ASSESSING THE OPERATIONAL CHALLENGES AND POLICY GAPS IN ECHS/CGHS EMPANELMENT AND RENEWALS AND ROLE OF HOSPITAL ADMINISTRATORS IN FACILITATING GOVERNMENT HEALTH SCHEME INTEGRATION: A POLICY ANALYSIS BASED ON GOVERNMENT AUDITS AND PUBLISHED REPORTS

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Pharmaceutical Management

by

Adarsh Kale

Under the Supervision and Guidance of

Dr. Saurabh Kumar

2025

Fortis Escorts Hospital
Jawahar Lal Nehru Marg, Malviya Nagar,
Jaipur - 302 017 (Rajasthan)
Tel : +91 141 254 7000
Appointment : +91 141 409 7007
Emergency : +91 141 254 7009
E-mail : contactus.jaipur@fortishealthcare.com
Website : www.fortishealthcare.com

31 May 2025

TO WHOM SO EVER IT MAY CONCERN

This is to certify that Mr. Adarsh Kale has successfully completed his dissertation in the Sales & Marketing Department at Fortis Escort Hospital Jaipur.

The Dissertation period was from 11 March 2025 to 31 May 2025. During this period Mr. Ganesh demonstrated exceptional dedication and commitment to his work, contributing valuable insights and advancements to our departments.

We Acknowledge and appreciate his efforts and wish him all the best in his future endeavours.

Authorized Signatory

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation title **"Assessing the Operational Challenges and Policy Gaps in ECHS/CGHS Empanelment and Renewals and Role of Hospital Administrators in Facilitating Government Health Scheme Integration: A Policy Analysis Based on Government Audits and Published Reports"** is a record of the research work undertaken by **Adarsh Kale** in partial fulfillment of the requirements for the award of the degree of MBA Pharmaceutical Management from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide
Dr. Saurabh Kumar Banerjee
School of Pharmaceutical Management
IIHMR University, Jaipur
Date: 24-06-25

School Dean
IIHMR University, Jaipur
Date: 24-06-25

2025

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **"Assessing the Operational Challenges and Policy Gaps in ECHS/CGHS Empanelment and Renewals and Role of Hospital Administrators in Facilitating Government Health Scheme Integration: A Policy Analysis Based on Government Audits and Published Reports"** is the Bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

ADARSH

Signature

Adarsh Kale

Date: 24-06-2025

ABSTRACT

Objectives: To analyse the operational challenges and policy gaps in empanelment and renewal of hospitals under India's CGHS and ECHS schemes, and to examine the role of hospital administrators in improving scheme integration. We aim to highlight systemic issues revealed by government audits and reports and propose actionable recommendations.

Methods: We conducted a policy-oriented qualitative analysis using secondary data. Key sources included Comptroller and Auditor General (CAG) performance audits, official scheme manuals and circulars, and published studies/surveys of CGHS/ECHS stakeholders. Data were collected from government reports (e.g. CAG audit of ECHS implementation and CGHS procurement), institutional documents (e.g. ECHS FAQs, NABH notifications) and news/media summaries (e.g. recent policy updates and scheme investigations). We synthesized findings thematically: covering scheme background, empanelment criteria and process, observed operational issues, and administrative roles. A literature table summarizes key studies. Analysis focused on identifying divergences between policy intent and ground reality (e.g. delays, fraud, compliance lapses) and on extracting insights for hospital management.

Key Findings: CGHS/ECHS are intended as comprehensive health coverage for government employees, pensioners, and ex-servicemen (4.3 million covered by CGHS; 20 lakh retired service personnel for ECHS). However, audits and surveys reveal serious implementation gaps. Polyclinics are understaffed and poorly supplied, forcing >70% of care to be referral to empanelled hospitals. Empanelment criteria (e.g. NABH accreditation, infrastructure) are inconsistently enforced: one audit found many hospitals non-compliant (277 of 591 CGHS HCOs lacked required accreditation). Reimbursements are routinely delayed, and private providers complain that CGHS/ECHS package rates are below market, causing f financial strain. Fraud and overbilling have been documented: e.g. CGHS recently de-empanelled 19 Delhi hospitals for forging bills. Policy gaps include lack of uniform renewal rules (ECHS MoUs valid 2 years, whereas CGHS validity remains undefined), poor enforcement of accreditation, and weak integration of IT systems for claim verification. New CGHS guidelines (2024–25) address many abuses by mandating bed availability displays, use of generic drugs, mandatory billing protocols, and heavy penalties.

Conclusions: The evidence suggests that both schemes suffer from systemic operational issues – from gaps in scheme design to lapses in oversight – which can jeopardize beneficiary care and scheme sustainability. Hospital administrators are critical to bridging these gaps: by ensuring compliance (NABH/QCI accreditation, banking guarantees), by training staff on guidelines (no denial of service, proper billing), and by liaising with scheme authorities (e.g. updating nodal officers, setting up helpdesks). Effective admin oversight can mitigate overcharging, fraud, and delays. Policymakers must strengthen enforcement (e.g. strict renewal audits, digital integration of records) and expand scheme reach (address urban-centric coverage) to fulfil the schemes' objectives. This analysis provides an evidence-based basis for reforms to improve empanelment processes and hospital engagement, thereby enhancing scheme performance and beneficiary protection.

ACKNOWLEDGMENT

I express my heartfelt gratitude to everyone who supported, guided, and encouraged me throughout the journey of completing my dissertation, undertaken as a part of my MBA in Pharmaceutical Management.

First and foremost, I would like to extend my sincere appreciation to the administration of **Fortis Escort Hospital, Jaipur.** For granting me the opportunity to undergo my dissertation in their esteemed organization.

These invaluable experiences have significantly contributed to my professional and personal development.

A special note of thanks to my hospital mentors —**Dr. Manikant Jain and Mr. Mansingh Gehlot Sir** — for their continuous support, insightful guidance, and for providing me with golden opportunities to learn in a real-time industry setting. Their encouragement and mentorship played a vital role in shaping my understanding of the pharmaceutical sector.

I express my deepest gratitude to **Dr. Saurabh Kumar Banerjee Sir**, my Faculty Mentor and Dean, for his invaluable support, expert advice, and continuous encouragement throughout the course of my dissertation.

His guidance has been instrumental in both my academic and professional growth. My sincere thanks to **Mr. Vinod Tejwani Sir** and the Placement Committee Team for their efforts in coordinating the dissertation process and providing us with all possible assistance.

Throughout the dissertation, I have learned and experienced a great deal that has enriched my knowledge and will serve as a strong foundation in my professional career.

I am committed to applying the insights and skills acquired through this journey in the most meaningful and impactful manner.

Thank you all for being an integral part of my learning journey

Yours Sincerely**,**

Adarsh Kale

TABLE OF CONTENT

Chapter 1: Introduction / Background

The Central Government Health Scheme (CGHS) and the Ex-Servicemen Contributory Health Scheme (ECHS) are cornerstone public health schemes in India, providing cashless healthcare to government employees/ pensioners and military veterans, respectively. CGHS was launched in 1954 to offer "comprehensive medical care" to Central Government employees and pensioners, deploying urban dispensaries and wellness centres plus a network of private empanelled hospitals and diagnostics [8]. Today it covers roughly 4.3 million beneficiaries nationwide. ECHS, introduced in 2003 (effective April 2004), is managed by the Ministry of Defence to serve ex-servicemen (ESP) and dependents. It was designed as "an adjunct to existing Armed Forces medical infrastructure" to reach ~20 lakh pensioners and their dependents (≈10 million total beneficiaries) across India [1]. Both schemes are fully government-funded and operate through direct payment to hospitals (unlike insurance), with specified package rates and protocols.

The empanelment of private hospitals (and other providers) is central to scheme access. Empanelled hospitals agree to treat beneficiaries at CGHS/ECHS-approved rates and abide by scheme rules. By 2024, ECHS had empanelled over 3200 private hospitals nationwide; CGHS has about 800+ across major cities. Hospitals must meet eligibility criteria (e.g. minimum beds, required specialties, NABH accreditation) and sign a Memorandum of Agreement (MoA) with the scheme authority. Once empanelled, they remain so for a fixed period (e.g. ECHS – typically two years) after which renewal or re-inspection is required. Ideally, this system extends government healthcare reach into both public and private facilities.

However, a growing body of evidence – from audits, beneficiary surveys, and media reports – suggests that policy design and ground-level operations are misaligned. For example, retirees in smaller cities report lack of CGHS facilities, forcing them to pay out-of-pocket and wait months for reimbursement. Hospitals frequently cite delays in claim settlement and low package rates as barriers to participation. Auditors have documented issues from resource shortages (dispensaries lacking drugs, diagnostic equipment) to systemic fraud (duplicate billing, overpriced implants). These challenges point to operational gaps (e.g. under-capacity, weak monitoring) and policy gaps (e.g. insufficient enforcement of accreditation, outdated renewal procedures). Crucially, the hospital administrator plays a key role in this ecosystem: they must navigate scheme requirements, ensure hospital compliance, and advocate for necessary resources. The success of scheme integration often depends on hospital

management's capacity to implement guidelines and adapt to scheme changes (as we discuss in later chapters). This study builds on government audit findings and published analyses to systematically assess these challenges. We organize the inquiry as follows: Chapter 2 reviews relevant literature and reports on CGHS/ ECHS performance. Chapter 3 details the research design (document review of audits and policies). Chapter 4 presents key results – discrepancies between policy and practice, backed by data from audits and news and discusses implications. Chapter 5 offers targeted recommendations (policy and managerial) to improve empanelment processes. Chapter 6 concludes by summarizing insights on operational realities and administrative strategies for scheme integration. Throughout, we emphasize evidence-based analysis and the interplay of policy intent with hospital-level execution.

CHAPTER 2: REVIEW OF LITERATURE

2.1 CGHS Empanelment and Service Delivery: The literature on CGHS reveals both achievements and persistent criticisms. Kumari et al. (2016) report that while CGHS beneficiaries generally express reasonable satisfaction with the care received (notably higher for empanelled private hospitals than for dispensaries), the participating hospitals themselves are dissatisfied with scheme terms. Specifically, CGHS-package rates are deemed below market norms and reimbursements are routinely delayed. These findings echo industry complaints: in 2019, the Association of Healthcare Providers of India (AHPI) warned that unresolved government dues (estimated at over ₹650 crore) were threatening hospitals' viability under CGHS/ECHS, compelling many to consider halting cashless services. Alongside financial issues, CGHS hospitals have faced compliance pressures; a 2025 Ministry directive mandates standardized treatment protocols, transparent display of rates, and justification for any denial of services. These reforms aim to address beneficiary grievances of overcharging and treatment denial. Academic analyses further emphasize structural challenges. CGHS has often been characterized as strained by rapidly expanding enrolment (over 25 cities by 2016) with limited resources.

The scheme's reliance on manual claim processing and third-party clearing agencies has been criticized for inefficiency. For example, a 2022 CAG audit of CGHS drugs and payments noted that claim settlement is handled by a Bill Clearing Agency (BCA) (UTIITSL) and found systemic delays: cashless payment approvals often exceed prescribed 10-working-day limits, forfeiting significant early-payment discounts (estimated at ₹34.10 crore lost). The audit also highlighted a misalignment between beneficiary databases and billing systems, hampering validation of eligible cases. In summary, CGHS literature points to a need for stronger contract oversight (e.g. enforcement of PBGs), better digital integration, and rate revision to sustain private hospital participation.

2.2 ECHS Empanelment and ESM Welfare: Research on ECHS has been more limited in academia, but veteran advocacy reports and audit analyses provide insight. The ECHS scheme was envisaged to extend CGHS-style cashless care to ex-servicemen, utilizing both military and civilian health resources. However, veteran commentators note serious shortfalls: as early as 2015, a CAG audit found that ECHS polyclinics suffered medicine stockouts and equipment shortages, and that administrative controls were weak. Anecdotal accounts (e.g. Dinesh Kumar 2025) lament routine payment delays that force veterans to pay out of-pocket, understaffed

polyclinics, and lengthy referrals for specialized care. Such reports also highlight rural-urban disparities, with veterans outside major cities facing far fewer facility choices. Importantly, the 2015 audit uncovered egregious billing irregularities: thousands of hospital bills (worth over ₹23.6 crore) were processed without proper authorization, leading to duplicate and inflated payments. These findings indicate that policy gaps (e.g. lack of real-time audit, unclear sanctions for noncompliance) contributed to scheme inefficiencies and resource leakage.

2.3 Hospital Administration and Scheme Integration: Though there is scant literature focusing specifically on hospital administrators' roles in CGHS/ECHS integration, broader health management studies underscore the importance of administrative leadership in interfacing with public schemes. Administrators must navigate regulatory requirements, ensure compliance (e.g. accreditation, MOA terms), and build hospital processes (like dedicated claims teams) to engage with external payers. For example, studies of 3 Ayushman Bharat/PM-JAY (a national insurance scheme) highlight that strong hospital management teams and information systems are critical for seamless claim processing and network accountability. By analogy, CGHS/ECHS integration similarly demands that hospital leaders align internal workflows (billing, patient verification, reporting) with government protocols. This review suggests that empowering hospital administration – through staff training, robust record-keeping, and proactive communication with scheme authorities – is key to bridging policy design with operational reality

CHAPTER 3: METHODOLOGY

Research Design

This study employs a qualitative policy analysis framework. We performed a comprehensive document review and content analysis of secondary data to assess CGHS/ECHS empanelment and renewal processes. Sources include official government audit reports (CAG performance audits of ECHS and CGHS), scheme guidelines and handbooks, and relevant academic and media publications. Data synthesis focused on identifying discrepancies between policy prescriptions and ground realities, as well as on administrative factors.

Data Sources and Collection

Government Audit Reports: Major data comes from CAG reports, notably the 2015-16 ECHS performance audit [2] and the 2022 CGHS procurement audit [3], which provide findings on scheme implementation, financial controls, and hospital compliance. These reports are publicly available and extract key metrics (e.g. fraud incidents, compliance rates).

Scheme Policy Documents: We reviewed official ECHS and CGHS guidelines and circulars (e.g., ECHS FAQs 2023 5 and 2024 newsletter 25, NABH/QCI empanelment notifications 4) to outline the formal empanelment procedures, criteria, and renewal rules. These documents inform the intended processes and validation requirements (e.g. NABH accreditation).

Published Literature: Peer-reviewed studies (such as Vellakkal et al., 2012) provide empirical insights (satisfaction surveys) and critique of scheme operations. We also considered academic papers on related scheme integration and hospital administration as context.

Media and Reports: Recent news articles and press releases (Financial Express, Times of India, Medical Dialogues) capture real-time developments (e.g. new CGHS guidelines 1 suspensions 6 7, hospital). These were used to illustrate current issues and policy responses. All sources were searched via academic and government websites. Key search terms included "CGHS empanelment", "ECHS audit report", "hospital administrator CGHS guidelines", etc. The literature table in Chapter 2 summarizes major findings from published studies and audits.

Data Analysis

Analysis involved qualitative synthesis and thematic categorization. We compared policy content (e.g. eligibility criteria, required documents, validity period) with audit findings (reported shortfalls, irregularities) to identify operational challenges and policy gaps. For

example, if an audit noted that many hospitals lacked NABH accreditation [3], we examined the corresponding accreditation policy to pinpoint enforcement gaps. We also contrasted CGHS and ECHS processes where applicable (noting overlaps such as ECHS recognition of CGHS-empanelled hospitals). Findings from different sources were triangulated for reliability (e.g. audit data with news reports of overcharging incidents).

Ethical Considerations

This research used only publicly available documents and aggregate data; no human subjects or private records were involved. The analysis is thus exempt from human subjects review. All sources are cited, and no proprietary or sensitive information is disclosed. We adhered to academic integrity by referencing original reports and publications.

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Empanelment Processes: Criteria and Procedures

CGHS Empanelment: The CGHS empanelment process (for private hospitals/clinics) is governed by MoHFW guidelines. Typically, a hospital must have requisite infrastructure (e.g. number of beds, specialty services) and adhere to quality standards. In 2024–25, new directives explicitly require NABH (or QCI) accreditation for renewal, though initial empanelment can occur without NABH if inspected by QCI. Empanelment validity is not fixed uniformly; NABH recently noted that CGHS letter validity is set by the CGHS head office, indicating potential variability. Hospitals must sign a MoU with CGHS and commit to package rates.

ECHS Empanelment: For ECHS (run by Defence), the process is linked to CGHS status.

ECHS recognizes CGHS-empanelled hospitals: a hospital already on CGHS rolls need only furnish the CGHS OM and MoU to ECHS, plus a QCI report if non-NABH. Non-CGHS hospitals must apply anew: ECHS facilitates a QCI inspection (hospital pays fees) and then forwards the report to the Screening Committee. Successful hospitals receive a government order (GL Note) and sign a two-year MoA . ECHS empanelment is 13 6 4 explicitly two-year, renewable subsequently (renewal requires resubmission to screening committee) [4].

Administrative Role: In both schemes, hospitals designate a Nodal Officer responsible for scheme liaison. Recent CGHS rules mandate immediate notification of any change in the Nodal Officer's details. Hospitals must maintain a CGHS helpdesk onsite to assist beneficiaries. Administrators oversee ensuring that all empanelment criteria remain satisfied (e.g. up-to-date equipment, staff rosters) and that renewal applications are submitted timely. Notably, NABH guidelines advise applying for renewal three months before expiry 27 28 29 to avoid de-empanelment.

4.2 Operational Challenges and Compliance Issues

The audit reports and media reports reveal numerous operational difficulties in adhering to empanelment and renewal policies:

• **Accreditation and Quality Standards:** Many hospitals lag in meeting accreditation requirements. In a CGHS drug procurement audit, 277 out of 591 listed CGHS hospitals lacked NABH/NABL accreditation, and CGHS had no records of mandatory QCI recommendations for them. This suggests poor enforcement: even though CGHS requires quality checks within

one year of empanelment, oversight was lax. Similarly, ECHS FAQs indicate hospitals must get QCI inspection if non-NABH [5], but the burden is on hospitals to apply and pay. In practice, delays or omissions in accreditation mean some "empanelled" hospitals may not truly meet standards.

Financial and Billing Irregularities: CAG audits expose serious fraud. For example, 19 Delhi CGHS hospitals were recently de-empanelled for raising "fake and forged bills" and billing family members repeatedly [6]. The ECHS audit reported ₹23.6 crores of duplicate payments and ₹3.51 crores of inflated bills. The root causes included inadequate internal audits and controls. Hospital administrators must implement strict billing oversight to prevent such malpractice; lapses here reflect both operational failure (e.g. no chain of custody for documents) and policy weakness (light penalties until recently).

• **Delays in Reimbursements:** Both audits and provider surveys note chronic delays in claims processing. The ECHS audit found the Bill Processing Agency (BPA) had no binding contract, so hospitals didn't get timely payments or prompt-payment discounts (costing ~₹34.10 cr) . Likewise, private providers surveyed by Vellakkal et al. cited "delays in reimbursements" as a major grievance. As a result, hospitals may be hesitant to extend credit to scheme patients, undermining cashless care. Administrators thus face cash-flow issues and must lobby to expedite payments.

• **Resource Constraints in Polyclinics:** The CGHS/ECHS polyclinics (government-run centres) are often under-resourced. The ECHS audit noted inadequate drug and equipment stocks, causing 70% of patients to be referred out[10]. CGHS analysis also reports dispensaries are "short-staffed with poor infrastructure". For hospitals, this means taking on high caseloads of referrals (especially for diagnostics). Administrators need to anticipate this volume, staffing emergency rooms and OT capacity accordingly, but often without additional funding.

Beneficiary Awareness and Behaviour: Many beneficiaries lack clarity on scheme rules. Instances were reported of direct emergency admissions without referrals, which complicates billing. The 7 30 Directorate of CGHS now requires hospitals to report such cases within 24 hours or face claim denial. Similarly, ECHS warns patients to always obtain referrals or risk non-payment. Hospital admins must train staff to verify referrals and explain policies to patients. For example, ECHS forbids beneficiaries paying hospitals directly; staff must refuse any such payment (or inform HQ if it happens) to comply with policy.

• **Technology and Data Integration:** The CGHS audit noted the e-claim portal is not integrated with the master beneficiary database. This means hospitals cannot auto-verify a patient's scheme eligibility during billing. For hospital administrators, this requires manual cross-checking and increases risk of rejected claims. It points to a policy gap in IT architecture. Administrators should push for integrated health IDs or linked systems; meanwhile, they must meticulously verify patient status against scheme lists (which they can access via official portals or helplines).

Communication and Support Systems: Beneficiaries report poor responsiveness from scheme offices (unanswered emails/helplines). When hospitals try to resolve billing or referrals issues, they often get no guidance. Hospital admins frequently must escalate to local CGHS/ECHS officials. The new CGHS guidelines aim to rectify some of this by mandating on-site CGHS kiosks and geo tagged case updates. Administrators will play a key role in implementing such measures (setting up kiosks, ensuring compliance with photo-upload rules) to streamline communication.

• 4.3 Policy Gaps and Recent Reforms

The above issues stem from both operational inertia and policy shortcomings. Key policy gaps identified include:

• **Enforcement of Accreditation**: While guidelines call for NABH accreditation, enforcement was historically weak. The recent NABH notification fixes some policy details: ECHS letters (post-June 2024) are valid 2 years, and hospitals must renew via the NABH portal 3 months before expiry or lose ECHS status. However, CGHS renewal rules are still vaguely defined. This inconsistency can lead to confusion among hospital admins about when and how to reapply. Clear, harmonized renewal cycles would reduce lapses in coverage.

Clauses for Performance Guarantees: Many schemes require hospitals to submit a Performance Bank Guarantee (PBG). The CGHS audit found that in Delhi, 305 of 591 HCOs failed to renew their PBGs on time. This implies a gap in monitoring and incentivizing financial guarantees. Hospitals may exploit this to enjoy empanelment without security. Policies need stricter monitoring or automated checks. Administrators should track such deadlines and ensure bank guarantees remain valid as part of contract management.

• 36 Preventing Overcharging and Denial of Service: Multiple complaints of denial of care or excess billing prompted the Health Ministry to issue hard-line guidelines in late 2024 [7].

These mandate hospitals must not deny eligible beneficiaries, must display CGHS package rates publicly, and must follow standardized clinical protocols. They also impose penalties (FIR, de empanelment) for fraud. These rules fill prior gaps where oversight was toothless. Hospital admins now must proactively implement compliance measures (for instance, ensure billing clerks apply correct rates, and signage is up) to avoid punitive action.

- **Coverage Expansion and Equity:** The CGHS was originally urban-centric; only in 2013 were India's f first tier-III cities included. The Times of India (2025) observes that retirees in Tier-2/3 cities still lack accessible CGHS hospitals. This reflects a policy gap in geographic coverage. While hospitals are not policymakers, administrators in underserved regions may lobby for empanelment drives or collaborate with local authorities to expand access.

Integration with National Health Policy: The integration of CGHS/ECHS with newer initiatives (such as Ayushman Bharat / NDHM) is still evolving. For example, use of digital health IDs (ABHA) or linking scheme records with national platforms could streamline processes. Hospitals will need to align their systems accordingly. Currently, such integration is largely absent (a policy gap) and shifts more burden onto hospital managers to manually coordinate across systems. 10 6 In summary, the results highlight a chasm between policy and practice. Many of the challenges are documented in official audits or beneficiary accounts: staffing shortfalls, resource diversions, fraud, and procedural loopholes. Most operational problems (delays, malpractices) are traceable to either insufficient enforcement of existing rules or the absence of key policy safeguards (as outlined above). Hospital administrators sit at the nexus of these issues: they must interpret and apply policy within their facilities, often dealing with outdated IT and limited support. Their effectiveness can either exacerbate or alleviate scheme problems. For example, an attentive admin can quickly address a compliance lapse (e.g. missing PBG) before it leads to de-empanelment, whereas a negligent one can incur scheme penalties.

4.4 Comparative Discussion of CGHS vs ECHS

While CGHS and ECHS have separate governance, their operational realities overlap. Both rely on private hospital networks and share similar payment mechanisms. However, ECHS is bound by Defence ministry protocols, and historically delegated much to a contracted Bill Processing Agency (as CAG noted). CGHS, managed by MoHFW, has also outsourced claim processing (via TPAs in some cities). Recent policy moves (like standardized guidelines [7] apply uniformly.

Key differences: CGHS covers civilian pensioners and has periodic budgetary allocations; ECHS is for veterans and links closely with CGHS (all CGHS hospitals automatically qualify). Despite this, audits show ECHS polyclinics often perform worse (70% referral rate), partly because army hospitals are reserved for active-duty personnel. So, ex-servicemen depend almost entirely on the civilian network. Administrators in ECHS empanelled hospitals may face higher caseloads. 10 25 On compliance, CGHS has only recently issued strict guidelines, while ECHS long had established Standard Operating Procedures (SOPs). Yet ECHS' own newsletter admits detecting "corrupt hospitals… fraudulently add [Ing] multiple ailments… to inflate the bills", indicating enforcement challenges. Both schemes now emphasize transparency and patient rights, but hospital admins must adapt to two different rulesets (e.g. CGHS generic drug policy vs. ECHS's referral-first policy). Integration means hospital management often maintains parallel processes for CGHS, ECHS (and even state schemes).

4.5 Role of Hospital Administrators in Scheme Integration

Our findings underscore that hospital administrators are pivotal in bridging policy and practice:

• Ensuring Compliance: Administrators must establish internal SOPs aligning with scheme rules. This includes training admissions/OPD staff to: verify ECHS/CGHS cards; obtain referrals properly; never demand cash deposits from beneficiaries (an ECHS policy); use generic prescriptions (CGHS rule); and follow ward allocation rules (no downgrading patients). For example, upon new CGHS guidelines, hospitals had to prominently display ward-wise bed availability and CGHS package rates. Admins coordinate these patient-facing changes to prevent violations.

Managing Documentation: Scheme rules require meticulous record-keeping (e.g. collecting attendant signatures on death bills, uploading case photos daily). Hospital administrators must assign staff to handle this digital compliance and ensure the Nodal Officer's contact information is updated in the CGHS portal. They must also track bank guarantees and audit requests, responding promptly if a PBG is expiring or an auditor needs data.

Quality and Accreditation: Admins drive the accreditation process by investing in quality standards. To obtain/renew empanelment, many hospitals must undergo QCI/NABH assessments. Administrators should proactively apply for these inspections (as required) and address any deficiencies. As [52] notes, lack of timely renewal leads to de-empanelment, so admins must schedule re-certifications well in advance. In practice, hospitals with strong

administration are more likely to maintain continuous accreditation and thus uninterrupted scheme access.

Financial Coordination: Since low tariffs and delayed payments are chronic complaints, administrators must manage hospital finances carefully. This can involve negotiating advances (ECHS allows up to 80% advance payment for referrals), and ensuring billing is done immediately to expedite processing. Admins might also liaise with the hospital's accounts department to submit clean claims and follow up on pending reimbursements, reducing cash-flow risks.

Patient Assistance and Grievances: Good administrators foster patient support. For example, CGHS now mandates a helpdesk or kiosk; the hospital admin must establish this and allocate staff. Similarly, ECHS requires feedback forms to be given and forwarded to polyclinics; administrators should integrate this into discharge procedures. By addressing grievances (e.g. if an ECHS patient was incorrectly billed), administrators help build trust and can pre-empt official complaints.

Coordination with Authorities: Administrators often act as the hospital's liaison to scheme offices. They inform CGHS/ECHS authorities about capacity changes (e.g. if the hospital adds new specialties, as ECHS might empanel extra services) and respond to audit inquiries. In the CGHS drug audit, lapses occurred partly because hospitals did not report direct cases of elderly beneficiaries to DGCGHS; diligent admins would institute protocols to report such cases to avoid claim rejection.

In sum, hospital management must be proactive and detail oriented. The schemes' success depends on administrators translating policy into practice on the ground. Negligence (e.g. not updating Nodal Officer details or failing to renew accreditations) can lead to de-empanelment and loss of patient base. Conversely, strong administration ensures hospitals can serve scheme beneficiaries effectively, upholding policy goals.

CHAPTER 5: RECOMMENDATIONS

Based on the above analysis of audits and schemes, we propose the following recommendations to address policy gaps and operational challenges. These are directed both at policymakers and at hospital administrators:

Strengthen Enforcement of Accreditation: The MoHFW and MoD should strictly enforce NABH/QCI accreditation for empanelled hospitals. NABH's new rule (2-year validity, renewal 3 months prior) should be publicized widely. Empanelment should be always made contingent on current accreditation status. Hospital administrators should maintain calendars of accreditation deadlines and engage with QCI bodies proactively.

Standardize Renewal Procedures: For consistency, the CGHS should set a uniform empanelment validity period (e.g. 2 years, matching ECHS practice) and mandate timely renewal applications. Automated reminders from scheme portals could alert hospitals before MoA expiry. Administrators must track these timelines and prepare renewal documentation (updated licenses, NABH certificates) well in advance.

Improve IT Integration: Develop an integrated IT platform linking CGHS/ECHS beneficiary databases with hospital billing systems. This would allow automatic eligibility checks and reduce claim rejections. In the interim, hospitals should verify patient status via official CGHS/ECHS web portals or establish direct digital connections. Administrators should invest in staff training on the required billing software (e.g. CGHS BIS/TMS portal) to reduce data entry errors.

Enhance Monitoring of Hospitals: Scheme authorities should institute periodic third-party audits of empanelled hospitals (e.g. financial audits, medical record audits) to detect fraud early. Instances of malpractice uncovered by ECHS vigilance 25 underscore this need. Hospital admins should conduct internal audits of billing and clinical records to ensure compliance (perhaps with external consultants). Transparent grievance redressal should be enforced so that beneficiaries (or staff whistle-blowers) can report issues.

Timely Payments and Fair Tariffs: Both CGHS and ECHS should review package rates periodically to reflect current costs and retain provider participation. Delayed reimbursements were a major grievance; stricter penalties for processing delays (as now in new guidelines) should be enforced. Hospitals should maintain dedicated claims teams to submit error-free bills

promptly. Administrators might negotiate short-term credit arrangements with providers to cushion the impact of occasional delays.

Capacity Building for Administrators: Government health ministries and professional bodies should offer training to hospital administrators on scheme regulations and digital tools. This could include workshops on recent CGHS/ECHS guidelines (e.g. Financial Express's crackdowns on fraud) and on claims management. Administrators should ensure relevant staff attend these trainings, and that scheme compliance is integrated into hospital standard operating procedures.

• **Expand Geographical Coverage**: The CGHS should expedite inclusion of Tier-2 and Tier-3 cities where govt retirees live, possibly by fast-tracking empanelment of reputable local hospitals. This reduces patient travel burden and OOP spending. Administrators in non-CGHS cities can collaborate with state health departments to promote scheme awareness and facilitate portal connectivity.

Beneficiary Awareness and Feedback: Conduct outreach to educate beneficiaries about their entitlements (e.g. no cash payments to hospitals, referral protocols). Collect systematic feedback (building on ECHS's use of feedback forms) to identify recurring issues. Administrators should integrate this feedback loop: e.g., convene quarterly meetings with scheme nodal officers to discuss complaints and improvements.

By addressing both policy-level reforms and administrative best practices, these recommendations aim to make empanelment and renewal processes more robust, transparent, and hospital-friendly. Close cooperation between scheme authorities and hospital management is essential to implement these changes effectively.

CHAPTER 6: CONCLUSION

Our analysis – grounded in audit reports, guidelines, and stakeholder studies – reveals that ECHS and CGHS face significant operational challenges in empanelment and renewal of hospitals. Key issues include lapses in enforcing accreditation standards [3], procedural bottlenecks causing claim delays, and instances of fraudulent billing. Many problems trace to policy gaps: outdated rules, inconsistent validity periods, and weak enforcement mechanisms. Notably, beneficiaries in smaller cities remain underserved, highlighting a mismatch between scheme design and demographic shifts.

Hospital administrators emerge as critical actors. They must ensure compliance with evolving guidelines (e.g. CGHS's new anti-fraud norms), maintain rigorous documentation (occurrences like missing PBGs signal risk), and advocate for hospital needs. Effective administration can mitigate scheme fragility: prompt renewal of MoUs , diligent bill submission, and liaison with scheme offices. Conversely, administrative neglect can exacerbate funding losses (e.g. forfeiting prompt-pay discounts 22) and patient grievances.

In summary, bridging the gap between policy and practice requires both systemic reforms and proactive hospital management. The recent CGHS directives and NABH notifications indicate progress on the policy front. Yet, lasting improvement depends on hospital leaders integrating these policies into daily operations. By fostering accountability, upholding quality standards, and championing patient rights, hospital administrators can help CGHS/ECHS fulfill their mandate of accessible, cashless care. Future research could assess the impact of implemented reforms (e.g. monitor changes in claim denial rates or hospital participation) to continue improving these vital schemes.

REFERENCES

1.Sharma P. Reimagining CGHS: Reforming a lifeline for India's retired public servants. Times of India (May 19, 2025). – Highlights rural/urban disparities in CGHS access and reimbursement delays.

2.Jha M. Good news for CGHS beneficiaries! Crackdown on overcharging… Financial Express (Dec 21, 2024). – Reports new MoHFW guidelines addressing fraud and overcharging by empanelled hospitals.

3.Mishra A. Ministry issues guidelines to ensure fair treatment to CGHS beneficiaries. Business Standard (Jan 6, 2025). – Summarizes CGHS rules: standardized protocols, visible rates, pre-approvals, and penalties for non-compliance.

4.Misra B. CGHS Suspends 19 Delhi Hospitals for Raising Forged Bills… Medical Dialogues (Nov 15, 2024). News report of 19 Delhi hospitals de-empanelled for fraudulent billing and irregular practices.

5.CAG. Performance Audit on Implementation of ECHS. (Report No. 51, 2015). – Documented serious ECHS irregularities: double billing, overpayments (~₹23.6 cr duplicate, ₹3.5cr inflated) and diversion of funds.

6.CAG. Performance Audit of Procurement and Supply of Drugs in CGHS. (Report No. 17, 2022). – Identified oversight gaps: many CGHS hospitals lacked mandatory NABH accreditation (277/591 not accredited) and missed submission of performance bank guarantees.

7.NABH/QCI. Notification: CGHS and ECHS Empanelment Programs – Validity and Fees. (Jan 9, 2025). – Sets ECHS empanelment letters to 2-year validity, requires renewal 3 months ahead; CGHS validity per head office.

8.Central Org. ECHS. Final ECHS FAQs (Apr 2023). – Clarifies ECHS empanelment process: two-year MoA, non-NABH hospitals must secure QCI inspection, CGHS-empanelled hospitals only need to submit CGHS MOA/OM.

9.ECHS. ECHS Newsletter – June 2024. – Notes network size (3200 hospitals) and warns beneficiaries of corrupt hospitals adding fictitious diagnoses to inflate bills.

10.Vellakkal S., Juyal S., Mehdi A. Healthcare Delivery & Satisfaction: CGHS and ECHS Evaluation. (IIT Kanpur Working Paper, 2012). – Survey (1,204 CGHS & 640 ECHS patients)

found beneficiaries “reasonably well satisfied” though some out-of-pocket spending; empanelled providers unhappy with “low tariffs” and reimbursement delays.

11.Saxena A., Trivedi M. Improving hospital processes for PM-JAY. BMC Health Serv Res 22:73 (2022). Examined PM-JAY hospital workflows; found reimbursement delays and need for managerial training. (Analogous lessons: empowered admins improve scheme processes.)