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 mul-

1. Citation: turn21view0; turn62search2; turn18search8.

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

tiple timed “Need More Information” loops; ECHS adds referral rigidity, multi-level approvals and budget-cycle carry-forward stress; WCL SWASTH appears designed to reduce manual 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]

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

4. Citation: turn21view0; turn15search3; turn18search8; turn37search16; turn42view0; turn30view0; turn48view0; turn53view0; turn59search0; turn57search3.

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

authorisation, documentation, scrutiny, finance processing, and payment. The evidence for WCL is therefore **directional rather than comprehensive**. [5]

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.

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 parameters come from public ESIC MoU/SOP documents; ECHS comes from SOP, finance instructions and parliamentary material; WCL comes from the official portal, CPDMSE manual, annual-report snippets and official WCL communications.[6]

Scheme	Publicly documented core clock	Publicly evidenced turnaround	Publicly evidenced rejection / l
Ayushman Bharat PM-JAY	Pre-auth decided within **6 working hours**; claim settlement within **15 days**; intra-state and **30 days** portability	WHO comparative assessment found claim decision times of **14 days** in Insurance states vs **48 days** in Trust states	Claim rejection rates **2.3%** in Insurance states vs **4.8%** in Tru states; lack noted much higher levels in one period; common i include delay, wrong package selection, non-compliance, documentation and fraud/abus
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 incompl referral/permission support, package overbilling, missing digital records, and from 2025 missing **geo-tagged photogra** upload rules

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

Scheme	Publicly documented core clock	Publicly evidenced realised cycle	Publicly evidenced rejection / I pattern
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 hospit claim without referral, part-payment by patient in cas pathway, unsupported stay/extensions, unnecessary procedures, missing hard copi delayed NMI replies
ECHS	Public SOP defines process stages, not one clear end-to-end payment SLA; finance instructions require expeditious processing and FIFO discipline	Parliamentary material says an empanelled-hospi tal bill **normally takes about two months**; government has also admitted cyclic carry-forward and occasional fund-flow constraints	Public disallowance triggers include no valid referral excep emergency, missing approval f unlisted procedure or extende stay, inadmissible extras withi package, missing implant/invo support, unjustified prolonged stay, late/non-complete documentation; intermediate c are not supposed to finally reje beneficiary claims on their ow

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

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 MoU/SOP documents; ECHS from SOP and recent parliamentary material; WCL from the official CPRMSE manual and official SWASTH descriptions.

Scheme deep dives

Scheme	Technical / portal bottleneck	Documentation bottleneck	Coding / package bottlenecks	Audit bottle
PM-JAY	State-to-state process variation and uneven portal	Query-heavy claims, delayed claim initiation in some states, variable provider document quality	Wrong package selection, medical necessity disputes, portability handling	Fraud morta review mistru
WCL SWASTH	Hospital-side portal shows sign-in only; no public SLA located	No public payment-age dashboard located	Official materials show document-deficiency holds, remarks, finance-stage movem cash-section crediting for CPR	
CGHS	HHA-platform transition on top of legacy BCA habits; still paper-plus-digital in practice	Referral/permission dependence, mandatory digital medical records, geo-tagged photo rules	Package/rate conformity and non-admissible extras	Overb empar enforc
ESIC	BPA-driven multi-stage workflow; multiple digital status windows	Hard-copy parity with uploaded copy; NMI cycles; waiver logic	Referral-linked package scrutiny, extension/continuity validation	Cashle vulner “part- rejecti over-t scruti
ECHS	Upload plus physical routing plus sanction hierarchy	Referral/EIR/implant/invoice/approval paperwork is heavy	CGHS-linked package constraints, unlisted procedure approvals, extended-stay justifications	Regior verific budge carry- anti-o scruti
WCL SWASTH	Public portal visibility is limited; hospital SOP not open	Missing claim-form fields, card copies, certificates, discharge papers trigger holds	Public coding/rate logic not available	Scruti financ visible taxono public

Ayushman Bharat PM-JAY

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-authorisation 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 experience that divergence identically, and some states look much worse than the mean. [8]

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 materi-

7. Citation: turn14search6; turn19search12; turn17search0; turn17search2; turn23search3; turn26search19; turn28search10; turn42view0; turn43view0; turn44view0; turn32view0; turn33view2; turn37search18; turn53view0; turn59search13.

8. Citation: turn15search3; turn21view0; turn62search2; turn18search8; turn18search3.

ally in staffing, operating logic and claims management. Fifth, **rate dissatisfaction**: multiple implementation studies report provider concern over low package rates and 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]

```
stateDiagram-v2
    [*] ⟶ BeneficiaryValidation
    BeneficiaryValidation ⟶ PackageSelection
    PackageSelection ⟶ PreAuthRequired
    PreAuthRequired ⟶ PreAuthReview
    PreAuthReview ⟶ Approved
    PreAuthReview ⟶ Rejected
    Approved ⟶ TreatmentAndDischarge
    TreatmentAndDischarge ⟶ ClaimSubmission
    ClaimSubmission ⟶ ClaimAudit
    ClaimAudit ⟶ QueryOrNMI
    QueryOrNMI ⟶ ClaimAudit
    ClaimAudit ⟶ ApprovedClaim
    ClaimAudit ⟶ PartApproved
    ClaimAudit ⟶ RejectedClaim
    PartApproved ⟶ PaymentToHospital
    ApprovedClaim ⟶ PaymentToHospital
    RejectedClaim ⟶ AppealOrGrievance
    AppealOrGrievance ⟶ PaymentToHospital
    PaymentToHospital ⟶ [*]
```

9. Citation: turn15search7; turn19search12; turn14search6; turn62search2; turn17search0; turn17search2; turn15search6.

10. Citation: turn14search6; turn15search15; turn15search6; turn19search12.

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**

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

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.

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

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

13. Citation: turn25search0; turn26search17; turn28search10; turn26search7; turn28search6; turn28search3.

package logic, and consequences for overbilling. Fifth, **diffuse escalation**: hospitals may interact with the BCA, city 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]

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

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

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

16. Citation: turn42view0; turn43view0; turn44view0.

17. Citation: turn43view0; turn44view0.

which claims are processed on available records and may be treated as closed. BPA itself can also return bills under NMI, 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]

```
stateDiagram-v2
    [*] ⟶ ReferralGenerated
    ReferralGenerated ⟶ HospitalAcknowledgement
    HospitalAcknowledgement ⟶ AdmissionIntimation
    AdmissionIntimation ⟶ Treatment
    Treatment ⟶ DigitalClaimUpload
    DigitalClaimUpload ⟶ PhysicalBillSubmission
    PhysicalBillSubmission ⟶ ESICVerification
    ESICVerification ⟶ NMIFromESIC
    NMIFromESIC ⟶ ESICVerification
    ESICVerification ⟶ BPAScrutiny
    BPAScrutiny ⟶ NMIFromBPA
    NMIFromBPA ⟶ BPAScrutiny
    BPAScrutiny ⟶ Hospital48hReview
    Hospital48hReview ⟶ ESICApproval
    ESICApproval ⟶ FinanceProcessing
    FinanceProcessing ⟶ Payment
    ESICApproval ⟶ RejectedOrPartApprove
    d
    RejectedOrPartApproved ⟶
```


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

19. Citation: turn30view0; turn32view0; turn33view0.

20. Citation: turn34view0; turn33view2; turn37search18; turn37search15.

bills generated late in a financial year often clear in the next financial year, and that occasional fund-flow constraints 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]

```
flowchart TD
    A[Referral from ECHS Polyclinic<br/>or emergency entry] --> B[Treatment at empanelled hospital]
    B --> C[Hospital upload on UTIITSL<br/>and physical bill to Regional Centre]
    C --> D[Polyclinic / Regional Centre verification]
    D --> E[Medical scrutiny and worksheet]
    E --> F[Bill value band]
    F -->|Lower bands| G[Regional Centre approval]
    F -->|Higher bands| H[Central Organisation / MoD sanction]
    G --> I[ECHS payment to hospital]
    H --> I
    D --> J[Observation / query / clarification]
    J --> C
    E --> K[Not recommended]
    K --> L[Forward with reasons to Central Org]
```

21. Citation: turn30view0; turn32view0; turn33view3.

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; turn59search13.

24. Citation: turn53view0.

That means the hospital-side bottlenecks can be inferred, but not yet measured publicly. The likely choke points are **authorisation 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.

```
flowchart LR
    A[Sanction / referral generated] ⟶ B[Hospital login / QR-based acceptance]
    B ⟶ C[Treatment and real-time record updates]
    C ⟶ D[Upload bills / discharge summary / supporting documents]
    D ⟶ E[Medical scrutiny]
    E ⟶ F{Any pending documents?}
    F -- Yes ⟶ G[Status: pending at Medical Dept]
    F -- No ⟶ H[Sent to Finance Department]
    H ⟶ I[Cash section / account credit]
    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:

```
xychart-beta
    title "Illustrative carrying cost on ₹1 crore receivable at 12% annual funding cost"
    x-axis ["15d","48d","60d","120d"]
    y-axis "₹ lakh" 0 --> 4.5
    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.

> The best mitigations are boring in the way that actually saves money.

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

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-ageing, but does not publish dashboard-level statistics, it is choosing opacity.

Mitigation	What it fixes	Indicative impact	Complexity
Scheme-specific rules engine before submission	Wrong package, missing referral field, missing documents, length-of-stay violations	Can cut avoidable queries/rejections materially; analyst estimate **20–40%** reduction in preventable defects	Medium
Daily NMI / query control tower	Claims dying in inboxes and expiry windows	Analyst estimate **5–15 day** reduction in avoidable stage ageing for ESIC/ECHS/CGHS-heavy portfolios	Low
Pre-discharge evidence pack	Missing summaries, approvals, implant stickers, geo-tagged images, emergency certificates	Reduces post-discharge chasing and clinician rework	Low
Payer-wise coding and package library owned by revenue cycle, not by memory	Package mismatch and rate leakage	Particularly high value for PM-JAY and ESIC	Medium
AR ageing by stage, not just by payer	Hidden inventory in “query pending”, “hardcopy mismatch”, “finance processed not paid”	Converts vague frustration into actionable escalation	Low

Open questions and primary data to collect

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 rulebook 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.

The minimum hospital-side dataset to collect, scheme by scheme, is straightforward: **claim ID, payer, hospital unit, package/procedure code, admission date, discharge date, bill 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.

Mitigation	What it fixes	Indicative impact	Complexity
Escalation matrix with clock triggers	Files stuck without consequences	For PM-JAY, CGHS, ESIC and ECHS; creates disciplined intervention at day thresholds	Low
Policy push for digital-only legally valid claims	Hybrid paper/digital mismatch	Could materially reduce reconciliation friction in CGHS, ESIC and ECHS	High
Public reason-code taxonomy and payment-age dashboards	Hospitals cannot learn from denials they cannot classify	System-level productivity gain; transparency deters arbitrary deductions	High
Interest or automatic compensation on delayed undisputed claims	Payers externalise working-capital cost onto hospitals	Strong incentive realignment; especially useful for ECHS, PM-JAY and CGHS	High

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.