CHAPTER-II: DEFICIENCIES IN THE IMPLEMENTATION OF THE SCHEME

2.1 Enrollment of beneficiaries

As per the concept of the Scheme sanctioned by the Ministry in December 2002, all Defence personnel retiring with effect from 1 April 2003 onwards were required to become compulsorily members of the ECHS. Membership Form was to be submitted by the applicant five to six months prior to the date of retirement. Based on the rank structure and the entitlements as authorized by the concerned Record Offices, the beneficiaries are issued life time smart cards, for treatment under the Scheme, by the concerned Regional Centres, ECHS.

During the course of review, we observed deficiencies in the process of enrollment of beneficiaries as discussed below:

2.1.1 Irregularity in agreement for smart cards

The responsibility of preparing the smart cards was decided to be outsourced by the Central Organisation, ECHS. Accordingly, in April 2003, MD, ECHS invited open tenders to implement a turnkey solution for management of the Scheme at Polyclinics, Regional Centres, Station Headquarters and the Central Organisation, ECHS. The main scope of the agreement was to provide smart cards for the beneficiaries with all necessary software and smart card related peripherals including computer hardware. The agreement was signed between the MD ECHS and M/s Score Information Technologies Limited (SITL) in January 2004 for an amount of ₹89.99 per card, valid for a period of five years, which was later extended by one more year.

For repetition of orders, Defence Procurement Manual (DPM) stipulates that (i) it should be ensured that the cost and terms and conditions of the contract are the same (ii) there is no downward trend in the price of the item and (iii) the requirement of the stores are of identical nature/specification, nomenclature, *etc.* Further as per the DPM, for any waiver against the provision of the manual, the approval of the Raksha Mantri is required.

We observed that the Central Organization, ECHS renewed the agreement for provision of smart cards with the same firm for a period of five years in May 2010 but did not specifically comply with the laid down stipulations. The types of violations are enumerated as follows:

- Renewal of agreement, which was to be done at the same cost, was however carried out at an enhanced cost of ₹135 per card against the existing cost of ₹89.99.

- Fresh RFP/open tender was not issued though the specification of the cards had significantly changed *viz.* switching over from stand-alone MIS application to web-based application connected through LAN in a polyclinic, increase in storage memory of card from 16kb to 32kb; and increase in periodicity of training to manpower at RCs from annual to biannual.

- There was no evidence available to establish that MD ECHS had done any market survey to verify the prevailing price.

Further, no sanction of the Competent Financial Authority (CFA) for renewal of contract was found in the documents produced to Audit.

While endorsing the audit point, MD ECHS however stated (October 2015) that the tangibles like card/hardware were enumerated in the contract but the significant intangible deliverables accrued by the system like uninterrupted continuation of the Scheme and prevention of fraud and misuse could not be quantified. Increase in rates was justified by stating the additional facilities like up-gradation of the software and hardware *etc.* were being provided.

The fact remains that as the enhanced specification warranted issue of fresh Request for proposal (RFP), renewal of the agreement without inviting fresh rates through open tenders should have been done with the approval of Raksha Mantri according to the provisions of DPM.

2.1.2 Issue of Smart Cards to beneficiaries on chargeable basis

MoD while sanctioning the Scheme, in December 2002, specified that one-time contribution at the rates prescribed for CGHS pensioners would be recovered from retiring service personnel to become members. No other charges were specified to be recovered from retiring service personnel under the Scheme. This was also in line with the practice followed in CGHS.

We, however, observed that in addition to membership fees, the cost of smart cards was also charged from the beneficiaries, by MD ECHS without the approval of the MoD. From January 2004 to May 2010, the beneficiaries were charged at a rate of ₹89.99 per card which was enhanced to ₹135 from June 2010 onwards. Accordingly, for 42,00,450 cards manufactured between 2004

and 2015 (February 2015) an amount of ₹47.84 crore, collected[12] from the beneficiaries, was paid to the firm.

Audit enquired the reasons for charging the beneficiaries which was against the spirit of the Scheme and specifically asked for the documents where the approval of MoD, if any, had been taken by MD ECHS, as the proposal involved substantial financial implications. While no such documents were made available, MD ECHS replied (October 2015) that ECHS is self-sustaining, thereby charging ESM for the cost of the smart card obviated additional burden on the State exchequer. Moreover, it was also informed that the Ministry had ruled that no funds would be paid for the cards by the Government.

The fact however remains that the justification given by MD ECHS was against the spirit of the sanction issued by the Ministry, which stipulated that only one time membership charges be recovered from the beneficiaries, as in CGHS. This also puts the ECHS beneficiaries to disadvantage *vis-a-vis* the CGHS beneficiaries. Further the assertion of MD ECHS that the Ministry had ruled not to provide funds for the cards, could not be validated as the documents pertaining to this decision of the Ministry were not provided, despite repeated requests. Further, the stand of the MD that the ECHS is self sustaining is incorrect as the Scheme is being funded by the Government and the contribution by the beneficiary is nominal.

2.1.3 Multiple enrollments of beneficiaries under the Scheme

As per the details furnished by MD ECHS, 42,00,450 cards were supplied by M/s SITL from 2004-05 to 2014-15 (up to February 2015). However, from the card production data maintained by M/s SITL and made available to Audit by MD ECHS, the total cards manufactured by the firm, as of March 2015, was only 41,93,019. The anomaly in these figures indicate that ECHS was holding 7,431 cards in excess of those held in the data maintained by M/s SITL. Holding and circulation of excess cards not only posed a risk of possible misuse but also resulted in extra payment of ₹6.69 lakh to the firm on this account.

The possibility of misuse of the cards held in excess of the data maintained by M/s SITL was further examined in audit. We observed that despite the design of card adopted by ECHS, wherein each pensioner along with the dependent members were assigned a unique card ID, 860 ESM were enrolled more than once under 1,725 unique card IDs. These cards, though issued in the name of one ESM were being used separately at different hospitals, even on the same

[12] The applicant submits demand draft for the requisite amount along with his application at the Regional Centre, which in turn remits it to SITL on receipt of cards.

particular day. It was also seen from the claims data of online bills of 10 selected RCs that the empanelled hospitals had raised 1,449 claims in respect of 169 ESM who were issued more than one card, with multiple card IDs. Out of those 169 ESM, 26 had used both cards simultaneously for self and their dependents. Illustrative cases depicting usage of more than one card by one ESM on same date are shown in **Table-3** below:

Table-3: Claims raised for beneficiaries using two cards on same day

Region	Claim ID	Card_ID	Name of ESM	Patient's Name	Relation with ESM	Date of treatment	Hospital Name
Delhi	988105	DL0017944	Kanwal Jeet Singh	Kanwal Jeet Singh	Self	15-10-2013	Kailash Hospital & Heart Institute
Delhi	994996	DL0008411	Kanwal Jeet Singh	Kanwal Jeet Singh	Self	15-10-2013	--do--
Delhi	449717	DL0017440	Nanak Chand	Nanak Chand	Self	03-10-2012	Bhardwaj Hospital
Delhi	252551	DL0004407	Nanak Chand	Indu Bala	Wife	03-10-2012	Icare Eye Hospital And Post Graduate Institute
Delhi	493560	DL0000930	Raj Kumar	Ravi Kumar	Wife	01-03-2013	--do--
Delhi	525950	DL0016127	Raj Kumar	Raj Kumar	Self	01-03-2013	Metro Hospital & Heart Institute - Noida

Source: *Claims data of empanelled hospitals provided by MD, ECHS.*

In reply to the draft report, while the MD ECHS stated (October 2015) that the payment for manufacture of cards to M/s SITL was released only on physical receipt of the cards at RCs, yet it was added that the figures provided to auditors may be at variation. No effort was, however, made by MD ECHS to reconcile the figure to justify the anomaly, despite repeated reminders. As regards multiple enrollments, MD ECHS agreed to the audit point and stated that more stringent scrutiny will be incorporated in the new RFP.

The fact remains that internal control system needs to be strengthened to weed out the unaccounted cards as well as to prevent any extra payment to M/s SITL.

2.2 Treatment process for ECHS beneficiaries

A. Through ECHS Polyclinics

The beneficiary reports to the ECHS Polyclinic and registers with his/her smart card at the reception and is allocated a Medical Officer (MO). In case of OPD patient the MO prescribes medicines which may be obtained from the pharmacy of the polyclinic**.** In case of in-patient treatment, the beneficiary is

referred by the MO to a Service hospital, in case the polyclinic is in Military station. In case of non-availability of bed in Service hospital, the patient is referred back to the polyclinic for referral to an empanelled hospital. Once referred, the patient gets treated from the empanelled facility[13] on cashless basis. The empanelled facility processes the claim online/manually after the patient is discharged **(Annexure-II).**

In case of polyclinics located in non-Military station, the OIC refers the patient to the nearest Service hospital/empanelled facility.

B. In case of emergency by empanelled hospitals

The beneficiary reports to an empanelled hospital in an emergency. The empanelled hospital assesses the emergency and generates an emergency information report (EIR) within 48 hours and sends it to the polyclinic online/manually. Thereafter, the polyclinic issues a referral for the empanelled hospital based on the EIR. The empanelled hospital treats the patient on cashless basis. On discharge the empanelled hospital processes the claim online/manually **(Annexure-III).**

C. In case of emergency by non-empanelled hospitals

The beneficiary reports to a non-empanelled facility in an emergency. The hospital assesses the emergency and commences treatment on payment basis. The patient/relative should report the admission to the nearest polyclinic by any means within 48 hours and get a reference to process the reimbursement claim later. After discharge from the facility the patient submits the reimbursement claim at the parent polyclinic. The parent polyclinic thereafter processes the reimbursement claim online/manually and cheque is finally issued to the patient **(Annexure-IV)**.

2.3 Polyclinics

ECHS Polyclinics are designed to provide 'Out Patient Care' which includes consultation, essential investigation and provision of medicines. Specialized consultations, investigations and 'In Patient Care' (Hospitalization) through spare capacity available in Service hospitals and through civil hospitals empanelled with ECHS.

Audit findings related to deficiencies in the Scheme as observed during the audit are discussed below:

[13] Empanelled facility refers to empanelled hospitals/empanelled diagnostic centres/ Pathological labs, *etc.*

2.3.1 Excess Load on polyclinics with respect to their designed capacity

Polyclinics are categorized as Type A to E based on the number of ESM dependant in the area**.** We examined the actual dependency of ESM with respect to the designed capacity in a test check in six polyclinics and found that the actual dependency of ESM of the polyclinics was manifold *vis-à-vis* their designed capacity as shown in **Table-4** below:

Table-4: Showing actual dependency of ESM on polyclinics

Sl. No.	Polyclinic	Type	Station	Designed capacity	Actual ESM Dependency
1.	Lucknow	C	Mil	5000 to 10000	34129
2.	Varanasi	D	Mil	2500 to 5000	37133
3.	Raebareli	D	Non Mil		8666
4.	Charkhi Dadri	D			15265
5.	Pune	B	Mil	10000 and 20000	37901
6.	Ahmednagar	C	Mil	5000 to 10000	10373

Since the provision of manpower and equipment in the polyclinics are based on their categorization, non up-gradation of the polyclinic according to the actual dependency of ESM has deprived the polyclinics of adequate number of doctors, medical specialists, para-medical staff, medical equipment, infrastructure *etc.* The inadequacy of resources in turn defeats the main objective of providing medicare to ESM and their dependants.

MD, ECHS while agreeing to the audit contention stated (October 2015) that there was a requirement to revise the manpower authorized to each of these polyclinics to overcome the additional load. It was further stated that a case for upgradation of the polyclinics was pending with the Ministry.

2.3.2 Failure to check the eligibility of beneficiary at the time of treatment

As per CGHS guidelines which is applicable for ECHS, dependent children include son(s) who are not physically/mentally handicapped, till he starts earning or attains the age of 25 years, whichever is earlier. The checks for verification of eligibility are exercised by the PCs.

Linking the claims data for the period 2012-13 to 2014-15 as maintained by BPA (UTI-ITSL) with the dependants date of birth from the card production data maintained by M/s SITL made available to Audit, revealed that in 36 claims, involving an expenditure of ₹1.92 lakh, ineligible dependent son(s) who had attained the age of 25 years were allowed treatment (**Annexure-V**). While in 14 of those 36 cases, the beneficiary had attained the age of 25 years after issue of the referral but before commencement of treatment, in 22 cases referrals were issued by polyclinic after the beneficiaries had attained the age of 25 years, which in three cases was more than 27 years.

We also looked into the data pertaining to the period February 2007 to March 2012 and observed the irregularity in manual bills too. 20 bills amounting to ₹4.5 lakh were paid by the SHQ Delhi Cantt. in respect of the beneficiaries, who had already attained the age of 25 years on the date of admission in the hospital, which in two cases was more than 28 years.

We observed that such lapses were due to following reasons:

- Design of the smart card was flawed. All the dependent members of the pensioner were linked to that unique Card ID of the primary member. As such, the dependent members could not be identified uniquely. This blocked the deactivation of the membership of a particular beneficiary once they lose the eligibility**.**

- Unlike CGHS, where the cards are issued for a fixed period of five years and renewed periodically, ECHS smart cards are issued with life time validity. Further there was no mechanism for re-verification of dependency, except voluntary disclosure.

- In the MIS, data related to the beneficiary *i.e.* date of birth, history of referrals *etc.,* is maintained by M/s SITL. Access to this data is however not available to the Bill Processing Agency (BPA), which processes these claims. In the absence of this information, BPA was unable to exercise any checks related to eligibility of the beneficiary before admitting the claims.

In reply, MD ECHS stated (October 2015) that the design, contents and modalities were conceived in 2003. The shortcomings and the lessons learnt over the years will be incorporated in the new system with specific attention to this aspect. In case of sons, the card is being hot listed[14] automatically on attaining the age of 25 years.

The reply is not acceptable as even after 12 years of the implementation of the Scheme, the aspect of elimination of ineligible beneficiaries was yet to be addressed.

2.3.3 Non-functioning of MIS Application in ECHS Polyclinics

The functioning of the ECHS polyclinic was planned to be automated by MIS application developed by M/s SITL. The application included six modules such as Reception, Doctor, Pathology, Officer-in-charge (OIC), Drug Store

[14] Hot list – refers to blocking of a card (as per SRS of MIS application, when a card holder applies for a duplicate card due to loss of the card, the need to block the original card arises. Hence a list is created which includes the information of all the lost cards which is referred as hot list.)

and Extension Counter. Analysis of data of MIS Application in respect of 10 selected polyclinics[15] as of April 2015 revealed that:

- Biometric check *i.e.* finger prints, to identify a patient through Reception module of MIS application was not exercised in 94 to 99 *per cent* of OPD registrations. Position at polyclinic at Varanasi, was however better, where percentage of non-exercising of such check was 44 *per cent* (**Annexure-VI)**. Non-exercising of bio-metric checks at the time of OPD registration in ECHS Polyclinics was fraught with the risk of impersonation. This lapse defeated the very purpose of introduction of the above checks for identification of genuine beneficiaries.

- Pathology Module, which includes the Report Template, Pathology Report Entry, Sample Collection Report, Test Category and Test details was not being used anywhere.

- Drug Module which includes Indent generation, Receipt and Issue of Drugs, Stock report *etc*. was being used partially as PVMS[16] indents were not generated through MIS and Store Inventory was not being updated.

In reply to the draft report, MD, ECHS agreed (October 2015) to the audit comments on lapses in biometric checks in the Reception module. With regard to the partial utilization of Pathology module it was stated that the Semi Auto Analyser used for the pathology test have inbuilt thermal printer. For partial utilization of the Drug module, it was stated that software for demand for medicines from AFMSD was different from MIS for ECHS.

It is evident from the reply that the very purpose of introduction of the checks for identification of genuine beneficiaries was defeated. The gains envisaged from the pathology module were also not accruing. The reply regarding mismatch between the compatibility of software used by AFMSD and that of MIS used for ECHS was not relevant as linkage between the two was not in the scope of audit query.

2.3.4 Short supply of medicines to the polyclinics

Drugs and other consumables for ECHS are procured by DGAFMS and arranged through the existing Armed Forces Medical Stores Depots (AFMSDs)/Forward Medical Stores Depots (FMSDs). Polyclinics raise indents for the required quantity of drugs on the concerned AFMSD/FMSD.

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[15] Ten polyclinics at Delhi Cantt., Chandigarh, Dehradun, Jammu, Lucknow, Ludhiana, Pune, Satara, Trivandrum and Varanasi.

[16] PVMS Indents are used by polyclinics for placing demands of medical stores *viz.* medicines, X-ray films and consumables, *etc.* on AFMSD Depot *etc*.

We however observed at AFMSD Delhi Cantt. and Mumbai, that the compliance rate against the indents raised by ECHS polyclinics was low, as shown in **Table-5** below:

Table-5: Showing short supply of medicines to the polyclinics by AFMSDs

Name of unit	Year	Nos. of items in indents	No. of Items issued	Items marked NA	Percentage of NA items
AFMSD Delhi Cantt	2012-13	49739	27356	22383	45
AFMSD Mumbai		49792	12339	37453	75
AFMSD Delhi Cantt	2013-14	51176	34006	17170	34
AFMSD Mumbai		54541	13222	41319	76
AFMSD Delhi Cantt	2014-15	86848	60794	26054	30
AFMSD Mumbai (up to Dec 14)		45288	16608	28680	63

The percentage of medicines not issued (NA)[17] by the AFMSD Mumbai against the indents of dependent polyclinics ranged from 63 to 76 *per cent*, whereas in case of AFMSD Delhi Cantt. the percentage of NA medicines ranged from 30 to 45 *per cent*. Since AFMSDs are the major source for supply of drugs and consumables for the Scheme, shortage in supply of medicines up to the extent of 76 *per cent* by the two AFMSDs, denied the benefits envisaged in the concept of the Scheme to the ESM.

2.3.5 Non disposal of life expired medicines/drugs

As per the terms of the supply orders (SO) placed by DGAFMS and other Direct Demanding Officers (DDO) for procurement of medicines/drugs, if the drugs are lying unconsumed, the DDO will inform the vendor three months in advance. The vendor is liable to replace such medicines. In case the vendors do not replace the stock, the DDOs are empowered to make recovery of the cost of medicines from their pending bills**.**

We however, observed that despite the provision in SO for replacement of shelf life expired medicine, AFMSD Delhi Cantt. and Polyclinic at Lodhi Road, New Delhi were holding life-expired medicines/drugs worth ₹73.44 lakh (March 2015). From the documents, it could not be ascertained whether AFMSD/PC had taken up the matter for replacement of these medicine, in time, with the supplier. As a result, the expenditure on procurement of medicine worth ₹73.44 lakh had become wasteful.

MD, ECHS stated (October 2015) that reply had been sought from DGAFMS.

[17] The drugs not available with the AFMSDs/AMSDs are marked as Not Available (NA) for which funds are allotted by DGFMS to the service hospitals for purchase of the same.

The fact remains that despite measures in place, AFMSD/polyclinic, failed to safeguard the Government interest by not getting the unconsumed stock replaced from the vendors.

2.3.6 Irregular procurement of Oxygen Concentrators

Oxygen Concentrators[18] were not authorised for issue to ECHS beneficiaries. The instructions were reiterated by Central Organisation in November 2013 and the Regional Centres were directed to instruct the polyclinics not to procure the equipment. Based on the authorisation for CGHS in March 2014, Oxygen Concentrators were also authorised for issue to ECHS members in January 2015.

We however observed that despite the fact that the equipment was not authorised during the period from January 2011 to December 2014, four polyclinics[19] under Regional Centre, Delhi Cantt. irregularly procured oxygen concentrators at a cost of ₹1.73 crore, with the approval of the Senior Executive Medical Officer (SEMO). The equipment were issued to patients by these polyclinics.

In reply MD, ECHS stated (August 2015) that equipment were procured for issue to patients who were advised to use oxygen concentrators by the concerned medical specialists.

The reply is however not tenable as the Ministry had not authorised the purchase of the equipment before January 2015.

2.3.7 Excess expenditure in procurement of BIPAP and CPAP

Bi-level Positive Airway Pressure (BIPAP) and Continuous Positive Airway Pressure (CPAP) are life saving devices that help patients with respiratory failure to breathe more easily.

Ministry of Health and Family Welfare (MoH&FW) had fixed the maximum ceiling limit of ₹1 lakh for reimbursement to the CGHS beneficiaries for BIPAP machine and ₹50,000 for CPAP machines. With effect from 5 March 2014, the ceiling for BIPAP was reduced to ₹80,000. Notwithstanding the ceiling, we observed that various polyclinics had procured both BIPAP and CPAP for an amount in excess of ceiling limit of ₹80,000 and ₹50,000, causing an irregular expenditure of ₹36.10 lakh. Station Commander, Delhi Cantt. had sanctioned 183 BIPAP for three polyclinics under its jurisdiction from 5 March 2014 onwards. The procurement was made by respective PCs at

[18] Oxygen Concentrator is a device used to provide oxygen therapy to patients at substantially higher oxygen concentrations than the levels of ambient air.
[19] Polyclinics at Lodhi Road, Noida, Gurgaon and Delhi Cantt.

a total cost of ₹181.84 lakh against the total admissible ceiling of ₹146.40 lakh resulting in an expenditure of ₹35.44 lakh exceeding the prescribed ceiling. Similarly, polyclinics under SHQ (ECHS Cell) Jaipur had procured one BIPAP and three CPAP between July 2014 and February 2015, at a cost which exceeded the ceiling by ₹66,750.

In reply MD, ECHS stated (August 2015) that though the Central Organisation was listed in the OM issued by CGHS in March 2014, the letter was not received in the Central Organisation and was later downloaded from the net only in August 2014. The delay in issuing the policy letter from the Central Organisation was due to ensuring that the proper detailed guidelines are issued to all the concerned authorities.

The reply is not tenable as though it was the responsibility of the Central Organisation ECHS to implement the revision in rates from effective date in CGHS, 65 BIPAP and CPAP had been purchased even after the receipt of communication by Central Organisation, in August 2014.

2.3.8 Excess payment in procurement of Oxygen gas

Liquid Medical Oxygen (LMO) was procured by the Army Hospital, Research and Referral (AHRR) through tankers from April 2012 to March 2015 and stored in storage tank at the Hospital. From storage tank the oxygen gas is supplied to the wards/departments through dedicated pipe line. Payment was made for the receipt of LMO as recorded in Expense Book maintained by Medical store of the AHRR.

We found that actual receipt of the gas in the storage tank was 18,96,891 kg, whereas as per the expense book the quantity received and paid had been shown as 21,41,470 kg. Thus, the payment for excess quantity of 2,44,579 kg of LMO amounting to ₹28.15 lakh was paid by AHRR.

MD, ECHS stated (August 2015) that there appeared to be technical mistake in the calculation. However, the mistake as purported by MD, ECHS was not reconciled and in their latest response (October 2015) the responsibility for reply has in turn been entrusted to office of the DGAFMS. Reconciliation for excess amount paid for 2,44,579 kg of LMO was, therefore, awaited (October 2015).

2.3.9 Diversion of ECHS funds/stores for Service personnel by Service hospitals

As per the procedure for procurement of drugs and consumables for ECHS, medical stores procured for ECHS should be accounted for separately by the Service hospitals and utilized for the benefit of members of ECHS only.

However, we noticed at Army Hospital Research & Referral (AHRR) Delhi Cantt. and Base Hospital, Delhi Cantt. that separate accounting for issue of medicines/stores to ECHS beneficiaries was not being done by the Service hospitals and the stores meant for the ECHS beneficiaries were utilized for treatment of regular Service personnel. Non maintenance of accounting documentation to delineate the expenditure on ESM and the regular service personnel was not only in violation of the laid down procedures, but also had an impact on the services to be provided to the ESM under the Scheme. Illustrative cases as observed in the test check are summarized as follows:

- AHRR, Delhi Cantt. procured test kits/reagents for its pathological laboratories worth ₹42.94 crore during 2012-13 to 2014-15. This included procurement for ESM from ECHS funds worth ₹37.84 crore and for service personnel from DGLP funds worth ₹5.06 crore. While the expenditure on procurement of these drugs for ECHS beneficiaries and service personnel was in the ratio of 7.5:1, we observed that the ESM and service personnel registered for treatment in AHRR during the three year period of 2012-13 to 2014-15 was in the ratio of 1:3. This disproportionately higher expenditure from ECHS funds (7.5:1) against the correspondingly lower patient ratio (1:3) was suggestive of the fact that the medicine and consumables meant for ECHS beneficiaries was unauthorizedly being used for other than ESM.

- We observed that during the period April 2011 to March 2015, quantity 5,603 nos. consisting of eight types of medicines of oncology costing ₹13.79 crore were procured by AHRR, Delhi Cantt., from ECHS funds. Out of this, 5,553 nos. costing ₹13.68 crore were issued by the hospital for treatment of regular service personnel. While accepting the audit point, AHRR stated that the medicine was issued to Service personnel in life threatening conditions. It was however added that they would try to adhere to the laid down procedure.

- In AHRR we observed that stents procured from ECHS funds were utilised for treatment of regular service personnel. Between April 2013 to December 2014, 116 stents were issued for treatment of regular service personnel. While no separate account was being maintained to keep track of such issues, Audit found from the available documents that only 84 out of 116 stents had been returned to ECHS stock up to December 2014. Thus, due to non adherence to the laid down procedure, the stores procured under ECHS were not being accounted for.

MD, ECHS in reply to the draft report stated (October 2015) that DGAFMS would reply on these issues.

2.3.10 Mismatch in authorisation of medical equipment and manpower in Type 'C' and 'D' polyclinics.

Ás per MoD's orders regarding authorisation of manpower and equipment to polyclinics, we observed that while X-Ray and Ultrasound machine were authorized to Type 'C' and 'D' Polyclinics, yet no manpower to operate the same had been authorised. Thus, there was a mismatch in authorisation of manpower and medical equipment for type 'C' and 'D' polyclinics, which resulted in wasteful expenditure on procurement and idling of the equipment in these polyclinics.

In all the 13 type 'C' and 'D' polyclinics selected for audit, it was observed that despite non availability of manpower, the Ultrasound and X-ray machines were provided to these PCs, which were lying idle as summarised in **Table-6** below:

Table-6: **Polyclinics holding Ultrasound and X-ray machines without manpower**

Sl. No.	Polyclinics		Ultrasound machine held in PCs	X-Ray machine held in PCs
	Type	Number		
1	'C'	5	5	4
2	'D'	8	6	7

MD, ECHS agreed (August 2015) to the audit point and stated that case has been taken up again to authorise manpower as per job requirement at each polyclinic. Spare equipment was being transferred to the nearest Military hospitals to look after ECHS patients as and when required. The mismatch in authorisation of medical equipment and manpower was yet to be rectified (October 2015).

The reply however does not justify the procurement of equipment without authorisation of manpower.

2.4 Manpower

2.4.1 Non authorisation of Establishment for Central Organisation and Regional Centres, ECHS

MoD while sanctioning the Scheme in December 2002 stated that manpower required to staff the Headquarters (Central Organisation ECHS) and Regional Centres would be provided by Army, Navy and Air Force from within their existing resources. No separate peace establishment (PE) authorising administrative staff to these controlling organisations had been sanctioned. However, a review of the 'existing health care system of the armed forces for

serving and retired personnel and dependents', including review of authorisation of Human resource for ECHS facilities was carried out by the Chopra Committee in November 2013. It was felt that the entire scheme of ECHS suffered from inadequacy of Human resources and that the present authorisation was outdated and cannot cater for the continuous increase in workload.

The deficiency in manpower as pointed out by Audit in the subsequent paragraphs and the need for additional manpower to meet the continuous increase in workload, as brought out by Chopra Committee, underscores the need for authorisation of a regular establishment for the Central Organisation and the Regional Centres, ECHS.

MD ECHS agreed (October 2015) to the above point and stated that formulation of PE will resolve the issue of shortage of manpower and efforts were being made for the same.

2.4.2 Shortage of Manpower with polyclinics

Against the total authorisation of 6,800 contractual manpower, which included medical officers/specialists, technicians and paramedical staff, for polyclinics, only 5,353 persons were in position at the PCs, as on 31 December 2014. Thus, there was overall deficiency of 21 *per cent* in manpower with the PCs. We observed that the deficiency was more in Medical Officers/Specialists, at 24 *per cent,* where against the authorisation of 1,745 only 1,316 doctors were available.

MD, ECHS replied (October 2015) that a Board of Officers for manpower review had been completed and a case had been forwarded to the MoD, seeking additional strength of 7,891 comprising various categories of contractual staff.

The reply furnished is not tenable, as the organization was not even able to meet the requirement against the existing authorisation. Hence any increase in authorisation will not necessarily improve the state of holding.

2.4.3 Deployment of available manpower

Despite shortage of manpower with the polyclinics, as commented in **Paragraph 2.4.2**, even the available manpower had not been deployed as per the authorisation of the PCs. We found that the manpower employed and meant for PCs was irregularly being deployed and utilised at Central Organisation and Regional Centres at Delhi, which do not have any authorisation for contractual manpower. Manpower was also being diverted from PCs located at remote locations in Guwahati, Patna, Jharkhand *etc.* to

polyclinics located at big cities, which affected the functioning and quality of services at the lending PCs, as discussed below:

- 50 medical and para-medical staff were attached from various polyclinics to Polyclinic at Delhi Cantt. in excess of the latter's authorisation. Various categories in which such transfers were made are shown in **Table-7** below:

Table -7: Showing holding of excess manpower by PC Delhi Cantt.

Polyclinics	Medical officer		Dental officer		Nursing Assistant/ Nurse		Lab Technician		Dental A/T/H		Total in Excess
	Auth	Held	Auth	held	Auth	held	Auth	held	Auth	Held	
Delhi Cantt.	06	19	02	06	03	13	01	12	02	14	50

We observed that though the technical manpower, was documented to have been attached to Polyclinic at Delhi Cantt., yet the same was actually being engaged to perform administrative duties like online billing, clerical duties *etc*. at the Ministry, Central Organisation Delhi Cantt., RC-I and II/AHRR/SHQ Delhi Cantt. Further, most of the para-medical staff like Lab technicians, Dental Assistants, Radiologists *etc.* was transferred from such PCs which had only one such post. Thus the diversion of manpower to PCs, Central Organisation and RC at Delhi had been done at the cost of efficacy of the lending polyclinics which were already having shortage of staff.

- Similarly, 33 doctors and para-medical staff had been transferred for more than one year from various polyclinics under RC Chandimandir to Polyclinic at Chandimandir during the period from 2012-13 to 2014-15, affecting the functioning of the lending polyclinics.

On a query about irregular diversion of manpower, MD, ECHS stated (October 2015) that Medical Officers and the para-medical staff had been shifted from polyclinics having low daily average sick report to polyclinics having high daily average sick report to fill the void and for better operational efficacy.

The reply is not tenable as the staff transferred from various polyclinics to Polyclinic Delhi Cantt. was not engaged for technical duties but used for administrative purposes at Central Organisation and Regional Centres.

- As per Indian Medical Council Act 1956 and Professional regulations 2002 stipulate that MBBS is the minimum qualification to practice modern system of medicine. Any qualification other than MBBS or MD pathology/biochemistry/microbiology is not eligible to sign a lab report

by law. At Polyclinic Lodhi Road, New Delhi, we observed that, due to inadequacy of the doctors, all types of tests *viz.* biochemistry/ microbiology (HIV, SGOT, SGPT, Lipid profile, urine test, creatinine, widal test, billrubin, indirect HB, ESR *etc.*) were being carried out and signed by the lab technician. This practice not only violated the law but also compromised the quality of medicare being provided to ECHS beneficiaries.

MD, ECHS, while agreeing with audit views stated (October 2015) that strict instructions have been issued to ensure that Lab reports are signed by a Medical Officer of polyclinics.

2.5 Empanelled Facilities

Empanelment of Hospitals/Nursing Homes and Diagnostic Centres in ECHS is done by entering into a Memorandum of Agreement (MoA) between the Hospital and Regional Centre ECHS. Expenditure incurred on services provided by an empanelled Hospital/Dental /Diagnostic Centre is paid directly to the empanelled facility concerned by Regional Centres/Station Headquarters, as per approved rates.

2.5.1 Delay in empanelment of hospitals under ECHS

MoD had issued guidelines/procedure for empanelment of hospitals, nursing homes and diagnostic centers for ECHS. We observed that during the years 2012-13 to 2014-15 Trivandrum and Kollam city had only one hospital each for major procedures (up to December 2014). RC Trivandrum had sent proposals for fresh empanelment of 18 hospitals to MD, ECHS/MoD. However, except for one, no other approval for empanelment was received even after a lapse of one/two years. In Trivandrum, only one hospital *i.e.* SK Hospital is empanelled for in-patient treatment for most of the medical ailments *viz.* Medicine, Surgery, Ortho, ENT, Gynaecology, *etc*. In Kollam city only one hospital *i.e.* Holy Cross Hospital, Kottiyam is empanelled for in-patient treatment.

MD, ECHS stated (October 2015) that process of empanelment had been speeded up. In the VIth and VIIth Screening Committee meeting, 241 hospitals including five from Kerala had been empanelled.

2.5.2 Irregular claim of OPD charges in IPD referrals

The Standard Operating Procedure (SOP) for online bill processing issued by the Central Organisation, ECHS stipulates that the referrals to empanelled facilities would be made by the authorised medical officers/specialists of the polyclinics after provisional diagnosis. The referrals will specifically indicate

whether the patient is referred for admission, investigation or consultation. Further, as per the guidelines for empanelment of hospitals issued by CGHS the package rates *inter alia*, include two pre-operative and two post-operative consultations.

Scrutiny of the claims data in respect of 10 selected online RCs revealed that in respect of 4,750 IPD patients the hospitals had separately raised claims for OPD consultation for the pre operative consultations. Since the referrals in these cases was for 'admission' of the patient and two pre-operative consultations formed part of the package rate, charging for OPD consultation separately was unwarranted. The amount paid for such claims by the RCs for the three years period from 2012-13 to 2014-15 worked out to ₹52.90 lakh.

We further observed that since these claims were processed online through the BPA, the admission of amounts for OPD consultation reflects on the absence of adequate controls in the BPA's application.

In reply, MD ECHS (August 2015) accepted the validity of the audit point and stated that an advisory in this regard would be issued to the empanelled hospitals to put up a single claim for both IPD and OPD claim with same dates. However, the fact remains that the BPA and CFA at RC failed to restrict the claims for OPD charges resulting in overpayment of ₹52.90 lakh.

2.5.3 Deficiencies in raising of Emergency Information Report (EIR) by empanelled hospitals

In emergencies and life threatening conditions, the patients are permitted to be admitted to nearest empanelled hospital. The empanelled hospital/facility assesses the emergency and generates an EIR within 48 hours, informing the particulars of patient and the nature of admission. The OIC polyclinic may make arrangement for verification of the facts and issue a formal referral accordingly.

During the scrutiny of claims data in respect of 10 selected online RCs, we observed that OIC polyclinics had made referrals without adhering to the above stipulations. The cases of deviation which suggest that the OICs had not verified the facts before issuing referrals are summarized as follows:

- In 18 *per cent* of emergency claims, the EIR was delayed by empanelled hospitals between three and 584 days, which included 13 *per cent* claims where the EIR was raised after the discharge of the patients (**Annexure-VII).** This delay was in violation of the prescribed time limit of 48 hours for the hospitals to inform the nearest polyclinic.

- The data also showed that in 30 *per cent* of the claims **(Annexure-VIII)**, EIRs were raised by the empanelled hospitals and referrals made by other than nearest polyclinics. Since the procedure says that only the nearest polyclinic can make such referrals after carrying out necessary verifications, the issue of referrals by other than the nearest polyclinics was in violation of the laid down procedure.

While agreeing with the audit point (October 2015), MD, ECHS justified the treatment given by the empanelled hospitals due to life emergency and stated that a procedural lapse of not informing the nearest ECHS polyclinic within 48 hours by empanelled hospitals had no financial implication.

The contention in the reply is not correct, as raising of EIR within the prescribed period of 48 hours enables OIC Polyclinics to verify the genuineness of the admission and in turn the correctness of the claims. Since the EIR had been raised after the discharge of the patients and the delay extended up to 584 days, it is evident that the OIC polyclinics could not exercise necessary checks. Hence, assurance on genuineness of the payments made against all these claims was not drawn.

Analysis of the claims data also revealed the cases where EIRs raised by the hospitals were rejected by the polyclinics. We observed that between July 2012 and March 2015, 1,847 such EIRs were rejected for not being in conformity with the laid down requirements **(Annexure-IX)**. The hospitals again raised 1,371 such EIRs and claims in respect of 870 had been paid so far. We observed that 284 out of those 870 fresh claims had been approved by the polyclinics other than those which had earlier rejected the EIRs. There were no checks placed in the system for the polyclinic to verify that compliance to the reasons for which the EIRs were previously rejected, had been made by the Hospitals, while raising a fresh EIR. This shortcoming in the system is a major control lapse, which might be misused by the hospitals.

In reply, MD ECHS stated (October 2015) that the hospitals had raised the EIRs correctly in terms of the local orders issued by Headquarter Delhi Area, which allowed the polyclinics in NCR to obtain referrals from two PCs, for administrative convenience.

The reply is not acceptable as the local order issued by HQ Delhi Area was against the provisions of SOP on the subject. Further, raising of fresh EIR in the same case by the empanelled hospital on another polyclinic, without mentioning about its previous rejection, provided a scope for misuse.

Certain cases where EIRs were not genuine and noticed during surprise checks by OIC/MO of polyclinic are illustrated below:

a. North Star Hospital Kanpur claimed for three emergency admissions on 22/3/2014, which were subsequently found fake by OIC and Medical Officer of ECHS Polyclinic, Kanpur during their visit to the Hospital. Documents submitted for OPD treatment by ESMs were fraudulently used by the Hospital to show them as emergency admission in fake case.

b. The OIC and the Medical Officer of Polyclinic Kanpur made surprise visit to two empanelled hospitals at Kanpur in March 2014 and found that four ECHS patients were admitted as emergency case, though no life or limb threatening condition was found. All the four patients were discharged subsequently suggesting that the hospitals indulged in devious practices for their business gain in violation of the terms of MoA. Army HQrs, Military Intelligence (MI-9) took cognizance of the matter and issued instructions in April 2014 to investigate similar cases in other polyclinics.

In reply MD ECHS (October 2015) stated that in view of the disciplinary powers now having been delegated to MD ECHS action will be initiated with the defaulting hospitals under RC ECHS Lucknow and Allahabad. Both the RCs are presently enquiring into the issue and their reply is awaited. Stern action will be taken on being found guilty.

The reply is not tenable as approval of EIR being a serious area, the OIC/MO at PCs have grossly deviated from the laid down practice and even approved EIRs after more than one and a half year after discharge of the patient. Due to perfunctory approach of the OIC/MO of polyclinics, there is a possibility of these cases being false and giving scope for private hospitals to manipulate their bills.

2.5.4 Raising of two claims for the same patients during the overlapping period

We observed from the claims data of 10 selected online RCs, that 64 claims amounting to ₹42.67 lakh were raised by empanelled hospitals and paid by RCs for the period in which the same beneficiaries were admitted in other empanelled hospitals. A statement containing details of such claims is given in **Annexure-X.** Payment of such claims indicated that there were no validation checks in the system for online bill processing by BPA to restrict raising of such claims by hospitals.

In reply MD ECHS stated (October 2015) that the beneficiary under treatment as IPD patient at a hospital may be referred to higher medical centre by the hospital providing the treatment and on occasions the ESM himself may opt to move to other hospitals for better treatment. In both the cases the admission date in the higher medical centre/freshly chosen hospital will show an overlap.

The BPA and the medical approver deduct the amount for the overlapping period, if any, thereby ensuring that no loss is caused to the exchequer.

In the eventuality explained by the MD, ECHS, there can at the most be one day's overlap. Audit has, however, pointed out only those cases where the period of overlap was more than one day.

2.5.5 Non invoking of penal clause of MoA against defaulting hospitals

In accordance with the MoA, empanelled hospitals are to provide cashless facility to the ECHS beneficiaries and not to indulge in unethical practices like over-billing/unnecessary procedures or medical negligence, *etc*. In case of violation of the provisions of MoA by the empanelled hospital, the Performance Bank Guarantee (PBG) submitted by the hospital could have been forfeited and the hospital be removed from the list of empanelled hospitals with the approval of MoD. Besides, in case of initial violation of the provisions of the MoA by the hospitals, an amount equivalent to 15 *per cent* of the amount of PBG shall be charged as agreed liquidated damages.

We observed that despite specific mention about penal action against violations like 'refusal of credit to eligible beneficiary and direct charging from them', 'overbilling', *etc*. in the MoA, the empanelled hospitals were violating the provisions of the MoA by overcharging from the ECHS beneficiaries and preferring claims for items already included in the package rates, refusal of cashless treatment, *etc.* Illustrative cases of violation as observed in audit are discussed below:

- From the claims data of empanelled hospitals, in respect of the 10 selected online RCs, we observed that the empanelled hospitals had raised inflated bills in 37 *per cent* of the cases. Cases of inflated bills were observed in all the 10 selected regions, with maximum number of cases *i.e.* 47 *per cent* at Lucknow. Range of deviation in each selected region, is shown in **Annexure-XI.** Though the claims for the over billed amount were eventually rejected by the CFA, no penal action as provided in MoA was taken against the defaulting hospitals. We further observed that while MD ECHS had proposed to introduce rate integration[20] in the BPA's application to arrest such cases of overbilling, the same were implemented in only two out of 10 RCs selected in audit.

- Apollo Hospital, Ahmedabad did not provide cashless facility to a patient despite submission of ECHS card and referral slip from the

[20] Rate integration planned by Central Organisation ECHS as a validation check to be incorporated in the BPA's Application which restricts empanelled hospitals to submit and upload claims for amount higher than the applicable packages rates for treatment of beneficiaries.

polyclinic within the prescribed time. The hospital took an advance of ₹1.10 lakh in June 2014 from the patient before administering treatment. The hospital also raised a claim against the polyclinic for the treatment and was paid an amount of ₹73,800. The claim raised by the hospital did not indicate the advance of ₹1.10 lakh taken from the patient. On being pointed out in audit on 13 March 2015, the matter was taken up by SHQ/Polyclinic Ahmedabad with the hospital and the amount of ₹1.10 lakh was refunded to the beneficiary by the Hospital on 30 March 2015.

- We observed that RC at Trivandrum had received complaints about charging of additional payment over and above the authorised package rates from the patients by the empanelled hospitals *viz.* SK Hospital Trivandrum, AIMS, Kochi, Holy Cross Hospital, Kollam and SUT Hospital involving an amount of ₹16.16 lakh. In response to audit observation, RC Trivandrum stated that all such cases had been taken up by their office and money refunded to patients by the hospitals. MD, ECHS stated (August 2015) that all the RCs were asked to investigate each case and ensure that there was no violation of ECHS policies. It was further stated that strict action needed to be taken and disempanelment option could be exercised after permission of MoD.

- We observed that SHQ (ECHS Cell), Dehradun and Meerut had received complaints (Dehradun-11 cases and Meerut-5 cases) stating that empanelled hospitals were charging amount from ECHS beneficiaries for treatment instead of providing cashless facility. MD, ECHS stated (October 2015) that prompt and immediate action was being taken by RCs and disciplinary action will be taken, if found to be true.

- Scrutiny of documents at various RCs revealed that empanelled hospitals were resorting to various types of unethical practices. One hospital at Lucknow submitted two claims using fake stamp and signature of OIC Polyclinic. Another hospital at Kanpur claimed an amount of ₹18,855 with fake documents for surgery, which, as confirmed by another hospital had not actually been done. Hospital at Varanasi forwarded two different bills in respect of an ECHS beneficiary amounting to ₹2.95 lakh and ₹68,332 covering the same treatment period. Two different hospitals at Lucknow claimed bills for treatment of an ECHS patient for overlapping period.

MD, ECHS while accepting the audit observations stated that all Regional Centres had been asked to follow ECHS policies and guidelines and take stringent punitive action against defaulting facilities.

The reply is not tenable as the RCs failed to invoke the penal provisions of the MoA against the defaulting hospitals.

2.6 Processing of bills

2.6.1 Manual processing

Prior to 1 April 2012, the bills in respect of reimbursement claims relating to medical expenses were being processed manually. Bills and connected documents were submitted by empanelled Hospitals, Nursing Homes, Diagnostic Centres or Consultants to the polyclinic from where the patient was referred. Officer-in-Charge (OIC) polyclinic would authenticate the bills and forward, bills exceeding ₹5,000 to the Senior Executive Medical Officer (SEMO) at the Service hospital concerned for scrutiny and onward despatch to Station Headquarters (SHQ) for payment. Payment would be made by cheque by the SHQ and would be subject to post-audit by regional Controllers of Defence Accounts (CsDA). In case the amount of bill is in excess of financial limit of the Station Commander, the same would be forwarded along the chain of command for Competent Financial Authority's (CFA's) sanction. After sanction is accorded by CFA, the SHQ would make the necessary payment. The financial powers delegated to various authorities for payment and reimbursement of Manual medical bills is indicated in **Annexure-XII**.

Irregularities noticed in test check in payments of manual bills of empanelled hospitals are discussed as follows:

2.6.1.1 Irregular payment by SHQ, Delhi Cantt. towards unaccounted medical bills of empanelled hospitals

As per procedure for processing of manual bills, the empanelled hospitals were required to submit the bills to the concerned Polyclinic and obtain a receipt. Further, as per the SHQ, (ECHS Cell), Delhi Cantt. instruction circulated in September 2005, Soft data of the bills was also to be provided by the empanelled hospitals to SHQ in 'Excel' as per the prescribed format for uploading on their system. Instead of maintaining the Bill Register for accounting the bills, the SHQ recorded the bills data in their system. The control on the bills was being exercised by the SHQ by updating the system on regular basis.

Medical bills of empanelled hospitals were received at the SHQ, for payment through three sources *viz*. **(i)** Senior Executive Medical Officer (SEMO),

Armed Forces Clinic, New Delhi **(ii)** SEMO, Base Hospital, Delhi Cantt., and **(iii)** bills amounting up to ₹5,000 directly from dependent four polyclinics[21].

From the system data of the SHQ (ECHS Cell), we noticed that as on 31 March 2012, 5,783 medical bills of 126 empanelled hospitals amounting to ₹16.44 crore were pending for payment. During the period 1 April 2012 to July 2015 total 43,662 hospital medical bills amounting to ₹140.67 crore were received at SHQ Delhi Cantt., from both the SEMOs and dependent policlinics. As of July 2015, 6,712 bills amounting to ₹23.32 crore were pending with SHQ for payment. Thus, 42,733 bills of empanelled hospitals amounting to ₹133.73 crore were available for payment between April 2012 and July 2015.

As against 42,733 bills, we observed that 47,719 bills amounting to ₹157.34 crore were paid by the SHQ between April 2012 to July 2015. Evidently, 4,986 medical bills of empanelled hospitals amounting to at least ₹23.61 crore were paid in excess than actually received from the two SEMOs and the four polyclinics, as shown in **Annexure-XIII,** for which no record was available/traceable in the SHQ (ECHS Cell), Delhi Cantt.

We called for (January/May/June 2015) bills receipt diary/bill register from the SHQ (ECHS Cell), but the same was not provided by them. The matter was again referred (July 2015) to the SHQ (ECHS Cell) for reconciliation of their records of receipt and payment of pending medical bills and to furnish copies of weekly reports of bills paid, but they could not justify/reconcile the payment of excess bills and also did not provide copies of weekly reports of bills paid (September 2015). Two SEMOs confirmed to Audit in February 2015 and April 2015 that they had no more pending bills.

It is apparent from above that 4,986 unaccounted medical bills amounting to ₹23.61 crore were paid without any justification and no supporting bills from all the sources (2 SEMOs and 4 polyclinics) mentioned above have been provided to Audit. However, payments of bills on the basis of data base were continuing from April 2012 to July 2015.

In reply MD, ECHS stated (October 2015) that though the pending 6,712 bills worth ₹23.32 crore had been loaded in the system maintained by Station Cell ECHS Delhi Cantt., but no payment was made as the bills were not received at Station Cell ECHS. The reply was not tenable as payment of 47,719 bills which included unaccounted 4,986 bills amounting to ₹23.61crore has already been made as explained above. The pending 6,712 bills have not been included in the paid bills.

[21] ECHS Polyclinic Lodhi Road , Delhi Cantt., Noida and Gurgaon.

Further, the discrepancy in accounting and payment of bills, as explained above gets substantiated by the fact that during the course of review, we observed certain cases of double payments and also the absence of control in accounting. Specific cases, as observed in audit are summarised as follows;

- 22 bills (same number) amounting to ₹8.20 lakh, generated by empanelled hospitals, were admitted and paid twice by SHQ Delhi Cantt. through 44 paid vouchers amounting to ₹16.40 lakh. This resulted in duplicate payment of ₹8.20 lakh made between November 2007 and March 2013. The SHQ (ECHS Cell) assured in August 2015 to investigate the matter and recover the excess amount paid.

- Empanelled hospitals raised 123 duplicate bills in respect of patients where the name, referral number, nature of ailment, period of treatment, amount claimed *etc.,* were the same. Since the claim ID had been changed by the Hospitals, the SHQ Delhi Cantt. could not detect the duplicate bills and admitted the amount of ₹23.18 lakh between March 2007 and February 2015.

- As a tool of Financial Management and to exercise internal checks for the payments being made out of Cash Assignment the provisions of the Financial Procedure for the ECHS-2003, stipulates that the Cash Book along with the paid vouchers and Bank reconciliation statement needs to be forwarded to the PCsDA/CsDA for post audit. We however found that while submitting the Cash Book, no bank reconciliation statements were prepared and submitted by the SHQ Delhi Cantt. to the PCDA, WC Chandigarh, during 2012-13 to 2014-15.

No reply on the cases on duplicate payment and non preparation of Bank reconciliation statement was furnished by MD.

2.6.1.2 Overpayment due to non-adherence to MoA

- ***Inflated bills***

MoD in December 2003 laid down the procedure for payment and reimbursement of medical expenses under ECHS. The procedure stipulates that the rates of payment to empanelled hospitals/Diagnostic centres in cities/towns covered under CGHS would be governed by the package deal rates as laid down for CGHS, which would include all charges pertaining to a particular treatment/procedure including cost of medicines *etc*.

Scrutiny of the paid medical bills (manual/offline) for the years 2012-13 to 2014-15 in selected SHQs (ECHS Cell) and PCsDA/CsDA revealed that the empanelled hospitals claimed bills in excess of the authorised package rates,

and the same were admitted by the concerned SHQs (ECHS Cell). We observed an overpayment to the tune of ₹1.92 crore (**Annexure-XIV**) at 20 station selected in audit. At Pune station alone, the extent of overpayment was ₹69.84 lakh.

MD, ECHS stated (October 2015) that documents were being rechecked in detail and recovery action will be initiated in case any unjustified overpayment has been made. It was further added that in case, the hospitals failed to deposit the amount in stipulated time frame, the recoveries will be made from their current bills being processed online by the RC.

Notwithstanding the reply, it is apparent that the SEMO and Station Headquarters had failed to exercise adequate checks before making payments.

- ***Non reduction of 10 per cent package rate for treatment in General ward***

As per the order issued by Ministry of Health and family welfare (MoH&FW) in August 2010, the package rates were for Semi-private ward. If the beneficiary was entitled for General ward, there would be a decrease of 10 *per cent* in the rates and for Private ward there would be an increase of 15 *per cent*. However, the rates would be the same for investigation irrespective of entitlement whether the patient was admitted or not and test *per se* did not require admission to hospital.

In respect of ECHS beneficiaries entitled for General ward, we observed that excess payment of ₹11.96 lakh was made to 29 empanelled hospitals by the SHQs under the jurisdiction of PCsDA, WC, Chandigarh and CC, Lucknow on account of non-deduction of 10 *per cent* on the package rate (**Annexure-XV**).

- ***Charging of ECHS patients at higher than non-ECHS rates***

As per the general instructions issued by MD, ECHS in October 2011, the empanelled hospitals were required to give a certificate of undertaking that "Hospitals shall not charge higher than the ECHS notified rates or the rates charged from non-ECHS patients".

We observed from medical bills of empanelled hospitals at Lucknow, Dehradun, Varanasi and Jabalpur that the accommodation charges claimed by the Hospital and admitted by the respective SHQ were more than the rates being charged by those hospitals from non-ECHS patients. Charging of higher rates by the hospitals was despite the undertaking given by the empanelled Hospitals. On this account a sum of ₹26.78 lakh was overpaid to the hospitals, as indicated in **Annexure-XVI.**

MD, ECHS stated (August 2015) that the bed charges as mentioned in CGHS and ECHS included diet charges, electricity charges, nursing charges, surgical sundries and also the tax applicable on them. When bed charges were being compared with non-ECHS patients' expenses on these accounts also need to be included in the bed charges.

The reply was not correct as, we found that all the extra charges quoted by MD ECHS in reply, were also being charged separately from ECHS patients too. Hence, charging of higher room rent to ECHS patients was in violation of MOA and the undertaking given by the Hospitals.

Similarly, a comparison of bills in respect of ECHS and non-ECHS patients pertaining to Fortis Hospital, Mohali (NABH hospital) was carried out. It was found that the rate of Total Knee Replacement (Bilateral) [TKR] charged by the Hospital in respect of ECHS patients was higher than that charged from the non-ECHS patients. This had resulted in excess payment of ₹99.49 lakh during April 2012 to October 2014 as indicated in **Table-8** below:

Table-8: Showing excess payment for TKR (B/L)

Type of accommodation	Rate for ECHS Patient (excluding cost of implants and bone cement) (₹)	Rate charged by Fortis Hospital for non-ECHS patients (excluding cost of implants and bone cement) (₹)	Difference in rates (Col.3-Col.2) (₹)	Total cases of TKR (Nos)	Excess amount paid (₹) (Col.4 x Col.5)
1	2	3	4	5	6
General ward	227700	172772	54928	105	5767440
Semi-private ward	253000	203590	49410	54	2668140
Private ward	290950	236890	54060	28	1513680
Total					**9949260**

MD, ECHS replied (October 2015) that Fortis Hospital Mohali had informed that their charges for Bilateral TKR for general public were higher than ECHS beneficiaries.

The reply is not factually correct as it was seen from the actual bills raised by the hospital in respect of ECHS and non-ECHS patients that the amount charged for the procedure (excluding implants and bone cements) from ECHS patients was more than non-ECHS patients.

- ***Non-obtaining of rebate on medicines used in Oncology treatment***

As per the guidelines issued by MD, ECHS in July 2011, the hospitals would provide chemotherapy medicine to ECHS beneficiaries at a discount of 10 *per cent* on MRP. Examination of claims submitted by four hospitals mentioned in **Annexure-XVII** revealed that 10 *per cent* discount of ₹20.55 lakh on

chemotherapy medicine was not obtained by SHQ (ECHS Cells) at Jabalpur, Gwalior, Pune and Jodhpur.

MD, ECHS replied (October 2015) that while action for recovery from defaulting hospitals at Pune and Jodhpur would be initiated, SEMO Jabalpur and Station HQ Bhopal have already initiated recoveries. It was however stated that Deenanath Mangeshkar Hospital at Pune was no more empanelled with ECHS and hence amount cannot be recovered.

Notwithstanding the reply, the fact remained that the SHQ failed to restrict the claims, which resulted in overpayments.

- ***Conclusion of MoA at higher than CGHS rate***

As per the MoD's orders of December 2003 and August 2010, in case of the polyclinics located in cities/towns not covered under CGHS, the rates of payment to the empanelled hospitals/diagnostic centres will, in any circumstance, not exceed the CGHS rates applicable to the nearest cities/towns covered under CGHS.

We observed that the nearest city covered under CGHS with respect to Dehradun and Bareilly station was Meerut. However, MoAs for various procedures with empanelled hospitals at Dehradun and Bareilly were concluded at CGHS rates for Lucknow which were higher than the CGHS rates applicable for Meerut. This resulted in violation of the Ministry's orders causing an extra expenditure of ₹5.81 lakh.

In his reply it was stated by MD ECHS (October 2015) that Dehradun was allowed rates as applicable to Lucknow vide Central Organisation's letter of 29 August 2013 and later rates of Meerut were allowed vide their letter of 22 April 2014.

The reply of MD was however not factually correct, as both the letters quoted in the reply, provided applicability of rate in Meerut for Dehradun.

2.6.1.3 Provision of discount on Medicine in MoA

As per the terms of the MoA between ECHS and empanelled hospitals, it was stipulated that the empanelled hospitals would not charge the cost of medicines more than the MRP. We observed that the empanelled hospitals were charging the cost of medicine at MRP in their bills and the same were paid by the ECHS.

As far as local purchase of drugs and consumables by the polyclinics is concerned, DGAFMS in December 2003 had sought an amendment to the

procedure for procurement of drugs and consumables for ECHS. Accordingly, the SEMOs had to ensure that the cost of drugs and consumables purchased by polyclinics would be at least 10 *per cent* lower than the MRP. We observed in a test check that while most of the polyclinics were procuring medicines at less than MRP, polyclinics at Unnao and Akbarpur Mati, had made procurements after availing a discount of even up to 35 *per cent* in 2014-15.

Examining the terms of the MoA between ECHS and empanelled hospitals *vis-a-vis* the instructions issued by DGAFMS on local purchase of medicines, we found that while the ECHS was availing rebate on local purchase of drugs, no such benefits could be availed from the empanelled hospitals for want of suitable condition in the MoA. The fact that the MRP rate charged by the empanelled hospitals were considerably higher than the discounted rates available in the local markets also gets substantiated by our findings during our audit at RC Jalandhar, where we observed that while empanelled hospitals under the RC had charged between ₹9,175 and ₹18,880 for Injection Peg-interaferon Alpha 2a & b[22] (Roche), the same injections had been procured by MH Jalandhar during the same period in 2014-15 for ₹3,543 to ₹5,670. This differential in cost resulted in extra expenditure of approximately ₹89.53 lakh.

Based on the above analysis it is apparent that there is a sufficient scope for introduction of a stipulation in the MoA with the empanelled hospitals for seeking discount over MRP in medicine being issued by them to the ECHS beneficiaries. The recommendation of audit assumes significance in the light of the fact that in the 10 selected online RCs, we observed the cost of medicine formed 32 *per cent* of the medical treatment related payments made to empanelled hospitals (₹540 crore out of ₹1,702 crore).

MD ECHS replied (October 2015) that since there was no mention of discount on MRP on medicines utilized for the patients during hospitalization, the payments were made as per the terms of the MoA.

Based on the facts emerging from above analysis, it is apparent that there is a need for introduction of a provision for availing discount on medicines in the MoA.

2.6.2 Online processing

With the objective to overcome the large pendency of bills of empanelled hospitals caused due to shortage of manpower at all levels, MoD outsourced the online processing of bills to M/s UTI (ITSL) *i.e.* Bill Processing Agency (BPA) in following three phases:

[22] Peg-interaferon Alpha 2a and Peg-interaferon Alpha 2b.

- from April 2012, in five Regional Centres (RCs) *viz.* Delhi, Chandimandir, Pune, Trivandrum and Secunderabad,
- from April 2013 five additional RCs *viz.* Jalandhar, Jaipur, Lucknow, Kolkata and Kochi by MoD were covered and
- In April 2015, the Scheme was further extended to all other remaining 18 RCs.

As per the sanction, BPA would carry out medical scrutiny of the bills (check appropriateness of treatment) by a team of qualified Doctors. Based on the eligibility/admissibility, the bills would be sent to the BPA's financial team for scrutiny. The work sheet along with recommended amount would thereafter be electronically submitted to the RC within two working days by the BPA. CFA at RC would examine the bill and the work sheet before according sanction for payment. The respective financial powers delegated to various authorities for sanctioning payment and reimbursements of online Medical Bills are indicated in **Annexure-XVIII**.

2.6.2.1 Implementation of online bill processing by BPA without any Memorandum of Agreement (MoA)

M/s UTI-ITSL was selected on nomination basis as the firm was Government owned and was providing similar services to CGHS under the Ministry of Health and Family Welfare. We observed that MD, ECHS proceeded with online bill processing from April 2012 without entering into any MoA with the BPA. The MoA with the BPA had not been signed (August 2015). We observed that in the absence of any MoA, there were no performance benchmarks for MD ECHS to ensure the effective discharge of services by the BPA. Absence of any MoA resulted in deficiencies like, non-adherence of time limit for bill processing, deduction of service charges at higher rates, charging of service charges from beneficiaries, non-development of audit module in implementation of the Scheme *etc.* which have been pointed out in the subsequent paragraphs.

2.6.2.2 Shortage of manpower at Regional Centres and Central Organisation ECHS affecting scrutiny of online claims

Prior to April 2012, SEMO would do the required checks on the bills of empanelled hospitals. Though the billing procedure was changed to On-line from April 2012 and the responsibility for checks was entrusted to RC, no corresponding transfer of resources was, however, done. We analysed the online claims processed by CFAs at Regional Centres and Central Organisation over a period of three years from 2012-13 to 2014-15 and observed that monthly average claims processed at Central Organisation and

Regional Centres varied from 634 to 17,951, 707 to 27,150 and 305 to 20,585, respectively. The increase over previous years was maximum in Regional Centres at Chandimandir, Delhi, Jalandhar, Kochi and Trivandrum. Region-wise details are given in **Annexure-XIX**. In view of the abnormal increase in the work load and without provision of manpower to cater for such workload at Regional Centres and Central Organisation, the scrutiny of bills was affected in terms of processing time as commented in **paragraph 2.5.5** (Ist bullet).

To speed up the bill processing at RCs and Central Organisation MD, ECHS in June 2012, issued directions to all RCs that only five *per cent* of the bills would be scrutinised in detail by the medical vetting authorities at the RCs as well as Central Organisation. In August 2013, the ibid directions were withdrawn and the discretion for sampling was left to be decided by RCs.

We observed that in view of non-implementation of rate integration in BPA's application and raising of inflated claims by empanelled hospitals, as commented in **paragraph 2.5.5,** restriction of scrutiny of bill at RCs up to five *per cent* only was not justified and prone to overpayments**.** The adoption of five per cent sampling checks by CFA at RCs and Central Organisation ECHS was in violation of the sanction of MoD which didn't specify any sampling to be exercised by CFA over the BPA's scrutiny.

In reply, MD, ECHS stated (October 2015) that no medical officers were authorized at Regional Centres and Central Organisation for medical scrutiny of online bills. To deal with the increased load of online bills, two additional contractual medical officers at Central Organisation ECHS and RCs with heavy load of bills have been posted in lieu of contractual staff authorised to non-functional polyclinics. Regarding sampling of claims by CFA at RCs, MD, ECHS stated that the instructions to re-validate only five *per cent* bills was issued with the aim to bring down the pendency at RC level and once the pendency was in comfortable zone/limit, instruction was withdrawn.

The reply furnished by MD, ECHS corroborates the fact that shortage of manpower affected scrutiny of bills thereby making it prone to errors. Reply regarding sampling of claims for scrutiny by CFA at RCs is not acceptable as the MoD's sanction for the online bill processing did not provide for scrutiny of bills on sampling basis and moreover, even now the sampling is continuing at the discretion of RCs.

2.6.2.3 Non-adherence of the time limit for payment of bills by BPA/CFA resulting in non availing of discount

MoD's sanction for online bill processing issued in February 2012, provided that BPA would complete their medical and financial scrutiny and would

submit work sheet along with recommended amount to the RC within two working days. CFA will examine the bill and accord sanction within five working days. The payment to hospitals and individuals will be made within two working days by the RC. The entire process for bills, from its receipt to payment, was therefore to be completed within nine working days. Besides, as per provisions of MoA with empanelled hospital, a discount of two *per cent* over the amount payable, will be deducted, if the payments were made within 10 working days of receipt of hard copy of bill or settlement of all queries by the hospital, whichever was later.

We observed that stipulated time limit was not being adhered to in processing the bills by BPA and CFA. Out of the total 19,19,343 bills paid, during three years, only 2,45,367 (13%) bills were processed and paid within the time limit. Remaining 16,73,976 were delayed at various levels. An analysis of delay at BPA, CFA and payment stages in respect of bills where delay in processing was more than nine working days (11 days) is shown in **Table-9** below:

Table-9: Analysis showing delay in processing of bills at BPA, CFA and payment stage

Year	Bills processed beyond 11 days	Percentage of Bills processed by BPA beyond 2 days	Percentage of Bills processed by CFA beyond 5 days	Percentage of Bills paid after CFA approval beyond 2 days
2012-13	2,35,633	91	59	43
2013-14	6,14,419	83	53	48
2014-15	8,23,907	94	64	65
Total	**16,73,976**	**90**	**59**	**56**

Source: *Data of audit trail of medical reimbursement claims provided by MD, ECHS*

Note: *1. Nine working days have been converted into 11 days by adding two days for Saturday and Sunday falling in between at CFA Stage.*

2. The percentages shown also include cases where the delay is on the part of more than one agency.

The above analysis revealed that on an average, BPA delayed 90 *per cent* bills, CFA delayed 59 *per cent* bills and paying authority delayed 56 *per cent* bills. This delay resulted in non availing of discount of two *per cent* amounting to ₹34.10 crore in respect of 16,47,930 bills[23] paid for ₹1,705 crore, during the period from 2012-13 to 2014-15.

We further observed that since no penal action was specified either by the MoD or MD, ECHS, the BPA could not be penalized for delay in processing of bills.

[23] The nos. of bills with total delay of 10 working days have been worked out by converting into 12 days by adding one day at payment stage in addition to 11 days already shown in Table-9 above.

In reply, MD, ECHS stated that BPA could not engage more staff for want of MoA and lack of adequate staff resulted in large pendency as well as delay in processing of the bills. In respect of the delay at the CFA level, it was stated that there was no authorized PE at RCs and there were shortage of funds from 2012 to 2014. It was also stated that a case was taken up with the DoESW to do away with the 2 *per cent* discount as this was impracticable.

The reply was however not tenable as absence of MoA cannot be an excuse for not engaging adequate manpower by the BPA. Rather it is evident that number of bills has increased over the year so the amount payable on account of service charge will also proportionately increase and BPA should be obliged to engage more staff for processing of claims for ECHS. Moreover the responsibility of signing the MoA and authorisation of PE rests with the MD ECHS and the DoESW. The reply regarding lack of authorized PE at RCs is also not tenable as the MD, ECHS in his earlier response to **paragraph 2.6.2.2** himself stated that to deal with increased load of online bills, two additional contractual medical officers have been posted at RCs with heavy load of bills. The contention of lack of funds is again not tenable as the delay in most of the case was observed at BPA/CFA level and not for want of funds at payment stage.

2.6.2.4 Approval of payment to empanelled hospitals by CFA (ECHS) after rejection of the same by BPA

We observed in April 2015 that the BPA had recommended 1,088 claims amounting to ₹1.16 crore pertaining to the period from April 2012 to November 2014 for rejection. CFA, however, passed such claims against the BPA's recommendation.

Out of these 1,088 claims, audit examined 423 claims each amounting to ₹1,000 or more with total approved amount of ₹1.14 crore. The sample was 42 *per cent* population-wise and 98 *per cent* amount-wise. Out of 423 claims we found that in 206 claims the recommendation of BPA for rejection of such claims was based on the policy of ECHS/CGHS and thus valid. The approved amount of such 206 claims was ₹58.54 lakh. The major reasons due to which BPA recommended rejection of claims were (i) claim being without valid referral, (ii) Non-submission of mandatory documents, (iii) Separate claims for items forming part of package (iv) Without pre and post procedure images[24], (v) hospital not empanelled for treatment *viz*., TKR, PTCA, *etc.* (vi) Without necessary approval of SEMO *etc.* CFA, however, approved such

[24] As per the checklist provided in SOP issued by MD ECHS for online processing of bills, pre and post real time images are required to be submitted by empanelled hospital for claims for procedures like PTCA, Joint Replacement, etc.

claims in contradiction to BPA's recommendation. Details are given in **Annexure-XX.**

In reply, the MD, ECHS stated that;

- OIC's signature and stamp was done away with at high pressure polyclinics as it was observed that the OIC was most of the time busy in signing the referrals;
- images were not uploaded but given in hardcopy/CD at RC and JD (HS) passed the bill after authenticating bill therefrom;
- On issue of hospitals not empanelled for treatment, it was stated that in an emergency, hospitals even if not empanelled for a particular treatment can admit the beneficiary.

The reply of MD, ECHS is not acceptable as the claims were passed without justification as discussed below:

- Selective doing away with signature and seal of OIC/MO in referral letters compromises the internal control mechanism.
- As per the procedure, all documents of uploaded claims are to be physically verified with hard copy of received bills in RC after which the BPA scrutinizes claims. Hence non-uploading of images, which is integral part of documents to be uploaded, tantamounts to breach of procedure. Further, we observed that in three out of 16 such cases, the claims were passed by JD (HS) involving overpayment of ₹43,402 on ineligible entitlements like type of ward entitlement, charges over and above the package charges *etc.*
- Out of 10 claims pertaining to hospitals not being empanelled for treatment, which the BPA had rejected but passed by CFA, Audit observed that disease in only two claims were covered under emergency *i.e.* PTCA[25] and CABG[26]. Other eight claims were for Total Knee Replacement, which is a non-emergency disease. Hence the BPA's recommendation for rejecting the claim was valid.

2.6.2.5 Allowing BPA to deduct service charges at rates higher than that applicable in CGHS

M/s UTI-ITSL was selected as BPA for ECHS on nomination basis as the firm was Government owned and providing similar services to CGHS. The BPA submitted their initial proposal which was in line with that of CGHS, both for

[25] PTCA – (Percutaneous transluminal coronary angioplasty)
[26] CABG – (Coronary Artery Byepass Grafting)

services and cost. We observed that since inception of online bill processing in April 2012, M/s UTI-ITSL had been charging at the cost, as were being charged by them in case of CGHS, in five different slabs. However, MD, ECHS, revised the rates for service charges in June 2013, by increasing in two slabs and decreasing in one slab. No change was made in other two slabs. The reasons for change were not available in the documents held by MD ECHS.

We observed that introduction of revised rates, which were not only at variance with the rates applicable in CGHS, but were also higher than the rates quoted by the firm in its original bid, resulted in an undue benefit of ₹41.21 lakh to the BPA for bills processed during the period from 2012-13 to 2014-15 as shown in **Table-10** below:

Table-10: **Showing detail of excess amount paid to BPA**

Hospital bill amt	Rate of M/s UTI-ITSL as being charged from ECHS			Rate of M/s UTI-ITSL as being charged from CGHS		Excess Amount charged by M/s UTI-ITSL (Difference of Col. No. 4 & Col No. 6)
	Rate at which BPA Charges applied	Claims (in nos.)	Total Amount	Rates as referred to in col. B above table	Total Amount	
1	2	3	4	5	6	7
501/ to 1000/-	20	165357	3307140	15	2972265	826785
1001/- to 5000/-	50	371724	18586200	35	15531180	5576210
5001/- to 10000/-	125	91269	11408625	150	16676400	(-)2281725
Total			148311968		144190698	**4121270**

In reply the MD, ECHS stated (October 2015) that rates were as laid down in Note of MoD dated 9 February 2012 and the organisation has followed the rate as per the ibid letter.

The reply is not acceptable as MD, ECHS and MoD failed to check that the proposal of M/s UTI-ITSL was same as that applicable in case of CGHS. Further, knowing the fact that BPA was charging higher rates, MD ECHS and MoD did not make any effort to rectify it and allowed BPA to charge higher rates. Moreover, absence of MoA with BPA also contributed to this anomaly.

2.6.2.6 Irregular recovery of service charges from individual reimbursement claims by BPA

In November 2013, MD, ECHS in reversal of his earlier decision of February 2012 permitted M/s UTI-ITSL to deduct service charges from reimbursement claims made by individuals. From the claims data for the period 2012-13 to 2014-15 in respect of the bills pertaining to the 10 online RCs, we observed that, M/s UTI-ITSL had charged service charges on individual reimbursement claims since commencement of online bill

processing. For 22,179 individual reimbursement claims, service charges amounting to ₹31.89 lakh were levied by BPA. The levy of service charges from individual's reimbursement claims was against the spirit of the Scheme, which stipulated that recovery of only one time membership charges from the beneficiaries shall be made, as in CGHS.

Any charges to be levied on ECHS beneficiaries therefore warranted approval of the Ministry.

In reply, the MD, ECHS stated (October 2015) that no specific instruction was existing for deduction of service charges from the reimbursement of individual claims. However, the BPA's software was deducting the service charges from these individual reimbursement claims. On being asked to waive off the service charges from these bills, the BPA did not agree. Hence the bills of the ESM kept getting piled at the BPA. Therefore, a conscious decision was taken to charge the BPA fees from the beneficiaries of individual reimbursement cases, purely to avoid harassment to the veterans.

The reply is not tenable as the levy of any charges in addition to the one time contribution puts ECHS beneficiaries to disadvantage *vis-à-vis* CGHS. Further, as seen from the reply, the BPA has taken an advantage of the absence of MoA and unduly levied service charges on individual beneficiaries.

2.6.2.7 Incorrect room type entitlement in case of indoor treatment for ECHS beneficiaries

The entitlement for indoor treatment for ECHS beneficiary in a hospital is shown in **Table-11** below:

Table-11: **Showing detail of entitlement and rates applicable**

Rank	Entitlement	Rates applicable for treatment
Officers	Private Ward	15 % in addition to notified rates.
JCOs (Nb Sub to Sub Maj including Hony Ranks of Lt/Capt and equivalent)	Semi-private Ward	Notified rates only
NCOs (Sep to Hav including Hony Rank of Nb Subedar and equivalent)	General	10% less on notified rates

We observed from the claims data for period from 2012-13 to 2014-15, in respect of 10 selected online RCs that in 1,487 claims the beneficiaries were paid for higher than their entitlement. In case of 755 claims amounting to ₹4.21 crore, though beneficiaries were actually entitled for 'Semi-Private Ward', the hospitals were paid at the rates for 'Private Ward', involving

overpayment of ₹54.72 lakh. Again, in 732 claims amounting to ₹3.57 crore, while the beneficiaries were entitled for 'General ward', the payment was made at the rates for 'Semi-Private' ward involving overpayment of ₹35.71 lakh. Thus, non-adherence to eligible room type entitlement for ECHS beneficiaries resulted in an overpayment of ₹90.43 lakh in 1,487 claims.

In reply, MD ECHS stated (October 2015) SITL erred while producing and issuing the cards to the veterans and thereby the hospitals have provided the wards beyond their entitlement based on the cards. The BPA and CFA do keep a check on the aberration but certain cases may go unnoticed. It was further stated that the contract between ECHS and SITL had been terminated and additional expenditure on the said cases has to be taken as *fate accompli*.

The reply is not tenable as in terms of the contract with SITL, the responsibility of furnishing details regarding the beneficiary entitlement *etc.* rests solely with the ECHS and therefore MD ECHS cannot disown the responsibility. Further, the cases as detected by audit were found only in a sample check. There is a strong possibility of more such cards in circulation. MD ECHS has not given any course of action to identify and weed out such cards to avoid further misuse.

2.6.2.8 Payment of claims in respect of beneficiaries declared dead in their earlier claims

We observed from the claims data for period from 2012-13 to 2014-15, relating to 10 selected online RCs that 27 claims amounting to ₹5.86 lakh were raised by empanelled hospitals and paid by the RCs in respect of such 18 beneficiaries who had been declared dead during the course of their earlier treatment. Such claims went unnoticed, both at the level of BPA and CFA, which indicate the weakness in controls.

In reply, MD ECHS (August 2015) stated that in case of one beneficiary it happened due to oversight by BPA and an advisory issued to all RCs for not honouring any claims against the particular card ID. In respect of the remaining cases, the anomaly was attributed to an error caused due to shortcomings in the old card (16kb) which had a system to pick the name of only primary member.

The reply is not tenable as the card was used with the MIS application at the ECHS polyclinics and has no linkage with the BPA's application. MD ECHS did not provide the scanned documents of the claims despite repeated requests so the response could be validated. It is also noticed that the reply of MD was confined only to the cases noticed by Audit and not addressing the issue comprehensively by plugging the lapses in internal control systems.

2.6.2.9 Overpayment due to delay in dissemination of revised rates

In February 2013, Ministry of Health and Family Welfare (MoH&FW) revised the rates for coronary angioplasty and coronary stents from the date of issue of the Office Memorandum and this revision led to considerable reduction in rates *i.e.* 44 *per cent* for angioplasty and 62 *per cent* for coronary stents. MD, ECHS, however, notified such revision after two months (**Annexure-XXI**). Due to delay in implementing/notifying revised rates of coronary angioplasty and coronary stents by MD ECHS, empanelled hospitals were allowed an extra payment of ₹62.18 lakh in respect of 133 claims paid by the 10 selected online RCs.

MD, ECHS replied that delay in implementing any downward revision of rates was not done with a view to benefit the empanelled hospitals. There are many factors to it like taking the concurrence of DGAFMS or Department of Ex-servicemen Welfare in MoD, taking necessary inputs from service hospitals as required and non intimation from CGHS about any revision of rates, *etc*.

The reasons put forth by the MD for delay in dissemination of revision of CGHS rates to all stake holders is not tenable as MoD guidelines sanctioning the Scheme clearly stipulate that CGHS rates have to be followed. Further, there is no requirement of concurrence of these rates by the DGAFMS or any other authority.

2.6.2.10 Non-development of audit module for post audit by PCsDA/CsDA

As intimated by CGDA in November 2010, BPA had agreed for online concurrent audit along with system audit. CGDA had accordingly requested the MD, ECHS for inclusion of this condition in the MoA with BPA. We, however, observed that the online post audit module had not been implemented in any of the PCsDA, except PCDA Secunderabad. We found that in implementation thereof, issues/modalities related to recovery trail, audit memo's issuance/settlement, *etc.* were yet to be resolved by the BPA.

In reply, MD ECHS stated (October 2015) that audit module underwent various modifications over a period of time as directed by PCDA Secunderabad and RC ECHS, Hyderabad. PCDA Secundrabad accepted the module in August 2014 and recommended that the same be extended to other CsDA. However, the issue was pending with CGDA for more than a year.

The fact therefore remains that while the module had been developed and found suitable for extension to other CsDA, the implementation is still awaited for want of approval by the CGDA. The existing module developed could have been extended to all CsDA and the deficiencies rectified during the course of usage.

We further observed that non-implementation of online audit module in all PCsDA resulted in non-completion of timely post audit as commented in **paragraph 2.6.2.11.**

2.6.2.11 Inadequate Post Audit of medical reimbursement bills

Financial Procedure for ECHS, issued by MoD in September 2003 stipulates that Bills and connected documents submitted by Hospitals, Nursing Homes, Diagnostic Centres or Consultants to the Polyclinic will be subject to post-audit by regional CsDA after payment by the concerned authority.

We noticed that during 2012-13 to 2014-15, percentage of post audited bills was between 1.99 *per cent* and 56.52 *per cent* only. The total outstanding bills in respect of the five[27] PCsDA/CsDA made available to Audit were 35,73,593 numbers **(Annexure-XXII).**

In reply to the Audit observations the concerned PCsDA/CsDA intimated that the low percentage of post audit was due to shortage of staff. The PCDA, SC, Pune also stated that the ECHS Cell (PCDA, SC, Pune) was formed in the month of June 2013. So, the audit of bills prior to June 2013 of empanelled hospitals (ECHS medical bills) was not conducted. PCDA, CC Lucknow intimated that no separate report for receipt of vouchers prior to 1/4/2013 was maintained.

The fact remains that the PCsDA/CsDA failed to carry out the post audit of the bills as per the laid down financial procedure.

[27] PCDA, WC, Chandigarh, PCDA, SC, Pune, PCDA, CC, Lucknow, CDA(Army) Meerut and CDA Jabalpur.