Public Private Partnership for Non-Communicable Diseases (NCDs) in District Hospitals

PPP Project Guidelines

CONTENT

Abbreviations

CGHS	Central Government Health Scheme
CHC	Community Health Center
CMC	Contracts Management Cell
COPD	Chronic Obstructive Pulmonary Disease
CSSD	Central Sterile Supply Department
GoI	Government of India
GRC	Grievance Redressal Cell
ICU	Intensive Care Unit
IPD	In-patient Department
KPIs	Key performance indicators
MoHFW	Ministry of Health and Family Welfare, Government of India
NCD	Non-Communicable Diseases
NGRO	Nodal Grievance Redressal Officer
NHPS	National Health Protection Scheme
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardio-Vascular Disease and Stroke
NSSO	National Survey Sample Organization
OPD	Out Patient Department
PHC	Primary Health Center
PPP	Public Private Partnership
PSC	Project Steering Committee
QA	Quality Assurance
RSBY	Rashtriya Swasthya Bima Yojana
SOP	Standard Operating Procedure
SPV	Special Purpose Vehicle
TOR	Terms of Reference
VGF	Viability Gap Funding

Definitions

Concessionaire	The Private Partner selected for design, rehabilitation, building, operating and managing the Project facility that is co-located in the District Hospital during the Term of the Concession.
District Hospital	District Hospital in which the Project is being co-located and implemented.
Project	PPP for Non-Communicable Diseases in District Hospitals.
Project Facility	Infrastructure that is expanded, upgraded and set up by the Private Partner exclusively for rendering services under the Project.
Project Site	Area within the boundaries of the District Hospital where the Project will be set up and implemented.
State Government	Government of the state in which the Project is being implemented.

1. Introduction

Sustainable Development Goal (SDG) 3 intends to "ensure healthy lives and promote well-being for all at all ages" and targets a one-third reduction in premature mortality from non-communicable diseases (NCDs) through prevention and treatment and promote mental health and well-being by 2030. The emergence of NCDs poses a renewed threat to the financial protection of the population, which is related not only to the high costs of treatment, but also compounded by the long duration of treatment for what are often chronic illnesses or long term disabilities.

The National Programme for Prevention and Control of Cancer, Diabetes, Cardio Vascular Disease and Stroke (NPCDCS), launched in October 2010, aims at institutionalizing the response to NCDs and supplementing state efforts through setting up of NCD Cells at the state level and integrating it within the National Health Mission (NHM) framework. Over the years, services under the NPCDCS has gradually expanded. Attendance at NCD clinics witnessed a 118 percent year-on-year increase from 2014-15 (59.24 lakhs) to 2015-16 (129 lakhs) (MoHFW, 2016). State NCD Cells have been set up in 36 states and Union Territories, 322 districts in the country already have District NCD Cells and 318 of them have NCD Clinics. There are 1705 NCD clinics at the CHC level and 221 Intensive Care Unit (ICU)/ Intensive Care Unit (ICCU) have been set up (Ministry of Health and Family Welfare, Government of India).

Challenges

Despite concerted efforts at the national and state levels over the last few years in establishing the NCD service delivery network, the system continues to remain constrained with a set of systemic issues. Constrained fiscal space within states to provide increased allocations for NCDs, large infrastructure gaps, especially in rural areas, and significant gaps in human resources, especially at the level of specialists are the key challenges. Shortage of infrastructure and human resources for health has led to 72 percent of the population in rural areas and 79 percent in urban areas to seek healthcare in the private sector[1]. This has exacerbated the situation demanding a multi-pronged response from the Government to augment its NCD response capacity, especially at the secondary levels to decongest tertiary facilities at the state level and expand access to secondary and basic tertiary level services at the district level.

Addressing the challenges

Continuing with its efforts to strengthen the national response to NCDs and addressing the gaps referred to above, the GoI is providing technical and financial support to the states. It is also exploring options of leveraging the strengths of the private health sector to infuse greater efficiencies and resources for strengthening its response to NCDs. Innovative options of engaging with the private sector may enable access to NCD services at the government hospitals delivered by the private partner to augment the gap in the operational capacity to deliver NCD services, while continuing to strengthen the capacity and response of the public health system.

[1] NSSO. Key Indicators of Social Consumption in India - Health: NSS 71st Round, June 2014: MInistry of Statistics and Plan Implementation, Government of India.

NITI Aayog, GoI's premier "think-tank" is mandated to provide the Centre and states with strategic and technical advice on evidence-based policy-making in various sectors including health. In line with this mandate, NITI Aayog is collaborating with the Ministry of Health and Family Welfare (MoHFW), Government of India and exploring opportunities to enhance private sector engagement through public-private partnerships for addressing the growing burden of NCDs in the country. The World Bank has been appointed to provide technical assistance for development of the PPP model and a draft model concession agreement for engaging with the private sector. It is envisaged that the draft model concession agreement will be finalized based on the pilot in select district hospitals in one or two states.

To address some of these challenges, the Government of India is launching a framework for 'Public Private Partnerships for Non-Communicable Diseases in District Hospitals' (the Project).

2. Objective of the Project

To improve access to quality screening, diagnostic and treatment services related to cardiology, oncology and pulmonology in district hospitals through public private partnerships.

It is expected that the Project will contribute towards:

a. improving access to the above NCD services at the district level and also decongesting tertiary facilities at the state level;
b. reducing out-of-pocket expenditures on diagnosis, treatment and care; and
c. creating infrastructure and augmenting capacity at district hospitals to provide at least basic tertiary care and advanced secondary care related to the three NCD specialties (cardiology, oncology and pulmonology) in the medium and long term.

3. Intended beneficiaries and their identification

3.1 NCD services under the Project will be accessible to everybody. For the purpose of this Project, the patients can fall under two categories:

a. Patients referred by the Government:

'Patients referred by the Government' will be those patients who are identified by the State Government and authorised by it to receive cashless NCD services under this Project and on whose behalf the State Government will reimburse the Private Partner at agreed rates. Prior authorization for such patients will be done by the designated government official of the District Hospital. This category will also include patients enrolled under any central or state government health insurance scheme.

b. Self-paying patients:

All other patients can receive services under the Project against payments at the agreed rates and all such patients will be referred to as 'self-paying patients'.

3.2 Pre-authorisation for patients referred by the State Government in states where the proposed National Health Protection Project (NHPS) / Rashtriya Swasthya Bima Yojana (RSBY) or any similar State Government Health Insurance Project is being implemented, will be issued following the mechanisms of pre-authorisation already in place under such Project(s) in that state.

4. Considerations for selection of district hospital

4.1 Depending on the current availability of the services, disease profile of the population, anticipated client load in the catchment area, the State Government may decide to set up either a 50-bed initially with a scope to expand later or a 100-bed PPP facility within the identified District Hospital for select NCD services.

4.2 The Project can be considered in those District Hospitals that meet the following minimum conditions:

a. The District Hospital should be located in Tier 2 or 3 cities. The Divisional Headquarters may be considered initially, but as the health services/ players increase, these may be planned for mofussil towns.
b. The District Hospital should have not less than 250 functional beds.
c. As the purpose of the PPP is to augment the current capacity at the District Hospital the hospital authorities should be able to allocate the following minimum space (indicative) for setting up the PPP facility:
    i. 30,000 square feet for a 50-bed facility
    ii. 60,000 square feet for a 100-bed facility
d. It is preferable that for a 50-bed facility, minimum 75 percent of this space requirement is within the built-up structure of the existing district hospital and the for the remaining, vacant land within the premises of the same District Hospital could be allocated by the State Government. Similarly, for a 100-bed facility, it is preferable that a minimum 50 percent space is available within the existing structure of the district hospital [2].
e. The district hospital should have an average per day OPD of around 1000 patients in the last two years. This is indicative and the purpose is to ensure that the district hospital is reasonably well functioning and has a fair patient load.

4.3 Both 50-bed and 100-bed facilities mayl be co-located within the premises of the district hospital.

5. Scope of services

5.1 Services to be offered in the district hospital

Scope of services under the Project will include NCD services through the continuum of care from screening to treatment.
Therefore under the Project the following minimum services will be offered in the identified district hospital/s[3]:

[2] The minimum requirement of built-up space to be allocated within the District Hospital is a suggestion that the State Government's may amend depending upon the situation and space available within the District Hospital where it intends to set up the PPP Project. Lesser the allocated space within the existing structure of the District Hospital, higher will be the construction cost and time required to construct and operationalize the facility.

[3] Minimum services to be offered under the District Hospital was determined through a series of intensive consultations over a period of three months with the Working Groups constituted by NITI Aayog (included participation of key private health care providers, MoH&FW, few states and an expert group of healthcare providers), four regional workshops organized by the Confederation of Indian Industries (CII), and inputs from representatives of the Ministry of Health and Family Welfare, Government of India, select state governments and district hospital representatives. While determining the list of minimum services, apart from the need for the services, the feasibility of offering such services at the district hospital were considered (e.g availability of specialists, infrastructure and equipment requirements, patient load, etc.).

a. **Clinical and clinical support services** (advanced secondary and basic tertiary) related to oncology, cardiology and pulmonology. Clinical services will at the minimum include:
   i. Out-Patient Department (OPD), In-Patient Department (IPD) and emergency management services (surgical and non-surgical) related to the three specialties mentioned above.
   ii. Patient stablisation and referral of co-morbidities associated with the three specialties under the Project to the extent possible within the Project facility.
   iii. Critical care, Intensive Care Unit (ICU), emergency beds, pharmacy, pathology / laboratory services and radiology.

b. **Associated non-clinical support services** including but not limited to food and beverage, housekeeping and laundry services, Central Sterile Supply Department (CSSD), infection control system and utilities management and all such services required for functioning of the facility. These will be subject to approval sby the respective state governments.
c. Under the *Project* the **minimum level of services** for the three specialisations will be as follows:

Specialization	Minimum level of services
Cardiology	Emergency management, up to coronary angiography and angioplasty
Oncology	- Emergency management - Surgical (up to laparoscopy surgery, palliative surgery) - Medical (chemotherapy, hormone therapy and growth inhibitors)
Pulmonology	Emergency management and referrals, up to interstitial lung disease management, Chronic Obstructive Pulmonary Disease (COPD) and bronchial asthma management.

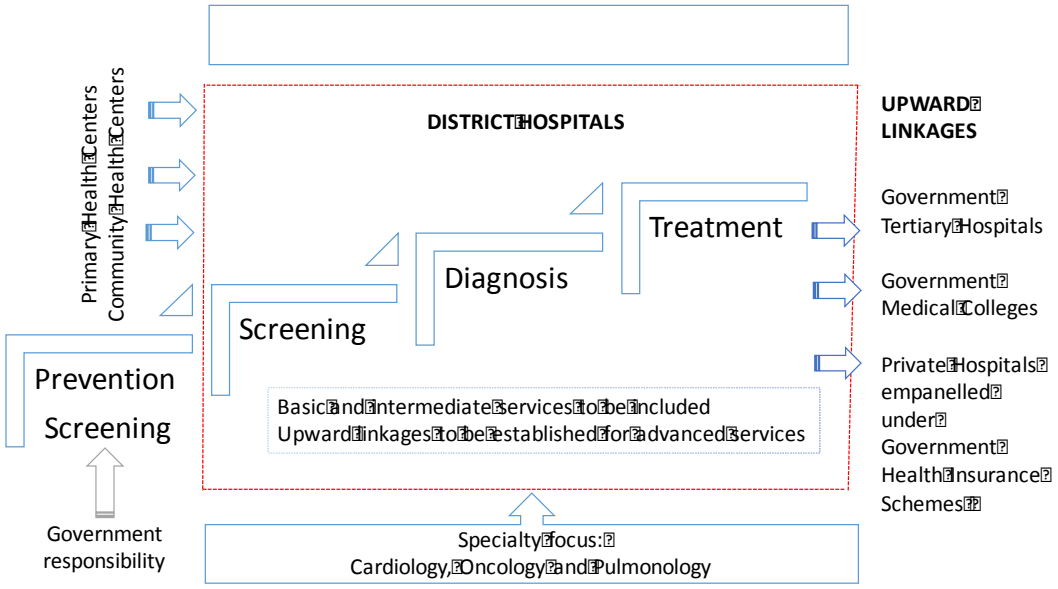
d. For a list of minimum screening, diagnostic and treatment procedures / services for the three specialties, refer to Annex 1.
e. Strong mechanisms of downward and upward linkages will be integrated within the system to ensure seamless access of services at different levels.

The service package proposed under this Project is aligned to support the NPCDCS. See Annex 2.

5.2 Upward and downward linkages

5.2.1 For the purpose of this Project, **downward linkages** imply linkages of the PPP Project Facility with the Primary Health Centers (PHCs) and Community Health Centers (CHCs) in the district where the Project is being implemented. Additionally, this may include linkages will PHCs, CHCs and district hospitals in neighboring districts also.

5.2.2 **Upward linkages** mean linkages with high level of facilities for treatment of conditions not covered under this Project and / or of complicated cases which cannot be handled by the PPP project facility. Such referral facilities will either be government tertiary hospitals, or government medical colleges or private health facilities that are empanelled by the State Government for providing treatment under one or more government health insurance schemes in that order of preference. See figure below:



5.2.3 To ensure that the PPP design is integrated within the public health system, State Government will endeavor to establish linkages with population based screening programmes under the NPCDCS at the level of sub-centers/ Health & Wellness Centres, PHCs and CHCs.

5.2.4 The State Government will ensure appropriate communication to all PHCs and all the NCD Clinics functional at the CHCs under the NPCDCS for referring patients to specialized services under the Project.

5.2.5 The State Government will also establish linkages with existing national and state initiatives such as the emergency transportation /ambulance services for patient referrals and health protection schemes such as RSBY/ National Health Protection Schemes/ state level health insurance schemes to leverage upon the facilities and resources to arrive at greater synergies[4].

5.2.6 In the first instance, all referrals to higher facilities for complicated cases which cannot be managed under the Project shall be to a government institution or to private facilities empanelled by the State Government under one or more health insurance schemes (in that order of preference) being implemented by the State Government.

5.2.7 In all such cases, it is recommended the Private Partner forward the case for referral to the Medical Superintendent (MS) of the District Hospital or her/his authorised representative for a decision which would be taken by the latter in consultation with the patient within a timeframe mutually agreed upon between the Private Partner and the district hospital authorities keeping in mind and clinical condition and best interest of the patient.

5.2.8 The Medical Superintendent may decide to link up such patients with any of the existing government schemes and / or funds like the Chief Minister Wellness Fund, etc.

5.2.9 Table below provides an overview of types of services at different levels including at the district hospital under the PPP (the private partner will only provide the services indicated at the district hospital, for all other levels only linkages with existing services are envisaged):

[4] State Government may provide a list of all such national and state Project that are operational in the state.

Services	Community	PHC / CHC	District hospital PPP	Government tertiary hospitals / medical colleges	Upward referrals for higher treatment at private facilities[5]
Prevention	Yes	Yes	Yes	Yes	No
Screening	Yes	Yes	Yes	Yes	No
Diagnosis	No	Yes	Yes	Yes	Yes
Treatment	No	Yes	Yes	Yes	Yes

5.3 Services shared with the district hospital

a. The NCD services offered under the Project may need to share one or more support services with the district hospital in which it is co-located.

b. Subject to necessary approvals, the shared services may include the following but not limited:
   i. Ambulance services
   ii. Blood Bank
   iii. Physiotherapy services
   iv. Bio medical waste disposal
   v. Mortuary services
   vi. Parking facilities
   vii. In-patient payment counter
   viii. Hospital security
   ix. Sanctioned electrical load

Note: Final list of shared services to be determined after a detailed facility profiling of the district hospital

c. The Private Partner will, in coordination with the Medical Superintendent of the District Hospital, develop an inventory of services that would be shared with the district hospital.

d. The Private Partner will also develop a Standard Operating Procedure (SOP) in consultation with the district hospital authorities documenting the process of accessing the support services. The Medical Superintendent will approve this SOP and it will be binding on both the Private Partner and the district hospital authorities.

e. The district hospital authorities will set up a Project Coordination Committee with representatives from the district hospital and the private partner. This Committee will meet regularly (recommend monthly) to update on progress and to resolve any operational challenges in smooth operations of the Project.

5.4 Facilities proposed under PPP

a. As already mentioned, services under this Project can be offered through two different options: a 50-bed facility or a 100-bed facility. Details of facilities proposed to be available under both the options are provided below:

[5] Only those private health facilities that are empanelled by the state government for providing treatment under one or more government health insurance schemes.

No.	Facility	50-bed facility	100-bed facility
1	Out-patient department	Yes	Yes
2	In-patient beds[6]	40 beds	75 beds
3	ICU beds	10 beds	25 beds
4	Operation theatre	2	2
5	Cathlab	1	1
6	Laboratory services (pathology)	Yes	Yes
7	Radiology services	Yes	Yes

b. The Private Partner will ensure the following under the Project:
   a. Availability of general OPD services as per the timelines of the District Hospitals.
   b. Availability of specialist OPD services as per the timelines of the District Hospitals.
   c. Availability of round the clock emergency services for all 365 days a year.
   d. Availability of at least one dedicated Advanced Life Support and one dedicated Basic Life Support Ambulance on call round the clock for all 365 days a year.
   e. Pharmacy within the Project facility functional round the clock for all 365 days a year.
   f. Access to blood bank and other support services as described in Section 5.3.

5.5 Managing existing overlapping facilities in the district hospital

a. It is recommended that prior to bidding the State government identify and develop a list of shared services and possibly overlapping services based on a detailed facility survey of the District Hospital. A detailed plan for managing such services should be developed and clearly specified at the time of the bid. The purpose of this is to provide clarity on the services that will be shared and the modalities for sharing them.

6. Salient features of the Project

a. Under this PPP Project the State Government has the option to set up either a 50-bed or a 100-bed NCD facility in district hospitals located in Tier 2 / Tier 3 cities.
b. All services in NCD PPP facility should be invited from a single private partner or a single consortium of private partners.
c. Private partner will invest in upgrading/ building, and equipping the facility; and will be responsible for operational management and service delivery. Government may provide Viability Gap Funding, if required.
d. It is envisaged that the State Government will:
   i. provide the required physical space (built up area and vacant area or land (as indicated in Section 4) within the hospital premises) and other infrastructure in as-is-where-is condition.
   ii. provide Viability Gap Funding, which may be used as the bidding parameter for selecting the private partner.
   iii. support in establishing referral linkages with screening programmes and NCD clinics and refer patients to the PPP facility.
   iv. Provide support facilities and hospital amenities.
   v. Ensure smooth functioning, overall coordination, monitoring and oversight of quality of services and payment administration.

[6] States may decide on the proportion of private beds / general ward beds

e. Tariff structure of the services offered under this Project may be fixed as per the package / procedure rates under the RSBY/ National Health Protection Scheme or any other relevant government health insurance scheme in the state. For states which do not have any such scheme being implemented, the Central Government Health Scheme (CGHS) rates could be used for benchmarking purpose.

7. Human resource requirements and management

a. The indicative human resources required for the 50-bed and the 100-bed facility is provided in Annex 3.
b. It is expected that the private partner will:
    i. ensure that all staff have the minimum qualifications as per standard industry practices and have the relevant experience.
    ii. make provisions of in-house training and continued medical education to ensure that staff are well trained, skilled and regularly updated to handle the assigned responsibilities.

c. The State Government will, at the time finalizing the agreement with the private partner, include a list of minimum human resource requirements that the private partner will be required to deploy.

8. Term of the concession, structure, renewal and exit provisions

a. The State Government will determine the Concession period of PPP Project after undertaking the feasibility study of the identified District Hospital where the State Government intends to set up the PPP project. For determining the Concession Period, the State Government will bear in mind that the duration of the Concession needs to be commensurate with the capital investments required for the Project. Based on the general assumptions and financial projections provided in Section 10 of this Guidelines, it is estimated that the concession period could be 30 years for the Project to be financially viable and attractive enough for Private Partners to invest in.
b. If the preferred bidder bid as a Consortium, it will mandatorily have to set up a Special Purpose Vehicle (SPV) registered under the Indian Company Act 2013, with the lead Consortium Member holding minimum 26 percent equity throughout the term of the Concession.
c. The State Government may, based on a transparent annual review process against performance indicators as indicated in Section 10.3 of this Guideline, decide to terminate the partnership as per the provisions of the Concession Agreement for the Project.
d. Subject to satisfactory performance against project indicators, the State Government will have the option to renew the Concession of the Private Partner for a period mutually agreed upon by the State Government and the Private Partner. The terms and duration of renewal will be specified prior to the bid.

9. Roles and responsibilities of partners

9.1 Roles and responsibilities of the private partner

<u>During Project Upgradation</u>

a. Undertake a facility survey and prepare detailed design and plan for upgradation and expansion of the facility, including new construction, if required. The plan should include but not be limited to:
    i. Architectural drawings including civil, electrical and plumbing specifications and implementation schedule.
    ii. Bio medical equipment plan along with load specifications including details of procurement, installation and testing, downtime of equipment and alternate plan during downtime to ensure continuity of services to patients at no addition cost.
    iii. Plan for quality control and inspections during upgradation.
    iv. Plan for ring-fencing the existing services at the district hospital, prepared in consultation with the district hospital authorities to ensure continuity of services being offered at the district hospital.
    v. Detailed human resource deployment plan including number of medical, para medical, administrative and support staff that the private partner proposes to deploy.
b. Upgrade as per approved plan and commission the facility for start of operations.
c. Set up all clinical and non-clinical support services as required including bio-medical and non-medical waste management, sewage treatment plant, effluent treatment plant, firefighting system, air conditioning, plumbing, medical gas pipeline and all other medical and non-medical support services required. as specified in Section 5.
d. Ensure service continuity during upgradation / ring fence the existing services.
e. Recruit all human resources within the agreed time frame.
f. Establish referral linkages with government health facilities at the sub-district levels within the catchment area and with tertiary facilities within and outside the state for referral of cases for services not offered under the Project.

<u>During Project operations and management</u>

g. Be responsible for all clinical services, non-clinical support services, operations and management of the Project facility including maintenance of infrastructure and equipment to ensure continuity of high quality services. This may include replacement of medical and non-medical equipment as and when required to ensure that quality of services are being maintained.
h. Subject to approvals, Private partner may be free to set up other commercial services that add value to beneficiaries in a hospital setting (like cafeteria, bookshop, ATM, etc.)
i. Ensure appropriate insurance cover for the entire Project facilities including annual maintenance contracts for all equipment.
j. Maintain medical records as per the laws of the land.
k. Monitoring and quality control of all services rendered under the Project.
l. Design and maintain a management information system for the project and submit required reports to the State Government within the prescribed timeframe.

9.2 Roles and responsibilities of the State Government

a. Review and approve upgradation plan submitted by the Private Partner.
b. Allocate built-up space and vacant land to the Private Partner as per the Plan within the agreed time frame. The allotted space should be without any access barriers and free of all encumbrances.
c. Facilitate referral linkages with sub-district level facilities and tertiary level facilities.
d. Develop eligibility criteria for determining the patients who would be referred by the State Government for cashless services under the Project and system for and pre-authorisation of patients.

e. Provide Viability Gap Funding in form of capital grant as determined through the bidding process.
f. Provide access to district hospital amenities as per the agreed plan referred to in Section 5.3 'Services shared with the district hospital'.
g. Set up and manage a counter for collection of all payments for services from the self-paying patients.
h. Ensure depositing of all such revenues collected in a timely manner into the designated Escrow account.
i. Undertake verification of all reimbursement claims made by the private partner.
j. Undertake period verification of medical records.
k. Timely reimbursement of payments on behalf of the patients referred by the State Government who have been treated at the Project facility.
l. Ensure smooth coordination between the district hospital authorities, private partner and other entities such as the District NCD Cell, State NCD Cell, and the Contracts Management Cell.
m. Overall Project monitoring, audits and quality control.
n. Set up the governance and management structures for smooth functioning of the Project and timely redressal of grievances.
o. Adhere to all provisions of the Agreement.

10. Financial structure of the PPP

10.1 Principles

a. The patients referred by the Government as well as the self-paying patients will receive the same standard of clinical care.
b. There will be no reserved beds or no quota of beds for free services.
c. The State Government can refer as many patients as it can up to the capacity available in the Project facility under this Project.
d. Self-paying patients will be able to seek services at the facility.
e. The State Government will reimburse private partner for the patients referred /approved by designated authority in the district hospital.
f. All patients except those reimbursed by the government would pay at the agreed rate.

10.2 Major assumptions and estimates

Note: The assumptions and estimates provided here are illustrative for the purposes of this Guideline and to arrive at a generic model. It is recommended that the State Governments may, at the time of PPP feasibility study of the identified District Hospital, adapt the assumptions and estimates, keeping in mind the principles stated in Section 10.1 and the returns on the capital investment of the Private Partner commensurate with existing market conditions.

a. The NCD-PPP facility will have either (i) 50 in-patient beds, including 15-16 ICU beds or (ii) 100 in-patient beds, including 30-32 ICU beds.
b. Average number of OPD cases per day in the selected district hospital, through existing services, is at least 1000.

c. The footfall and number of patients for the specified NCD services will increase over time due to availability and referral linkages with government health facilities at the sub-district level in the catchment area.
d. Occupancy of in-patient beds is expected to be at 50% in year 1, 70% in year 2, 80% in year 3, increasing to 90% in year 4 and stabilizing at this level thereafter.
e. Built up space in the district hospital is estimated to be 75 percent of the total requirement for 50-bed facility and 50 percent of the total requirement for 100-bed facility. Remaining space in form of vacant land in the same district hospital premises can be provided by the State Government where the private partner can construct the remaining structure.
f. Duration of the Concession: 30 years (suggested) and may be decided by the State Government based on the overall financial viability of the project and reasonable returns for the private partner to attract right kind of partners.
g. Estimated IPD volume share by disease specialty: 75 percent cardiac cases, 10 percent oncology cases and 15 percent pulmonology cases[7].
h. Annual inflation has been taken at 6.5 percent for salary expenditure and 5 percent for all non-salary expenditure.

10.3 Capital and operational expenditure

Note: The estimates provided here are illustrative for the purposes of this Guideline and to arrive at a generic model. It is recommended that the State Governments may, at the time of PPP feasibility study of the identified District Hospital, modify the estimates, keeping in mind the principles stated in Section 10.1 and the returns on the capital investment of the Private Partner commensurate with existing market conditions.

a. Taking in view the above assumptions, the capital cost is broadly estimated to be Rs 18 crore for a 50-bed facility and Rs 33 crores for a 100-bed facility, excluding the cost of land.
b. All capital investment will be done by the private partner.
c. The State Government may support viability gap funding through capital grant at the stage of upgradation of the Project Site. The viability gap funding will be determined through a competitive bidding process.
d. Private partner will be responsible for all costs related to complete management, operations and maintenance of the PPP facility through the revenues generated from permissible sources only as mentioned in Sections 10.4 and 10.5 below.

10.4 Tariff structure

a. The State Government may adopt a uniform tariff structure. This will be specified in the bidding document.
b. The tariff for services offered by the Project may not be more than the package rate of procedures for NHPS/RSBY (whichever is applicable) or any government health insurance scheme if NHPS/RSBY is not being implemented in the state.
c. If there are no such ongoing schemes, the rates for procedures and packages under this Project may be benchmarked against the Central Government Health Scheme rates.

[7] These assumptions may change from state to state or from district to district based on epidemiological profile and existing patient load / referral patterns to be determined during feasibility study for the project. This is currently based on the national data.

10.5 Revenue Sources

a. For services rendered under this Project, the private partner will have two sources of revenues:
   i. From the State Government
   ii. From self-paying patients

b. **From the State Government**: The State Government shall ensure reimbursement to the Private Partner on behalf of patients referred by the State Government through one of the following options:

For patients enrolled under the RSBY/ NHPS or any other state government health insurance scheme:

   i. The Project facility would be empanelled under the NHPS / State Government Health Insurance Scheme and all reimbursements for such enrolled patients up to available sum insured under such Scheme will take place through the contracted Insurance Company. The Private Provider shall follow all guidelines related to pre-authorization and claims submission.
   ii. For those patients enrolled by the State Government under one of its insurance programs and for whom the available sum insured is either zero or inadequate for seeking services, the Private Partner will send a pre-authorization request to the Medical Superintendent of the district hospital or her /his authorised representative. The Private Partner will be reimbursed by the State Government only for the pre-authorized procedures and up to the agreed rates for the services finalized thorugh this PPP model.

For patients not enrolled under the NHPS or any other state government health insurance scheme but are eligible to be government referred patients under this Project:

   iii. The Medical Superintendent of the District Hospital or her /his authorised representative will, as per the provisions under this Scheme, authorise and refer all such cases to the private partner.

c. The State Government, if it so desires, can decide to purchase 100 percent of the services or can indicate a cap on number of patients that the Government can refer in a year and for whom it can reimburse the private partner.[8]

From Self-paying Patients:

d. All self-paying patients will directly pay for services out of pocket at the agreed tariff, which shall be transparently displayed.

10.6 Payment Administration

10.6.1 The State Government will be transferring payments to the Private Partner under three streams:

   a. Viability gap funding through a one-time capital grant as determined through the bidding process; and

[8] State government should analyse its budgetary provisions and the projected demand for services in the Project facility and determine the cap.

b. Partial usage payment wherein the State Government will reimburse the private partner only for the services received by the patients referred by the State Government up to a ceiling specified in Section 10.5(c).
c. Revenues collected from self-paying patients.

10.6.2 **Administration of VGF payment:**

10.6.2.1 *If Private Partner's capital contribution is through 100 percent equity, no debt:* The State Government will disburse the VGF only after the Private Partner has expended 100 percent of its capital contribution required for the Project and will be released in full within 15 days of receiving the request from the private partner.

10.6.2.2 If Private Partner's capital contribution is through a mix of equity and debt: The State Government will disburse the VGF only after the Private Partner has fully expended the equity contribution required for the Project and will be released in proportion to debt disbursements remaining to be disbursed thereafter.

10.6.2.3 Delays in release of VGF by the State Government:

a. For delays in receipt of the VGF, the State Government will pay a penal interest equivalent to State Bank of India's prime lending rate applicable at that point in time + 2 percent penal charges for every one month of delay or part thereof.
b. The Private Partner will not be held responsible for any delays in Project commission in the event that there are delays in the release of VGF by the State Government, provided the delay is not on account of the private partner's non-compliance to any of the terms and conditions of the Concession Agreement.

10.6.3 **Administration of partial usage payments**

a. The State Government will reimburse the Private Partner on behalf of all patients referred by the State Government and who have received services at the Project facility.
b. For ensuring security and timeliness of payments to the Private Partner, all such payments will be administered through an Escrow Account.
c. An Escrow Agreement shall be developed stating the terms of payment and eligibility conditions. The State Government may have a balance of three months of revenue against Partial Usage Payments in the Escrow Account.
d. The State Government will release 70 percent of the invoiced amount within 30 days of receiving the claim and the remaining 30 percent shall be released within 45 days of receiving the claim and after appropriate due diligence.
e. In the event of any default or delay in payment by the State Government beyond 30 days for the 70 percent of claim and beyond 45 days for the remaining 30 percent of the claim, the Private Partner can withdraw such amount from the Escrow Account without notice. In such an eventuality, the State Government will replenish the Escrow Account within 30 days of such withdrawal.
f. The Private Partner will have the right to cease services if Escrow transactions and terms are not maintained by the State Government.

10.6.4 **Administration of payments collected by the State Government from the self-paying patients**

a. The State Government will transfer all receipts from self-paying patients to the Escrow Account within 15 days of its receipt as per the terms of the Escrow Agreement from where the funds will get transferred to the Private Partner's designated bank account.

11. Governance and management

11.1 For effective governance and management of the Project, the following structures are proposed to be set up:

a. Project Steering Committee
b. Contracts Management Cell
c. Project Coordination Committee

11.2 Project Steering Committee (PSC):

a. The State Government will set up a PSC as the highest body providing governance, leadership and oversight to the Project.
b. The PSC will be chaired by the Principal Secretary of the Department of the Health and Family Welfare and will have members which may include but not be limited to the Head of the State NCD Cell, Director General Medical / Health Services and the Principal / Director of the Apex Medical College in the state.
c. The PSC will meet quarterly or earlier.
d. The PSC will constitute a Quality Assurance Cell (QA Cell) to monitor the quality of services offered by the private partner and monitor patient satisfaction levels.
e. The QA Cell shall report directly to the PSC.

11.3 Contracts Management Cell (CMC):

a. The State Government will set up a dedicated CMC at the State level.
b. CMC will be headed by the Director Health Services / Director Medical Services, the State Program Officer of the State NCD Cell and District Program Officer of the concerned District NCD Cell. It will also include other members as determined by State Government to ensure availability of the following skills within the CMC: (i) contracts management; (ii) project management and monitoring; (iii) financial management; and (iv) legal expertise.
c. The CMC will:
    i. Coordinate with the Project facility and primary care facilities (CHCs and PHCs) to ensure referrals.
    ii. Ensure ongoing compliance to the terms and conditions of the Concession Agreement including monitoring of output specifications and payment administration.
    iii. Monitor the overall functioning of the Project.
d. The Medical Superintendent of the district hospital or her / his authorised representative will liaison with the CMC as and when required.
e. The private partner and the CMC will receive training on the technical and managerial aspects of the PPP model.
f. A Standard Operating Procedure or an operational manual will be prepared for effective management of the Project.

11.4 Grievance Redressal Mechanism:

a. Grievance redressal mechanism will be integrated into the design to handle all complaints and grievances in a timely manner.
b. The Head of the CMC will be designated as the Nodal Grievance Redressal Officer (NGRO).
c. The NGRO will handle beneficiary complaints, complaints of the private partner and that of the district hospital.
d. Complaints, if any, that the Private Partner may have against the CMC can be filed directly with the PSC.
e. All grievances will be resolved by the CMC within a period of not more than 30 days following the principles of natural justice. Complaints requiring faster redressal will be dealt with by the NGRO who will coordinate with the CMC to ensure faster redressal.
f. Appeals against the decisions of the CMC will be escalated to the PSC.

12. Risk Management

In the Project, three major types of risks are anticipated. They are discussed here along with details of how the design of the Project addresses these risks:

a. Demand risk
   i. Demand risk is shared between the private partner and the State Government through the payment mechanism.
   ii. Payment mechanism is a mix of user fees (to be directly paid by the self-paying patients) and partial usage payment (wherein the State Government will reimburse the Private Partner on behalf of patients referred by the State Government and who were authorised to seek services).

   Refer to Section 10.5 for details.

b. Risks in payment administration
   Delays in release of payments from the State Government to the private partner constitutes a major risk to project liquidity and finances. This has been addressed through penal interest for delays in one-time capital grant in form of VGF and through Escrow Account Mechanism for delays in settling reimbursement claims for services offered to government reimbursed patients. (refer to Section 10.6 for details).

c. Governance and management risk
   Sub-optimal oversight, weak monitoring and ineffective contracts management lead to premature closure of or sub-optimal results from most of the PPP projects. This risk has been addressed through structures such the Project Steering Committee, Contracts Management Cell, Project Coordination Committee, and the Grievance Redressal Cell. Refer to Section 11 '*Governance and management*' for details.

13. Monitoring and Reporting

13.1 Scope and Process

a. Monitoring and verification for the Project will be based on the principles of measuring outputs / results including monitoring quality of services and patient satisfaction levels as per project indicators and Key Performance Indicators referred to in Section 13.3.
b. Overall responsibility of monitoring will vest with the CMC. For onsite monitoring of the Project, a Project Coordination Committee (PCC) will be set up at the Project facility level, which will include the In-charge/Medical Director of the Project Facility, the Medical Superintendent of the District Hospital and representative from the District NCD Cell.
c. The PCC will meet monthly to review the functioning and discuss and address all operational challenges.
d. The PCC will submit its monthly monitoring reports to the CMC.
e. Next level of monitoring will be done by the PSC in its quarterly meetings.
f. The State Government will have the right to commission (on its own or through a third party), periodic external audits of the Project facility and the services rendered by the Private Partner from the Project facility:
    i. Hospital audit: every six months.
    ii. Beneficiary audit (during hospitalization): 30 every quarter to be divided across the 3 medical specialties based on IPD admission ratio across the specialties.
    iii. Beneficiary audit (post hospitalization): 30 every quarter to be divided across the 3 medical specialties based on IPD admission ratio across the specialties.

g. All monitoring will be undertaken by the State Government against a set of key performance indicators and a set of process indicators (refer to Section 13.3) on a quarterly basis.
h. Monitoring results will be discussed with the Private Partner in a participatory way and corrective actions shall be initiated by the Private Partner as and when required within the rectification period stated by the CMC.
i. Disputes, if any, emanating from the monitoring results, will be escalated to the GRC and redressed amicably between the concerned parties.

13.2 Quality assurance and Accreditation

a. The Private Partner will develop an Internal Quality Assurance Plan and follow the same. The CMC will have the right to inspect and monitor the implementation of the Plan by the Private Partner.
b. The Private Partner will develop a 'Patient Charter' in local language and in English and ensure that it is prominently displayed in the OPD area, in-patient wards and the Emergency Department.
c. If the total space allotted by the State Government for setting up the project facility under this Project fulfils the minimum space requirement as laid down under the latest National Accreditation Board of Hospitals (NABH) guidelines, within three years of the date of commissioning and start of services, the Private Partner will ensure that the Project facility is NABH accredited having '**Full Accreditation**' Status along with other relevant accreditations such as the National Accreditation Board of Laboratories (NABL) and will take all appropriate measures to ensure recertification at required intervals to ensure continuity in the accreditation status of the Project facility. The scope of such accreditation will include clinical services, laboratory services, diagnostic services, transfusion services, pharmacy, professions allied to medicine (dietetics and physiotherapy, if set up) and support services (ambulances).

13.3 Monitoring indicators, KPIs and penalties

a. The State Government will provide a list of performance indicators which will be a part of the Concession Agreement.
b. An illustrative list of Project indicators are as follows:
    i. Number of patients treated
    ii. Percentage of BPL patients to total inpatients
    iii. Percentage of BPL patients to total outpatients
    iv. No. of repeat visits in the OPD for the same illness
    v. Average Length of Stay (ALOS) disaggregated by disease specialties
    vi. ALOS of BPL and of private patients
    vii. Rate of unscheduled returns to the operation theatre
    viii. Elective surgery cancellations
    ix. Leave against medical advice
    x. Post treatment infection rate
    xi. Out-patient / inpatient conversion rate
    xii. Emergency / IP conversion rate
    xiii. In-patient mortality rate
    xiv. Complaints redressal rate of BPL patients and of private patients
    xv. Patient satisfaction index which may include but not be limited to service availability and waiting time, hygiene and cleanliness, behaviour and promptness of hospital staff, Facilities, amenities and infrastructure, doctor patient communication

c. Apart from the monitoring indicators the State Government will develop a set of Key Performance Indicators (see Annex 4) that will have threshold levels. Performance below the specified threshold level will attract stringent penalties will be detailed in the Concession Agreement.

13.4 Management information system and reporting

a. At its own cost the Private partner will develop a web-based hospital management information system (HMIS) with full access rights to the State Government along with a management dashboard as a visual interface to provide information against key indicators.
b. All project data as per identified indicators will be captured on the HMIS and entered by the Private Partner. The State Government may, either directly or through a third party appointed directly by it, undertake performance audits and verification to assess the quality of data being entered in the HMIS.
c. The Private Partner will submit monthly summary reports of all unusual occurrence.[9] The Private Partner will also submit details of all such occurrence as and when they occur.
d. The Private Partner will submit overall quarterly reports in the format prescribed by the State Government.

14. Selection of the private partner

a. The State Government will select the Private Partner for the Project based through a 2-stage competitive bidding process: technical evaluation and the financial evaluation.

[9] Incidents such as (i) death or injury to any person; (ii) episode of sexual assault or rape; (iii) suicide of a patient or staff; (iv) transfusion reactions; (v) surgery on wrong patient or wrong body part; (vi) smoke or fire; (vii) unintended retention of foreign object in the body of a patient after surgery or other procedure; (viii) any other incident similar to these

b. Bid parameter will be the percentage of estimated capital cost sought by the bidder from the State Government as VGF.
c. First the prequalification documents will be reviewed for compliance to minimum eligibility criteria.
d. Financial tender of only the qualified applicants shall be opened.
e. Bidder seeking the lowest VGF support will be the preferred bidder and subject to all other conditions of the bidding documents and administrative requirements being fulfilled and due diligence being done, be declared as the Successful Bidder.
f. The State Government will thereafter enter into a Concession Agreement with the preferred bidder.

15. Essential Points for Consideration by the State Government

a. It is recommended that the State Governments provide an enabling PPP Ecosystem within the state and undertake measures that may include nut not be limited to:

    i. Having a PPP policy framework or guidelines for PPP in place, if one does not already exist, to ensure that it not only provides an authoritative framework for the State Government to implement the PPP Project but also provides a clear road map to potential Private Partners via-a-vis the State Government's intent and commitment to public private partnerships.
    ii. Augment the capacity to design and manage complex public private partnerships within the Department of Health and Family Welfare. Capacity includes not just the skills needed to manage and monitor PPP contracts but also appropriate governance and leadership structures at different levels to provide stewardship to the PPP projects.

b. State Government may exercise its discretion to determine the number of District Hospitals where it intends to launch this model bearing in mind that having a minimum of five to six facilities would assist the state the required breadth to test the viability of the model and based on the emerging lessons, modify the project design for expansion within the State.

Annex 1: Scope of services

Whereas for each NCD specialty, the minimum set of screening, diagnostic and treatment services are provided in the tables below, the Private Partner will be at liberty to offer additional and higher levels of services within under the Project, without any additional cost implication to the Government

Minimum services related to Oncology

ONCOLOGY SERVICES		
Screening	**Diagnostic**	**Treatment**
▪ Pap smear ▪ Mammography ▪ Clinical examination ▪ FNAC ▪ Biopsy (CT and USG guided)	▪ X-ray ▪ Colonoscopy ▪ CT Scan (16 slice) ▪ Pathology, histopathology, cytology, hematology and biochemistry	▪ Excision of benign cancer ▪ Laparoscopy ▪ Tracheostomy ▪ Palliative management ▪ Medical Oncology (chemotherapy, hormone therapy and growth inhibitors)

Minimum services related to Cardiology

CARDIOLOGY SERVICES		
Screening	**Diagnostic**	**Treatment**
▪ Body Mass Index ▪ BP estimation ▪ Clinical examination	▪ Hematology and biochemistry ▪ ECG ▪ X-ray ▪ ECHO ▪ TMT ▪ USD (with Doppler) ▪ CT (16 slice) ▪ Coronary angiography	▪ Coronary angioplasty

Minimum services related to Pulmonology

PULMONOLOGY SERVICES		
Screening	**Diagnostic**	**Treatment**
▪ Clinical examination ▪ Spirometry ▪ Sputum examination	▪ Pathology, histopathology, cytology, hematology and biochemistry ▪ X-ray ▪ USD (with Doppler) ▪ CT (16 slice) ▪ PFT ▪ Bronchoscopy	▪ Emergency management of acute syndromes ▪ Tracheostomy ▪ COPD management

Note on Pathology and Radiology services

a. The same private partner managing the NCD services, will either directly or through one or more of its consortium partners set up and manage the pathology and radiology services within the hospital premises as per the scope defined earlier.

b. The pathology and radiology department shall offer a full range of nationally accredited services responding to the need of the entire District Hospital and not just the NCD PPP facility.
c. If there is any development in technology/ services provided, the same shall be considered for incorporating in the existing level of services.
d. In addition, IEC activities, as finalized with the State Government, may be undertaken.

Annex 2: Alignment of services under the Project with the NPCDCS

No.	Services at DH level under NPCDCS[10]	Services proposed under NCD PPP
1	Diagnosis and management of cases of CVDs	✓
2	Diagnosis and management of cases of Diabetes	✓
3	Diagnosis and management of cases of Stroke	No
4	Diagnosis and management of cases of Cancer	✓
5	OPD for 1 to 4 above	OPD for 1,2 &4
6	IPD for 1 to 4 above	IPD for 1,2 &4
7	Intensive care for 1 to 4 above	ICU for 1,2 &4
8	Emergency services for myocardial infarction	✓
9	Emergency services for stroke	No
10	Lab. investigations and Diagnostics: Blood sugar, Lipid Profile, KFT, XR, ECG,USG ECHO, CT Scan, MRI etc.	✓
11	Referral of complicated cases to higher health care facility	✓
12	Health promotion for behavior change and counseling	No
13	'Opportunistic' Screening of NCDs including common cancers(Oral, Breast and Cervix)	✓
14	Follow up chemotherapy in cancer cases: 2-beds (day care)	✓
15	Rehabilitation and physiotherapy services	✓
16	Provide guidance to develop skills for Home based palliative care for chronic and debilitating patients.	No
17	4 bedded Cardiac Care Unit (CCU) will be established / strengthened in identified district hospitals	✓ (30 beds)
18	Training of CHC level human resources	No

[10] *NPCDCS Operational Guidelines 2013-17*, MoHFW, GoI, 2013: Section 2.1 package of Services (pages 8-9) and Section 2.5.4 (page 24)

Annex 3: Indicative human resource requirements from the Private partner

The list of indicative core competencies that are needed in the human resources deployed under the PPP Project facility are provided below.

The State Government will ensure that a detailed survey of the catchment area is done to estimate demand for services related to the identified disease specialties, based on which the minimum numbers of staff / consultants for each of the positions can be estimated and specified in the tender document.

1. Onco-surgeon
2. General Surgeons
3. Clinical Cardiologist
4. Pulmonologist
5. Internal Medicine Specialist
6. ICU Intensivist
7. OT anesthetist
8. Radiologist
9. Pathologist
10. Staff for ICU and Emergency room
11. Junior Residents
12. ICU Nurses
13. Nurses trained in OT
14. IPD Nurses
15. OT Technicians
16. Cath lab technicians
17. Perfusionist
18. Radiology Technicians
19. Pharmacist
20. Pharmacy Assistance
21. Onco Pharmacist
22. Front office staff
23. Management Staff
24. Other administrative staff (accounts, HR, IT, etc.)

Annex 4: Key Performance Indicators

1. Key Performance Indicators (KPIs) shall have 8 indicators as set forth in the table below in this Schedule 12.
2. KPIs 1 to 7 have a combined weightage of 90% and KPI 8 has a weightage of 10%.

No.	Category	Indicator	Numerator (N)	Denominator (D)	Calculation (C)	Threshold	Weightage (W)
1	Human Resource	Availability of Service Providers- specialists	Total no. of person days (FTEs) of specialists - present against required in the Project Facility	Total no. of specialists to be present (as per plan) X no. of days in the month	(N / D) * 100	85%	20%
2		Availability of support staff/ nurses	Total no. of person days (FTEs) of nurses present against required in the Project Facility	Total no. of nurses to be present (as per plan) X no. of days in the month	(N / D) * 100	90%	10%
3	Quality of care	Unscheduled visits post discharge	No. of patients making unscheduled revisit to the Project Facility within 48 hours after discharge	Total number of discharges in the month	(N / D) * 100	95%	10%
4		Rate of unscheduled returns to the operation theater (OT)	No. of unscheduled returns to the OT in the month	Total number of surgeries in the month	(N / D) * 100	95%	10%
5		Patient satisfaction levels	No. of beneficiaries with ≥85% satisfaction score from an app based tele-survey	Total beneficiaries who responded to the app-based tele-survey	(N / D) * 100	85%	20%
6	Financials	Timely submission of claims	NA	NA			10%
7		Error ratio in claims submission	No. of claims in the previous month for which the Implementing Authority asked for clarifications	Total number of claims submitted by the Concessionaire in the previous month	(N / D) * 100	90%	10%

No.	Category	Indicator	Numerator (N)	Denominator (D)	Calculation (C)	Threshold	Weightage (W)
8	Facility maintenance	No. of adverse observations related to adherence to rectification / remedial measures/ incidents of defaults in the quarterly O&M Inspection Report	NA	NA		No adverse observations	10%
						Total	**100 %**