REVIEW ARTICLE

Strengthening Cooperative Federalism in Health: Decentralizing the Administration (PM-JAY operations) of Government of India Hospitals under AB PM-JAY

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ABSTRACT

Background : The Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is the largest publicly financed health insurance program globally, covering over 12 crore vulnerable families in India. The program empaneled hospitals throughout the country, both government and private. Within the geographical boundaries of a state, State Health Agencies (SHAs) have administered the scheme, however hospitals run by various Government of India (GoI) ministries (e.g., Railways, Defence, Labour/ESIC, Coal, Steel, Petroleum) were directly overseen by the National Health Authority (NHA), creating a dual administrative structure within a state. On 23 June 2025, the Government of India issued a notification transferring the AB - PMJAY operations of all GoI hospitals under AB PM-JAY from the NHA to respective SHAs. **Methodology:** This review critically analyzes official policy documents, existing literature on federal health governance, and operational guidelines of AB PM-JAY. Comparative assessment was undertaken to examine the pre- and post-policy administrative structures with respect to the above mentioned notification. Key themes including efficiency, accountability, resource utilization, and cooperative federalism were explored. **Results:** The transition of administrative authority from the NHA to SHAs is expected to streamline hospital empanelment, claims processing, and grievance redressal by better integration of GoI hospitals into state health systems. Anticipated benefits include improved efficiency, stronger accountability, better beneficiary experience, and enhanced utilization of centrally managed facilities. However, significant challenges were identified, such as inter-ministerial coordination gaps, variation in SHA capacities across states, IT system interoperability issues, claims management delays, and risks of grievance escalation. **Conclusion:** The transfer of GoI hospital management to SHAs represents a pivotal step in strengthening cooperative federalism in Indian health governance. The policy demonstrates the Government of India's commitment to decentralization while retaining national-level oversight.

Mitigation strategies-including capacity building for SHAs, IT standardization, robust centre-state coordination, and proactive beneficiary communication-are essential for ensuring a smooth transition. If implemented effectively, this reform could serve as a model for integrated governance in large-scale health insurance programs and contribute significantly to India's progress toward Universal Health Coverage (UHC).

KEYWORDS

Ayushman Bharat, PM-JAY, Health Insurance, Public Health Policy

INTRODUCTION

1. The Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), launched in 2018, is the largest publicly funded health insurance scheme in the world, with an intended coverage of approximately 500 million beneficiaries across India (1). This scheme represented the shift of focus of the Government of India (GoI) from creating and managing healthcare institutions to empowering the common man to buy healthcare from the available market players, be it government or private. The scheme provides financial protection for secondary and tertiary inpatient care services through an insurance-based model and has been considered a major step towards achieving Universal Health Coverage (UHC) in India (2,3).

The governance of PM-JAY has been characterized by a dual structure. At the central level, the **National Health Authority (NHA)** functions as the apex implementing agency responsible for policy design, standards setting, and oversight. At the state level, implementation has been delegated to **State Health Agencies (SHAs)**, which manage empanelment of hospitals, claims settlement, quality assurance, treatment as per standard treatment protocols, beneficiary grievance redressal etc. within their jurisdictions. This duality reflects India's broader federal health system, where health is constitutionally a state subject but centrally sponsored schemes provide funding and guidance (4).

A unique category within PM-JAY has been the **Government of India (GoI) run hospitals**, operating under various central ministries such as Railways, Defence, Labour and Employment (ESIC), Coal, and Steel. These hospitals, though primarily established for serving specific employees and their family populations, were empanelled under PM-JAY to expand provider networks and enhance accessibility for the beneficiaries of AB - PMJAY who can now gain cashless access to indoor treatment at these GoI Hospitals. Until mid-2025, their administrative management (AB - PMJAY Operations) including empanelment, transaction management, and oversight-was directly undertaken by the NHA.

On **23 June 2025**, an Office Memorandum issued by the Government of India announced a significant structural reform: the transfer of administrative management (AB - PMJAY Operations) of all GoI hospitals empanelled under AB PM-JAY from the NHA to the respective SHAs. This policy shift reflects an effort to harmonize the management of all empanelled hospitals within states under a single administrative framework, thereby aiming to improve efficiency, accountability, and resource utilization. However, such a transition also raises critical questions about federal coordination, institutional capacity, and continuity of service delivery.

This review seeks to critically examine the implications of this policy change. Specifically, it will (i) outline the historical context and rationale for the transfer, (ii) analyze the operational and governance implications for key stakeholders, (iii) identify anticipated challenges in the implementation process, and (iv) suggest mitigation strategies and policy recommendations. By nestling this reform within the broader discourse on decentralization in health systems, the paper aims to contribute evidence-based insights relevant for policymakers, administrators, and health system researchers.

2. Background and Rationale for the Order

The operational architecture of AB - PM-JAY was deliberately designed to balance central guidance with state-level flexibility. As the apex body for implementing AB PM-JAY,

National Health Agency, started functioning as a registered society on 23rd May, 2018. Pursuant to Cabinet decision for full functional autonomy, National Health Agency was reconstituted as the National Health Authority on 2nd January 2019, under Gazette Notification Registered No. DL –(N) 04/0007/2003-18 (5). It oversees scheme guidelines, standard treatment protocols, IT systems, fraud detection, and overall monitoring. In parallel, **State Health Agencies (SHAs)** are responsible for implementing AB - PM-JAY within their respective jurisdictions, including empanelment of hospitals, claims processing, and grievance redressal (6).

A distinct category within AB - PM-JAY empanelled hospitals comprises the **Government of India (GoI) hospitals** functioning under various central ministries such as Railways, Defence, Labour and Employment (Employees' State Insurance Corporation), Coal, Steel, Petroleum, and Power. The AB - PMJAY operations of these hospitals were directly administered under the NHA's IT and transaction management platforms (HEM and TMS), bypassing the SHAs. The rationale for this centralized arrangement was rooted in their administrative control by line ministries at the Union level and their specialized role in serving employees and dependents of respective ministries (7).

However, several limitations of this arrangement became evident over time. First, the **fragmentation of administrative responsibility** led to duplication of processes and inconsistent practices between state-managed and NHA-managed hospitals. Second, GoI hospitals often operated in **isolation from state health systems**, resulting in weaker integration with local referral pathways and monitoring structures (4). Third, the lack of uniformity in claims processing and grievance handling created inefficiencies and sometimes delayed service delivery. These concerns were highlighted in inter-ministerial discussions and in earlier correspondences (8), which advocated for aligning GoI hospitals with state-level structures to improve coordination and resource utilization.

In response, the Government of India issued an Office Memorandum on **23 June 2025**, directing that the administrative management of all GoI hospitals empanelled under AB PM-JAY be transferred from the NHA to the respective SHAs. This transition was justified on three primary grounds:

i. **Integration and harmonization**: Bringing all hospitals under a single state-level administrative umbrella to standardize processes within the state.
ii. **Resource optimization**: Facilitating better utilization of infrastructure and human resources by embedding GoI hospitals into state-level referral and claims networks.
iii. **Decentralized ownership**: Strengthening state capacity and accountability, consistent with the federal design of India's health system.

This policy reform thus represents an effort to **reduce fragmentation, enhance efficiency, and improve beneficiary experience** under PM-JAY. At the same time, it signals a larger trend towards empowering SHAs as pivotal actors in India's health governance framework.

3. The Policy Shift: Transfer of Administrative Management (AB - PMJAY Operations)

The notification dated **23 June 2025** represents a major structural reform in the governance of AB PM-JAY. By transferring the administrative management of all **Government of India (GoI) hospitals** from the **National Health Authority (NHA)** to the **State Health Agencies (SHAs)**, the reform seeks to streamline operational responsibilities and improve integration of service delivery. (15)

Prior to this order, GoI hospitals under central ministries such as Railways, Defence, Coal, Steel, Labour and Employment (ESIC), and Petroleum were directly administered by the NHA through its centralized IT platforms, including the Hospital Empanelment Module (HEM) and the Transaction Management System (TMS). This arrangement, while ensuring uniform central oversight, resulted in fragmentation from the state-level networks where most other public and private hospitals were managed.(10)

The new order mandates that all GoI hospitals will now be managed at the state level by SHAs, similar to their other empanelled hospitals. The transition will include backend

reclassification in NHA's IT systems, with SHAs assuming responsibility for day-to-day operations, including empanelment, claims processing, and grievance redressal. For states operating their own IT systems, new categories will be created for GoI hospitals, while maintaining continuity of historical data through mapping with existing hospital codes. This **before-and-after comparison** highlights the changes entailed by this policy shift:

Table 1. Administrative Management of GoI Hospitals under AB PM-JAY: Before vs After the June 2025 Order

Aspect	Before 23 June 2025 (NHA-led)	After 23 June 2025 (SHA-led)
Administrative control	Directly under NHA	Transferred to respective SHAs
Hospital empanelment	Managed centrally by NHA through HEM	Managed by SHAs within state empanelment frameworks
Claims processing	Centralized processing on NHA's TMS	Decentralized processing via SHAs (or state IT systems)
Grievance redressal	Directly handled by NHA	Handled by SHAs, with local units such as District Implementation Units (DIUs) providing support
Integration with state systems	Limited; operated as a separate category	Full integration with state-level PM-JAY networks
Data management	Entirely on NHA platforms	Shared responsibility; continuity ensured through hospital code mapping
Accountability	Primarily NHA	Primarily SHA, with NHA retaining policy oversight
Coordination	Direct reporting to NHA	Dual coordination with SHAs (operational) and NHA (policy)

This reconfiguration reflects a broader **decentralization trajectory**, aligning centrally controlled institutions with state-level administrative structures. While intending to enhance **efficiency, ownership, and harmonization**, it also necessitates careful management of **transitional challenges**, including capacity gaps, coordination between central ministries and SHAs, and IT system integration.

4. Key Implications of the Order

The transfer of administrative management (AB - PMJAY Operations) of Government of India (GoI) hospitals from the National Health Authority (NHA) to State Health Agencies (SHAs) has significant implications for the governance, efficiency, and effectiveness of AB PM-JAY. These implications can be grouped into following domains:

4.1. Improved Integration and Harmonization - By shifting GoI hospitals under SHA management, all empanelled facilities within a state whether public, private, or centrally administered (GoI Hospitals) start operating under a **common administrative framework**. This harmonization reduces institutional fragmentation, simplifies and integrates referral pathways, and creates a unified ecosystem for beneficiaries. Previous analyses of health insurance schemes in India have emphasized that integration of providers into a single state-level framework improves monitoring and efficiency (6. 11).

4.2. Enhanced State Ownership and Accountability - The decentralization of responsibilities aligns with India's federal health system, where health is primarily a state subject under the Constitution. Empowering SHAs with administrative authority over GoI hospitals (for AB - PMJAY Operations) fosters greater **state-level ownership** for utilisation of these hospital's resources for the treatment of state subjects and strengthens accountability for service delivery. This approach resonates with global experiences where decentralization has been associated with stronger responsiveness to local needs (9).

4.3. Optimized Resource Utilization - GoI hospitals are often well placed in terms of infrastructure and human capital. However, their access is restricted to the organizations' employees and their beneficiaries. Hence the scope of improving its utilisation has been enabled by registering these GoI Hospitals with AB - PMJAY. Until recently, these AB - PMJAY

Operations for GoI Hospitals were directly under NHA. Embedding them within SHA networks facilitates better integration with **local referral systems**, enabling optimal utilization of existing capacities for the benefit of local populace also. This is particularly critical for specialized GoI institutions such as railway and defence hospitals, which can now serve a larger beneficiary base under PM-JAY without administrative isolation.

4.4. Streamlined Beneficiary Experience - Prior to the order, beneficiaries often faced confusion when accessing GoI hospitals because administrative procedures and grievance mechanisms differed from those of state-managed facilities. Shifting the oversight to SHAs will standardize processes for **empanelment, claims settlement, and grievance redressal** thereby improving beneficiary experience, familiarity and trust in the scheme.

4.5. Strengthened Monitoring and Support Structures - With SHAs now directly managing the AB PM-JAY operations of GoI hospitals, existing **district implementation units (DIUs)** and state-level monitoring mechanisms can extend their support to these institutions. This enables better oversight of fraud prevention, quality assurance, and adherence to treatment protocols, the areas in which limited assistance was available to GoI hospitals in previous arrangement due to distance and bureaucratic complexity.

4.6. Policy Signaling Towards Decentralization - Beyond operational benefits, the order signals a clear **policy trajectory towards decentralization** of health governance in India. It underscores the role of SHAs as not merely implementing agencies but as **primary custodians of health financing reform**, with the NHA serving as a guiding and regulatory body. This shift strengthens the long-term sustainability of PM-JAY by embedding and integrating it more firmly within state health systems. (6)

5. Implementation Challenges - The transfer of administrative management of Government of India (GoI) hospitals from the National Health Authority (NHA) to State Health Agencies (SHAs) (for AB PM-JAY) introduces several implementation risks across governance, operational, and technical domains. Anticipating these challenges is essential to preserve historical data, service continuity, data security, data retrieval and the integrity of AB PM-JAY during the transition period.

5.1 Centre-State and Inter-ministerial Coordination - GoI hospitals are owned and governed by Union ministries (Railways, Defence, Labour/ESIC etc.), while SHAs are state-level bodies. Aligning administrative directives, budgetary processes, and performance expectations across these federal tiers will be a new territory for the officials concerned. It may become difficult, particularly where existing ministry protocols diverge from SHA norms. Absent directives on clear intergovernmental communication channels, ambiguities in authority and escalation ladder could delay decisions and dilute accountability (6,12).

5.2 Heterogeneity in SHA Institutional Capacity - SHAs vary in staffing, provider-management capability, claims adjudication expertise, claims adjudication process and contracting sophistication. States with limited institutional capacity may struggle to absorb GoI hospitals rapidly, risking uneven performance and beneficiary experience across jurisdictions (6,12).

5.3 IT Interoperability and Data Governance - States operating their own IT stacks must integrate GoI hospitals as a distinct category while preserving historical records and hospital codes on national systems (HEM/TMS). Risks include API mis-mapping, latency in transaction processing, duplicate records, and breaks in longitudinal data needed for audit and fraud analytics. Data protection, consent artifacts, and access controls will need to be consistently enforced across federated platforms (10,15).

5.4 Continuity of Claims and Provider Payments - Handling of pending claims at the time of transition from NHA to SHA administration will need framing of clear cut rules and procedures to be followed, to prevent rejection, duplication, or delayed settlement. Any lag in tariff recognition, package mapping, or pre-authorization pathways during the handover could affect

hospital cashflows and willingness of these hospitals to serve PM-JAY beneficiaries (6,10).

5.5 Change Management within GoI Hospitals - Operational cultures in GoI hospitals-accustomed to direct interfaces with NHA, must adapt to SHA SOPs, district-level handholding, and state monitoring dashboards. Transitional uncertainty may increase administrative burden for clinical managers and claims teams, with potential knock-on effects on turnaround times (TATs) and discharge processes (6, 12).

5.6 Accountability Chains and Grievance Redressal - Introducing SHAs as the operational locus lengthens the accountability chain (Hospital → DIU → SHA → NHA for policy). Without time-bound escalation matrices, beneficiary grievances and hospital queries may experience slower closure, eroding trust and perceived responsiveness (14,12).

5.7 Dual Governance in Non-PM-JAY States - In states/UTs not implementing PM-JAY, GoI hospitals remain under NHA administration. This creates a parallel governance model that complicates national reporting, comparative performance assessment, and cross-border portability for beneficiaries (4, 14).

5.8 Fraud Control, Audit, and Quality Assurance - NHA's centralized analytics and blacklist registries must remain effective when operational oversight is decentralized. Differential SHA capacities in audit, coding review, and anti-fraud surveillance heighten risks of upcoding, unnecessary admissions, and package gaming unless common tooling and periodic joint audits are enforced (13,14). Capacity building initiatives of SHAs in these areas become more urgent and necessary activities with this order.

5.9 Communication and Beneficiary Experience - While entitlements remain unchanged, beneficiaries may encounter transient confusion (authorization routes, helplines, grievance portals). Poorly sequenced IEC can translate into avoidable care delays, especially for planned tertiary procedures (6,13).

5.10 Policy Drift and Tariff Variability - Decentralized administration can unintentionally widen inter-state variation in package adoption, pre-auth criteria, and provider payment timelines. Without a strong common minimum standard, this may undermine portability and equity across states (11,12,14).

5.11 Intraministerial reconciliation - The GoI hospitals under each Central ministry, situated in different states may now be dealing with different Health Benefit Packages, different rates and different time lines in terms of pre-auth criteria, pre-auth process, pre-auth timelines and provider payment timelines. Individual hospitals will be bound by respective SHA's policies and procedures but in the ministries it may result in confusion and will require reconciliation at the central level.

6. Mitigation Strategies and Implementation Framework

The successful transfer of administrative management of GoI hospitals under AB PM-JAY to State Health Agencies (SHAs) requires a structured approach that balances **decentralization** with **national oversight**. Drawing on health systems research and global experiences of decentralization, the following strategies can mitigate risks and support effective implementation. (15,16)

6.1. Centre-State Coordination Mechanisms

- **Tripartite MoUs:** Formal agreements between NHA, SHAs, and respective Union ministries (e.g., Railways, Defence, ESIC) can clarify roles, escalation protocols, and budgetary flows. These MoUs will have to be hospital and state specific and thus each GoI ministry will have to enter into multiple MoUs.
- **Joint Steering Committees:** Establishing committees at national and state levels will enable regular dialogue, resolve operational bottlenecks, and ensure policy coherence across federal tiers. (17)

6.2. Strengthening SHA Institutional Capacity

- **Capacity-building programs:** Targeted training for SHA and District Implementation Unit (DIU) staff in provider management, claims adjudication, and hospital engagement.
- **Resource augmentation:** Additional staffing and technical assistance for SHAs in low-capacity states, potentially financed

through the PM-JAY administrative budget.

- **Peer learning platforms:** Facilitating cross-state knowledge exchange to replicate good practices from high-capacity/ better performing states.

6.3. Ensuring IT Interoperability and Data Continuity

- **API standards:** Enforcing national interoperability standards for API design and data exchange to ensure seamless mapping of hospital codes and transaction records.
- **Data governance protocols:** Clear guidelines on ownership, consent, and access to hospital and beneficiary data to avoid fragmentation and duplication.
- **Unified dashboards:** Maintaining a central NHA dashboard that aggregates SHA-level performance and hospital activity for oversight and comparative monitoring.
- Dashboards for GoI Ministries: A dashboard depicting the hospitals of respective Ministries will make the intraministerial coordination easier and processes transparent. (18)

6.4. Smooth Transition of Claims and Payments

- **Clear cut-off protocols:** Defining responsibility for pending claims before and after 23 June 2025 to avoid disputes and payment delays. (16)
- **Bridging teams:** Temporary joint teams from NHA and SHA to monitor payment continuity during the transition window.
- **Escrow mechanisms:** States may use escrow accounts for time-bound settlements, reducing liquidity risk for hospitals.

6.5. Change Management within GoI Hospitals

- **SOP harmonization:** Developing and disseminating standard operating procedures for empanelment, claims, and grievance redressal aligned with SHA systems.
- **Training and orientation:** Induction sessions for hospital administrators, claims managers, and clinical staff on SHA workflows.
- **On-site support:** SHA/DIU nodal officers deployed to GoI hospitals for initial handholding.

6.6. Strengthening Grievance Redressal and Accountability

- **Time-bound escalation matrices:** Defining maximum response times for DIUs, SHAs, and NHA to address hospital and beneficiary grievances.
- **Integrated helplines:** Synchronizing SHA helplines with NHA's grievance systems to ensure beneficiaries receive consistent responses. (17, 18)
- **Public dashboards:** Transparency tools displaying turnaround times, claims settlement, and grievance closure rates. (18)

6.7. Fraud Control and Quality Assurance

- **Hybrid audits:** Joint NHA-SHA audits of GoI hospitals during the first two years to safeguard against upcoding and package misuse.
- **Fraud analytics tools:** Extending NHA's central fraud detection algorithms to SHA-level monitoring units.
- **Standard treatment guidelines:** Reinforcing compliance with NHA's Health Benefit Packages (HBPs) and guidelines to minimize variability.

6.8. Communication and Beneficiary Engagement

- **Targeted IEC campaigns:** Informing beneficiaries that their entitlements remain unchanged despite the administrative shift.
- **Beneficiary-facing FAQs:** Disseminated through hospitals, call centers, and SHA portals to reduce confusion.
- **Feedback loops:** Collecting patient feedback during the transition period to adapt communication strategies.

6.9. Preventing Policy Drift and Tariff Variability

- **Common minimum standards:** NHA should issue binding guidelines on packages, tariffs, and payment timelines to avoid inter-state inequity.
- **Periodic convergence reviews:** Quarterly reviews comparing SHA practices to national benchmarks to minimize divergence.

6.10. Implementation Roadmap

The transition requires a **phased framework**:

1. **Preparation Phase (0-3 months):** Finalize MoUs, issue SOPs, and conduct training for SHAs and hospitals.
2. **Transition Phase (3-12 months):** Operationalise joint NHA-SHA monitoring teams, migrate IT systems, and ensure claims continuity.
3. **Stabilization Phase (12-24 months):** Consolidate accountability structures, refine grievance redressal, and embed fraud analytics.
4. **Maturity Phase (>24 months):** SHA fully assumes operational control with periodic NHA oversight audits.

CONCLUSION

The notification dated **23 June 2025**, transferring administrative management of Government of India hospitals under Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) from the **National Health Authority (NHA)** to respective **State Health Agencies (SHAs)**, represents a significant policy shift India's health governance landscape. This change reflects the Government of India's continued commitment to strengthening **federal cooperation**, improving **operational efficiency**, and enhancing the **responsiveness of health services** to beneficiary needs.

By decentralizing the day-to-day administration of centrally governed hospitals to SHAs, the Government has recognized the importance of **state-level ownership** while maintaining NHA's role in policy framing, financing, and oversight. This transition is expected to streamline service delivery, reduce administrative fragmentation, and ensure optimal utilization of available infrastructure in Union ministry hospitals for the benefit of PM-JAY beneficiaries. Importantly, it also reinforces the principle of **cooperative federalism**, which has long been emphasized as essential for health sector performance in India.

At the same time, the change brings into focus challenges related to **inter-government coordination, IT interoperability, claims management, fraud control, and continuity of care**. The Government's proactive steps, such as maintaining hospital codes on the national platform, clarifying transitional protocols, and directing SHAs to provide support through District Implementation Units (DIUs), demonstrate foresight in anticipating operational bottlenecks.

Moving forward, the way to sustain the success of this change will involve:

1. **Strengthening intergovernmental coordination** through tripartite agreements and steering committees between NHA, SHAs, and Union ministries.
2. **Investing in SHA capacity** to reduce heterogeneity in implementation performance across states.
3. **Ensuring IT and data governance standards** to maintain seamless claims processing and fraud surveillance.
4. **Prioritizing beneficiary communication** to reinforce trust and minimize confusion during transition.
5. **Embedding accountability mechanisms** to align state-level operations with national policy objectives.

RECOMMENDATION

This reform is a testament to the **Government of India's resolve to adaptively evolve PM-JAY**, ensuring that the world's largest publicly financed health insurance scheme continues to deliver equitable, efficient, and high-quality care. By leveraging both central oversight and state-level proximity, India is setting an example of **dynamic health governance reform** in a large and complex federal system.

If implemented with careful attention to change management, capacity-building and system integration, this initiative has the potential to not only improve resource utilization in GoI hospitals but also strengthen the overall resilience and inclusiveness of India's health system.

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RJK & RN involved in Conceptualization, literature search, writing the original draft of manuscript, literature search, planning, conduct and editing. RS, AG & SS involved in review and editing. All the authors have read and agreed with the submitted manuscript.

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