inpatient beds with adequate spacing and supporting staff as per norms.

ii. Separate male and female wards with toilets and other basic amenities should be available.

iii. General wards should have at least 80 sq. ft. per bed, include basic amenities, and can be non-AC but equipped with fans/coolers and heaters in winter.

iv. Exceptions for daycare centres like centres for eyes, ENT, stand-alone dialysis centres, etc., may be granted.

b. QUALIFIED MEDICAL AND NURSING STAFF:

i. The hospital should have adequate qualified medical and nursing staff (doctors and nurses) available around the clock. A doctor can only work in three hospitals simultaneously.

Qualified Doctors *must hold an MBBS degree recognised and approved as per the Clinical Establishment Act and the State Government rules and regulations as applicable from time to time.*
Qualified Nurses *per unit per shift should be available as required, in accordance with the guidelines set forth by the Nursing Council, Clinical Establishment Act, and the State Government rules and regulations as applicable from time to time.*

c. MEDICAL AND SURGICAL SERVICES:

i. Hospitals offering medical and surgical services must be adequately equipped and aligned with the scope of services provided, available specialities, and bed capacity. This includes:

a. Round-the-clock availability (or on-call) of a Surgeon and Anaesthetist where surgical services/day care treatments are offered.
b. Hospitals providing surgical services must have a fully equipped operation theatre with qualified nursing staff available around the

clock. The hospital should mandatorily have a Post-op ICU with ventilator support systems.

c. Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anaesthetist where maternity services are offered.
d. Round-the-clock availability of specialists (or on-call) in the concerned specialities having enough experience where such services are offered (e.g., Orthopaedics, ENT, Ophthalmology, Oncology, etc.)

d. SUPPORT SYSTEMS:

i. The hospital should have adequate round-the-clock support systems like pharmacy, blood bank, laboratory, X-ray, etc. facilities, either in-house or through outsourcing arrangements with appropriate agreements and in the nearby vicinity.

e. EMERGENCY SERVICES:

i. Hospitals offering emergency services should have 24-hour emergency departments managed by technically qualified staff. The casualty area should be well-equipped with necessary medical equipment and attached toilet facilities. The Hospital should also have round-the-clock ambulance services (own or tie-up).

f. INTENSIVE CARE SERVICES (ICU/HDU):

i. Hospitals offering intensive care services should have an ICU and/or HDU with requisite staff, equipment, and facilities, which includes:

a. ICU/HDU should be in close proximity to Operation Theatres and acute Medical or Surgical Care ward units.

b. Access to oxygen, compressed air and suction available to each bed.

c. ICU/HDU should have the following around the clock:

- Piped Gases, Multi-sign Monitoring Equipment.
- Infusions for Ionotropic Support.
- Equipment for Maintenance of Body Temperature.
- Weighing Scale, Manpower for 24x7 Monitoring.
- Emergency Crash Cart, Defibrillator, Equipment for Ventilation.
- Availability of paediatric equipment like paediatric ventilators, paediatric probes, resuscitation equipment, etc., must be available in Paediatric ICU(s).

- ICU/HDU should be equipped with all the equipment and manpower as per the respective norms.

g. RECORDS MAINTENANCE:

i. The hospital must maintain complete records and provide records with designated SHAS authorities when required.

ii. The hospital should maintain complete records of all BSKY cases.

iii. The hospital should maintain patient-level cost data for all BSKY cases and provide the data to designated SHAS authorities when required.

iv. Wherever automated systems are used, they should comply with MoHFW/ABDM/SHAS Electronic Health Records guidelines (as and when they are enforced).

h. LEGAL REQUIREMENTS:

i. The hospital must comply with the legal requirements mandated by the Clinical Establishment Act, relevant State Government rules and regulations, and the SHAS guidelines that are issued periodically.

i. STANDARD TREATMENT GUIDELINES:

i. The hospital must adhere to the Standard Treatment Guidelines (STG) or Clinical Pathways for procedures as mandated by SHAS from time to time.

j. FINANCIAL REQUIREMENTS:

i. The hospital should be registered with the Income Tax Department and possess an NEFT-enabled bank account.

k. INFRASTRUCTURE:

i. Hospitals must have the following infrastructure working at all times:
   - Telephone/Mobile and Internet Connection;
   - Safe Drinking Water; Toilets and other basic amenities;
   - Uninterrupted Electricity Supply along with Generator Facility;
   - Waste Management Support Services (Including Bio-Medical Waste Management in Compliance with the Bio-Medical Waste Management Act);
   - Appropriate Fire-Safety Measures;
   - Swasthya Mithra Kiosk with required IT and office equipment at the hospital's main entrance area.
   - Criteria on General Appearance and Upkeep are detailed in Annexure - I.

l. PROMOTION OF BSKY:

i. The hospital will ensure the effective promotion of BSKY within and around the hospital premises (Display Banners, Brochures, IEC Materials, etc.) in coordination with the BSKY District Implementation Unit.

m. IT HARDWARE:

i. The hospital must have IT hardware as mandated by the SHAS, including desktop/laptop with internet, printer, webcam, scanner, and biometric devices etc.

n. MEDICAL COORDINATOR:

i. The hospital must designate a medical officer as the Medical Coordinator, who will be responsible for overseeing and managing the BSKY scheme.

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*The **Swasthya Mithra** will serve as concierge and helpdesk personnel to assist BSKY beneficiaries visiting the hospital. They will act as facilitators for beneficiaries and serve as the primary point of contact for beneficiary interactions. They will ensure all patient inquiries are handled professionally and promptly in a timely manner. They will work closely with the hospital staff to ensure beneficiaries receive the care and attention they require.*

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*The **Medical Coordinator** is a designated doctor within the hospital who will assist with pre-authorisation and claim submission processes. They will be responsible for addressing any deficiencies and coordinating the necessary and appropriate treatment for beneficiaries. They will be the point of contact between the hospital and SHAS, ensuring compliance with regulatory requirements.*

4.2. CRITERIA for EMPANELMENT in ASPIRATIONAL DISTRICTS

4.2.1. Some relaxations are provided on the criteria for empanelment of Health Care Providers in Aspirational Districts, as designated by NITI Aayog. All the criteria remain the same for Aspirational Districts as mentioned above, apart from the following:

a. *Bed Capacity:*
The hospital must have a minimum of 5 inpatient beds, ensuring adequate spacing and supporting staff as per norms, unless the hospital only provides day-care services covered under BSKY.

b. *Qualified Medical Staff:*
Minimum of one Doctor with a minimum qualification of MBBS is mandatory.

c. *Intensive Care Services (ICU/HDU):*
Hospitals without ICU/HDU facilities must establish referral linkages with hospitals that have ICU/HDU facilities through a Memorandum of Understanding (MoU) or tie-up. This is a mandatorily self-declared during empanelment.

d. *Emergency Services:*
The Hospital casualty should be, at minimum, equipped with an Emergency Tray.

Sl. No.	*Aspirational Districts in Odisha*
1.	Balangir
2.	Dhenkanal
3.	Gajapati
4.	Kalahandi
5.	Kandhamala
6.	Koraput
7.	Malkangiri
8.	Nabarangpur
9.	Nuapada
10.	Rayagada

Table 01: Aspirational Districts in Odisha (Niti Aayog)

4.3. ADVANCED CRITERIA

4.3.1. REQUIREMENTS FOR EMPANELMENT UNDER SPECIALITY SERVICES

a. *Specialised Services:* Empanelled hospitals may offer speciality services such as Cardiology, Cardiothoracic Surgery, Burns, Plastic and Reconstructive Surgery, Interventional Radiology, Neurosurgery, Nephrology, Neonatology, Oncology, Paediatric Surgery, Urology, etc.

b. *Empanelment for Multiple Specialties:* A hospital can be empanelled for one or more specialities, provided it meets the specific criteria for each speciality.

c. *Intensive Care Facilities:* Hospitals offering these speciality services must be equipped with appropriate Intensive Care Units (ICUs) such as ICCU, SICU, NICU, or relevant speciality-specific ICUs that support and complement the hospital's Operating Theatre (OT) facilities.

d. *Capacity and Capability:* Facilities should have adequate capacity and resources to manage all patients requiring operations and other critical interventions in emergencies.

e. *Qualified Specialists:* Hospitals must employ sufficient numbers of experienced specialists with the required qualifications in their respective fields. These qualifications should meet the standards of professional and regulatory bodies, as specified in the Clinical Establishment Act and the STGs.

f. *Diagnostic Equipment and Support Services:* Adequate diagnostic equipment and support services must be available in the specific fields for which the hospital is empanelled. Compliance with the requirements specified in the Clinical Establishment Act is essential.

4.3.2. INDICATIVE SPECIALITY-SPECIFIC CRITERIA ARE AS UNDER

4.3.2.1. *Cardiology / CTVS:*

a. Qualification - DM in Cardiology and MCh in CTVS or equivalent degree.
b. CTVS OT with Open Heart Tray, Gas pipelines, Heart Lung Machine with TCM, defibrillator, Machine, ACT Machine, Hypothermia Machine, IABP, Cautery, etc.
c. Well-equipped ICCU with cardiac monitoring and ventilator support.
d. Well-equipped Post-operative ICU with ventilator support.
e. Fully equipped Catheterization Laboratory Unit with qualified paramedics.
f. Round-the-clock support services of a Cardiologist.
g. Availability of support services of Physician and Paediatrician.

4.3.2.2. *Burns, Plastic & Reconstructive Surgery:*

a. Qualification - MCh in Plastic Surgery or equivalent degree.
b. Full-time/on-call services of plastic surgeon and support staff.
c. Well-equipped OT with operating microscope.
d. Surgical ICU for post-op care with ventilator support.
e. Specialised Burns ICU with Isolation ward equipped with monitor, defibrillator, and central oxygen line.
f. Trained support staff.
g. Post-operative rehab, physiotherapy, and psychology support.

4.3.2.3. *Interventional Radiology:*

a. Qualification - DM in Interventional Radiology or equivalent degree.
b. Sterile IR Suite with appropriate ventilation, air exchanges and conditioning, and electrical utilities with backup power.
c. Availability of C-arm Fluoroscopy unit, DSA or equivalent angiographic unit, Power injectors for contrast administration, equipment for radiation monitoring and management, including radiation shielding equipment and immediate access to advanced cardiac life support equipment.
d. Pre and post-procedural High Dependency Units (HDUs).
e. Trained Support staff.
f. Reserved for tertiary care facilities with all support specialities.

4.3.2.4. *Neurosurgery:*

a. Qualified MCh in Neurosurgery or equivalent degree.
b. Well-equipped theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with Operating Microscope and Head Holding Frame (horseshoe, may field/sagittal or equivalent frame).
c. Post-operative ICU with ventilator support.
d. Facilitation for round-the-clock MRI, CT, and other support biochemical investigations.
e. Round-the-clock support services of a Neurologist/Physician.

4.3.2.5. *Neonatology:*

a. Qualification - MD in Paediatrics or equivalent degree.
b. Neonatal ICU (NICU) adequately equipped with functional ventilators, phototherapy units, incubators, nebulisers, pulse oximeters, multipara monitors, resuscitation trolleys, isolation area and other essential equipment.
c. Round-the-clock services of Paediatrician(s).
d. Round-the-clock support services of radiology labs, serology labs and blood banks.
e. Mother rooms with feeding area.
f. Trained Support Staff

4.3.2.6. *Cancer Care:*

a. Qualification - DM in Medical Oncology, MD in Radiation Oncology, MCh in Surgical Oncology or equivalent degree.
b. In-house Tumour Board or established links to nearest RCC.
c. Established guidelines for evaluating and re-treating relapses.
d. Appropriate infrastructure for Radiotherapy, SRS/SRT, treatment planning, and dosimetry systems.

4.3.2.7. *Paediatric* Surgery:

a. Qualification – MCh in Paediatric Surgery or equivalent degree.
b. Well-equipped OT with ventilator support.
c. Paediatric and Neonatal ICU.
d. Round-the-clock support services of paediatrician.
e. Round-the-clock support services of radiology labs, serology labs and blood banks.
f. Availability of mother rooms and feeding area.

4.3.2.8. *Nephrology and Urology:*

a. Fully equipped and staffed dialysis unit.
b. Well-equipped OT with C-ARM unit.
c. ICU with ventilator support and dialysis portal.
d. Availability of DTPA scan and Endoscopy support.
e. Availability of lithotripsy equipment.

4.3.3. SPECIFIC CRITERIA FOR STAND-ALONE DIALYSIS CENTRES

4.3.3.1. The Medical institutions seeking to be empanelled under "Dialysis Single Speciality Hospital" should be a separate physical and legal entity and not be attached to or a part of any other multispecialty hospital or medical college. A Self-declaration format is detailed in Annexure - II, and the stand-alone dialysis centres must submit a duly signed and scanned copy of the same on the institute's letterhead at the time of application submission.

4.3.3.2. An empanelled hospital that has partnered with a dialysis centre (outsourced or PPP model) can seek empanelment under BSKY. The outsourced dialysis centre must be a separate parent company and legal entity, and a self-declaration form, as detailed in Annexure - III, must be submitted by the facility on the institute's letterhead at the time of application or enhancement.

4.3.3.3. The stand-alone dialysis centres shall be registered under the Nursing Home Act or Medical Establishment Act and have necessary licences like:

a. NOC from Fire Department.
b. Ambulance - Commercial Vehicle Permit, Commercial Driver License, Pollution Control Licenses.
c. DG Set Approval for Commissioning.
d. Diesel Storage Licenses.
e. Medical Gases Licenses / Explosives Act.
f. Clinical Establishments Act Registration (if applicable).
g. MoU / agreement with outsourced services (e.g., human resource agencies as per labour laws, security services, housekeeping services, canteen facilities, pharmacy etc.).
h. MoU with Multispecialty Hospitals for Emergencies.
i. Blood banks License/ MoU with registered blood banks.

4.3.3.4. Space and Facility Requirements:

a. *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 70-72°F (21.1-22.2°C) temperature and 55 to 60% humidity.
   vi. Patients with viral diseases such as HIV, HBV, and HCV should be separated from those without viral infections, and separate, dedicated machines shall be allotted to such patients.
   vii. Facilities for hand washing/hand rub; sterillium or alcohol-based hand rub/sterilant dispensers must be available in each patient area.

b. *Machinery / Physical facilities:*
    i. Minimum 5 dialysis units should be available to empanel any centre. However, depending on the requirement and situation in the state, the SHA may change the criteria by recording reasons in writing.
    ii. All precautions to prevent infection, including HIV, HBV, and HCV, should be taken.

c. *Preparation, Storage, and Work Area:*
    i. Independent area for reprocessing the dialysers.
    ii. Two storage areas, one for storage of new supplies and one for reprocessed dialysers.

d. Consultation room for the Doctor in charge of the unit.

e. Office area for nurses and technicians.

f. Storage facility for individual patients' belongings.

g. Space for a water treatment unit.

h. Patient and Patient attendant waiting area.

4.3.3.5. Manpower Requirements:

a. *Qualified Nephrologist* having DM or DNB in nephrology or MD/DNB Medicine with two years of training in Nephrology from a recognised centre on a Full-time or Part-time basis, performing the clinical review of all patients.

b. *Dialysis doctor* (at least one doctor per shift for a maximum of 10 machines)
    i. M.B.B.S. with valid registration in each shift.
    ii. One-year clinical experience post-registration.
    iii. Certified in advanced cardiac life support (ACLS).
    iv. Experience in central line placement.
    v. Experience in critical care management.
    vi. To be trained under the care of a nephrologist for six months or more.
    vii. To report to a nephrologist in the same institute or, in the case of a stand-alone unit, to the visiting nephrologist from the nearest facility.

c. *Dialysis Technician* (Full-time)
    i. One year or longer certificate course in dialysis technology (after high school) certified by a government authority or medical technician with verifiable hands-on experience in dialysis care.
    ii. One technician for every three machines and one dedicated to a dialysis machine for patients with blood-borne infections per shift.

d. *Dialysis nurses* (Full-time)
    i. The centre shall have qualified and trained nursing staff as per the service scope. The nursing care shall be provided as per the requirements of professional and regulatory bodies.
    ii. One nurse for every three machines and one nurse dedicated to a dialysis machine for patients with blood-borne infections per shift.

e. *Dialysis attendants* (Full-time)
    i. One attendant for every five machines per shift.

f. Dietician (Optional)

g. Social worker (Optional)

h. *Housekeeping service* (Full-time)
    i. One personnel for every five machines per shift.

4.3.3.6. Equipment Requirements:

a. Emergency Equipment:
    i. Resuscitation equipment including laryngoscope, endotracheal tubes, suction equipment, xylocaine spray, oropharyngeal and nasopharyngeal airways, Ambu Bag (Adult & Paediatric) (neonatal if indicated).
    ii. Oxygen cylinders with flow meter, tubing, catheter, face mask, and nasal prongs.
    iii. Suction Apparatus.
    iv. Defibrillator with accessories.
    v. Equipment for dressing, bandaging, and suturing.
    vi. Basic diagnostic equipment such as Blood Pressure Apparatus, Stethoscope, weighing machine, and thermometer.
    vii. ECG Machine.
    viii. Pulse Oximeter.
    ix. Nebuliser with accessories.

b. Other Equipment for Regular use:
    i. Stethoscope.
    ii. Sphygmomanometer.
    iii. Examination light.
    iv. Oxygen unit with gauge.
    v. Minor surgical instrument set.
    vi. Instrument table.
    vii. Gooseneck lamp.
    viii. Standby rechargeable light.
    ix. ECG machine.
    x. Suction machine.
    xi. Defibrillator with cardiac monitor.
    xii. Stretcher.

xiii. Wheelchair.
xiv. Haemodialysis Equipment.
xv. Haemodialysis Set.
xvi. Monitor.
xvii. Pulse Oximeter.

c. *Machine and Dialyser:*
   i. Haemodialysis machines.
   ii. Peritoneal Dialysis machine (optional).
   iii. CRRT machine (optional).
   iv. Dialysers.

d. *RO PLANT Water Plant / Reverse Osmosis (RO) System Components:*
   i. Feed water temperature control.
   ii. Backflow preventer.
   iii. Multimedia depth filter.
   iv. Water softener.
   v. Brine tank.
   vi. Ultraviolet irradiator (optional).
   vii. Carbon filter tanks.

4.3.3.7. Medical Records Requirements:

a. *Patient Care*
   i. Dialysis Charts.
   ii. Standing order for haemodialysis by a nephrologist – updated quarterly.
   iii. Physician's order.
   iv. Complete and duly signed consent forms.
   v. Standing order for medications.
   vi. Laboratory results.
   vii. History and physical examination.
   viii. Complication list.
   ix. Transfer/referral slip (for patients that will be transferred or referred to another health facility).

b. *Incident and Accident (In logbooks)*
   i. Complications related to dialysis procedure.
   ii. Complications related to vascular access.
   iii. Complications related to disease process.
   iv. Dialysis adequacy of patients on thrice weekly treatments outcomes.
   v. Staff/patient's hepatitis status.

c. *Staff and patient vaccination and antibody titre status as applicable*
   i. Hepatitis B (double dose) – 0,1,2,6 months.
   ii. Influenza – annually.
   iii. Pneumococcal – every five years.

d. *Water Treatment*
    i. Bacteriological.
    ii. Endotoxin.
    iii. Chemical.

e. *Facility and equipment maintenance schedule*
    iv. Preventive maintenance.
    v. Corrective measures.

5. INSTITUTIONAL STRUCTURES AT STATE

5.1. STATE EMPANELMENT COMMITTEE (SEC) - STRUCTURE AND ROLE

5.1.1. The State Empanelment Committee (SEC) is established at the state level to oversee the empanelment process and conduct disciplinary proceedings against fraudulent healthcare service providers who are empanelled under BSKY. The SEC will supervise the activities of the District Empanelment Committee (DEC), ensuring efficient and prompt empanelment of healthcare service providers and addressing issues related to the rejection or pending hospital applications at the SHAS.

Sl. No.	*Members*	*Designation*
1.	Joint CEO, SHAS	Chair
2.	Medical Director - SHAS	Co-Chair
3.	SAFU - Lead	Member
4.	Representative nominated by DHS	Member
5.	Representative nominated by DME	Member

Table 02: Composition of SEC

5.2. DISTRICT EMPANELMENT COMMITTEE (DEC) - STRUCTURE AND ROLE

5.2.1. The DEC is established at the district level to assist SEC and SHAS in the empanelment process and disciplinary proceedings of healthcare providers within the district. The responsibility of the DEC include:

i. Thorough validation and scrutiny of certifications and licenses to ascertain legal requirements and conduct on-site assessments of hospitals to ensure alignment with the minimum empanelment criteria during empanelment and inquiry of infrastructure-related complaints.

ii. Prepare and submit verification reports to the SEC or SHAS with recommendations to approve or reject empanelment applications, with valid reasons for rejection.

iii. Recommend any relaxation in empanelment criteria, when warranted, with rationale for such recommendations.

Sl. No.	*Members*	*Designation*
1.	District Chief Medical Officer	Chair
2.	SND assigned to the district	Co-Chair
3.	District Coordinator	Member
4.	District Vigilance Officer	Member

Table 03: Composition of DEC

5.3. OUTSIDE STATE EMPANELMENT COMMITTEE (OSEC) – STRUCTURE AND ROLE

5.3.1. The OSEC is established at the state level to perform roles similar to those of the DEC to assist SEC and SHAS in the empanelment process and disciplinary proceedings of healthcare providers located outside the state. The responsibility of the OSEC is similar to the functions of the DEC.

Sl. No.	*Members*	*Designation*
1.	SND assigned by SHAS	Chair
2.	State Quality Coordinator, SHAS	Co-Chair
3.	District Vigilance Officer assigned by SHAS	Member

Table 04: Composition of OSEC

6. EMPANELMENT OF HEALTHCARE PROVIDERS

6.1. APPLICATION and REGISTRATION on the PORTAL

6.1.1. Healthcare providers seeking empanelment under the BSKY scheme need to complete the registration process on the Hospital Empanelment Module (HEM), a web-based platform accessible at https://bsky.odisha.gov.in. The initial step for empanelment is to submit an application through this portal.

6.1.2. To create an account on the HEM portal, healthcare providers need to register themselves in the portal by furnishing essential information. After completing the registration process, the hospitals will receive a unique Hospital Reference Number and password in the registered mobile number. With these credentials, hospitals can log into the HEM portal and fill out the detailed application form for empanelment.

6.1.3. After the healthcare provider submits the detailed application for empanelment, SHAS will undertake the verification and approval process. However, only those healthcare providers that have been registered as establishments under the relevant state acts will be eligible for empanelment. The verification process may involve one or more of the following methods:

6.2. VERIFICATION OF THE HOSPITAL APPLICATION

6.2.1. Healthcare Providers Within the State

6.2.1.1. DEC is responsible for scrutinising applications within 15 working days of receipt of an application. SHAS provides a dedicated login account to the concerned DECs for downloading applications and uploading inspection reports.

6.2.1.2. The DEC will conduct an initial desktop verification of the uploaded documents for completeness. In case any discrepancies or inadequacies are found, the application will be returned for rectification.

6.2.1.3. Upon completion of the desktop verification, the DEC will perform a physical inspection of the hospital premises to verify the accuracy of the information provided in the empanelment application. The areas of scrutiny include, but are not limited to, the hospital's infrastructure, human resources, service availability, and adherence to quality standards. The DEC will ensure that the hospital has applied for empanelment under all the available specialities in the facility.

6.2.1.4. If a hospital is found to have not applied for certain available specialities during the inspection, the DEC will instruct the hospital to rectify the issue by applying for the missing specialities within 15 working days from the date of inspection. The hospital must then modify its application on the HEM portal to include these specialities and resubmit for verification. Failure to comply may result in disqualification.

6.2.1.5. While partial speciality empanelment is generally not permitted, exceptions for certain tertiary care specialities such as Paediatric Oncology, Paediatric Surgery, Radiation Oncology, Medical Oncology, Surgical Oncology, Neurosurgery, Neonatology, Burns Management, Plastic and Reconstructive Surgery, Cardiology, and Interventional Radiology may be granted on a case-by-case basis by the SHAS. This is to ensure that BSKY beneficiaries have access to speciality services that are currently unavailable.

6.2.1.6. If during the inspection it is discovered that a facility that has applied under the category of 'Stand Alone Dialysis Centre' is, in fact, operating as a multi-speciality facility, its application will be rejected, and a Show Cause Notice (SCN) will be issued to the hospital for deliberately providing misleading or fraudulent information. However, this does not apply to hospitals with a dialysis centre under a partnership model (either outsourced or through a Public-Private Partnership), provided that the dialysis centre is managed by a distinct legal entity or a separate parent company and the associated hospital is not empanelled under the BSKY scheme.

6.2.1.7. If during the inspection, it is discovered that the hospital has applied for multiple specialities, but all do not meet the minimum requirements under BSKY; the hospital will only be empanelled for the specialities that comply with BSKY norms.

6.2.1.8. Upon receiving an application request, the DEC will carry out an inspection and submit the final report to the SEC within 15 working days. The report will be uploaded through the portal login assigned to the DEC. The DEC can exercise the following options while forwarding the case to the SEC:

i. *Recommend Approval:* If the hospital meets all minimum criteria, the DEC will forward a recommendation for approving the empanelment to the SEC, accompanied by a detailed report of their findings.

ii. *Recommend Relaxation and Approval:* To ensure a sufficient number of empanelled facilities in the district, the DEC can recommend necessary relaxations in the empanelment criteria (while adhering to the minimum required standards). All such relaxations need to be documented with their explicit rationale and must be approved by the SEC and SHAS.

iii. *Raise Clarification:* In cases where minor lacunae are identified, the DEC will notify the hospital to rectify them within 30 working days. During this period, the application status will be marked as 'Clarification Required', giving enough time for the hospital to rectify and upload the additional documents. The hospital will receive weekly automated reminders to submit the necessary rectifications and/or additional documentation. Failure to comply within the given timeframe will result in automatic rejection of the application. If the hospital rectifies the issues satisfactorily, the DEC may then proceed to recommend approval.

iv. *Recommend Rejection:* Applications that fail to meet the minimum standards or involve misrepresentation of information will be recommended for rejection. The SEC must review all such recommendations. Rejected applicants will be notified within 3 working days of the decision, including detailed reasons for the rejection. This information will also be accessible in the Hospital Empanelment Module

6.2.2. Healthcare Providers Outside the State:

6.2.2.1. NABH/JCI Accredited Healthcare Providers:

6.2.2.1.1. Healthcare providers outside the state that are NABH or JCI accredited can be auto-approved for empanelment under BSKY, provided they have successfully submitted their application through the web portal and meet the minimum criteria.

6.2.2.1.2. A system-based auto-verification will cross-check the provided credentials against the JCI/NABH database within 5 working days. Successful matching will result in auto-approval at the DEC level, with the application then being forwarded to the SEC along with a notification to the DEC.

6.2.2.1.3. In cases where credentials do not match the JCI/NABH database, the DEC will undertake a desktop verification against the BSKY criteria, based on the submitted NABH/JCI certification. Following this verification, the DEC may either recommend approval, request additional documents/clarifications, or reject the application within 5 working days. The case will subsequently be sent to the SEC for the final decision.

6.2.2.2. Non-NABH/JCI Accredited Healthcare Providers:

6.2.2.2.1. Healthcare providers outside the state, not accredited by JCI/NABH, seeking empanelment under BSKY, must submit their applications via the online portal, including video/geotagged photos. The OSEC will initially perform a desktop-based verification against BSKY empanelment criteria.

6.2.2.2.2. Following desktop verification, the OSEC or officials designated by SHAS will conduct physical verification of the facility. Based on these verifications, OSEC may recommend approval, request further clarification/additional documents, or reject the application within 30 working days. The case will subsequently be sent to the SEC for the final decision.

6.2.3. Fast Track Empanelment with Physical Verification Within 3 Months:

6.2.3.1. Under certain exceptional circumstances, the SEC is authorized to approve empanelment applications for BSKY without prior verification. This may apply to districts with a scarcity of empanelled hospitals, areas lacking specific specialities, or any other exceptional situations as determined by the SHAS. The SHAS must comprehensively document the rationale for utilising this fast-track option.

6.2.3.2. The SHAS is responsible for ensuring a comprehensive physical verification for all hospitals empanelled through the fast-track process. This verification must be conducted either by the DEC, OSEC or by an official(s) nominated by SHAS within 6 weeks following the approval of their application.

6.2.3.3. In instances where physical verification is performed by a SHAS-nominated nodal officer, it is mandatory to capture and upload timestamped video footage and geotagged photographs of the healthcare provider's facilities. These should be systematically recorded and stored in the HEM portal.

6.3. DECISION ON HOSPITAL APPLICATIONS

6.3.1. The SEC will meticulously review reports submitted by the DEC/OSEC and consider their recommendations to approve or reject the hospital application.

6.3.2. Applications approved for empanelment will be promptly updated on the BSKY portal. The healthcare provider will be informed of the approval via SMS and email within 3 working days of the decision.

6.3.3. The SEC will also evaluate and decide on DEC's recommendations for relaxation on empanelment criteria, considering the local healthcare needs and maintaining a balance between quality of care and healthcare accessibility.

6.3.4. If an empanelment application is rejected, the SEC will provide detailed reasons for the rejection. These reasons, along with the decision, will be updated in the BSKY portal within 3 working days of the decision.

6.3.5. The final decision by the SEC on empanelment under BSKY should be completed within 30 working days of receiving the application.

6.3.6. If the DEC, OSEC, or SEC fail to act within the stipulated timeframe, an alert will be sent to the SHAS for necessary action.

6.3.7. There are no restrictions on the number of healthcare providers that can be empanelled under the BSKY scheme in any district or state.

6.3.8. If a hospital is discovered to have been inappropriately empanelled (due to not meeting minimum criteria or involvement in misconduct or fraudulent activities), the empanelment will be revoked, and disciplinary actions may be considered, if necessary.

6.3.9. Hospitals that have been blacklisted or de-empanelled can reapply after the completion of the specified period or upon revocation of such orders, assuming they have fulfilled all corrective measures directed by the SHAS.

6.3.10. The final authority for approval or rejection of hospital empanelment lies with the SHAS.

6.3.11. Healthcare providers have the right to appeal the rejection of the empanelment application. If the empanelment application is rejected, the hospital may seek review with SHAS within 15 working days from the date of rejection.

6.3.12. Hospitals wishing to withdraw the BSKY network must provide a 30-day advance notice to SHAS. They are allowed to withdraw after serving the notice period, provided their withdrawal wasn't due to punitive action by government entities, including BSKY. Such hospitals will only be permitted to reapply for empanelment after one year.

6.4. ON-BOARDING PROCESSES AFTER APPROVAL

6.4.1. Upon approval of the empanelment application, each healthcare provider will be issued a unique hospital registration number through the portal. SHAS will ensure that the status of the application is promptly updated on the BSKY portal and notify the healthcare provider via email and SMS within three working days.

6.4.2. SHAS and the healthcare service provider will sign an MoU within 15 working days of updating the decision on the portal. A prefilled contract copies as per the defined of 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 the hospital and physically signed with two original copies (one for each party). A copy of the signed contract will be uploaded on the HEM portal within 3 working days of signing.

6.4.3. A Memorandum of Understanding (MoU) will be signed between SHAS and the healthcare provider within 15 working days of updating the decision on the portal. The system will generate prefilled contract copies as per the defined MoU for the healthcare provider. The hospital must print the contract on a non-judicial stamp paper of INR 100 value and sign it physically with two original copies (one for each party). A copy of the signed contract must be uploaded on the HEM portal within 3 working days of signing.

6.4.4. Following empanelment, user admin credentials will be issued to the provider. Healthcare providers are required to appoint a Medical Coordinator as the primary contact for the scheme. A Medical Coordinator is a designated doctor within the hospital who will assist with pre-authorisation and claim submission processes. They will be responsible for addressing any deficiencies and coordinating the necessary and appropriate treatment for beneficiaries. They will be the point of contact between the hospital and SHAS, ensuring compliance with regulatory requirements.

6.4.5. SHAS will assign Swasthya Mithras to each hospital empanelled under the BSKY scheme. They will act as facilitators for beneficiaries, serving as the primary point of contact and ensuring that all beneficiary interactions are managed effectively. They are responsible for addressing patient inquiries in a professional and timely manner, and work in close coordination with hospital staff to guarantee that beneficiaries receive the necessary care and attention. Hospitals are required to provide a substantial kiosk for Swasthya Mithras with BSKY branding and located in a prominent and easily visible area, preferably near the hospital reception.

6.4.6. Upon the signing of the MoU, SHAS will facilitate the auto generation of Transaction Management System (TMS) login credentials within 7 working days. Access to training videos will be provided concurrently.

6.4.7. SHAS will ensure that training on various systems and processes like Beneficiary Identification, TMS, HBPs, STGs, and claim settlement processes is provided within 15 working days of signing the MoU.

6.4.8. Hospitals are required to regularly update any changes in their basic information, infrastructure, or manpower in the HEM portal. In the absence of any changes, a 'Nil' change update should be recorded in the HEM portal at the end of each month.

7. DISCIPLINARY PROCEEDINGS AND DE-EMPANELMENT OF EHCPs

7.1. RATIONALE for DISCIPLINARY PROCEEDINGS and DE-EMPANELMENT

7.1.1. Disciplinary proceedings or De-empanelment may be instigated against an EHCP participating in the scheme if they fail to uphold the minimum empanelment criteria or engage in misconduct during patient care. The primary objectives of the SHAS are to expand the empanelment network, guarantee high-quality care to beneficiaries, and prevent fraudulent activities that could tarnish the scheme's reputation. Disciplinary procedures and de-empanelment processes serve as deterrence and control mechanisms within the scheme, ensuring the consistent delivery of medically appropriate, quality care to beneficiaries while mitigating wasteful and preventable expenditures.

7.2. PROCESS for DISCIPLINARY PROCEEDINGS and DE-EMPANELMENT

7.2.1. INVESTIGATION OF SUSPECT CLAIMS / HOSPITALS

7.2.1.1. As part of their responsibilities, the SHAS, SAFU, or their authorised representatives will conduct ongoing analytics to detect outlier or potentially suspicious EHCPs. Suspicious hospitals are also detected through desk and field audits conducted by the SAFU. Furthermore, any grievances or complaints by patients or third parties concerning an EHCP may prompt the SHAS or SAFU to initiate the audit.

7.2.1.2. The transaction data of such EHCPs shall undergo analysis for pattern, trend, and anomaly detection. If high-risk suspect cases are identified, a field medical audit may be conducted to gather and analyse evidence.

7.2.1.3. The investigation and subsequent submission of the report will be diligently carried out within ten working days of flagging a hospital. SAFU or DEC will make all efforts to close the case within the period mentioned above. In case of any delay, a report must be submitted to the SHAS Joint CEO, citing the reasons for the delay.

7.2.2. SHOW CAUSE NOTICE TO THE EHCP

7.2.2.1. Upon receiving an investigation report, if the SAFU or SEC observes that there is substantial evidence or reasonable suspicion of malpractice(s) by the EHCP, a formal Show Cause Notice (SCN) shall be promptly issued to the EHCP within 7 working days from the receipt of the investigation report. In case of any delay, a report citing the reasons for the delay shall be submitted to the SHAS Joint CEO.

7.2.2.2. The SCN sent to the EHCP shall explicitly mention that contacting the involved beneficiaries is prohibited, as it could lead to evidence tampering by the applicable laws. If evidence of tampering is identified, legal action may be pursued accordingly. The SCN will also explicitly mention the SAFU email address to which the EHCP is required to submit their response to the SCN.

7.2.2.3. The SCN shall be sent to the registered email address of the EHCP, provided during empanelment, or to the latest email address on record with the SHAS. Additionally, the hard copy of the SCN shall be dispatched via speed post or hand-delivered by the District Coordinator to the notified address of the EHCP. The SAFU shall securely maintain proof of receipt of the SCN by EHCP, either in the form of the registered speed post receipt or an acknowledgement of hand delivery, as evidence.

7.2.2.4. The EHCP shall, within a period of 5 working days from the date of receipt, provide a response to the SCN. This response shall be sent to the SAFU at the email address specified in the SCN letter, and the hard copy of the response shall be dispatched to the return address indicated in the registered post. The response must be supported by evidence collected in accordance with the applicable laws of India.

7.2.2.5. If the response to the SCN received from the EHCP is deemed satisfactory, their operations shall continue without disruption. However, if the response is found unsatisfactory, the SAFU may request further information or evidence via email. The EHCP shall provide the requested documents or information within 3 working days through email.

7.2.2.6. If the response to SCN is not received within 5 working days, or if additional information is not received within 3 working days, it will be deemed that the EHCP has not been compliant. Failure to comply will result in the temporary suspension of the EHCP for a specified period not exceeding 6 months until a decision is reached in the ongoing proceedings.

7.2.2.7. Once suspended, the EHCP will not be permitted to initiate new preauthorisations. However, treatment of the existing patients admitted under the scheme will continue uninterrupted until their discharge. The notice of suspension will be sent via email, and the hard copy will be dispatched through registered speed post. All efforts will be made to convey this notice within 3 working days of the decision. In case of any delay, a report citing the reasons for the delay shall be submitted to the SHAS Joint CEO.

7.2.2.8. In the absence of documented evidence confirming the receipt of the SCN by the EHCP and the EHCP disputes having received the SCN, the SAFU may resent the notice, either through physical delivery or via email, and obtain an acknowledgement of receipt. The EHCP will then be required to furnish a response within 3 working days from the date of SCN receipt.

7.2.2.9. To ensure uninterrupted services, beneficiaries requiring continued care beyond the scope of current pre-authorisation must be referred to the nearest EHCP that offers the required services.

7.2.2.10. If the specified timelines are not adhered to, either party retains the right to seek resolution through the SHAS competent authority by submitting a grievance.

7.2.3. DETAILED INVESTIGATION OF EHCP:

7.2.3.1. In cases where the EHCP is suspended due to the reasons mentioned above or when a beneficiary or third party lodges a serious complaint, a detailed investigation of the hospital will be carried out. The detailed investigation may include an on-site audit of the EHCP, examination of case records, interview beneficiaries (if necessary), and review of hospital records.

7.2.3.2. SAFU will make every effort to complete the investigation and submit the investigation report within 10 working days of issuing the SCN. In case of any delay, a report citing the reasons for the delay shall be submitted to the SHAS Joint CEO.

7.2.3.3. All statements provided by the beneficiaries will be documented in writing in the language known to the beneficiary. It shall be ensured that the statement is read out to the beneficiary for validation. Beneficiaries will be required to attest to their statement via their signature or thumb impression. In cases where possible, a video recording will be made with consent, and a copy of the beneficiary's photo ID will be retained for use as evidence.

7.2.3.4. If the detailed investigation reveals that the report, complaint, or allegation against the EHCP lacks validity and no malpractices are detected, the suspension shall be revoked, and normal operations will resume. The SAFU will attempt to revoke the suspension within 5 working days of submitting the investigation report. In case of any delay, a report citing the reasons for the delay shall be submitted to the SHAS Joint CEO.

7.2.3.5. If the detailed investigation substantiates the suspicion or alleged misconduct on the part of the EHCP, and additional instances of wrongdoing are identified, the SAFU may recommend suspension for a defined period, not exceeding 6 months.

7.2.3.6. In case the original suspicions or alleged misconduct on the part of the EHCP are found to be invalid, but further malpractices are identified during the detailed investigation, a new SCN shall be issued to the EHCP. SAFU will make all efforts to issue the SCN within 7 working days of identifying such malpractices. The EHCP will be granted no more than 5 working days to respond, and a similar investigation shall be pursued if required.

7.2.4. SUSPENSION OF THE EHCP:

7.2.4.1. *Suspension Following SCN:* In cases where sufficient evidence of malpractices exists, and the EHCP is unable to provide satisfactory justification, the SAFU may suspend the EHCP for a specified period, not exceeding a period of 6 months.

7.2.4.2. *No Response to SCN:* If an EHCP fails to provide a response to the SCN within the stipulated time, the SAFU may suspend the EHCP for a specified time, not exceeding 6 months.

7.2.4.3. *Response During Suspension:* Should the EHCP submit a response to the SCN during the suspension period, the SAFU may review it, and if found satisfactory, the suspension may be revoked.

7.2.4.4. *Immediate Suspension with SCN:* If the SAFU finds undeniable evidence that the actions of the EHCP have or may cause grievous harm to a patient's health or life, the SAFU may immediately suspend the EHCP for a specified period, not exceeding 6 months. This suspension must be accompanied by a SCN, granting the EHCP 5 working days to respond. In such instances, the SAFU will share the notice, along with a comprehensive justification for the suspension, with the SHAS CEO and the Secretary of the Department of Health and Family Welfare. The SAFU will also conduct a thorough investigation, as outlined above, in these cases.

7.2.4.5. *Suspension Due to Non-Payment of Fine:* If a penalty is imposed on the EHCP for an offence, and the EHCP fails to remit the penalty amount within the stipulated timeframe, the SAFU may adjust the fine against any outstanding payments to the EHCP. If the outstanding amount remains unpaid even after the adjustment, a reminder may be sent to the EHCP. In the absence of a response, the SAFU may opt to suspend the EHCP until the outstanding amount is recovered.

7.2.4.6. In all the scenarios outlined above, the notification of suspension will be sent via email and dispatched through registered speed post. Every effort will be made to send the notifications within 3 working days of the decision. In case of any delay, a report citing the reasons for the delay shall be submitted to the SHAS Joint CEO.

7.2.4.7. After the EHCP is suspended (or de-empanelled), various scenarios shall be managed as outlined below:

i. *Suspicious Cases:* All the paid and unpaid cases flagged as suspicious by the IT system shall be promptly investigated within 15 working days of suspension/de-empanelment. These cases will be confirmed as fraudulent or non-fraudulent, and recovery shall be initiated for confirmed fraudulent cases that were already paid, and the unpaid fraudulent cases shall be rejected.

ii. *Non-Flagged Unpaid Claims:* At least 20% of such claims shall be audited (with a minimum of 10 cases and a maximum of 100 cases), and the settlement shall be based on audit findings. If any fraudulent claim(s) are identified during the audit, then 100% of the remaining unpaid cases will be

also audited. The audits shall be completed within 30 days of suspension/de-empanelment.

7.2.4.8. *Claims Adjudication:* Adjudication of all claims shall be done based on merit, in accordance with the package blocked and the documents submitted by EHCP, following the standard BSKY adjudication guidelines.

7.2.4.9. *Release of Payment:* SHAS will ensure that the payment of all outstanding claims is released only after the recoveries and penalties, as required, have been levied.

7.2.4.10. *Final Settlement Letter:* A final settlement letter clearly outlining the recoveries and/or penalties and their adjustment from pending claims will be issued to the suspended/de-empanelled EHCP.

7.2.4.11. *Legal Proceedings:* In situations where the matter of suspension or de-empanelment has been taken to court by the EHCP or is Sub-Judice (being studied by the court of law), the claims under the jurisdiction of the court shall not be subject to the aforementioned guidelines until the matter is concluded in the court of law. All other claims (not forming part of the court case) shall be managed in accordance with the above guidelines.

7.2.4.12. *Appeal Process:* The EHCP may file an appeal against suspension for review of the order along with the submission of necessary evidence and an undertaking to not engage in similar instances of malpractice(s). This appeal must be raised within 30 working days from the issue of the suspension order. The SHAS may decide to revoke the suspension after examining the evidence and the undertaking submitted by EHCP. If the EHCP is unable to refute the allegations with evidence, the SHAS will present the case to the SEC to initiate the de-empanelment proceedings against the EHCP.

7.2.5. PRESENTATION TO SEC AND DE-EMPANELMENT PROCEEDINGS:

7.2.5.1. The SAFU may commence the process of de-empanelment by presenting the case to the SEC after conducting the necessary disciplinary proceedings as previously outlined. The SEC shall convene within 30 working days or schedule an emergency meeting considering the extraordinary circumstances of the case at hand. All relevant documents, including the Detailed Investigation Report, shall be submitted to the SEC either upon the filing of the case or at least 10 working days prior to the meeting. The SEC must ensure that the EHCP has been issued a SCN seeking an explanation for the alleged malpractice. Both the SHAS and the EHCP shall be provided a fair opportunity to present their cases with necessary evidence during the meeting convened by the SEC.

7.2.5.2. If the SEC determines that the complaint or allegation against the EHCP is valid, it shall order the de-empanelment of the EHCP with appropriate legal advice and may impose additional disciplinary actions like penalties, FIR, etc., as it may deem appropriate.

7.2.5.3. Should the SEC 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 SHAS. The SEC shall provide clear justifications and reasons underlying the final decision.

7.2.5.4. All efforts shall be made to reach the final decision within 30 working days of the 1st SEC meeting. In case of any delay, a report citing the reasons for the delay shall be submitted to the SHAS CEO.

7.2.5.5. All efforts shall be made to execute any disciplinary proceedings as determined by the SEC within 30 working days of the decision taken. In case of any delay, a report citing the reasons for the delay shall be submitted to the Secretary of the Department of Health and Family Welfare.

7.2.5.6. If either party is dissatisfied with the SEC decision, they can escalate the matter to the SHAS Competent Authority for grievance redressal.

7.2.6. ACTIONS TO BE TAKEN AFTER DE-EMPANELMENT:

7.2.6.1. After a decision has been made to de-empanel a hospital, the notice for de-empanelment will be sent via email to the EHCP's registered email ID, and the hard copy of the notice will be dispatched to the EHCP's registered postal address within 3 working days. Once the EHCP is de-empanelled, new pre-authorisations will be disabled, and ongoing treatments or existing pre-authorisations must be completed.

7.2.6.2. The SEC can direct the SHAS to initiate legal actions against the EHCP, such as lodging an FIR, in cases where there is suspicion of criminal activity or to pursue other permissible legal actions under applicable laws of India.

7.2.6.3. When instances of professional misconduct and violation of medical ethics are confirmed, the SHAS shall notify the appropriate state medical professional bodies/councils with all the case details, including the treating doctor and the hospital involved. The State Medical Council shall assume responsibility and take appropriate measures as dictated by the Code of Medical Ethics Regulation, 2002, and/or applicable laws. This information will also be communicated to other insurance companies, the Employees' State Insurance Corporation (ESIC), the Central Government Health Scheme (CGHS), the Insurance Regulatory and Development Authority of India (IRDAI), and other relevant regulatory bodies.

7.2.6.4. A list of de-empanelled hospitals will be prominently displayed and readily accessible on the BSKY website to ensure beneficiary awareness. Additionally, local media may be employed to inform the public about entities found guilty of malpractice and the actions taken against such EHCPs engaging in malpractice.

7.2.6.5. De-empanelment will typically be for a period of 1 year unless otherwise specified. De-empanelled EHCPs cannot seek re-empanelment until the completion of 1 year from the date of de-empanelment. Such hospitals will not be permitted to change

their names and reapply, and local teams will keep a check on such practices. If the SHAS/SEC decides to re-empanel an EHCP within the 1-year timeframe, the rationale for the re-empanelment shall be documented.

7.2.6.6. In cases involving a hospital chain, only the specific branch will be de-empanelled, while the other hospitals may be permitted to operate as usual.

7.2.6.7. Depending on the severity of the offence, SEC may opt to de-empanel an EHCP for a period exceeding 1 year or may blacklist an EHCP. In such cases, the SHAS/SEC shall duly inform the Commissioner cum Secretary of the Department of Health and Family Welfare of their decision, along with a detailed explanation and justification for the same.

Sl. No.	*Action*	*TAT*
1.	Investigation of Suspect Claims	Within 10 working days of flagging the claims.
2.	Show Cause Notice Issuance	Within 7 working days of receipt of the investigation report.
3.	Response to Show Cause Notice by EHCP	Within 5 working days of receipt of Show Cause Notice.
4.	Clarification of the response from EHCP	Within 3 working days of raising the clarification.
5.	Detailed Investigation with submission of report	Within 10 working days of sending the Show Cause Notice.
6.	Response to Suspension by EHCP	Within 5 working days of receipt of Suspension Notice.
7.	File appeal against suspension	Within 30 working days of receipt of Suspension Notice.
8.	Final Action to De-empanel and/or Penalty	Within 30 working days of the 1st SEC meeting.

Table 05: Timeline for Disciplinary Proceedings and De-empanelment

7.2.7. GRADATION OF OFFENCES:

7.2.7.1. Based on the investigation report and/or field audits, the following gradation of penalties may be levied by the SEC. However, it should be noted that these penalties are intended as guiding principles rather than rigid mandates.

7.2.7.2. These recommended penalties serve as a framework, and the SEC possesses the discretion to impose more substantial or lesser penalties, depending upon factors such as the gravity, frequency, scale, and intentionality of the misconduct(s) assessed on a case-by-case basis. In cases where a hospital is found to be engaged in unethical practices or criminal malpractices, the SHAS may also initiate legal action.

Case Issue	First Offence	Second Offence	Third Offence
Cash Payments by Beneficiary.	Full refund and a penalty of 3 times the amount paid by the beneficiary. Penalty to be paid to SHAS within 7 working days of the receipt of notice. SHA shall thereafter transfer the amount charged in actual to the beneficiary within 7 working days.	In addition to the actions mentioned for the first offence, rejection of the claim and suspension of the hospital.	De-empanelment and/or Blacklisting.
Claiming for Services not provided.	Rejection of the claim and a penalty of 3 times the amount claimed. Penalty to be paid to SHAS within 7 working days of the receipt of notice.	Rejection of the claim and a penalty of 8 times the amount claimed. Penalty to be paid to SHAS within 7 working days of the receipt of notice. Suspension of the hospital.	De-empanelment and/or Blacklisting.
Up-coding / Unbundling / Unnecessary Procedures	Rejection of the claim and a penalty of 8 times the excess amount claimed. Penalty to be paid to SHAS within 7 working days of the receipt of notice.	Rejection of the claim and a penalty of 16 times the excess amount claimed. Penalty to be paid to SHAS within 7 working days of the receipt of notice. Suspension of the hospital.	De-empanelment and/or Blacklisting.
Claiming for Services provided to Non-BSKY Beneficiaries	Rejection of the claim and a penalty of 3 times the amount claimed. Penalty to be paid to SHAS within 7 working days of the receipt of notice.	Rejection of the claim and a penalty of 8 times the amount claimed. Penalty to be paid to SHAS within 7 working days of the receipt of notice. Suspension of the hospital.	De-empanelment and/or Blacklisting.
Non-adherence to BSKY minimum empanelment criteria and quality standards	**Minor Gaps:** SCN with a compliance period of 2 weeks for rectification and rejection of claims with identified gaps. **Major Gaps and Wilful suppression/misrepresentation of facts:** SCN with a compliance period of 2 weeks for rectification; suspension of the hospital if not rectified within 2 weeks. Rejection of claims with identified gaps and a penalty of 3 times the amount claimed. Penalty to be paid to SHAS within 7 working days of the receipt of notice. Suspension of services until rectification of gaps and validation by DEC.	A penalty of 5 times the claim amount of all the claims with identified gaps and suspension of the hospital until rectification of gaps and validation by DEC.	De-empanelment and/or Blacklisting; penalty of 5 times the claim amount of all the claims with identified gaps.

Table 06: Gradation of Offences by Empanelled Hospitals

ANNEXURE - I: GENERAL APPEARANCE AND UPKEEP

Facilities seeking empanelment under BSKY must maintain specific standards in their appearance, upkeep and preparedness for disasters and emergencies. Adherence to these standards is integral to ensuring safety, accessibility, and a conducive environment for patients and visitors alike. Below are the minimum infrastructure requirements that a hospital must maintain to qualify for empanelment under BSKY:

I. MAINTENANCE AND UPKEEP:

- Hospitals must implement systematic procedures for the periodic monitoring, maintenance, and upkeep of their infrastructure and facilities.
- The external and internal structures should be well-maintained and free from seepage, cracks, and broken window panes.
- All areas should be clear of outdated or unnecessary posters and hoardings.

II. WAYFINDING / SIGNAGE:

- Clear and adequate signage is required on main and connecting roads leading to the facility, with legible font visible from a distance.
- A prominently displayed board at the facility's front should state the facility's name in Odia, Hindi, and English.
- Essential contact information, including numbers for fire services, police, ambulance, blood banks, and referral centres, should be clearly visible.
- Display of visit schedules and the layout of the coverage area near the entrance is required.
- Safety, hazard, and caution signs must be prominently placed at relevant locations.
- Consideration of fluorescent fire exit plans and tactile pathways for the visually impaired and elderly is encouraged to enhance safety and accessibility.

III. ACCESSIBILITY AND SAFETY:

- The facility should have a boundary wall with adequate lighting for visibility from the approach road and to prevent the entry of stray animals.
- Floors must be anti-skid and non-slippery to ensure safety, particularly for disabled and elderly individuals.
- Provisions for easy access for disabled and elderly visitors are mandatory, ensuring inclusivity and ease of use.
- Facilities must ensure clear access for vehicles, especially ambulances.
- Designated parking areas should be reserved specifically for disabled individuals, elderly visitors, and ambulances, with clear 'no parking' signage for unauthorised vehicles.
- An area of 100m around the hospital should be defined as a “Silence Zone”, as per the Noise Pollution (Regulation & Control) Rules, 2000
- There should be a clear and separate entrance for the Emergency area, OPD area and the main entrance for other clinical services, including in-patient areas.

IV. GARDEN AND GREEN AREAS:

- The presence of gardens and green spaces is encouraged to foster a healing environment. These areas can significantly reduce stress, anxiety, and mental fatigue in patients and visitors.
- Facilities should strive to incorporate and maintain greenery and open spaces wherever feasible.

V. ENVIRONMENT-FRIENDLY FEATURES:

- Empanelled facilities should prioritise environmental sustainability and energy efficiency.
- Implementation of rainwater harvesting, the use of solar energy, and employing energy-efficient lighting and equipment are highly encouraged.

VI. DISABLED AND ELDERLY-FRIENDLY ACCESS:

- Infrastructure should be aligned with the 'Guidelines and Space Standards for Barrier-Free Built Environment for Disabled and Elderly Persons' issued by the Government of India.
- Compliance with the 'Persons with Disability Act' is mandatory.
- Existing facilities lacking these provisions should undergo necessary retrofitting.
- For visually impaired visitors, tactile signs with high contrast between letters and background are advised. Installation of tactile guiding blocks along accessible routes is recommended.
- The entire length of these routes should be free from obstacles like trees, poles, or uneven surfaces.
- Provision of ramps with railings for wheelchair and stretcher trolley access is essential wherever feasible.

VII. CIRCULATION AREAS, CORRIDORS, AND RAMPS:

- The flooring of circulation areas such as corridors, ramps, staircases, and other common spaces should be anti-skid and non-slippery. Patient & service lifts are preferred over ramps for buildings with vertical expansion. Ramps for patient movements from one floor to other are space occupying and costly whereas lifts can operate efficiently with little space. However if lifts are installed, alternative source of power needs to be ensured with maintenance facility for the lifts. The size of corridors, ramps, and stairs should be conducive for maneuverability of wheeled equipment. Ramps shall have a slope of 1:15 to 1:18 and should be checked for maneuverability.

VIII. DISASTER AND EMERGENCY PREPAREDNESS:

- *Resilience to Climatic and Environmental Changes:* Healthcare facilities must be equipped to remain resilient and functional during climatic changes, disasters, and unforeseen emergencies, including epidemics and pandemics.
- *Compliance with National Building Code (NBC) 2016:*
  - Hospitals located in seismic zones IV and V, as well as those in wind zones with basic wind speed 42 m/s or more, must adhere to the safety mechanisms prescribed in the NBC 2016.
  - Facilities not originally built considering the seismicity of their zones should plan and implement appropriate retrofitting measures.
- *Safer and Functional Hospital Initiative:*
  - Hospital structures must be fortified against extreme forces such as earthquakes, in alignment with the goal of maintaining 'safer and functional hospitals.'
  - Mitigation measures outlined in the NBC should be urgently undertaken by hospital authorities to enhance structural safety.

- *Post-Earthquake Inspection and Retrofitting:*
  - Post any damaging earthquake, competent licensed engineers should inspect healthcare facilities to assess damages to both Structural Elements (SEs) and Non-Structural Elements (NSEs).
  - Documentation of damages and recommendations for detailed studies and necessary retrofitting should be conducted.
- *Staff Training and Preparedness:* All staff members should receive training in disaster prevention and management, focusing on climate and environment-resilient features.
- Both structural and non-structural earthquake-proof measures, in accordance with State Government guidelines, should be implemented.
- Non-structural safety measures, such as securing shelves and equipment, are crucial.
- In flood-prone areas, structural adaptations like raised floors and sloping RCC roofs for rapid rainwater drainage should be incorporated.

IX. FIRE SAFETY:

- *Compliance with Guidelines:* Healthcare facilities must adhere to state and central government fire safety regulations, ensuring a fire-safe infrastructure.
- *Infrastructure Requirements:*
  - Open spaces around the facility should be available and unobstructed.
  - Clearly marked and well-illuminated fire exits, even during power outages.
  - Fire extinguishers must be easily accessible and in visible locations.
  - Fire exit doors should remain unlocked, be fire-resistant, and be equipped with a push bar system opening outside.
- *Fire Safety Equipment and Maintenance:*
  - Facilities must have functional fire detectors, extinguishers, sprinklers, and water connections.

- Periodic monitoring, audits, for fire safety including drills should mandatory organised and conducted.
- The facility should have an identified nodal officer for ensuring fire safety.

❖ *National Building Code (NBC) 2016 Compliance:*

- Hospitals must meet provisions in NBC 2016 (4.5.2-subdivision C-1) for fire emergencies.
- Fire detection and alarm systems, fire prevention, and training programs for isolation and evacuation must be in place.

❖ *Hospitals shall provision for two levels of safety within their premises:*

- **Comparative Safety:** Protection measures within the hospital when evacuation isn't feasible, including compartmentation, fire-resistant materials, and independent ventilation systems. Comparative Safety may be achieved through (a) Compartmentation, (b) Fire Resistant Walls integrated into the Flooring, (c) Fire Resistant Door of approved rating, (d) Corridor, Staircase, (e) Pressurised Shaft or naturally ventilated stair balconies, (f) Refuge Area, (g) Independent Ventilation System, (h) Fire Dampers, (i) Automatic Sprinkler System, (j) Automatic Detection System, (k) Manual Call Point, (l) First Aid, (m) Fire Fighting Appliances, (n) Fire Alarm System, (o) Alternate Power Supply, (p) Public Address System, (q) Signage, (r) Fire Exit Drills and Orders.
- **Ultimate Safety:** Complete evacuation measures, including assembly points outside the hospital. Ultimate Safety may be achieved through (a) Compartmentation, (b) Fire Resistant Door of approved rating, (c) Corridor, Staircase and Shaft, (d) Public Address System, (e) Signage, (f) Fire Drills and Orders.

❖ *Open Space Requirements:*

- Adequate open space for free movement of patients and emergency/fire vehicles.
- Clear access for firefighting vehicles, with the width of entrances not less than 4.5 meters with clear headroom of not less than 5 meters.
- The width of the access road shall be a minimum of 6 meters.
- A turning radius of 9 meters shall be provided for fire tender movement.
- The covering slab of storage/static water tank shall be able to withstand the total vehicular load of 45 tone equally divided as a four-point load (if the slab forms a part of path/driveway).
- The Setback area shall be a minimum 4.5 meters.
- The width of the main street on which the hospital building abuts shall not be less than 12 meters & when one end of that street shall join another street, the street shall not be less than 12 meter wide.
- The roads shall not be terminated in dead ends.
- Prohibition of using open space around the building for parking or other purposes.

❖ *Staff Instructions and Fire Incident Response:* All hospital staff should be familiar with the following:

- Locations of Manually Operated Electronic Fire Alarms (MOEFA) fire alarm boxes, extinguishers, hose-reels, nearest exits and assembly point.

- Reporting procedures for any safety hazards or malfunctions.
- Instructions and actions to be taken during a fire incident, including using fire alarms and extinguishers.

X. ELECTRIC POWER SUPPLY:

- *Reliable Electricity Supply:* Empanelled healthcare facilities must have access to a reliable and adequate electricity supply. Facilities should ensure an ample number of electric points at a safe height (< 1.5 m from the floor) for easy and safe connections.
- *Safety Precautions:* The use of explosion-proof plugs and sockets is crucial for safety against potential explosions.
- *Energy Efficiency:*
  - New electrical appliances should have a minimum 3-star rating from the Bureau of Energy Efficiency or an equivalent organization to minimize energy consumption.
  - Adoption of low-energy LED lighting or other energy-efficient lighting options is recommended to reduce indoor lighting costs.
- *Compliance to NBC 2016:*
  - Proper backup power/inverters to ensure uninterrupted services.
  - Two earthing connections at each electrical installation, with a preference for copper plate earthing.
  - Surge protection to handle voltage spikes should be appropriately rated for the equipment protected.
  - Accurate load calculations for electrical distribution, switchgear ratings, circuitry, and cabling.
  - Cabling and wiring size should be 1.5 times or more than the actual electrical load.
  - Adequate power backup from alternative sources like diesel generators or photovoltaics, synchronized with the primary source.
  - Provisions for uninterrupted power supply in critical areas.
  - Proper phase sequence for motorized loads and load monitoring to prevent overloading.
  - Power factor improvement for motorized and semiconductor devices.
  - Secure connections and joints with appropriate thimbling.
  - Regular load balancing and monitoring using measuring devices.
  - Strategic selection of locations for electrical installations.
  - Use of UPS with the proper rating for sensitive equipment to protect against voltage spikes and electrical noise.
- *Electrical Switch Room Requirements:*
  - The Electrical Switch Room should be housed in a dedicated, easily accessible room on the ground floor, adjacent to an external wall.
  - It should facilitate economic distribution of services and not obstruct adjacent spaces.
  - The main switchboard must be metal-clad cubicle design as per approved standards, with spare capacity and electronic surge protection on the mains.

- Regular electrical audits by qualified engineers are required to ensure safety and efficiency.

XI. ILLUMINATION:

- All illumination levels should adhere to the specifications prescribed by the Bureau of Indian Standards (BIS).

Sl. No.	*Department*	*Illumination (Lux)*
1.	Reception and Waiting Room	150
2.	General Wards	100
3.	Rooms	150
4.	General / Minor Operation Theaters	300
5.	OT Tables	Shadowless Lighting
6.	Laboratories	300
7.	Radiology	100
8.	Casualty and OPDs	150
9.	Stairs and Corridors	100
10.	Dispensaries/Medicine Store	300

XII. WATER SUPPLY:

- *24-Hour Piped Soft Water:* Facilities should have arrangements for round-the-clock piped soft water supply.
- *Water Storage:* An overhead water storage tank capable of storing at least a 3-day water requirement is necessary, along with appropriate pumping and boosting arrangements.
- *Water Sources and Treatment:* Water can be sourced from springs, wells, or boreholes but must be treated to potability standards before consumption. Untreated water can be used for non-potable purposes like gardening and toilet flushing.
- *Firefighting Water Supply:* Adequate water supply for firefighting purposes should be factored into the total water capacity planning for health facilities.

XIII. DRAINAGE AND SANITATION:

- *Compliance with Standards:* The construction and maintenance of drainage and sanitation systems, including wastewater, surface water, subsoil water, and sewerage, must comply with prescribed standards.
- *Urban Slum Areas:* In healthcare facilities located in urban slum areas, the availability of adequate drainage systems within and around the facility should be ensured.
- *Water Harvesting:* Given the challenges posed by climate change, the implementation of water harvesting techniques is recommended.

XIV. WASTE MANAGEMENT:

- *Bio-Medical Waste (BMW) Management:*
  - Healthcare facilities must ensure proper collection, transportation, treatment, and disposal of BMW as per the latest Bio-Medical Waste Management Rules.
  - A central waste collection room within the facility is required for storing BMW until collection.
  - Facilities must have dedicated biomedical waste disposal systems, including deep burial pits, septic tanks, and soaking pits.
  - Disposal of human anatomical waste, soiled waste, and biotechnology waste should occur within 48 hours.
- *Deep Burial Pits:*
  - Deep burial pits are mandated for facilities located more than 75 km from a common biomedical treatment plant, as per Biomedical Waste Management Rules & Guidelines 2016.
  - BMW must be decontaminated and shredded before disposal in these pits, with approval from the prescribed authority and adherence to Chapter-III Standards.
- *General Waste Management:*
  - General waste, not in contact with hazardous or infectious materials, should be managed as per Solid Waste Management Rules and Construction & Demolition Waste Management Rules.
- *Liquid Waste Management:*
  - Adequate attention is required for liquid waste management.
  - Smaller healthcare facilities should treat liquid waste and effluents on-site before disposal in the drainage system.
- *Other Wastes:*
  - Disposal of electronic equipment, used batteries, and radioactive wastes, not covered under biomedical wastes, should comply with E-Waste (Management) Rules, Batteries (Management & Handling) Rules, and Rules/Guidelines under the Atomic Energy Act.

XV. INFECTION PREVENTION & CONTROL:

- *Infrastructure Design:* The design of healthcare facilities should facilitate the practice of infection prevention and control measures. This includes architectural and spatial planning that allows for physical distancing, adequate handwashing stations, and areas for mask distribution and personal protective equipment (PPE) donning and doffing.
- *Waste Segregation:*
  - Color-coded bins are essential in every service area, including patient waiting areas, to ensure waste is segregated at the source.
  - This segregation is crucial for effective waste management and minimizing the risk of infection spread.
- *Infection Control Protocols:*

- Facilities should implement and strictly adhere to protocols for infection prevention, such as frequent sanitisation of surfaces, proper ventilation, and ensuring the availability of hand sanitisers.
- Staff training on infection control practices, including the correct use of PPE, is mandatory.

❖ *Patient and Staff Safety:*

- Measures should be in place to protect both patients and staff from potential infections.
- This includes clear signage for infection control practices, designated areas for screening and isolation as needed, and the availability of protective barriers where necessary.

XVI. INFRASTRUCTURE FOR CLINICAL SERVICES:

1. *Screening and Holding Area:* Healthcare facilities should have a designated space for preliminary screening for infectious symptoms before registration, which is especially crucial during epidemics and pandemics.

2. *Registration:* Healthcare facilities must have computerised registration systems for efficient patient management in the OPD.

3. *Waiting Area:* The area should offer adequate, space-efficient seating with clear signage prioritising elderly, pregnant women, disabled persons, children, and adolescents. It should cater to those using mobility aids and have an ambiance conducive to patient comfort. Essential amenities like fans, clean drinking water, and clean, gender-sensitive toilets are necessary. Desirable amenities include air-conditioning and informational displays.

4. *Consultation Room:* Consultation rooms need to be spacious enough for a table, chairs, and an examination table, ensuring patient confidentiality and dignity. They should be well-lit and ventilated with handwashing facilities and privacy curtains.

5. *Clinical Laboratory:* Laboratories must be equipped for all prescribed tests, which needs to be clearly displayed, have well-organised and designated areas, and maintain cleanliness and safety standards.

6. *Record Keeping:* Healthcare facilities should have an efficient and secure record management system in place for maintaining patient records and facility documentation, ideally through IT systems.

7. *Inpatient Wards:* Bed layout should be optimised for visibility and ventilation. Wards must have accessible toilets, appropriate security (like female guards for maternity wards), and essential rooms like procedure rooms, drug and linen stores, pantries, and housekeeping areas. Privacy for patients with changing rooms and personal storage facilities should be ensured. Wards should be equipped with call bells, and one-third of the beds should have emergency support facilities like oxygen, suction, multipara monitors, etc.

8. *Day Care Beds:* Healthcare facilities should have adequate infrastructure for day care beds is necessary for patients requiring extended medical supervision but not hospitalisation.

9. *Operation Theatre Complex:* The OT complex should be in a quiet, contamination-free area, with critical linkages to surgical wards, imaging, labs, and blood banks. Specialized services like medical gas supply, proper ventilation, and efficient lift services, if located on upper floors, should be ensured. Zoning for cleanliness, aseptic conditions, and well-managed traffic flow for patients, staff, and supplies must be available. The OT should maintain specific environmental standards and be equipped with necessary monitoring devices.

10. *Labour Room Complex:* Facilities should adopt the Labour, Delivery and Recovery (LDR) model, ensuring privacy, natural light, and a conducive environment for childbirth. It should be located near the obstetric OT and on the ground floor. The complex should include an examination room for initial assessment, doctors' duty room, nursing station, changing room, etc.

11. *Emergency Care:* The emergency wing requires easy accessibility, a distinct entry, and equipped with necessary medical equipment and resources. It should have a layout that facilitates efficient clinical management, with proper signage and proximity to essential services.

12. *Store:* The facility should have adequate and spacious stores located away from patient traffic with facility for storing drugs, consumables, records, linen, furniture, equipment, and sundry articles. Guidelines for safe disposal of expired drugs and vaccines should be adhered to. The store should have adequate space for keeping 5-7 days stock of drugs and linen.

13. *Oxygen Supply:* The COVID 19 pandemic has affected all level of care. Thus, oxygen support at empanelled facilities through cylinder or concentrator is essential to manage COVID or other patients requiring the support. However, care should be taken to store the cylinder/concentrator carefully as per GoI guidelines. Every facility must ensure 48 hours in house storage of oxygen with assured refilling at regular defined periodicity. There should be one flowmeter with pressure regulator per bed for oxygen supported beds.

ANNEXURE - II: SELF DECLARATION FOR STAND-ALONE DIALYSIS CENTRES

Every institution applying under the category of "Stand-Alone Dialysis Centre" must upload signed copy of the Self Declaration Document on its letterhead in the attachment section. The format for the same is as follows:

I, the undersigned, hereby declare that all the information submitted in the BSKY empanelment application form is factual and correct. I declare that we are a STAND-ALONE DIALYSIS CENTRE and that all supplementary details and attachments submitted to the State Health Assurance Society, which forms the written evidence, are a true and accurate representation of our service provision against the standards for BSKY empanelment, to the best of my knowledge.

Signature:

Designation:

Name of the Dialysis Centre:

Location:

Date:

ANNEXURE - III: SELF DECLARATION FOR OUTSOURCED DIALYSIS CENTRES

Every institution applying under the category of "Dialysis Centre affiliated with Hospital" (outsourced/PPD model) must upload signed copy of the Self Declaration Document on its letterhead in the attachment section. The format for the same is as follows:

I, the undersigned, hereby declare that the information submitted in the BSKY empanelment application form is factual and correct. I declare that we are a DIALYSIS CENTRE affiliated with the hospital but operates as a separate entity and having separate parent company, and all supplementary details and attachments submitted to the State Health Assurance Society, which forms the written evidence, are a true and accurate representation of our service provision against the standards for BSKY empanelment, to the best of my knowledge.

Signed:

Designation:

Name of the Dialysis Centre:

Name of the hospital affiliated with:

Location:

Date: