

Hospitals' Recovery Issues Under Government Healthcare Schemes in India

Executive summary

Hospitals' recovery problems under Indian government and government-linked healthcare purchasers are not one problem; they are five different operating systems wearing roughly the same bureaucratic face. The highest-confidence finding is that **PM-JAY is the most documented scheme and shows a clear gap between policy SLA and actual claim decision time**: the National Health Authority's public parliamentary position is that intra-state claims should be settled within **15 days** and portability claims within **30 days**, yet a WHO-supported comparative assessment found materially longer claim decision times in Trust-model states than in Insurance-model states, with **48 days versus 14 days** on average for claim decisions; the same study also found higher claim rejection rates in Trust states (**4.8% versus 2.3%**).¹

Across schemes, the same friction pattern repeats at different layers of abstraction: **identity/referral validation, package/rate coding, document sufficiency, manual-imposed query loops, hybrid paper-plus-digital workflows, non-standard escalation paths, and weak interoperability between hospital HIS/EMR systems and payer portals**. PM-JAY adds state-model variation and anti-fraud scrutiny; CGHS adds legacy BCA/physical-bill habits and now more stringent digital evidence such as geo-tagged photographs; ESIC adds a highly parameterised BPA workflow with multiple timed "Need More Information" loops; ECHS adds referral rigidity, multi-level approvals and budget-cycle carry-forward stress; WGL SWASTH appears designed to reduce man-

ual friction but public evidence on hospital-facing payment performance remains thin.²

For hospitals, the cash-flow effect compounds quickly. On a simple working-capital basis, every **₹1 crore** of receivables delayed by **15 days** costs roughly **₹0.49 lakh** per year at a **12% annual carrying cost**, **48 days** costs about **₹1.58 lakh**, **60 days** about **₹1.97 lakh**, and **120 days** about **₹3.95 lakh**. That is before counting the hidden tax of billing staff time, medical-record retrieval, clinician clarifications, repeated portal uploads, and write-offs from part approvals or procedural deductions. These are analyst calculations using the documented elapsed times below; they are not scheme-notified values. The punchline is blunt: the schemes do not merely delay revenue, they convert hospitals into unwilling working-capital financiers of the payer.

The most actionable operational conclusion is that hospitals should stop treating these schemes as a monolithic “government receivables” bucket. They need **scheme-specific claim factories, pre-bill validation logic, query/NMI turnaround discipline**, and **aged-AR escalation ladders**. The most actionable policy conclusion is equally blunt: **hybrid paper-digital processing, non-public reason-code taxonomies, and vague dispute processes are avoidable design defects, not unavoidable features of Indian public finance.**³

2. Citation: turn23search3; turn26search19; turn42view0; turn44view0; turn30view0; turn33view2; turn59search0; turn60search0.

3. Citation: turn42view0; turn43view0; turn44view0; turn28search10; turn37search15.

Evidence base and framing

This report prioritises **official scheme guidelines, portal documentation, government circulars, parliamentary answers, audit findings, WHO and peer-reviewed studies, and then credible news** where primary material is incomplete. For PM-JAY, the evidence base is strongest because it includes parliamentary answers, CAG audit findings, NHA-linked FAQs/process notes, WHO comparative assessments and peer-reviewed implementation studies. For CGHS, the evidence base is fragmented across empanelment memoranda, circulars, citizen-charter material, and portal-transition notices. For ESIC, public MoU/tender/SOP materials are detailed and unusually explicit about timelines and validation stages. For ECHS, the public SOP is detailed, and recent parliamentary material helps on payment-cycle realities. For WCL SWASTH, public hospital-facing documentation is sparse; the analysis therefore relies on the official portal landing page, an official CPRMSE claim-tracking manual, the WCL annual-report snippet surfaced in search, and official WCL social/LinkedIn descriptions of SWASTH features.⁴

A caution matters. **WCL SWASTH is not a nationwide public health insurance scheme in the same sense as PM-JAY, CGHS, ESIC or ECHS**; it is a PSU-linked healthcare management and reimbursement environment. I have still included it because the user asked for it and because from the hospital's point of view the recovery problem is similar: treatment authorisation, documentation, scrutiny, finance processing, and payment. The evidence for WCL is therefore **directional rather than comprehensive**.

Where public sources do **not** disclose a national rejection rate, a scheme-wide median payment delay, or a publicly downloadable reason-code master, I say so directly. That silence is not a drafting inconvenience; it is itself a governance signal. Hospitals can only improve what they can see, and several of these schemes still operate with poor public observability on hospital AR ageing, reason-code taxonomy, and appeal outcomes.

5. Citation: turn48view0; turn53view0; turn59search0; turn60search0.

Cross-scheme comparison

The table below pulls together the most policy-relevant comparison points.

Table note: PM-JAY clocks and realised turnaround time come from parliamentary answers, CAG/FAQ material and WHO comparative assessment; CGHS parameters come from CGHS

circULARS and citizen charter/grievance material: ESIC para Ayushman Pre-authentication WHO comparative Claim rejection rates SHA/insurer, Blunders come from public ESIC MoU/SOP documents, ECHS PM-JAY working hours: claim decision times states vs 4.8% in hospital-spec helpline 1441 material: WCL days from the official portal CDRMSE manual, annual report snippets and official WCL communica claim irregularities: tions. 6 30 days portability 48 days in Truste states delay, wrong package grievance sys under PM-JA selection, documentation and fraud/abuse flags

A second comparison helps more than a seminar, because claim pain is usually born in the same five chokepoints.

CGHS	Legacy/UTI-ITSL guidance aimed for provisional payment within 10 days of physical-bill submission; online paperless billing migrated to NHA IT/TMS from 2021	Current pan-India hospital payment ageing is not publicly consolidated in sources located for this review	Public criteria include incomplete referral/permission support, package overbilling, missing digital records, and from 2025 missing geo-tagged photographs with upload rules	BCA / city Additional Director / CG grievance por / national helpline 1800-208-8
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Scheme	Publicly documented core clock	Publicly evidenced realised cycle	Publicly evidenced rejection / hold pattern	Escalation routes visible in public sources
ESIC UTI BPA	Hospital intimation in 4-24 hours depending on clause; upload claim docs within 7 working days ; physical bills within 7 working days and not beyond 30 days unless waived; ESIC verification 3 working days ; BPA 10 working days after last query/NMI window; ESIC approval 3 working days ; finance 3 working days	No public all-India average found; a clean claim can still run close to a month in calendar terms, longer with NMI loops	Explicit validation layers: identity/date/referral validity mismatch, non-mapped hospital, claim without referral, part-payment by patient in cashless pathway, unsupported stay/extensions, unnecessary procedures, missing hard copies, delayed NMI replies	ESIC Hospital/SMO Regional Director office, separate dispute process, arbitration clauses in MoU

6. Citation: turn21view0; turn15search3; turn62search2; turn18search8; turn23search3; turn26search14; turn28search10; turn42view0; turn43view0; turn44view0; turn30view0; turn33view2; turn37search15; turn37search18; turn48view0; turn53view0; turn59search0; turn60search0.

<p>Table note: the PM-JAY entries are drawn from CAG findings, WHO comparisons, and implementation studies; CGHS from circulars and audit/tracking materials; ESIC from public MeU/SOP documents; ECHS from SOP and recent parliamentary material; WEB from the official CPRMSE manual and official SWASTH descriptions.</p>			
	<p>Technical/Documentation bottleneck</p> <p>State-to-state Query-heavy claims, delayed claim</p> <p>process-to-state initiation in some states, Punjab is a low-cost state, Regional Centres made in private hospitals, official SWASTH descriptions.</p> <p>performance one clear end-to-end payment SLA; finance instructions require expeditious processing and FFO discipline</p>	<p>Documentation bottleneck</p> <p>Query-heavy claims, delayed claim</p> <p>initiation in some states, Punjab is a low-cost state, Regional Centres made in private hospitals, official SWASTH descriptions.</p> <p>empanelled-hospital bill normally takes about two months; Government has also admitted cyclic carry-forward and occasional fund-flow constraints</p>	<p>Coding/package</p> <p>Wrong package</p> <p>Regional Centres</p> <p>disputes, jurisdiction</p> <p>ECHS, and claim-routing higher sanctioning levels depend on bill size</p> <p>valid referral except emergency, missing approval for unlisted procedure or extended stay, inadmissible extras within package, missing implant/invoice support unjustified</p>
CGHS	<p>NHA-platform transition on top of legacy BCA habits; still paper-plus-digital in practice</p>	<p>Referral/permission dependence, mandatory digital medical records, geo-tagged photo rules</p>	<p>Package/rate conformity and non-admissible extras</p>
ESIC	<p>Publicly visible multiple windows, only no multiple digital states window located</p>	<p>No public parity with up to NMyet, age dashboard located</p>	<p>Official copy, show document-deficiency remarks, finance-stage movement and cash-section crediting for CPRMSE claims; official SWASTH communications mention hospital logins, QR sanction orders and real-time record updates, but not a public rejection-code master</p>
SWASTH	<p>Publicly visible multiple windows, only no multiple digital states window located</p>	<p>No public parity with up to NMyet, age dashboard located</p>	<p>Referral package validation Department / designated no contacts</p>

Ayushman Bharat PM-JAY
Schedule/portal bottleneck

Coding / package
 bottleneck

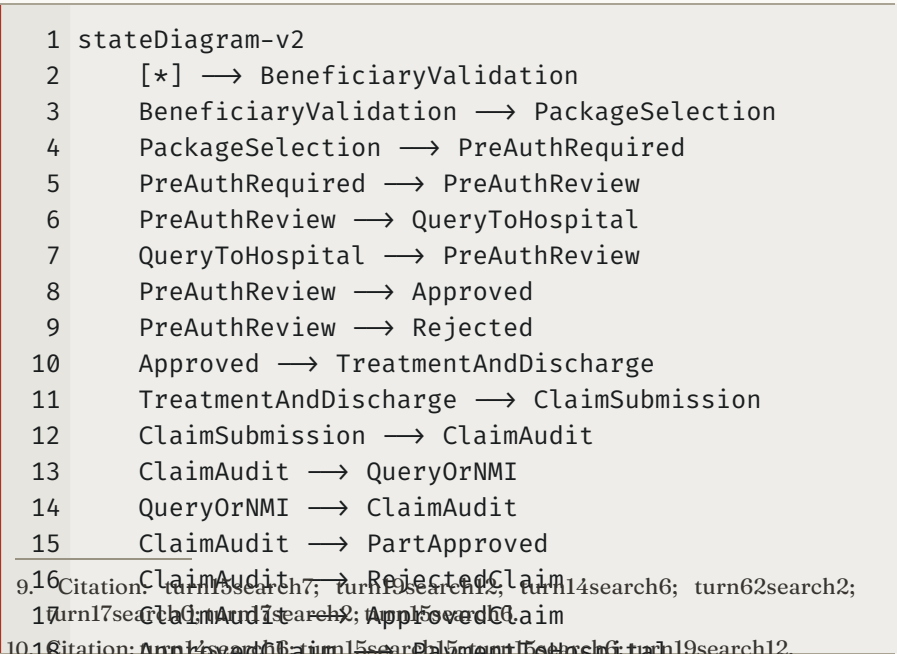
PM-JAY's hospital recovery problem is a study in contrasts. On paper, it is among the most modern systems in this set, public policy material indicates **six working hours** for pre-authorization decisions and **15 days** for intra-state claims settlement, **30 days** for portability claims. In practice, the comparative evidence says performance diverges sharply by operating model: Insurance states processed claim decisions far faster than Trust states, and Trust states also showed higher rejection rates. Public and private hospitals do not always experi-

ence that divergence identically, and some states look much worse than the mean. Operational bottlenecks are concentrated in six places. First, **pre-authorisation timing**: the six-hour target is calculated inside defined working hours and excludes time when the hospital is expected to answer a query, which means "SLA met" can still feel slow on the ground. Second, **package and code selection**: in Bihar, an RTI-based analysis reported that a large share of rejected pre-authorisations were linked to delay, wrong package selection, or non-compliance. Third, **late claim initiation and file discipline**: CAG found instances of delays from **one to 404 days** in processing rejection cases, claims raised **16 to 504 days** late in Ladakh test checks, and hospitals in Rajasthan paid even when claims were filed beyond prescribed timelines without penalty. Fourth, **state-model variation**: Trust and Insurance models differ materially in staffing, operating logic, and claims management. Fifth, **rate dissatisfaction**: multiple implementation studies report provider concern over low package rates and

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delayed reimbursement. Sixth, **fraud-control overlays**: NHA and states have strengthened audits and anti-fraud controls, which may protect the scheme but also add friction to normal recoveries.⁹

The documented rejection parameters are clearer than public “reason-code masters”. Publicly accessible sources support the following rejection or reduction triggers: **wrong or expired beneficiary validation, inappropriate or wrong package selection, non-compliance with package or scheme rules, insufficient or delayed documentation, fraud / abuse / incorrect entries, and claim delays beyond prescribed windows at state level**. Public code lists visible to hospitals inside state systems were not located in open sources for this review, so the table here uses public criteria rather than a downloadable codebook.¹⁰



The workflow above reflects the public PM-JAY architecture: beneficiary validation, package selection, pre-authorisation where required, treatment, claim submission, audit/adjudication, payment, and grievance/appeal. Pre-authorisation is meant to run inside a six-working-hour logic, and claim settlement is officially expected within 15/30 days after claim submission; hospitals can escalate payment irregularities through the hospital-specific helpline **14413**, while broader grievance systems also exist.¹¹

For cash flow, PM-JAY is the only scheme here with reasonably solid comparative timing data. If a hospital's receivable under PM-JAY sits at **₹1 crore**, the difference between the official **15-day** expectation and the WHO-observed **48-day** Trust-state average decision time is the difference between roughly **₹0.49 lakh** and **₹1.58 lakh** of annual carrying cost at a 12% funding rate, before denials, deductions or staff time. That spread is not abstract; it is the cost of operating in one administrative design versus another.

11. Citation: turn15search3; turn21view0; turn20search0; turn19search9.

CGHS

CGHS is the scheme where the paperwork's ghost still walks the corridors, even after digitisation. Public orders show that CGHS shifted hospital-bill processing onto the **NHA IT platform for paperless hospital billing** in 2021, yet the publicly visible operating logic still includes **BCA-led processing, electronic billing, digital medical records, and physical-bill routing to the BCA or the office of the Additional/Joint Additional Director in some cases**. In other words, the scheme looks digitally modern at the front but still carries legacy processing DNA in the spine.¹²

The hospital-facing bottlenecks fall into five clusters. First, **hybrid process design**: the coexistence of NHA/TMS-style online billing and physical-bill/BCA handling creates reconciliation risk, especially where documents, scan quality or indexing differ. Second, **evidence burden**: CGHS now requires **geo-tagged photographs** in specified inpatient situations; for hospitalisation beyond seven days, an additional geo-tagged photograph is required every seventh day, and photographs must be uploaded in real time or within **24 hours**. Third, **non-public reason coding**: while public circulars state that non-compliance can lead to withholding of payment or rejection, there is no public pan-India codebook that hospitals can build their denial analytics around. Fourth, **rate and admissibility policing**: empanelment agreements repeatedly emphasise CGHS rates, non-admissibility of extras beyond package logic, and consequences for overbilling. Fifth, **diffuse escalation**: hospitals may interact with the BCA, city

12. Citation: turn23search3; turn37search16; turn26search19; turn28search1; turn28search6.

Additional Director, TMS, or grievance route depending on claim type and beneficiary category.¹³

Publicly documented rejection or hold parameters under CGHS include at least these items: **missing or invalid referral/permission support, incomplete electronic or physical bill sets, missing digital medical records, package/rate non-compliance, overbilling, and from 2025 failure to comply with geo-tagged photograph requirements.** The circular language is explicit that non-compliance can trigger **withholding of payments and/or rejection of claims.** A public all-India rejection-rate series was not located for this review.¹⁴

```

1 flowchart LR
2   A[Referral or permission<br/>or emergency
   admission] → B[Treatment]
3   B → C[Hospital captures records<br/>and
   required geo-tagged photos]
4   C → D[Electronic claim on NHA/CGHS
   platform]
5   D → E[Physical bill and records<br/>to
   BCA or city office where applicable]
6   E → F[BCA / CGHS scrutiny]
7   F → G{Complete and admissible?}
8   G -- No → H[Query / withhold /
   rejection]
9   H → C
10  G -- Yes → I[Payment to hospital]
11  I → J[If dispute: grievance portal /
   helpline / Additional Director]

```

A legacy CGHS guideline routed via UTI-ITSL said the mechanism was intended to ensure **provisional payments within**

13. Citation: turn25search0; turn26search17; turn28search10; turn26search7; turn28search6; turn28search7

14. Citation: turn28search10; turn25search0; turn26search19; turn23search2.

10 days of submission of physical bills, which is administratively attractive. The problem is not the absence of target language; it is the coexistence of new digital controls and old handling habits, plus the lack of a public current-ageing dashboard for hospital claims. CGHS also provides a national helpline (**1800-208-8900**) and a grievance portal, but those are support routes, not a substitute for transparent payment analytics.¹⁵

Because current pan-India hospital-cycle data are not publicly consolidated in the sources located, CGHS cost quantification has to remain scenario-based. If a clean CGHS claim clears in a legacy-style **10–30 day** window, the carrying-cost burden is modest; if hybrid processing or digital-evidence issues stretch it into **60+ days**, the cash cost looks much more like ECHS than like an efficient digital payer. The governance gap here is straightforward: **CGHS enforces more digital evidence, but does not publicly expose equivalent public data on hospital receivable ageing by stage.**

15. Citation: turn26search14; turn28search2; turn28search3.

ESIC UTI BPA

ESIC's UTIITSL/BPA architecture is the most formally parameterised hospital-claims workflow in the set. That is good news if you like process clarity, and bad news if you are a hospital with weak billing discipline. In the public ESIC MoU/-SOP material, the hospital must acknowledge the referral, send online intimation with clinical details within **4 hours** in one clause-set and within **24 hours of admission** in another, upload digitally signed claim papers within **7 working days** after discharge, submit physical hard copies within **7 working days** and not beyond **30 days** unless a waiver is obtained, after which the ESIC institution verifies within **3 working days**, BPA scrutinises within **10 working days** after the relevant verification/NMI event, ESIC approvers act within **3 working days**, and finance is supposed to complete deduction and payment within another **3 working days**.¹⁶

That design creates two types of bottleneck. The first is **strict rules friction**. The validation stack includes name mismatch, insurance-number mismatch, date mismatch, expired referral validity, continuity/extension mismatch, wrong mapped hospital, and missing seal/signature on the referral. Claims without referral are to be **summarily rejected**, and if a supposedly cashless patient has partly paid the hospital for an implant or similar item, BPA may also **summarily reject** the claim at the recommendation level. The second is **loop friction**. ESIC institutions can raise "Need More Information" within **seven working days**; hospitals then have **15 days** to respond, failing which claims are processed on available records and may be treated as closed. BPA itself can also return bills under NMI,

16. Citation: turn42view0; turn43view0; turn44view0.

followed by a hospital response window and then a **48-hour** post-scrutiny rectification viewing window before the file moves on. The process is transparent, but it is not forgiving.
17

Public regional ESIC documents also show a policy-design inconsistency worth naming plainly. Several older or parallel empanelment documents still state that bills sent **beyond 15 days shall not be entertained**, while newer MoU/SOP material allows physical submission within 7 working days and up to **30 days** with waiver logic. That inconsistency matters because hospitals build operating discipline around the strictest rule they have seen, not the most elegant rule on paper.¹⁸

```
1 stateDiagram-v2
2     [*] → ReferralGenerated
3     ReferralGenerated →
4     HospitalAcknowledgement →
5     AdmissionIntimation → Treatment
6     Treatment → DigitalClaimUpload
7     DigitalClaimUpload →
8     PhysicalBillSubmission →
9     ESICVerification → NMIFromESIC
10    NMIFromESIC → ESICVerification
11    ESICVerification → BPAScrutiny
12    BPAScrutiny → NMIFromBPA
13    NMIFromBPA → BPAScrutiny
14    BPAScrutiny → Hospital48hReview
15    Hospital48hReview → ESICApproval
16    ESICApproval → FinanceProcessing
17    FinanceProcessing → Payment
18    ESICApproval → RejectedOrPartApproved
19    RejectedOrPartApproved →
20    DisputeResolution → [*]
21    Payment → [*]
```

17. Citation: turn43view0; turn44view0.
18. Citation: turn40search15; turn40search12; turn40search13; turn42view0.

The workflow's cost implication is ugly but measurable. A **clean claim** can still consume roughly a calendar month once hospital submission time is included. A claim that hits both ESIC-side and BPA-side NMI loops can stretch much longer, and the public rules explicitly make delayed clarification the **sole responsibility of the hospital**. On **₹1 crore** of outstanding ESIC receivables, a notional **36-day** clean path at 12% funding cost is about **₹1.18 lakh** annually; a roughly **78-day** NMI-heavy path is about **₹2.56 lakh**. Those are not official ESIC figures; they are analyst calculations based on the documented timing architecture above.¹⁶

ECHS

ECHS is structurally different from the pure insurance-style systems because it is rooted in a strong **referral-and-sanction culture**. The public SOP still matters. It routes care through ECHS polyclinics except for emergencies, defines package-duration rules, requires approval for unlisted procedures, and contains a detailed bill document checklist including membership proof, referral form, emergency certificate where applicable, admission case note, original bill sets, prior approvals, discharge summary, chronological investigation reports, implant stickers/pouches and procedure-specific supporting material. Claims are uploaded on the **UTIITSL website in PDF format** and submitted in physical form to the **Regional Centre**.¹⁹

ECHS bottlenecks arise from three structural sources. First, **referral rigidity and policy ambiguity**: a 2025 ECHS advisory had to clarify that hospitals were misinterpreting special provisions for beneficiaries aged **70 years and above**, causing harassment; it clarified that listed investigations, including CT/MRI/PET and others above ₹3,000, did not require separate polyclinic referrals when properly prescribed. Second, **sanction layering**: the SOP's bill workflow shows different handling bands, Regional Centre scrutiny, Central Organisation review for higher-value bills, and MoD sanction for very large items. Third, **budget-cycle and fund-flow stress**: recent parliamentary material states that processing of empanelled-hospital bills is dynamic and time-taking, that bills generated late in a financial year often clear in the next financial year, and that occasional fund-flow constraints

19. Citation: turn30view0; turn32view0; turn33view0.

can affect the payment cycle. A parliamentary committee was told that an empanelled-hospital bill **normally takes approximately two months** to process.²⁰

The public rejection or reduction criteria under ECHS are especially concrete. Additional stay beyond package duration is payable only if justified and approved; no extra stay is allowed if prolonged recovery is due to infection from improper procedure or negligence. Unlisted procedures, implants and tests need prior approval. Post-discharge drugs are payable only for **7 days**. Ambulance charges are not admissible. Package-period medical management is part of the package and extra billing is not allowed. Implant invoices require matching pouches and stickers. For beneficiary claims, an important protective rule exists: if a claim is not recommended, **intermediate functionaries are not supposed to reject it themselves**; it must be forwarded to Central Organisation ECHS with detailed reasons.²¹

1 flowchart TD

2 A[Referral from ECHS Polyclinic
or
emergency entry] → B[Treatment at
empanelled hospital]

3 B → C[Hospital upload on UTIITSL

and physical bill to Regional Centre]

4 C → D[Polyclinic / Regional Centre
verification]

5 D → E[Medical scrutiny and worksheet]

6 E → F{Bill value band}

7 F → |Lower bands| G[Regional Centre
approval]

8 E → |Higher bands| H[Central

20. Cited in Organisation of Medical Sanction Search 18; turn37search15.

9 G → I[FCS payment to hospital]

21. Citation: turn30view0; turn32view0; turn33view3.

10 H → I

11 D → J[Observation / query /
clarification]

12 J → C

13 E → K[Not recommended]

The financial effect is painfully visible in public anecdotes as well as official admissions. A Times of India report from Goa described a private ECHS-empanelled hospital halting service after dues reportedly reached **₹5.2 crore**; the Defence Ministry's own parliamentary responses have attributed delays to verification intensity, carry-forward liability and occasional fund-flow constraints rather than to a formal withholding of funds. In practice, that distinction matters little to a hospital payroll. On a **₹1 crore** ECHS receivable delayed for the "normal" **two months**, annual carrying cost at 12% is roughly **₹1.97 lakh**.²²

22. Citation: turn29search14; turn37search18; turn37search11.

WCL SWASTH

WCL SWASTH is the least transparent scheme in public source terms, but not the least interesting. The public portal visible through search is a sign-in page for **SWASTH – Smart Wellness & Assistance System for Treatment & Health**. Search-surfaced official and quasi-official descriptions say the system is a comprehensive platform for **managing empanelled hospitals**, gives hospitals **role-based logins**, uses **QR-based sanction orders**, shows **real-time updates** including patient photos, doctor information, bills and discharge summaries, and aims to reduce office visits while speeding reimbursement and increasing transparency.²³

What is publicly documented in more detail is the linked **CPRMSE** reimbursement/tracking side for retired executives. WCL's CPRMSE manual says the PRMB cell created an online portal to track claims; it lists a pre-submission checklist that includes a completed claim form, medical card copy, original prescription, original pharmacy bills, and in some emergency/non-empanelled cases an emergency certificate plus detailed bills and discharge summary. Once bills are submitted, the portal status moves from **“Bill is received and sent for scrutiny”** to potential pendency at Medical Department if documents are missing; after scrutiny, the bill is sent to **Finance Department**, then to **Cash section** for payment, with SMS updates and credited amount visible in the completed-bills menu.²⁴

²³ Citation: turn48view0, turn59search0, turn57search3, turn60search0, turn60search1, turn59search11.
²⁴ Citation: turn53view0.

risation capture, real-time documentation quality, scrutiny remarks, and finance-stage processing. The likely strengths are also visible: QR-based sanctioning, role-based hospital access and real-time record capture should reduce late-document chaos if implemented consistently. The unresolved issue is that **no open hospital-facing SOP, SLA, rejection master, or payment-age series was located in public sources.** So the right conclusion is not guesswork but disciplined modesty: WCL SWASTH likely reduces front-end authorisation friction, but its back-end payment performance still needs primary data from hospitals and WCL finance teams.

```
1 flowchart LR
2   A[Sanction / referral generated] →
3   B[Hospital login / QR-based acceptance]
4   B → C[Treatment and real-time record
5   updates]
6   C → D[Upload bills / discharge summary
7   / supporting documents]
8   D → E[Medical scrutiny]
9   E → F{Any pending documents?}
10  F -- Yes → G[Status: pending at Medical
11  Dept]
12  F -- No → H[Sent to Finance Department]
13  H → I[Cash section / account credit]
14  I → J[Status update / completion]
```

For cost quantification, WCL is the place where the report must be honest rather than overconfident. Public timing data are not sufficient to estimate a median payment delay. The right operational move for any hospital materially exposed to WCL is to collect its own stage-ageing data immediately and not wait for public disclosure.

Cost model and mitigation priorities

The basic working-capital arithmetic is simple and merciless:

**Carrying cost = receivable amount × annual funding cost
× delay days ÷ 365**

Using **₹1 crore** receivable and **12% annual funding cost**, the carrying cost looks like this:

```
1 xychart-beta
2   title "Illustrative carrying cost on ₹1
   crore receivable at 12% annual funding cost"
3   x-axis ["15d", "48d", "60d", "120d"]
4   y-axis "₹ lakh" 0 → 4.5
5   bar [0.49, 1.58, 1.97, 3.95]
```

Those values are author calculations using the documented or modelled delay points described above. The scheme-specific examples most useful for finance teams are these:

For a hospital carrying **₹5 crore** of exposed government-scheme receivables, multiply those figures by five. That is the part finance sees. Operations carries another cost layer: if a clean claim costs roughly **20–30 staff minutes** to assemble and a queried or rejected claim costs **60–120 minutes** including record retrieval and clinician clarification, then each avoidable NMI loop becomes a direct labour leak as well as a cash leak. Those time estimates are analyst assumptions for planning, not published benchmarks.

Scenario	Delay basis	Carrying cost on ₹1 crore @ 12%
PM-JAY official intra-state target	15 days	₹0.49 lakh
PM-JAY Trust-state claim decision average in WHO comparison	48 days	₹1.58 lakh
ECHS “normal” hospital bill processing reported to parliamentary committee	~60 days	₹1.97 lakh
ESIC clean-path model with documented submission/approval stages	~36 calendar days	₹1.18 lakh
ESIC NMI-heavy model	~78 calendar days	₹2.56 lakh
Severe delayed-payment scenario across any scheme	120 days	₹3.95 lakh

Mitigation	What it fixes	Indicative impact	Complexity
<p>The policy recommendations above are not dreamy. They follow directly from the choke points in the workflows. If a scheme uses digital submission, but still requires large volumes of manual paper reconciliation, it is asking hospitals to do double-entry clerical theatre. If a scheme can reject or reduce claims, but does not publish a standard reason taxonomy, it is sabotaging provider self-correction. If a scheme knows its own stage agents, but does not publish a dashboard-level statistics, it is choosing opacity.</p>	<p>Wrong package missing referral field, missing documents, length-of-stay violations</p> <p>Claims dying in inboxes and expiry windows</p>	<p>Can cut avoidable queries/rejections materially; analyst estimates 20-40% reduction in preventable defects</p> <p>Analyst estimate: 5-15% day reduction in avoidable stage ageing for ESIC/ECHS/CGHS-heavy portfolios</p>	<p>Medium</p> <p>Low</p>
<p>Scheme-specific rules engine before submission</p>			
<p>Pre-discharge evidence pack</p>	<p>Missing summaries, approvals, implant stickers, geo-tagged images, emergency certificates</p>	<p>Reduces post-discharge chasing and clinician rework</p>	<p>Low</p>
<p>Payer-wise coding and package library owned by revenue cycle, not by memory</p>	<p>Package mismatch and rate leakage</p>	<p>Particularly high value for PM-JAY and ESIC</p>	<p>Medium</p>
<p>AR ageing by stage, not just by payer</p>	<p>Hidden inventory in “query pending”, “hardcopy mismatch”, “finance processed not paid”</p>	<p>Converts vague frustration into actionable escalation</p>	<p>Low</p>

Open questions and primary data to collect

Focus on matrix Files stuck For PM-JAY, CGHS, Low
 with clock without ESIC and ECHS, ESIC and ECHS,
 triggers consequences creates disciplined
 The biggest evidence gaps are not small. **CGHS does not publicly expose a pan-India hospital-claims ageing series in the sources located for this review. ESIC publishes the rule-book more clearly than it publishes realised payment statistics. ECHS publishes process documents and explains delays, but not a public time-series of claim-age buckets by Regional Centre. WCL, SWASTH has the thinnest public evidence base of all. Those gaps should be treated as a primary data agenda, not as a footnote.**

Interest on Payer-side database Strong incentive High
 automatic working-capital realignment;
 compensation on cost onto especially useful for
 package/procedure code, admission date, discharge date, claims
claims amount, submission date, hard-copy receipt date if

applicable, first-query date, query reason, response date, approval date, paid amount, deduction amount, payment date, appeal date, appeal outcome, and responsible internal owner. Add three operational fields that most hospitals forget and later regret: **portal downtime minutes, time spent per claim by staff, and clinician clarification count.** That is where hidden admin cost becomes visible.

The most decision-useful primary study would be a **12-month multi-hospital receivables cohort** by scheme, with at least these cuts: public vs private hospital, single-specialty vs multi-specialty, state of operation, claim-value deciles, and high-frequency packages. For PM-JAY, the key segmentation is **Trust**

vs Insurance mode. For ESIC and ECHS, the key segmentation is **clean claims vs NMI/objection claims**. For CGHS, it is **beneficiary class and city office/BCA route**. For WCL, it is **hospital-facing authorisation-to-payment clock**, because the public record there still shows more architecture than performance.

The short version is this: the money is not merely delayed because hospitals are sloppy or governments are slow. It is delayed because the systems combine **complex clinical purchasing, legacy process inheritance, fraud anxiety, unclear digital-paper boundaries, and weak observability**. Fixing recovery therefore requires work at three layers of abstraction at once: **hospital process discipline, portal and data design, and payer policy reform**. Without all three, the same claims will keep dying of preventable bureaucracy before the cash arrives.