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**Internal Control Submission And Payment Of Claims
On BPJS: Study Of Ethnomethodology**

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Abstract

The study aims to see and investigate the implementation and process of internal control on the process of submission and payment of claims by *BPJS Kesehatan* Yogyakarta. This research uses qualitative research using ethnomethodology method in which the data are obtained through interviews and observation. The results show that the internal control of *BPJS Kesehatan* has been implemented optimally. Internal controls are capable to detect red flags in the submission process and payment of claims. Although there are some problems that occur also in the realm of *BPJS Kesehatan*, but the management has been controlling against the various risks that are most likely to occur mainly in the process of submission and payment of claims. Therefore, the strengthening of internal control system in all aspects of activity in *BPJS Kesehatan* should always be attempted.

Keywords: internal control, claims

INTRODUCTION

Indonesian government has an obligation to increase the growth and progress of nation, especially in the sector of public health, because health is a basic right for all individuals and it is entitled to a qualified health service especially among the poor.¹ One of the people's programs administered by the Government establishes National Health Care Security (BPJS) with the aim of prospering society especially in the scope of health. In explanation of the constitution of the Republic of Indonesia Number 9 Year 1960 on health issues "*that people's health is one of the principal capitals in the framework of the growth and life of the nation, It also has a crucial role in the complication of the national revolution and socialist society of Indonesia*"

Listening to some of the problems that had become a hot discussion related to the world of health insurance from various aspects. As it is explained by the President Director of the National Health Care Security (BPJS) Fachmi Idris disclosed, the problem that became the scourge of *BPJS Kesehatan* is a premium rate and it is not in accordance with the expectations. In fact it has already undertaken evaluation of the premium calculation in line with the policy. It needs for other special options and able to overcome the deficit such as *financial invention* and *police intervention* and *cost sharing* (Jawa Pos, 2015).

Another problematic that became complaints among the parties is the process of wrong claims between health facilities and *BPJS Kesehatan* which causes claims filed by the Hospital is higher than it should be. Yet, it has not been ascertained that the cause of the mistake is deliberate action or not. The more popular *BPJS Kesehatan*, the more participants also. However, if the problematic reality that occurs is not accompanied by good internal controls, it will adversely affect the operational system in various aspects (Kompas, 2015). As at the end of 2016, polemic of *BPJS Kesehatan* in Yogyakarta had conceptual problem that is not the guarantee of effectiveness of BPJS performance in achieving the mission to facilitate and equitably access to health services in various regions. It is not only in the sector of service but also from the process of policy and the setting of the agenda along with relationships between institutions that cooperate with *BPJS Kesehatan*, most of them have not run well (TribunJogja, 2016).

The above problems are related to research by Mohamed and Handley (2014), which discloses that every health insurance company really needs strategy for the prevention of cheating/fraud either from side of financial report or data manipulation. Studying from the research above, it cannot be denied that the insurance domain is very vulnerable to fraud both from internal and external parties. So the insurance company should analyze exactly how the internal controls on all types of transactions, especially the claim process.

It is undeniable fact that individual and organizational factors may lead to fraud due to the weak of internal controls built to prevent and detect fraud. Romney and Stainbart (2009) in the world of accounting and organization, internal control is an information technology system designed to assist organizations in

¹ The Constitution of the Republic Indonesia 1945 Article 28h

achieving certain goals. This study is motivated from the previous researchers who observed the theme of internal control, but using the implementation of COSO model (The Committee of Sponsoring Organization). Furthermore, This study tries to answer how the role of internal control on submission process and payment of claims applied *BPJS Kesehatan "X"* in Yogyakarta with the aim of research to know the implementation of internal control on the process of submission and payment of claims by the *BPJS Kesehatan*. Therefore, this research provides useful contribution to the development of research on internal control of *BPJS Kesehatan* claims.

LITERATURE REVIEW

Definition of Internal Control

An internal control structure is very important for a corporate entity in performing the daily activities and conducting various transactions. Therefore, to establish the internal control structure, it must first be understood the notion of internal control itself. According to Mulyadi (2001) The system of internal control is the coordination of organizational structure, methods, and measures in which it is aimed to maintain the wealth of the organization, to check the accuracy and reliability of accounting data, to encourage efficiency and the compliance of management policies. Meanwhile, according to Romney and Stelbart (2012) the definition of internal control is a process that is included in the operational activities and it is an effort formed of the internal control management activities that provide complete and reasonable guarantee.

Moreover, according to Harrison and Horngren (2012) internal controls are organizational plans, systems and procedures that are implemented by management, and board of directors, and they are structured to meet the following objectives: safeguarding assets, encouraging employees to follow company policies, and improving accounting records that is accurate and reliable. Based on the above descriptions it can be assumed that internal control is an effort formed by the board of commissioners, the companies' management and other personnel to conduct surveillance, and monitoring and control in every activity that occurs. It is in order to create reliability in financial reporting, achieving performance effectiveness, operational efficiency, and asset safety and compliance with applicable laws and policies.

Insurance Claims

Insurance claim is an official request to the insurance company, to request a payment under the provisions of the covenant. The proposed Insurance Claim will be reviewed by the company for its validity and then it is paid to the insured party upon approval. (Constitution of the Republic of Indonesia, Number 24, Year 2011). According to Ilyas (2006) the claim is a request from one of the two parties that has such a relation will submit its claim to the other party in accordance with the agreement or policy provision mutually agreed by both parties.

COSO (Committee of Sponsoring Organization of the Treadway Commission)

COSO model is one of the internal control system models which has been widely used by the auditors as the basic foundation for the evaluation activity or the development of an entity's internal control. In 2001, COSO collaborated with *Pricewaterhouse Coopers* who started a project to develop the framework of risk management performance and can be used to evaluate or to enhance the effectiveness of ERM in a company. Furthermore, COSO ERM describes the eight components of risk management that can be applied by the company itself. These eight components are derived from the results of management performance in running the company. The components are as follows²:

- 1) Internal Environment
- 2) Goal setting
- 3) Identification of Events
- 4) Risk Assessment
- 5) Risk Response
- 6) Control Activities
- 7) Information and Communication
- 8) Monitoring

METHODS

Type of Research

In line with the intent and the purpose, this section discusses the research methods that will be used in the theme of this study by using qualitative methodologies. Moelong (2007) explains that a qualitative study uses a naturalistic approach to search and find explanation or understanding of the phenomenon in a background of specific context. The researchers' reason using this type of qualitative research is in the terms of data collection. It is not rigid but in accordance with the reality of conditions in the field. That this research uses qualitative methodology because in the process of taking data is referring more to the emic perspective that is considered successful in the context of exploring ideas, opinions, feelings, attitudes, and opinions which are developing in a group of community (Bungin, 2001). In the process of searching data, this study will refer to the qualitative data in the form of interviews, observations, and documentation analyzed by researchers as a research tool. (Kamayanti, 2016).

² COSO (2004), Enterprise Risk Management- Integrated Framework

Respondent

Respondent is a supporting factor for the researcher because without any respondents hence this research will not get information and data needed. Moelong (2007) explains that an informant must have plenty of experiences and extensive knowledge on the background of the research. Having experience and knowledge, the informant is very helpful for the researcher to get information related to the whole activity that happened. Researchers have criteria in determining the informants, informants who understand how the accounting information system on submission and payment process of claims from the Hospital to *BPJS Kesehatan* at the City of Yogyakarta. Related to this research, the appropriate informant is the head of MPKR unit, Finance Division, and IT Helpdesk of Yogyakarta *BPJS Kesehatan* Office because the three parts that have the authority and understanding to regulate and control every transaction process that occurs mainly at the claim process.

Data Collection Techniques

Data collection technique is a major step in a research because the main purpose of data collection it self is aimed to obtain data which is going to be analyzed in the research (Sugiyono, 2008).

Interview

In addition to the observations, researchers will conduct interviews with informants in the Office of *BPJS Kesehatan*. Interviews that are conducted by researchers are structured because previously the *BPJS Kesehatan* has asked for guidelines and draft of interview questions in order to be coordinated by the internal office. Then, researchers had to make a number of questions, related to the theme of research to support the data and information needed. According to Bungin (2001) structured interviews is the interviewer applies his own problems and questions to be asked. But in this study the interview will also be conducted at a certain time so there are some questions that are spontaneous and researchers can capture the answer as well as it is from the respondents.

Observation

Researchers not only conduct structured interviews in collecting data, but it is also in line with ethno methodological approach. The researchers made a direct observation. Researchers visit at the time that is in compliance with the agreement and schedule that is determined directly by the *BPJS Kesehatan*, and then researchers observe and note the highlights from every daily activity in the office to explore the value of each activity that occurred. From most of the data or documents that have been obtained, the researchers will process by writing analysis and result of the research as the final step of the study. Thus with the fulfilment of data, this research is expected to help researchers in completing the research properly.

Study Object

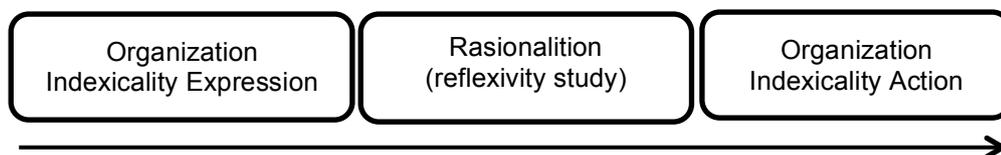
Researchers intend to examine the internal control system of billing and payment process of claims applied by *BPJS Kesehatan*. The beginning of the establishment of *BPJS Kesehatan* was on December 31, 2013 and started to be operated on January 1, 2014 by the government. *BPJS Kesehatan* was held due to the government program that is JKN (National Health Insurance) and KIS (Indonesian Health Card) formed by the government so that people of Indonesia, especially in particular low communities are guaranteed health services.

A Data Analysis Forum of Ethnomethodology

This research uses ethnomethodology approach trying to understand and to explain every daily activity that happened in an entity especially on the application of internal control process. (Heritage, 1984) describes that ethnomethodology as a group of science derived from common sense and a set of procedures and methods that make the layman can understand, and act in accordance of the conditions in which they find themselves. Kamayanti (2016) emphasized that Ethnomethodology is a study that focuses on the meaning of each activity agreed upon by members of a particular organization. Ethnomethodology studies emphasize a presumption that an ethno methodologist should not criticize, and fix just might understand. Although every activity violates norms and rules, but an entomologist must assume that it is true.

Furthermore, it is also explained that ethnomethodology expounds daily activities routinely conducted by group members and it is not individual. So the researchers will get a rational justification why such an activity is performed. Thus, ethnomethodology emphasizes more on the search for practical rational reasons, understood by organizations / groups so that they will reproduce certain activities in its daily (Kamayanti 2016). As the initiator of ethnomethodology study, Kamayanti (2016: 134) it is formed three stages of analysis carried out in this study. The first stage is the analysis of indexes, which aims to find the symbols or expression in daily activities of internal control in *BPJS Kesehatan*, and then researchers analyze the intent of the symbol or the expression. The second stage is reflexivity analysis that intends to observe and then analyzes reflexivity, which discloses such uninteresting things to the informant or the actor on each activity that occurs. The third stage is the researchers performed index analysis. Here the researcher will disclose actions that are seen and considered rational for the entity derived from the results of the analysis of indexes and reflexivity (Kamayanti 2016).

Figure 1. Order between expression and index action



Source: Kamayanti, 2016

In the Kamayanti (2016) states that the role of ethnomethodology would be better to directly become a "*participant observer*" in order that researchers get the form of activity and relate directly to the indexes and reflexivity. Answering the various questions are, the first step is to find the indexes of each answer and expression of the informant, then researchers rationalize every answer and expression seen by the informants or an actor in the office of *BPJS Kesehatan* Yogyakarta. Finally the last step conducted by the researcher is to observe every index was done on the actions and activities that occurred in the office of *BPJS Kesehatan* Yogyakarta.

FINDINGS

Surrounding of BPJS Kesehatan

BPJS Kesehatan is a public legal entity which is responsible to the president and aims to organize a health security program for all Indonesians including foreigners who work for a minimum period of 6 (six) months in Indonesia. Based on that case, *BPJS Kesehatan* becomes a forum of facilitators who will be ready to help welfare of all participants in the field of health either from the lower or upper class. Because BPJS was formed not only to protect one of the circles but *BPJS Kesehatan* was formed for all circles indiscriminately in all circles of Indonesian society. This is in accordance with the function of *BPJS Kesehatan* based on the BPJS Law which explains that "*BPJS Kesehatan serves to organize health security program*" health security according to SJSN Law held nationally based on the principles and rules of social security and equity principles with a purpose to guarantee *BPJS Kesehatan* participants benefit health care and protection in fulfilling the basic needs of health.

*As an organizing agency, BPJS Kesehatan has a vision and mission that became our performance goal philosophy. It is the realization of Social Health Security JKN and KIS Quality and the continuous for all the citizen of Indonesia in Year 2019 based on the principle of mutual assistance, which became the motto in our performance as an organizing agency.*³
(E, disguised)

Even though *BPJS Kesehatan* is only a forum for facilitators, it also has the authority to execute its tasks in several contexts such as the following: charging contributions, managing Social Security Fund (DJS) as a short-term and long-term investment with a specific consideration of aspects, executing the supervision and examination to the participants' compliance and employer as well as the provisions of social security legislation, making or terminating the employment contract with health facility, and executing cooperation with other parties in the implementation of social health security program.

³ Interview with the financial department the informant name is hidden.

Finding the answer of a question “where is our premium paid for?”

The World of health insurance is a means of convenience that is created to prosper a society in supporting health and demanding rights to use qualified medical treatment. It is not only the rich people who get high-class of health services when they were getting sick, but with the existence of social security it makes the service indiscriminately even for all circles of society. *BPJS Kesehatan* provides convenience with the types of PBI participants (Premium Beneficiary) that come directly from the government. The PBI participants do not need to pay the premium fees per month as non-PBI participants that is obliged and regularly pays premium fees every month. However, with the enactment of premium fees rates by the government, it actually emerges the perception that *BPJS Kesehatan* seems to incriminate the participants against premium rates that have been determined.

Responding to the various public complaints about the existing policy, BPJS Kesehatan is an organized agency, under Ministry of Health regulator, Health Department, and Presidential Regulation of JKN-KIS program. So many people who think that BPJS forms the program and determines the premium fees rates. Whereas BPJS is a institution and means to implement the policy in order to support the welfare of society in health. ⁴ (R, disguised)

That is actually realized or whether the policy that has been established, *BPJS Kesehatan* will strive to realize the vision and mission. Although the reality is still a lot of participants who have not understood well the policy or consider deliberately the liability of the premium fee, but it has been answered that it is not the authority of *BPJS Kesehatan* to determine the amount of premium fees, or to increase the premium fee, but *BPJS Kesehatan* is only a program organizer under the auspices of policy from the regulators.

If the problematic of the deficit perceived by the DJS at the end of 2016, it is not due to the internal but a result of moral hazard from some people in order to obtain a profit. The deficit occurs because of the mismatch between expending and unbalanced premium. Moreover the premium fees rates, now, have been raised automatically. This will make a number of people feel objected and some are feeling advantaged. But whatever the responses and complaints of the community related premium fees rates that have been set, the government and related institutions still give priority to the welfare of society in obtaining good health services.

Most of the participants asked where their premium is paid for? Actually the premium money that is paid will rotate throughout Indonesia to support service facilities and treatment of all participants of BPJS who are sick. Because with the rates that has been determined, there is no purpose to incriminate the participants, it will help among other BPJS participants throughout Indonesia ⁵ (Zz, disguised)

⁴ Result of interview with with MPKR Division the informant name is hidden.

⁵ Interview with IT Helpdesk division the informant name is hidden.

There are several groups said that the policy of fines on late payment of premiums in BPJS Kesehatan is Haram (forbidden). So the internal BPJS Kesehatan proposes a new strategy to change the fines policy of delaying participant's premium by disabling the membership, and it will be re-activated if the participant has already done the procedure to reactivate the membership.⁶ (E, disguised)

The premium fees which are paid by the participants are like a rotating wheel, where the funds will spin and benefit each other among *BPJS Kesehatan* participants who will get a treatment. Because the premium fund is really used for the fulfillment of health facilities, means and services, and the quality of medicines that become the basic patients' needs of the hospital. So this makes *BPJS Kesehatan* must be able to actually implement the premium funds in order that participants *BPJS Kesehatan* participate in getting the ease. In the premium fee provisions, there are three classes, namely Class III of IDR. 25,500,00, - for class II of IDR 51,500.00, - and in class I of IDR. 80.000,00, - According to the provisions above, the participant is required to pay the premium every month on the 10th of every month.

According to the result of observations and interviews with related parties, most people will register as BPJS participants if their family members have already been hospitalized, and most of the registered participants will pay the premium if their members are getting sick. So automatically they will be fined if the participant is aged over 21 years. However, the related fines applied by *BPJS Kesehatan* reap many complaints and perceptions; there are some communities who argued that the policy of fines for the delay in payment of premium fees is haram (forbidden). It is stressed by the determination of the premium fees rates per participant class and the magnitude of the fine charge is not unlawful to incriminate the participants, but by stipulating the rule of paying the fine as an attempt to arouse the participants not to be late or lost to pay.

After there was a debate about the haram or not the policy of delays fine application in paying premium fees by participants, then BPJS Kesehatan under the regulator re-formed a new policy to remove the fine, but participants who pay late will be automatically deactivated as a participant of BPJS Kesehatan. So, if the participants will seek treatment using the BPJS' service then they must activate membership status again by starting to pay the premium fees.⁷ (E, disguised)

Based on information on the reality that occurs surrounding the phenomenon of premium fees and fines is a finding for the researchers. All the issues are answered on problematic in *BPJS Kesehatan*, and all of them are not necessarily from the mistake of management in running policy but life is free. The communities freely choose the obedient to the rules continuously or require rules in order to get the results. As *BPJS Kesehatan* participants, they may register only for a way out at the time of hospitalization, but it does not make *BPJS Kesehatan* as an institution of ease for treatment process.

⁶ Interview with financial division the informant name is hidden.

⁷ Interview with financial department the informant name is hidden.

Disclosing the activity of Submission Process towards Payment of Claims

The claims process from Hospital to *BPJS Kesehatan* must pass through various agreed procedures. The procedure is established for all process of claims are not ambiguous and error. Moreover *BPJS Kesehatan* has applied several supporting applications as an effort of internal control on the process of submissions and payment of claims. There are two units that have the authority to administer the claim from the First Level Medical Facility to the Hospital. The MPKR (Referral Health service Management) Unit has the corresponding authority for the RJTL (Advanced Outpatient Care) claim process and RITL (Advanced Inpatient Care) claims. While the MPKP unit (Primary Health Service Management) only takes care of the RITL claim process (Advanced Inpatient Care) and RJTP (First Outpatient Care) where each type of claims has other claims in it, including claims for medicines and Medical Equipment.

It can be seen from the division of units that handles claims process already in the classification appropriate with the level of the first health facility to the Hospital, in order that all of them can be handled effectively, so there is no equipping work function in each division because there are many the type and number of claims. All claims of data from the Hospital will be specified based on the type of BPJS participants, there are three types of participants registered in *BPJS Kesehatan* namely PBI (Premium Beneficiary) where the participants of PBI are not required to pay monthly premium but it is the responsibility of the government. Participants of PPU (Wage Beneficiary Workers) were from a company agency that the premium fees would be directly deducted from salary or wage per month. The third is the participants of PBPU (Pekerja Bukan Penerima Upah/Non-Wage Beneficiary Workers) who register and pay premium per month independently.

The applied systems and applications that make every claim process easy and efficient, BPJS is learning from the experience since the beginning of BPJS establishment to the date, the related management formed several applications that can process any incoming and outgoing data, store and performing back-up data and online procedures that can indicate the occurrence of input errors, or output data. The following explanation is the flow chart of accounting information system of Yogyakarta "X" BPJS claim submission process can be seen.

The flow of accounting information systems explains that the first stage of submission is begun from the data of patients who become members of JKN-KIS in the Hospital, will be input in next hospital by the Hospital sent to SEP (Participants Eligibility Letter). This application belongs to *BPJS Kesehatan*, which produces documents containing data and files related to patients' information of JKN-KIS members. Once it is processed on the *SEP* application, then it will form a memorial to achieve at the application of *eclaim/inacbgs* that belongs to the Ministry of Health. By *eclaim/inacbgs* it contains graphing, diagnosis and procedure as well as the premium that must be paid, then it generate a report named *TXT*, and this report will be accepted by the verifier to do the verification of Hospital's file.

Before conducting the verification, there is an internal control application that detects red flags, since verification has its own verification guidelines. The verifier is occupied by someone who understands medical and information regarding medical world and it is in the Hospital rather than the *BPJS Kesehatan* Office. By medical-savvy verifiers, it will be able to selectively claim data on care, service, or medication. After conducting verification, if there is a file that is still lacking and not feasible to be filed a claim, then it will be returned to the *eclaim*. If the file is appropriate and fulfill the procedure, it will go into the type of data named *xml*, which contains about the fee that have been approved by Hospital and BPJS as well as Verifier.

The next step after the verification process is perfect, then it will be processed by office of *BPJS Kesehatan* and processed by MPKR unit (*Manajemen Pelayanan Kesehatan Rujukan/Referral Health Service Management*) to check the completeness and feasibility of claim file. If it is found that the less files, it will be immediately returned to the Hospital, and if it is complete, it will be immediately processed using an application called *BOA*. This *BOA* application is used as a gateway to enter the next stage for claim payment process. After the file was in the *BOA* application, then it would soon be processed by the financial department of office to make a claim payment to the bank in collaboration with the BPJS and Hospital that has relation.

The process of BPJS claim submission has applied various supporting applications that are able to indicate errors and other risks. By applying the application, it also becomes an internal control that can reduce the level of occurrence of risks and errors in the process of filing and payment of claims, because each data and incoming files do not miss from the process of checking completeness and feasibility of the file, and it will be safely stored available data and files. Each transaction either input data or data output has been well monitored to avoid loss of files, human error, and other risks.

Requirements of Claim Submission:

- a) Receipt
- b) FPK (Claim submission Form)
- c) Feedback Claims
- d) XML
- e) Copy Data Base
- f) Resume Verification
- g) Absolute Liability Letter
- h) Last TXT
- i) Official Report
- j) Claim Letter of FKRTL (Advanced Referral Health Facility)

It is not only the process of claim submission that has procedures, but on the process of claim payment it is also through stages and procedures. It is not much different from the claim submission process, this payment process is

governed by BOA application, which with this application will connect between authorized divisions to manage claim. The data and files are stored and easily accessed among related divisions.

The first stage of file from the service unit is sent to the BOA application, which will be processed by the finance department and performed verification using the accounting application. Accounting application is more to perform activities of receipt, recording, payment and storage of financial files. Furthermore, if it has already performed verification, it will form an approved memorial or the filing of the claim. If it is not approved, then it will be returned to the BOA application to be processed again. If the memorial is approved, it will be submitted to the cashier. By the cashier, it will be test for cashing bookkeeping to make payment after 14 days of submission process. If it is already entered to the limit of 14 days, then the claim will be paid by the cashier to the related bank and it will paid to the hospital account. If it has already made a payment, then the financial unit will form a bank expense voucher.

Payments must be made with the intermediary bank which has cooperated with *BPJS Kesehatan*. Banks officially which cooperated with BPJS are state-owned banks (BUMN). For the process of claim payment such as Bank account of *BPJS Kesehatan* is named Bank A while Bank account owned by Hospital is named Bank B, then the payment disbursement shall be made through Bank account owned by BPJS firstly, then the Bank will be transferred to the Hospital's bank account that purposes the claim. It is not the authority of *BPJS Kesehatan* because every Bank has its own procedure in the payment process with different types of Bank, so it is not the authority of *BPJS Kesehatan* to make direct disbursement to the hospital's bank account.

Internal Control as An Actor of Claim Process Evaluation

As the explanation above, it is about the flow of the submission process and the payment of *BPJS Kesehatan* claims, and then all activities are from internal control activities. Although, it has implemented a structured system, but it is needed a strategy in the internal control activities especially on the process of filing and payment of claims. If it is related to the research findings about the answer of the participants' question who asked "*where is our premium paid for?*" Precisely from this matter the BPJS should strengthen its internal control system, especially in upholding the openness to the participants who have an obligation to pay the premium and it is not lost anymore. Communities are free to think rationally about their rights and obligations especially this is very influential need for their own health. MPKR unit in *BPJS Kesehatan "X"* as internal audit actor for each claim submission activity because in Head Office it has division of Internal Supervisory Unit. *BPJS Kesehatan* implements internal control system through 3 stages, namely:

- a. Prospective, this control is performed before the verification. For example, the Hospital conducted data entry of patients using JKN card which is still active or not.

- b. Concurent. This application will be a data filter/file in accordance with the submission procedure, as well as able to show other red flags, and
- c. Retrospective. This control is performed after payment process by the hospital and BPJS internal. The BPJS internal will make review utilization every month. Claim files that have been entered into BPJS and have been paid, then the claim will be audited. In the audit file of the claim, there is an absolute liability letter legalized by signature of director of the Hospital. If in the letter of absolute liability there is a discrepancy in the payment, for example, *BPJS Kesehatan* has overpayment, then the Hospital will refund the overpayment. It is also vice versa, if *BPJS Kesehatan* gets minus payment, then *BPJS Kesehatan* will also pay the shortage of the payment. The auditor claims not only BPJS internal but also the hospital.

BPJS Kesehatan has fraud control program with the types of fraud that comes from external and internal parties. For the process of claims, after performing verification, there was a cost-efficiency report.

From the report, fraud will be detected, for example there are JKN patients who should make once medical treatments but Hospital may consider that the BPJS fee is less, and then the Hospital made medical treatments four times per a month. For the medical treatment four times per a month, it is a medical provision but the medical treatment it could not be recommended by the medical. Derived from these types of fraud, BPJS Kesehatan will make a warning to the Hospital that the report is not in accordance with medical procedures and claims. If the report is deliberately proven, then any unreasonable claim by BPJS Kesehatan will not be paid (R, disguised)⁸

Internal controls that exist in the process of submission and payment of claims are correlated with components in the theory of COSO ERM. *BPJS Kesehatan* management has formed a strategy to anticipate the innate risk and other external risks. By linking COSO ERM, it will be known how effective internal control on the process of filing and payment of claims between hospitals with *BPJS Kesehatan "X" Yogyakarta*. COSO ERM risk management has eight interrelated components, namely:

- a. Internal Environment
BPJS Kesehatan "x" Yogyakarta controls its internal environment by building the soul and mental human resources within the entity in order to have loyalty, integrity and determination in carrying out all tasks fit its division. The employees must be consistent with the code of ethics set up for performance effectiveness. In addition *BPJS Kesehatan* also often provides training for employees in order to deepen the ability of each individual. This will be avoided from the red flags that occur from the internal office.

⁸ Interviews with MPKR division initial name is hidden

b. Goal Setting

As in the vision and mission of *BPJS Kesehatan*, it aims to achieve a quality and sustainable Social Health Care for all Indonesian Populations in the Year 2019, that the main target in the operation is all the people of Indonesia both rich and poor, both young and old, both men and women, public health welfare is a priority *BPJS Kesehatan*.

c. Identification of Events

Internal and external events that may affect the achievement of goals and objectives should be identified so the process of submission and payment of *BPJS Kesehatan* claims identifies each submission procedure, and an indication of fraud or errors that are detected through the established system and the division of work functions in each division, in order to be selective and observant in checking file, and using application.

d. Risk Assessment

The various risks are analyzed based on the identification of events, and then the results of risk analysis will be the basis for determining the risk treatment. *BPJS Kesehatan* should be able to assess the various risks that have occurred and affected operational activities and it must be able to assess the risk that might repeatedly happen or not by performing internal controls in every control of activities, especially the process of submission and payment of claims.

e. Risk treatment

The management of *BPJS Kesehatan* "X" Yogyakarta treats the risks that occur in the process of submission and payment by implementing alternative reduction and alternative avoidance. By applying the accounting information system to the submission and payment, internal party of *BPJS Kesehatan* "X" Yogyakarta attempt to the risk that has possibility of recurrence or there is a new risk occurs.

f. Control Activity

Realizing a policy and procedure is to ensure that risk treatment has worked effectively or not. Internal controls conducted in the process of submission and payment of claims have pass through several stages, and have been re-checked the completeness of the file, as well as reports at each stage. The function is in order that the process of submission and payment of claim do not result in a report or document that contains input or output error data.

g. Information and Communication

Information is communicated in the appropriate manner and time in order that every personnel can carry out their duties and responsibilities correctly as well as it is done in the office of *BPJS Kesehatan* "X" Yogyakarta. Every morning before running an operational activity, each board of directors and divisions perform a *morning briefing*. This activity intends to inform, report, evaluate and commission that each activity can be targeted and in accordance with existing policies.

h. Monitoring

The whole activity of ERM must pass monitoring and evaluation in order to be developed for the future. Internal controls on the submission and payment process of claims have monitoring control from the head office which is handled by regulators such as the Ministry of Health, and the Health Department because *BPJS Kesehatan* is just an organizational agency and insurance facilitator that works as the policy.

CONCLUSION

It can be concluded that internal control on the process of submission and payment of claims by *BPJS Kesehatan "X"* Yogyakarta in general has been run optimally. This is indicated by the existence of an accounting system that the applications support internal control at each stage. In addition, by dividing the unit the authorization takes care of the claim and verifier in charge of verifying the claim, and it is a person who is a medical expert. As well as in applying the three stages of the prospective approach, concurrent, and retrospective, it also shows that *BPJS Kesehatan "X"* Yogyakarta tries to avoid and reduce the risks that are likely to occur in the process of submission and payment of claims. Our study also finds that *BPJS Kesehatan* needs to be firm on its activities to respond the deficit to improve the internal control.

Furthermore, this study gives an implication that socialization to the consumers and strategic partners on the policy of premium price is needed. Furthermore, for the process of submission and payment of claims, there are a bit of weaknesses because the flow of the submission process system has a long vulnerable that can still cause errors and obstacles that could happen. This study is limited to the data coverage due to the research policies and procedures applied by *BPJS Kesehatan*. Our study gives the implications that socialization on the premium price to customers and strategic partners are needed to improve the performance of *BPJS Kesehatan*.

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