

Purchasing of Referral Services Under JKN

Introduction

The JKN benefits package covers a comprehensive range of secondary and tertiary referral services for participants. Purchasing of referral services under JKN is carried out by *Badan Penyelenggara Jaminan Sosial-Kesehatan* (BPJS-K), with some purchasing functions distributed across other institutions, including the Ministry of Health (MOH) and local government. The Social Security Council (*Dewan Jaminan Sosial Nasional*—DJSN) is responsible for overseeing the

implementation of JKN and as part of that mandate commissioned a review of strategic purchasing under JKN in partnership with USAID, the World Bank, Abt Associates and Results for Development (R4D). This policy note summarizes the results of the strategic purchasing review focused on the current status, results, and challenges of strategic purchasing of secondary and tertiary services from referral facilities (FKTRs) under JKN.

BOX 1. FOUNDATIONS OF STRATEGIC HEALTH PURCHASING

Strategic purchasing requires an **institutional home** where most purchasing functions will be carried out, although other institutions will likely be responsible for some purchasing functions. being clear and deliberate about **what is being purchased**, which starts with a well-defined benefits or essential services package. Once the service package is defined, the purchaser pays health providers specifically to deliver these services, which is referred to as **output-based payment**. Output-based payment typically goes hand-in-hand with some form of **contracting** to clarify the obligations of the provider and also the purchaser. It also requires that providers have some autonomy to make decisions to respond to incentives—they can decide to shift their staff around or other inputs. All of this requires new **accountability** measures and better use of **information**.

What to Purchase

Strategically deciding what to purchase for referral services means:

- a. The package of covered secondary and tertiary services covered is clearly specified.
- b. Quality or service delivery standards are defined that are used for purchasing decisions.
- c. Mechanisms and/or financial incentives are in place to ensure that services are delivered at the appropriate level of care

REFERRAL SERVICE PACKAGE AND SERVICE DELIVERY STANDARDS

The JKN entitles participants access to a comprehensive package of necessary health services, including comprehensive referral care [*Presidential Regulation Number 12 of 2013 Chapter IV on Health Care Benefits*]. The referral service package is defined as:

- a. outpatient specialty services, which consist of:
 - administrative services;
 - examination, treatment and specialist consultation by a medical specialist or sub-specialist;
 - specialist medical treatment in line with the medical diagnosis.
 - medicine and medical consumables
 - medical implant services
 - advanced diagnostic services in line with the medical diagnosis
 - medical rehabilitation
 - blood services
 - medical forensic services
 - morgue services at health facilities
- b. inpatient services, which consist of:
 - non-intensive care hospitalization
 - intensive care hospitalization
 - other medical services as stipulated by Minister

There is lack of clarity in the JKN law and regulations about authority for setting standards of care for referral services purchased by BPJS-K. *Law No 40/2004 Article 19* states that BPJS-K sets the standards, the role of MOH is to support hospitals accreditation, and the role of local government is to contribute incentive payments for specialized physicians. Some stakeholders also argue that the responsibility for setting service delivery standards is also clear in *President Regulation number 19/2016*

article 43 A, which states that “BPJS-K develops the system of technical operationalization of services, quality control system, cost control system and the health facility payment in order to increase efficiency and effectivity in coordination with related ministries.” Purchasing agencies often have the authority to select which service delivery and quality standards (e.g. standard clinical practice guidelines) will be used for purchasing services, even if they do not develop them. The role of BPJS to establish quality and service delivery standards for referral services has not yet been operationalized.

REFERRAL SYSTEM

The health system in Indonesia has defined classes of hospitals that form the basis for a tiered referral system [Minister of Health Regulation Number 56 in 2014]. Type A hospitals provide a wide range of sub-specialty services, and include teaching hospitals owned by the MOH. Type B hospitals provide a wide range of specialist services and a limited range of sub-specialist services. Type B hospitals are established in each provincial capital as the referral point for district hospitals. Type B also include some teaching hospitals that are not classified as Type A and receive case referrals from district hospitals. Type C hospitals provide limited specialist services, which should at the minimum include internal medicine, surgery, pediatric medicine and obstetric services. Type C hospitals receive case referrals from the puskesmas. Type D hospitals those that are in transition to becoming Type C hospitals, which currently only provide general medicine and dental services.

The tiered referral policy that limits referrals according to level of care (e.g. Level C hospitals can only accept referrals from puskesmas; Level B hospitals can only accept referrals from Level C hospitals, etc.). The MOH also has recently enacted a stricter referral policy, which limits payment for hospital cases that were not referred by the appropriate class of health facility. There is also a referral back system from hospital to primary care. BPJS-K has begun refusing to pay claims for inappropriate referrals, but this has been challenged by specialists. Furthermore, the lack of availability of certain medicines in puskesmas makes it difficult to enforce the referral system consistently. Some stakeholders note that the policy is discouraging inappropriate referrals in some cases. For example, the national referral hospital noted a steep decline in lower severity cases, which is likely to be a more appropriate case mix for that level, but there is also now less opportunity to cross-subsidize more costly cases with excess revenue from simpler cases. Nonetheless,

BPJS-K found that 1.2 million cases referred directly to Type A hospitals by puskesmas. BPJS-K is working to the health management information system by bridging P-Care and claims data to better enforce the tiered referral policy.

From Whom to Purchase

Strategically deciding from whom to purchase secondary and tertiary services means:

- a. Ensuring there are sufficient providers with adequate capacity to deliver the PHC referral service to all JKN participants (“supply-side readiness”).
- b. Standards are established for hospitals to be contracted by the purchaser to deliver services to JKN participants (credentialing), and public and hospitals can be contracted equally if they meet credentialing criteria.

SUPPLY-SIDE READINESS

Local governments have the overall responsibility to ensure there is adequate infrastructure to supply the referral services covered by JKN [Law Number 23 year 2014 concerning local government; Law number 32 year 2004 article 22; Health Law Number 36 year 2009 article 16, 17; President Regulation 12/2013 article 35]. The licensing of private hospitals has also been decentralized, with subnational authorities responsible for issuing two-year licenses, according to standards set by the MOH. The MOH Directorate of Referral Services of the Ministry of Health also provides an overall roadmap for ensuring that there is a match between supply and demand of health services. Mismatch between supply and demand for JKN referral services continues, however, with under-supply in many rural and remote areas. On the other side, there can be over-supply of higher level facilities when investment decisions are made at the local level that are based on political pressures rather than an assessment of service need. These supply-side decisions also affect the costs to BPJS-K, because the agency is obligated to contract with all public facilities that meet credentialing criteria and when a hospital is upgraded to a higher level BPJS-K is obligated to pay higher tariffs.

CREDENTIALING AND SELECTIVE CONTRACTING

BPJS-K contracts with health providers that meet the criteria for credentialing specified by the MOH (*Regulation of Minister of Health Number 71 of 2013 Chapter III Cooperation of Health Facilities with BPJS Healthcare Section Two Article 9*). The purpose of credentialing is to improve the availability and accessibility of health facilities as well as the standardization effort of health facilities quality. Of the 2,408 registered hospitals in Indonesia, and there are 1,614 (67%) are credentialed as JKN providers. The BPJS-K credentialing process is as follow:

mapping of providers → profiling → needs analysis → credentialing → tariff agreement → contract

According to *Minister of Health Regulation number 71* hospitals that have a contract with BPJS must have the certificate of accreditation. Many of the government hospitals do not have the certificate of accreditation or even meet the minimum standards for their hospital class, but they are still contracted by BPJS-K. Preliminary evaluation by BPJS-K of hospital input standard compliance shows that: only 6% of class A public hospitals complied with *Ministry of Health Regulation Number 56*, nearly all of the class B hospitals were non-compliant, and only 15% of the class C hospitals were compliant, and 6% of class D hospitals were compliant.

How to Purchase

Strategically deciding from whom to purchase secondary and tertiary services means:

- a. Contracting procedures are in place that are leveraged to specify and create incentives to adhere to service delivery and quality standards, specify reporting requirements for providers, and include other provisions that specify the responsibilities of providers and the purchaser.
- b. Provider payment systems are selected, designed and implemented to create the right incentives to drive provider behavior and service delivery toward quality, efficiency, and other objectives.
- c. Monitoring of hospital performance and quality assurance systems are carried out routinely by the purchaser and used to provide feedback to improve provider performance.

CONTRACTING AND PROVIDER PAYMENT FOR PHC

The original social security law of 2004 [Law no. 40 Article 44 the National Social Security System] states that “The Social Security Administering Body shall develop a health service system, a service quality control system, and health service payment system to improve the effectiveness and efficiency of health insurance.” A 2013 regulation [Regulation of Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control], however, states that the MOH should coordinate with the Health BPJS to develop the technical operation of the health care system, quality control system, and health care payment system to improve the efficiency and effectiveness of the Health Insurance.

By regulation, refers to the Indonesian Law: 44/2009 article 49 stated that the MOH is responsible to develop provider payment systems for both at primary care facilities and hospital levels. In fact, the MOH has not only developed the provider payment systems but also the payment rates paid to the health facilities. Presidential Regulation Number 12 Article 37 states that payment rates should be based on agreement between BPJS-K and the association of health facilities “with reference to” the standard tariff specified by the Ministry. The regulations on which institution is responsible for developing the payment systems for referral services and establishing payment rates are unclear and contradictory, and in practice BPJS-K has had a very limited role in provider payment policy and rate-setting. The MOH sets the INA CBG tariffs based on input from the National Casemix Center (PPJK). BPJS-K and professional associations have not been significantly involved in tariff calculations. Since most of the public hospitals, in particular type A and some type B, are owned by the central MOH, MOH may have conflicting interests in the price-setting.

Presidential Regulation number 12 year 2013 states that BPJS-K should pay FKTRs based on *Indonesian Case Base Groups* (INA-CBG's), with the INA-CBG tariffs reviewed at least every two years by MOH in coordination with the Finance Minister. There are many challenges with the current INA-CBG payment system that have limited its effectiveness for strategic purchasing. The INA-CBG payment system consists of several components that are inter-related. The first component is the set of case groups that organize diagnoses into groups for payment. The case groups relate to the service output, the clinical pathway, and

coding. A separate component is based on costing that assigns a weight and any accompanying tariff to each case group.

In addition to the payment rates (tariffs) being considered to be low overall, representatives from hospitals and hospital associations noted that the grouping and weights are inadequate to capture actual relative cost differences, particularly for the national referral hospital, even given that Type A national referral hospitals have higher costs that are accounted for in their payment rates. For example, no differentiation in payment outlier cases or for ICU cases was considered, putting the hospitals at great financial risk. The hospital representatives noted that while in many cases the relative tariffs are too low, in some cases such as cataract the relative tariff is too high, which pushes hospitals toward more profitable types of cases so they can cross-subsidize underpaid cases such as ob-gyn.

The INA-CBG tariffs are adjusted by the class of hospital, based on a review of the average cost-per case discharged from the hospitals in that class obtained from costing exercises across several hospitals. Under the JKN program, the tariffs of specialty hospitals are differentiated from non-specialty hospitals. *Article 16 of the MoH Regulation No. 52 of 2016* states that a health service delivered by a specialty hospital beyond its specialization is paid according to the INA-CBG tariff of hospitals class one level higher than the hospital. There are a number of inconsistencies in the regulations on classification and tariff calculations for specialty hospitals that create confusion and lack of transparency. If the case groups for the INA-CBGs were technically valid, however, the level of hospital would not need to be part of the tariff. There are incentives to invest in expensive equipment to upgrade hospitals to a higher classification to receive higher tariff payments. On the other hand, it may be appropriate to differentiate INA-CBG tariffs by region because of Indonesia's geographic diversity, but this has not been done.

A more general concern with all of the payment systems used to purchase services under JKN is that they are fragmented across different levels of care with no linkages between capitation for PHC and the INA-CBG payment system for secondary and tertiary services.

Although there is agreement across all stakeholders that it is necessary to more fully engage the private sector in JKN to improve supply-side capacity, current



government purchasing mechanisms do not create a level playing field for private providers and encourage investment. For example, BPJS-K pays the same INA-CBG rates to both public and private providers, although public providers are highly subsidized by the government, which covers health worker salaries and investment costs. Furthermore, private providers complain that unlike public providers, they cannot access medicines at favorable prices through the government procurement system. Some private, not-for-profit hospitals are forming networks to be able to negotiate better prices for medicines. Private hospitals are at a further disadvantage as they are taxed as business enterprises. The Ministry of Health has raised the issue of tax exemption status for private hospitals, but it has not yet been addressed.

MONITORING PROVIDER PERFORMANCE AND QUALITY OF REFERRAL SERVICES

Both Presidential Regulation Number 12 of 2013 on Health Care Benefits and Regulation of the Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Article 38 state that BPJS-K is responsible for monitoring provider performance, although the same regulations also give the MOH responsibility for monitoring and quality control, so the institutional responsibility for this function is unclear.

Regulation of the Minister of Health Number 71 states that BPJS-K should monitor quality through a cost and quality control team (Tim Kendali Mutu dan Biaya-TKMKB) made up of representatives of professional organizations, academicians, and clinical experts. TKMKB is independent but BPJS-K provides support for the activities. The TKMKB structure comprises the central level, regional division level and branch level. Regular meetings are held with relevance to:

- a. health care quality service evaluation, utilization review
- b. medical audit performance
- c. ethical and professional orderliness dissemination and guidance

BPJS-K also periodically conducts claims audits with agreement of all parties involved. The auditors come from the Financial Services Authority (OJK), Financial Examination Agency (BPK), Corruption Eradication Committee (KPK), Public Accountant Office (KAP), as well as internal auditors of the hospital and BPJS-K.

The detection, classification, monitoring and reporting of fraud are based on *BPJS-K Regulation No. 7 of 2016 on Fraud Prevention System in the Implementation of Health Insurance Program*. The Anti-Fraud Management Department in MPKP and MPKR Groups monitor and report on incidents of fraud by JKN participants, health facilities, and BPJS-K officers, as well as implement preventive mechanism that:

- a. Strengthens cooperation agreement (PKS)
- b. Provides Early Warning System for Participant Eligibility Letter (SEP) Application verification (consensus-generated warning)
- c. Provide Fraud Incidents Detection System or Techniques

Options for Improvement in Strategic Purchasing of PHC Under JKN

Some of the challenges with strategic purchasing of secondary and tertiary services under JKN stem from lack of clarity in the regulation (contracting and provider payment and provider performance and quality monitoring), while others stem from the general status of health facility infrastructure and clinical capacity (referral system, supply-side readiness and credentialing and selective contracting of FKTPs).

OPTIONS TO IMPROVE STRATEGIC HEALTH PURCHASING UNDER JKN

Purchasing Function	Related Regulations	Options for Improvement
Accountability	<p>Law no. 40 on the National Social Security System</p> <p>Law No. 24 of 2011 Chapter VIII Accountability Article 37</p>	<ul style="list-style-type: none"> Strengthen accountability through improved governance system of JKN with clear definition of which institutions are responsible for which outcomes of JKN implementation. Clarify the mandate and accountability of BPJS-K as both a health and a finance institution, increasing accountability for access to service by JKN participants, effective and efficient service delivery, quality of care, and cost management. Establish a routine monitoring system based on a jointly used database of BPJS-K claims data, other MOH service utilization data, and other key indicators and data sources. Establish a link between central-level financial transfers to sub-national governments and accountability for JKN implementation.
WHAT TO PURCHASE		
Service delivery standards	Law No 40/2004 President Regulation number 19/2016 article 43 A	Gradually shift authority to BPJS-K to select which service delivery and quality standards (e.g. standard clinical practice guidelines set by MOH) will be used for purchasing services, even if the agency does not develop them.
FROM WHOM TO PURCHASE		
Supply-side readiness	<p>Law Number 23 year 2014 concerning local government</p> <p>Regulation of Minister of Health No. 71 of 2013</p>	<ul style="list-style-type: none"> Establish regional-level joint service delivery planning team including representation of local governments, District Health Offices, professional associations (public and private), and local branches of BPJS-K to discuss service delivery investment needs to meet service delivery standards but in consideration of the budget impact on BPJS-K. Increase regional commitment to allocate funds used to build adequate health facilities, particularly in rural and remote areas. Improve regulations to allow compensation funds as an alternative for source of health expenditure in some rural and remote areas with low fiscal capability. Increase partnerships with the private sector, particularly for rural and remote areas, with the payer for the health care, BPJS-K, as the guarantor.
Selective contracting	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	<ul style="list-style-type: none"> Increase the role of BPJS-K in the contracting function by giving greater authority to establish provider selection criteria, establish the terms of contracts, negotiate contracts with providers, and monitor and enforce contracts. Implement the BPJS-K credentialing process in a participatory way with DHOs, local governments, professional associations (public and private), and other stakeholders to jointly carry out mapping in the regions, analyze population growth, and project future PHC supply needs for JKN. Create more opportunity for private FKTPs to contract with BPJS-K: <ul style="list-style-type: none"> Specify the role of private providers in JKN/BPJS-K regulations Engage private professional associations in credentialing



Purchasing Function	Related Regulations	Options for Improvement
HOW TO PURCHASE		
Contracting and provider payment policy	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	<ul style="list-style-type: none"> • Increase the role of BPJS-K in the selection and development of provider payment systems, and provider rate-setting. • Explore options to better harmonize between capitation payment for PHC and INA-CBG payment for secondary and tertiary services. • Provide fair contracting conditions for private providers, including tariff adjustments and access to government medicines prices. • Consider establishing an independent provider payment policy analysis unit to gather cost information, conduct analysis to inform provider payment system design and parameter development, and budget impact analysis (possibly built from the MOH Case Mix Unit) <p>Capitation</p> <ul style="list-style-type: none"> • The capitation rate-setting should be more explicitly linked to the package of services and, include adjustments for geography and other factors related to health need. • The capitation payment system should be refined to include regulations on the upper and lower limits of ratios of registered participants to physicians in a FKTP. • The pay-for-performance component should be evaluated and revised to ensure that incentives are aligned with service delivery objectives and rural and remote FKTPs are not disadvantaged. <p>INA-CBGs</p> <ul style="list-style-type: none"> • The INA-CBG payment system should be refined to improve alignment between case groups and relative costs. • The hospital costing system should be evaluated and possibly refined • Consider transitioning the INA-CBG payment system to a budget-neutral payment system (either volume caps or adjustable base rate).
Provider autonomy	Regulation of Minister of Health Number 19 of 2014 regarding the Use of Capitation Fund of the National Health Security For Health Care Service And Operational Cost Support on Regional Government-Owned First-Level Health Facilities MOH regulation no 21/2016	<p>Test a capitation waiver that allows puskesmas meeting certain criteria to pool revenues from multiple sources (capitation, BOK, local funds, etc.) with increased autonomy for management and allocation of funds.</p> <ul style="list-style-type: none"> • Set up a district-level platform for communication and monitoring among 4 entities: DHO, BPJS-K, puskesmas providers, and local government • Monitor effects on service delivery
Provider performance monitoring	Regulation of Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Articles 33, 37 and 38 Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review Article 39	<ul style="list-style-type: none"> • Establish an integrated health information system that can be used by multiple stakeholders for multiple purposes. • Improve the P-Care data system to that it can be used effectively by all stakeholders, especially FKTPs, for planning, management, and performance monitoring and improvement and link it to the BPJS-K claims database. • Establish a routine monitoring system within BPJS-K that analyzes and reports on a set of standard indicators related to service delivery and other key JKN outcomes. • Build on the BPJS-K cost and quality control team to build Joint provider monitoring and quality assurance commissions at the district level, including representation of the local branch of BPJS-K, DHO, and local government. • Establish the authority of BPJS-K to act on results of the cost and quality control teams utilization reviews, etc. and possible link to financial or other incentives. • Establish a routine reporting system for BPJS-K to report routine monitoring and evaluation results to MOH and DJSN on a regular basis

Annex 1.

Health Sector Laws and Regulations in Indonesia Related to Purchasing Referral Services

STRATEGIC PURCHASING FUNCTIONS	REGULATIONS	IMPLEMENTATION/ ROLE OF STAKEHOLDERS
ACCESS/infrastructure	<ul style="list-style-type: none"> • Health Law Number 36 year 2009 article 16,17 • Law number 32 year 2004 article 22 about the Local government's role to provide Health facility • President Regulation 12/2013 article 35 	Role of local government to provide health facilities and infrastructure.
Standards of service delivery and quality	<p>SISN Law No 40/2004 article 19 and article 23</p> <p>Regulation of the Minister of Health Number 71 year 2013 : The Hospital that cooperates with BPJS-K must have the certificate of accreditation.</p>	<ul style="list-style-type: none"> • Article 19 • ROLE OF MOH: • Subsidy for the Hospital's Accreditation • ROLE OF LOCAL GOVERNMENT • Additional incentive for Specialized Doctors • ROLE OF BPJS-K : Set the standard • Article 23 • ROLE OF MOH: Special incentives for specialized doctors
	<p>Regulation of the Minister of Health Number 71 year 2013 : The Hospital that cooperates with BPJS-K must have the certificate of accreditation.</p>	Many of the Government's Hospitals do not have the certificate of accreditation, but they should be contracted by BPJS.
	<ul style="list-style-type: none"> • President Regulation number 19/2016 article 43 A: BPJS-K develops the system of services' technical operationalization, quality control system, cost control system and the health facility payment in order to increase efficiency and effectivity -> coordination with related ministries • President regulation number 12/2013 article 42 : The implementation of KMKB system is managed by the BPJS regulation • BPJS regulation number 8/2016) : about the QUALITY CONTROL AND COST-CONTROL TEAM and also Medical Consideration Council 	<p>ROLE OF BPJS</p> <p>The role of BPJS-K to form the standard quality of service and the payment system to increase quality is not yet optimum.</p>
CREDENTIALING AND SELECTIVE CONTRACTING	<ul style="list-style-type: none"> • Ministry of Health Regulation Number 12/2013 article 36 • President Regulation number 19 year 2016 article 36: Government's health Facility must meet the standard requirements to participate 	The reality in the field: BPJS-K should arrange a participation with Government's health Facility even they do not meet the standard requirements



STRATEGIC PURCHASING FUNCTIONS	REGULATIONS	IMPLEMENTATION/ ROLE OF STAKEHOLDERS
PROVIDER PAYMENT (Tariff)	<ul style="list-style-type: none"> • Hospital Law Number 44 year 2009 • Ministry of Health Regulation number 85 year 2015 about the national tariff's scheme, National hospital tariffs • President regulation 12/2013 article 37: The amount of payment considered based on BPJS-K agreement with Health Facility Association Facility • President Regulation 19/2016 article 39: capitation payments and INA CBG tariffs should be assessed by the Ministry of Health once every 2 years • President Regulation 12/2013 article 41: The ministry determines the JKN standard tariffs • Ministry of health regulation number 52 year 2016 about the JKN standard tariffs • SJSN Law number no 40/2004 article 24 : the amount of payment to the health service facility is based on the agreement between Regional Health Facility Association • (3) BPJS-K developed the health service system, KMKB system and payment system to increase efficiency and effectivity. 	<p>The ministry should determine the tariff schedule and the Governor determine the maximum limit of fare based on national fare scheme (Hospital Regulation), nevertheless, the Ministry of Health determining the JKN's fare arrangement (INA CBGs)</p>
	<p>Ministry of health regulation number 455/2016 : Health Facility Association without the professional organization □</p>	<p>The absence role in Health Facility Association and BPJS-K because the JKN's fares is determined by the Ministry of health.</p>
	<p>Ministry of Health 252/2016 : Health facility association with the professional organization rule out a negotiation to set tariffs with BPJS-K</p>	<p>The role of Professional Organization and the Health Facility Association in the fares negotiation with BPJS-K is not optimum yet.</p>
	<ul style="list-style-type: none"> • Ministry of Health regulation number 52/2016 : The Specific Hospital fares is outside its own specification • Ministry of Health Regulation 76/2016 • The Specific Hospital fares is outside its own specification • Ministry of Health Number 56/2016 • Hospital Classification 	<p>The determination of Specific Hospital fares outside its own specification (as mentioned in Ministry of Health number 56/2016)</p> <p>The fares is one level lower than the hospital class, in Ministry of Health regulation number 72: suitable with the Classes</p>
	<p>Directorate general Regulation year 2014</p>	<p>ROLE OF MOH : Subsidy ROLE OF LOCAL GOVERNMENT: Subsidy for the province's referral hospital</p>
MONITORING AND EVALUATION	<p>BPJS-K ROLE NUMBER 8/2016 Ministry of Health Regulation</p>	<p>BPJS-K forms QUALITY CONTROL AND COST-CONTROL TEAM and Medical Consideration Council, while the Ministry of Health forms the QUALITY CONTROL AND COST-CONTROL TEAM</p>
FRAUD	<ul style="list-style-type: none"> • Ministry of Health regulation • BPJS Regulation number 7 year 2016 	