The Implementation of Fraud Prevention on the National Health Insurance at Salewangan Maros Hospital, Indonesia: A Qualitative Study

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Abstract

Background: Various fraud control methods are designed to overcome potential fraud that occurs by every element that involved in the National Social Health Insurance System in Indonesia. This study aims to analyze how the implementation of fraud prevention efforts that have been carried out by the National Health Insurance (JKN) Fraud Prevention Team which was formed at the SalewanganMaros Regional Hospital. Method: This study used a descriptive qualitative approach with data collection techniques through in-depth interviews and observation. The informants were the Head of the Service Division, the Chair of the Hospital Medical Committee, the Head of the Nursing Sub-Division, the Head of the Finance Sub-Division, and the Casemix team.**Results:**Efforts to increase the fraud prevention is still weak, efforts to detect and resolve fraud are already underway, but efforts to detect fraud have not been continuous, detection through observation at service locations is not routinely carried out, while detection efforts through data analysis still rely on service data feedback obtained from BPJS, as well as monitoring and evaluation by the Fraud Prevention Team at SalewanganMaros Regional Hospital has been implemented but is still very poor.Conclusion: Fraud prevention efforts must be carried out comprehensively and involve all individuals. There must be an automated integrated system at each service point so that fraud prevention can be optimized.

Keywords: *Fraud Prevention, Indonesia, National Health Insurance*

Background

Indonesia's health coverage program, the National Health Insurance (JKN) program, is administered by Health Care and Social Security Agency (BPJS). A membership comprising 222.8million people in April 2021, the program is one of the biggest health insurance in the world [1]. Fraud can be seen in all insurance types including health insurance. Fraud in health insurance is done by intentional deception or misrepresentation for gaining some shabby benefit in the form of health expenditures [2, 3]. In the United States, which is a developed country, reported by the General Accounting Office (GAO) in 1990, claims for indications of fraud were recorded at around US $ 100 billion or 10% of the total health costs per year [4].

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Further, based on a survey conducted by the Association of Certified Fraud Examiners (ACFE) in 2010, fraud on Health Care was in fourth place at 7.3%, and Indonesia was in third place with the highest number of cases out of 30 countries surveyed[5]. Fraud on Health Service Providers (PPK), especially Hospitals can be caused by Hospital dissatisfaction with INACBG rates (Indonesia Case Base Groups), an application used by hospitals to file claims to the government) and unpreparedness of Information Technology systems in Hospitals. In addition, the motivation to seek "economic gain" could lead PPK to commit fraud[6].The causative factor itself consists of high unmet needs and low salaries received which can result in employees taking actions that have the potential to be fraudulent[7, 8].

In addition, if aninternal control of the company's is work weakly, the possibility of errors and fraud is increasing[9, 10]. As an example fraud can result in losses for Manggala Regional Hospital in Indonesia because claims for services that have been performed cannot be paid [6]. A research was conducted by in-depth interviews in Indonesia, the interviewed informants had knowledge regarding the control of potential fraud at dr. AchmadMoechtar Bukit Tinggi, the results of the interview were the factors in the potential for fraud at dr. AchmadMoechtar as follows; differences in payment systems, the INA CBGs payment system is a prospective payment system, while the payment system for dr. AchmadMoechtar Hospital still uses the Governor Regulation Number 58 of 2015 on Health Service Rates for dr. AchmadMoechtarBukittinggi by using a fee-for-service payment system. Factors that can hinder the potential for fraud at dr. AchmadMoechtarBukittinggi, by implementing Standard Operational (SOP) and Clinical Pathway can prevent potential fraud, Based on in-depth interviews from informants, RSUD Dr. Low birth weight (LBW) and non-haemorrhagic stroke [9].

Furthermore, various fraud control methods are designed to overcome potential fraud that occurs by every element that involved in the National Health Insurance System in Indonesia. Through presidential regulation number 82 of 2018 and its derivate regulations, it is mandatory for Stakeholders, Health Department, BPJS,and Health Facilities which cooperating with BPJS to build a fraud prevention system and done systematically, structured, and comprehensive by engaging all human resources.

Taking into account the findings from the audit of the State Development Audit Agency(BPKP) at the SalewanganMaros Regional Hospital in 2018 with the result that there were 51 cases, including 6 cases of readmission and 45 cases of multiple claims (fragmentation, unbundling, cloning), even more there are problems with delays in claim submissions which is indicate that there a problems of governance system at SalewanganMaros Hospital in the year of 2020.

As mention in the Presidential Regulation number 82 of 2018 article 93 paragraph 3 states that BPJS, Health Department and Hospital must build fraud prevention system through, developing policies and guidelines for fraud prevention, developing an enhancement fraud prevention culture, developing the high quality and cost oriented health services and forming a fraud prevention team. Then as a form of obedience on that regulation, fraud prevention teams that was formed at the SalewanganMaros Regional Hospital based on the Director's Decree of the Fraud Prevention Team at the SalewanganMaros Regional Hospital in 2020, Number 197/24 / RSUD / 2020, the duties of the Fraud Prevention Team is Conduct early detection of JKN fraud based on data on health service claims conducted by the hospital. Disseminating new policies, regulations, and culture oriented towards quality control and cost control. Encourage the implementation of good organizational governance and clinical governance Increase the ability of Coder and Doctors and other officers related to claims Make efforts to prevent, detect and prosecute JKN fraud monitoring and evaluation.Based on the background above this study aims to analyze how the

implementation of fraud prevention efforts that have been carried out by the National Health Insurance (JKN) Fraud Prevention Team which was formed at the SalewanganMaros Regional Hospital.

Methods

This is a descriptive qualitative study thatusedtypes of data such as opinions, facts, knowledge, with data sources from ordinary informants and key informants. Data collection techniques were used in-depth interviews with a structured interviews guideline. The data analysis technique was carried out in three stages; first, reducing the data, second describing the data, and third is making conclusions. Data analysis begins with preparing and organizing data (text data in the form of transcripts or documents) for analysis, then the next stage is done by reducing the data to themes through the coding process, and summarizing the code and the final stage presenting the data in the form of analysis.To ensure the validity of the data in this study, researchers used triangulation by validating information by looking at the consistency of information obtained by researchers through in-depth interviews. The data analysis using Nvivo 12 (a qualitative software).

Results

Table 1. The Empirical findings of the improvement of the fraud prevention culture

Respondent	Fraud Prevention Culture
FA	Claim verification control is not layered between casemix team and fraud prevention team Dispute claim remain
IA	Delay in payment of services fees No socialization of fraud prevention in the hospital and no technical meeting to discuss the teams duties
YU	The audit findings and result received and executed according to the provisions without discussing the prevention how should it not be repeated

Table 2. The empirical findings of the implementation of organizational governance and clinical governance

Respondent	Good Organizational Governance and Good Clinical Governance
IA	Claim submission to the Payer (BPJS) is delayed in process. Consumable medical material less provide about 70% and it is mostly substitute which low quality below the standards
FA	Clinical pathway is not complete
SW	Medical record and Information system is still combining manual and digital process

Table 3. The empirical findings of the detection and settlement of fraud (fraud) at the hospital

Respondent	Detection and settlement of fraud
IA	Information System did not provide utilization data for analysis Patients complaint did not fully conveyed
FA	Whistle blowing system did not provide by the management and fraud prevention teams. The Employee have no access and remain afraid of the action consequences due to the fraud potential reported
SR	Bed occupancy rate is not being analyzed to the amount of population and not customized with the length of stay of each patient.

Table 4. The empirical findings monitoring and evaluation carried out by the Hospital fraud prevention team

Respondent	Monitoring and evaluation
IA	Field observation direct to the services point's was not routinely implemented There is no task details, technical instructions or implementation guidelines was made to help the teams. And no plan of action arranged. Medical committee consisting of the specialist and subspecialist doctors was not attained the meeting to discuss fraud prevention due to limited facilitation.
FA	No person in charge to do the monitoring routinely Some member of the teams have current positions and hard to manage time and people

The fraud prevention team at SalewanganMaros Regional Hospital, which consists of management (structural) elements, the Hospital Internal Supervisory Unit (SPI), the Medical Committee and Casemix have tried to prevent fraud, but some things are still not optimally implemented. Referring to the research objectives and interview result, we found 4 major findings:

The first, efforts to increase the fraud prevention that are being carried out are still poor and not working well. The difficulty of managing schedules with the various activities of each team and the conditions of the COVID-19 pandemic that occurred in 2020 has made it even more difficult. Bringing together a team of structural elements with a team of functional elements. Cultural changes in fraud prevention have not been initiated by the management and fraud prevention team. Anti-fraud commitment signatures, anti-fraud posters and other new things have not been implemented. There are still several factors inhibiting the culture of fraud prevention, such as a lack of desire to change, indifference, busyness, and lack of communication. Fraud is considered taboo to discuss, because it damages self-image and organization. So it tends to be discussed in private and confidential[2].

Secondly, the implementation of good organizational governance and clinical governance in the hospital is quite good, but needs to be improved in several aspects. Efforts to apply the principle of accountability are shown by the availability of standard operating procedures, but clinical guidelines for all disease management are incomplete. This is slightly different in the application of the principles of openness and accountability related to filing claims and calculating medical services. Claims submitted late and not in accordance with the provisions of the submission routine. Meanwhile, some specialist doctors have difficulty calculating the action compared to the medical services received, and also complaints about the delay in distributing medical services[11, 12].

Thirdly, efforts to detect and resolve fraud are already underway, but efforts to detect fraud have not been continuous, detection through observation at service locations is not routinely carried out, while detection efforts through data analysis still rely on service data feedback obtained from BPJS. It still needs hard work from the fraud prevention team to sit down together to formulate structured preventive measures, create a whistleblower that is safe, reliable and confidential. Fraud settlement is carried out after the audit findings, by deducting claims, which will result in reduced operational costs, difficulties in financial management and even losses for the hospital. Therefore, it can also be seen that the higher the number of fraud findings, the lower the team's performance in preventing fraud[11].

Fourth, monitoring and evaluation by the Fraud Prevention Team at SalewanganMaros Regional Hospital has been implemented but is still very poor. Monitoring is carried out by officials in concurrent positions, there are no detailed tasks yet to carry out monitoring in any way. Meanwhile, the evaluation has not been carried out continuously. The difficulty in evaluating was due to the difficulty of managing time and gathering all teams to conduct regular meetings and evaluations.

In addition, the driving actors for the potential for fraud at the SalewanganMaros Regional Hospital are the lack of understanding regarding fraud, specialist doctors, verifiers, coders do not fully understand the use of the state budget that must be accounted for and patients are consumers who must be provided with quality, effective and efficient services. Complaints about real hospital rates with INA CBGs rates also become a rationalization for fraud. If there is a dispute of opinion regarding the determination of whether or not JKN fraud exists, the Provincial Health Office or District / City Health Office can forward the complaint to the JKN Fraud Prevention Team formed by the Minister.

Discussion

According to Priantara (2013: 48), the fraud triangle consists of three conditions that are generally present when fraud occurs, namely: 1). Pressure to commit fraud (pressure). Pressure can be divided into 4 types, namely: financial problem, being involved in a crime or not in accordance with the norm, work-related stress and other pressures. 2). Opportunity or opportunity to commit fraud (opportunity); weak internal control system, poor organizational governance and a pretext to justify action (rationalization). Rationalization occurs because someone seeks justification for activities that contain fraud. Fraud perpetrators believe or feel that their action is not a fraud but is something that is their right, sometimes even the perpetrator feels that he has done a lot for the organization[13, 14].

Fraud prevention system according to Ministry of Health (Permenkes No. 36 of 2015) namely: 1).advanced level of healthcare facilities(FKRTL) compiles internal regulations in the form of good organizational governance and clinical governance. 2) FKRTL is able to develop health services that are oriented towards quality control and cost control through the use of effective and efficient management concepts, evidence-based information technology and forming the JKN Fraud Prevention Team at the FKRTL. 3) FKRTL is able to develop a JKN fraud prevention culture as part of organizational and clinical governance oriented towards quality control and cost control based on the principles of TARIK (transparency, accountability, responsibility, independence and fairness) [6, 15].

Based on Permenkes No. 36 of 2015, the JKN Fraud Prevention Team at the FKTP took action against JKN fraud and resolved the JKN dispute settlement based on a report or discovery. As stated in Article 16 Permenkes No. 36 of 2015, they are:

1). Transparency is the openness of information, both in the decision-making process and in disclosing information in accordance with the need for the

prevention of JKN fraud. 2). Accountability is the clarity of the function of the system structure and service accountability so that management is carried out effectively. 3). Responsibility is conformity or compliance in service management with the principles of a healthy organization in the context of preventing JKN fraud. 4). Independence is a condition in which an organization is managed professionally without conflict of interest and influence or pressure from any party that is not in accordance with the principles of a healthy organization in the context of preventing JKN fraud. 5). Fairness is a fair and equal treatment in fulfilling stakeholder rights arising from an agreement in the context of preventing JKN fraud[15].

Furthermore,Permenkes No. 36 of 2015, guidance and supervision of the prevention of JKN fraud at the Menggala Hospital has involved hospital supervisory bodies, hospital supervisory boards, hospital associations / associations, and professional organizations. One of the components in the supervision is to oversee compliance with the application of hospital ethics, ethics profession, and laws and regulations including Permenkes No. 36 of 2015.For complaints of alleged JKN fraud, it must include at least: the identity of the complainant, the name and address of the agency suspected of carrying out JKN fraud, and the reasons for the complaint (Permenkes No. 36 of 2015). With the JKN fraud complaint, the head of health facilities, the District / City Health Office and / or the Provincial Health Office must follow up on the complaint by conducting an investigation. The investigation was carried out by involving BPJS, the JKN Fraud prevention team at hospital[15].

Conclusion

The fraud prevention teams at SalewanganMaros Regional Hospital, which consists of management (structural) elements, the Hospital Internal Supervisory Unit (SPI), the Medical Committee and Casemix have tried to prevent fraud, but some things are still not optimally implemented.

The driving factors for the potential for fraud at the SalewanganMaros Regional Hospital are the lack of understanding regarding fraud, specialist doctors, verifiers, coders do not fully understand the use of the state budget that must be accounted for and patients are consumers who must be provided with quality, effective and efficient services. Complaints about real hospital rates with INA CBGs rates also become a rationalization for fraud. Cultural changes in fraud prevention have not been initiated by the management and fraud prevention team. Anti-fraud commitment signatures, anti-fraud posters and other new things have not been implemented. There are still several factors inhibiting the culture of fraud prevention, such as a lack of desire to change, indifference, busyness, and lack of communication. Fraud is considered taboo to discuss, because it damages self-image and organization image. So it tends to be discussed in private and confidential.

Recommendations

The fraud detection need tools and big data analysis to be able to find where the place is over loss or fraud happened at SalewanganMaros Hospital. SalewanganMaros Hospital need to strengthen the hospital information system, digitalization of the patient registration and automation and implementation of e-medical records..

Lack of routinely monitoring is carried out by officials in concurrent positions, and there are no guidelines made or detailed tasks to carry out monitoring in any way. Meanwhile, the evaluation has not been carried out continuously. The difficulty in evaluating was due to the difficulty of managing time and gathering all teams to conduct regular meetings and evaluations.

The fraud prevention team needs to be more intense in holding meetings or compiling a work plan, formulating matters or findings submitted by the auditor, then discussing steps to prevent it to happening again. The prevention team determines future action

plans, establishes appropriate control mechanisms according to hospital conditions, then also establishes a path for complaints (whistleblowing system) of violations or fraud through media, correspondence or email.

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