IOSR Journal of Nursing and Health Science (IOSR-JNHS)
e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 14, Issue 6 Ser. 3 (Nov. – Dec. 2025), PP 47-60
www.iosrjournals.org

Qualitative Exploration Of The Supply-Side Facilitators And Barriers In The Implementation Of The Pradhan Mantri Jan Arogya Yojana In Madhya Pradesh, India

Rajna Mishra[1], Preeti Kumar[1], Ipchita Bharali[2], Sakthivel Selvaraj[1], Wenhui Mao[2], Gavin Yamey[2]
Public Health Foundation Of India
Center For Policy Impact In Global Health, Duke Global Health Institute, Duke University

Abstract
India's Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY), launched on September 23, 2018 is the largest health assurance scheme in the world. PMJAY aims at providing a health cover of INR 5 lakhs (around 7000 USD) per family per year for secondary and tertiary care hospitalization to reduce catastrophic out of pocket health expenditures, improve access to hospital care and reduce unmet among the poor and vulnerable families. It is an entitlement-based scheme, without any explicit enrolment process. Identification of beneficiaries is based on the Socio-Economic Caste Census (SECC, 2011) database.
A qualitative study was undertaken to perceive the challenges related to seven dimensions of the program that are crucial for its success namely: 1) enrollment and awareness generation; 2) health benefit packages, rates and revisions to packages; 3) service delivery; 4) hospital empanelment; 5) financing mechanisms; 6) utilization and 7) capacity building. The study was carried out in two purposively selected districts, Bhopal and Shahdol in the state of Madhya Pradesh. Key Informant Interviews were conducted among 21 purposely sampled implementers and administrators involved in the implementation of the scheme in various capacities. Data collection was carried out virtually using the notebook method. Thematic analysis was conducted and contents were analyzed manually.
The study found that in MP, apart from SECC marked families, households covered under the National Food Security Act and Sambhal Patra Family were eligible under the PMJAY scheme, ensuring a more comprehensive beneficiary list. However, there is still scope to expand inclusiveness. MP opted for the trust model under which the scheme is directly implemented by the State Health Agency (SHA) – Deen Dayal Swasthya Suraksha Parishad. Despite efforts to generate awareness by the state, our study found that there is still scope for further improvement. Intentional fraud and over use of packages were reported from private facilities. Delays in provider payments was another challenge reported by the state. Initiatives taken by the state to enhance beneficiary enrolment include involvement of Common Service Centers, employment of Ayushman Mitras in the public and private hospitals and organization of camps. Empanelment of hospitals is done by the state and the decision on empanelment is subject to approvals from the empanelment committee. The study highlighted the need for strengthening capacities of stakeholders and re-visiting guidelines based on emerging challenges.

Date of Submission: 03-12-2025 Date of Acceptance: 13-12-2025

I. Background

Access to affordable healthcare is essential for maintaining and improving the health status of individuals and households and has a long-term impact on a country's economic prosperity.(1) Affordability of healthcare can be ensured through financial protection provided by the welfare state, by protecting the poor and vulnerable from the adverse effects of catastrophic health expenditure. The government of India and state governments have launched several initiatives that aim to achieve Sustainable Development Goal target 3.8, i.e., ensuring financial protection against catastrophic health expenditure and access to affordable and quality healthcare for all.(2) Apart from providing affordable healthcare in the public sector through the National Health Mission, the central government introduced several publicly funded health insurance (PFHI) schemes, such as the Central Government Health Scheme (CGHS)(3), Employee State Insurance (ESI)(4), and Rashtriya Swasthya Bima Yojana (RSBY)(5). CGHS is a scheme for central government employees and ESI is a scheme for employees working in the private sector, drawing wages up to a defined amount. Some PFHIs have also been initiated at the state level, such as the Chief Minister's Comprehensive Insurance Scheme in Tamil Nadu(6), Yeshasvini health insurance scheme in Karnataka(7), Mahatma Jyotiba Phule Arogya Yojana in Maharashtra(8), and Mukhyamantri Amrutam

Yojana in Gujarat.(9) Unlike central schemes, these schemes function at the individual state level and also do not provide a wide coverage.

The National Health Policy of India, 2017 further emphasized the goal of achieving universal health coverage (UHC) through increased public financing of health equivalent to 2.5% of GDP by 2025.(10) With a vision to achieve UHC, the Ayushman Bharat program was launched in 2018 by the Government of India which had two key components: (i) health and wellness centers to deliver comprehensive primary health care; and (ii) the Pradhan Mantri Jan Arogaya Yojana (PMJAY), a national PFHI scheme to provide financial risk protection (FRP) to the poor and vulnerable population for secondary and tertiary hospitalizations(11). Launched as the world's largest government funded health insurance scheme, the scheme is an upgraded version of RSBY, designed as a cashless and paperless mechanism to cover 500 million poor and socio-economically vulnerable people, which accounts for over 100 million families. PMJAY aims to ensure comprehensive coverage for catastrophic illness, reduce out-of-pocket expenditure (OOPE), improve access to hospital care, and reduce unmet health needs. It also converges various health insurance schemes across the states and provides national healthcare portability. It is completely government funded where costs are shared between the central and the state governments. The national ceiling amount per family is decided by the central government; the amount is currently set at Rs. 500,000 (approximately USD 7,000) with no cap on the number of beneficiaries from each family. The actual premium is decided through an open tendering process. Under PM-JAY, more than 1,350 medical packages covering surgery, medical and day care treatments, cost of medicines and diagnostics are provided. Secondary and tertiary care hospitalization both in government or empaneled private facilities are provided and also includes pre-existing disease conditions.(12) States can increase the benefit cover beyond the USD 7,000 ceiling by bearing the cost of additional coverage by themselves. States also have the flexibility to choose the scheme design and implementation and to deduct a certain percentage of claims amount that is being paid to the public facilities.(12)

A well designed PFHI scheme can contribute to development goals like access to health care, financial protection against the cost of illness, and improved social inclusion.(13) Prior to PMJAY, the large-scale publicly funded scheme RSBY scheme aimed to cover 65 million poor families (approximately 300 million people), with a benefit cover of Rs. 30,000 (approximately USD 500) per year for a family of five. In addition to providing higher financial coverage, PMJAY widened the coverage to women, children and elderly within the enrolled households, who were unable to access health insurance under RSBY due to limited coverage of the scheme and possible intra-household exclusion. Unlike RSBY, PMJAY does not have a limit on family size per eligible household. The identification of beneficiaries in PMJAY scheme follows the Socio-Economic Caste Census (SECC, 2011) database.(14) Though RSBY and PMJAY are both entitlement-based schemes, the PMJAY, however, does not have any explicit enrolment process. This means that the PMJAY scheme has already pre-selected the group of beneficiaries based on deprivation indicators from the SECC database for rural areas, 11 occupational criteria for urban areas and RSBY beneficiaries who had active RSBY cards as of 28 February 2018.

The predecessor of PMJAY, i.e., RSBY, was often criticized for its low enrolment ratio and the lack of awareness about the program among population(15,16). A study from the state of Gujarat showed that information, education and communication of the scheme were left mostly to the insurance company or ever-burdened peripheral health staff, who could not generate enough awareness about enrollment or utilization of the RSBY scheme.(17) Similarly, a study conducted in the districts of Patiala and Yamunanagar in the states of Punjab and Haryana, respectively, found that insurance companies had considerable implementation responsibilities which led to conflict of interest in enrolment and empanelment.(18) The study also reported a low enrolment ratio. Despite having the potential to change access to healthcare and improve FRP, studies found that RSBY did not affect the level and likelihood of inpatient OOPE or catastrophic inpatient spending.(19) Another study from Gujarat reported that 44% per cent of patients who had enrolled in RSBY and used the RSBY card still faced OOP payments at the time of hospitalization.(20) A study from a tribal area of Odisha state reported that more than 50% of beneficiaries were forced to spend from their own pocket even though the scheme assured coverage. Non-cooperative hospital staff and exploitation among health service providers were also reported.(21) There is much to be learnt from the experiences of these PFHIs for the PMJAY scheme to move towards the goal of UHC.

PMJAY is a relatively new scheme and thus still lacks a large body of empirical evidence. With an increasing population burden and the epidemiological transition, India is facing the challenge of a changing disease burden.(22) Lack of infrastructure and workforce shortages add to the supply-side constraints of providing healthcare under the scheme. A survey of 2,700 households conducted during June-July 2019 using a two-stage sampling study in the states of Bihar, Haryana and Tamil Nadu showed that only 9.84% of the beneficiaries in Bihar and 12.41% of the beneficiaries in Haryana are aware of PM-JAY, although for Tamil Nadu there is more awareness about the program (59%).(23) A study based on household surveys in Chhattisgarh found that enrollment under PMJAY or other PFHI schemes did not increase use of hospital care. The study also found that OOPE and the incidence of catastrophic health expenditure did not decrease with enrollment under PMJAY or

other PFHI schemes, and the size of OOPE was significantly higher for the private sector, irrespective of enrollment under PMJAY.(24) A study conducted in Chennai, Tamil Nadu reported that many hospitals were named and shamed for scheme malpractices.(25) A study on awareness and readiness of health care workers in implementing PMJAY in a tertiary care hospital in Rishikesh, Uttarakhand, emphasized the need to increase awareness.(26) Some studies suggested that monitoring and governance played a crucial role for the success of the program.(27,28)

PMJAY in Madhya Pradesh

Madhya Pradesh (MP) is one of the largest states in India, with a population of 72.6 million (as per Census 2011). The per capita Net Domestic Product is INR. 98418 (USD 1312) at current prices in 2020-21, which is lower than the all-India average (INR. 128829 (USD 1718)).(29) MP, a centrally located state, is one of the states where PMJAY is implemented and running successfully. According to the Tendulkar Committee Report 2009,(30) around 48.6% of the population is estimated to be living Below Poverty Line (BPL). We selected MP for our study given the huge population with low socio-economic status representing the target group of PMJAY beneficiaries.

Currently, 25.6 million beneficiaries in MP have an Ayushman card, among which 0.98 million beneficiaries availed the benefits using the card as of 6th October, 2021. 432 private hospitals and 455 government hospitals in Madhya Pradesh are empaneled with PMJAY. In MP, in addition to the beneficiaries identified in the SECC, beneficiaries of the PMJAY scheme in MP includes households covered under the NFSA and Sambhal Patra Family, a state government scheme initiated in 2018 to provide social security to the poor and scheduled caste and scheduled tribe beneficiaries.(31)

Key implementers and service providers of the PMJAY scheme include Ayushman Mitras (AMs), Medical Coordinator, District Coordinator, Common Service Centres (CSCs), Nodal Officer, State Health Agency (SHA), insurance company and members of the community. The Appendix Table shows the roles and responsibilities of these stakeholders. The roles and responsibilities of the AMs cover the entire process from admission of the patient to the hospital until discharge; they are involved in identifying the beneficiaries, card making, addressing patient complaints, guiding patients to hospitals, addressing issues related to card, biometric process, package blocking, providing documents for claim settlements, and conducting awareness camps. CSCs that have obtained a Memorandum of Understanding (MoU) with the National Health Agency (NHA) also generate Ayushman Bharat cards and conduct enrollment camps. In MP, non-government organizations (NGOs) are not involved in the process of enrollment or in implementation, rather they are support partners. The District Coordinator is in charge of the districts for the PMJAY programs and supports AMs and CSCs for any query. Medical coordinators are employed by the hospitals to support AMs to identify the packages. The Nodal Officer or officer-in-charge looks after the overall management of the program in the district. The SHA monitors the PMJAY program in the states and gets guidelines from the NHA. The SHA collaborates with the department of health and family welfare and the NHA operationalizes the program. The SHA in MP follows trust model for insurance.

The perspective of the supply-side stakeholders for PFHI schemes, especially for PMJAY, has not been adequately studied. This study aims to understand the perspectives of implementers and service providers of the PMJAY scheme, to highlight key bottlenecks and to provide recommendations for further improvement in the implementation of the program. Since PMJAY includes both public and private hospitals, our study captures the perspectives from both sectors to assess whether the scheme addresses the health needs of the beneficiaries in Madhya Pradesh state in India.

II. Methods

Study design and setting

We conducted a qualitative study to identify key challenges, gaps, and opportunities for improving the implementation of the PMJAY in MP and determine whether the scheme addresses the health needs of the vulnerable population in MP. We collected primary qualitative data through key informant interviews (KIIs) and triangulated these data against existing literature and secondary sources to analyze and interpret interview findings. The study aimed to understand the challenges related to seven dimensions that would be crucial for the success of the PMJAY program – enrollment and awareness generation, health benefit packages, rates and revisions to packages, service delivery, hospital empanelment, financing mechanisms, utilization and capacity building. We also aimed to identify the bottlenecks of the system through analysis of these dimensions and to assess the scope for improvement addressing implementation challenges.

The study was conducted in two districts in MP, Bhopal and Shahdol. Bhopal is the administrative headquarters of Madhya Pradesh and one of the most developed districts in the state, with a population of 23,68,145 and an area of 2,772 sq. km. Shahdol district, on the other hand, is a less developed district with an area of 5,610 sq. km. and population of 10,66,063. Bhopal's estimated GDP was INR 304671.2 million (USD

4761) in 2016-17 while Shahdol's estimated GDP was INR 107023.6 million (USD 1673) during the same year. The two districts were purposefully selected to represent different socio-economic backgrounds to assess the inclusiveness of the PMJAY scheme and the implementation challenges faced.

Sampling and data collection

Data collection was aided by semi-structured interview guides. The study tools were translated into the local language, Hindi, and were pre-tested in the study area before the instruments were finalized. Data was collected through key informant interviews (KIIs) structured into the seven dimensions described above to understand the supply side challenges and obstacles faced in the roll out and implementation of the PMJAY scheme in MP.

We used a purposive sampling approach in which we targeted implementers and administrators directly involved in implementation of PMJAY. Twenty-one in-depth interviews were conducted with stakeholders involved at different levels of the PMJAY scheme. Respondents interviewed included representatives from the State Health Agency (2), Nodal Officers at the state level, representatives from Vidal – the Third Party Administrators (2), District Nodal Officers (2, one from Bhopal and one from Shahdol), District Coordinators (2, one from each district), Ayushman Mitras (8, four from each district) and Medical Coordinators (2, one from each district) from sampled government and private facilities providing PMJAY services and service providers from Common Service Centres (3, one from Bhopal, two from Shahdol).

Interviews were conducted by the research team in the local language, Hindi. Interviews were conducted virtually and as per the convenience of the respondents. The data collection was carried out between July to September, 2021. The notebook method was followed to capture the responses as respondents did not agree to the interviews being audio recorded.

Data analysis

After the interview data was transcribed in English, thematic analysis was conducted manually using 'a priori' codes identified along with emerging themes from the transcripts. Names were anonymized. State level respondents were referred to as SHA, district nodal officers as DNOs, district coordinators as DCs, Ayushman Mitras as AMs, medical coordinators as MCs and respondents from common service cetres as CSCs. Double coding of transcripts was done, and the coding was reviewed by a team member to resolve discrepancies and to ensure quality control. To strengthen validity, peer debriefing was done.

Ethical Considerations

Ethics approval was obtained from PHFI IEC (Institutional Ethical Committee) with PHFI IEC Approval Number & Date: TRC-IEC 470/21, July 13, 2021. Necessary state approvals were obtained for the study. Informed consent was obtained from the respondents and the confidentiality of the respondents was maintained. Anonymity of identity and confidentiality of information was assured to all the participants.

III. Results

We have organized the key themes emerging from the 21 key informant interviews, triangulated with a secondary analysis of existing documents, into the seven dimensions critical to the success of the PMJAY program.

Enrollment and Awareness Generation

Challenges in beneficiary enrollment due to data issues

PMJAY is an entitlement-based scheme where beneficiary identification is based on the Socio-Economic Caste Census (SECC 2011) data, with flexibility for states to cover additional beneficiaries using their own criteria. Interview respondents noted that while the beneficiary list is comprehensive, certain key vulnerable population groups are still being left out by the PMJAY scheme and there is scope to improve inclusiveness. One respondent noted that: *"Many NGOs provided suggestions and also requests from – widows, orphans, old age homes etc., should be included".* To accommodate the left-out vulnerable population groups, the SHA in MP in coordination with the government, identified two schemes - the state-level Chief Minister's Sambal Yojana and the National Food Security Act, in which the database of poor families getting benefits were available. These databases were integrated into the SECC database through the Samagra ID - the live database for the residents of MP, and used to verify left-out families to expand the PMJAY beneficiary pool. Additionally, government issued IDs like the Aadhar and Below Poverty Line (BPL) cards were used for identity verification. With these efforts, left-out vulnerable groups have since been enrolled under the PMJAY in MP. One state level official said that building and construction workers have also now been included. Apart from the 84 lakh beneficiary families approved through the SECC database, additional 10.8 million and 47 million individual PMJAY beneficiaries have been included in MP through the NFSA and Sambal Yojana respectively. In Shahdol, target groups are

mainly the rural poor – those falling below the poverty line and the tribal population, many of whom have been enrolled through the Sambal Yojana.

Since the SECC 2011 database is outdated, most respondents identified targeting the beneficiaries as a major challenge. Some disadvantaged groups are excluded, missed, or, not covered under the scheme due to issues such as – (i) actual details including their names and family details do not match; (ii) ineligibility due to enrollment under a separate Samagra ID; (iii) ineligibility due to change in economic status, e.g., people whose parents were better off or had stable income, but whose economic condition has since deteriorated. As per a district level official, about 15-20% have a document but are not eligible, and 3-4% are eligible but do not have a card. One of our respondents (AM) noted *"Some patients come who are very poor, and have no document. We get 10-12 such cases per month. They are poor and require card but do not have card."* These include mostly daily wage workers, some tribal and very poor people (about 5-10% in Shahdol district), poor farmers and farm workers, vegetable vendors, migrant laborers, beggars, and destitute people.

Additionally, merger of the databases has led to duplication of beneficiaries. One interview respondent noted, *"There may be some overlaps of the two data sets. NHA also accepted it. So applied a pro rata basis – 71 per cent is SECC and remaining 23 per cent is state data base and payment was decided accordingly".* Another respondent proposed that: "*for registration and ensuring maximum enrolment of beneficiaries, card enrolment drives should be organized at the district collectorates, as it would ensure to reach out to maximum beneficiaries.*

Need for improved awareness generation

Since PMJAY is an entitlement-based scheme and does not involve any advance enrollment process, demand generation through information, education and communication (IEC) activities and dissemination of scheme information to target beneficiaries is vital. Respondents felt that many IEC initiatives involving various stakeholders have been launched to improve awareness. The first major drive was the "Gram Swaraj Abhiyaan" of the Ministry of Rural development on 30th April 2018, named as Ayushman Bharat (AB) Diwas. Awareness was raised about the scheme benefits and entitlements by involving grassroot health workers like ASHAs, ANMs and Gram Sevakas covering around 300,000 villages across the country. In addition, a dedicated web portal for the scheme, www.pmjay.gov.in, has been created to provide details about the scheme with all relevant information and links to the list of empaneled hospitals, an "am I eligible" portal, grievance redressal policy, gallery, and operational guidelines.

The scheme information is displayed in all public and private hospital facilities and CSCs using hoardings, banners, posters or flex boards. The AMs and CSC operators are actively involved in IEC activities such as providing information about the scheme, scheme helpline, empaneled public and private hospital and facilities directly to visiting patients or through mobile phones to local residents and district coordinators. Additionally, a dedicated AB room/*Ayushman Kaksh* is available in the medical college hospitals, and efforts are made to organize camps and distribute pamphlets. However, one of the district officials pointed out that: "*banners and posters are there. But since patients come to the hospital in critical condition, he or his attendants often miss to notice those banners."*

Despite the efforts to generate awareness, respondents felt that it needs further improvement. One respondent argued that "*frontline workers such as ANMs and ASHAs could be best utilized during home visits to increase awareness about the scheme*". A medical coordinator from one of the district-level facilities mentioned that *"people don't have [any] idea about medical terminologies. Even if people are literate, they cannot understand the banner*." Hence, it should be ensured that the hospital information display flex and hoardings are made in simple language that is easily understood by the general public.

One of the suggestions offered by a district official was to engage local governments at village level to build awareness of the scheme. A district official stated: "*In villages, people generally have contacts with the patwari/ panchayat sachivs. If they could be approached and requested to inform people about PMJAY, this could not only generate awareness about the scheme but also enhance enrolment as they have details and information pertaining to each and every family in that village. In urban areas, ward-in-charges who generally work with municipality/Nagar Nigam could be used to conduct awareness meetings and improve enrolment. Card making is done in wards but however, people are not aware about where to go or what benefits they can get through it*". The lack of awareness has also led to issuance of fraudulent cards. As one respondent said: *"If we can provide Universal Health Coverage, that would curb problem of fraud cards. Sometimes person gets to know on day of emergency that he/she has a fraud card and it is already cancelled and this becomes catastrophic for him/her".*

Respondents mentioned that many of the activities to improve beneficiary enrollment mentioned above were disrupted and had to be halted when the COVID-19 pandemic struck. Beneficiary card generation in Shahdol district was affected, especially among those from the poorest areas, but has since resumed. District-level officials are engaged in organizing enrollment camps along with the CSCs. Efforts are underway to issue cards to 80-90 per cent of the beneficiaries through CSCs with full support from district collector.

Health Benefit Packages, Rates and Revisions to Packages:

Smooth process of benefits package development and revision

PMJAY provides more than 1500 packages and their prices have been fixed by the NHA. PMJAY defines the treatment packages as the bundle of medical procedures and the corresponding package rates are applied. However, every state makes its own decision on what packages are to be included. Since there are differentials in the disease profiles and cost of services across the states, states have been provided with the flexibility for revision and expanding the package numbers and prices within a limit. The state of MP has successfully adopted the national level PMJAY scheme package and revised it to add additional benefits and packages for beneficiaries. MP adopted the national packages, and included packages such as infertility and IVF, which were being provided through existing state-level schemes. As per the NHA guidelines, MP added additional features such as a beneficiary critical illness fund that was subsumed into PMJAY scheme. One state level official stated: "*Review of guidelines is an ongoing process. Our package document was reviewed 4 times recently. Even when a hospital complains that some procedure is not there, SHA had raised the requirement of some procedures at state level such as that for the infertility treatment*."

Measures to avoid misuse of benefits package

In order to avoid misuse and overuse of certain services by the private facilities, certain PMJAY packages are 'reserved' exclusively for public facilities. The set of conditions to qualify as a reserved package is decided by the NHA and can be revised by the state.(12) Although the reserved packages were open when the COVID pandemic hit, some of these packages were taken back from private facilities. According to one of the state level respondents, one third of the initial 472 PMJAY packages in MP were reserved packages: "*At that time, initially there were only 1300 packages, considering that government set up will use them. These were largely high-volume low-cost packages. For example, emergency packages such as for fracture were also reserved. After 1 year, we found that the tertiary packages cannot be reserved, so we convened a meeting of Medical Colleges, and the committee reduced the reserved packages to 236. Currently there are 191 reserved packages."* 131 packages are now included for private medical colleges. Cataract treatment and laparoscopic C-sections are open to private medical colleges as reserved packages to help benefit the medical students. One of our respondents noted: "*Reserved packages have been included to avoid misuse. Emergency is also open to both sectors, since we cannot make the patient wait for receiving care".*

Best practices in Madhya Pradesh

The PMJAY scheme in MP has 1578 approved packages and there are additional 94 smaller packages that were initially added by the state as unspecified packages. These are now part of the updated Health Benefit Package HBP 2.2 in MP. Service like kidney transplantation was not available in any state in the country and only dialysis was part of the initial national level PMJAY scheme. MP is the first state to include kidney transplants under Ayushman Bharat, and these have since been included by the NHA in the national package.

To ensure that hospitals do not overcharge and that rates across the hospitals in the state do not vary, empaneled health care providers are paid based on specified package rates. The package consists of all costs associated with the treatment including pre and post hospitalization expenses. Respondents mentioned that surgical packages are paid as "bundled"- a single all-inclusive payment. This payment includes registration charges, bed charges, nursing and boarding, fees for medical team, operation theater medicines and drugs charges, cost of devices/implants pathological and radiological tests, food for patients, and pre and post hospitalization charges up to 15 days of discharge for the same ailment. Day care packages are paid just as surgical packages. Medical packages are paid on a per day rate based on the admission unit (general ward, ICU, etc.), with certain pre-decided add-ons that need to be paid separately.

Challenges in categorization and access to benefits packages

According to Medical Coordinators, one of the major issues of the PMJAY scheme is the availability of medicines for patients. However, the coordinators manage to handle this challenge to a large extent with the help of the pharmacists and the designated AMs. Additionally, certain illnesses were not covered in the PMJAY package.

During the pandemic, initially there were no COVID-19 packages available to PMJAY beneficiaries, but were introduced later to facilitate COVID-19 treatment under the scheme. One District Coordinator mentioned that "*It was only later around April, that a separate package for COVID was introduced, after several rounds of online discussions/meetings with public, private, AMs etc. There were problems initially. However, some flexibility was provided by SHA so that free treatment for COVID could be provided under the Ayushman Bharat."* Even after addition of COVID-19 packages, TPA stakeholders noted that access to treatment was hindered due to hesitancy of private hospitals to provide care at the low package rates offered under the scheme.

Governance

Rationale for choosing trust model over insurance model

The central government allows states to choose from different models for PMJAY implementation based on different levels of preparedness and capacities for managing the schemes. Under the trust model, the financial risk of implementing the scheme is borne by the Government and the SHA reimburses the health care providers directly. Insurance companies are not involved, instead the SHA employs the services of an Implementation Support Agency (ISA) for claims management and related activities. MP opted for the trust model which is implemented by the SHA – *Deen Dayal Swasthya Suraksha Parishad* and Vidal Health Insurance is deployed as the ISA. Since there is no insurance company involved, the SHA is also involved in other specialized tasks such as empanelment of hospitals, beneficiary identification, audits, undertaking surveys of hospitals and sending the report to the executive committee, and tasks like issuance of show cause notices to empaneled hospitals The SHA works in close collaboration with the Directorate of Health and Family Welfare and is guided by the NHA directives. The SHA is the supreme and ultimate deciding authority for fixing the rates for packages. Though package rates are decided by the NHA, the CEO of the SHA has the discretion to increase the package rate by 10%. Payments to beneficiaries and grievances management also come under the purview of the SHA. Similarly, for grievance redressal, SHA is the key authority and the grievances are routed through ISA, Vidal health insurance agency.

One state level respondent argued that the government preferred to go through TPA/ISA model rather than an insurance agency because: "*TPAs are now basically doing all the roles of insurance companies, in my opinion both are the same; instead of having an insurance company it's better to go directly through the TPA as insurance agency will not do this work directly, they too will forward the work to TPA. Hence, it is good for SHA to hire the TPA directly as it is more cost effective. Insurance companies do not take the risk which they are supposed to take, so better to go for TPA."* However, another state level official pointed out that the Vidal Health Insurance TPA, is '*understaffed, unclear about staff requirements and needs skilled people*.'

Efforts to align hospital empanelment with healthcare needs

As of September 2021, a total of 455 government hospitals and 430 private hospitals have been empaneled under Ayushman Bharat in the state of MP.(32) Both public and private hospitals have to apply online through the PMJAY Hospital Empanelment Management (HEM) portal. Empanelment and de-empanelment are done by the SHA in collaboration with the Directorate of Health, involving the Chief Medical Health Officer (CMHO). Describing the process, one of our respondents, a TPA official, noted that "*application for hospital empanelment is done through PMJAY portal Hospital Empanelment Management system. Hospital raises requests with information on doctor's certificate, nurse's certificate, biomedical certificate. Request goes to MP-SHA. If documents are not sufficient, then they are asked to submit required documents. State Empanelment Committee (i.e., a three-member committee consisting of a specialist, a district quality assurance committee member and an MBBS doctor) gives a nod if found suitable. District coordinators provide independent feedback too to the SHA which is considered separately*". Checklists, guidelines and scoring systems are available for National Accreditation Board for Hospital and Healthcare Providers (NABH) and Non-NABH facilities based on several criteria such as number of beds and overall infrastructure. Normally, a score of 80-90 points is essential for empanelment. Hospitals with scores above 70% are eligible and recommended for empanelment. All mandatory documents are to be submitted along with the 70% scores. Relaxation in points and the marking system is allowed, especially to improve access in hard-to-reach interior regions. For instance, according to one state level official, to enhance access to services at non-NABH facilities catering to tribal/hard to reach areas, the minimum requirements were relaxed from 50 beds to 10 beds. Based on NHA guidelines, hospitals in aspirational and tribal districts were provided 10% incentives over and above the rates used for government/private hospitals, government medical colleges and teaching hospitals.

Timely empanelment of hospitals affected by lack of clear guidelines

Respondents mentioned that there is a lack of specific guidelines and documentation regarding the adequate number of hospitals to be finalized and the timelines for empanelment. The SHA decides whether additional hospitals are to be empaneled. Due to issues in the provision of required documents by hospitals there are delays in the empanelment process. One TPA respondent explained: *"There are no such timelines, or MOU exist with regard to the time taken for the empanelment process. It has been seen that normally within 40 days the report comes back. Hospitals are not very "internet savvy" so they take their own time to get back to SHA with supporting documents, providing details etc., which are the main causes for the delay. There are no mechanisms, SHA comes back to Vidal's District Co-coordinators (DCs) DCs act as a link/mediator/bridge between the SHA and the hospitals for removing the hindrances, uploading documents on the portal etc. Empanelment was not the job of TPA. It was the job of the development partners like KPMG etc. Now the DCs help with the process. In all the committees including the district committee, the DC is a member. "*

Measures in place to detect fraudulent practices

In order to keep corruption and malpractice in check, said one state level official, an anti-fraud mechanism is in place and is responsible for overall monitoring and control of fraudulent practices. A special state anti-fraud committee is in charge of checking misuse of the scheme. The general public is also encouraged to report any cases of fraud via telephone, written complaints, or through the AMs/DCs/call centres/CRRMS portal. The common types of fraud are related to exaggerated medical bills presented by a hospital and overuse of certain packages by some private hospitals. One TPA respondent further noted: *"The major complaints received were on over charging, package misuse, over use of certain procedures, fraud and other violations. In some cases, OPD cases are being treated as IPD cases by the hospitals and as per one of the respondents and this happens in some private hospitals and this could be missed as the hospital is smart enough to manipulate the documents".* Respondents mentioned that private hospitals commit these types of fraud when beneficiaries are not aware of what they are entitled to. A state-level respondent said: *"If such complaints are received about a hospital 2-3 times, inspection of the fraud is done and the hospital is penalized*." A financial penalty amounting to three times the amount that is to be actually charged is levied in some cases.

De-empanelment is done only in response to serious complaints or grievances against the hospital. De-empanelment is based on the triggers shared by the NHA and a state audit. If the complaint is about a certain procedure, then that procedure is stopped, especially if it is found that the procedure is being misused or overused. In such cases, the bills against the payments are verified and necessary action sought. Only in cases where the damage caused is irreversible does the hospital face de-empanelment. CEO Trigger Mechanisms and Anti-Fraud Units are available with the SHA and the power lies with the CEO of the SHA to decide whether to de-empanel the hospital or not. The concerned hospital is informed about the investigation and a First Information Report (FIR) against the hospital is filed in the case of a grave offence. In the case of financial complaints, the SHA reaches out to hospitals. In MP, 3-4 hospitals were de-empaneled during the last three years. One state level official noted that: "*fraud was getting detected only after it takes place. But our motive should be to prevent the fraud and not merely detect it later*."

Financing Mechanisms

Claim settlement process

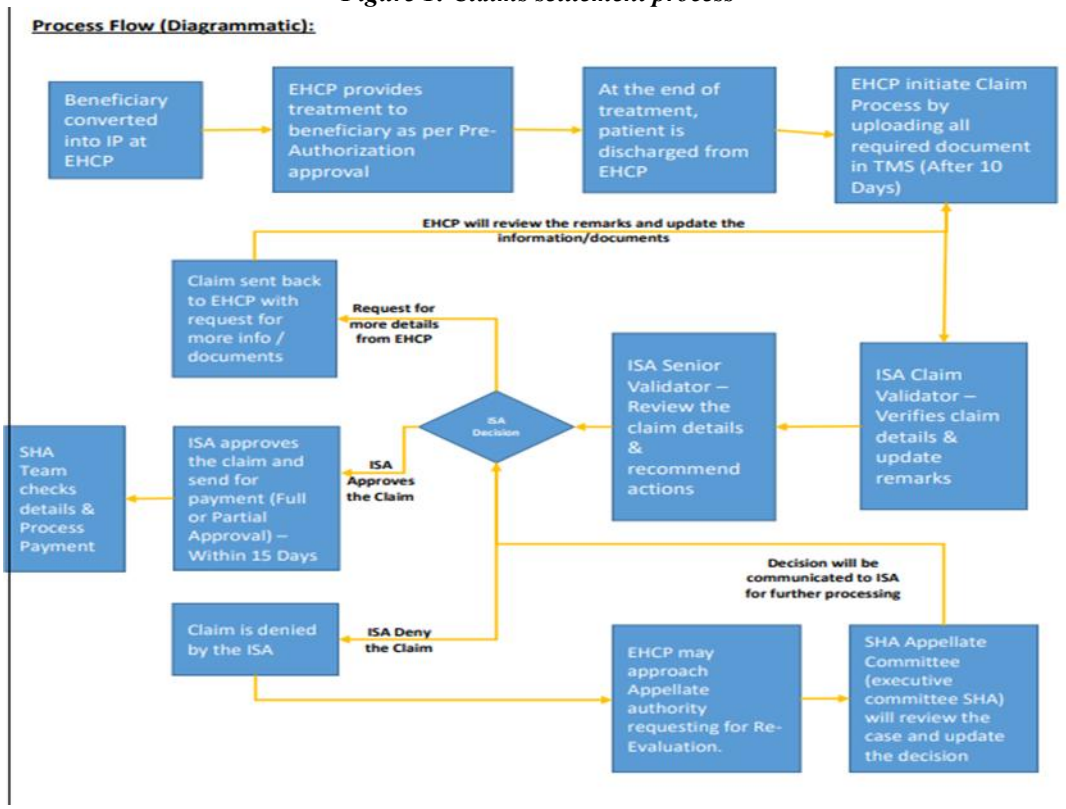
The average cost of PMJAY packages is fixed both for the private and the public facilities. The NHA provides the money per family in the ratio of 60:40, i.e., 60 per cent by the center and 40 per cent by the state based on the total number of families. As a per claim-based reimbursement was not viable, claims are paid to the empaneled hospitals as per the package rates provided by the Government of MP.

The AM at hospitals upload all the mandatory documents to the mptms.pmjay.gov.in website. As per one of the AMs, "*when a patient comes for IPD, I collect the Ayushman card/other available document, else the IPD number and enter it on the Transaction Management System (TMS). The medical coordinator at the facility does the diagnosis and helps in identifying the package code and the patient is admitted as per the package code. Pre-authorization is requested and obtained from the TPA and then the treatment starts. At the time of discharge, I collect all the supporting documents including the discharge summary sheet from the patient/hospital and upload them on the TMS for claims processing.*" Claims documents, including package details and procedures performed, preauthorization details, final diagnosis, clinical notes, postoperative photographs, and discharge summary, are checked and approved by the ISA. If there are queries, the documents are sent back to the DCs. There are more claims from public (70%) compared to private facilities (30%). Audits of the claims are done by the ISA. In addition, a sample of the claims approved by the ISA/TPA-Vidal is audited by the SHA before the claims are passed. Hospitals also have an opportunity to appeal any rejected claims. In such a case, the claim is reviewed by the claims committee constituted under the chairmanship of the CEO of the SHA. If a claim is found to be wrongly rejected, the ISA reviews the case again and sends the report to the SHA which is the final decision-making authority. One of our respondents from the SHA mentioned that "*as a part of prepayment audits, ISA is required to perform random audit of 5% of claims quarterly and submit the report to SHA. Independent claim audits are undertaken separately by the team from SHA. Reports are given by ISA but actions are taken by the SHA."* If any discrepancies in claims are noted, the ISA is penalized. There is an internally agreed upon 4 per cent industrial error rate. Penalties are levied in the case of false claims approved. Figure 1 shows the claim settlement process.

The timeliness and smooth functioning of the claims process solely depends upon the co-operation by the hospital authorities. Claims are raised only after discharge of the patient. Average time for processing is normally 10-15 days. As per the PMJAY guidelines for claim settlement, the process in relation to a claim is to be carried out to ensure that the turnaround time is no longer than 15 calendar days irrespective of the number of working days. However, as per the AMs, the '*final claim settlement takes about 15 days in the absence of any queries and up to a maximum of three months*.' According to the respondents, some of the challenges faced and reasons for claim rejections include obtaining pre-authorization, selection of the wrong package, incomplete

documentation and inability to upload documents properly. Some of the AMs mentioned that although pre-authorization should be given within 6 hours, there are delays of up to 24 hours to obtain pre-authorization, thus resulting in delay at the start of treatment. A Medical Coordinator said: "*not only are there delays in pre-authorization, but sometimes the queries raised during pre-authorization are not in line with the treatment protocols*." One of the AMs noted: *"another problem is rejection as a result of remarks/queries put forward by the Claim Panel Doctor – CPD who checks the medical related documents. If all documents are proper the CPD approves for payment, else, it is sent back to the facility. We have had 54 CPD rejections since 2018. These have not been resolved till date and are still being audited."*

Figure 1: Claims settlement process



Source: CLAIMS SOP, Deen Dayal Swasthya Suraksha Parishad, November 2018.
https://www.ayushmanbharat.mp.gov.in/

Performance-based incentives to improve service provision

Performance-based incentives for providers are decided by the states, but not mandated or expected by the NHA. All respondents felt that incentives help to keep the staff motivated, which impacts quality of service provision. Respondents mentioned that when there are no incentives, sometimes doctors did not provide certain services. With provision of incentives, performance was better and hospitals could also push doctors to promote the PMJAY scheme. The PMJAY incentives for both public and private hospitals are same. While the incentive money given to private hospitals are utilized by them, the money generally goes to Rogi Kalyan Fund in public hospitals, a government fund to improve public hospitals(33). While 40% of the funds under Rogi Kalyan Fund can be used as incentives for all categories of staff, including the doctor, these funds remained unused.

Utilization

Claims settlement process impacted by administrative delays

Service use is reflected by the claims raised. Higher valued claims represent complex and costly procedures. As per one TPA, on an average, the state receives about 1500-2000 PMJAY claims in a day. ISA respondents said that the average claims of the state are at par with the national average. MP is one of the best performing states after Chhattisgarh under PMJAY and has made payments of INR 50,000 million. The average claim per episode is around INR 18000-20,000 for 4-5 days of hospitalization in a private facility according to one of the TPA's. The claims rejection rate in MP is around 5%. Rejection of claims occurs when there is lack of documentation from the hospital. In such cases, reminders are sent twice to the hospitals concerned. Under the PMJAY scheme in MP, many hospitals, especially private hospitals, face payment issues. There is a time lag of

30 days from claims initiation to disbursement to hospital. Payments to private hospitals are pending in many cases, which creates liquidity problems. Moreover, private hospitals are also dissatisfied with the low PMJAY package rates. Issues with regard to claims from private hospitals are usually dealt with by the District Coordinator. While the DC can speak to hospital authorities to resolve the issues, they do not have any financial powers. Delays in payments are also caused by lack of documentation, especially by public hospitals. According to one of the district officials, "*some hospitals are reluctant to give the documents to AM for uploading as a result of which he is unable to provide pre authorization and also results in delays. Claim process solely depends on the co-operation with the hospitals*." One of the respondents suggested that there should be stipulated norms on the turnaround time for payments and provision for appeals in case of delays. Another district level official suggested that reimbursements should be routed through nodal officers, who can conduct checks such as unnecessary or over prescription of medicines and monitor any improper use of government funds.

Volume of claims were lower during the first two waves of the COVID pandemic

Key informants mentioned that about 75% of treatments received at medical colleges daily are PMJAY cases. However, during the COVID pandemic, especially during the first wave, only about 30% obtained treatment under PMJAY. The reasons for this low proportion were that documents were not available, or attendants were not present. Overall, during COVID-19 pandemic, there was almost 50% decline in PMJAY cases. Only those who were absolutely in need of services came to hospital to avail them. According to one of the AM, "*Prior to COVID in the District Hospital alone, per day on an average about 40-50 claims were received. During COVID this reduced to around 10".* Another respondent from Vidal TPA added: "*during COVID the number of claims fell drastically. It was around 60/70 or a maximum of 200 per day; but pre COVID it was around 1000 per day. 3 months of 1st wave (period) and 2 months of 2nd wave (period) claims were about 200 per day. Now claims have increased to 1500-1600 per day."*

Claims volume highlights disparities in access and quality of care under PMJAY

Respondents noted that there is low utilization of PMJAY services in public hospitals as beneficiaries preferred accessing private facilities over government facilities. Distribution of claims from private vs public hospitals is in the ratio of 60:40 as per one of our respondents. One stakeholder noted: *"we advise the beneficiaries to use the Ayushman Bharat card in public hospitals if they have a card. However, some people are reluctant to use the card in public facilities as services are already being provided for free at these facilities.".* Another respondent (AM) said "*Patients are not willing to hand over documents relating to PMJAY, since it is a government hospital, where treatment is free. They want to utilize the card in private hospitals."*

Key informants mentioned the disparities in health care access in urban vs rural areas is also reflected by the difference in claims volumes. While the capital district of Bhopal has a high concentration of hospitals, other remote districts and inaccessible tribal areas do not have enough hospitals. According to the district level official from Bhopal, around 40-50 claims per day are raised by Medical Colleges, 10 + claims per day by District Hospital (DH), around 5 per day by Civil Hospitals and around 3 per day CHCs. In CHCs, cases are mainly deliveries, fractures etc. In Bhopal, only about one-fifth of the monthly beneficiaries utilize PMJAY services from public facilities, majority of the services utilization is at private facilities. In Shahdol, as per the district level official, around 250 cases utilize services from the District Hospital - around 10 cases average a day. Talking about the disparities in service access, key informants pointed out that out of 55 districts in the state, only 15-20 districts have good public and private hospitals, and there is a need to focus on these High Priority Districts (HPDs). For instance, in Rajpur, an interior, rural district, even a single claim has not been raised. Where private hospitals are not present, district hospitals should be upgraded. Some hospitals were empaneled on an emergency basis during COVID-19 and they were de-empaneled after the pandemic, but they are open to reapply for empanelment in future.

Capacity Building

Established and well-functioning process for training and capacity building for PMJAY operative staff

All interview respondents felt that there were adequate training and capacity building initiatives for the PMJAY staff in MP. About 3-4 months prior to the initiation of the scheme and even before the bidding process and hiring of the TPA, the SHA, along with the development partner organization KPMG, visited all districts in MP and recruited AMs. Besides providing the AMs with a Login ID and password, they were also briefed and trained about the scheme including the inputs, processes and other salient features. Since empanelment of district hospitals and medical colleges was automatic, Vidal was actively involved in trainings and refresher courses across the districts, over and above other district-level trainings. The NHA also provides training at the state level on a monthly basis.

At the district level, regular monthly and need-based trainings are conducted for the AMs by the district coordinators and nodal officers. While initially trainings were mostly class room based, during the COVID-19

pandemic, online trainings were initiated, mainly through video conferencing. One of our respondents noted*," trainings are good. Face to Face trainings is definitely better especially in cases where approvals etc., are pending as the process is much faster.".* Another respondent pointed out that "*Online trainings have recently been initiated; during COVID. Earlier class room-based trainings were conducted. Online trainings are conducted once in 2 months for AMs. Trainings mostly include for addressing/sorting out problems that arise in TMS etc."* In Shahdol, however, being a poorly resourced district, monthly trainings offered for AMs are class room-based trainings, though these were affected by the pandemic. The SHA also organizes periodic trainings to address issues related to the Transaction Management Systems (TMS), newer additions introduced, changes/updates in software (e.g., when ESIS was merged), and solutions for grievances for AMs. Trainings are also conducted for all other staff associated with the scheme, such as ANMs and ASHAs, for motivating and bring beneficiaries to get their PMJAY cards made. Almost all respondents felt that the trainings were helpful.

Trainings related to PMJAY are also provided for CSCs operators. In cases where CSCs are located in villages, the DCs conduct the trainings. Sometimes trainings for CSCs are also organized by the Collectorate. CSCs and DCs also provide support to resolve issues through a WhatsApp group, audio and video calls.

IV. Discussion

This study aimed to understand the supply side challenges and obstacles faced in the roll out and implementation of the PMJAY scheme in MP, one of the largest and fifth most populous state in India. PMJAY has evolved with lessons from the long history of PFHI schemes in the country, such as the ESIS, CGHS and RSBY. One of the major criticisms of PFHI schemes is that these often exclude certain section of population (like children, elderly and unmarried members) who need financial risk protection.(34) The results from our study indicate that beyond the eligibility determined by the main criteria of the SECC 2011 database, the use of MP state's own databases, such as the NFSA and Sambal Yojana databases, has enabled the state to ensure that the beneficiary list is comprehensive and covers a greater number of beneficiaries. However, there is still scope to expand inclusiveness. Our study confirms that those excluded beneficiaries are mostly daily wage workers, some tribal groups and very poor people, poor farmers and farm workers, vegetable vendors, migrant laborers, beggars/destitute people, who are either so poor that they do not have any document or are living away from their home. Mismatch of data across different documents has been a challenge for enrollment. Our study also found that some deserving people are not eligible due to the outdated SECC 2011 list. A more recent survey would provide better inclusion and exclusion results. MP state has undertaken efforts to include building and construction workers, widows, orphans, destitute people, and residents of old age homes.

To overcome the criticism of low enrolment rates under the RSBY(35), the PMJAY scheme in MP under various IEC initiatives involves all levels of health workers and providers. Apart from launching various enrolment campaigns like "Apke Dwar Ayushman" and camps and setting up Common Service Centres, frontline workers like ASHA, ANMs, and AMs are actively involved in information sharing and beneficiary enrolment. MP is one of the states with the highest beneficiary enrollment and evidence from our study shows that around 80-90% of the target population in the sampled districts now have PMJAY cards. While efforts to provide scheme information at empaneled hospitals through hoardings and banners/flexes on their premises are helpful, our study points to the need to ensure that banners displayed are in simple, regional and non-medical and non-technical language that can aid in increasing awareness. Under the RSBY scheme, at the time of registration, booklets were provided to beneficiaries that contained detailed information on the list of empaneled hospitals, availability of benefits/entitlements, and details of contact persons.(36) Such a booklet would be a useful source of information to beneficiaries as currently they need to rely on hospitals for information.

PMJAY in MP provides benefits for 1578 approved packages in secondary and tertiary level hospital care following HBP 2.0, which had certain advantages, including enhanced coverage of both disease conditions and procedures, across specialty packages, and multiple procedures in a package as compared to HBP 1.0. The state adopted the national packages and also included packages such as kidney transplantation, infertility treatment and IVF, as well as added pre-existing schemes and packages that were already running in the state. Interview respondents reported that package documents are reviewed regularly at the request of hospitals or through SHAs assessments. Currently there are 191 reserved packages for government hospitals, which were listed as 'reserved' to avoid misuse of the packages. Our study found that the private medical colleges in the state have requested to allow them to handle reserved packages for the benefit of the medical students. Reserved packages also include some services that are required in emergency care, and those should be reviewed so that patients should not be kept waiting to receive care in the private or public sector.

MP opted for the trust model under which PMJAY scheme is directly implemented by the SHA and TPA for claims management and related services on a three-year contract basis. Interview respondents felt that this trust model is more cost effective. Moreover, since insurance companies do not bear the risk that they are supposed to take, the TPA is preferred for any government funded insurance. While discussing the claim settlement process, respondents noted that there is a need for reassessment and training to align the interpretation of the documents

required for a claim settlement among Ayushman Mitras and TPA, as this results in delays. The TPA also needs more skilled personnel for efficient management of the system.

In order to provide quality care to beneficiaries, it is important to maintain and grow a network of hospitals, which is done through the empanelment of hospitals. Empanelment is done by the state and CMHO; DHO and nodal officers are involved in the process and the decision on empanelment is subject to approvals from the empanelment committee. As found in other studies(37), our study found a low incidence of de-empanelment of hospitals in the sampled districts of MP. In general, hospitals are only de-empaneled as a result of grave complaints or grievances like irreversible damage/harms caused by a treatment. The major complaints received were on over charging, package misuse, over use of certain procedures, fraud and other violations. More defined and streamlined regulations are needed to address these issues and to reduce their incidence. Respondents such as the Ayushman Mitras and CSC service providers who interact with beneficiaries emphasized that poor people in MP are aware of the program and are receiving health benefits from the program. However, they also reported that some people are reluctant to use the card in public facilities as services are already being provided for free. Our study points out that beneficiaries prefer to seek treatment from public facilities for minor treatments and those treatments that are provided for free. However, they prefer to save up and avail their PMJAY entitlements for more serious conditions/high end specialized treatments from private facilities. In a state where the state-financed health system and state-financed insurance system co-exist, this reluctance is a challenge.

While discussing the use of incentives to improve performance, respondents said that the performance was better when incentives are provided and was used as a mechanism to promote the PMJAY scheme. However, utilization of incentive funds needs to be improved, especially in public hospitals, where the funds are allotted under the Rogi Kalyan Fund and remain unused.

Our study findings indicate the need to further streamline the backend processes thereby reducing and preventing unnecessary delays. As found in previous studies(38) our study also reports delays up to 24 hours in obtaining pre-authorization approvals and issues with queries raised at the time of pre-authorization approvals that are sometimes not aligned to the treatment protocols, thereby resulting in delay in initiation of treatment. To streamline payment processes and avoid delays, respondents suggested introduction of stipulations regarding the turnaround time and mechanisms to make appeals for pending payments. Moreover, documentation delays need to be addressed to reduce delays and rejection of claims.

While respondents are generally satisfied with the PMJAY capacity building and training activities in MP, more skilled staff are needed to facilitate smooth functioning of the PMJAY program. Many of the staff have acquired their skills on the job and though they are provided with online/offline trainings, there is a need for further capacity building activities of stakeholders and re-visiting guidelines based on the emerging challenges. Respondents also mentioned that there is a need to expand PMJAY services in high priority remote districts and tribal areas which lack access to health facilities and hospitals.

Study strengths and weaknesses

Our study highlights some of the supply-side enablers and challenges faced by the PMJAY program based on assessments carried out among a wide range of stakeholders at state, district and facility level. The study does not intend to assess outcomes (which ideally requires a quantitative approach) but rather to infer the enablers and barriers for effective functioning of the scheme based on qualitative assessments of respondents. For improved population outcomes, it would be ideal to explore the demand-side perspective i.e., the perspectives and experiences of beneficiaries, which was not the focus of our study. Additionally, our study was conducted during the initial years of roll out of the scheme and hence, the findings pertain to challenges, barriers and realities faced during the early stages of implementation of the program. Besides, during the initial phase of roll out of the scheme, all public health facilities i.e., Community Health Centres, District Hospitals and Medical Colleges were automatically empaneled. This has however changed over time, with more private hospitals being empaneled especially in cities like Bhopal where there is a large presence of private sector. Another limitation is that being a qualitative study, a purposive sampling strategy was adopted.

V. Conclusion

PMJAY is one of the nationwide schemes that have successfully benefitted many people from poor and vulnerable sections of the population who could not otherwise afford the high treatment costs. Despite its success, the program may consider to include the poor and the vulnerable population who are currently not covered. For better functioning and inclusiveness, there is a need to identify gaps in the program design and implementation process. Better awareness, monitoring, grievance redressal and co-ordinations between different stakeholders are essential for smooth functioning of the scheme at all levels. Key stakeholders including the NHA, SHA and health care providers should collectively explore and continue focusing on leveraging digital technology for streamlining processes and ensuring efficiencies across different domains including beneficiary identification, claim settlement, grievance redressal, empaneling providers, fraud mitigation, among others.

Appendix 1 Interviewees

Table 1: Description of the stakeholders, their roles and responsibilities

Stakeholders	Roles and responsibilities
Ayushman Mitra	All government hospitals have an Ayushman Mitra (AM) appointed by Vidal who is responsible for collecting documents, checking eligibility, enrollment and uploading claims on the TMS portal. When beneficiaries visit the hospital, AM collects the documents, and if they are eligible, the cards are made. AM's roles/ responsibilities include providing clarification on queries of the patients who come for treatment, guiding patients to hospitals, assisting in issuance of Ayushman card, addressing issues related to card, handling the biometric process, pre-authorization, package blocking, addressing patient complaints, conducting awareness camps etc. They also help in enrollment of patients; identifying and ensuring that eligible patients who names are missing are added. They also address the challenges in pre-authorization and issues involved in claims rejection. They work in close co-ordination with the medical coordinators. AMs for public hospitals are provided by Vidal, the TPA. In case of private hospitals, AMs are appointed by the private hospitals themselves. Currently, total of 282 AMs in government hospitals are in Madhya Pradesh. 8 AMs were interviewed, both from public and private sector hospitals.
Medical Officer	They are also called Nodal Officer/Medical Coordinators. They have medical background and they also work as doctor in the hospital (or Assistant Professor in Medical College). Their main role is to monitor and supervise AMs. They solve queries from the AM about package selection and claim management. They help AMs in package identification. 2 Medical Officers are interviewed, one from Bhopal and another from Shahdol district.
Common Service Centre	They are involved in making the Ayushman Bharat cards. They are village entrepreneurs, who, apart from issuing AB cards, makes cards for government schemes like PM Jivan Jyoti Bima Yojana, Atal Pension Yojana, Grahak Seva Kendra, Pradhan Mantri Shram Yogi Maan-dhan Yojana, IRCTC (Train tickets), LIC (Life Insurance) and process other online forms. They have a CSC certificate, CSE ID and registration which is done online. Based on these, they are entitled to provide services. 3 CSCs were interviewed from the two districts.
District Coordinator	Every district has a District Coordinator (DC). AMs work under the DC who supervises the functioning of PMJAY scheme in public and private hospitals. DCs play a key role in grievances redressal related to issuance of cards, issues related to mismatches in the names and other documents etc., adding beneficiaries who are entitled but have been missed out for various reasons etc. DCs also support in organizing awareness camps and organizes training for AMs. Currently, there are 51 district coordinators in Madhya Pradesh.
District Nodal Officers	The role of the District Nodal Officer is to collaborate with District Coordinator and Ayushman Mitras to supervise and monitor the overall functioning of PMJAY scheme in the district.
TPA	Vidal is the ISA and responsible for compete implementation. One of the major roles of TPA is claims processing. Vidal is currently the TPA for the whole of MP, functioning with effect from 30th September, 2018 when the scheme started. It has been selected as TPA for PMJAY through a tendering process and was the L1 agency. Apart from claim processing, it is involved in managing the HR for Ayushman Mitras i.e., AMs are appointed for the public hospitals. Vidal was registered with RSBY. Vidal is working in PMJAY in 9 states (covering about 120 districts) in the country and is the biggest TPA in PMJAY. It is working in the states of Punjab, MP, Chhatishgarh, Gujarat, Rajasthan, Tamil Nadu and UP. Vidal has its presence in all 51 districts of MP.
SHA	It is the supreme authority and the ultimate deciding authority for fixing of the rates for the packages etc. SHA monitors the PMJAY program in the state and gets guidelines from National Health Agency. Hospital empanelment, payments for beneficiaries, grievances management are all are responsibilities of SHA.

References

[1]. Bredenkamp C, Mendola M, Gragnolati M. Catastrophic And Impoverishing Effects Of Health Expenditure: New Evidence From The Western Balkans. Health Policy Plan. 2011 Jul;26(4):349–56.

[2]. SDG Target 3.8 | Achieve Universal Health Coverage, Including Financial Risk Protection, Access To Quality Essential Health-Care Services And Access To Safe, Effective, Quality And Affordable Essential Medicines And Vaccines For All [Internet]. [Cited 2024 Feb 8].
Available From: Https://Www.Who.Int/Data/Gho/Data/Themes/Topics/Indicator-Groups/Indicator-Group-Details/GHO/Sdg-Target-3.8-Achieve-Universal-Health-Coverage-(Uhc)-Including-Financial-Risk-Protection

[3]. Central Government Health Scheme [Internet]. Available From: Https://Cghs.Nic.In/

[4]. Employees' State Insurance Scheme| National Portal Of India [Internet]. [Cited 2024 Feb 8]. Available From: Https://Www.India.Gov.In/Spotlight/Employees-State-Insurance-Scheme#Tab=Tab-1

[5]. Rashtriya Swasthya Bima Yojana| National Portal Of India [Internet]. [Cited 2024 Feb 8]. Available From: Https://Www.India.Gov.In/Spotlight/Rashtriya-Swasthya-Bima-Yojana

[6]. Chief Minister's Comprehensive Health Insurance Scheme [Internet]. [Cited 2024 Feb 8]. Available From: Https://Www.Cmchistn.Com/

[7]. YESHASVINI - SAHAKARA SINDHU - DEPARTMENT OF COOPERATION [Internet]. [Cited 2024 Feb 8]. Available From: Https://Sahakarasindhu.Karnataka.Gov.In/Page/YESHASVINI/En

[8]. Mahatma Jyotirao Phule Jan Arogya Yojana [Internet]. [Cited 2024 Feb 8]. Available From: Https://Www.Jeevandayee.Gov.In/

[9]. Myscheme - One-Stop Search And Discovery Platform Of The Government Schemes [Internet]. [Cited 2024 Feb 8]. Mukhyamantri Amrutum Yojana Scheme. Available From: Https://Myscheme.Gov.In

[10]. Ministry Of Health And Family Welfare, 2017. National Health Policy Of India 2017 [Internet]. [Cited 2024 Feb 8]. Available From: Https://Main.Mohfw.Gov.In/Sites/Default/Files/9147562941489753121.Pdf

[11]. About PM-JAY - National Health Authority | GOI [Internet]. [Cited 2024 Feb 12]. Available From: Https://Nha.Gov.In/PM-JAY

[12]. About PMJAY [Internet]. [Cited 2024 Feb 8]. Available From: Https://Pmjay.Gov.In/About/Pmjay

[13]. Preker AS, Lindner ME, Chernichovsky D, Schellekens OP, Editors. Scaling Up Affordable Health Insurance: Staying The Course. World Bank Publications; 2013 May 31 [Internet]. [Cited 2024 Feb 8]. Available From: Https://Documents1.Worldbank.Org/Curated/En/105061468340809824/Pdf/Scaling-Up-Affordable-Health-Insurance.Pdf

[14]. Expert Committee Report-SECC-2011 | Ministry Of Rural Development | Government Of India [Internet]. [Cited 2024 Feb 8]. Available From: Https://Rural.Gov.In/En/Secc2011/Expert-Committee-Report-Secc-2011

[15]. Pandve HT, Parulekar CV. Health Insurance: Is Indian Rural Population Aware? Int J Appl Basic Med Res. 2013;3(2):132.

[16]. Kusuma YS, Pal M, Babu BV. Health Insurance: Awareness, Utilization, And Its Determinants Among The Urban Poor In Delhi, India. J Epidemiol Glob Health. 2018 Dec;8(1–2):69–76.

[17]. Trivedi M, Saxena DB. Third Angle Of RSBY: Service Providers' Perspective To RSBY-Operational Issues In Gujarat. Journal Of Family Medicine And Primary Care. 2013 Jun;2(2):169.

[18]. Khetrapal S, Acharya A. Expanding Healthcare Coverage: An Experience From Rashtriya Swasthya Bima Yojna. Indian J Med Res. 2019 Mar;149(3):369–75.

[19]. Karan A, Yip W, Mahal A. Extending Health Insurance To The Poor In India: An Impact Evaluation Of Rashtriya Swasthya Bima Yojana On Out Of Pocket Spending For Healthcare. Soc Sci Med. 2017 May;181:83–92.

[20]. Devadasan N, Seshadri T, Trivedi M, Criel B. Promoting Universal Financial Protection: Evidence From The Rashtriya Swasthya Bima Yojana (RSBY) In Gujarat, India. Health Res Policy Syst. 2013 Aug 20;11:29.

[21]. Panda B, Rout HS. Does Public Health System Provide Adequate Financial Protection To Its Clients Through RSBY? An Exploratory Study Of Tribal Odisha. Journal Of Health Management. 2019 Dec 1;21(4):497–509.

[22]. Bharali I, Selvaraj S, Kumar P, Mao W, Ogbuoji O, Yamey G. India's NDIA'S HEALTH TRANSITIONS: COUNTRY PROFILE [Internet]. [Cited 2024 Feb 8]. Available From: Https://Centerforpolicyimpact.Org/Indias-Health-Transitions-Country-Profile/

[23]. Dash U, Muraleedharan VR. Accessing Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (PM-JAY): A Case Study Of Three States (Bihar, Haryana And Tamil Nadu).

[24]. Garg S, Bebarta KK, Tripathi N. Performance Of India's National Publicly Funded Health Insurance Scheme, Pradhan Mantri Jan Arogaya Yojana (PMJAY), In Improving Access And Financial Protection For Hospital Care: Findings From Household Surveys In Chhattisgarh State. BMC Public Health. 2020 Jun 16;20(1):949.

[25]. Sriee G V VP, Maiya GR. Coverage, Utilization, And Impact Of Ayushman Bharat Scheme Among The Rural Field Practice Area Of Saveetha Medical College And Hospital, Chennai. J Family Med Prim Care. 2021 Mar;10(3):1171–6.

[26]. Reddy NKK, Bahurupi Y, Kishore S, Singh M, Aggarwal P, Jain B. Awareness And Readiness Of Health Care Workers In Implementing Pradhan Mantri Jan Arogya Yojana In A Tertiary Care Hospital At Rishikesh. Nepal J Epidemiol. 2020 Jun;10(2):865–70.

[27]. Bakshi H, Sharma R, Kumar P. Ayushman Bharat Initiative (2018): What We Stand To Gain Or Lose! Indian J Community Med. 2018;43(2):63–6.

[28]. Angell BJ, Prinja S, Gupt A, Jha V, Jan S. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana And The Path To Universal Health Coverage In India: Overcoming The Challenges Of Stewardship And Governance. PLOS Medicine. 2019 Mar 7;16(3):E1002759.

[29]. Per Capita Net State Domestic Product - State-Wise (At Current Prices) [Internet]. [Cited 2024 Feb 8]. Available From: Https://Rbi.Org.In/Scripts/Publicationsview.Aspx?Id=20414

[30]. Government Of India, Planning Commission. Report Of The Group To Review The Methodology For Estimation Of Poverty. November, 2009 [Internet]. [Cited 2024 Feb 8]. Available From: Http://Www.Indiaenvironmentportal.Org.In/Files/Rep_Pov.Pdf

[31]. Sambal Portal, Jankalyan Portal, Shramik Sewa Portal [Internet]. [Cited 2024 Feb 8]. Available From: Https://Sambal.Mp.Gov.In/

[32]. Ayushman Bharat In Madhya Pradesh [Internet]. Available From: Https://Ayushmanbharat.Mp.Gov.In/

[33]. Guidelines_For_Rogi_Kalyan_Samities_In_Public_Health_Facilities.Pdf [Internet]. [Cited 2024 Feb 8]. Available From: Https://Nhm.Gov.In/New_Updates_2018/Communization/RKS/Guidelines_For_Rogi_Kalyan_Samities_In_Public_Health_Facilities.Pdf

[34]. Roberts M, Hsiao W, Berman P, Reich And M. Getting Health Reform Right: A Guide To Improving Performance And Equity. Oxford, New York: Oxford University Press; 2008. 352 P.

[35]. Narayana D. Review Of The Rashtriya Swasthya Bima Yojana. Economic And Political Weekly. 2010;45(29):13–8.

[36]. Sarwa A, Aggarwal AK, Prinja S. Local Elected Leaders ("Panchayat") Can Play Key Role For Enrolment Under National Health Protection Mission (NHPM) Under 'Ayushman Bharat': Lessons Learnt From Rashtriya Swasth Bima Yojna (RSBY) Implementation. International Journal Of Health Systems And Implementation Research. 2018;2(1):39–48.

[37]. Ministry Of Labour And Employment, Government Of India. 2014. Rashtriya Swasthya Bima Yojana (RSBY) Operational Manual [Internet]. Available From: Http://Www.Rsby.Gov.In/Documents.Aspx?ID=2

[38]. Saxena A, Trivedi M, Shroff ZC, Sharma M. Improving Hospital-Based Processes For Effective Implementation Of Government Funded Health Insurance Schemes: Evidence From Early Implementation Of PM-JAY In India. BMC Health Services Research. 2022 Jan 15;22(1):73.