A Research Project Report for

The Operational Research Program

By

Tamil Nadu Health System Reform Program

and

Indian Institute of Technology Madras (Nodal agency)

Titled

EVALUATION OF CHIEF MINISTER'S COMPREHENSIVE HEALTH INSURANCE SCHEME TAMIL NADU (CMCHIS-TN)

Identify factors associated with hospitals having low insurance admission (performance) and to propose measures to improve the performance of government institutions under CMCHIS.

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Abbreviations

Abbreviations	Full forms
CMCHIS	Chief Minister's Comprehensive Health Insurance Scheme
TPA	Third-Party Administrator
UIIC	United India Insurance Company Limited
JD	Joint Director
GH	Government Hospital
MCH	Medical College Hospital
DH	District Hospital
OT	Operational Theatre
CMO	Chief Medical Officer
NGO	Non- Governmental Organisation

Executive Summary

The Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in Tamil Nadu plays a vital role in expanding access to healthcare by enabling beneficiaries to receive treatment at both government and private hospitals. While government hospitals in many districts demonstrate strong utilization under CMCHIS, in certain districts, private hospitals account for higher utilization in terms of the total number of claims. This study examines the factors contributing to these variations, analysing both supply-side challenges faced by government hospitals and demand-side factors influencing patient choices.

Government hospitals play a key role in the service delivery of CMCHIS, particularly for underserved populations, but infrastructure availability, human resource distribution, and specialty service accessibility vary across districts. Some hospitals experience a high patient load, while others may have limitations in certain specialties or medical equipment, leading to referrals to tertiary centres or private hospitals. Administrative processes related to claims management and third-party administrator (TPA) coordination also influence hospital utilization patterns.

On the demand side, patient preferences are shaped by perceptions of care quality, hospital amenities, and accessibility. Private hospitals are often seen as offering shorter waiting times, specialized services, and greater convenience. Additionally, awareness levels about CMCHIS vary, and in some cases, beneficiaries may not be fully informed about the range of services available in government hospitals under the scheme.

To strengthen CMCHIS implementation and enhance the role of government hospitals, targeted efforts are required. Expanding specialty services at district hospitals, optimizing resource allocation, and streamlining administrative processes can improve hospital efficiency. Awareness initiatives can help beneficiaries make informed choices, and enhanced coordination between hospitals and TPAs can ensure smooth claims processing. These measures will further increase the utilisation of CMCHIS in government hospitals in Tamil Nadu.

1. Introduction

The Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) is a flagship health initiative in Tamil Nadu that aims to provide financial protection and equitable healthcare access to the state's economically vulnerable populations. Initially introduced in 2009 as the "Chief Minister Kalaignar's Insurance Scheme for Life Saving Treatments" (KHIS), the program targeted severe illnesses requiring expensive medical interventions, with an annual family insurance cap of ₹1 lakh. In 2011, the scheme was expanded and relaunched as CMCHIS, offering broader coverage, including common medical conditions and secondary care services, with an enhanced annual limit of ₹1.5 lakh per family. The integration of CMCHIS with the Pradhan Mantri Jan Arogya Yojana (PM-JAY) in 2018 further strengthened its scope, creating PMJAY-CMCHIS. This integration enabled access to a more extensive network of accredited hospitals nationwide while aligning the benefits and operational structure of the two schemes.

Tamil Nadu has consistently been a leader in public health innovation, being the first Indian state to enact the Public Health Act and demonstrating strong governance in healthcare delivery. Therefore, CMCHIS plays a pivotal role in the state's pursuit of Universal Health Coverage (UHC) as the scheme's design focuses on reducing out-of-pocket healthcare expenditures, often posing significant financial challenges to low-income households. CMCHIS covers hospitalization costs, diagnostic services, and even follow-up treatments, making it more comprehensive. Its features, such as the family-floater model, cashless claims, free health camps, and round-the-clock assistance, aim to provide a seamless healthcare experience for beneficiaries.

Government hospitals, which form the backbone of Tamil Nadu's healthcare infrastructure, are critical for serving rural and underserved populations, serving as the first point of contact. A crucial component influencing government hospital performance under CMCHIS is the purchasing mechanism and allocation of funds. Under the scheme, reimbursements from CMCHIS to government hospitals contribute to facility-level funding, allowing hospitals to reinvest in infrastructure, medical equipment, and essential healthcare services. Tamil Nadu has implemented a structured allocation pattern for these reimbursements, ensuring that government hospitals can utilize the funds effectively to improve service delivery. According to Government Order (G.O. 154)[1] Issued on May 29, 2014, a revised sharing pattern of reimbursements was established, ensuring that hospitals retain and reinvest funds for infrastructure and service improvements (Government Orders, CMCHIS). Furthermore, a one-time allocation of ₹200 crores from the CMCHIS corpus fund was sanctioned to improve infrastructure in government institutions, demonstrating the scheme's role in enhancing healthcare delivery (Government Order No. 15)[2]. Understanding how these financial mechanisms operate provides context for evaluating the utilization trends and identifying gaps in service provision.

There is limited evidence and significant gaps in the literature on the factors influencing the choice between government and private healthcare services when both offer free treatment under publicly funded health insurance schemes (PFHI). While many studies focus on the increased utilization of healthcare services under these schemes, they often report no corresponding reduction in Out-of-Pocket Expenditure (OOPE) for beneficiaries. For instance, a 2017 study in Chhattisgarh[3] found that despite insurance coverage, most beneficiaries still incurred OOPE, with expenditures being higher in private healthcare settings compared to government ones. Similarly, a research study conducted in three southern states: Andhra Pradesh, Karnataka, and Tamil Nadu[4] showed that neither OOPE nor the incidence of Catastrophic Health Expenditure significantly decreased after PFHI enrolment. Notably, OOPE was consistently higher for services utilized in the private sector, regardless of insurance

[1] Link to Government Order 154: G.O 154.pdf

[2] Link to Government Order 15: New Doc 02-05-2025 12.24

[3] Nandi, S., Schneider, H. Using an equity-based framework for evaluating publicly funded health insurance programmes as an instrument of UHC in Chhattisgarh State, India. Health Res Policy Sys 18, 50 (2020). https://doi.org/10.1186/s12961-020-00555-3

[4] Dubey, S., Deshpande, S., Krishna, L., & Zadey, S. (2023). Evolution of Government-funded health insurance for universal health coverage in India. *The Lancet Regional Health. Southeast Asia*, *13*, 100180. https://doi.org/10.1016/j.lansea.2023.100180

enrolment status. A systematic review conducted in 2017[5] also highlighted that healthcare utilization is improved among those enrolled in these schemes, there is no conclusive evidence to suggest that this has led to reductions in OOPE or greater financial risk protection for beneficiaries. According to the National Health Authority, as of 17 December 2024, 36,24,67,878 Ayushman cards have been issued across the nation and 6,86,17,508 hospital admissions. In Tamil Nadu, 77,24,749 Ayushman cards have been generated and 90204.23 Cr hospital admissions have been done.[6] According to the data received from the program management unit, certain districts show higher utilization in private government hospitals. This study seeks to understand the reasons for the low utilisation of the scheme in government hospitals focusing on supply-side challenges in government hospitals and demand-side factors influencing patient preferences. By identifying and addressing these gaps, the study aims to increase CMCHIS utilisation in secondary and tertiary government hospitals in Tamil Nadu.

2. Study Objectives

I. **Factors influencing scheme utilisation in government hospitals:** This objective includes identifying and analysing the factors that directly or indirectly influence the low utilization rates under CMCHIS in government hospitals.

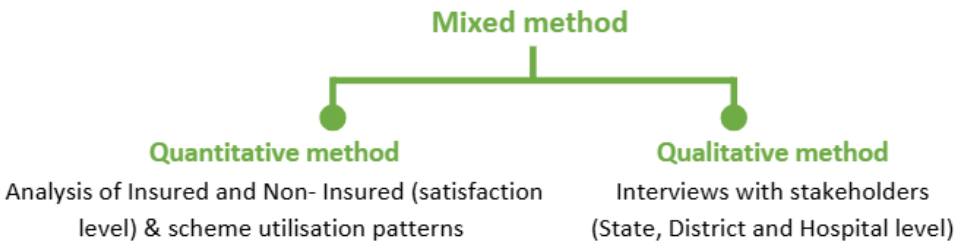
II. **Comparative analysis between insured and non-insured:** This includes analyzing claim utilization patterns across districts, assessing satisfaction levels among insured patients at private hospitals and uninsured patients at government hospitals, and examining the challenges faced by patients in government facilities.

III. **Enhancement/improvement strategies:** Based on quantitative and qualitative findings, developing strategies to enhance the performance of the government hospitals empanelled under CMCHIS.

3. Research Methodology

The study employs a mixed-method approach combining both quantitative and qualitative research methods. The quantitative component involves an assessment of scheme utilization patterns across districts and a comparative analysis of satisfaction levels, assessing the experiences of insured patients receiving treatment at private hospitals versus uninsured patients accessing care at government hospitals. The qualitative aspect includes interviews with key stakeholders at the state, district, and hospital levels, including both supply- and demand-side perspectives. This approach provides an understanding of the factors influencing hospital performance in terms of utilisation and patient decision-making of choosing a healthcare facility.

Figure 1: Study Design



[5] Prinja, S., Chauhan, A. S., Karan, A., Kaur, G., & Kumar, R. (2017). Impact of Publicly Financed Health Insurance Schemes on Healthcare Utilization and Financial Risk Protection in India: A Systematic Review. *PloS one*, *12*(2), e0170996. https://doi.org/10.1371/journal.pone.0170996

[6] Link to NHA Dashboard: https://dashboard.pmjay.gov.in/pmj/#/

Quantitative Method

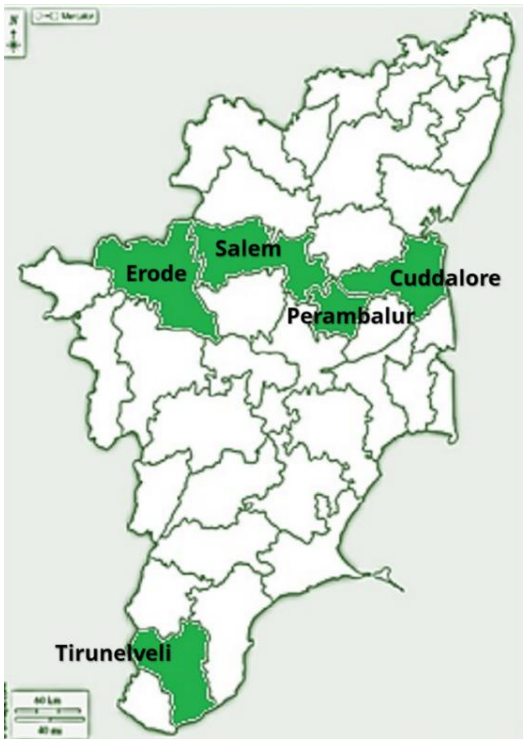
- The quantitative analysis assesses utilization patterns and patient satisfaction levels under CMCHIS. The utilization analysis examines claim data to evaluate trends across government and private hospitals in 38 districts. This includes analysing the total number of claims to identify variations in hospital performance and utilization patterns under the scheme. The findings from this analysis were used to select districts for further qualitative exploration, helping to understand the underlying reasons influencing patient preferences and hospital performance.
- In addition to utilization trends, the study also incorporates a comparative analysis of patient satisfaction levels among insured and uninsured patients providing insights on infrastructure and cleanliness, overall hospital accessibility, availability and attention of medical/paramedical staff, and availability of medicines and diagnostic tests.

Qualitative Method:

- Primary data collection was conducted through structured exit interviews with patients at selected secondary and tertiary government hospitals (district hospitals and medical college hospitals), and private hospitals. The exit interviews targeted two groups: beneficiaries receiving treatment at private hospitals and non-beneficiaries seeking care at government facilities. These interviews aimed to capture patient experiences, perceptions, and barriers to accessing care under CMCHIS.
- In addition to patient exit interviews, qualitative data was gathered through semi-structured interviews with key hospital staff, including medical superintendents, specialists, the nodal officer of CMCHIS, Joint Director of each state, Third-Party Administrator (TPA) staff, and the Insurance company (UIIC). These interviews explored operational challenges, staff perspectives on scheme implementation, and factors influencing the scheme's utilisation at the facility level.

Selection Criteria

Figure 2: District selection



- **District Selection:**
  Almost every District in Tamil Nadu has a Medical College and Hospital (either government or private). To ensure a geographically representative sample, the districts were grouped based on different geographical regions (North, South, East, West, and Centre). Within each zone, a list of districts was sorted based on the utilization rate (lowest to highest) of the scheme. Districts with the lowest utilization rate were selected for the study. Based on the inputs from state officials, Dindigul, which was part of the south zone and therefore was changed to Tirunelveli. The final districts studied were: **Perambalur, Cuddalore, Tirunelveli, Salem, and Erode**

- **Hospital Selection (District Hospital and Medical College Hospital):**
  Five government medical college hospitals (MCHs) and five district hospitals (DHs) were selected from each of the five districts. In consultation with state officials, Tiruchirappalli MCH was included instead of Preambular, as the latter does not have a government medical college hospital. Selected medical college hospitals are listed in **Annexure 1: List of facilities visited**

- **Insured/ Beneficiary Selection (from private hospitals):**
  The three private hospitals with the highest utilization providing treatment under multiple specialties were

selected. Within each hospital, around six to eight beneficiaries under the scheme were selected for exit interviews, randomly from the list of patients recently discharged. From private hospitals, a total of 94 beneficiaries across all five districts were interviewed. The selected private hospitals are listed in **Annexure 1: List of facilities visited**

- **Non-Insured/ Non-Beneficiary Selection (from government hospitals):**
  In the selected government hospitals, including Medical College Hospital and District Hospital, around 6- 14 non-beneficiaries were selected randomly from the list of patients currently discharged. A total of 115 uninsured patients/non-beneficiaries were selected randomly for in-depth interviews across all 5 districts.

Table 1: Stakeholders and Number of Interviews

Levels	Stakeholder's Category	No. of Interviews
State	Insurance Company	1
	TPA	6
District	TPA	2
	JD	4
Government Hospitals	Hospital Management (MCH)	15
	Hospital Management (DH)	15
	Non-Beneficiaries (MCH and DH)	115
Private Hospitals	Beneficiaries	94
Total		**252**

4. Findings and Discussion

Study findings are based on a combination of quantitative analysis of utilization data and satisfaction levels between insured and non-insured and qualitative insights gathered from state, district, and hospital-level stakeholders. This will provide an understanding of the factors influencing the performance of government hospitals under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in Tamil Nadu.

Quantitative Analysis

The quantitative analysis is based on data from the CMCHIS management unit, including the total number of claims and total claim amounts used to identify scheme utilization patterns across districts. Additionally, patient satisfaction data were examined to compare the experiences of insured patients in private hospitals with non-insured patients in government hospitals. The findings provide insights into the overall performance of government and private hospitals under the scheme, highlighting utilization trends, variations across districts, and patient perceptions of healthcare services.

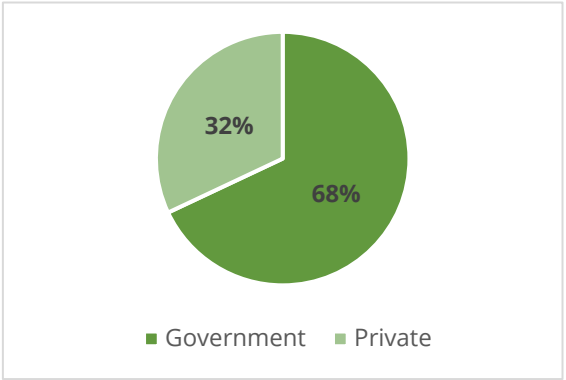
Table 2: District-wise utilisation of the scheme

		Government Hospitals		Private Hospitals	
S. No.	**District Name**	**No. of Claims**	**Claim Amount**	**No. of Claims**	**Claim Amount**
1	Ariyalur	2,224	2,11,99,100	804	42,68,375
2	Chengalpattu	9,954	12,12,14,315	17,561	28,68,85,879
3	Chennai	1,44,196	160,41,18,585	36,399	75,05,08,298
4	Coimbatore	20,813	27,93,34,883	28,907	74,47,84,247
5	Cuddalore	8,316	7,27,85,267	16,685	27,10,55,917
6	Dharmapuri	7,016	6,53,85,060	3,496	3,72,20,683
7	Dindigul	7,051	5,47,09,560	8,963	15,01,98,002
8	Erode	8,585	6,45,05,995	18,396	25,63,38,876

9	Kallakurichi	4,435	3,36,17,450	6,565	5,29,12,765
10	Kancheepuram	9,744	8,96,41,287	15,876	25,03,25,782
11	Kanyakumari	21,541	14,57,02,816	19,445	24,45,15,365
12	Karur	6,702	4,85,70,810	3,143	3,65,83,645
13	Krishnagiri	7,285	5,41,62,275	5,718	13,84,78,981
14	Madurai	40,018	54,62,27,034	39,239	77,88,50,467
15	Mayiladuthurai	2,414	1,83,87,600	239	11,34,243
16	Nagapattinam	4,143	2,43,37,570	239	22,01,950
17	Namakkal	7,998	4,68,56,710	5,452	8,54,48,689
18	Nilgiris	1,625	1,42,18,950	1,307	2,00,94,213
19	Perambalur	2,799	1,75,12,499	5,860	14,25,00,223
20	Pudukkottai	12,894	8,69,96,697	4,062	4,53,70,075
21	Ramanathapuram	3,931	2,62,34,900	3,047	1,35,96,825
22	Ranipet	1,867	1,58,55,350	1,663	1,75,18,699
23	Salem	22,677	22,07,14,272	25,906	45,63,25,757
24	Sivagangai	10,123	6,99,07,369	3,993	4,18,81,365
25	Tenkasi	2,732	2,08,33,450	1,744	69,28,200
26	Thanjavur	27,626	37,68,53,681	8,715	12,33,87,656
27	Theni	11,648	9,96,88,981	3,165	2,75,01,586
28	Thirupathur	2,567	2,27,05,900	4,749	6,64,20,071
29	Tiruchirappalli	17,021	18,50,73,989	19,400	37,47,32,026
30	Tirunelveli	27,682	29,49,59,031	5,000	6,74,62,236
31	Tirupur	3,991	3,47,19,365	4,908	5,66,65,403
32	Tiruvallur	11,902	8,58,13,436	10,423	16,10,20,765
33	Tiruvannamalai	11,279	7,61,44,150	3,404	2,69,55,620
34	Tiruvarur	11,943	9,53,96,300	3,191	3,48,68,492
35	Tuticorin	15,933	13,81,35,711	4,016	2,75,06,148
36	Vellore	14,581	15,41,90,755	8,620	9,38,54,293
37	Villupuram	11,959	11,67,85,564	4,006	3,71,01,522
38	Virudhunagar	9,377	9,16,90,811	9,248	5,05,29,187

The district-wise claim data shows that in most of the districts, government hospitals have higher utilisation in terms of the number of claims than private hospitals.

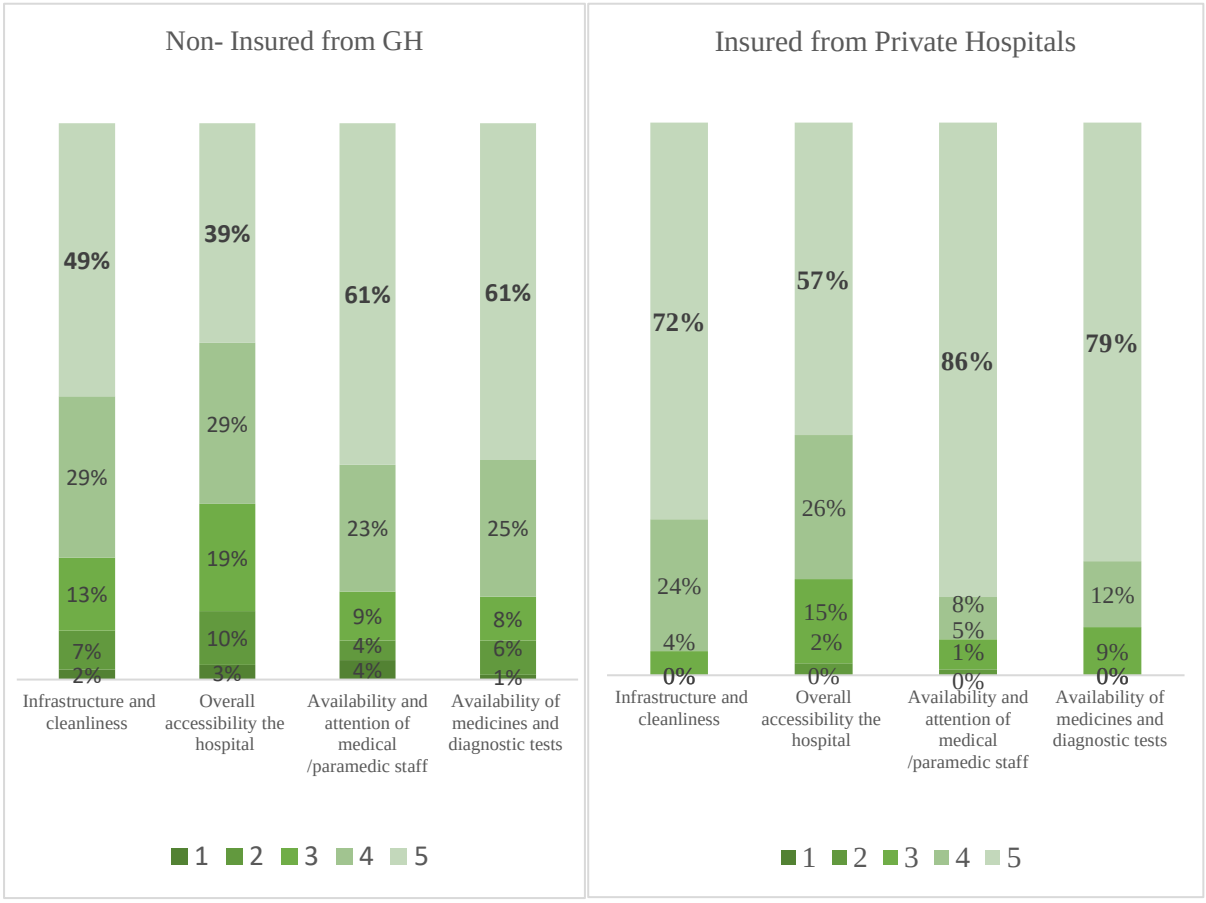
Figure 3: Utilisation distribution between government and private hospitals



Out of the 38 districts, 26 demonstrate higher utilization rates at government hospitals, as reflected in the total number of claims. On the other hand, private hospitals show slightly higher utilization rates in the remaining 12 districts, although the differences are not significant. These 12 districts are: Chengalpattu, Coimbatore, Cuddalore, Dindigul, Erode, Kallakurichi, Kancheepuram, Perambalur, Salem, Thirupathur, Tiruchirrappalli, Tirupur.

This indicates that government facilities are effectively utilized under the scheme in most regions, demonstrating their critical role in providing care. However, the slightly better performance of private hospitals in a few districts suggests the presence of local factors influencing patient choices and hospital performance in those areas. Furthermore, to better understand patient preferences, the satisfaction levels of insured patients at government hospitals and uninsured patients at private hospitals were assessed.

Figure 4: Satisfaction level: Non-Insured and Insured patients



The satisfaction levels among insured patients in private hospitals are generally higher than non-insured patients in government hospitals across all four parameters—Infrastructure and Cleanliness, Overall Accessibility, Availability and Attention of Medical/Paramedic Staff, and Availability of Medicines and Diagnostic Tests. While private hospitals appear to have a slight edge in patient satisfaction, government hospitals still manage to deliver services that meet patient expectations to a large extent. The gaps are not significant, suggesting that despite resource constraints, government hospitals continue to provide care that is broadly comparable in-patient perception to that of private hospitals.

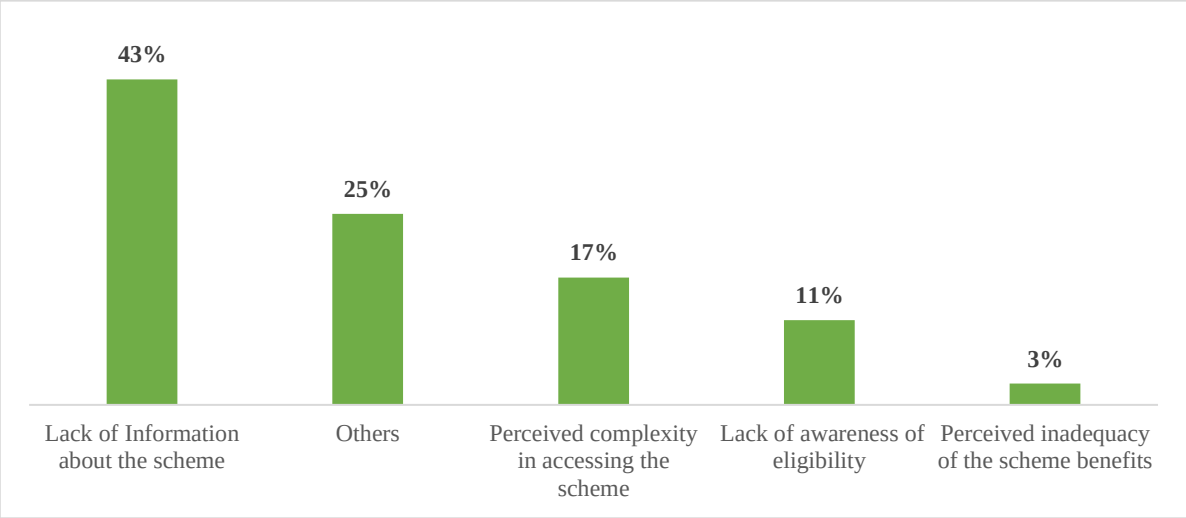
Qualitative Analysis:

This section examines the key reasons cited by non-insured patients (from government hospitals) for not seeking treatment under the CMCHIS, the factors influencing scheme utilization from both demand and supply perspectives, the challenges encountered by beneficiaries and healthcare providers, and insights from insurance companies and TPAs on these issues.

"41% of non-insured patients from government hospitals heard of CMCHIS but did not avail the scheme"

The graph below highlights key reasons reported affecting scheme utilization:

Figure 5: Reasons reported by non-insured patients for not availing treatment at GHs



A significant proportion (43%) of non-insured patients cited a lack of information about the details of the scheme as the primary reason for non-utilization. 25% of patients reported other reasons, including issues such as inactive or unrenewed CMCHIS cards, documentation mismatches, or emergencies where updating details was not feasible. Perceived complexity in accessing the scheme was noted by 17% of respondents, indicating the perceived complexity in accessing the scheme. Furthermore, 11% of patients were unaware of their eligibility. A small percentage (3%) of patients perceived the scheme's benefits as inadequate.

These insights emphasize the importance of targeted interventions to improve awareness, simplify processes, and strengthen engagement between beneficiaries and healthcare facilities to ensure greater utilization of the scheme.

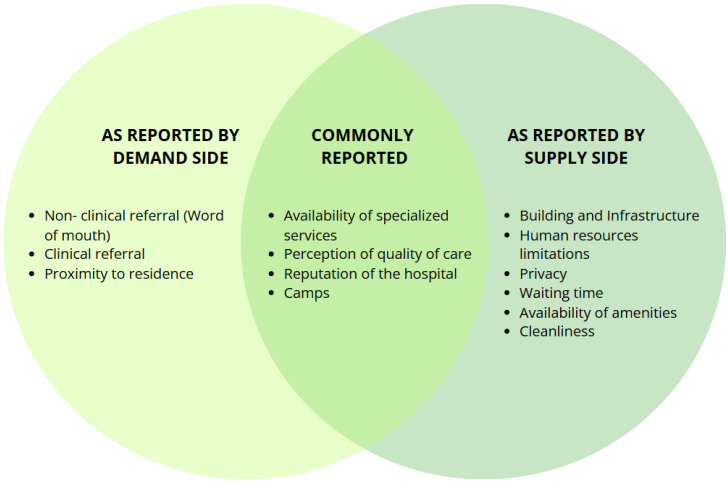
The following section reports the factors influencing the decision to choose the healthcare facility for treatment. Interviews with the demand side and supply side were conducted to provide deeper insights, including challenges and patient preferences. Therefore, it highlights the interplay between systemic factors and patient behaviours in determining hospital utilization patterns under CMCHIS. By addressing these multifaceted challenges, policymakers can take meaningful steps to improve the utilization of the scheme at government hospitals.

1. Factors influencing the scheme utilization in government hospitals

This section explores both demand- and supply-side aspects, followed by the challenges faced by government hospitals. The section is structured based on the frequency of factors, starting with the most common ones. The respondents in the patient category include beneficiaries from empanelled private hospitals and non-beneficiaries from empanelled Government Hospitals (GHs). The respondents from the provider's category included administrative staff (CMCHIS Nodal Officer, Medical Superintendent, etc.), specialist and superspecialist doctors

serving in empanelled GHQHs (Government Head Quarter Hospital of a District), and MCHs (Government Medical College Hospitals in the same Districts or adjacent District), and representatives of the Third-Party Administrators (TPAs) Companies (including Medical Officer, Liaison Officers, etc.).

Figure 6: Factors influencing the scheme utilization in government hospitals



1.1. As Reported by demand side

One direct question specific to the context was asked during the interviews for which the patients were requested to choose one or more of all the factors (options) given to them as these factors were commonly known from the literature. A list of seven factors was: (i) proximity to residence, (ii) availability of specialized services, (iii) good reputation, (iv) better quality of care, (v) suggested by family/ friends, (vi) referred by a doctor, (vii) camps. Additionally, they were asked if there was any other factor they could think of/ or if we had missed including them in the options, and the same was captured. The options were neither weighted nor followed any order of importance. Also, since it was a multiple choice and multiple answers kind of question the cumulative number of answers exceeded the number of respondents. The total number of respondents interviewed was 94 (n).

In this sub-section, we report the responses in the decreasing order of frequency starting with the most commonly reported factor and ending with the least common responses.

1.1.1. Non-Clinical Referral (word of mouth)

The most commonly reported factor influencing treatment at private hospitals was recommendations from family or friends, reported by 43 beneficiaries (46%). These suggestions, often based on personal experiences or hearsay, emphasize better service quality, patient care, and outcomes in private hospitals. Such word-of-mouth endorsements impact healthcare-seeking behaviour, underscoring the importance of trust in healthcare providers.

1.1.2. Perceived better quality of care

Perceived quality of care was another reason influencing beneficiaries' choice of private hospitals, with 35 (37%) citing this as a determining factor. They believe that private hospitals offer better quality of care compared to government facilities.

1.1.3. Good Reputation

'Good reputation and better quality' were cited by 33 (35%) beneficiaries. This reputation for quality draws CMCHIS beneficiaries to private facilities, even though competent professional staff in government hospitals. Patients often prefer private hospitals due to the strong reputation and goodwill they have established within the community.

1.1.4. Clinical Referral

About 27 (29%) of the beneficiaries reported that a direct referral from a doctor influenced their choice of hospital. These referrals often stem from clinical consultations where the referring doctor explicitly recommended the private hospital. Such referrals create a pathway for patients to access private over government facilities.

1.1.5. Proximity to residence

Accessibility plays a critical role in patients' decision-making, especially for those in rural areas. Among the 94 beneficiaries seeking treatment at private hospitals, 14 (15%) highlighted proximities as a key reason for their choice. In many regions, government healthcare facilities offering secondary and tertiary care are limited to a District Hospital or a Government Medical College. In contrast, private hospitals are more numerous and often located closer to residential areas, making them more convenient. This geographic disparity results in a "convenience gap," where patients find private hospitals more accessible than traveling long distances to government facilities.

1.1.6. Availability of specialized services

The limited availability of specialized care at government hospitals was cited by 7 (8%) beneficiaries as a reason for opting for private hospitals. Patients often perceive private hospitals as offering a broader range of specialty services, which can be crucial in addressing their healthcare needs.

1.1.7. Camps

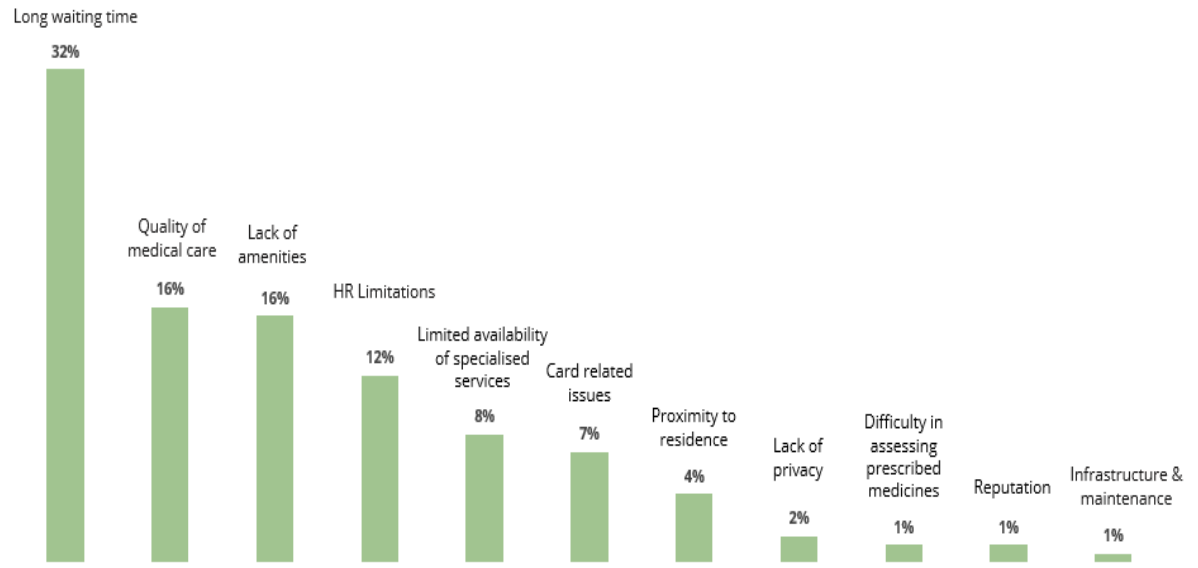
Few beneficiaries attributed their decision to seek treatment at a private hospital to a health camp organized by the private hospital in their community.

In addition to the specific question on factors influencing, the beneficiaries and non-beneficiaries were also asked about the challenges they faced while seeking care from government hospitals, as a proxy to the reasons for choosing private hospitals over government hospitals were also considered as potential factors for choosing between government and private hospitals. The same are reported below:

1.1.8. Challenges as reported by the demand side in the government hospitals

This section includes the challenges faced by patients at government hospitals in order of frequency, starting from the most common issues.

Figure 7: Challenges reported by the demand side in GH



1.1.8.1. Long Waiting Time

'Long waiting time' is the most commonly reported challenge in government hospitals, cited by 32% of the patients. The overcrowding often leads to delays affecting their treatment journey, from registration and diagnostics to consultations and pharmacy services.

"There's a long queue for everything in the government hospitals."

Patients reported waiting up to five hours for scans and two more days for results.

"We waited five hours for the scan and another two days for report results."

In critical cases, these delays can exacerbate health risks. A mother recounted her experience with her daughter's admission for heart issues saying:

"They admitted my daughter to the ward but didn't start treatment on the first day. By the second day, her pulse dropped below 25, and we had to arrange blood ourselves."

The limited availability of services at particular times also adds to the burden, especially for procedures like dialysis.

"Dialysis is available only at specific times, and there's no flexibility."

To address these challenges, patients suggested increasing diagnostic facilities. Enhancing the patient experience by reducing delays could significantly boost trust and satisfaction in government healthcare services.

1.1.8.2. Quality of Medical Care

16% of patients highlighted the quality of medical care as one of the challenges. One patient shared,

"I have never sought treatment from a government hospital because of its quality medical care."

This perception often leads patients to seek treatment elsewhere. For example, one patient mentioned,

"My mother used to visit the GH for her nervous problem, but when it came to eye issues, we always went to an eye hospital because of the quality of care."

The experience of subpar treatment during emergencies has further reinforced these beliefs.

"Initially, we went to GH, but they didn't provide proper treatment."

"They took treatment at GH in the past and were told that the patient would die in 5–10 minutes and removed life support. We rushed her to another hospital, and they saved her life. It's hard to trust the treatment quality after such incidents."

1.1.8.3. Limited Amenities

16% of patients accessing government hospitals mentioned that they faced challenges due to the limited availability of basic facilities. These issues impact patient comfort affecting overall hospital experience. One of the most commonly cited concerns is the condition of toilets and bathrooms.

"The bathroom and toilet facilities need significant improvement. Drinking hot water should also be made available."

"Bathrooms are not clean, there is a smell, and they are not being cleaned properly. Some bathrooms don't even have doors."

"The treatment is good, better than private hospitals, but the hospital environment isn't clean. Bathrooms and rooms need regular cleaning"

Other issues include facilities like water leakages, ventilation, drinking water, damaged water pipelines etc.

"In the nighttime, there is a mosquito problem, and drainage water from the upper floor leaks into our floor."

"There's water scarcity, and the damaged pipeline in the bathroom leads to over water wastage."

"There's no ventilation in the wards, and the rooms are not well-cleaned or equipped for patients."

"Drinking water facilities need to be provided. On this floor, there's no proper provision for drinking water."

Facilities for attendants accompanying patients are also inadequate. They often have to sleep on the floor or find makeshift arrangements.

"..There's no staying place for attenders.."

Cleanliness, drinking water availability, functional bathrooms, proper ventilation, and supportive facilities may create a patient-friendly environment in government hospitals.

1.1.8.4. Human resource limitation

12% of the patients have reported challenges related to human resources at government hospitals. Most common issue highlighted is the shortage of both medical and support staff.

"I had to wait for three weeks to undergo surgery because of the unavailability of the Surgeon…"

Limited staff availability impacts the patient's decision to choose the healthcare facility. Moreover, patients reported that they were not adequately informed or guided throughout their treatment.

"… not properly informed about the tests and their reports" …

Patients also mentioned the lack of support staff during critical times.

"Sometimes there is a single staff member in charge at night, and at times, there are no attendants in the ward, just trainees"

Further concerns were raised about the quality of care provided in the wards. Several patients pointed out that nurses, often trainees, lacked the knowledge and competence to administer the correct medications.

"The nurses do not know which medicine to give and discuss among themselves before administering the medicine,"

Additionally, issues were raised regarding punctuality and attention from the medical staff, with some patients stating that.

"Doctors do not visit the bed and check on patients regularly, and the change in doctors leads to delays in understanding patient history" ….

Patients also mentioned that the staff should be more polite and stated…

"Staff should not show irritation while speaking with patients, and should respond quickly to queries" …

These responses suggest that the challenges patients face is largely rooted in the shortage of trained medical and support staff, and a lack of communication and empathy from the hospital staff. These factors, therefore, contribute to a negative patient experience.

1.1.8.5. Limited Availability of Specialized Services

8% of the patients cited limited access to specialized services as a pressing concern. Limited specialty services often lead patients to travel long distances to larger hospitals, causing delays in treatment and additional financial burdens.

"Our GH has no CT scan facility. For any major diagnostic needs, we have to go to distant hospitals."

Patients also mentioned that there is an unavailability of critical specialties, such as cardiology in some of the government hospitals.

"There's no cardiology specialist at this hospital."

Dialysis services, vital for patients with kidney conditions, are notably absent in several hospitals. A resident of Arachalur shared

"No dialysis facility is available in the nearby GH. Even though I'm aware of the scheme, I have to travel far for treatment."

1.1.8.6. Card-related issues

7% of patients face challenges related to the CMCHIS card, often preventing them from accessing the scheme's benefits. One of the most common issues is the mismatch between the name on the card and other identification documents. In some cases, mismatches in mobile numbers further complicate the process, requiring up to 20 days for rectification.

"The hospital staff told me it would take at least 20 days to fix the name and number mismatch. I couldn't wait that long for treatment."

In instances where patients are unaware of the scheme, delays, and administrative errors add to their burden.

"I was diagnosed with cancer, but my claim was rejected because of a name mismatch on the card. No one helped me fix it in time."

These issues highlight the need for streamlined processes and better support mechanisms to ensure that patients can effectively utilize the CMCHIS scheme.

1.1.8.7. Proximity to residence

4% of beneficiaries mentioned this point, highlighting the challenges of distance and accessibility. Improving access to government healthcare services in remote areas could help reduce the reliance on private facilities, ensuring that more patients can utilize government sector care without the burden of long travel times.

"The nearest government hospital is far away from our residence."

1.1.8.8. Lack of Privacy or Comfort

2% of patients highlighted the lack of privacy and comfort in government hospital facilities. Private hospitals offer private rooms and a higher level of privacy, which many patients find reassuring. In contrast, government hospitals use bed screens as makeshift privacy solutions.

"There is a lack of privacy at government facilities."

1.1.8.9. Difficulty in Accessing Prescribed Medications

1% mentioned challenges in obtaining prescribed medications. Despite the availability of free medicines in government hospitals, stockouts or logistical inefficiencies can lead patients to procure them from external sources.

1.1.8.10. Reputation

“Private hospitals in my area have a good reputation, and many of my friends and family have had positive experiences there.”

1% mentioned that private hospitals have a better reputation when compared to government hospitals. They expressed feeling more comfortable and confident receiving treatment at private hospitals.

Building goodwill through improved patient care, community outreach, and positive patient experiences can help government hospitals establish a stronger presence in the community and attract more patients who trust the system.

1.1.8.11. Infrastructure and maintenance

1% mentioned challenges related to infrastructure. They highlighted issues such as maintenance of the buildings, with some describing difficulty in navigating these buildings. One patient remarked:

"The old building's infrastructure is in bad condition. There is no proper maintenance."

Patients also raised concerns about the shortage of beds. Frequent relocation of patients within the hospital due to insufficient bed availability was a recurring issue. As one patient noted:

"Very often, they move patients to different places in the hospital."

Suggested solutions

To address these challenges, patients emphasized the need for improved building maintenance and upkeep, ensuring basic infrastructure is functional and meets their needs.

1.2. As Reported by the Supply side

The issues reported by the supply side must be seen from two distinct provider perspectives as their mandates and roles are different. While the Government Head Quarter Hospitals which are essentially District or Sub-District Hospitals, are mandated to provide all secondary care and some tertiary care, the Government Medical College Hospitals are mandated to provide specialty and super-specialty tertiary care along with all secondary care. During this study, the specialists and superspecialists in both categories were interviewed.

An overarching statement that came from almost all the Government Hospital’s staff was that government hospitals cannot be and should not be compared to private hospitals, since private hospitals offer secondary and tertiary care, with a broader range of specialties and better infrastructure under one roof.

The providers' perspectives on the factors influencing patients' decisions when choosing a healthcare facility are outlined below:

1.2.1. Building and Infrastructure

9 out of 10 government hospitals highlighted building and infrastructure as a factor that can influence patients' decision to choose private over government hospitals, particularly in critical departments.

"Current infrastructure is insufficient for high-end treatments. For example, the oncology and cardiology departments at GMCH Tirunelveli experience a bed occupancy rate of 80-90%, leading to overcrowding.”

This causes treatment delays and increases patients' discomfort due to insufficient bed capacity.

“Dialysis department faces a high caseload but has limited dialysis machines and the capacity to treat many patients due to infrastructure limitations."

Surgeons added that they have to share OTs among multiple specialties, which means surgical procedures are scheduled on a rotational basis. As a result, patients are often left waiting for weeks before they can get surgery, prompting some to seek treatment elsewhere. Therefore, it was suggested by hospital staff and patients that it is

crucial to upgrade the infrastructure of government hospitals, especially in high-demand areas like oncology and dialysis. Modernizing facilities would help meet rising patient expectations and improve satisfaction, contributing to better retention rates in the government sector.

1.2.2. Human resource limitation

Administrative staff and specialists added that the shortage of medical and support staff can be one of the key factors contributing to patients choosing private hospitals over government ones as mentioned by 9 out of 10 government hospital staff. The hospital faces a significant challenge with having only one specialist per department, in contrast to private hospitals that have teams of specialists for each specialty.

"There is a difference between the number of patients one doctor can manage versus a team of doctors."

Additionally, the lack of dedicated staff for managing the CMCHIS scheme results in frequent clerical errors and delays in patient care. The ward managers are especially burdened with administrative tasks, including patient documentation, data entry, etc.

"The ward managers are expected to do everything CMCHIS patients require, without any support for administrative work."

These staffing shortages, compounded by long wait times and overcrowding, create an environment where patients often seek quicker and more comfortable treatment at private hospitals. Specialists mentioned that

"The hospital cannot compete with private hospitals as their human resources and other facilities cannot be provided in a government hospital."

Many hospitals suggested that deploying specialists, particularly in accident and trauma care, would address critical service gaps in government hospitals. Strengthening hospital staffing by appointing dedicated personnel to manage CMCHIS-related tasks would relieve doctors and medical staff from administrative responsibilities, allowing them to focus on patient care. Training programs for hospital staff, including doctors, on navigating the CMCHIS processes and engaging with third-party administrators (TPAs) could improve efficiency in handling claims and negotiations. TPAs should also include medical professionals in their review panels to ensure that claims are evaluated based on sound clinical knowledge, reducing unnecessary rejections.

1.2.3. Availability of specialized services

As secondary care facilities, District Hospitals (DHs) often face the challenge of providing a comprehensive array of medical specialties and super-specialties, essentially a function of tertiary care hospitals such as the Government Medical College Hospitals (MCHs). This leads to a frequent need for patient referrals to tertiary care institutions for specialized care which may not always be very near to the DHs. 5 out of 10 government hospitals mentioned the limited availability of specialties as the reason for patients choosing private over government hospitals.

"We refer patients to Salem for higher-end treatments, as we don't have the required facilities here."

They mentioned that patients from district hospitals are usually referred to nearby medical colleges/ hospitals instead of private hospitals. However, certain specialties are unavailable in some cases at Government Medical College/ Hospital; for example, in GMCH Erode, cardiology and nephrology are unavailable, compelling them to refer patients to Salem for more advanced treatment options.

This pattern across district hospitals and medical colleges/ hospitals highlights a significant challenge in patient care access. As a result, many patients choose private hospitals, which generally offer a wider range of specialized services. This not only improves health outcomes but also reduces travel-related expenses. In contrast, when patients visit a government hospital and discover that the required specialty is unavailable, they often travel to another facility, leading to additional costs and delays in receiving care.

1.2.4. Privacy

3 out of 10 government hospital staff mentioned that there is a gap in privacy provisions in government hospitals, especially when compared to private healthcare facilities, which can be one of the influencing factors for the patient to choose a healthcare facility. Administrators and Specialists highlighted that patients increasingly expect a level of privacy similar to that offered in private hospitals, where private rooms are often available. In government hospitals, however, privacy is generally maintained through screens rather than private or semi-private rooms, which does not meet patient expectations.

"We offer screens to the patients for privacy, but they demand special/ private rooms"

This lack of private rooms or pay wards in government hospitals contributes to patient dissatisfaction, especially for those accustomed to the privacy standards in private facilities. Respondents noted that addressing these expectations by establishing pay wards or private room options within government hospitals could improve patient experience and satisfaction. Enhancing privacy accommodations could encourage more patients to utilize government sector services, potentially increasing hospital utilization and reducing referrals to private hospitals for non-clinical preferences.

1.2.5. Waiting time

Long waiting times were cited by 3 government hospital staff that may influence patients' decision of choosing a healthcare facility. Administrators and Specialists pointed to high patient volumes and overcrowding, which result in extended waiting periods compared to private hospitals.

"They feel the GHs are very crowded and the waiting time is longer than the private hospitals."

Streamlining patient flow and implementing efficient scheduling practices could reduce wait times, helping government hospitals retain patients who might otherwise turn to private facilities for quicker service.

1.2.6. Amenities

4 out of 10 government hospital staff mentioned that inadequate amenities in government hospitals compared to private hospitals may lead patients to choose private over government hospital.

"Patients demand better amenities, for instance, high- end services and technologies, Air conditioning during hot weather, etc."

These expectations reflect a shift in patient preferences, as they seek comfort and facility enhancements often found in private hospitals. Two hospitals raised concerns about cleanliness in government hospitals, noting that patients often perceive these facilities as less hygienic compared to private hospitals.

"Patient demand better cleanliness"

The demand for improved cleanliness standards indicates that patient perceptions of sanitation significantly influence healthcare choices. Enhancing cleanliness protocols and maintaining high sanitation standards could improve public confidence in government facilities.

1.2.7. Camps

Another concern raised by one hospital is that the private sector uses agent networks to identify and attract CMCHIS patients, leveraging a commission-based system to direct patients to private hospitals. This practice increases patient awareness of private options and highlights the need for government hospitals to establish outreach initiatives to inform CMCHIS beneficiaries about the services available in government hospitals.

1.2.8. Others

- **Perception of Quality and Efficiency**

  Private hospitals are often perceived to provide faster and more efficient services compared to government hospitals. Many patients believe that the quality of care in private hospitals is better. Over the past decade, the private sector has gained dominance in the health sector, especially in districts like Salem. This dominance, coupled with the stigma created against government hospitals, has led to a significant shift of patients from government to private hospitals.

- **Understanding and Awareness of CMCHIS**

  There is a widespread misconception about the CMCHIS card and its purpose. Many beneficiaries view the card and the ₹5 lakh insurance amount as their entitlement, which they believe should be "encashed." This misunderstanding extends to the belief that the insurance funds can only be utilized in private hospitals, as government hospitals already provide free services. Additionally, some patients think that the CMCHIS card functions like a debit card with money stored in it. This belief is reinforced by the OTP verification process during treatment, which resembles online financial transactions. The lack of awareness about the scheme's actual purpose and processes contributes significantly to these misunderstandings.

- **Economic Considerations**

  In economically better-off districts like Erode, families often have the financial capacity to afford private healthcare services. As a result, they tend to bypass government hospitals, despite free treatment being available under the CMCHIS scheme. Moreover, some beneficiaries prefer to save their CMCHIS benefits for future emergencies when they might need private hospital care, instead of using them in government hospitals.

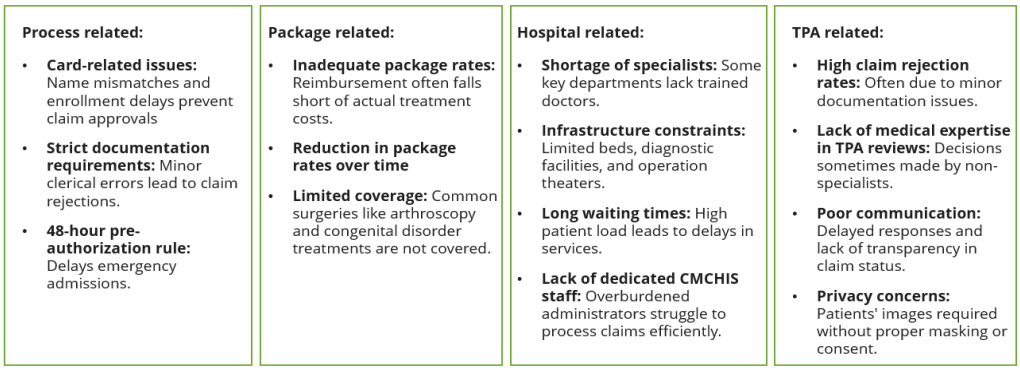
- **Documentation Requirements in Government Hospitals**

  Patients frequently question the need for presenting the CMCHIS card and other documentation in government hospitals, especially since treatment in these facilities is already free. This requirement often leads to frustration and confusion, with some patients leaving without availing of the services. Many patients express their discontent by asking, "Why do you need a card from us when we are anyway getting this treatment for free?" Additionally, there is a general perception that documentation is unnecessary for treatment in government hospitals, further discouraging patients from complying with these requirements.

- **Mistrust Toward Government Hospitals**

  There is mistrust among some beneficiaries toward government hospitals. A section of patients believes that government hospitals are "taking away their money" from their insurance entitlement when the CMCHIS card is used. The OTP confirmation process during treatment adds to this mistrust, as patients associate it with financial deductions. This lack of trust, coupled with misinformation, deters many beneficiaries from utilizing government hospital services under the scheme.

1.2.9. Challenges as Reported by Administrators and Specialists



1.2.9.1. Process related

The discussions with administrators and specialists highlighted operational challenges in implementing CMCHIS. They frequently referred to card-related issues that arise during enrolment or claim processing. Errors in card details, such as mismatched names, aliases, or incomplete information, often lead to delays or claim rejections.

"In many cases, children's names are either not listed or incorrectly recorded on family health cards, which causes issues during claim approval."

Another significant issue is the pre-authorization process, which mandates that **claims must be raised within 48 hours** of diagnosis. This rigid timeframe poses difficulties, especially when patients require time to retrieve their cards or seek a second opinion. Emergency cases exacerbate the problem as families often arrive at hospitals without carrying the required documents.

"In critical situations, families are understandably more focused on the patient's condition. They may not bring their cards or other documents, which can complicate the process."

Hospitals, in such cases, provide the necessary treatment but may face challenges in registering these patients under CMCHIS later.

The enrolment process for CMCHIS cards was also discussed. Stakeholders mentioned that obtaining or updating cards can be time-consuming, especially for patients from rural areas. It was mentioned that the families sometimes face delays in acquiring necessary documents, such as income certificates, which affects their ability to use the scheme immediately. Administrative procedures for claims submission were also discussed where providers shared that the claim submission process requires thorough documentation, and even minor clerical errors can lead to rejection.

"If claims are not submitted within the stipulated time frame, or if there is a minor error in dates or diagnosis codes, the claims may not go through. This is particularly challenging when submissions coincide with weekends or holidays."

Respondents provided examples of how cross-border cases add to these challenges. A hospital staff member shared that the patients from neighbouring states such as Karnataka, who often seek care in Tamil Nadu hospitals, are not eligible for CMCHIS benefits as they are non-residents.

"We receive a significant number of patients from Karnataka, especially in emergencies, but they are unable to avail of CMCHIS as the scheme is limited to Tamil Nadu residents"

Overall, the interviewees expressed optimism that streamlining these processes and addressing operational gaps could enhance the efficiency and reach of CMCHIS.

Suggestions included simplifying documentation requirements, revising card enrolment procedures, and ensuring timely communication between hospitals and TPAs. These measures, they believed, would improve the scheme's ability to serve its beneficiaries effectively.

1.2.9.2. Package related

Administrators and Specialists shared that the challenge related to package rates under CMCHIS is a significant concern. Hospitals often find that the final approved amount for claims is lower than the original package rate. One respondent mentioned

"If the package rate is for ₹48,000, they sometimes receive only ₹20,000."

According to the staff, this creates financial constraints for hospitals, particularly in surgical departments such as orthopaedics, neurology, and oncology, where treatment costs are typically higher due to the use of implants, additional procedures, or extended post-operative care. In orthopaedics, it was reported that, the reimbursement for procedures often does not align with the actual expenditure. Similar feedback was received from specialists in neuro-surgery, who shared examples of complex procedures such as endovascular surgeries.

"These surgeries can cost ₹8 lakhs or more, but the package rate under CMCHIS is ₹1 lakh."

Another concern raised during the discussions was the reduction in package rates over time. For instance, a specialist shared that hysterectomy packages, which were earlier reimbursed at ₹18,000, are now set at ₹12,000. Departments like paediatrics have reportedly experienced significant reductions as well. In addition, it was highlighted that there is an absence of some essential procedures in the package list. Examples include arthroscopic surgeries, surgeries for congenital disorders.

"When common procedures are not included, patients assume the scheme does not support them, and they avoid seeking care under CMCHIS."

They also emphasized the benefits of expanding coverage and revising package rates. A hospital administrator pointed out that certain high-cost procedures, especially in neuro-surgery and oncology should be supported with updated packages.

1.2.9.3. Hospital-related

Government hospitals encounter numerous challenges that hinder their effective utilization under the scheme. A critical issue is the shortage of specialized medical staff.

"…Non-availability of specialists, such as neurosurgeons and oncologists, due to non-sanctioned posts…"

This compels hospitals to refer patients to other institutions, impacting scheme utilization since treatments requiring these specialties cannot be accommodated. For instance, the absence of orthopaedic specialists in certain hospitals limits their ability to handle trauma cases, despite their location near highways with frequent accident cases.

"…Emergency departments also operate with far fewer doctors than required, severely restricting the volume of surgeries and procedures under the scheme…"

Moreover, it was highlighted that the lack of dedicated staff to manage insurance-related tasks forces the existing workforce to handle administrative responsibilities, increasing errors and claim rejections.

Infrastructure deficiencies further exacerbate the situation.

"…Many hospitals operate with outdated buildings and inadequate operation theatres, leaving critical services such as dialysis and advanced oncology treatments unavailable…"

For example, in some hospitals, only a single operation theatre is functional and is largely reserved for specific procedures like obstetrics and gynaecology, limiting access to other specialties. Patients requiring advanced treatments are referred to higher centres due to a lack of essential equipment, such as dialysis machines and high-end oncology facilities.

High patient load is another pressing concern. Beds allocated for the scheme are consistently at full occupancy, forcing hospitals to use general ward beds to accommodate additional patients. While some departments generate sufficient revenue through the scheme to meet their operational needs, others face significant resource shortages.

"…Limited operation theatre availability, managed on a rotational basis, results in delayed surgeries. Many patients, unwilling to wait for extended periods, opt for private facilities, affecting the overall scheme utilization…"

Compared to private hospitals, which offer features like private rooms, air conditioning, and better ambiance, government hospitals often lack these comforts. Longer waiting times for outpatient services, diagnostics, and surgeries compound patient dissatisfaction and drive them toward private care.

Logistical challenges associated with scheme management add to the hospitals' burdens. For instance, the responsibility for uploading treatment cycles and managing patient data falls entirely on overburdened staff.

"…Some hospitals also lack the equipment needed for specific procedures, such as specialized cameras for ophthalmology, delaying treatment due to incomplete preauthorization processes…"

Referral challenges due to limited hospital capabilities further strain resources. Patients requiring specialized treatments in cardiology or nephrology are often sent to other institutions, which places additional pressure on the hospitals' referral systems, including their limited ambulance fleet.

Despite these challenges, hospital staff remain committed to providing optimal care within the constraints of available resources. Addressing issues such as specialist shortages, infrastructure gaps, and logistical inefficiencies is essential for improving the performance of government hospitals under the scheme.

1.2.9.4. TPA related

Government hospitals face multiple challenges associated with the functioning of Third-Party Administrators (TPAs) under the CMCHIS. One of the most common issues was rejection of claims due to minor clerical errors such as mismatched names, discrepancies in documents, or overwritten entries, leaving hospitals financially strained.

Another issue is the frequent rejection of claims based on petty reasons, such as the absence of time or date stamps on diagnostic reports, or delays in completing diagnostic tests due to operational constraints. For instance, TPAs do not accept outside diagnostic scans conducted before admission, requiring patients to repeat costly and unnecessary tests, which raises ethical and logistical concerns. The strict adherence to the 48-hour rule also disproportionately affects specific departments like dialysis and urology, where evaluation and treatment decisions typically take longer than two days. This results in a significant proportion of cases being excluded from CMCHIS coverage.

While interacting with doctors, they were of the view that many times expressed disappointment on TPAs' lack of understanding of medical decision-making. Furthermore, hospitals face multiple, often repetitive, queries from TPAs during the claim approval process, consuming valuable time and energy. These queries are spread across different stages of treatment, creating delays and increasing the chances of rejection.

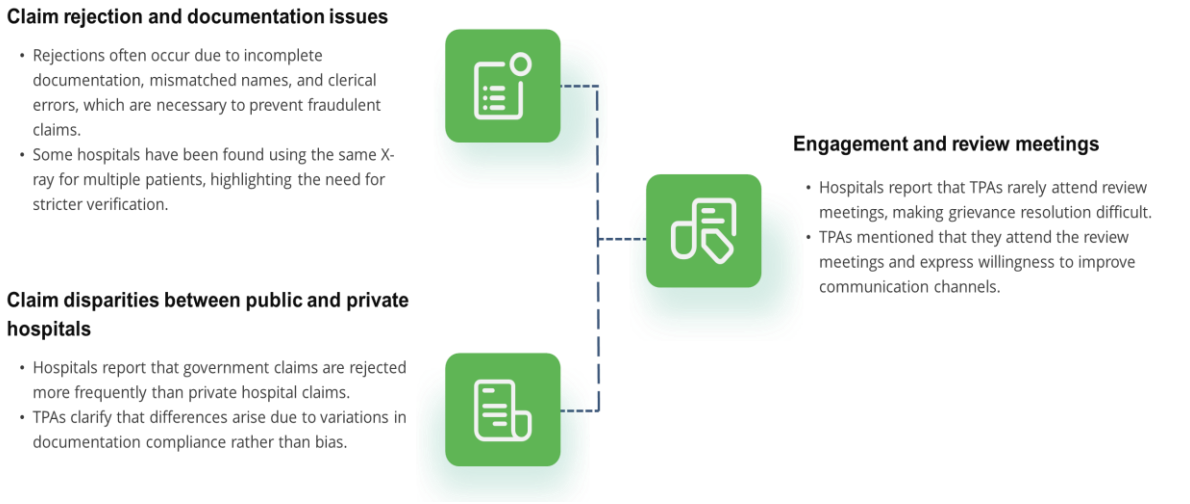
Doctors and administrators are of the view that claims from government hospitals are rejected more frequently than those from private hospitals. Delayed responses to grievances and poor communication from TPA representatives further exacerbate operational inefficiencies. In some cases, hospitals report that TPA officials deliberately avoid resolving issues for government hospitals while prioritizing private hospitals. Additionally, TPA staff rarely attend review meetings, leaving hospitals with unresolved grievances and no immediate point of contact for clarification.

Addressing these issues requires a systemic review of TPA practices, greater flexibility in rules, and improved oversight mechanisms to ensure fair and efficient operations.

1.3. Insurance and TPA perspective

This section provides insights from interviews conducted with the project manager (UIIC), TPAs, and CMOs of VIDAL, Medi-Assist, and MD India, providing a broader understanding of the challenges faced by government hospitals related to them and the operational difficulties they face in implementing the CMCHIS scheme.

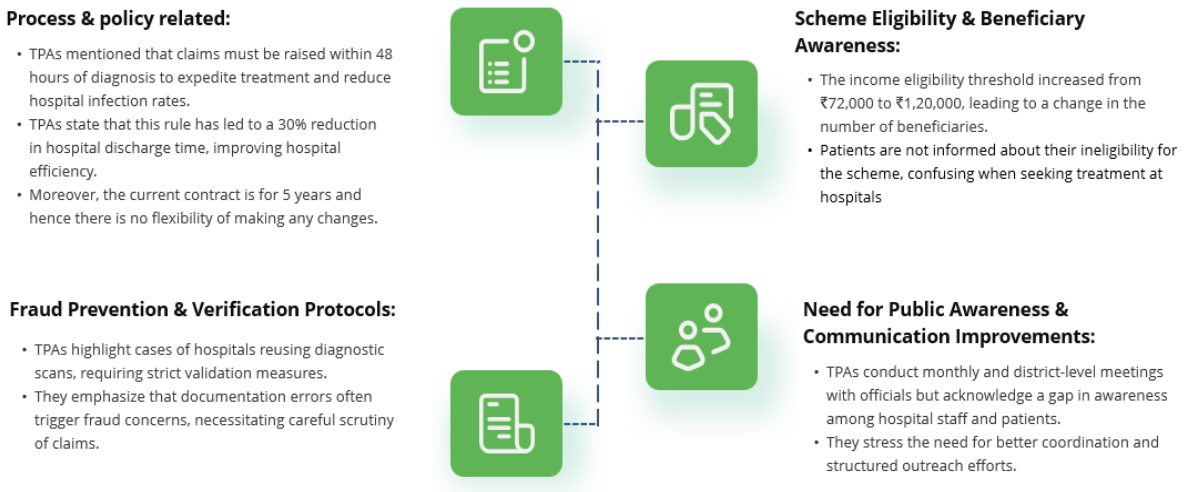
Figure 8: Insurance and TPA response to the supply side challenges



As mentioned in the previous section, government hospitals reported various operational challenges related to Insurance companies and Third-Party Administrators (TPAs) under the CMCHIS scheme. One of the key concerns was documentation and claim processing. TPAs emphasize the importance of proper documentation to ensure smooth claims processing and prevent discrepancies. It was mentioned that there are instances where the same X-ray has been used for multiple patients, highlighting the significance of verification processes. Government hospitals mentioned that their claims face higher rejection rates compared to private hospitals. TPAs clarify that these disparities stem primarily from variations in documentation compliance rather than any systemic bias. Private hospitals typically have dedicated administrative teams managing claims, ensuring accuracy and adherence to required documentation standards. In contrast, government hospitals integrate claims processing within their existing administrative framework, which may lead to differences in submission practices.

Engagement between hospitals and TPAs plays a key role in the claims process. While hospitals highlighted challenges in accessing TPAs for grievance resolution, TPAs stated that they participate in addressing grievances and recognize the importance of strengthening communication channels to improve coordination.

Figure 9: Insurance and TPA perspective on operations and policy decision



The claims process under the CMCHIS scheme operates within specific policy guidelines aimed at ensuring timely treatment and efficient hospital management. TPAs emphasize that the current contract is for five years, limiting flexibility in making modifications to existing policies during this period. They also highlighted that kee48-hour timeline helps to expedite patient care, reducing hospital infection rates and has contributed to a 30% reduction in hospital discharge times, improving overall efficiency. Additionally, Fraud prevention and verification protocols are essential components of the claims process to maintain transparency and accountability. TPAs have identified instances where diagnostic scans have been reused for multiple patients, necessitating strict validation measures. They stress that documentation errors can often raise fraud concerns, requiring careful scrutiny of claims. Ensuring adherence to proper verification protocols helps in maintaining the integrity of the claims process while facilitating smoother approvals.

In cases where patients forget their insurance card, TPAs clarified that an e-card can be generated using the ration card. There is also no lock-in period for new enrolments, meaning patients can avail treatment the day after their card is issued. TPAs further mentioned that special enrolment camps are conducted when recommended by the government, wherein TPAs visit sites directly instead of requiring patients to visit district kiosks.

Changes in scheme eligibility criteria have had an impact on beneficiary awareness and accessibility to services. The income eligibility threshold was increased from ₹72,000 to ₹1,20,000, leading to a change in the number of beneficiaries covered under the scheme. However, patients are often not informed about their ineligibility until they seek treatment at hospitals, leading to confusion. They suggested enhancing awareness about eligibility criteria can help beneficiaries make informed decisions and reduce uncertainty during hospital visits.

Effective public awareness and communication play a crucial role in the smooth implementation of the scheme. TPAs conduct regular district-level meetings with officials to discuss operational aspects and address concerns. However, they acknowledge that gaps remain in awareness among hospital staff and patients. To address this, TPAs emphasize the need for improved coordination and structured outreach initiatives. Strengthening communication efforts can ensure better understanding of the scheme’s provisions and enhance accessibility for beneficiaries.

Discussion:

The findings from this study bring to light a wide range of interconnected factors influencing the underutilization of government hospitals under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in some districts of Tamil Nadu. These factors can be broadly categorized into elements driving patient preferences for private hospitals and systemic barriers such as awareness challenges and operational inefficiencies that impede access to healthcare under CMCHIS in both government and private facilities. Together, they underscore the need for targeted reforms to optimize the scheme’s impact and improve its accessibility and effectiveness for all eligible beneficiaries.

Patient preference for private hospitals is deeply rooted in the perception of quality, comfort, and efficiency. Private hospitals are often viewed as offering superior care due to their modern infrastructure, personalized attention, and shorter waiting times. Beneficiaries frequently cited the availability of private rooms, air-conditioned wards, and better food options as major draws to private facilities. Such amenities enhance the patient experience and contribute to a broader perception of private hospitals being more patient-centric. In contrast, government hospitals were often described as overcrowded, with insufficient attention to cleanliness, privacy, and comfort, leaving patients feeling neglected and undervalued.

Resource gaps in government hospitals further exacerbate this perception. Many district hospitals do not have specialty services, forcing patients to seek referrals to tertiary centres or private facilities. Even at tertiary care centres, resource constraints such as insufficient dialysis machines, operating theatres, and inpatient beds lead to overcrowding and long treatment delays. Patients reported waiting weeks for surgeries or diagnostic tests, reflecting systemic inefficiencies that discourage reliance on government healthcare facilities. Geographic disparities also play a role, as private hospitals are often more accessible, particularly in urban and semi-urban areas, reducing travel time and associated costs for patients. For many, the convenience of proximity combined

with the reputation of private hospitals as reliable providers of quality care reinforces their preference for private-sector healthcare.

Beyond these logistical and service-level factors, awareness challenges emerged as a critical barrier to the effective utilization of CMCHIS. Both supply- and demand-side factors contribute to a widespread lack of understanding about the scheme's scope, benefits, and processes. From a supply-side perspective, limited outreach and publicization efforts have left many eligible beneficiaries unaware of their entitlements. Unlike other high-profile government initiatives that employ comprehensive media campaigns, CMCHIS lacks visibility in channels accessible to rural populations, such as local radio, television, and community newspapers. This gap is particularly pronounced in underserved areas, where beneficiaries often rely on these mediums for information about government programs.

Government hospitals themselves have not done enough to bridge this gap. Many facilities lack dedicated help desks or staff to guide beneficiaries through the enrolment and utilization process. Without hospital-based support systems, patients are often left to navigate the complex enrolment procedures on their own, requiring travel to district offices for card processing. This burdensome requirement disproportionately affects rural populations, who face significant time and cost constraints. The absence of localized and efficient support systems not only limits access but also prevents beneficiaries from fully understanding and utilizing CMCHIS's potential for routine and preventive healthcare. Instead, engagement with the scheme tends to be reactive, driven by immediate medical needs rather than proactive utilization for ongoing health management.

Misconceptions about CMCHIS further diminish its effectiveness. Many beneficiaries mistakenly believe the CMCHIS card functions like a debit card, entitling them to cash benefits or refunds. Others assume the scheme is limited to specific hospitals or treatments for major ailments, excluding coverage for routine or preventive care. Such misunderstandings create confusion and dissatisfaction during healthcare visits, often leading to unmet expectations and eroding trust in the scheme. These misconceptions are exacerbated by the lack of proactive educational initiatives from healthcare providers. In many instances, patients completed treatment without ever realizing their expenses could have been covered under CMCHIS, reflecting missed opportunities for government hospitals to build awareness and engagement.

Informal networks often become the primary source of information about CMCHIS, but these channels are prone to inaccuracies. Beneficiaries frequently rely on friends, family, or community members for guidance, resulting in the dissemination of incomplete or incorrect information. This reliance on informal networks perpetuates myths about the scheme's applicability and coverage, discouraging eligible beneficiaries from seeking care. Without consistent and accurate messaging from government hospitals or government representatives, these information gaps remain unaddressed, further limiting the scheme's reach and utilization.

Operational inefficiencies within CMCHIS also pose significant barriers, affecting beneficiaries and providers alike. Administrative processes, particularly claim processing, emerged as a major pain point. Government hospital staff reported delays caused by minor clerical errors and a lack of real-time feedback from third-party administrators (TPAs). The 48-hour admission rule adds another layer of complexity, disproportionately impacting patients who require urgent care. These inefficiencies often lead to financial strain on hospitals and frustration among staff, undermining their efforts to serve beneficiaries effectively.

The limited capacity of TPAs to handle claims in a timely and transparent manner further compounds these challenges. Stakeholders emphasized the need for decentralized claim review processes at the district level, staffed by medical professionals and government representatives, to expedite approvals and reduce disputes. Increasing TPA staffing and extending their working hours were also identified as practical solutions to address claim backlogs and improve the scheme's overall efficiency.

Despite these challenges, there is a growing interest among government hospital staff in enrolling CMCHIS patients, driven by the financial incentives linked to the scheme. However, this enthusiasm is often tempered by systemic bottlenecks such as staffing shortages and inadequate infrastructure. Overburdened staff struggle to balance clinical duties with administrative responsibilities, leading to delays and errors that frustrate both patients

and providers. These limitations underscore the need for targeted investments to modernize government hospitals, expand specialty services, and recruit dedicated personnel to manage CMCHIS operations effectively.

In summary, the underutilization of government hospitals under CMCHIS is shaped by a combination of patient preferences for private facilities, awareness challenges, and systemic inefficiencies. Addressing these issues requires a comprehensive strategy that enhances government hospital infrastructure and service quality, improves awareness through targeted outreach, and streamlines administrative processes. By fostering trust and understanding through robust educational campaigns and operational reforms, CMCHIS can better fulfil its promise of providing equitable and accessible healthcare to all.

5. Recommendations

Targeted interventions must be implemented at multiple levels to enhance the effectiveness of the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) and increase the utilization of government hospitals. The following recommendations address key supply-side and demand-side challenges, administrative inefficiencies, and policy gaps identified in the study:

1. Strengthening Awareness and Outreach

Targeted awareness campaigns must be conducted using digital media, community outreach programs, and health camps to improve knowledge about CMCHIS benefits among beneficiaries. It is essential to address misconceptions regarding the scheme's coverage and accessibility through clear and consistent messaging. Government hospitals should leverage local networks such as community health workers and NGOs to disseminate accurate information, particularly in rural and underserved areas. This will encourage more people to utilize CMCHIS for their healthcare needs.

2. Care Coordination for CMCHIS Beneficiaries

The study findings highlight the challenge of "patient friction' as a key bottleneck for the beneficiaries of the CMCHIS. Our study findings show that even after being an eligible beneficiary, the patient has to navigate through multiple administrative hurdles for admission using the scheme. This situation can be resolved by ensuring a "Care Coordination Model" which can facilitate the patient admission through an integrated referral system to CMCHIS hospitals. This can reduce patient friction and ensure that accurate and complete information is seamlessly transmitted across the care continuum.

3. Streamlining Administrative Processes

The efficiency of CMCHIS implementation can be improved by simplifying claim processing through the use of digital submission and automated verification systems. Real-time communication between hospitals and TPAs must be strengthened to ensure quick resolution of claim disputes. Additionally, the enrolment and card issuance process should be expanded by organizing more mobile registration camps and introducing online registration options, making it easier for eligible beneficiaries to access CMCHIS services. The current duration of the contract with the insurance company is five years, i.e., from 11.01.2022 to 10.01.2027. Having a longer duration contract has its own merits, considering the time taken for conducting a tender for identifying insurance companies within the government system, it also has some drawbacks. The evidence on various aspects of the scheme, such as beneficiary enrolment, claims management, and package issues, which are short-run in nature and which require a change in the process flow, cannot be adapted if there is no room for flexibility in the agreement with the insurance company. Hence, it is recommended to bring in flexibility of contractual terms so that the evidence from the field can be adapted through mutual consensus during the implementation phase.

4. Enhancing government hospital infrastructure and capacity

Investment in government hospital infrastructure must be increased to improve facilities, expand bed capacity, modernize operation theatres, and upgrade diagnostic and specialty service equipment. By enhancing the physical

environment and technical capabilities of secondary-level government hospitals, the quality of care can be significantly improved. Additionally, specialty services must be expanded at the district level to reduce referrals to tertiary centres or private hospitals. Real-time bed availability tracking systems should also be implemented to optimize resource allocation and reduce unnecessary patient transfers.

5. Addressing Human Resource Gaps

To address the persistent shortages of healthcare professionals, it is crucial to recruit additional specialists in key fields such as cardiology, nephrology, and oncology. Support staff numbers must also be increased to ensure efficient patient care. Proper workforce management should be implemented to optimize staff deployment and reduce waiting times. Moreover, dedicated CMCHIS units should be established within hospitals to handle insurance-related administrative processes, relieving medical professionals from non-clinical duties and ensuring smoother claim processing.

6. Enhancing Patient Experience

Reducing waiting times through the implementation of appointment scheduling systems and fast-track lanes for specific procedures will improve patient convenience and satisfaction. Hospitals should also focus on improving cleanliness and hygiene by enforcing strict sanitation protocols in wards, operation theatres, and other patient areas. Basic facilities such as clean drinking water, hygienic toilets, and proper ventilation should be improved to create a more patient-friendly environment in government hospitals.

6. Conclusion

Government hospitals continue to play a pivotal role in the delivery of CMCHIS, accounting for higher utilization in 26 out of 38 districts (68%). This underscores their extensive reach and their critical role in ensuring access to healthcare for beneficiaries. While private hospitals demonstrate slightly higher utilization in 12 districts, the gap remains minimal, reaffirming the strong presence and reliability of government facilities under the scheme. Despite resource constraints such as limited specialty services, shortages of medical equipment, and high patient loads, government hospitals remain a trusted choice, reflecting their resilience and commitment to service delivery.

Perceptions of care quality also influence hospital choice, with some beneficiaries viewing private hospitals as more favourable due to modern infrastructure, personalized attention, and shorter wait times. Strengthening patient experience in government hospitals through service enhancements and improved infrastructure can further reinforce their appeal. Additionally, raising awareness about CMCHIS benefits and addressing misconceptions through targeted communication efforts can encourage more beneficiaries to seek care at government facilities. Streamlining operational processes, including addressing claim processing challenges and administrative delays, will enhance efficiency and ensure a more seamless experience for both hospitals and patients. By implementing these measures, the effectiveness of CMCHIS can be further strengthened.

Annexures:

1. **List of facilities visited**

S. No.	District	Government hospital	Private hospital
1	Perambalur	Government Head Quarters Hospital Government Medical College Hospital, Trichy	Dhanalakshmi Srinivasan Hospital
			Dhanalakshmi Srinivasan Super Specialty Hospital
			Lakshmi Nursing Home
2	Cuddalore	Government Head Quarters Hospital Government Medical College Hospital	JIPMER Hospital, Pondicherry
			Manakula Vinayagar Medical College, Pondicherry
			Krishna Cancer Institute
3	Erode	Government Head Quarters Hospital	Erode Cancer Centre
		Government Medical College Hospital	Kalyani Kidney Care Centre
			KMCH Specialty Hospital
4	Salem	Government Head Quarters Hospital	Dharan Hospital
		Government Medical College Hospital, Mettur Dam	Shanmuga Hospital Private Limited
			Kauvery Hospital, Seelanaickenpatti
5	Tirunelveli	Government Head Quarters Hospital	Subramanian Nursing Home,
		Government Medical College Hospital, Nanguneri	Aravind Eye Hospital
			Shifa Hospital

2. **In-depth Interview Tools**

Respondents: Hospital Administrators, Medical superintendents, and Nodal officer- CMCHIS

Survey on evaluation of CMCHIS, Tamil Nadu		
S. No.	**Questions**	**Answer**
	A. General Information	
A1	**Hospital Information**	
A1.1	Hospital Name	Government Head Quarters Hospital (GHQH), Cuddalore
A1.2	Type of Hospital • Medical College • District Hospital • Sub District Hospital	District Hospital
A1.3	Location	Cuddalore, Tamil Nadu
A1.4	Year of joining the scheme	February 2012
A1.5	Number of Hospital Beds	
A1.6	Specialties that are empanelled under scheme (Yes/ No) 1. General Surgery 2. ENT 3. Ophthalmology 4. Obstetrics and Gynaecology 5. Orthopaedics 6. Cardio Thoracic Surgery 7. Paediatric Surgery 8. Genitourinary Surgery 9. Neuro Surgery	

	10. Surgical Oncology 11. Medical Oncology 12. Radiation Oncology 13. Burns Management Plastic & Reconstructive Surgery 14. Polytrauma 15. Dental Surgery 16. Paediatric Cancer 17. Critical care 18. General Medicine 19. Paediatrics 20. Neonatology 21. Cardiology 22. Nephrology 23. Neurology 24. Chest Diseases & Respiratory Medicine (Pulmonology) 25. Psychiatry 26. Intervention Neuroradiology 27. Mental disorder 28. Otorhinolaryngology 29. Oral and maxillofacial 30. Urology 31. Radiology 32. Pathology 33. Gastroenterology 34. Rheumatology 35. Interventional Cardiology 36. Endocrinology 37. Intervention Neuroradiology 38. Accident & Emergency	
A1.7	Any other insurance scheme empanelled in the hospital	
A2	**Administrator Information**	
A2.1	Name	
A2.2	Designation	
	B. CMCHIS Implementation Status	
B1	What is the average number of in- patients accessing hospital facilities/ month	
B2	What is the average number CMCHIS beneficiaries accessing hospital services per month?	
B3	How are the CMCHIS beneficiaries made aware of their eligibility for the scheme? 1) Helpdesk / CMCHIS Kiosk 2) Banner / IEC 3) Sensitizing the doctors / medical staff about CMCHIS beneficiaries 4) Others (specify) 5) Don't know	
B4	Do you refer CMCHIS patients to other hospitals? (Yes/ No)	
B5	If B4 is yes, where do you refer? (Multiple select) 1) Government hospital 2) Private empanelled hospital 3) Private non- empanelled hospitals	

B6	If B5 is yes, why do you refer? (Multiple select) 1) Specialists not available 2) Equipment not available 3) Specialization not available 4) Reserve package 5) Others (Specify)	
B7	If B5 is yes, Does the hospital have referral transport services 24*7? (Yes/ No)	
B8	Does the hospital take patient feedback? (Yes/ No)	
B9	Is there a separate ward present for AB PM-JAY patients? (Yes/ No)	
B10	How many help desks under AB PM-JAY you have in this hospital?	
	C. Organization's Perspective	
C1	What challenges, if any, has the hospital faced in the implementation of the CMCHIS scheme?	
C2	Which specialties are having a very low admission rate in your hospital? Specify the departments	
C3	From your perspective, what factors do you believe contribute to low admissions under the CMCHIS scheme in the government hospital?	
C4	How does the hospital currently communicate information about CMCHIS to potential beneficiaries within the community?	
C5	Do you face any issue with regard to the facility infrastructure and human resources in the implementation of the CMCHIS scheme?	
C6	How do you use the claims amount for improving the service delivery of the hospital?	
C7	What challenges, if any, has the hospital faced in the implementation of the CMCHIS scheme	
C8	Reasons for low admissions in a particular specialty? (To be asked to the treating doctor of a particular specialty having low admissions.	
	D. Improvement Strategies	
D1	What strategies or initiatives do you believe could be implemented to increase admissions under the CMCHIS scheme?	

Respondents: Insured/ Beneficiaries from Private Hospitals

Survey on evaluation of CMCHIS, Tamil Nadu		
S. No.		**Answer**
	A. Patient Information	
A1	Name (Optional)	
A2	Age	
A3	Gender	
A4	City/ Town/ Village of Residence	
A5	Distance from Hospital	
A6	Nature of Ailment (Medical/Surgical)	
A7	Duration of stay in the hospital (in days)	
	B. CMCHIS Scheme	
B1	What is the primary reason for your hospitalization? (Under which department)	
B2	Which facility did he/she first seek care before hospitalization? • HSC	

	• PHC • CHC • TH/DH • Medical College • Private Doctor • Private Hospital • Others Specify	
B3	Whether the hospital was a CMCHIS-empanelled hospital? • Yes • No • Don't Know	
B4	Did the patient incur any expenses? • Yes • No • Don't Know	
B5	If yes, Doctors Fee: Rs. Medicines and Consumables: Rs. Diagnostic Tests: Rs. Other expenses (blood, oxygen, etc.): Rs. Transportation expenses: Rs. Total Expenses: Rs.	
B6	What influenced your decision to seek treatment from a private hospital rather than a government hospital under the CMCHIS scheme? (Select all that apply) • Close to the residence • Good reputation and better quality of care • Availability of specialized services • Suggested by relatives/friends • Referred by doctors • CMCHIS empanelled hospital Other (please specify): _____	
B8	Why was it used for partial payment? • Insufficient funds in the card • All services not covered • No reasons provided • Others (specify) • Don't know	
B9	Were all diagnostic tests during your stay in this hospital free by the empanelled hospital? • Yes • No • Don't Know	
B10	How much money did the patient incur as **LOST WAGES?** (loss of wages of patient and household members)	
B11	Did you face any challenges related to your hospitalization? • Yes • No If yes, please specify the challenges	
B12	Do you know that government hospitals are also empanelled under the CMCHIS scheme?	

	• Yes • No If yes, please specify the challenges	
B13	Have you ever sought treatment from a government hospital under the CMCHIS scheme? • Yes • No • Don't Know	
B14	If yes, in your experience, what are the common challenges faced? • Long waiting time for medical services • Limited availability of specialized services • Lower quality of medical care • Difficulty in accessing prescribed medications • Lack of privacy or comfort in hospital facilities • Challenges in communication with healthcare providers • Administrative hurdles in the CMCHIS claim process Other (please specify): _____	
	C. Patient Satisfaction and Feedback	
C1	Rate your satisfaction level regarding the hospital's infrastructure and cleanliness on a scale of 1 to 5	
C2	Rate your satisfaction level regarding the overall accessibility of the hospital on a scale of 1 to 5	
C3	Rate your satisfaction level regarding the availability and attention of medical /paramedic staff of the hospital on a scale of 1 to 5	
C4	Rate your satisfaction level regarding availability of medicines and diagnostic tests on a scale of 1 to 5	
C5	Is there any specific feedback you would like to provide to healthcare providers based on your experience?	

Respondents: Non-Insured (Non- Beneficiaries) Inpatient from Government Hospital

Survey on evaluation of CMCHIS, Tamil Nadu		
S. No.		**Answer**
	A. Patient Information	
A1	Name (Optional)	
A2	Age	
A3	Gender	
A4	Level of education attained	
A5	Occupation	
A6	City/ Town/ Village of Residence	
A7	Distance from Hospital	
A8	Nature of Ailment (Medical/Surgical)	
A9	Duration of stay in the hospital (in days)	
	B. CMCHIS Scheme	
B1	What is the primary reason for your hospitalization? (Under which department)	
B2	Were you aware of CMCHIS before your hospitalization? • Yes • No	
B4	If eligible, what are the reasons for not availing CMCHIS scheme? (misconceptions or concerns)	

	• Lack of Information about the scheme • Perceived complexity in accessing the scheme • Preference for other healthcare providers • Lack of awareness of eligibility • Perceived inadequacy of the scheme benefits • Distance of the facility • Other (please specify)	
B5	Which facility did he/she first seek care before hospitalization? • HSC • PHC • CHC • TH/DH • Medical College • Private Doctor • Private Hospital • Others Specify	
B6	Did the patient incur any expenses? • Yes • No • Don't Know	
B7	If yes, Doctors Fee: Rs. Medicines and Consumables: Rs. Diagnostic Tests: Rs. Other expenses (blood, oxygen, etc.): Rs. Attender's Diet Expenses: Rs. Transportation expenses: Rs. Total Expenses Rs.	
B8	Under which medical specialty treatment was availed? (Use discharge summary)	
B9	Whether all medicines prescribed for the patient available in the facility? Yes, all were available No, from outside the facility Others, Specify	
B10	Whether all diagnostic tests for the patient available in the facility? Yes, all were available No, from outside the facility Others, Specify	
B11	How much money did the patient incur as **LOST WAGES?** (loss of wages of patient and household members)	
B12	Did you face any challenges related to your hospitalization? • Yes • No If yes, please specify the reasons.	
	C. Patient Satisfaction and feedback	
C1	Rate your satisfaction level regarding the hospital's infrastructure and cleanliness on a scale of 1 to 5	
C2	Rate your satisfaction level regarding the overall accessibility of the hospital on a scale of 1 to 5	
C3	Rate your satisfaction level regarding the availability and attention of medical /paramedic staff of the hospital on a scale of 1 to 5	

C4	Rate your satisfaction level regarding availability of medicines and diagnostic tests on a scale of 1 to 5	
C5	Is there any specific feedback you would like to provide to healthcare providers based on your experience?	
C6	Are there any factors that could have increased your awareness or understanding of the scheme?	

Respondents: District-Level Stakeholders (Joint Director of Health)

Survey on evaluation of CMCHIS, Tamil Nadu		
S. No.		**Answer**
	A. General Information	
A1	Name of the Official	
A2	Department	
A3	Position/Role	
A4	Years of Experience	
A5	Age	
	B. Organization's Perspective	
B1	How long has your organization been associated with the CMCHIS in Tamil Nadu?	
B2	What is the primary role of your organization in the scheme implementation?	
B3	What is the current distribution of government hospitals under the scheme in your district and specialties covered by the scheme (Probe for the pattern of distribution of government providers across districts and specialties)	
B5	What are the key issues raised by the secondary and tertiary government hospitals in the implementation of the scheme? (Probe for the operational issues, capacity building and training needs and institutional issues)	
B6	In your experience, what are the common challenges faced by government hospitals in the claim processing under CMCHIS?	
B7	What institutional systems are in place for continuous engagement with secondary and tertiary government hospitals in the implementation of the scheme?	
B8	How often does your organization conduct training sessions for healthcare providers regarding CMCHIS policies and claim procedures?	
	C. Collaboration	
C1	How does your organization communicate with government hospitals regarding CMCHIS related matters?	
C2	Does your organization have a structured feedback mechanism for hospitals to report challenges faced during CMCHIS implementation?	
C3	What grievance redressal mechanisms exist for government hospitals participating in the scheme? What are the processes laid out for grievance redressal (Probe for institutional avenues for conflict resolution; type of grievances from public providers, mechanisms of grievance resolution)	
	D. Factors affecting Hospital admission Performance	
D2	Are there any challenges faced by these hospitals in meeting the documentation requirements for CMCHIS claims?	

D4	Do you think there is a need for additional efforts to enhance hospitals' understanding of CMCHIS policies?	
D5	Can you identify any operational bottlenecks that have affected the smooth functioning of the CMCHIS scheme in the district?	
	E. Suggestions and Improvements	
E1	In your opinion, what areas need improvement in the current CMCHIS implementation to enhance hospital admission performance?	
E2	How can the collaboration between your organization and hospitals be enhanced to improve CMCHIS outcomes?	
E3	Are there any specific strategies you would recommend to enhance the performance of the scheme?	
E4	Any other comments or suggestions?	

Respondents: State-Level Stakeholders (United India Insurance Company and TPAs)

Survey on evaluation of CMCHIS, Tamil Nadu		
S. No.		**Answer**
	A. General Information	
A1	Name of the Official	
A2	Department	
A3	Position/Role	
A4	Years of Experience	
A5	Age	
A6	Email Id	
	B. Organization's Perspective	
B1	How long has your organization been associated with the CMCHIS in Tamil Nadu?	
B2	What is the primary role of your organization in the CMCHIS implementation?	
B3	What institutional systems are in place for continuous engagement with secondary and tertiary government hospitals in the implementation of the scheme?	
B4	How often does your organization conduct training sessions for healthcare providers regarding CMCHIS policies and claim procedures?	
	C. Collaboration	
C1	How does your organization communicate with government hospitals regarding CMCHIS related matters?	
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	D. Suggestions and Improvements	
D1	In your opinion, what areas need improvement in the current CMCHIS implementation to enhance hospital admission performance?	
D2	How can the collaboration between your organization and hospitals be enhanced to improve CMCHIS outcomes?	
D3	Are there any specific strategies you would recommend to enhance the performance of the scheme?	