Determinants of private sector engagement and empanelment under PMJAY

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Acknowledgements

This report explores 'Determinants of private sector engagement and empanelment under PMJAY'. It highlights motivations, constraints and perspectives of the private sector vis-à-vis their reason to engage or not engage with the PMJAY scheme.

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Abbreviations

Abbreviations	Full forms
AB-PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
API	Association of Private Hospitals of India
CGHS	Central Government Health Scheme
CII	Confederation of Indian Industry
DEC	District Empanelment Committee
EHCP	empanelled health care providers
FICCI	The Federation of Indian Chambers of Commerce and Industry
GSHIS	government-sponsored health insurance schemes
HBP	health benefits package
HEM	hospital empanelment management system
IMA	Indian Medical Association
ISA	Insurance Service Agency
NHA	National Health Agency
OOP	out-of-pocket expenditure
PMAM	Pradhan Mantri Arogya Mitra
RGJAY	Rajiv Gandhi Jeevandayee Arogya Yojna
RSBY	Rashtriya Swasthya Bima Yojana
SCHIS	Senior Citizen Health Insurance Scheme
SECC	Socio-Economic and Caste Census
SHA	State Health Agency
TMS	Transaction Management System
TPA	third-party administrator
UT	Union Territory
WHO	World Health Organization

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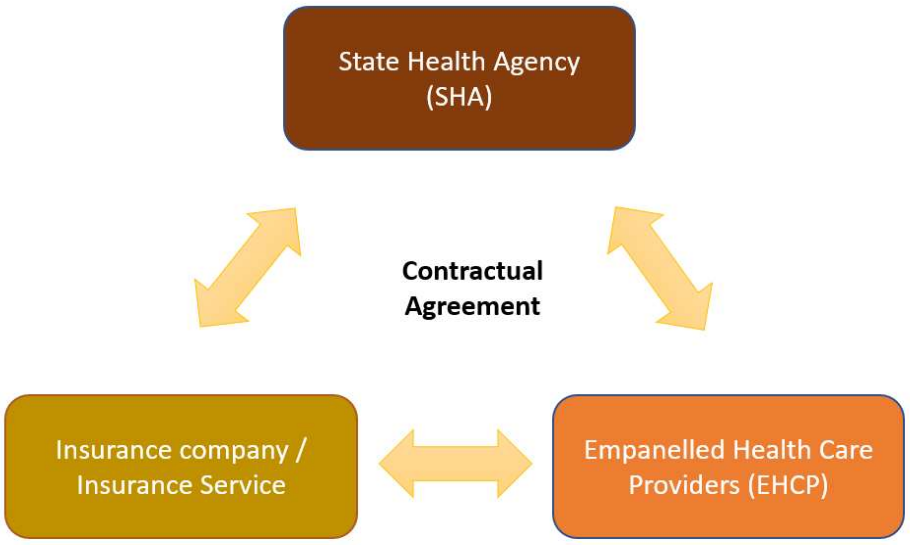
Introduction

In 2018, the Government of India launched Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) - a tax-funded national health insurance scheme, to cover 100 million families with an annual household coverage of INR 500 000 for the provision of hospitalization services provided through a network of public and private hospitals. The AB-PMJAY scheme subsumed the functional RSBY schemes - Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS). PMJAY was launched to reduce the financial burden on poor and vulnerable groups from catastrophic hospital episodes and ensure quality health services. It is an entitlement-based system where the beneficiaries have been selected based on the Socio-Economic and Caste Census (SECC) data. PMJAY is fully funded by the government with cost-sharing between the central and State governments, with ratios of 100:0 for union territories (UTs) without legislatures, 90:10 for North-Eastern states and three Himalayan states, and 60:40 for the other remaining Indian states.

In PMJAY, hospitals are important stakeholders that provide treatment. They are involved in real-time verification and authentication of beneficiaries, preauthorization for treatment, and coordination with the state agency for timely claims reimbursement. Under PMJAY, guidelines have been developed for each step of hospital-based transactions. These include guidelines for preparatory activities for the empanelment of the hospital and routine processes carried out for beneficiary authentication, medical treatment (also referred to as package under PMJAY) selection, preauthorization, discharge, and claim reimbursement. The empanelled hospitals are paid based on services provided and offer fixed rates for particular packages. As deemed suitable in a State by the State Health Agency (SHA), packages prone to abuse in the form of unnecessary procedures or fake surgeries are reserved for public hospitals.

Fig. 1: Service delivery mechanism of the PMJAY scheme



One of the key objectives of the PMJAY is to increase the availability and choice of healthcare facilities such that beneficiaries can avail of free treatment through public or private healthcare providers. The approach to empanelment of private providers by different States is governed by their existing public health infrastructure and the State's capacity to provide treatment for different specialties. Empanelled health care providers (EHCP) are engaged in real-time authentication of beneficiaries, preauthorization of care, and cooperation with the State agency for prompt claim reimbursement. Guidelines are established for beneficiary identification, treatment package, selection, preauthorization, discharge, and claim reimbursement. These procedures are for the hospital's empanelment. The hospitals with empanelled status are compensated based on the services rendered and set fees for specific packages.

Private sector participation in the AB PMJAY scheme[1]

According to the latest Annual Report of PMJAY (2020-21), 26 137 hospitals are empanelled under the scheme, including 12 776 public, 729 Government of India, and 12 302 private institutions. Private providers account for 43% of the total empanelled hospitals, and the empanelment of private hospitals in focus and aspirational districts is 8360 out of 18 703 hospitals. Table 1 presents the state-wise empanelment status of public and private hospitals across the PMJAY implementing States.

Table 1: State-wise hospital empanelment status under PMJAY

State	Public	Private for profit	Not-for-profit	Private total	Private share	Institutional model
Andhra Pradesh	1239	1184	0	1184	48.5	Trust
Arunachal Pradesh	44	1	1	2	5.4	Trust
Assam	213	167	42	209	47.9	Trust
Bihar	573	308	60	368	35.7	Trust
Chhattisgarh	1000	526	25	551	34.6	Trust
Goa	21	14	0	14	40	Trust
Gujarat	1938	761	90	851	29.4	Hybrid
Haryana	761	457	81	538	74.5	Trust
Himachal Pradesh	138	95	26	121	44.1	Trust
Jammu & Kashmir	121	80	14	94	43.7	Insurance
Jharkhand	224	507	67	574	71.8	Hybrid
Karnataka	2916	795	16	811	21.4	Trust
Kerala	195	383	166	549	74.9	Trust
Madhya Pradesh	449	452	63	515	52.1	Trust
Maharashtra	306	779	4	783	70.1	Hybrid
Manipur	33	21	2	23	32.7	Trust
Meghalaya	157	12	5	17	9.8	Insurance
Mizoram	79	5	2	7	14	Trust
Nagaland	68	14	2	16	17.1	Insurance

[1] Ayushman Bharat PMJAY Annual report 2020-21. https://nha.gov.in/img/resources/Annual-Report-2020-21.pdf

State	Public	Private for profit	Not-for-profit	Private total	Private share	Institutional model
Punjab	212	582	103	685	76.4	Insurance
Rajasthan	846	206	0	206	18.5	Hybrid
Sikkim	11	0	1	1	8.3	Trust
Tamil Nadu	2047	2228	10	2238	52.2	Hybrid
Tripura	126	3	0	3	1.6	Trust
Uttar Pradesh	102	87	29	116	64.6	Trust
Uttarakhand	1047	1762	379	2141	54.3	Trust

Source - Computed from NHA website accessed on 26/11/2022[2]

In recent years, various studies have also analysed the participation of private sector engagement in the PMJAY scheme. A recent study by Jaison et al. found that out of the total empanelled facilities under PMJAY, 56% were in the public sector, 40% were in private for-profit, and 4% were private, not-for-profit entities. The study also showed that five states contributed to more than 60% of all empanelled facilities under PMJAY: Karnataka with 2996 (14.9%), Gujarat with 2672 (13.3%), Uttar Pradesh with 2627 (13%), Tamil Nadu with 2315 (11.5%) and Rajasthan with 2093 facilities (10.4%). State-wise distribution of empanelment was skewed in favour of public facilities except in nine States and one union territory (Andhra Pradesh, Goa, Haryana, Jharkhand, Kerala, Maharashtra, Rajasthan, Punjab, and Uttar Pradesh, and Chandigarh), which had a higher proportion of private facilities (for profit and not for profit combined) empanelled when compared with the public sector facilities. Otherwise, the public sector dominated empanelment across states. Further, the rate of private providers was 1 per 100 000 eligible population.

Dong D et al. (2019)[3] studied the trends and patterns of empanelment of providers under PMJAY using the claims database and hospital information and empanelment status drawn from the Hospital Empanelment Management (HEM) system from 23 September 2018 to 29 February 2020. The study found that there were 16 410 hospitals empanelled under PM-JAY (excluding 4,855 PHCs), of which 56% were private. Over 72% of all private empanelled hospitals were located in just seven states: Uttar Pradesh, Rajasthan, Tamil Nadu, Gujarat, Maharashtra, Punjab, and Karnataka. Further, private hospitals accounted for 61 % of the provider network in brownfield states compared to 51% in greenfield states. The study also found that only 50% of all private empanelled hospitals were active and providing service delivery. In terms of size distribution, it was found that private hospitals are relatively small, with over 77% reporting 50 or fewer beds and 44% with fewer than 25 beds. Private hospitals were mostly offering surgical packages only. In financial terms, 75% of PMJAY's total claim value was reimbursed to private hospitals with significant state-wise variation.

[2] https://hospitals.pmjay.gov.in/Search/empnlWorkFlow.htm?actionFlag=ViewRegisteredHosptlsNew
[3] Dong D, Sehgal PK, Chhabra S, Naib P, Smith O. Policy Brief 9.The role of Private Hospitals PM-JAY 201123 WB NHA 2020.
[4] Dave HS, Patwa JR, Pandit NB. Facilitators and barriers to participation of the pri-vate sector health facilities in health insurance and government-led schemes in India. Clinical Epidemiology and Global Health. 2021 Apr;10:100699.

Dave HS et al. (2021)[4] analysed the facilitators and barriers to the participation of private hospitals in Government Sponsored Health Insurance Schemes (GSHIS) using a cross-sectional study in Vadodara. Low package rates were identified as the major reason for the non-enrolment of private hospitals in government health insurance schemes. Additionally, administrative problems with a heavy patient load and delayed reimbursement were cited as reasons for non-enrolment. The study also investigated the issues faced by private hospitals which were part of GSHIS. Unawareness about the detailed terms and conditions of health insurance, TPA taking longer to process the claims, and delayed payments were cited as major challenges all hospitals face. Apart from these, request to inflate bills, request for unnecessary hospitalization and diagnostic tests, moral hazards and fraudulent activity, and demanding patients and relatives for hospitality facilities were common in small and mid to large hospitals. Further, the limited scope of services offered and cumbersome administrative processes were reasons for non-active participation in government schemes in small hospitals. The study also found that mid and large hospitals are ready to enrol in any scheme or model that increases clients and revenue. For small hospitals, additional manpower requirement for the administration of health insurance and reimbursement-related issue adversely affects their working capital cycle.

Private hospitals face major operational and institutional challenges that can reduce the attractiveness of GSHIS and may harm the desired outcomes of the scheme (Anush Saxena et al., 2022)[5]. Trivedi et al.[6] (2022) found that despite PMJAY being a cashless program, patients reported making payments directly to the pharmacies or laboratories outside the hospitals, as they were told that certain inputs were either unavailable or not covered under the PMJAY. The average out-of-pocket (OOP) payment was around three times higher for those patients whom the hospitals asked to make a part payment on top of their insurance coverage. The study also found that most of the respondents from private hospitals of Madhya Pradesh who made high OOP payments were hospitalized for tertiary care procedures like cardiology and oncology. Various studies have analysed the process-related and implementation-level issues of PMJAY. Still, there is a knowledge gap in the scheme's facilitators and inhibitors of the empanelment of private hospitals.

[5] Saxena, A., Trivedi, M., Shroff, Z.C. et al. Improving hospital-based processes for effective government-funded health insurance schemes: evidence from early implementation of PM-JAY in India. BMC Health Serv Res 22, 73 (2022).

[6] Trivedi M, Saxena A, Shroff Z, Sharma M. Experiences and challenges in accessing hospitalization in a government-funded health insurance scheme: Evidence from early implementation of Pradhan Mantri Jan Aarogya Yojana (PM-JAY) in India. PLoS ONE. 2022 May 12;17(5):e0266798.

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Scope of the study

The launch of Pradhan Mantri Jan Arogya Yojana (PMJAY) ushered in a paradigm shift in the level and depth of service coverage and financial protection offered to households against health care expenditures. Private providers contribute a large share of service volume and value as there is an inherent preference among beneficiaries to avail services in the private sector, thus making them an integral part of the scheme. However, despite their engagement and involvement in great numbers, many private hospitals still tend not to empanel themselves with the scheme or do not see the value of continuing their engagement with PMJAY. Various factors, such as low payment rates, payment delays, and onerous conditionalities for empanelment, are attributed to this private sector behaviour. A systematic assessment of the reasons for the private sector's low level of engagement will help identify, assess and resolve some of the systemic and process issues that may hinder or discourage private providers from empanelling in the scheme. The study aims to understand the determinants of private hospitals' decision-making vis-à-vis empanelment under PMJAY and the issues and challenges private sector hospitals currently part of the scheme face.

Study objectives

The main objectives of the study are

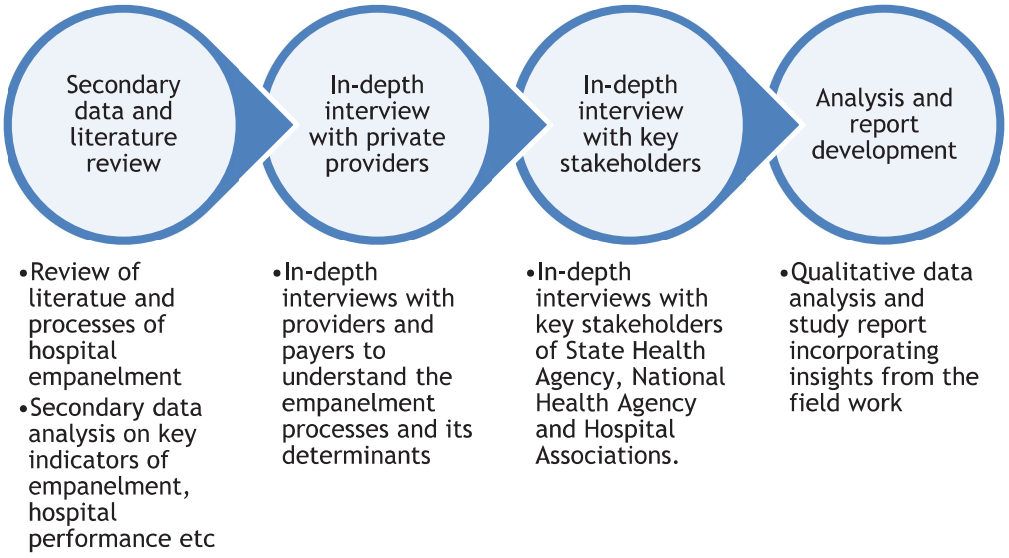
1. Elicit motivations for hospitals to empanel, de-empanel or not empanel under PMJAY (previously empanelled, currently empanelled, as well as not empanelled) based on considerations at a policy and process level
2. Identify constraints faced by 'inactive' hospitals (empanelled but not providing service) in servicing beneficiaries
3. Identify health system-wide factors that impact scheme enrolment (regulations, legal framework, etc.).
4. Draw out primary concerns of hospitals empanelled under the scheme about day-to-day engagement with SHA/TPA/Insurance companies
5. Solicit feedback on ways in which the scheme can better address the issues identified

Study methodology

Study design

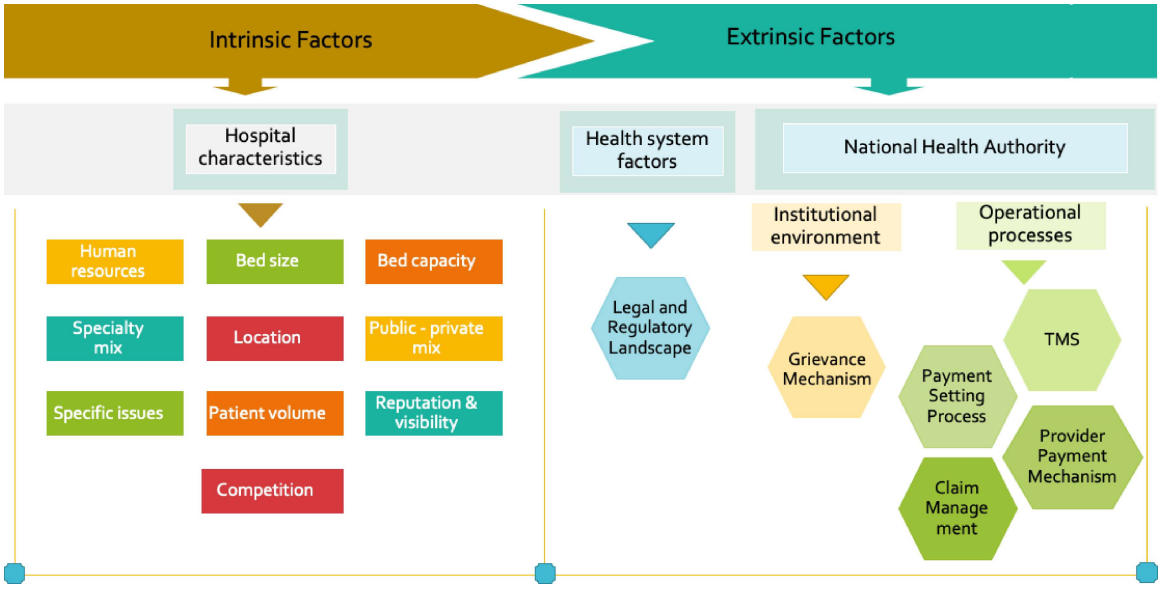
The study mainly used a qualitative design with quantitative inputs and collection of primary and secondary information from the National Health Authority (NHA), State Health Agencies (SHA), Third Party Administrators (TPA's), private hospitals, both single-owner and network hospitals, and from hospital association representatives. Fig. 2 depicts the study methodology and study phases.

Fig. 2: Study methodology



In the study's first phase, secondary information was collected on the empanelment processes and quantitative analysis of secondary data obtained from the National Health Authority (NHA). The secondary data included information on the state-wise trends in the empanelment of active and nonactive hospitals across the study states. In the second phase, in-depth interviews were conducted with key stakeholders, including (1) Providers (Private Hospitals), (2) Payers (NHA/SHA) and (3) Other actors in the ecosystem (Industry associations like private hospital associations). The in-depth interviews covered six thematic areas (Fig. 3), and this includes

Fig. 3: Framework for qualitative research



In any health insurance scheme, the purchaser-provider relationship concerns purchasers' use of financial, contractual, regulatory, and monitoring mechanisms as levers to ensure that healthcare providers deliver technically efficient and quality services. One of the core objectives of the PMJAY scheme is to improve access to inpatient services through effective engagement with private sector providers. Thus, understanding the factors that affect private sector engagement is essential, and the framework outlined above can help us identify the determinants that private hospitals consider when deciding to join the PMJAY network. This conceptual framework consists of two categories of factors: intrinsic and extrinsic. Intrinsic factors align with the private sector market, such as bed capacity, location of the hospital, specialty mix and reputation of the hospital. For example, hospitals with larger bed capacities may be better positioned to join PMJAY as they can accommodate more volumes and generate more revenue. Extrinsic factors refer to external circumstances or factors that can influence the hospital provider's actions, such as financial incentives for healthcare providers to participate in the scheme, regulatory requirements for participation, payment setting and provider payment mechanism. The extrinsic factors are primarily shaped by the National Health Authority (NHA) decisions and include health system factors that affect institutional engagement, such as those related to insurance companies, State Health Agencies (SHA) and TPAs. Hospital operational processes, such as claims management, payment, and grievance redressal, are also influenced by NHA policies. Understanding both intrinsic and extrinsic factors can help policymakers identify ways to increase private sector engagement with the PMJAY scheme and improve access to high-quality healthcare services.

Structured in-depth interview tools were devised specifically for engaging with private providers, key stakeholders of SHA, and insurance service providers. These interview tools comprehensively cover the key thematic areas outlined above, allowing for the elicitation of relevant information pertaining to the research questions. The qualitative interviews were transcribed and coded according to the thematic areas and sub-themes outlined earlier. This approach enables proper categorization of data and simplifies the analysis process.

Annex 3 to 5 contains the complete set of in-depth interview tools utilized for this research.

Sampling strategy

PMJAY is implemented through three implementation models, namely (1) Insurance Model, (2) Trust Model, and (3) Hybrid Model. We use purposive sampling, and the state selection was made in consultation with the National Health Authority (NHA). Based on the implementation model, we have selected the following States

1. Trust Model - Kerala, Madhya Pradesh
2. Hybrid Model - Maharashtra
3. Insurance Model - Jammu & Kashmir

In each of the study states, key informant interviews were conducted with private sector providers, district program managers, key officials of the State Health Agency (SHA), and representatives of private hospital associations. The sampling pattern for qualitative research is presented in the table below. The detailed list of stakeholders interviewed is shown in **Annex 1 to 2**

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Key findings

Table 2: List of stakeholders for key informant interviews

Health facility (private hospitals)	District level	State level
• Active hospitals • Single owner hospitals and network hospitals • Inactive hospitals • Delisted/de-empanelled hospitals • Hospitals that have not joined the scheme	• District program manager/coordinator - PMJAY	• Manager, network and hospital management • Representatives of hospital associations

Table 3: Key informant interviews of private sector hospitals conducted in study states

State	Category of hospital			Total
	Active	Inactive	Delisted/De-empanelled	
Kerala	7	5	1	13
J&K	12	0	0	12
Maharashtra	5	3	3	11
Madhya Pradesh	7	1	4	12
Total				48

We conducted 48 interviews with key stakeholders of private hospitals, including active hospitals, inactive hospitals, and delisted/de-empanelled hospitals. The research team wrote detailed field notes and transcripts of the interviews to analyse the qualitative data.

PMJAY implementation in the intervention states

All four States have been implementing the PMJAY scheme since its inception, and all States except Madhya Pradesh have been implementing the RSBY scheme before its inception of the PMJAY scheme. Maharashtra was implementing the State scheme of Rajiv Gandhi Jeevandayee Arogya (RGJAY), now known as Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY)[7]. Except for Maharashtra, all the other three states are covering additional families with funding from the State government. The table presents a snapshot of the key features of PMJAY implementation in the four study states.

[7] Beneficiaries under Mahatma Jyotirao Phule Jan Arogya Yojana are divided into three categories Category A Families holding Yellow ration card, Antyodaya Anna Yojana ration card (AAY), Annapurna ration card, Orange ration card (annual income up to INR 1 lakh) issued by Civil Supplies Department, Government of Maharashtra for 36 districts of Maharashtra. Category BWhite ration card holder farmer families from 14 agriculturally distressed districts of Maharashtra (Aurangabad, Jalna, Beed, Parbhani, Hingoli, Latur, Nanded, Osmanabad, Amravati, Akola, Buldhana, Washim, Yavatmal, and Wardha). Category C 1. Children of Government Orphanages, Students of Government Ashram Shala, female inmates of Government Mahila Ashram & senior citizens of Government old age homes.2. Journalists & their dependent family members approved by DGIPR 3. Construction workers and their families having live registration with Maharashtra Buil

Table 4: Brief profile of PMJAY implementation in the intervention states

State PMJAY Profile	Kerala[8]	Madya Pradesh[9]	Maharashtra[10]	Jammu & Kashmir[11]
Number of PM-JAY eligible families as per SECC/RSBY data	2 205 505	8 357 257	8 363 664	597 801
Number of PM-JAY additional families covered by the State*	1 957 783	2 504 396	-	1 456 497
Total	4 163 288	10 861 653	8 363 664	2 054 298
No. of Non-PM-JAY families covered by the State scheme*	215 000	-	13 845 824	
Type of Health Benefits Package being followed in the State (HBP 1.0/HBP2.0/ State Specific Packages)	HBP 2.1	HBP 2.2	State Specific Packages	HBP 2.2
Hospital admissions are authorized till September 2022	4 380 015	2 053 233	698 672	244 724
Number of Claims submitted till September 2022	4 325 655	1 952 242	606 768	225 054
Scheme Name	Karunya Arogya Suraksha Padathi (KASP-PM-JAY)	Ayushman Bharat-Madhya Pradesh 'Niramayam' Yojana	Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY)	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) SEHAT
Name of State health agency	State Health Agency, Kerala	Deen Dayal Swasthya Suraksha Parishad	State Health Assurance Agency	State Health Agency Jammu & Kashmir
Implementation Model	Trust	Trust	Hybrid	Insurance

Source: State Fact Sheet and PMJAY Profile, National Health Authority

* Claims since the inception of the PMJAY scheme.

mpanelment in the intervention states

Data from NHA shows that Maharashtra has the highest number of empanelled hospitals followed by Kerala, Madhya Pradesh, and Jammu & Kashmir. In J&K, there is a higher share

[8] Karunya Arogya Suraksha Padathi (KASP) in the State was rolled out on 01-04-2019 and provides coverage for an additional 19 lakh (approximately) families

[9] The scheme is called Ayushman Bharat-Madhya Pradesh 'Niramayam' Yojana in the State and was rolled out on 23-09-2018

[10] Rajiv Gandhi Jeevandayee Arogya (RGJAY), the state government of Maharashtra's major health insurance programme, was introduced. Phase 1 of the RGJAY was launched in 8 districts of Maharashtra on July 2, 2012, while the rest 28 districts were added in Maharashtra (Phase 2). From April 1 2017, the programme will be known as the Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) and rolled out in 23-09-2017. Beneficiaries of this programme are households residing in any of Maharashtra's 36 districts and holding Orange Ration Card, Yellow Ration Card, Antyodaya Anna Yojana Card (AAY), Annapurna Card, and Farmers from 14 districts in Maharashtra that are struggling with agriculture. The Plan offers coverage for all costs associated with Beneficiary hospitalisation up to Rs. 1,50,000 per family per year

[11] The scheme called Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) SEHAT and was rolled out on 01-12-2018

of public hospitals than private. The table shows the details of hospital empanelment in the study states.

Table 5: Total number of empanelled providers in the PMJAY scheme

Total number of empanelled providers in the PMJAY scheme			
States	**Private**	**Public**	**GOI**
Maharashtra	785	306	6
Madhya Pradesh	520	447	30
Kerala	546	195	5
J&K	96	121	78
Total	**1947**	**1069**	**119**

Source- Information from National Health Authority

The following section outlines the main findings and analysis of our research, which focuses on four key thematic areas. These thematic areas include:

1. Motivations for hospitals to empanel, de-empanel, or abstain from empanelment under PMJAY
2. Key constraints faced by "inactive" hospitals in providing services to beneficiaries
3. Health system factors affecting private sector participation
4. Primary concerns of hospitals regarding daily engagement with SHA/TPA/Insurance companies

The findings in these areas are discussed in detail based on the conceptual framework introduced in the previous section.

1. The motivation of private hospitals to engage with the PMJAY scheme

The primary research question was to understand the motivation of hospitals to empanel or not to empanel under the PMJAY scheme based on considerations at the policy and process level. The qualitative interviews with private sector providers revealed various economic and social factors that motivate decision-making on empanelment or not to empanel for the scheme. The interviews found that multiple economic factors encouraged the providers to join PMJAY or other government-sponsored health insurance schemes, including the health system characteristics, type of hospital ownership, size and bed capacity of the hospital, and bed occupancy rate.

The PMJAY scheme facilitated the private providers in getting patient volumes, which is one of the key reasons that motivated them to join the scheme. Across all four states, private providers reported a significant increase in footfall ranging from 20% to 40% after empanelling with the scheme. The scheme offered several benefits to providers, including driving up outpatient services and revenue generation from OPD services. By empanelling with PMJAY, hospitals gained access to a large pool of potential patients who may not have otherwise been able to afford healthcare services. This influx of patients helped increase hospital revenue and drove growth in their business. Moreover, PMJAY helped hospitals to reduce the cost of consumables and medicines through bulk procurement. As patient footfall increased, the demand for these

essential items also increased. Hospitals used bulk procurement to negotiate lower prices for these items, which helped reduce their overall costs. By lowering their expenses, hospitals were able to improve their bottom line and increase their profitability.

"So overall, we can say that the scheme has increased the patient footfall, so there is an increase in revenue. Payment may come after four months, three months or two months, or one month. But the scheme is generating income. With the scheme, our OPD has also increased, which is an additional source of income." - Private Provider Interview - Maharashtra

The bed capacity of the hospitals also plays an essential role in the decision-making process. Most large hospitals typically have an average bed occupancy rate of around 60 to 70%. While this occupancy rate may seem substantial, it also means a significant amount of "idle capacity" within the hospital for which it incurs fixed costs, such as staffing, equipment maintenance, and facility upkeep. This idle capacity can be detrimental to the financial sustainability of the hospital, especially when fixed costs cannot be easily reduced. The pooling of resources and sharing of financial risk through PMJAY allowed hospitals to use their idle bed capacity more efficiently. Hospitals could reduce their per-patient fixed costs and increase their patient volumes by providing a larger pool of patients to draw from. This increased utilization of idle capacity significantly impacts the financial sustainability of hospitals, particularly those that serve disadvantaged communities.

"Most large hospitals calculate their profit margin based on 80% occupancy, mostly catered by paying patients and private insurance providers. Hospitals are still left with 20% of beds that can be allotted to such schemes, which help in fulfilling social obligations and also help in recovering fixed costs." - Private Hospital Interview - Kerala

Bed occupancy rates also deter hospitals from joining the scheme. Our interviews with the private providers not part of the scheme revealed that they had very high bed occupancy rates. They don't consider joining the scheme as they have enough paying and private insurance patients to charge considerably higher rates than the scheme package rates. Most of the corporate hospitals in Kerala, Mumbai, and other cities are not part of the scheme, primarily due to their ability to attract patients and charge considerably higher rates than the scheme package rates.

"We have very high bed occupancy rates, and often there is a waiting list. There is no point in joining the scheme and accepting with this low package rates, when we already have paying and private insurance patients." - Private Hospital Interview - Kerala

Private providers, especially larger ones, have a range of medical specialties and services on offer. Engaging with PMJAY allowed them to leverage these services to reach a broader patient population and generate revenue from the scheme. It was observed that PMJAY also attracts private players by enabling them to develop new service lines and expand their existing service offerings. The private players were keen on providing a broader range of medical specialties and services under the scheme to generate revenue and enhance their reputation in the healthcare sector.
"I am more than happy to empanel all my specialities with the scheme." - Private Hospital Interview, Maharashtra

The reputation and visibility of the hospital as a result of being part of the scheme is another

critical factor influencing the decision to empanel. Many private providers opined that they want to provide free treatment to beneficiaries, do community service, be a part of the world's biggest health insurance scheme, and associate with the Prime Minister's vision. Several trusts, mission, and charity hospitals have become part of the PMJAY scheme, as it aligns with their social objectives of serving the population and improving the visibility and reputation of their organizations in society. Participating in the scheme allows these hospitals to expand their reach and make healthcare more accessible to underserved communities.

"This is a great scheme. Ultimately, it is benefitting the poor patients. Many procedures were beyond the reach of a certain segment of society. Though the rates barely offer us to make profits, but I have enrolled with the scheme for the greater good." - Private provider in Maharashtra.

Many providers believed the scheme had benefited patients who could never afford quality treatment. For instance, one provider said that cases of kidney removal were reduced to almost zero due to patients coming in time for treatment for kidney stones.

"The main motivation was to enable poor people to get treatment under the scheme. We always try to motivate people to get their cards and get their treatment done for free. In Jammu, plenty of poor people cannot afford private treatment. You won't believe that earlier in our hospital; we used to perform 8 to 10 nephrectomies in a month. After the scheme's introduction, there are no cases because people can come to the hospital to get treatment on time." - Private provider in J&K

The type of hospital is another intrinsic factor influencing the motivation to participate in the scheme. Across all the states, we found that private medical colleges are empanelled in the scheme, and most had comprehensive empanelment covering all medical and surgical specialties. These hospitals are also teaching hospitals and have to meet the National Medical Council (NMC) requirements, which include maintaining a minimum bed occupancy rate and patient footfall for teaching purposes. As a result, they often join PMJAY or other public insurance schemes to meet these regulatory requirements. The primary revenue source for these providers is from the fees charged to students rather than from hospital services, and they typically have high bed capacity. However, their bed occupancy rates are often low, and participation in government schemes creates a win-win situation for providers and the government.

"We are a teaching institution, and we must meet the requirements of the National Medical Council (NMC), and the total number of beds is based on the general ward beds. PMJAY scheme is operational in a general ward, and since we have empanelled for all specialties, it helps us as a teaching institution". - Private Medical College Interview, Kerala State

It was also observed that healthcare providers who are already empanelled with other government-funded health insurance schemes, such as the Central Government Health Scheme (CGHS) tend to remain motivated to stay empanelled with PMJAY. This can be attributed to their familiarity with the insurance system and Technology Management System (TMS) used by such schemes, making it easier for them to work with PMJAY's claim management system and provide better services to the scheme's beneficiaries. Hospitals that are empanelled with CGHS are already accredited by the government and have met the required quality standards. This makes it easier for hospitals already empanelled with CGHS to get empanelled with PMJAY, as they have already gone through the accreditation process

and have demonstrated their ability to provide quality healthcare services. Additionally, the quality standards required by CGHS are similar to those required by PMJAY, which further streamlines the empanelment process for hospitals that CGHS already accredits.

"We were able to grasp everything related to PMJAY empanelment at a faster rate because we already had CGHS panel. The portal was the same." - Private provider in J&K

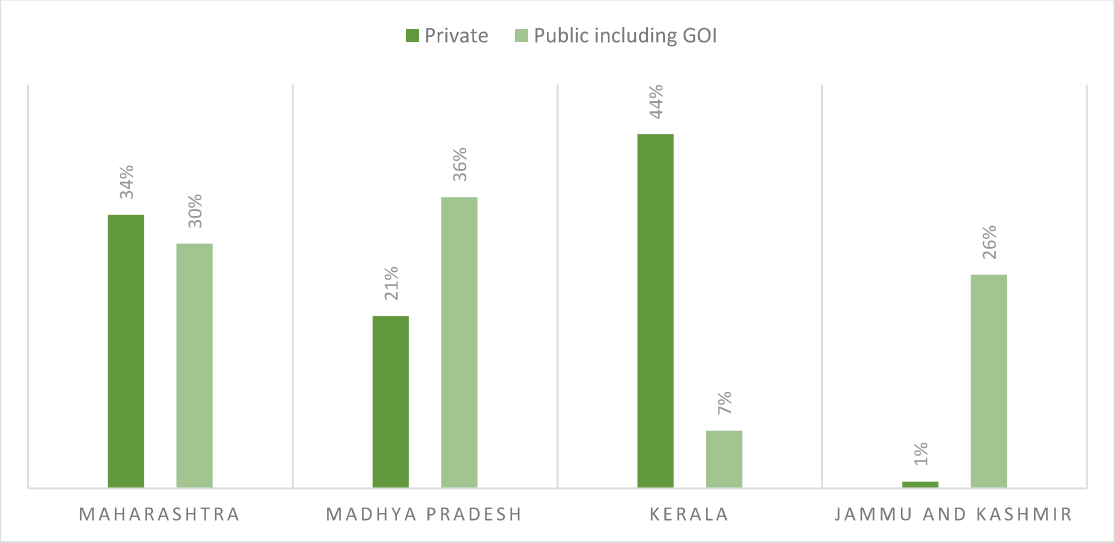
2. Constraints faced by inactive hospitals

As depicted in Fig. 5, Maharashtra has the highest number of active hospitals (666) followed by Madhya Pradesh (445), Kerala (392) and J&K (93). Fig. 6 presents the inactive hospitals across all four study states. Kerala tops the list with 154 hospitals (44%), followed by Madhya Pradesh with 131 (21%) and Maharashtra with 119 (34%). J&K had only three inactive hospitals (1%).

Fig. 4: Number of active hospitals in the past six months

Source- Information from National Health Authority

Fig. 5: Number of inactive hospitals in the past six months



Source- Information from National Health Authority

The in-depth interviews with the private providers analysed why hospitals were "inactive" even after being empanelled under the scheme. During the COVID-19 pandemic, State governments leveraged the private sector's capacity for patient management using various legal and regulatory acts, such as the Clinical Establishment Act, Epidemic Diseases Act, and Disaster Management Act. During this time, many state governments applied mandatory empanelment to cater to the surge capacity of COVID patients. In most states, PMJAY or state insurance schemes were used to treat both COVID and non-COVID patients. Various contracting methods were used, such as price capping of COVID treatments, reservation of beds in private hospitals for COVID treatment, package rates under PMJAY for COVID, and reimbursement for referrals from the government sector. Maharashtra was one of the first states to introduce package rates under the MJPJAY/PMJAY and reserved 80% of beds in the private sector for COVID treatment. Kerala regulated the package rates for COVID treatment in consultation with private providers. Madhya Pradesh and Jammu & Kashmir used the PMJAY COVID packages to treat COVID patients.

After easing COVID regulations, many private providers refrained from providing service delivery under the PMJAY scheme. Many private providers opted out of the scheme once the price capping and mandatory enrolment guidelines were lifted. During discussions, health-care providers cited delays in payments for COVID treatment and rejection of claims as the major reasons. We observed that many inactive hospitals have voluntarily de-empanelled themselves due to a prolonged delay in receiving reimbursement payments. Many hospitals that were initially empanelled during the COVID-19 period reported many unpaid claims, and this financial strain led to their decision to no longer participate in the scheme.

Most inactive hospitals have reported rejected payments for the service rendered during the COVID period. They have also approached the district and state grievance committees to recoup the losses during the COVID. Hospitals also reported the administrative hassles and the time required for the follow-up with SHA, DGRC, and SGRC to reconcile the pending payments. Participants opined that frequent changes in guidelines and regulations during COVID and lack of training and understanding among the hospital staff led to many documentation

mistakes. In addition to this, there was also no real-time support to hospitals during COVID period. Many mistakes persisted and eventually led to the rejection of multiple claims.

"Our hospital provided services during COVID, and our total claim was around Rs 87 lakhs, of which Rs 25 lakhs worth of claims were rejected, and the balance payment is pending. Our first payment came nine months after the claim's submission, affecting our survival entirely." - Private provider in Kerala

Providers opine that there was lack of clear guidelines from the SHA/NHA side during COVID. However, they acknowledged that COVID was still a learning phase for each of them, and SHA could not be blamed for a certain level of chaos prevalent during that time. It was also mentioned that even during COVID times, the package offered was really less, provided the course of the treatment varied from patient to patient. The hospitals faced unnecessary deductions and delays during pandemic times as well.

"There were many rejections, due to lack of RT-PCR, since the only accepted report was from govt facilities. It was not possible for very sick parents to run to govt facilities for RT-PCR. CT scan was not accepted. This was a huge issue. Pre-auth was not a problem, but at the time of settlement, the claim was either rejected, or was partially paid based on the number of days the patients stayed with us. Some of them passed away, and our payments were deducted." - Private provider in Maharashtra

In addition to issues with regard to the COVID service delivery, other extrinsic factors impact the hospitals' active status. The majority of small and mid-scale inactive/de-empanelled hospitals across study states expressed their apprehensions with the government's decision to reserve specific procedures like hysterectomy, cataract, appendectomy, etc., exclusively for public hospitals. It was reported from Madhya Pradesh that these changes came into the picture after the second wave of COVID was over, and the revision of packages eventually de-empanelled his hospital from the scheme. The main concern raised by private hospitals is that this affects the patient footfall and makes the scheme unviable to them. For example, in Maharashtra, 169 procedures are reserved only for government hospitals and similarly, in Madhya Pradesh and J&K, many procedures are reserved for public hospitals. Even though there are more than 1500 procedures, the most common procedures and where the expected volumes are expected are reserved for public hospitals. This creates an inequitable situation for private providers. They feel they are left with those procedures where the package rates are low and volumes are not high. Further private hospitals also face the challenge of convincing patients that certain packages are not included in private hospitals.

"I did contact the SHA about extending the ENT and eye procedures to private players as well, however, I was informed that this was a national level decision." - Private provider in Madhya Pradesh

Private providers also reported that the scheme demands significant paperwork and documentation to support the claims for medical treatment. These include medical investigation reports, prescriptions, bills, and other documents. Submitting and verifying these documents can be time-consuming and complicated, leading to delays in reimbursements for the healthcare providers. As a result, some private providers were unwilling to participate in the scheme as they see it as an additional administrative burden that could impact their financial viability.

"If there is a snake bite, a lot of things are required of me to prove that it was really a snake bite. I don't have time or energy to do this. When would I treat patients otherwise?" - Private provider in Maharashtra

One of the main goals of PMJAY is to provide financial protection and access to quality healthcare services to vulnerable and economically disadvantaged populations in India. For several reasons, private providers were reluctant to provide free healthcare services to wealthy beneficiaries under the PMJAY program. The participants opined that presence of wealthy beneficiaries, who may have the means to pay for healthcare services outside of the program, divert resources away from those who genuinely need them. Private providers also felt that they were not adequately compensated for the care they provided to such beneficiaries.

"My hospital has been there since 2013, and I had a huge patient footfall. I once was empanelled with the scheme but with time more and more patients started getting the card, irrespective of their economic status. My private patients started getting converted into the scheme. I had to stop entertaining the scheme patients at some point." - Private provider in Maharashtra

While private providers were willing to participate in PMJAY and provide free healthcare services to vulnerable and economically disadvantaged populations, the presence of wealthy beneficiaries create challenges that need to be addressed in order to ensure that the program achieves its intended goals.

3. Health system factors impacting private sector engagement

In addition to the intrinsic factors that influence the private providers to join the scheme, certain extrinsic factors affect private sector engagement in the PMJAY scheme, such as the empanelment policy of the respective states, health system characteristics, operational issues like pre-authorization process, claims management, claim payment turnaround time, and provider payment mechanisms.

The empanelment of providers under PMJAY is governed by the guidelines of empanelment and de-empanelment of hospitals issued by the National Health Authority. The approach to employing private providers by different states is determined by their existing public health infrastructure and state capacity to provide treatment for different specialties. All study states, except Maharashtra, followed the empanelment guidelines of NHA for empanelling private providers. Maharashtra was already implementing the state scheme and continued with the network of hospitals and the empanelment criteria of Mahatma Jyotiba Phule Jan Arogya Yojana. In Kerala, the SHA monitors the empanelment process, and the State adheres to the guidelines for comprehensive empanelment of hospitals. The number of hospitals doubled from around 250 during the scheme's inception to the current network of more than 500 hospitals. There has been an increase in private sector participation during the COVID period, whereas some hospitals have also become inactive. All private medical colleges and other teaching institutions like nursing colleges are empanelled under the scheme. However, the major corporate hospitals in all the cities are still not part of the hospital network. The state also has some form of specialty empanelment, especially in cardiology and dialysis. There are standalone cardiology centres in major hospitals, like inside a hospital, the cardiology centre is rented to specific groups. These centres are now empanelled in the scheme and for all other cases, the SHA is only considering comprehensive empanelment of all departments

in the hospital.

"We are not getting any complaints from beneficiaries that this hospital or specialty is not empanelled with us; all the private medical colleges in Kerala are empanelled with us, and they will have many beds, and wards to cater to scheme demand." - SHA, Kerala

In J&K, during the inception phase, some relaxation was given to the empanelment process considering the availability of private providers and the hilly terrain of the state. The SHA had relaxed infrastructure requirements in far-flung areas like Kupwada and Bandipur. In the initial phase, hospitals could choose whichever specialties they wanted to opt from the scheme. However, since the universalization of the insurance scheme, the SHA no longer allows this practice. Since the scheme has become universal in the UT, the SHA only promotes comprehensive empanelment.

"If a multi-specialty hospital has ten specialties, they will be bound to empanel all the specialties with us. But earlier we gave them a choice to choose whatever they wanted to empanel." - SHA, J&K

In Madhya Pradesh, the empanelment of private providers is a mix of comprehensive and selective specialties. In major cities of the State like Bhopal, Gwalior, Indore, Jabalpur, etc., there are a lot of private hospitals and SHA gives empanelment for specialties or super specialty. But in smaller cities and rural areas, even single specialty hospitals are empanelled based on the district's requirement. This is done based on specialty-wise gap analysis across the districts.

"There are two or three districts in Madhya Pradesh where we don't have any private hospitals empanelled. So, this has become our priority. If there is any hospital coming up and applying for the empanelment, then we take a positive call on that. The geographical distribution of the hospitals makes us feel where we should improve the provider network." - SHA, Madhya Pradesh

The State is also designing a policy on incentives for private provider empanelment which can be given to places with some geographical difficulties with no private hospitals. In the tribal blocks or scheduled blocks also, SHA is designing policies to improve the private sector uptake. In such places, the biggest challenge is meeting the infrastructure and human resources criteria, especially specialists ready to take up empanelment under the scheme.

"In remote districts, there are already fewer private practitioners. As they are selective and one of the few players in that area, they prefer to opt out of the scheme as they are already generating more revenues. So, this problem we had faced initially, we are still facing this problem in few districts, but with the revised policy, hopefully, we'll be able to onboard more and more hospitals." - SHA, Madhya Pradesh

Universalizing health insurance and convergence of state schemes with implementing PMJAY also determined the decision-making process. With the universalization of PMJAY in J&K, the scheme expanded its coverage to include all eligible beneficiaries, not just those living below the poverty line. This led to a significant increase in potential patients who could avail themselves of healthcare services under the scheme. It became crucial for a private healthcare provider to engage with PMJAY to tap into this vast pool of patients.

"When people are given a choice between free and paid service, it is obvious that people will choose free services. When most of the hospitals got empanelled with the scheme, we had no choice left but to get in the scheme. The reason being that our work declined drastically. Other private hospitals who were empanelled in our district were providing these facilities, and we had no option but to apply for the scheme." - Private provider in J&K

The State Health Agency (SHA) in Jammu & Kashmir also observed that as the demand for healthcare services under PMJAY grew, hospitals that were initially hesitant to empanel with the scheme came forward, requesting to become part of it. This was primarily due to the scheme's success in attracting many patients, thereby increasing the revenue potential for empanelled hospitals.

"In the initial phase of PMJAY, we invited the private sector to join the scheme, but many were not ready to do that. And when the universalization took a good peek in our UT, everybody was after us that we needed empanelment now because eventually, the footfall started falling, and they had no other choice rather than coming to the scheme." - SHA, J&K

The provider empanelment landscape of J&K changed after the universalization of the health insurance scheme. Before introducing the universal health insurance scheme, only 53 private hospitals were enrolled in the program. However, following the scheme's launch, the number of participating hospitals increased to 93, signifying a significant expansion in the provider network. Similarly, in Maharashtra, nearly 85% of the population is covered by the State scheme and PMJAY; hence, providers don't want to lose the footfalls due to non-empanelment in the scheme.

"Patients are now stress-free, they know they don't have to pay or travel to bigger cities for quality treatment." - Private provider in Maharashtra

The pre-authorization process is essential in verifying the medical treatment plan and confirming that the patient meets the eligibility criteria for the PMJAY package. However, private providers expressed major concerns about the high rate of claims rejections following pre-authorization. Providers across all study states reported that rejections were often communicated after a considerable delay, sometimes four to five months. The delayed communication of rejections was problematic, as providers had already incurred costs for treatment and the pre-authorization process. In addition, there was no way for providers to recoup the financial losses incurred due to the rejected claims. This situation was a significant concern for hospitals, underscoring the need for greater clarity and transparency in the PMJAY pre-authorization process to ensure that providers can effectively manage the financial risks associated with participating in the program.

"Private insurance companies tell us within 48 hours that this patient is not going to get approved. You first give pre-authorization, you say you can do it, and then we discharge, and we submit the case, and after that, they keep digging into the queries, and then they reject". - Private provider in Maharashtra

Another challenge that the States reported was the delay in approval after requesting pre-authorization. The guidelines mention that pre-authorization requests will be auto-approved if the insurer takes no action within six hours. However, no hospital indicated the system of auto-approval, which also led to payment delays in a few cases.

The States are working towards streamlining the process to ensure no delays at the pre-authorization levels. They also stated that they are committed to being vigilant, active, and proactive in revoking cases when hospitals write to them. It was reflected from J&K State-level interviews from SHA and IFFCO Tokyo stakeholders (insurance providers in J&K) that sometimes the delay in payments are the hospital's fault. Even after multiple trainings and instructions, they do not provide complete documents, or sometimes they submit incomplete discharge papers. The state always tries to release the payments as soon as possible.

"We do not hold back payments. There might be some delays in processing claims for a few hospitals because of technical glitches or when we had wrong account number, wrong PAN number, and any document related issues." - Stakeholders from IFFCO Tokio, J&K

One key issue the providers raised is the delay in payments after the TPA/Insurance company approved the claims. As per the agreement, the Government or TPA has to pay the claim settlement amount to the hospital within 15 days of the patient's discharge, as per the MoU. However, in the present study, most of the service providers did not receive the claim settlement amount within those days. Most of them reported delays ranging from 3 to 6 months to receive it, which shows lacunae in the system.

The delay in payments to private providers is mainly due to issues in the operational process and also due to issues in the institutional mechanisms. Among these, the operational aspects dominate the reason for delayed provider payment, with a few of them being: repeated queries, the need for more documentation from hospitals as part of their claim submission, change in the insurance company, delay in processing a large number of claims received on the portal due to the increase in volume, and delay from the hospital side to provide histopathology and biopsy reports. It was surprising that a few hospitals had pending payments for more than a year. The extent of delay in payments was such that some hospitals felt their economic viability was at stake. Delays in claim reimbursements impacted hospitals and their ability and willingness to continue participating in the scheme. They believed that volumes of patients could make up for the low rates offered by the scheme. However, timely payments were considered essential to provide quality patient services.

"We need payments to sustain and make my hospital viable, otherwise I will crumble and give up the scheme." - Private provider in Madhya Pradesh

The institutional issues for the delay in payments are mainly due to the resource envelope for the scheme from the State and Central governments. In all the study states, it was found that the State governments bear the major share of the scheme's expenditure and at times there is a delay in the transfer of funds to the SHA which in turn leads to delays in payments to the provider. The Madhya Pradesh government recently faced several issues with fund allotment from the government of India. However, they are developing mechanisms to ensure that such delays do not occur in the future.

"There were some fund allotment issues from the Government of India to Madhya Pradesh. As you know, the funds come from two places; one share comes from Government of India, the other from Government of Madhya Pradesh. So, there are some issues of this kind and we are working to resolve it soon. Hopefully, in a couple of months this situation will be rectified soon." - SHA, Madhya Pradesh

Some of the hospitals were dissatisfied, or rather aggravated, regarding the full or partial rejection of claims by the insurer without giving clear reasons for the rejection. The other thing that most respondents said was that they felt that not all raised queries aligned with treatment protocols, which made them question whether the person raising the query had any medical knowledge. This issue was particularly prevalent among providers from J&K, highlighting the need for specific interventions in that region to address this concern. A few hospitals also felt that the reasons for rejection were beyond any reasoning, and they wondered if there was any hidden agenda behind unnecessary rejections.

"The claims rejection reasons are very illogical such as one of the reasons was that the picture of the specimen was in the right hand and not in the left. We believe this is a tactic to delay the payment." - Private provider in J&K

Most hospitals surveyed across the study states cited that the package rates offered by PMJAY were not financially viable compared to the market rates. The hospitals indicated that the package rates did not accurately reflect the current market conditions and did not account for the rising costs of inputs and services. For example, in Kerala, the cost of human resources and the incentive system has changed over time, and many state governments have introduced regulatory reforms bringing in legislation for ensuring the minimum wages to the hospital staff. Along with this, the consumables and equipment costs have also increased, which is not reflected in the package costs of the PMJAY scheme. Certain surgeries, which consist of more than 70% of the patient load, are priced very low, whereas surgeries that are not conducted are overpriced. This leads to a loss to the hospital.

"The scheme should be a win-win situation for both parties. Here one person is benefiting at the cost of the other and changing this situation could be a game changer." - Private Provider Interview from Kerala

Across all states, the providers were of the view that the increase in input costs, consumables and human resources costs were not aligned with the package rates. Hospitals report the medical packages as unviable and believe in many instances, the patient requires multiple investigations, consumables, and medicines. Still, the reimbursement rates are very low and not enough to meet the cost incurred by the provider.

"*The scheme puts our finances in a bitter way. For example, normal delivery is priced at Rs 6500, but the average cost of delivery ensuring minimum quality standards comes to around Rs 11 000 to 13 000. There is a difference of around Rs 3500, and hospitals have paying patients ready to pay much more than the scheme offers." - Private Provider Interview Kerala*

In Maharashtra, for example, the rates have not been revised since 2012, and in many packages, there is also a reduction in the rates. The providers say this is no longer viable for operating the scheme.

"Last two years, the prices of the things have gone too high. They are not considering inflation. They are not considering that the cost of everything is increasing. I mean, the cost of everything has increased, and after COVID times, everything has increased by 30%. But the cost of these packages is the same since 2012. I mean, there is no revision of costs." - Private provider in Maharashtra

In the provider payment setting, we also need to factor in the resource availability and budgetary constraints at the State level. The health benefits package (HBP) revision and the guidelines are done at the national level by the NHA and the implementation of the package rate revision is left to the discretion of the respective SHA. But at the state level, there are budgetary constraints due to which SHA's have not fully implemented the revisions in package rates. For example, in Kerala, the medical package rates are still not revised by the SHA as the financial implication of the revision has to be borne by the state health department.

"NHA has revised the package rates, but we have still not fully implemented the same. The medical package rate according to HBP 2 is Rs 1000 per day, but we are still continuing with Rs 750 per day. Our last year's overall expenditure was around Rs 1400 crores of which the central share is only Rs 138 crores and the state has to bear the majority of the financial burden." - SHA stakeholder in Kerala

The providers from all study states raised concerns about the inability to select multiple patient packages, limiting patients' options for the best possible care. This meant that patients did not receive the best possible care that met their unique needs. This also limited the providers to be ability to offer a range of treatments, medications, or procedures that could be critical to the patient's care.

"The treatment should be need-based and not based on packages. The scheme should allow us to choose multidisciplinary treatment so that we can provide services across a variety of different fields, such as mental health, addiction counseling, physical health care, and other services that help improve well-being." - Private provider in Maharashtra

There were many conditions that were not explicitly listed in the available package options, which made it difficult for providers to know which package to select for those unspecified cases. Consequently, hospitals ended up performing unspecified procedures for free, which resulted in financial losses for the hospitals.

PMJAY uses Transaction Management System (TMS) to facilitate the management of claims from hospitals (pre-authorization, claims management, and processing). The TMS drives the workflow of the scheme and effective use of this system is also dependent on the hospital infrastructure and availability of trained manpower. During the interviews, private providers expressed their concern about the complexities of the hospital operations and mainly the TMS of the PMJAY scheme. Common issues reported from TMS were slow response, lag in loading the pages, delay in getting auto-approvals, inability to upload the thumb impression/ geo-tagging at the time of discharge, etc. Providers mentioned that the website was usually slow, and it took multiple sessions to upload the documents. Over and above, the maximum size of file upload was of 500kb, and larger files, even after compressing, went beyond this size. It was mentioned that similar portal for CGHS never had such issues, and the providers demanded similar technical support for PMJAY TMS as well.

"Discharge is a very complex process as it is mandatory to take biometric GPS pictures in the TMS and many a time, the website doesn't work. This creates a hassle for the patient and the provider." - Private provider in Kerala

The Pradhan Mantri Arogya Mitra (PMAM) from one of the private hospitals pointed to a lack

of guidelines on storing and discarding the personal photos of patients.

"My phone gallery is full of private and personal photos of patients, that I have clicked for bio-tagging. I have no instructions for how long I have to keep these pictures. It makes me uncomfortable to have all these pictures in my phone." - Private provider in Maharashtra

Using bio-authentication was also one of the most common challenges reported by hospitals. Majority of the providers mentioned failures to upload both the thumb impressions and face authentications. It was highlighted that only one between the two systems should suffice instead of uploading both. A few providers also mentioned that there are provisions to upload an iris scan as a substitute; however that option is never highlighted on the portal. They believed that having a third option as fail safe mechanism could save a lot of time at discharge.

It was observed in Madhya Pradesh that the circular for including bio-authentication as a means of identification came in October 2022. However, cases submitted before October were also rejected due to missing bio-authentication. One of the hospitals mentioned that there is no provision for capturing thumb impression of the patients who walk away with "left against medical advice"/"discharge against medical advice". One hospital mentioned the patient's rights and ethical dilemma around clicking pictures of patients' faces along with the operation scar. The challenge is particularly pertinent for female patients.

"The picture of the scar along with the patient's face is needed at the time of discharge, I think this is a very sensitive issue. We could have legal implications for this, especially for women patients." - Private provider in J&K

4. Primary concerns of hospitals with regard to the day-to-day engagement with key stakeholders

Managing purchasing functions in a government-sponsored health insurance scheme for private providers involves multiple tasks ranging from pre-authorization and claims management, claims processing, insurance payments on time, and other administrative challenges. The complexity of managing various tasks also depends on the size and ability of the hospitals to negotiate these tasks with the ISP or TPA effectively. During discussions with providers, it was identified that there were several concerns raised by hospitals regarding their day-to-day interactions with SHA, TPA and Insurance companies. These concerns include issues related to the reimbursement process, claim disputes, and lack of support and guidance. Distinct variations were observed in the context and mechanism of engagement with the SHA across four states. All the providers from J&K mentioned that they faced no issues while trying to connect with the SHA. They stated that the communication mechanism with the SHA was strong and they were periodically heard for their issues and challenges. The providers also said they were given enough time to solve any issue/complaint via email.

"CMO invites all the private hospitals for a meeting at a common platform to hear our complaints. Individual complaints are also heard. SHA is always quick to respond." - Private provider in J&K
Further, it was observed that the monitoring and surveillance system in J&K was robust.

"There are frequent checks and audits by TPA, SHA and insurance company (IFFCO), they talk with patients and check our file." - Private provider in J&K

Maharashtra and Madhya Pradesh, however reported that state-level authorities did not interact with them regularly and they did not have any functional grievance redressal mechanism. Most of the providers from Madhya Pradesh mentioned that their mails are also not reverted and most of the time they had no clear idea about the concerned authority for their grievance redressal. To add about Kerala

"There is absolutely no grievance redressal mechanism at all. There is no one to solve our problems." - Private provider in Madhya Pradesh

A few hospitals highlighted that not all hospitals currently empanelled with PMJAY qualify for the scheme. They strongly felt that SHA should conduct periodic monitoring and audits to check these hospitals. It was mentioned that instead of having more hospitals empanelled with the scheme, it was more important that selected few hospitals provide quality service.

"Though there are checks for fraudulent claims, there is still a need to improve surveillance. We want a national team to audit and check the eligibility of hospitals to qualify for the scheme." - Private provider in Madhya Pradesh

Almost all the private providers felt that the scheme's management was not adequately addressing their concerns and grievances. Poor redressal mechanisms for private providers from PM-JAY lead to many issues for providers and beneficiaries. The lack of a proper complaint mechanism and poor redressal mechanisms lead to a lack of trust among private providers towards the scheme. Providers felt that they were not being treated fairly. Kerala is a good example of developing an engagement platform to connect with Empanelled Health Care Providers (EHCPs) through the District Project Coordinators of the State Health Agency, Kerala (SHA). The "District EHCP Connect" initiative is an online platform developed for information sharing, feedback on grievances, addressing queries related to scheme guidelines, and capacity building of private providers. This initiative was developed during the COVID period and currently serves as a platform for discussing all issues about the engagement of private providers with the State Health Agency.

During the interviews, private providers opined that there is a lack of clarity of guidelines and systems among the implementors. Guidelines often change in between without giving any time to adapt to the changes, which are cited as reasons for rejecting claims. The private insurance systems are not complex compared to the PMJAY system in terms of the documentation and monitoring part.

"There is implementation failure in the so-called full-proof system. There is a belief that hospitals are always there to cheat or fleece, and then systems keep this belief, making the operations complex. Hence, there is tremendous pressure on the hospital managers and administrative staff. Making things complex also allows hospitals to derail the system." - Private Provider from Kerala

Some providers also opined that beneficiaries raise false complaints (cases where beneficiaries make unfounded or exaggerated claims against private providers for services that were not provided or were not necessary) against health-care providers under PMJAY, creating significant problems, such as:

a) Damage to reputation: False complaints damaged the reputation of private providers

and negatively impacted their business. This caused long-term harm to their practice and make it difficult for them to attract new patients.

b) Legal implications: False complaints resulted in legal action being taken against private providers, which was time-consuming and expensive to resolve.

c) Financial loss: False complaints led to delayed or denied payments, which caused significant financial losses for private providers.

d) Increased administrative burden: Dealing with false complaints created an administrative burden for private providers. This can detract from their ability to provide quality healthcare services to patients.

e) Decreased trust in the healthcare system: False complaints created a perception of fraud and corruption within the healthcare system, which decreased trust in the system as a whole.

The providers felt that the system was skewed blindly towards benefitting patients, without giving them any rights.

"There should be strict action against patients who file wrong complaints against doctors. At present doctors are not being trusted. Moreover, there is no timeline for patients to raise complaints. Sometimes they file complaint after years of getting discharged. Patients know this loophole in the system and they blackmail hospitals" - Private provider in Maharashtra

"One patient decided to lodge a complaint against me after two years, after getting manipulated by a fellow competitor. There is no window after which a patient cannot complain against the treating doctor. The sad part is that the system is patient centric and our side of the story is not given proper consideration." - Private provider in Madhya Pradesh

The determinants of empanelment and active participation in the PMJAY scheme is dependent on intrinsic and extrinsic factors, as detailed in the previous sections. The intrinsic factors mostly depend on the overall market structure of the private health sector, bed capacity and

4

Discussion and conclusion

turnover of providers, availability of specialists, the reputation of the provider, location of the providers, and penetration of insurance coverage, both private voluntary insurance and publicly funded insurance schemes. Intrinsic factors also vary across states and incentive structure needs to be tailored according to the state context to attract more private providers. SHA needs to engage with large hospital chains to sensitize them about the potential benefits of PM-JAY. They can tap into a wider patient base, and the scheme can act as a platform to showcase their expertise and services to a broader audience. Moreover, joining PM-JAY can help these chains expand their operations to under-served areas and boost their CSR initiatives. The analysis shows that extrinsic factors like the provider payment rate setting, timely disbursement of payments, proactive engagement of private providers by the State Health Agency and insurance companies play a very important role in the successful implementation of the scheme. The key findings of the study discussed in the previous sections point out the bottlenecks hindering private-sector provider engagement in the PMJAY scheme, based on which we are suggesting specific recommendations in three domains to improve the participation of private-sector providers.

Structural issues

The key constraint raised by the active and inactive hospitals was about the benefit package rates of PMJAY. The difference in the PMJAY package rates and the prevailing market rates especially for the medical specialty packages is an important deterrent for not empanelling or being inactive hospitals under the scheme. Currently, the Health Benefits Package (HBP) rates of NHA are followed by most states with some state-specific flexibility. It is recommended that states have more flexibility to negotiate contracts with private sector providers specifically for specialty and super specialty packages. This would mean that SHA can negotiate graded package rates considering the bed capacity, specialty mix, and geographical considerations. This will improve the uptake of schemes among the major private hospitals which are now not part of the program.

Secondly, regarding the cost of packages, SHAs can adopt more flexible “dynamic package rates” which consider the increase and decrease in input cost as an alternative to the current system of benefit package rates. To begin with, SHA can analyse the historical claims data in each state to understand the key benefit packages with high volumes and undertake detailed costing exercises for considering the scale of the private sector. Private providers or associations should have equal participation with SHA’s key stakeholders in revising the benefits package costing.

Operational issues

The major operational issue evident from our findings is related to the claims processing and payment process. Rejection of claims and denial of payments after treatment were cited as the major reasons for either withdrawing from the scheme or being “inactive” hospitals. Part of this problem is also linked to the hospital operational processes of the scheme, and providers cited that processes are much more streamlined to reduce the delay in payments.

a payment cycle of around 30 to 45 days is often the optimal time for the private providers as they also pay their suppliers, keeping this payment cycle. Although, there are provisions made in the MoU with the TPA and Insurance companies with regard to the turnaround time for pre-authorization, claims processing, and payment to EHCP it is not strictly adhered to. Hence, it is recommended that SHA monitor the performance of the TPA and insurance companies for undue delay in payments to the providers and providers need to be compensated in such instances through the penal provisions mandated in the MoU.

Concerning the rejection of payments, the major issue is rejection after the pre-authorization of the cases. Further, there is a time-lapse in intimation to the provider and they also cannot recover the payment from the beneficiary. Currently, once a claim is rejected, even if due to documentation issues, the providers end up losing the entire package cost. This system needs to be changed and in case of rejection of cases after pre-authorization, providers need to be paid for the actual services, they have done based on the verification of the treatment documents. Some common errors or issues against which partial payments can be released include:

1. **Eligibility issues:** If there are eligibility issues with the beneficiaries who received services, partial payments can be released to the private players for the eligible beneficiaries while the issue is being resolved for the ineligible ones.

2. **Disputed claims:** If there are disputes over the claims submitted by private players for reimbursement, partial payments can be released while the dispute is resolved.

3. **Incomplete documentation:** If there are issues with the documentation submitted by private players for reimbursement, partial payments can be released while the required documentation is obtained.

4. **Payment delays:** If there are delays in the processing of claims by the PMJAY authorities, partial payments can be released to private players to ensure that they have access to cash flow while the claim is being processed.

5. **Other technical issues:** If there are technical issues with the claims submission process, partial payments can be released to private players while the issues are being resolved.

Providing partial payments to private players under PMJAY can help improve their engagement in several ways, including:

1. **Ensuring cash flow:** Partial payments can help ensure cash flow for private players, particularly those who may not have sufficient resources to continue providing services until full payments are received. This can help reduce the financial burden on private players and enable them to continue providing services to PMJAY beneficiaries.

2. **Encouraging participation:** Offering partial payments can encourage private players to participate in PMJAY by providing greater financial incentives. This can help increase the number of private players participating in the program and improve access to healthcare services for beneficiaries.

3. **Improving trust:** Providing partial payments can help build trust between private players and PMJAY authorities by demonstrating that the program is committed to ensuring timely and fair payments. This can help improve the overall perception of the

program and encourage more private players to participate.

4. **Enhancing program effectiveness:** By ensuring private players receive partial payments for their services, PMJAY can help enhance the program's effectiveness by ensuring that beneficiaries have access to the services they need. This can help improve the overall health outcomes of beneficiaries and reduce the burden on public healthcare facilities.

Engagement of the private providers with institutional systems is another key area of reform. In our discussions, providers mentioned that they are not treated as equal stakeholders in providing care for a patient. There are many ways to ask the patients if they are being charged any money or are satisfied with the treatment. However, hospitals have no redressal mechanism should the patient lodge a false complaint against them. It was strongly recommended that the monitoring and surveillance mechanism be strengthened to overcome this challenge. All hospitals should be visited regularly, and coordinators should know all the procedures/cases from admission to discharge. The J&K model is a good example for ensuring the monitoring and surveillance of private hospitals.

Providing new services and increasing coverage will require a parallel concerted effort to ensure that quality assurance, appropriate governance, and proper referral pathways are maintained when new services are provided and coverage increases. As a result of the importance of private healthcare providers in India, the government's stewardship function must be strengthened in order for it to be able to monitor how well the providers are providing the quality of care they provide. It is possible to accomplish this in a number of ways, including through the creation of robust referral pathways for patients, quality audits of providers, incentives for the improvement of efficiency and quality of care, and an overall strengthening of the capability of the public sector to contract with and regulate the private sector effectively.

Enabling institutional architecture

Providers had pointed out multiple issues with the Transaction Management System (TMS) and the claim processing and settlement guidelines. Undoubtedly, PM-JAY's IT-enabled platform is a crucial component of its operations. The current system is very complex and requires consistent technical support which is an issue for most small and mid-sized private providers. Hence a simpler workflow for the TMS could help private hospitals and also reduce the issue of claim rejection to a greater extent. Similar systems used by private insurance providers can be analysed to create a much leaner transaction management structure which could also be user-friendly for private providers.

Annexures

Annexure 1: State-level interviews

Jammu & Kashmir			
S. No.	**Designation**	**Name**	**Date**
1	State Medical Officer, State Medical Agency, Ayushman Bharat	Dr Kamna Gorka	6 December
2	State nodal officer, Ayushman Bharat	Dr Khurshid Ahmad Khan	6 December
3	Deputy General Manager, IFFCO Tokio General Insurance Co. Ltd.	Mukhtar Lone	13 December
4	Deputy General Manager, IFFCO Tokio General Insurance Co. Ltd.	Harendra Prasad	13 December

Madhya Pradesh			
S. No.	**Designation**	**Name**	**Date**
1	General Manager (Operations), Ayushman Bharat 'Niaramyam'	Dr OP Tiwari	16 December

Maharashtra			
S. No.	**Designation**	**Name**	**Date**
1	Senior Manager, State Health Assurance Society	Dr Arpana Makwana	15 December

Kerala			
S. No.	**Designation**	**Name**	**Date**
1	General Manager Operations	Dr Bijoy Erattil	25 October
2	Hospital Network Manager	Dr Vimal	8 December

Annexure 2: Private hospitals

Jammu						
S. No.	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**	**Empanelment status**	**Date**
1	Acharya Shri Chander College of Medical Sciences and Hospital	Dr Aliya	Coordinator	Multi-speciality	Empanelled	16 November 2022
		Dr Rabinder Rattan Pal	Medical Superintendent			
2	Triveni Hospital	Mr KK Sharma	Administrator	Multi-speciality	Empanelled	17 November 2022
		Mr Vijay Kumar	PMAM			
3	Raksha Kidney Centre	Dr Amit Suri	Owner	Multi-speciality	Empanelled	17 November 2022
		Dr Sheetal	Administrator			
		Isha	PMAM			
4	Jammu City Oncology	Dr Arjun Singh	Owner	Single-speciality	Empanelled	17 November 2022
5	Bee Enn General Hospital	Manju Rajput	Operations Head	Multi-speciality	Empanelled	17 November 2022
		Rajan Sharma	Incharge - Empanelment; PMAM			
6	Pulse Hospital	Dr Zaffar	PMAM	Multi-speciality	Empanelled	18 November 2022
		Dr Bhupinder	Executive Director			
7	Ankur Maitrika	Dr Ajay Wakhloo	Owner	Multi-speciality	Empanelled	18 November 2022
		Sandeep Bhatt	PMAM			

Kashmir						
S. No.	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**	**Empanelment status**	**Date**
1	New City Multi-speciality Hospital	Altaf Hussain Beigh	Owner	Multi-speciality	Empanelled	1 December 2022
		Raja Gulzar	PMAM			
2	Ibn Sina	Dr Ashraf Bashir	Medical Officer	Multi-speciality	Empanelled	1 December 2022
			Owner			
3	Shifa Medical Centre	Dr Gulzar Ahmed	Director	Multi-speciality	Empanelled	1 December 2022
4	Safa Marwah Hospital	Dr Mufti Khawar	Managing Director	Multi-speciality	Empanelled	1 December 2022
5	Noora Hospital	Manzoor Wagay	Managing Director	Multi-speciality	Empanelled	1 December 2022

Buldhana						
S. No.	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**	**Empanelment status**	**Date**
1	Sancheti Hrudayalaya	Dr Saurabh	Owner	Multi-speciality	Empanelled	5 December 2022
2	Amrut Hrudayalaya and Superspeciality Hospital	Amol D. Kothalkar	Owner	Multi-speciality	Empanelled	5 December 2022
3	Laddhad Hospital	Dr Deepak Laddhad	Owner	Multi-speciality	De-empanelled	5 December 2022
4	Ashirwad Multi speciality	Dr Suresh Chhajed	Owner	Multi-speciality	Inactive	5 December 2022

Aurangabad						
S. No.	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**	**Empanelment status**	**Date**
1	IKON Hospital	Dr Faizal	Owner	Multi-speciality	Empanelled	6 December 2022
2	Apex Super-speciality Hospital	Dr Ashish	Owner	Multi-speciality	Inactive	6 December 2023
3	Kabra Hospital	Dr Vijendra Kabra	Owner	Multi-speciality	De-empanelled	6 December 2024
4	Carewell hospital	Dr Mahesh Shinde	Owner	Multi-speciality	Inactive	6 December 2025

Mumbai						
S. No.	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**	**Empanelment status**	**Date**
1	HJ Doshi Hindu Mahasabha Hospital	Dr Vaibhav Deogirkar	Medical Director	Multi-speciality	Empanelled	7 December 2022
2	Lion Tarachand Bapa Hospital	Dr Desai	Owner	Multi-speciality	Empanelled	7 December 2022
3	Surana City Hospital	Dr Prince	Owner	Multi-speciality	De-empanelled	7 December 2022
4	Wockhardt Hospital	Refused to participate		Multi-speciality	Inactive	7 December 2022

Bhopal						
S. No.	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**	**Empanelment status**	**Date**
1	Narmada Trauma Centre	Pawan Mehta	HR Manager	Multi-speciality	Empanelled	8 December 2022
2	Noble Multi-speciality Hospital	Dr Padma	Medical Director	Multi-speciality	Empanelled	8 December 2022
3	Divya advanced ENT hospital	Dr Satya Prakash Dubey	Director and owner	Multi-speciality	De-empanelled	8 December 2022
4	Parul Hospital	Deepak	HR Manager	Multi-speciality	De-empanelled	8 December 2022
5	Sahara Hospital	Dr Piyush Vyas	Owner	Multi-speciality	De-empanelled	8 December 2022
6	Swami Vivekanand Regional Spine Center	Dr Sunil Pandit	Owner	Multi-speciality	Empanelled	8 December 2022

Gwalior						
S. No.	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**	**Empanelment status**	**Date**
1	SSIMS Super-speciality Hospital	Dr Neeraj Sharma	Director	Multi-speciality	Empanelled	9 December 2022
2	Vaidansh Hospital	Dr Grisham	Owner	Multi-speciality	Inactive	9 December 2022
3	Parivar Multi-speciality	Dr Manoj Gulati	Director	Multi-speciality	Empanelled	9 December 2022
4	RJN Apollo Spectra Hospitals	Dr Priyamwada Bhasin	Owner	Multi-speciality	De-empanelled	9 December 2022
5	BMIR	Govind Deora	Executive Trustee	Multi-speciality	Empanelled	12 December 2022
6	Atishay Hospital	Dr Nitin	Owner	Multi-speciality	Empanelled	12 December 2022

Kerala				
Sl. No	**Hospital**	**Stakeholders contacted**	**Designation**	**Speciality**
1	Pulse Hospital Trivandrum	Ms Preeta	Administrative Officer	Multi-speciality
2	SUT Medical College, Trivandrum	Dr Rajapradeep	Medical Superintendent	Medical College
3	Karunya Hridyalaya Trivandrum	Mr Surur	Manager	Single Speciality
4	Lords Hospital Trivandrum	Harikumar	Manager	Multi-speciality
5	KIMS Hospital Trivandrum	Dr Asher	Managing Director	Multi-speciality
6	Saraswathy Hospital Trivandrum	Mr Sreejith	Manager	Multi-speciality
7	CSI Medical College , Trivandrum	Dr Bennet Abraham	Director	Medical College
8	City Hospital Ernakulam	Dr Vinod Rajagopal	Managing Director	Multi-speciality
9	Sudheendra Hospital, Ernakulam	Dr Junaid Rahman	Medical Director	Multi-speciality
10	PS Mission Hospital, Ernakulam	Sr Annie	Medical Superintendent	Multi-speciality
11	Welcare Hospital, Ernakulam	Sanil Kumar	Group CEO	Multi-speciality
12	B&B Hospital	Mr Shanty	Manager	Multi-speciality

Annexure 3: In-depth interview tool for key stakeholders - private hospitals

Section - A

General information

	Date of interview	
	Name of the hospital	
	Name and designation of the respondent	
	Year of joining the scheme	
	Number of hospital beds	
	Whether all specialties are empanelled under the scheme	
	Specialties are empanelled under the scheme.	
	Any other insurance schemes empanelled in the hospital.	
	Number and amount of claims raised by the hospital	
	Payment received by the hospital.	
	Pending claims, if any.	

Section B

1. What was your motivation/interest in joining the PMJAY scheme? (Probe for the key reasons for joining the scheme; and the main value proposition of PMJAY for the hospital)

2. Can you briefly explain the process followed in empanelling your hospital to the scheme (Probe for the application, inspection, and review process; the role of DEC)

3. What is the contractual agreement/relationship with the ISA, and what are the key processes involved in the agreement? (Probe for contractual management and role of key stakeholders in contractual management)

4. Did you face any major issues in the empanelment process under PMJAY? (Probe for the key issues in the empanelment process)

5. Whether you have empanelled your hospital for all specialties under PMJAY? If not, what are the reasons for selective empanelment?

6. What are your views on the various treatment packages in your hospital? Do you feel the package rate is low, acceptable, or high? (Probe for key concerns in package rates)

7. How different is it when compared to the market rates and rates given by other insurance schemes? (Probe for the issues in specialty packages and differences with private insurance schemes)?

8. What are the legal and health system issues private providers face in the PMJAY scheme? (Probe for the regulatory issues, coordination with the public health system)

9. What are the key operational challenges in implementing the PMJAY scheme? (Probe for the contractual issues; operational issues, and institutional issues)

10. What are the key concerns that you face in day-to-day engagement with
    a. ISA/TPA
    b. SHA
    c. Public Health System

11. Have you received any training programs about implementing the scheme? (Probe for the type of training received by the hospital; continuous training programs)

12. What is the TAT for pre-authorization of claims in normal cases and emergency cases concerning cashless settlement?

13. What is the TAT for settlement of claims in normal cases and emergency cases concerning cashless settlement? (Probe for the issues in claims settlement; Operational IT-related issues; variation within specialties)

14. What type of query the ISA/SHA raises during the audit of cases? Does the audit of cases delay claims processing and payment to hospitals? (Probe for the typical issues raised in audit; issues in the audit of claims in the hospital?

15. What is your experience with claims settlement of the scheme? Have you experienced a delay in payment of claims? (Probe for the current unsettled claims of hospital duration of outstanding claims)

16. What are the major reasons for the delay in claim settlement? How do you resolve the issue of delay in payments?

17. What are the key issues faced by the hospital in case of rejected and pending claims? How do you resolve this issue? (Probe for the details of rejected and pending claims of the hospital for the last year)

18. Are you aware of the grievance redressal mechanisms of the PMJAY scheme? What is your experience with the grievance redressal processes? (Probe grievances raised by the hospital and redressal status)

19. Do you have regular meetings with ISA or SHA to resolve implementation issues about the PMJAY scheme? (Probe for meetings with DEC, CMHO, District Coordinator of SHA)

Questions for inactive hospitals

20. What are the specific reasons for the inactive status of your hospital? (Probe for the specific reasons for not providing PMJAY services after empanelment)

21. Did you raise your issues/concerns with ISA and SHA? What was the outcome of the discussions? (Probe the mechanisms used by the hospital to raise the issues concerning the scheme)

22. What are the key reasons for the non-resolution of the issues? (Probe whether the resolution of the issues increases the willingness/ability of hospitals to offer services)

23. Q. Are there factors outside of SHA's control creating an impediment to the scheme implementation?

Questions for de-empanelled hospitals

24. What are the specific reasons for the de-empanelment of your hospital?

25. Did you raise your issues/concerns with ISA and SHA? What was the outcome of the discussions? (Probe the mechanisms used by the hospital to raise the issues concerning the scheme)

26. What are key reasons for the non-resolution of the issues raised?

27. Are you interested in joining the scheme again?

Section C - Recommendations

28. What, according to you, are the key reason(s) for low participation in the scheme among private players?

29. What important bottlenecks must be addressed to improve private hospital empanelment and active participation in the PMJAY scheme? Do you have any solutions to address these bottlenecks?

30. Any other comments or suggestions?

Thank you for your time.

Annexure 4: In-depth interview tool for key stakeholders - State Health Agency

Section A: General information

1. Date of Interview
2. Name and designation of the respondent

Section B

1) Can you provide a brief overview of the implementation of PMJAY and State Health Schemes in the State? (Probe for the population and service coverage, target population)

2) What is the current network of public and private provider networks of the Scheme/s in the State (Probe for public-private distribution of provider network)

3) What is the current distribution of private providers under the scheme across all districts of the State and specialties covered by the scheme (Probe for the pattern of distribution of private providers across districts and specialties)

4) Can you briefly explain the process of empanelment of hospitals and the role of SHA in the process flow? (Probe for the institutional structures within SHA for hospital empanelment; duration and the role of committees)

5) What criteria need to be fulfilled for hospital empanelment? Who oversees the review of this process? (Probe for the review process and the role of key stakeholders involved in the process)

6) Do you have introduced any flexibility in the empanelment criteria to increase participation of the private hospitals in your State?

7) What is the process of entering a Service Contract Agreement with private hospitals? (Probe for the role of ISA/Insurance company; State and District empanelment committee)

8) What are the major issues faced while empanelling private providers under PMJAY?

9) What, according to you, are the key reason(s) for low participation in the scheme among private players?

10) What are the key issues raised by the private providers in the implementation of the scheme? (Probe for the contractual issues; operational issues, and institutional issues)

11) What are the key issues raised by private hospitals about the ISA?

12) What training/capacity-building opportunities exist for the private sector hospitals regarding the operational and implementation issues of PMJAY? (Probe for the details of the training programs)

13) Since the scheme's implementation, how many private hospitals have opted out of the scheme, and what are the key reasons (s) for private players opting out of the PMJAY scheme?

14) In the current provider network, how many private hospitals are “inactive hospitals”? (Probe for the number of private hospitals; reasons cited by inactive hospitals, and strategies of SHA about these hospitals)

15) Which benefit package is used by the SHA for implementing the PMJAY scheme in the State? What are the main concerns raised by private providers/associations about the benefits package (Probe for the benefit package differentials between public and private hospitals; institutional systems in place for discussion of the benefit packages with the private sector)

16) What is the Turnaround Time (TAT) for settlement of claims with private hospitals? Is there a deviation from the mandated time as per the scheme guidelines? If yes, what are the reasons for the deviation?

17) How is a delay in settlement of claims affecting service delivery by private hospitals? (Probe for the current unsettled claims of private provider network; duration of outstanding claims; the role of ISA in reducing the delay in settlement)

18) What are the primary reasons for the delay in claim settlement of private hospitals? What measures are in place to tackle the delay in payments of private hospitals?

19) Has the SHA implemented an incentive system for promoting the accreditation of service providers? What type of quality improvement systems are in place currently? (Probe for number of quality certified hospitals since the inception of the scheme)

20) What are the key mechanisms involved in fraud management? What type of fraud triggers are reported from private hospitals?

21) How many private hospitals have been de-empanelled by SAST? What were the main reasons for the de-empanelment of hospitals? (Probe for the number of facilities de-empanelled in the last three years.

22) What grievance redressal mechanisms exist for private providers participating in the scheme? What are the processes laid out for grievance redressal (Probe for institutional avenues for conflict resolution; type of grievances from private providers, mechanisms of grievance resolution)

23) What institutional systems are in place for continuous engagement with private sector providers both empanelled and non-empanelled in the State?

Recommendations

24) What critical bottlenecks must be addressed to improve the empanelment and active participation of private players in the PMJAY scheme? Do you have any solutions to address these bottlenecks?

25) Any other comments or suggestions?

Annexure 5: In-depth interview tool - Insurance Support Agency

Section A: General information

1. Date of Interview
2. Name and designation of the respondent

Section B

1) Can you provide a brief overview of the functions of the ISA in implementing the AB-PMJAY scheme?

2) Can you briefly explain the process of empanelment of hospitals and the role of ISA in the process flow? (Probe how ISA coordinates with SHA, DEC and Private providers)

3) What criteria need to be fulfilled for hospital empanelment? Who oversees the review of this process? (Probe for the review process and the role of key stakeholders involved in the process)

4) What is the process of entering into a Service Contract Agreement with private hospitals? (Probe for the role of ISA/Insurance company; State and District empanelment committee)

5) What are the major issues faced while empanelling private providers under PMJAY?

6) What, according to you, are the key reason(s) for low participation in the scheme among private players?

7) What are the key issues raised by the private hospitals in the implementation of the scheme? (Probe for the contractual issues, operational issues, and institutional issues)

8) What type of training/capacity-building opportunities exist for the private sector hospitals about the operational and implementation issues of PMJAY? (Probe for the details of the training programs)

9) Since the scheme's implementation, how many private hospitals have opted out of the scheme, and what are the key reasons for private players opting out of the PMJAY scheme?

10) In the current provider network, how many private hospitals are "inactive hospitals"? (Probe for the number of private hospitals; reasons cited by inactive hospitals, and strategies of SHA about these hospitals)

11) What are the main concerns raised by private providers/associations about the benefits package? (Probe for the benefit package differentials between public and private hospitals; institutional systems in place for discussion of the benefit packages with the private sector)

12) What is the Turnaround Time (TAT) for settlement of claims with private hospitals?

13) Is there a deviation from the mandated time period per the scheme guidelines? If yes, what are the reasons for the deviation?

14) What are the major reasons for the delay in claim settlement of private hospitals?

15) What measures are in place to tackle the delay in payments of private hospitals?

16) How many private hospitals have been de-empanelled by SAST? What were the main reasons for the de-empanelment of hospitals? (Probe for the number of facilities de-empanelled in the last three years)?

17) What grievance redressal mechanisms exist for private providers participating in the scheme? What are the processes laid out for grievance redressal (Probe for institutional avenues for conflict resolution; type of grievances from private providers, mechanisms of grievance resolution)

18) What strategies are used by ISA to improve provider empanelment and the performance of inactive hospitals?

Section C: Recommendations

19) What are the important bottlenecks that must be addressed to improve private players' empanelment and active participation in the PMJAY scheme? Do you have any solutions to address these bottlenecks?

20) Any other comments or suggestions?

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