

PRADHAN MANTRI JAN AROGYA YOJANA (PM-JAY), THE WORLD'S LARGEST FULLY FUNDED HEALTH INSURANCE SCHEME WAS LAUNCHED ON SEPTEMBER 23, 2018, FOR PROVIDING COVERAGE TO NEARLY 10.74 CRORE POOR FAMILIES OF THE COUNTRY IDENTIFIED AS PER THE SOCIO-ECONOMIC CASTE CENSUS SURVEY-2011. THE OBJECTIVES OF THE SCHEME INCLUDE REDUCING CATASTROPHIC OUT-OF-POCKET HEALTH EXPENDITURE, IMPROVED ACCESS TO THE POPULATION FOR HOSPITALISATION CARE.

PM-JAY PROVIDES A CASHLESS COVER OF UP TO RS. 5,00,000 ON A FAMILY FLOATER BASIS WHICH MEANS THAT IT CAN BE USED BY ONE OR ALL MEMBERS OF THE FAMILY.



Figure highlighting the successful one year of PM-JAY

BACKGROUND

Health spending is one of the important causes of poverty in India, and more than 65% of the expenditure on health is through out-of-pocket (OOP), which is one of the highest in the world (NHA 2014-15).

OOPs adversely affects the poor, forces them to use expensive and impoverishing coping mechanisms such as high-interest loans, distress selling of assets, and reducing consumption of food; and pushes them deeper into the hole of catastrophic impoverishment.¹

At the same time, policy makers and influencers at the State and National level in India are continuously debating and developing ways to provide quality health care to the poor and destitute, without worsening their economic situation. The recent evolution of largescale schemes such as Ayushman Bharat at the Central level and health financing measures at the State level with a robust regulatory framework are the result of such debates and commitments. The health insurance initiatives are also a reflection of the commitment towards Universal Health Coverage (UHC). Like other countries, India is striving towards United Nations Sustainable Development Goals to achieve UHC by 2030, and also aligning them with the country's National Health Policy (NHP) 2017.

1 Household's Coping Mechanisms of Out-of-Pocket Expenditure on Health Care: a Case Study of Assam, India

HEALTH INSURANCE LANDSCAPE IN INDIA

India's landscape of health insurance has undergone a tremendous change in recent years with the launch of several health insurance schemes in the country, largely initiated by Central and State governments. The Rashtriya Swasthya Bima Yojana (RSBY), a Central Government health insurance scheme for Below Poverty Line families, was launched in 2007-08 and it became fully operational on April 1, 2008.² At its peak, the scheme was operational across 25 states of India covering 41,331,073³ households. Moreover, the currently State-run health insurance schemes in Andhra Pradesh and Tamil Nadu have managed to cover as much as 50-80 per cent of their population under the health insurance umbrella. Further, States like Himachal Pradesh and Kerala are trying to deepen the benefits of packages for their poor and vulnerable strata. There are some States who are on the path of UHC such as Meghalaya with its Megha Health Insurance and Goa with its Deen Dayal Swasthya Seva Yojana to provide health insurance coverage for the entire resident population of the State.

Ayushman Bharat PM-JAY launched by the Government of India in September 2018 is one of the most promising flagship programmes enforcing the goals of the NHP and achieving UHC. The PM-JAY initiative is addressing health (covering prevention, promotion and ambulatory care), at the secondary and tertiary levels and aiming to cover around 40 per cent poor and vulnerable population of the country (50 crore beneficiaries). PM-JAY has evolved with learnings from programmes like Employee State Insurance (ESI), Central Government Health Scheme (CGHS), and RSBY, which are notable schemes for formal and informal sectors, respectively, but the benefits and coverage under PM-JAY are much bigger than the existing schemes. Therefore, the States considered tweaking their original schemes by leveraging PM-JAY.

PM-JAY is completely funded by the Government and costs are shared between Central and State Governments. One of the biggest strengths of PM-JAY is its flexible design which considers the federal nature of the country where health is constitutionally a "State subject". The scheme gives the freedom to the States in deciding the mode of implementation which is contextually appropriate.

2 Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out-of-pocket spending for healthcare

3 www.rsby.gov.in/index.aspx

- **Insurance Model:** States engages with an insurance company to purchase healthcare services
- **Trust Model:** Purchase services directly by the State-owned agency
- **Mixed Model:** Use insurance company for one part and trust for the other part

Insurance Mode (10 States/UTs)	Trust Mode (17 States/UTs)		Mixed Mode (6 States/UTs)
Meghalaya	Andhra Pradesh	Tripura	Chhattisgarh
Mizoram	Arunachal Pradesh	Uttar Pradesh	Gujarat
Nagaland	Assam	Uttarakhand	Jharkhand
Dadra & Nagar Haveli	Bihar	Lakshadweep	Maharashtra
Daman & Diu	Goa	Andaman & Nicobar	Rajasthan
Jammu & Kashmir	Madhya Pradesh	Chandigarh	Tamil Nadu
Puducherry	Manipur	Karnataka	
Kerala	Sikkim	Haryana	
Punjab	Himachal Pradesh		

RATIONALE OF THIS DOCUMENT

The PM-JAY scheme was built on the learnings of its predecessor schemes, and accordingly the risk and mitigation plans were in place before implementation. But in an environment challenged by low public health financing across States, issues in public delivery systems, benefit packages rates, purchasing functions by States, quality of care standards and scheme penetration, etc., many operational challenges were faced during the first year of implementation of the scheme. Some of these challenges were resolved via doing mid-course corrections while some were taken as lessons learnt.

There are several lessons that PM-JAY offers from the National and State level implementation to make the scheme more effective and efficient. These relate to scheme design, its implementation primarily beneficiary identification through IT ecosystem, empanelment of health facilities, role of insurance companies, contracting and regulation, etc.

This document highlights that by building on the learnings from all divisions of the National Health Authority (NHA) implementing PM-JAY and enforcing strong regulations, transparency, trust and public awareness to reduce OOP health spending, PM-JAY may well be the proverbial giant leap towards Universal Health Coverage in the country.

IT ECO-SYSTEM



CHALLENGES

- Lack of easy identification of beneficiaries
- Supporting horizontal expansion and use of own software by States
- Creating robust IT systems in a short timeframe
- Enabling portability
- Approaches to control fraud and abuse



LESSONS LEARNT

- A State Health Agency (SHA) workers plus technology can support rapid data collection and awareness
- Open Application Program Interface model as an approach for flexibility
- Partnering with government organisations and State governments to integrate best-in-class solutions for rapid delivery
- Clear guidelines and easy to use software for portability
- Fast Proof of Concepts help understand if a technical approach is useful

BACKGROUND

The NHA has developed comprehensive IT based solutions that are designed to help States/UTs rapidly implement the PM-JAY scheme. States have flexibility to use NHA provided IT system or their existing IT platform. In all cases, States are required to provide data to the NHA in a standardised format that enables monitoring on a set of common parameters. Since the scheme's launch, the IT system is a backbone to the scheme implementation throughout the nation and it also uses various business intelligence tools under PM-JAY 1.0 version. The robust IT ecosystem includes end-to-end information security and privacy of personally identifiable data for beneficiaries, portability, grievance management and anti-fraud measures, etc. Besides being the best of IT solutions and regular upgradation of mechanisms, continuous feedback was received from States to enhance and include innovative solutions to make the system more vigorous. Some of these feedbacks/challenges were adapted as good learnings and implemented accordingly.

CHALLENGES

a. Lack of easy identification of beneficiaries

The criteria described by the NHA for eligibility of beneficiaries under the scheme was a subset of SECC 2011 or anyone with an existing RSBY card at the time of launch of PM-JAY. The NHA needed an IT-based solution to educate and create awareness that a family was eligible for the scheme, and also ways to rapidly identify the family if any member came to a hospital for treatment.

b. Supporting horizontal expansion and use of own software by States

While the Centre had the criteria of supporting SECC and RSBY, many States decided to horizontally expand coverage to a larger base. The brownfield States which had excellent experience implementing health insurance schemes also wanted to continue with their existing software and processes. It is important that IT at NHA came up with a way to support both these requirements as they were key factors for the States to join the scheme.

c. Creating robust IT systems in a short timeframe

During the launch, the NHA had less than six months to offer an IT solution to the States for implementation of the scheme. For a scheme of this nature and size, this was an extremely tight timeframe for the work to be executed.

d. Enabling portability

The stated objective of the NHA is to ensure that patients can get treatment anywhere across the country without travelling back to their home states. This was especially critical as many States and UTs do not have good tertiary care facilities within their States and this is one of the largest out-of-pocket payment areas. Portability is new construct and had not been effectively implemented for government health insurance schemes in the past. There was a need to clarify guidelines and also come up with a process that ensured that portability was implementable on the ground.

e. Approaches to control fraud and abuse (FA)

Over use of packages and intentional fraud were areas that the NHA and SHAs needed to keep an eye on during implementation of the scheme. The challenge was to come up with an approach that would work across all the States – both using their own software and those using software provided by the NHA. Detecting fraud and abuse is not just about using analytics but requires specialists who can analyse the output of the models and identify areas where more investigation is required. The NHA approach to FA was at a very nascent understanding at this time and building relevant capacity of the NHA was key.

LESSONS LEARNT

a. ASHA workers plus technology can support rapid data collection and awareness

The Additional Data Collection Drive (ADCD) was designed to generate awareness and to help collect a ration card number and a mobile number for each family that could be used to search for the family to verify eligibility. The process used was

- The NHA created a PDF listing all eligible members at a village/ward level for all States
- The files were downloaded and printed by the Collector's office in each district; and a dashboard was provided to States to monitor the progress of downloading and printing
- Each PDF was printed with an activation code. Once the ASHA worker picked up the PDF they dialled a toll free number and punched in the code; the same process was repeated whereby a dashboard was provided monitoring the progress of distribution of printed lists to ASHAs
- The ASHAs organised a camp along with the panchayat and carried out door-to-door

campaigns. Awareness about the scheme was conveyed during this process. They noted down a ration card number along with mobile numbers in the space provided for each family

- The filled-out files were sent for data entry operations where the ration cards and mobile numbers collected were captured against the SECC data. Incentives were paid to both ASHA workers and data entry operators for the activities.

Apart from the IT enablement to track and monitor all the steps, appropriate incentives was key to the success of this drive. In a span of just three months, 5.44 crore families were identified, along with mobile and ration card numbers linked into the NHA-SECC database.

b. Open API model as an approach for flexibility

The NHA decided to use the API approach to support the States. States were allowed to onboard any beneficiary database they wanted as long they implement on an open API database, which could be accessed by the NHA

Beneficiary Identification System. This has been used extensively by 10 States & UTs to expand the beneficiary base that is covered by PM-JAY.

The NHA also created Open APIs for sharing of data in standardised formats for States that wanted to use their own software. The process allowed the States to fully retain the existing software while providing all the data the Centre required for monitoring and evaluation of the scheme. This has been used by 10 States to continue working with their own software.

c. Partnering with government organisations and State governments to integrate best-in-class solutions for rapid delivery

The NHA chose various best-in-class solutions within the government eco-system including:

- Phonetic search technology first developed by CDAC for electoral rolls, with the search capabilities of approximately 50 crore beneficiary base
- NIC's extensive experience of working with Aadhaar, a gateway capability for high volumes and experience in large government projects helped bring the Beneficiary Identification System (BIS) to life
- Government of Telangana's extensive experience and excellent software used for implementing the Arogyashri scheme was used as the base for the NHA Transaction Management System (TMS)

d. Clear guidelines and easy to use software for portability

The NHA first drafted and shared portability guidelines with the States for feedback. The rules for portability were kept as simple as possible and articulated as rules that were easy to understand, as States had to make a decision about portability. The IT software was designed to re-use the existing UIs/flows to ensure the low learning curve for hospitals and states to implement portability. The current efforts have ensured launch of portability with over 43,498 patients getting benefit. There is a need to make portability much easier and future IT implementations should work on improving this further.

e. Fast Proof of Concepts (POC) help understand if a technical approach is useful

The NHA decided to conduct POCs with partners who had expertise in FA systems globally. Over 23 companies showed interest in participating in the POC and the NHA selected five companies to execute the POC. The NHA provided a sandbox to all companies; they had access to data in a secure environment and could apply their techniques in FA and demonstrate their capabilities. This approach allowed the NHA to understand the various approaches taken in the market and capabilities of the partners. The NHA is now in the process of procuring a fraud control partner based on these learnings.

RECOMMENDATIONS AND WAY FORWARD

PM-JAY 2.0 Version includes:

- Scalability from 25,000 transactions per day to over 1 lakh transactions per day over the next 2-3 years, and the consequent increase in data size
- Interoperable solution with an architecture conforming to IND EA Standards - Enterprise Data Architecture, Enterprise Application Architecture and Enterprise Technology Architecture
- Conformance to National Digital Health Blueprint (NDHB) standards to enable PHR to be established, and to enable the ecosystem players to use PM-JAY 2.0 effectively
- To move towards a paperless and cashless system, conforming to a Decision Support System (DSS)

HEALTH BENEFIT PACKAGES



CHALLENGES

- Inconsistencies in package nomenclature
- Duplication of packages
- Unviable rates for packages
- Large difference in rates of similar procedures across different specialties
- Implants included in the rates
- Different rates for same procedure in different specialties
- Overlap with national health programmes



LESSONS LEARNT

- Rationalising Health Benefit Packages and aberrations in their price
- Limiting utilisation of unspecified packages
- Designing cross-specialty packages
- Defining stratified packages
- Addition of subsets of packages
- partial payment provision
- Inclusion of follow-up component

BACKGROUND

The NHA adopted a total of 1,393 treatment packages out of which 1,083 were surgical, 309 were medical and 1 unspecified package. The services were rolled out as received by the NHA in all greenfield states, while the package masters were customized for brownfield states in line with their ongoing schemes. With continuous flow of feedback from various professional bodies, practitioners, industry experts and other relevant stakeholders on package prices, a more nuanced approach was required to ascertain the costs involved in healthcare delivery and understand their impact at different strata of the value chain. To arrive at unbiased and rational conclusions, the NHA aligned its approach on costing with the ongoing project of DHR (Department of Health Research – MoHFW) which going ahead could form the basis for rationalisation of package pricing. Key feedback received by the NHA can be described as under:

CHALLENGES

a. Inconsistencies in package nomenclature

At some places the procedure is named and at other places the disease is named, for example, Fibroadenoma – Bilateral & Fibroadenoma – Unilateral are diagnosis while Fissurectomy is a procedure. During the initial months of implementation of the scheme, this complexity and vagueness across States raised the scope for provision of unnecessary or inappropriate services.

b. Duplicate and lateralised packages

A lot of procedures appear more than once under the same specialty in the list either with exact match of terminology or with alternative terminology, for example, package number 00012 under M1 states 'Acute exacerbation of COPD' and package number 00046 under the same specialty also states 'Acute exacerbation of COPD'. Similarly, package number 00019 and 00047 under M1 state Pneumonia and Severe Pneumonia, respectively.

There are some procedures which require the same kind of effort, skill set, etc., so there is no need to include different packages separately for right and left side, e.g. 'Breast Lump - Left –

Excision' and 'Breast Lump - Right – Excision'.

Duplicate and lateralised packages were identified by purchasers and had implications beyond the issue of "fraud and abuse,".

c. Unviable rates- difference between rates of similar procedures, implants included

The pricing philosophy adopted for costing of the identified services was based on the intensity of care required (minimum acceptable level of resource input) that included both fixed and variable costs towards providing end-to-end treatment. But there were large differences in rates of similar procedures; and implants were also included in the rates. With the maturity of the scheme, it was observed that, with the imposition of implants, the potential for arbitrary variation in quality arises. Also, various professional bodies made representations to the NHA that the HBPs offered under the scheme were priced too low.

d. Unspecified packages

As per the NHA guidelines, if any inpatient treatment is not available in the packages defined, the hospital could provide that treatment (up to Rs. 100,000) to the beneficiary

only after the same gets approved by the insurance company/ trust; and is reflected as unspecified package. Accordingly, the EHCP to be reimbursed as per the package cost specified in the Tender Document agreed for specified packages or as pre-authorized amount in case of unspecified packages. Also, the unspecified packages are applicable only in surgical cases.

But it was observed, that nearly as many as 31,00 pre-auths were raised under unspecified category and unspecified regimen took first place in the ranking of package utilisation across States.

e. Overlap with national health Programmes

In the process of examining the convergence of benefits under AB PM-JAY with other national health programmes, many packages appeared to be getting replicated. For example, Dialysis and Cataract were independently covered under both AB PM -JAY and national health programmes.

LESSONS LEARNT

Rationalising health benefit packages

The consolidated issues in the Health Benefit Packages were brought to the notice of the NHA Governing Board in the meeting on April 19, 2019. The Governing Board decided that the NHA should undertake an exercise to remove the aberrations and anomalies in the HBP and to rationalise them. The following procedure was agreed to:

- Specialist committees to examine HBP and make suggestions.
- Review committee to examine the suggestions made by specialist committee and moderate them.
- Recommendations of review committee to be put up to the Governing Board for consideration.

The NHA notified 24 specialist committees as approved by the chair of the Governing Board (Honourable Minister for Health & Family Welfare). It was also decided to involve the Department of Health Research (DHR) which is in the process of conducting a study 'Costing of Health Services in India (CHSI)'. It was decided to use the data of this study wherever feasible. The DHR provided the cost of 855 packages spread over 8 specialties, as per study completed in public hospitals.

Three distinct processes were followed:

- Process I:** Wherever CHSI study data was available (Specialty of: Cardiology, Cardio Thoracic & Vascular Surgery, Otorhinolaryngology, General Surgery, Ophthalmology, Obstetrics & Gynaecology, Urology, Orthopaedics), the data was presented to the specialist committee along with other relevant inputs which could be provided to them. Based on the inputs and the collective clinical experience of the committee members, the committees were requested to provide inputs on the following:
- Continuation / discontinuation of the package
 - Suggested terminology
 - Suggested implant and its price (if any)
 - Suggested package rate
 - Justification (if there is any change)
- Process II:** The NHA entered into an MoU with Tata Memorial Hospital (TMH), the apex institute for cancer care in the country. TMH spearheaded

the same process as described in Process I for 4 specialties, namely Surgical Oncology, Medical Oncology, Radiation Oncology, and Paediatric Oncology.

Process III: For the specialties not covered under Process I or Process II, it was decided to consult with subject experts from public hospitals to rationalise the packages without changing the rates. This exercise was undertaken in General Medicine, Paediatric Medical Management, Neo-natal Care, Emergency, and Polytrauma. Other specialties could not be taken up.

Note: The AIIMS Neurology Department and Indian Society of Vascular and Interventional Radiology (ISVIR) submitted a list of packages suggesting their inclusion in the HBP. These were also discussed with the Neurology specialist committee and Radiology Department, AIIMS, respectively.

In addition to the above, a compiled list of all three processes was shared with all State SHAs for their comments and feedback. A State consultation workshop was held on August 13, 2019. The feedback received from different States before, during and after the workshop was compiled and presented to the review committee on August 27, 2019 by HBP team for final moderation before presenting the recommendations to NHA Governing Board.

b. Limiting utilisation of unspecified packages

Guidelines for utilisation for unspecified packages were prepared and shared with all stakeholders. After discussion with experts and series of committee meetings, the most utilised unspecified packages were incorporated in the HBP list with defined payouts which will effectively decrease the utilisation of unspecified packages and enhance savings as the packages will be better regulated.

c. Addition of subsets of packages

The cost of implant and consumables has been separated from cost of procedure to allow for choice of implants. This will help to customise the procedure and implant cost independently as and when there is a need for the same without changing the entire package pricing.

d. Partial payment provision

An incentivisation matrix was introduced, which allowed hospitals to claim a premium over the base AB PM-JAY rates built over their quality accreditation status / teaching status.

e. Inclusion of follow-up component

Follow-up packages have been proposed to be included in order to limit the booking of unspecified packages and also to ensure that the beneficiary receives due care post hospitalization.

RECOMMENDATIONS AND WAY FORWARD

- Map the packages to International Classification of Health Interventions (ICHI) and International Classification of Diseases (ICD-11)
- Minimise the potential moral hazards by following the principles as defined for the 'the fraud and abuse' prone packages
- HBP rationalisation should be a regular periodic exercise so that AB PM-JAY keeps pace with changes in medical technology as well as imbibes any new practices and treatments

**HOSPITAL
EMPANELMENT
AND QUALITY
ASSURANCE**



CHALLENGES

- Non-uniformity in quality standards
- Non-coverage of
 - PSUs (Railways, Coal India etc.)
 - NHCPs
 - Multi Super-specialty Private hospitals



LESSONS LEARNT

- New certification process under PM-JAY to provide swift accreditation process.
- Brining other hospitals like PSUs/ ESIC hospitals to improve access
- Self-assessment quality checklist to encourage culture of quality among empanelled hospitals

BACKGROUND

To build an effective and accountable network of providers, a set of minimum criteria were developed, based on which hospitals under PM-JAY were empanelled. In addition, a performance-linked payment system was designed to incentivise hospitals to continuously improve quality and patient safety, based on successive milestones. It was envisaged that hospitals qualifying for NABH entry-level accreditation will receive an additional 10 per cent, while those qualifying for full accreditation will receive an additional 15 per cent over and above package rates. To promote equity in access, hospitals providing services in aspirational districts will receive an additional 10 per cent. In addition, States have the flexibility to increase rates up to 10 per cent or reduce them as much as needed to suit local market conditions.

Continuous Quality Improvement (CQI) efforts were planned to be undertaken in PM-JAY network hospitals, so as to ensure that appropriate and consistent quality services are delivered to the beneficiaries, to improve the permanency, safety and well-being of beneficiaries in care; to reduce the possibility of adverse occurrences and to maintain a system for continuous quality improvement with regard to patient centred outcomes.

Since the implementation of the scheme till September 4, 2019, a strong network of nearly 18,019 empanelled hospitals are created under PM-JAY, out of which 603 are quality accredited or certified. Out of the total 603 facilities, 293 are Entry Level NABH Certified which are incentivised by 10 per cent on base rates and 310 are NABH Accredited which are incentivised by 15 per cent on base rate. In addition, 168 hospitals with National Quality Assurance Standards certification are also eligible for additional 10 per cent payment which is same as NABH entry level accreditation.

CHALLENGES

a. Non-uniformity with quality standards

It was observed that the low volumes of accredited/ certified hospitals currently empanelled under PM-JAY are primarily due to the long time taken and stricter quality criteria to achieve accreditation.

b. Non-coverage of PSUs (Railways, Coal India etc.), NHCPs and Multi Super-specialty Private hospitals

With the maturity of the scheme, it was realised that contractual and ad-hoc staff at various public sectors are somehow missing the benefits under PM-JAY. To enable more and more people to seek and avail inpatient care at the country's best hospitals, there were two challenges

- a. To identify such additional facilities
- b. To directly empanel PSUs/ ESICs, advanced tertiary care public and private hospitals such as AIIMS Delhi, PGIMER, etc.

LESSONS LEARNT

a. New quality standards

The NHA proposed to bring a new certification process under PM-JAY to provide swift accreditation process.

A three-level PM-JAY quality certifications—Bronze, Silver and Gold in the said chronological order—was developed to ensure hospitals comply with certification criterion. The levels differ in terms of their certification criteria, financial incentivisation, and provides leverage to the empanelled hospitals that are already certified by nationally recognised accreditation bodies (NQAS/NABH). The incentives under PM-JAY quality certification are a modification of the existing outcome-based incentive for NABH hospitals.

Bronze quality certificate is an entry level certificate in Ayushman Bharat Quality Certification. NQAS certified or NABH entry level certified hospitals are directly eligible for Silver certification, while NABH full accredited hospitals are directly eligible for Gold certification.

MoU with QCI (Quality Council of India)

The NHA and Quality Council of India (QCI) have signed an MoU for launching a joint initiative of digital quality certification for PM-JAY empanelled hospitals. The initiative is to help the hospitals to get fast-track certification while enhancing healthcare services. The MoU seeks to put in place a simple, swift, transparent and paperless mechanism to encourage hospitals to apply for certification.

b. Coverage of PSUs, NHCPs and multi-specialty hospitals

The NHA directly empanelled 11 NHCPs, 21 Delhi Private Hospitals, 91 National Railway Hospitals by signing MoUs with Railway Board, Coal India, North Municipal Corporation and New Delhi Municipal Council. Several beneficiary identifications and awareness drives were conducted in collaboration with the South Eastern Coalfields Limited, Ranchi; South, Northern and Eastern Railways. The drives were executed by CSCs.

c. Self -assessment

The NHA has implemented quality assessment checklist to encourage culture of self quality grading among empanelled hospitals

RECOMMENDATIONS AND WAY FORWARD

- Rigorously implementing PM-JAY quality certifications across all States
- Regional workshops with QCI for dissemination of quality standards
- Awareness for quality in all empanelled hospitals
- Hospital empanelment according to the need

**INFORMATION
EDUCATION AND
COMMUNICATION
(IEC)**



CHALLENGES

- Branding
- Dedicated HR for IEC
- Target group



LESSONS LEARNT

- Branding – flexibility to states to use creatives
- Handholding of states
- Increased focus on demand side
- Target audience through social media

BACKGROUND

PM-JAY has popularly and progressively impacted the lives of many beneficiaries within one year of implementation, and IEC played a crucial role in it. The guidelines and branding details developed by the IEC division at the NHA helped to inculcate positive and accurate beliefs among the audiences about the scheme.

Further, to bring significant attention about such a large insurance scheme among policy makers, influencers and beneficiaries, the IEC division at the NHA analysed several health schemes run by Ministry of Health and Family Welfare as an information source about creatives and content placement.

They effectively developed communication strategies, and orientation material to bring a social change among the target group (through SHAs) for such a massive flagship programme; and segregated target audience as

- a. Primary Audience—the beneficiaries of PM-JAY who are uninformed, uncertain and solution seekers
- b. Secondary Audience—the policy makers including media
- c. Facilitators—hospitals, frontline workers, ISAs, CSCs

To reach out to the unreached and directly inform beneficiaries, the IEC division at the NHA coordinated with the Prime Minister's Office (PMO) to send personalised PM letters to 7.5 crore beneficiaries, did branding at hospitals and institutionalised 24x7 multilingual toll-free Helpline Number. For the secondary audience and facilitators, the methods of outreach included letters to MPs from HFM, press conferences, press releases, advertorials, interviews and publicity campaigns. Tremendous efforts were put in towards finalising branding guidelines of the scheme to penetrate down to State level, but the journey of implementation was full of challenges. Some of the challenges were rectified as mid-course corrections and some emerged as lessons learnt.

CHALLENGES

a. Branding

PM-JAY branding created a common and easily recognisable visual identifier which the beneficiaries related to and identified with. But States' usage of colours had a constant clash with the colours specified by the NHA.

Moreover, crafting a unified message by greenfield and brownfield States was a big challenge because the brownfield states already had enough experience of running health insurance schemes whereas the greenfield states were totally new to the health insurance vertical.

b. Lack of dedicated human resources

Traditionally IEC has suffered due to the absence of a specific budget allocation and dedicated human resources and PM-JAY is no exception. Under the scheme, IEC budget is generally accorded under the administrative head. The disparity in IEC funds are compounded by scarcity of dedicated human resources.

c. Target groups

The primary target group of PM-JAY is regional and mostly illiterate; and majority of them are

not able to read/write except in their regional languages. The usual strategy for such audience is to use highly visual materials that reduces the need for text. The IEC division at the NHA developed sample templates and unique materials to enable beneficiaries to have a recall value of the brand without going into textual details, but States had no vendors for production of such material and also no creative agencies to execute the same.

LESSONS LEARNT

a. Branding

It was decided that the discipline of logo layout will remain same as specified by the NHA, but States may have autonomy about the colours. Moreover, if the State wants to display both PM-JAY and the State scheme together, then PM-JAY will always precede the State-run scheme nomenclature, e.g. PM-JAY MSBBY.

The guidelines and SoPs were also made available at PM-JAY website www.pmjay.gov.in carrying all the branding and communication protocols, for easy reference by States.

b. Hand-holding to States

In absence of dedicated resources at States, the NHA provided hand-holding support to States, as and when requested by them. This mainly comprised of preparation and refinement of IEC plans of States. Some examples are;

- Complete support for IEC Execution Plan of Bihar and Maharashtra
- Providing creative support to Gujarat

However, some of the States like Uttar Pradesh managed to deploy their own creatives in the form of jingles, etc., after discussions with the NHA.

c. Increased focus on demand side

With the maturity of the scheme, the NHA identified IEC as an imperative in expanding

access of the beneficiaries to PM-JAY, though it was not explicitly examined as one of the essential elements in the design and evolution of the scheme. Consequently, for the major focus on beneficiaries, the following was executed through IEC:

- Presence across major events across countries
- Promotion and endorsement of PM-JAY through regional level influencers
- Increasing on-ground interactions through health camps, leveraging CSC presence for Adhikaar camps, etc.
- Outdoor branding: Railway stations, bus shelters and other touchpoints, including major landmarks

Also Involving Service Providers for

- Awareness at empanelled hospitals through hospital empanelment certificates, hoardings, posters and pamphlets
- Training to hospital and CSC personnel about PM-JAY

d. Targeting audiences through social media

Virtual communication through social media including Twitter, Facebook, LinkedIn, and YouTube played an increasingly important role as information sources for the scheme. Also, a mixed media approach was adopted through electronic and print media campaigns, initiatives like live phone in through AIR and this made substantial contribution in mass awareness about PM-JAY.

RECOMMENDATIONS AND WAY FORWARD

- a. Focus on beneficiaries:
 - Partnering with social enterprises that are working with a behaviour change communications approach by leveraging technology to connect with and assist beneficiaries.
 - Regular periodic van campaigns, street plays, village and health camps
 - Collaborating with Public Service Undertakings (PSUs) to seek Corporate Social Responsibility (CSR) funding for CSCs to propel beneficiary enrolment
 - Collating beneficiary feedback on print and digital media
- b. Designated HR for IEC at States
- c. IEC execution with fund utilisation in States
- d. Investing minimal Rs. 50 per beneficiary in States for IEC for huge impact

FRAUD AND ABUSE



CHALLENGES

- Fraud was only getting detected after it took place; lack of prevention of fraud from happening
- Lack of capacity of implementers to detect and control fraud
- Lack of knowledge of beneficiary was also leading hospital taking advantage



LESSONS LEARNT

- Analytical teams were put in place to detect and identify fraud triggers before it occurring, for the same Artificial Intelligence (AI) and Machine Learning (ML) was put in place to detect the fraud on live basis
- Extensive training and capacity building of States to detect and identify fraud
- Beneficiary empowerment: updating beneficiaries via SMS at each state of the treatment including package blocked, grievance redressal, entitlement under the scheme

BACKGROUND

Global experience shows that healthcare programmes are prone to integrity violations. Fraud and abuse in such programmes lead to financial waste as well as potential harm to people's health. Thus, anti-fraud controls and measures are a critical part of programme implementation. The NHA follows a zero-tolerance approach against fraud and abuse in implementing PM-JAY at National and State levels, permeating all aspects of scheme management.

Current frame work for fraud and abuse control

Fraud and abuse control covers the entire gamut of activities for prevention, detection, and deterrence of different kinds of fraud that could occur in PM-JAY at different stages of its implementation. Proactive action has been taken by the NHA to implement comprehensive framework at different levels as explained below:

Prevention

- Strong policy framework: Anti-fraud guidelines, mandatory pre-authorisation, reservation of abuse prone packages to public hospitals, IT system with built-in checks, transparent processes, etc.
- Beneficiary Empowerment Guidelines for empowering beneficiary through awareness, information and knowledge about his/her rights under the scheme and mechanisms to report grievances, etc.
- Setting up of National Anti-Fraud Unit (NAFU) and State Anti-Fraud Units (SAFU) for overall monitoring and control

Detection

- Advanced analytics using Artificial Intelligence and Machine Learning techniques, etc.
- Monitoring of empanelled hospitals, analysis to identify trends of over utilisation, malpractices
- Regular Medical Audits (surprised and planned) by NAFU and SAFUs

Deterrence

- Anti-fraud provisions and penalties under contract
- Disciplinary actions against defaulter entities – suspension/de-empanelment of hospital found indulging in unethical/malpractices, levying penalties, financial recoveries, lodging FIR, etc.
- Whistle Blower Policy provision

CHALLENGES

- Data quality and inadequacy for conducting robust analytics
- Lack of integration in three key modules – Hospital Empanelment System, Beneficiary Identification System and Transaction Management System
- Enforcement of disciplinary/punitive action against errant hospitals
- Recovery of fraudulent claims and penalties after payment of claim to hospital
- Limited capacity at State level for effective implementation of anti-fraud framework
- Unavailability of trained medical auditors and field investigators in the country
- Lack of standard treatment protocols and care pathways to pin down unnecessary surgeries and procedures
- Insufficient legal provisions to deal with fraudsters

RECOMMENDATIONS AND WAY FORWARD

- System level controls need to be strengthened. Fraud detection and risk scoring through Artificial Intelligence and Machine Learning layer on real-time basis is being deployed to alert SHA/insurer before approval of pre-authorisation or payment of a claim
- Medical Guidelines/Standard Treatment Guidelines for abuse prone packages are being introduced, Hysterectomy Guidelines issued, work on others has started. Fraud prone procedures/packages have been mandated to be reserved for public hospitals.
- Mandatory documents have been listed for all procedures/packages which hospitals have to furnish while submitting claim
- Stricter control on 'Add-member' functionality – guidelines for the same along with system level alerts have been put in place
- Biometric authentication has been introduced at the time of admission and discharge, shall be made mandatory once testing is completed in all States/UTs
- Capacity-building workshops have been carried out for States and further scale up is required
- Empanelment of independent agencies/professional experts for medical audit and field investigations is required at national level, to be used by States as need be
- De-empanelment guidelines need a revision for making the same more effective along with guidelines for recovery of money
- Legal provisions need strengthening: An anti-fraud law with stringent provisions and punitive action is highly recommended for effective deterrence
- Contractual provisions and guidelines need to be strengthened for effectively tackling fraudsters, suspect entities

MONITORING AND EVALUATION



CHALLENGES

- M&E framework
- Consistency in dynamic data
- Periodic analysis
- Knowledge management/process documentation



LESSONS LEARNT

- Factsheets
- Working papers/ policy briefs
- Knowledge products

BACKGROUND

Monitoring and Evaluation (M&E) is key for successful implementation of such a large insurance scheme. Monitoring of PM-JAY is a complex, multi-disciplinary and skill-intensive activity that provides the management and key stakeholders, the progress made in Key Performance Indicators (KPIs) and achievement of results. At the NHA, a dedicated M&E team is continuously providing updates on the process and output indicators of the scheme through a strong real-time online Management Information System (MIS). The MIS has been set up at a national level to review KPIs through various dashboards. The dashboards are developed by the insights team at the NHA, using business intelligence tools, which helps in identifying the gaps and provide an overview of the performance. It is a continuous process that includes national, state and district level data integration, performance reporting and data analytics.

Main dashboards include:

- Operations dashboard
- State and district performance dashboard
- District dashboard
- Portability dashboard
- Pre-authorisation dashboard
- Hospital empanelment dashboard
- Change request dashboard

To scientifically measure the outcomes of the scheme and to generate evidence through baselines and endlines, evaluation studies were conducted with premier research institutions and development partners including GIZ, World Bank and WHO.

The main areas on which research has been done or is under process at the NHA are:

- a. Impact of the scheme on out-of-pocket health expenditure
- b. Impact of the scheme on access to healthcare
- c. Impact of the scheme on the supply side
- d. Gender related impact of the scheme
- e. Comparison of Assurance vs. Insurance mode
- f. Awareness mechanisms and their effectiveness
- g. Processes at the hospitals

The findings from the completed studies helped in answering few questions around the scale, and service uptake by beneficiaries under the scheme; and also, record providers' feedback to strengthen the supply initiatives.

Even after setting such robust monitoring and evaluation mechanisms, implementation of uniform M&E plan was a big challenge. Another challenge was to measure this varied plan and provide updates due to customisations adopted by the States. Some of the challenges and lessons learnt from M&E perspective are listed below.

CHALLENGES

a. M&E framework

The PM-JAY scheme has gone through series of evolution during one year of implementation; and key data platforms (dashboards) were developed in response to the ad-hoc requests, historical precedence and routine administrative reporting. With the scaling of the scheme, it was felt that framework relied solely on administrative reporting rather than a robust M&E plan

b. Consistency in dynamic data

The IT ecosystem at the NHA is the mainstay of the scheme providing high end solutions for beneficiary, claim, grievance management; and provider empanelment, etc. But with geographical expansion of the scheme, the dynamic data showed great variations month over month challenging reliability and correctness of data. The reason being API integration and additional data drives in the States, which impacted denominators.

c. Periodic analysis for course correction

There were no explicit M&E blueprints or KPIs designed to define the baseline of such a massive insurance scheme. So, baselines assessing the initial environment of the scheme and operation research studies measuring supply-demand based outcomes were institutionalised at NHA with the support of development partners and research agencies. But need was also felt for regular data analysis up to the district level combining packages utilised under the PM-JAY scheme with a particular disease pattern prevailing in the States for maximum gains under the scheme.

d. Knowledge management/process documentation

With increase in the country wide reach of the scheme, Knowledge Products (KPs) were deemed very essential. KPs specifically exploring to what extent and in which ways scheme considerations are explicitly or implicitly included in the conceptualisation, formulation and implementation of PM-JAY. Some of the KPs were implemented in terms of process documentation.

LESSONS LEARNT

a. Factsheets

To gauge the consistency in dynamic data and also measure the progress made in particular month, a factsheet was envisaged. Factsheets highlighting details on beneficiary's coverage, claims submitted, and providers' empanelment created a big impact at the implementation level with minimum information in the public domain (PM-JAY website). The factsheets helped to indicate the crest and trough in the data of particular State in particular months. The data

discrepancies (if found any) during the months force the individuals to drill down the reasons for it in discussions with State stakeholders; and accordingly take remedial actions.

b. Working papers/policy briefs

M&E team initiated the working paper series at the NHA and developed working papers based on PM-JAY package utilisation data and triangulated with the State-specific disease patterns. Moreover, for informing policy makers on certain topics and comparing the

implications, arguing in favour of a particular course of action and take the policy decisions accordingly, policy briefs were developed and made available in the public domain.

c. Knowledge Management

Knowledge products like key learnings and best practices from the scheme become vital for implementation of similar programmes globally, and locally as well. The M&E team at the NHA initiated developing these knowledge pieces covering major parameters within the scheme along with data to be disseminated to influencers, policy makers and reputable institutions to build on their capacity to understand, replicate, analyse, comment and adapt from the scheme. The documents carry various innovative models implemented across States, which harbingered the positive change in the life of many beneficiaries who suffered from various diseases. Document were prepared on lessons learnt and way forward covering learnings from all the verticals of the scheme with the information as 'what worked well', 'what were the challenges' during one year of implementation of the scheme and then learnings from those challenges.

RECOMMENDATIONS AND WAY FORWARD

- Developing and defining the M&E framework of the scheme, with revised objectives and define catalytic approaches to achieve those objectives
- Define targets and benchmarks for key performance indicators (KPIs)
- Periodic bulletin to assess progress made across all verticals of the scheme; and accordingly do mid-course corrections
- Collaboration with premier research Institutions to conduct research studies and high-quality research publications
- Identify M&E personal at State level and conduct periodic data driven reviews

CAPACITY DEVELOPMENT



CHALLENGES

- Complete handholding of greenfield states; and brownfield states in IT platforms
- Involvement of wide range of stakeholders from policy makers, influencers and PMAM at hospitals



LESSONS LEARNT

- MoU signed between NHA and NSDC for development of SOPs and conducting trainings
- Engagement with ASCII for training of state and policy level officials
- Cascade level training

BACKGROUND

The priority for capacity-building division in the initial months of scheme launch was to operationalise PM-JAY in all partner States by equipping key stakeholders with essential knowledge for performing their roles. Mass trainings for SHA personnel and Arogya Mitras by NHA personnel were part of this mission. While these activities were progressing, the division also worked on a document to guide all capacity-building activities under PM-JAY in the long term.

The division is currently planning and performing its activities based on this guideline which concentrates on three elements a) institutional strengthening, b) building capacity of personnel who are part of these institutions and c) knowledge management. But there were certain challenges the division had to face while moving from mass training in the initial phase to targeted standardised training at present.

CHALLENGES

National level:

The key constraints at the national level were limited availability of resources for all thematic areas and non-standardised sessions in the initial period. This was addressed to an extent through making available training materials at a centralised location and partnership with other agencies. Institutionalising capacity building within the NHA was also a challenge due to limitations in coordinating various verticals and support units.

State level:

The challenges at the State level were attributed to difference in scheme implementation, involvement of multiple stakeholders and lack of resources. Non-availability of dedicated personnel to coordinate capacity-building initiatives owing to low priority given for capacity building at the State level was also a challenge. Experience of the States in implementing health financing schemes was also determined the acceptance of engagement. Greenfield States with no existing health financing scheme were more receptive to new learnings while brownfield states with running schemes were not willing to unlearn and adapt to new processes.

LESSONS LEARNT

a. NHA cannot meet the capacity building needs alone. Partnerships are required for bridging the gap:

It was evident that the NHA as an independent entity cannot fulfil the capacity-building needs for the scheme in terms of technical knowhow as well as volume at least in the initial years. Partnerships with development agencies, educational institutions, other ministries and professional organisations could help fill this gap. Partnership with Administrative Staff College of India for trainings, State Health Agency personnel, partnership with Ministry of Skill Development for training and certification of Arogya Mitras and engagement with Insurance Institute of India for capacity building of claim adjudication personnel, etc., were some of the outcomes of this learning.

b. NHA as an organisation also needs to establish certain systems for better control over the activities:

While partnerships are helping to meet the capacity-building requirements, there are certain areas where NHA must establish its system. Development of an e-learning platform for systematic delivery and tracking of learning process by various stakeholders is one such initiatives to meet the above objective.

RECOMMENDATIONS AND WAY FORWARD

- Institutionalise capacity building at national and state level – make it a strategy for the scheme and not operation alone
- Conduct need assessment, develop structured content for all thematic areas, identify resources for cascade model of learning, building partnerships for national and international knowledge sharing and rollout of NHA's own learning management system

GRIEVANCE REDRESSAL



CHALLENGES

- Establishment of District and State level committees
- Defining roles and responsibilities
- Implementation of standardised and accountable grievance redressal mechanism



LESSONS LEARNT

- Creation of new Central Grievance Redressal Management System; portal incorporating all relevant guidelines
- Standardised procedure for Central Public grievance management system

BACKGROUND

Grievance redressal system is an integral part of any organisation or programme which plays a vital role in empowering its stakeholders. Any dissatisfied stakeholder should be able to reach out to concerned authorities to get justice. AB PM-JAY is designed to serve more than 50 crore beneficiaries across the country. There are many stakeholders involved at various levels in the implementation of the scheme. Hence, there is a need to have a robust and structured mechanism to resolve grievances in timely and effective manner. The National Health Authority took the initiative to develop such system.

The objective of CGRMS is to ensure that grievances of all stakeholders are redressed within the time frames prescribed in the grievance redressal guidelines up to the satisfaction of the aggrieved party based on the principles of natural justice while ensuring that cashless access to timely and quality care remains uncompromised.

- To achieve the above objective, a detailed grievance redressal guideline was released by the NHA in January 2019
- A new Central Grievance Redressal Management System portal was launched by Hon. Minister of Health and Family Welfare on August 21, 2019.

CHALLENGES

One of the major challenges under grievance management is to ensure timely and quality resolution of grievances. The earlier CGRMS portal was lacking few features which were causing hindrances in many aspects of grievance resolution. Few of those challenges faced are listed below:

- i. The grievance registration form on the portal did not have standardised drop downs, auto fetching of beneficiary details, list of empanelled hospitals, etc. There were many fields to enter free text which was making it difficult for the petitioner to register his/her grievance.
- ii. Grievances were being registered through various modes viz. online, email, letters, directly with DGNO and through call centre. It was a challenge to track and ensure disposal of these grievances.
- iii. The earlier portal was not mobile friendly. Nowadays majority of people use mobile to access internet. And also,

there were no facility of intimating the petitioner about the status of the grievance.

- iv. The grievance nodal officers were not logging in regularly on the portal leading to increased pendency of grievances. The grievances which were not addressed were also going untracked.
- v. Reporting and MIS plays an important role to understand the trends of grievances and their redressal. Absence of a comprehensive reporting structure was causing difficulty to decision makers/managers in ensuring redressal of grievances on time.
- vi. There were no adequate and dedicated resources deployed under grievance redressal management leading to poor response from the States.

To address all these challenges an initiation was taken to build robust portal under CGRMS and to direct the States to build capacity.

LESSONS LEARNT

Based on the experience, steps were taken to create a robust grievance redressal portal incorporating all relevant grievance redressal guidelines. The Central Grievance Redressal Management System is an online web-enabled system developed to redress Ayushman Bharat Pradhan Mantri Jan Arogya Yojana related grievances. The CGRMS primarily aims to enable submission of grievances by the aggrieved party from anywhere and anytime (24x7). The three-tier system under CGRMS, i.e. District, State and National level officers and committees, scrutinise and act for speedy and favourable redressal of these grievances. Tracking grievances is also facilitated on this portal through the system generated unique registration number.

The aggrieved party can now submit grievances through the online portal <https://cgrms.pmjay.gov.in> or offline means (e.g. letter/email/fax). Beneficiaries can register their grievances by calling the Call Centre at 14555 / 1800-111-565.

Some of the features which are integrated in the new portal are:

Easy grievance registration format: To ease the process of grievance registration, steps were taken to provide fetching of data from the database using the PM-JAY card by the beneficiary.

The new portal comes with the option of many drop downs where the petitioner can easily select stakeholder name, nature of grievance, and other demographic details. This feature enables standardisation of data and segregates the grievances based on types.

All grievances in one database: An option has been given in the portal to enter all other grievances which are received in the form of letter, fax, email etc. to the concerned nodal officers and call centre team. This ensures that all the grievances are in one place and can be easily tracked and addressed as per turnaround time.

Responsive portal design: Since majority of people use smart phones to access internet, the portal is optimised for mobile use.

Intimation to petitioner: Auto SMS will be sent to the petitioner at various levels viz. registration of grievance, acknowledgement and status update. This enables the petitioner to stay updated about the grievance status.

Intimation to Grievance Officer: Auto SMS and email alerts are sent to concerned officer whenever a new grievance is registered. This enables better compliance and quick resolution of grievances.

Escalation of grievances: To ensure adherence to timely resolution of the grievances, a feature of auto escalation of grievances based on the timelines has been incorporated. If any grievance officer fails to take action as per the prescribed turnaround time, the grievance will be escalated to his/her higher authority.

Mapping of all stakeholders on portal: To speed up the process of resolution, a step has been taken to map all the stakeholders in the portal. A feature to forward the grievance and ask an explanation from the concerned stakeholder helps to save time.

Comprehensive report and dashboard: The new portal shall be having all kinds of reports viz. date wise grievance status, types of grievances, grievance registered by and grievance against summary, etc. The comprehensive report will aid decision makers to understand grievance trends and take appropriate actions for effective implementation of the scheme.

Apart from the above, States were directed to nominate District Grievance Nodal Officers and State Grievance Nodal Officers who will be responsible for resolution of grievances. The States were also directed to form District Grievance Redressal Committee and State Grievance Redressal Committee to ensure proper redressal of cases.

CALL CENTRE



CHALLENGES

- Regional language callers
- No follow-up mechanisms especially for grievances



LESSONS LEARNT

- State call centre integration with NHA call centre
- Grievance portal access to call centre executives for raising grievances raised on calls
- Deployment of call centre disposition tool to monitor disposition of grievances received at call centres
- Outbound calls for follow-up

BACKGROUND

The Call Centre is an effort to provide access to timely information and address citizens' grievances through multichannel approach at their convenience; and effectively redress them in a time bound manner. The PM-JAY National Call Centre is operational since August 24, 2018 and aims to provide a common platform in the country and handle incoming and outgoing telephone calls from/ to the citizens/insurance companies/ Health Service Providers (hereinafter called HSP), SHAs and other stakeholders.

It addresses the information needs of citizens and beneficiaries and other stakeholders across the country, including from States that participate and those that are not participating in PM-JAY, and provides information on entitlement, benefit cover, enrolment, process for availing benefits, empanelled providers, national portability, etc. The Call Centre facilitates access of national portability benefits to PM-JAY beneficiaries who may be outside their State; and in need of services.

CHALLENGES

a. Regional language callers

The beneficiary engaged in PM-JAY scheme are from rural society who are not so versatile with the website and online applications. Also, regional language callers faced challenges as the Call Centre languages were either Hindi or English.

b. No Follow-up Mechanism

During the initial phases of PM-JAY, the State call centres lacked the capacity to receive huge number of calls; there was no follow-up mechanism in place.

LESSONS LEARNT

a. State Call Centre integration with NHA call centre

NHA partners for Call Centre

Mahanagar Telephone Nigam Limited (MTNL) is a state-owned telecommunications service provider in the metro cities of Mumbai and New Delhi in India; and in the island nation

of Mauritius in Africa. MTNL is associated with the NHA to promote and make PM-JAY scheme successful by not only routing calls to the National Call Centre but has also provided Toll Free number-1800111565 (14555)

Medi Assist India Pvt. Ltd. provides third party administrator (TPA) services for health insurance-related claims.; Medi Assist has signed an agreement with the NHA to run PM-JAY call centres smoothly across 3 locations – Bengaluru, Hyderabad and Kolkata

State call centre locations

The complete call centre system can be administered by the central location in Delhi. The service provider may use Hub and Spoke Model so that the Service Provider can establish a Zonal Call Centre.

The National Call Centre solution having geotagging capabilities is in progress, which shall enable the government to serve the citizens in more efficient and effective ways. This capability will enable a call from a citizen to be automatically identified by location and routed to the nearest call centre location if needed.

To overcome the language barrier, 9 more regional languages will be added soon in addition to the three locations at Bengaluru, Hyderabad and Kolkata. The call centre is operational on all days (24*7) without any holiday. The executives are working in seven different shifts. In later stages, it is envisaged that these call centres will be functional in 30 states. All information pertaining to Ayushman Bharat is provided by the the call centre.

Services

The call centres are providing the following services:

- Handling inbound voice calls
- Making outbound voice calls.
- End-to-End Responsibility
- Registering grievances

b. Quality Assurance:

Twelve quality auditors across 3 locations are placed to audit calls of the call centre agents, check the health of the process and make sure that quality standards are maintained, and everyone adheres to the same.

Monitoring the performance of CCEs and Sr. CCEs based on NHA provided Quality Template by reviewing at-least 30 calls per CCE/Sr. CCE per month. Auditors provides feedback and executing Continuous Improvement Plan (CIP) to exceed the target service levels and Key Performance Indicators (KPIs) mentioned. They perform root cause analysis for repeated failure in service delivery and share the report for the same with the NHA.

RECOMMENDATIONS AND WAY FORWARD


- Handholding of States in setting up State level call centres
- 100% integration of State call centres with Centre
- Specific desk to be assigned for regional languages at National Call Centre
- Call centre to prepare the performance dashboard of the NHA Operations, which include all KPI and SLA parameters



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