Health Policy Plus
October 2020

Strategic Health Purchasing Reforms for HIV

Targeting Better Outcomes at a Better Price

Summary Recommendations

HIV Program Requirements to Support Scale-up of the HIV Response	Recommended Strategic Purchasing Actions to Support HIV Program Requirements
1. Incentivize primary care facilities to retain HIV patients on antiretroviral therapy within their care.	1. Implement performance-based capitation at the primary healthcare level to incentivize retention in care of people living with HIV.
2. Promote multi-month dispensing and decentralized service delivery models.	2. Strengthen referral and down-referral policies to ensure case management of people living with HIV at the appropriate facility level.
3. Increase back-referral from hospitals to primary care facilities for stable HIV patients on antiretroviral therapy.	3. Revise HIV-related case-based groups to discourage retention of people living with HIV at hospitals for cases not requiring hospitalization.
4. Support the scale-up of antiretroviral procurement and routine viral load testing.	4. Support more efficient procurement of antiretrovirals and improved pricing for the scale-up of viral load testing.

Note: The first three recommendations are complementary and mutually reinforcing. They are best implemented as a suite of solutions to reform HIV purchasing arrangements.

Introduction

The Government of Indonesia plans to rapidly scale up access to HIV services to meet newly established minimum service standards and achieve ambitious HIV targets under its Antiretroviral Therapy (ART) Acceleration Plan. The significant scale-up of the HIV response, combined with projected declines in external financing support for HIV and limited domestic resource availability, require the government to consider strategic purchasing reforms for HIV service provision. This will ensure optimal use of resources to achieve targets and successfully curb the HIV epidemic.

In 2018, the Health Policy Plus (HP+) project—funded by the U.S. Agency for International Development—completed analyses of the costs of implementing a fast-track strategy to scale-up the HIV response in Indonesia. This strategy forms the basis of the ART Acceleration Plan. HP+ also completed a unit costing exercise tailored specifically to the HIV epidemics in Jakarta and Papua. Based on the projected resources needed to achieve ambitious scale-up targets, HP+ assessed the options available to fund the response through improved purchasing arrangements with the national health insurance scheme—Jaminan Kesehatan Nasional (JKN). Funding more HIV services through JKN could improve the efficiency, effectiveness, and sustainability of HIV financing by (1) reducing reliance on input-based, supply-side financing from central or local governments and (2) reducing reliance on external financing.

Through this financing analysis, HP+ found that financial resource requirements for HIV are estimated to more than double between 2018 and 2023. Given this, the implementation of strategic purchasing reforms for the financing of HIV commodities and service delivery through JKN and the national HIV program will be essential to contain costs, promote efficiency, and improve outcomes.

This document summarizes findings and recommendations from analyses and consultations that have taken place among the HIV Strategic Health Purchasing Technical Working Group, led by the Ministry of Health's Center for Health Financing and Insurance and the Ministry of Health's HIV Sub-directorate, with support from HP+. Consultations included a workshop in November 2019 with Jakarta-based clinicians (from both primary healthcare and hospitals), implementing partners, and civil society organizations to understand the current state of HIV service provision firsthand from practitioners, including provider perceptions on managing HIV patients and implementing referral and down-referral policies.[1] The HIV Strategic Health Purchasing Technical Working Group is aligned with similar working groups established to consider strategic purchasing reforms for maternal and neonatal health services and tuberculosis. This document:

1. Provides a summary of key areas in which improved HIV service delivery arrangements tied to more efficient financing mechanisms can improve outcomes for people living with HIV
2. Outlines recommended financing and strategic purchasing arrangements and the potential for their impact in Indonesia
3. Suggests next steps to move these recommendations forward, including through a pilot project
4. Serves as a basis for further consultation with government counterparts and key stakeholders

State of HIV in Indonesia

HIV Policy Objectives

As mentioned previously, the Government of Indonesia plans to rapidly scale up access to HIV services to achieve ambitious targets for identification, ART, and viral load testing through the Ministry of Health's ART Acceleration Plan (Circular Letter No. 1822/2019). The latest HIV case report, from the second quarter of 2020, estimates that there are 543,100 people living with HIV in Indonesia. As of June 2020, 63 percent of people living with HIV knew their status, 25 percent of people living with HIV were on ART, and 4 percent of people living with HIV were virally suppressed (see Figure 1). The goal under the ART Acceleration Plan is to have 40 percent of people living with HIV on ART by December 2020 (approximately 217,000 people—1.6 times the number of those that were on ART in June 2020), and 90 percent of people living with HIV on ART by December 2027. At current retention rates—only 48 percent of people living with HIV who are initiated on ART are retained on ART—an additional 170,000 people living with HIV would need to be initiated on ART to achieve the 2020 target. However, with concerted effort to improve retention and find patients that have been lost to follow-up, the number of new ART initiations required to meet the 2020 target could be significantly lower.

[1] Down-referral, sometimes referred to as back-referral, is the process of referring back to a lower-level facility for appropriate care, as long as the patient's immediate health is not at risk.

Figure 1. HIV Care Cascade (June 2020)

Source: Indonesia Global Fund Grant Quarterly Review Meeting (second quarter, unofficial)

Apart from the ART Acceleration Plan, the other major policy document guiding the HIV response in Indonesia is Ministry of Health Regulation 4/2019, which sets out technical requirements to meet minimum service standards for health. This regulation requires local governments to apply minimum service standards for basic preventive and promotive services within public and private primary healthcare facilities. HIV screening and prevention services constitute one of the twelve standards all local governments are responsible for. Coupled with District Health Office directives under the ART Acceleration Plan (see Box 1), local governments will be identifying and linking many more people living with HIV who know their status to facilities for ART services. Strategic purchasing reforms can support several of these directives, in particular: incentivizing more providers to deliver ART and retain patients on ART, appropriately financing improved HIV counseling services, supporting the rollout of multi-month scripting for eligible HIV patients, requiring HIV/AIDS information system reporting as a pre-condition for payment, and supporting the scale-up of viral load testing services.

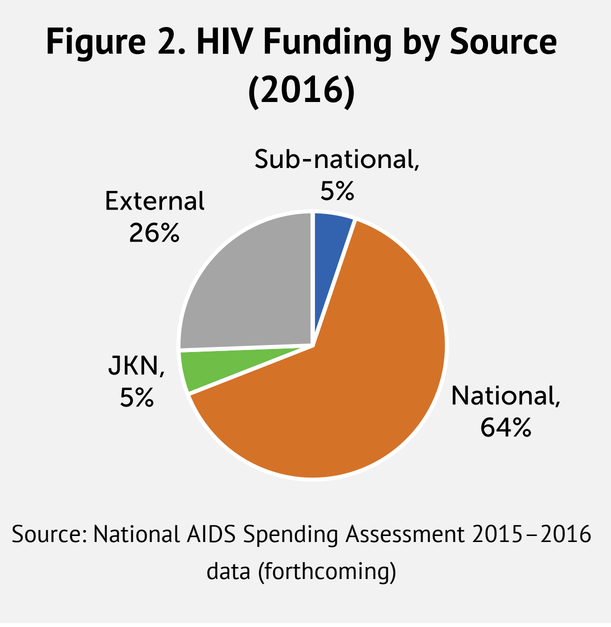
Box 1. District Health Office Directives under the ART Acceleration Plan

1. Apply the HIV test and treat policy and provide tuberculosis preventive therapy as part of ART services
2. Reconvene the sustainable service forum to accelerate ART
3. Expand the number of providers delivering ART services
4. Improve HIV counseling services
5. Expand mentoring support through district clinical mentoring team
6. Strengthen reporting of HIV service provision into the HIV/AIDS information system
7. Improve linkage of people living with HIV to ART services
8. Improve HIV testing, counseling, viral load monitoring, and outreach services among priority populations on ART

HIV Financing

In 2016, the government financed 74 percent of the HIV program in the country, with the remainder funded by donors (see Figure 2). This does not include out-of-pocket spending by patients on HIV services, which mostly cover consultation fees not paid for by JKN or the HIV Sub-directorate. Antiretrovirals (ARVs) and viral load tests are paid for through the national budget and donors. JKN played a small role, funding just 5 percent of the response, mostly through Indonesia case-based group payments for care at the hospital level. The national health insurance agency, Badan Penyelenggara Jaminan Sosial Kesehatan or BPJS-K, funds HIV services through JKN using provider payment mechanisms employed at different levels of the health system.

Figure 2. HIV Funding by Source (2016)



Source: National AIDS Spending Assessment 2015–2016 data (forthcoming)

For JKN members, the cost of a primary care provider's time associated with provision of HIV services is assumed to be covered through a combination of JKN (through capitation at the primary care level) and supply-side financing, as there is no separate payment for these consultations. Basic bio-chemistry services are covered under JKN, however HIV rapid test kits, CD4 tests, and viral load tests are all excluded from JKN and funded by the national government. The national government also pays for most ARVs. The Global Fund procures second-line ARV drugs, and covers any shortfall of first-line ARV drugs on occasions when national procurement tenders are unsuccessful (the last instance being in 2018). Meanwhile, local government transfers cover a portion of facility costs and public health services for HIV. BPJS-K essentially covers the consultation fee, and if an HIV patient does not have JKN membership or does not use it (for any number of reasons, including not wanting to access care from their regular primary care provider), they may pay out-of-pocket for the consultation fee. Overall, fragmented funding streams for the delivery of HIV services result in conflicting incentives, ambiguous accountability for the HIV response among institutions, and ultimately access and financial protection challenges for people living with HIV.

At the hospital level, BPJS-K uses Indonesia case-based group (INA-CBG) payments to reimburse providers for both inpatient and outpatient HIV services. Since 2014, there has been an increase in the amount that BPJS-K pays for HIV services. Total inpatient case volume coded to HIV infection (INA-CBG: A-4-15) has increased from 10,678 cases in 2014 to more than 20,000 cases in 2017. Total expenditure has also risen from IDR 63 million in 2014 to more than IDR 260 million in 2017. Approximately IDR 160 million (81 percent) of this increase is due to steadily increasing INA-CBG rates across all three severity levels. The rates increased by 127 percent, 119 percent, and 87 percent for mild, moderate, and severe cases, respectively, between 2014 and 2016.

Given the increase in HIV patients on ART expected through implementation of the ART Acceleration Plan, it is opportune to revisit potential efficiency opportunities that could be realized through improved purchasing of HIV service delivery at all levels of the health system, funded through both JKN and the HIV program. Similarly, given the significant increase in ARV drugs and viral load tests required as more HIV patients are identified, initiated, and retained on ART, there is a need to explore options to scale up and increase the efficiency of ARV drug and viral load test procurement, distribution, and payment.

Strategic Health Purchasing for HIV Services

The HP+ technical team, which included Indonesian experts, analyzed the role of purchasing arrangements and provider payment incentives in HIV service delivery and financing. The team found that the current financing arrangements for HIV are not optimal to facilitate the rapid scale-up of persons on ART proposed by the ART Acceleration Plan. The analysis suggests that a combination of improved service delivery arrangements and appropriate purchasing reforms could incentivize providers to support the scale-up of HIV service provision and promote improved quality and outcomes for HIV patients, as well as more sustainable financing of HIV services.

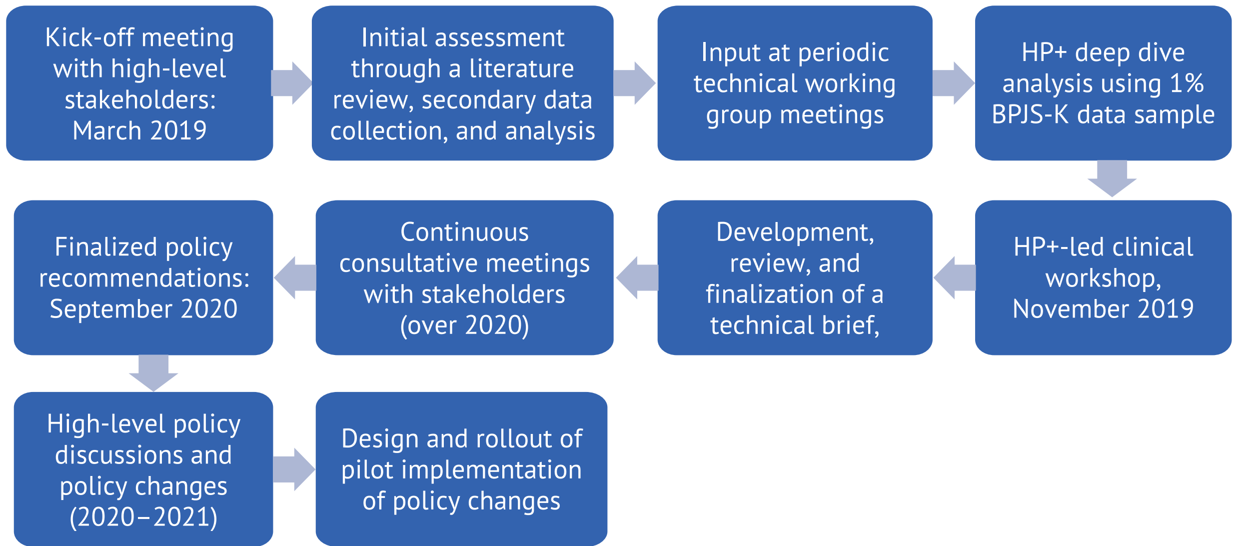
Strategic purchasing of health goods and services can create stronger incentives for efficient delivery of high-quality, cost-effective services. To improve purchasing arrangements and create stronger incentives for more efficient and effective HIV service delivery, a comprehensive approach was taken to assess and optimize the four key components of purchasing. These include:

- Specification of the benefits and service delivery standards (*"what to buy"*)
- Contracting arrangements (*"from whom to buy"*)
- Payment mechanisms and rates (*"how to buy"*)
- Provider monitoring

Since the launch of JKN in 2014, some inefficiencies in the design and implementation of purchasing arrangements have resulted in rapid HIV expenditure growth at the hospital level, insufficient reliance on primary care facilities across all provinces as the backbone of the HIV response, and insufficient scale-up of optimized ARV treatment regimens and viral load testing to confirm suppression. The way HIV services are currently funded through JKN creates weak incentives for primary care providers to accept and retain HIV patients for lifelong ART care and creates strong incentives for hospitals to continue treating stable HIV patients on ART rather than referring them down to the primary care level.

HP+ has developed a policy implementation process, working with the Center for Health Financing and Insurance and HIV Sub-directorate, which is summarized in Figure 3. This process is meant to ensure consensus-building and technical scrutiny of the recommendations for changes to provider payment mechanisms for HIV through both JKN and HIV program funding.

Figure 3. Development of HIV and JKN-Related Recommendations for Policy Shifts and Implementation Plan



HIV Priorities Amenable to Purchasing Reforms

Based on the Government of Indonesia's policy priorities and financing landscape, the HIV Strategic Health Purchasing Technical Working Group identified key HIV service delivery and financing priorities that could be addressed (at least partially) by improved purchasing arrangements and provide incentives under both JKN and program funding. These HIV priorities are focused on the latter two components of the strategic purchasing framework, namely payment mechanisms and rates and provider monitoring. Indonesia's HIV benefits package is already comprehensive, if somewhat fragmented in funding as noted previously. Therefore, the technical working group did not identify a need to focus on "what to buy" but rather on "how to buy." Similarly, HIV services are available at all levels of the health system and there was limited need to focus on contracting mechanisms ("from whom to buy"). Rather it was agreed to focus on driving cost efficiencies and expanding access using reforms to payment mechanisms and rates as well as provider monitoring to ensure HIV services are delivered at the appropriate level of the health system. Priorities for the HIV response are detailed next, followed by policy options and recommendations to address them through reforms to payment mechanisms and provider monitoring.

1. Incentivize primary care facilities to retain HIV patients on ART within their care

Primary care facilities are expected to deliver HIV services for stable HIV patients as part of the 144 standard diagnoses included in the Indonesian Doctors Competency Standards (Indonesian Medical Council Regulation of 2012).[2] These services should be recorded under code B20 in the P-Care system.

Based on the current ART cascade, 90 percent of patients on ART who had a viral load test were virally suppressed. Given viral suppression is a critical determinant of patient stability, and if we assume the current small number of viral load tests (17.2 percent of patients on ART have received a viral load test in the first six months of 2020) is representative of the total population of HIV patients on ART, it appears approximately 90 percent of patients could be considered stable. This was corroborated with anecdotal evidence from the clinical workshop where some providers estimated that more than 90 percent of their current cohort of HIV patients are stable and able to be managed at the primary care level.

Analysis of BPJS-K's 1 percent data sample from 2015 and 2016 (which includes both hospital and primary care datasets) suggests that approximately 45 percent of HIV patients on ART are seeking care through JKN. The proportion of HIV patients who are JKN members has increased since, with a 2019 survey by USAID's LINKAGES project of key populations receiving PEPFAR-supported community-based services in Jakarta province revealing that 88 percent of HIV-positive key populations and 65 percent of HIV-negative key populations are JKN members, respectively. Nevertheless, some patients may elect not to use their JKN coverage for HIV services to grant greater flexibility in accessing care. Regardless, all HIV patients have their ARV drugs covered by the national program (or donors in limited cases) and if a patient chooses not to use JKN to access ART from public primary health care centers (known as *puskesmas*) they would be required to pay a nominal consultation fee, or alternatively pay out of pocket to access drugs and services through the private sector.

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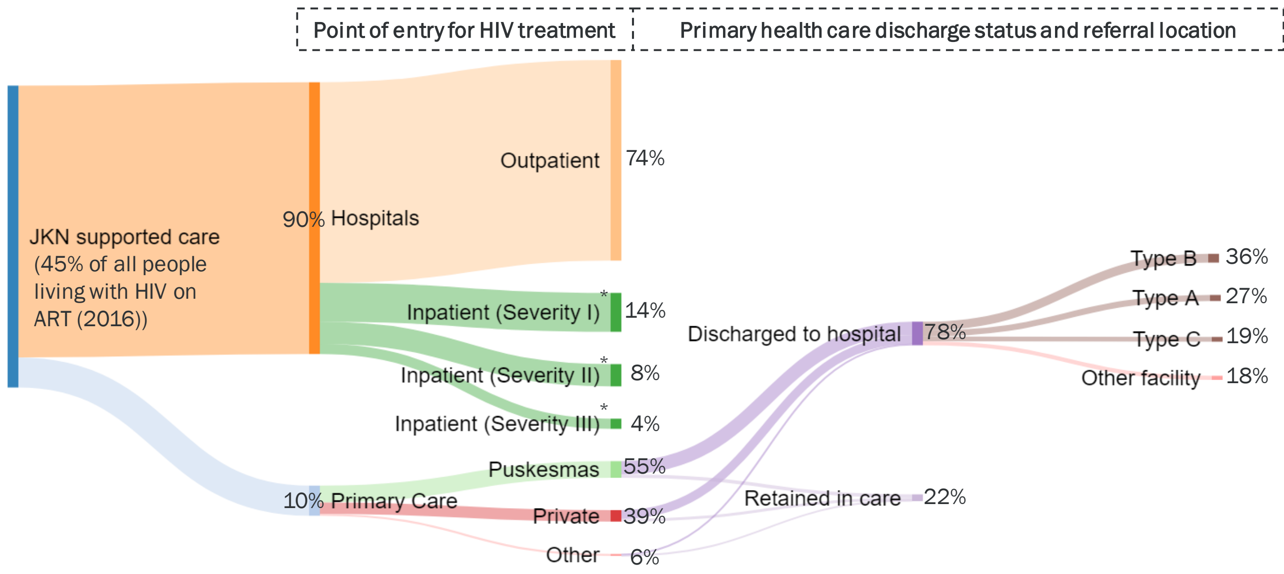
[2] The ART Acceleration Plan defines stable/uncomplicated patients as: (1) having been receiving ARVs for at least one year, (2) without adverse drug reactions requiring regular monitoring, (3) not currently sick, with a good understanding of adherence, and (4) with evidence of successful treatment (viral load undetected or CD4 cell examination twice within six months with a CD4 cell count > 200 cells/mm^3).

Of the 45 percent of HIV patients on ART who are JKN members and use their BPJS-K benefits to access care, it appears only around 10 percent are accessing ART at the primary care level (see Figure 4). The remainder are accessing care at hospitals. Furthermore, the discharge status for most HIV patients (79 percent) who first seek care at the primary care level is "referred to hospital." By facility type, most referral cases came from puskesmas (56 percent), followed by private clinics (39 percent). The referral rate from puskesmas was slightly higher (81 percent) than from private providers (77 percent). The most common referral destination was Type B hospitals (36 percent), followed by Type A and Type C hospitals (27 percent and 19 percent, respectively).[3]

Figure 4. Level of Care for HIV Patients using JKN from Point of Entry to Referral (2015 and 2016)



Source: HP+ analysis of BPJS-K 1 percent data sample (2015 and 2016)

* For inpatient care, the INA-CBG reimbursement system allows the provider to code diagnoses based on their assessment of severity according to three levels: I (mild), II (moderate), and III (severe).

The low proportion of HIV patients using JKN coverage to access ART at the primary care level (4.5 percent of all HIV patients) has been corroborated through stakeholder discussions that point to two main factors:

- In 2015 and 2016 (the time frame for this data sample), ART was still mostly delivered at the hospital level, as decentralization of ART had not been fully implemented. In 2014, Ministry of Health Regulation 87/2014 appointed 508 hospitals and 367 puskesmas to perform HIV services and treat people living with HIV and those at risk of contracting HIV. This set up an HIV response that was led by hospitals
- Full decentralization of ART has only occurred in Jakarta province, where 42 puskesmas deliver ART; in many outlying provinces, HIV care is still delivered at the hospital level, and ARVs do not reach the puskesmas

[3] Type A hospitals are top referral hospitals and provide a wide range of subspecialty services. Type B hospitals are established in each provincial capital as the referral point for district hospitals and provide a wide range of specialist services and limited subspecialist services. Type C hospitals receive case referrals from puskesmas and provide limited specialist services. (Mahendradhata, Y., L. Trisnantoro, S. Listyadewi, P. Soewondo, T. Marthias, et al. 2017. *The Republic of Indonesia Health System Review*. Health Systems in Transition, Vol-7 No.1. WHO Regional Office for South-East Asia.)

Revised purchasing of HIV services through JKN at the primary care level can improve compliance with the requirements for primary care facilities to treat and retain stable HIV patients, rather than referring them to hospitals.

2. Promote multi-month dispensing and decentralized service delivery models

There are opportunities to improve the efficiency of HIV service delivery at primary care facilities to significantly increase the number of patients on ART over the coming years. The ART Acceleration Plan calls for multi-month dispensing of ARVs (up to a maximum of three months) for stable HIV patients, and the new HIV regulations being developed in collaboration with the World Health Organization includes further guidance on multi-month dispensing. However, feedback from consultations with ART providers indicates that currently, multi-month dispensing is implemented on an ad-hoc basis, considering patient preferences (e.g., working offshore or overseas for extended periods of time) rather than clinical criteria of eligibility. More systematic and protocol-driven implementation of multi-month dispensing will reduce provider workload as the number of HIV patients increases, and also will reduce the financial burden on HIV patients from costs associated with travel to and from facilities and absence from work.

As mentioned previously, in Jakarta, ART has been decentralized to the puskesmas level, however many outlying provinces still deliver ART at the district hospital level. Reforms to purchasing and ART supply chain management are needed to allow decentralized service delivery to be scaled up nationally to provide improved access to ART for HIV patients. This aligns with the ART Acceleration Plan directive to expand the number of providers (both public and private) delivering ART services and will allow for lower cost provision of care if the right incentives for retention of HIV patients are implemented concurrently.

3. Increase down-referral from hospitals to primary care facilities for stable HIV patients on ART

To increase the number of HIV patients managed for care at the primary care level, there is a need to strengthen down-referrals from hospitals to primary care facilities for stable HIV patients on ART. This will expand access and choice for patients, while also driving greater efficiency by reducing unnecessary spending at higher-level facilities. The BPJS-K 1 percent data sample reveals that 74 percent of HIV patients managed at the hospital level are managed in the outpatient department, where the hospital still receives INA-CBG payments for each visit. These patients are likely strong candidates for down-referral. Even for HIV patients with co-morbidities, down-referral may be clinically valid, as 66 percent of patients on ART at the hospital level had secondary diagnoses that were within the list of 144 diagnoses to be managed at the primary care level. Patients have the right to disregard down-referral instructions and elect to remain in care at a hospital. However, BPJS-K is under no obligation to reimburse such claims; therefore, patients who elect to continue treatment at hospitals would have to pay out of pocket for it.

Participants at the clinical workshop confirmed that many patients who have established trust with a particular hospital want to remain there for ongoing ART treatment. In addition, patients appreciate the additional privacy afforded by attending a hospital for ART as opposed to their local puskesmas where they may be recognized by family and friends. This highlights a need for HIV case management review and strengthening at the primary care level to ensure ART care meets minimum quality standards. An interim measure that would still promote patient privacy would be for HIV patients to receive ART at an alternative puskesmas rather than a hospital. A mechanism to allocate funding to the alternative puskesmas (a portion of the JKN member's capitation payment or

some other allocation method) will allow it to be adequately reimbursed for delivering ART care to patients outside their catchment area, while still generating efficiency gains of providing ART at the primary rather than hospital level.

A possible mechanism to encourage down-referral of clinically appropriate cases is to review the hospital payment model for HIV care—specifically, INA-CBG payments under the overall heading "HIV infections" should be reviewed. Further, a continued increase in rates may incentivize hospitals to retain or admit HIV cases beyond what is medically necessary or efficient. For example, rates for INA-CBG inpatient code A-4-15 (HIV infection) increased by 127 percent, 119 percent, and 86 percent for mild, moderate, and severe cases, respectively, from 2015 to 2016. The underlying shifts in input costs or service standards informing any rate revisions should be reviewed retrospectively before further increases occur. The underlying clinical diagnoses and related BPJS-K reimbursement rates for HIV-related outpatient INA-CBG case groups (Q-5-34 and Q-5-35) should also be reviewed to see if they have continued validity when reconsidering the capacity of the primary care level for HIV care. One possibility is that the diagnoses these codes cover are not appropriate to manage at the hospital level. Therefore, the clinical standards informing these case-based groups could be reviewed to ascertain if they should continue to be hospital-based or down-referred. Ideally, the INA-CBG case-related diagnosis definitions and related rates will be set to encourage hospital-based outpatient specialized care and admission for those cases that will benefit from advanced HIV care, including those with multiple conditions. Meanwhile, hospitals will have a medical as well as cost-efficiency rationale to down-refer stable patients or those presenting without complicating conditions, in a way that eases the transition for the individual and leads to them being managed effectively at the primary care level.

4. Support the scale-up of routine viral load testing

There is a need to significantly scale up viral load testing to meet the guidelines of two tests in the first year followed by annual tests for stable patients on ART. In 2019, only 10,009 tests were conducted, despite 127,613 HIV patients on ART. Seventy-eight percent of these viral load tests were completed on hospital-based Abbott machines, with the remainder performed on GeneXpert machines. Providers at the clinical workshop suggested that part of the reason for low volume of viral load testing is a predilection to use the test to verify elevated viral load rather than as a routine check of viral load suppression. Pricing of viral load tests in Indonesia are also much higher than global prices, making scale-up less affordable. The HIV Sub-directorate has identified discrepancies in the reimbursements it pays for viral load tests between different hospitals and, in 2020, seeks to standardize pricing to ensure equitable and fair payments.

One may also consider leveraging the scale-up and rollout of GeneXpert machines that has occurred under the tuberculosis program to hospitals and puskesmas around the country. These machines are not operating at full capacity and would be able to handle current and planned increases in HIV patients on ART in need of an annual viral load test. Viral load test reagents would need to be quantified, procured, and managed to ensure they exist in facilities when needed to minimize risk of expiry. HP+ has been working with the HIV Sub-directorate to estimate the cost of viral load delivery and scale-up across the country.

Policy Options and Recommendations

Based on published and unpublished reports, BPJS-K's 1 percent data sample, stakeholder consultations, and feedback from the HIV Strategic Health Purchasing Technical Working Group, the technical team formulated and refined a set of policy options and recommendations. These options and recommendations aim to improve purchasing and provider payment arrangements to enable better resource allocation and align provider incentives with service delivery objectives. In the long term, these changes will also benefit patients by incentivizing primary care providers to offer HIV care at locations nearer to their homes or work, and at improved levels of quality. However, with ongoing discussion regarding the services to be included within the Basic Health Needs, which determines JKN benefits package coverage, there is a risk that HIV services may be specifically excluded from JKN and therefore reliant on HIV program funding (both central and regional). Therefore, the proposed recommendations consider that implementation may be either through JKN or HIV program funding.

The recommendations have been put forth for consideration by the HIV Strategic Health Purchasing Technical Working Group. The first recommendation proposes comprehensive reform to strategic purchasing of HIV services at the primary care level, encompassing both revised payment mechanisms and enhanced provider monitoring. The second and third recommendations address HIV care provided at the hospital level. The second emphasizes the need for strengthened implementation of down-referrals (enhanced provider monitoring) and the third focuses on revising ART reimbursement rates to better manage incentives (revised payment mechanisms). The final recommendation focuses on the critical need to scale up viral load testing services to verify viral load suppression and ultimately reduce HIV transmission. This final recommendation highlights the need to standardize payment mechanisms and rates for viral load testing and institute provider monitoring processes to ensure adherence to viral load testing guidelines once increased viral load testing capacity is available.

1. Develop HIV-related performance-based payments for primary care facilities to incentivize retention in care for ART patients

To better incentivize primary care providers to retain HIV patients on ART at their facility, implementation of a performance-based payment will orient providers towards the HIV care cascade. Targets could focus on new ART initiations, retention on ART, and viral load suppression. In cases of target non-achievement, there should potentially be a disincentive mechanism to ensure that providers consider HIV program management as a priority health area. There are two scenarios considered for this recommendation given the uncertainty of the Basic Health Need determination: one under the JKN scheme and the other under the HIV program.

- *Under the JKN scheme:* An adjustment to the existing performance-based capitation payment system is recommended. This adjustment can add to existing performance-based capitation elements that are implemented across all puskesmas in relation to contact rates, referral rates, and implementation of the Prolanis program. The adjustment to capitation payment should operate based on HIV outcomes of interest at the end of a specified period (for example, number of new ART initiations or total number of patients on ART and virally suppressed). Or, these outcomes could be combined into an "ART retention rate," defined as the percentage of ART patients counted at the beginning of the period in the facility who are retained in care at the end of the period. Patients retained in care are more likely to have better health outcomes.

The current capitation system does not address HIV in any way and, compared to other services covered by non-capitation fee-for-service payments, HIV case management is not incentivized, meaning primary care facilities have no incentives to retain these patients and may over-refer them. Figure 5 shows targets and weight distribution of the three current performance-based capitation criteria for services delivered at primary care facilities, with non-specialist referral rate as the most significant parameter. To align the recommendation with the ART Acceleration Plan, HP+ proposes adding an HIV-specific target with adjusted weighting. For the current discussion, HP+ proposes using the ART retention rate, with a target of at least 75 percent, with the indicator bearing a weight of 5 percent within the performance-based capitation system. The addition of HIV to the performance-based capitation system is a lower-cost method of addressing incentives for management of HIV at primary care facilities compared to setting and paying a new fee-for-service rate for HIV services.

Currently, as per BPJS-K regulations on performance-based capitation, puskesmas and primary care facilities receive capitation payments adjusted based on the weighted score derived using the indicators related to contact rate, referral rate, and Prolanis performance. For those receiving a weighted score of four for the preceding period, 100 percent of capitation is paid. For those with lower scores (less than four), a sliding scale of reduction in capitation between 3–15 percent is applied, with larger reductions for puskesmas. When adding the HIV indicator, puskesmas or primary care facilities would be marginally penalized for lack of performance in HIV care, although the weight applied to this indicator is modest, as shown in Figure 5. Meeting or exceeding the target means the puskesmas or facility will receive the full capitation. This system will not impose additional costs for BPJS-K and hence not affect the sustainability of the JKN scheme.

Figure 5. Proposed Addition of HIV Elements to Existing Performance-Based Capitation Model

Current criteria	Targets	Weight
Contact rate	≥150‰	40%
Non-specialist outpatient referral rate	<2%	45%*
Share of Prolanis participants with controlled DM & HT	>5%	10%
Proposed new indicator: HIV program management		
ART retention rate	>75%	5%

Source: HP+, based on BPJS-K Regulation 7/2019

* Original weight: 50 percent

DM: diabetes mellitus, HT: hypertension

While this model of incentivizing HIV care works based on a marginal penalty, a model of positive reinforcement is also possible. One possibility is to add fee-for-service payments for HIV testing and ART case management at the primary care level, with rates based on comprehensive facility-level cost data. While currently there is limited scope for adding additional fee-for-service payments to JKN until overall financial sustainability improves, these payments could be made from local government budgets. Local governments are expected to meet the minimum service standards' targets for HIV. They currently fund some HIV services and cover operational and infrastructure costs of puskesmas. Reimbursement rates for HIV tests and certain aspects of ART care could be set and funded from various elements of the subnational budget. The subnational budget's funding sources include transfers from the national budget as well as locally generated revenue. In principle, funds transferred to local levels that are not earmarked for specific uses, such as for infrastructure or salaries, could be used to pay for HIV prevention and treatment services. Similarly, the Ministry of Health's deconcentration fund spending at the local level could be better applied to priority needs, such as for HIV-related health promotion, prevention, and testing.

- *Under the HIV program:* Conceptually, incentivizing primary care facilities with local government funding will be similar to the incentives under JKN by having local government facility funding contingent, in part, on achievement of agreed upon targets. However, the lack of an established mechanism for local governments to administer this performance-based mechanism will pose administrative challenges. Local governments will need to develop a process to administer the mechanism, pay or withhold funds depending on the mechanism's structure, and verify target achievement.[4]

The payment structure for either performance-based mechanism (funded by JKN or the HIV program) should also consider how to incorporate critical elements of the government's ART Acceleration Plan related to the provision of improved counseling services, appropriate implementation of multi-month dispensing, and complete, timely, and accurate reporting to the HIV/AIDS information database. There are several factors to consider in implementing performance-based payments for ART provision (for both the pilot and eventual national rollout). These include the value of performance adjustments, what the exact metrics are, how they are verified, how and when payments are processed, and how patient choice and mobility are addressed, among others. Appropriate design can be proposed and then refined during and after pilot implementation.

In consultations around the possibilities for incentivizing the primary care level, stakeholders in Jakarta highlighted that tapping local government funding will be important to supplement the overall payment and performance-based systems. Therefore, an appropriate mix of performance-based capitation as well as specific reimbursements for key HIV services at the primary care level could be very impactful in raising the caseload of HIV handled at this level. Next steps will be to use comprehensive cost data, which will become available in 2020, to propose appropriate reimbursement rates for consideration, which could be paid from subnational budget funding sources.

[4] These activities would be a significant undertaking for local governments and require substantial investment in the development of technical capacity for each to act as a strategic purchaser. JKN is much more qualified to enact strategic purchasing reforms for the delivery of HIV services due to their significant technical expertise and experience operating as a centralized payer organization adept at implementing pooling and payment mechanisms.

2. Strengthen referral and down-referral policies and improve enforcement to ensure HIV care is delivered at appropriate levels of the health system

Implementing down-referral from hospitals to lower-level facilities for HIV care will require certain regulatory changes. Ministry of Health Decree 32/2014 explicitly limits the down-referral program to certain diseases, especially non-communicable diseases such as diabetes mellitus, hypertension, cardiovascular disease, asthma, chronic obstructive pulmonary disease, epilepsy, schizophrenia, hepatitis-related cirrhosis, and lupus syndrome. Currently, HIV is not included in the down-referable list. Therefore, there is a need to update the Ministry of Health's down-referral regulation to include an appropriate down-referral process for stable patients on ART who currently access care at secondary- and tertiary-level hospitals. Depending on their case type, especially presence of complicating conditions, some could be retained at the hospital level, and others may be down-referred to an appropriate primary care facility where they continue to receive quality care.

Down-referral can generate significant savings for the health system, which may be reinvested into care for HIV patients, especially to meet the needs of a rising overall caseload across levels in line with the government's ART Acceleration Plan. Using the 1 percent data sample from BPJS-K, recent indicative analysis by HP+ suggested that shifting ART patients currently coming to hospital outpatient departments as well as mild severity-admitted cases to primary care facilities would reduce visits for HIV care at the hospital level by 89 percent. This would generate savings of about IDR 50 billion a year alone.[5] These estimates are based on the current structure and based on down-referring appropriate patients. With the implementation of performance-based payment mechanisms incentivizing retention of ART patients at primary care facilities, there will be reduced referral to hospital-based care, which will add to the system-level savings, benefitting both the JKN scheme and the HIV program.

A change to the regulation will only be effective in improving practice, and hence the efficiency of the whole system, if it is appropriately monitored and enforced. The HIV Sub-directorate and BPJS-K will need to collaborate to update the appropriate guidelines and develop policies and enforcement mechanisms so that notifications are triggered and appropriate sanctions are implemented. A robust information system coupled with updated guidance is required to implement, monitor, and evaluate this recommendation. For example, hospitals would need to have a clear clinical guideline to determine whether the patient should be classified as stable and appropriate for down-referral, which must come from the Ministry of Health.

3. Review and revise HIV reimbursement rates to retain people living with HIV at the appropriate care level

Current HIV reimbursement rates for both outpatient and inpatient case categories require further review to understand if they are appropriate to incentivize the retention of clinically appropriate ambulatory and admitted HIV cases at the hospital level. A possible outcome of this analysis, which may require chart review of current cases in a wide enough sample of hospitals and types of cases, would be a finding that tariffs are too high compared to costs, which may be driving hospital behavior. Another finding may be that underlying clinical guidance linked to the diagnoses informing the case groups are up-to-date with current thinking on the capability of the primary care level, HIV case management best practices, and definitions of a stable patient on ART.

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[5] See Prabhakaran, S., A. Dutta, R. Ross, and C.B. Cantelmo. 2018. Options to Finance the Rapid Scale-Up of the HIV Response in Indonesia: The Role of the National Health Insurance Scheme (JKN) and Local Governments. Washington, DC: Palladium, Health Policy Plus.

Depending on the results of this analysis, BPJS-K, the HIV Sub-directorate, and the Center for Health Financing and Insurance may collaborate to review and revise tariffs to incentivize retention at the hospital level only of clinically appropriate HIV cases, especially those requiring specialist outpatient care, and admission to care for complications and comorbidities. Patient experience and quality of care should be a key concern, such that no patients are denied care and there is no excessive down-referral of patients to a health system level they are not comfortable with or may face other barriers in accessing, such as stigma or cost of travel. Another element of HIV care to be considered is the current payment model for viral load testing. Currently, BPJS-K reimburses for viral load services (not viral load commodities, which are paid for by the government or donors) at the hospital level, but only for patients admitted in the inpatient department. This may contribute to low viral load testing rates as the majority of people living with HIV are stable and only require a viral load test as an outpatient service. It also contributes to an inefficient use of BPJS-K resources.

A possible policy option to influence hospital provider behavior would be to impose limits to the number of visits at the hospital level for stable patients, such that after a set number of claims, the clinician is encouraged to promote further care at an appropriate primary care facility. This will also ease transition for the patient, compared to an abrupt down-referral. The performance of such policy changes will require a monitoring system using claims data and patient and provider quality of care surveys. Private provider reimbursement rates should also be reviewed for their HIV-related claims with appropriate differentiated adjustments made to their rates as needed.

It is important to think of reinvesting the savings generated through the down-referral system back into the HIV program. Prior to the implementation of any global budget type system, estimated savings (potential claims without efficiency gains, minus actual claims) for the period could be reinvested by BPJS-K as top-up payments to primary care facilities that manage ART patients effectively and achieve good treatment outcomes. BPJS-K currently operates a top-up payment program for hospitals, mostly for expensive drugs related to cancer and other non-communicable diseases. For HIV, it may use the savings generated through down-referral to contribute toward the cost of HIV commodities, which continue to be funded through the central government budget rather than through the JKN scheme. As the number of people living with HIV on ART increases, broadening the sources of funding for ARVs, as the major cost associated with HIV care, will be critical to ensure sustainable domestic financing to maintain people living with HIV on lifelong ART.

4. In the long term, make appropriate regulatory changes to improve pricing for the scale-up of viral load testing

Currently there is no provision for BPJS-K to make payments for the cost of reagents and equipment for HIV-related viral load tests. In Indonesia, multiple technologies are in use for viral load testing. The government already contributes 100 percent of the cost of cartridges for Gene Xpert machines for diagnostic testing related to tuberculosis from the national budget and substantially contributes to the use of the same platform for HIV viral load testing. The HIV Sub-directorate has emphasized the need for a standardized reimbursement rate on the service fees hospitals charge for viral load testing, separate from the commodities they receive at no charge from the government and donors, to aid in planning and also facilitate scale-up of viral load service provision. Currently, those service fees are covered by the Global Fund, but in order to promote a pathway toward sustainability, standardization of these fees, based on cost (being assessed through a joint study by HP+ and the HIV Sub-directorate), would support domestic financing through central government funding potentially through JKN's reimbursement mechanisms.

This mechanism would incentivize scaled-up viral load testing (performed for both hospital-based patients as well as patients whose samples are referred) and is intended to promote a more efficient use of resources. There is also a need to enhance coordination with the national tuberculosis program on the use of GeneXpert machines for viral load tests. In principle, the determination of a standardized reimbursement rate on viral load testing as well as scaling-up viral load service capacity aim to reduce out-of-pocket payments and expand the use of viral load testing in line with national guidelines. The payment reforms and expanded testing capacity will need to be accompanied by strengthened provider monitoring activities by the HIV Sub-directorate to ensure viral load testing service provision to people living with HIV adhere to established viral load testing guidelines, including HIV/AIDS information system reporting requirements, rather than being administered on an ad-hoc basis.

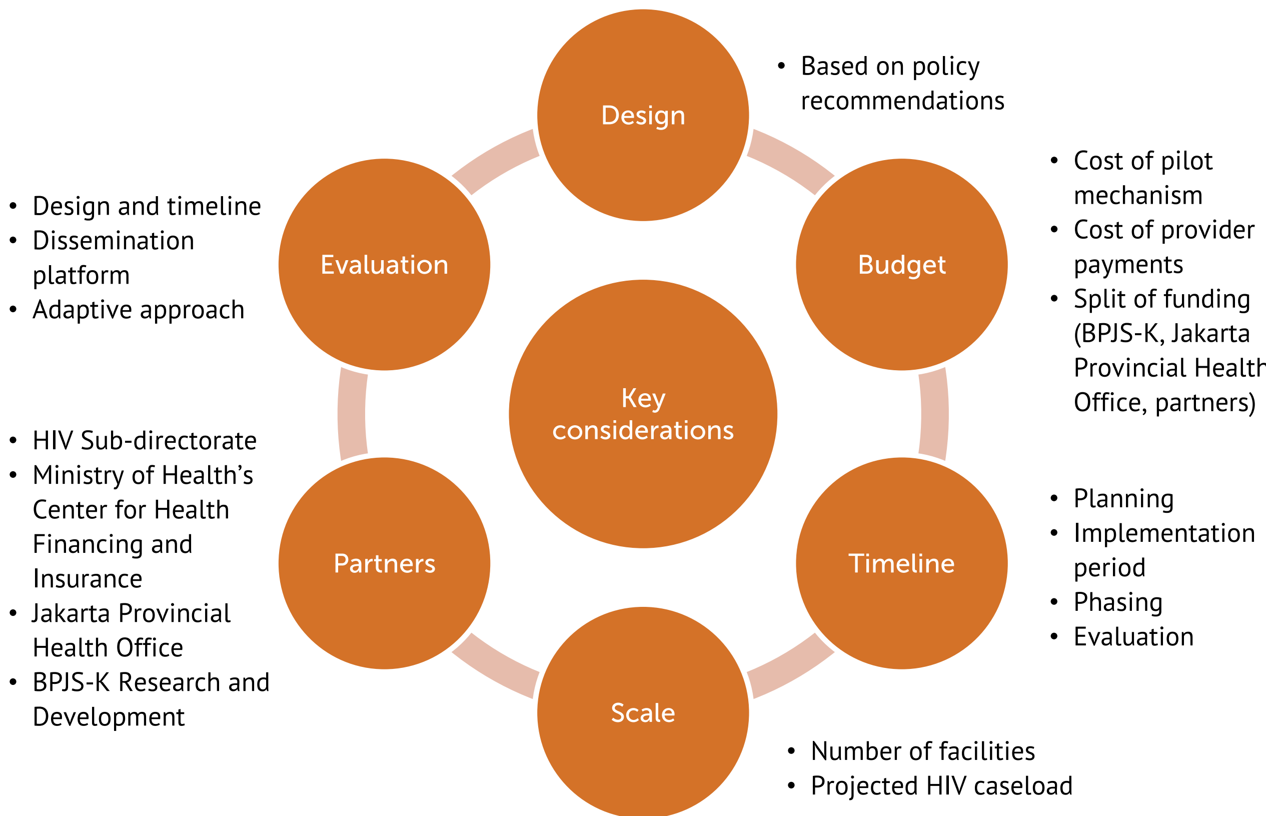
Timeline and Next Steps

Several recommendations to improve purchasing and provider payment systems for HIV have been put forward in this document. These will be reviewed by the HIV Strategic Health Purchasing Technical Working Group to obtain feedback on and acceptance of the recommendations from the HIV Sub-directorate, Center for Health Financing and Insurance, and BPJS-K. In the future, it will be necessary to test and further refine these recommendations through pilot implementation. Stakeholder consultations suggest the pilot location could be Jakarta province.

The recommendations put forward in this document are being further refined and agreed upon through development of a concept note for the pilot, based on input from government and key stakeholders (see Figure 6). The concept note will define which of these recommendations can be implemented in a pilot setting in a geographical area such as Jakarta and define the number of facilities that will be involved. The refinement of the concept note will require scoping visits to facilities delivering HIV services in Jakarta to assess the operational constraints and process improvements necessary to implement the pilot. Eventually, the pilot implementation will allow the recommendations to be tested on a small scale so they can be assessed and iterated upon before national rollout. Costs associated with the pilot, both direct in terms of performance payments to providers and indirect in terms of design, management, and monitoring and evaluation, will need to be carefully considered and discussed with stakeholders. An appropriate mix of financing between donors, central and local government budget allocations, and BPJS-K could promote buy-in and shared ownership in the outcomes.

Several questions need to be considered and addressed during the design and implementation of the pilot intervention. For example, how will the legal and regulatory framework changes required to implement aspects of the recommendations in this document be managed to allow local-level implementation, without requiring national-level changes to regulations? HP+ has separately conducted a *Legal and Regulatory Review to Support Strategic Health Purchasing for HIV in Indonesia*, which details the regulatory framework currently governing HIV service delivery and makes specific recommendations on the laws and regulations that require revision. National-level changes will also require evidence from the pilot and a policy consultation process with all necessary government actors. Also, the pilot requires the buy-in of the province and, potentially, of districts and providers. The levels of technical support required, and the implementing partners providing this, should also be confirmed.

Figure 6. Key Considerations for Pilot Concept Note



Finally, a set of policy recommendations as discussed in this document can only succeed and gain acceptance if the process of developing them and piloting the ideas is accompanied by a robust monitoring and accountability framework. This framework would require data-sharing from different actors and levels, and transparent analysis and dissemination of results. Monitoring indicators and periodic analytical results when shared appropriately will inform stakeholders and can be used to make decisions on any required modifications to the design. Most importantly, implementing partners and government institutions implementing the pilot and taking up its findings for potential scale-up should consider the importance of continuously improving the coverage, quality, and equity of the health interventions affected by the changes, such that people living with HIV in Indonesia can benefit from improved health and financial protection.

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