INTERNATIONAL SOCIAL SECURITY ASSOCIATION
ASSOCIATION INTERNATIONALE DE LA SÉCURITÉ SOCIALE
ASOCIACIÓN INTERNACIONAL DE LA SEGURIDAD SOCIAL
INTERNATIONALE VEREINIGUNG FÜR SOZIALE SICHERHEIT

Good Practices in Social Security

Good practice in operation since: 2017

Implementing digital claim hospital verification in National Health Social Security in Indonesia

Social Security Administering Body for the Health Sector
Indonesia

Published 2018 www.issa.int

Summary

The increasing number of participants in Indonesia's Health Insurance Program has greatly increased the utilization of the services of and the number of claim reimbursements received by the Social Security Administering Body for the Health Sector (BPJS Kesehatan). This required a large number of additional resources and staff for claim administration processing. BPJS Kesehatan thus launched an initiative to simplify claims processing and management so that less resources would be needed. The initiative was named VEDIKA, short for Digital Claim Verification, a digital application for the claims verification process for secondary health facility reimbursement. The objectives of VEDIKA are to improve the financial performance of BPJS and its reputation, and to enable the organization to meet the service level agreement on claims processing time, thus optimizing the performance of the claims verification staff. After the implementation of VEDIKA, BPJS Kesehatan was able to reduce the length of claims processing from 45 days to 15 days. Another result of VEDIKA is that the total number of staff needed to support the verification process has fallen from 1,345 to 961. The key takeaways from the successful implementation of VEDIKA are provider support and a digital system.

The issue or challenge

What was the issue or challenge addressed by your good practice? Please provide a short description.

The BPJS Kesehatan was established by Law No. 24 of 2011 as the enforcer of the National Health Insurance System in Indonesia as mandated by Law No. 40 of 2004. BPJS Kesehatan membership has increased from 16 million participants in 2014 to more than 193 million participants by March 2018. BPJS Kesehatan continually improves access to services by contracting with more health facilities. The number of health facilities in partnership with BPJS Kesehatan has increased from 18,437 primary care facilities and 1,681 secondary facilities in 2014 to 21,893 primary care facilities and 2,336 secondary facilities by March 2018. The increase in access leads to an increase in utilization of health care services every year. Usage has soared from 92.3 million cases at the end of 2014 to 219.6 million cases by the end of 2017. This has escalated the claim processing workload, the number of staff needed and higher operational costs.

BPJS Kesehatan usually assigns more than one staff to every partner hospital, to approve participants' eligibility, provide information and handle complaints, benefit package and claims processing and verification. The large number of staff was also due to the massive workload since each claim submission had to be checked manually. Low hospital compliance in terms of submission time was also a problem, with hospitals submitting incomplete documents on a non-standard schedule.

Due to operational cost constraints, BPJS Kesehatan was forced to station less staff in partner hospitals, which caused complaints from health facilities due to longer claim processing time and lower verification quality. This often triggered conflicts between BPJS Kesehatan and the health facilities because the service level agreement for claim reimbursement was not met and claim documents were not well organized or even missing sometimes. Another issue was that the application claim information system was not online nor centralized, leading to outdated data for financial planning and evaluation utilization

Addressing the challenge

What were the main objectives of the plan or strategy to resolve the issue or challenge? List and briefly describe the main elements of the plan or strategy, focusing especially on their innovative feature(s) and expected or intended effects.

The main objectives of VEDIKA are to improve financial performance and reputation of BPJS Kesehatan by meeting the service level agreement on claim processing time and, at the same time, optimize the service provided by the claims verification staff:

1. Standardized claims processing
2. Clear service level agreement on reimbursement process
3. Optimized number of verification staff
4. Clear planning of claims payment both from time and cost perspectives
5. Application support in the verification process and the availability of centralized updated data

With VEDIKA, BPJS Kesehatan has redeployed to the branch offices all the verification staff formerly stationed at partner hospitals. The underlying rationale is that the staff will perform better when stationed at the branch office because they will be more focused, with less interruptions from complaints handling and administrative roles. Complaints handling is now handled by both the partner hospitals and the BPJS Customer Care Center.

Since VEDIKA optimizes digital claims reimbursement, the verification staff checks 30 per cent of the claim documents and 70 per cent are checked by the VEDIKA system. Since it is digitalized, hospitals are now required to submit claims collectively in accordance with a standardized schedule.

Targets to be achieved

What were the quantitative and/or qualitative targets or key performance indicators that were set for the plan or strategy? Please describe briefly.

Expected outcomes:

1. BPJS Kesehatan Health meets the service level agreement on reimbursement claim processing and payment of 15 working days from the current average of 45 working days.
2. Reduction in the number of verification staff needed, so that the same staff could be assigned to other job functions.

Evaluating the results

Has there been an evaluation of the good practice? Please provide data on the impact and outcomes of the good practice by

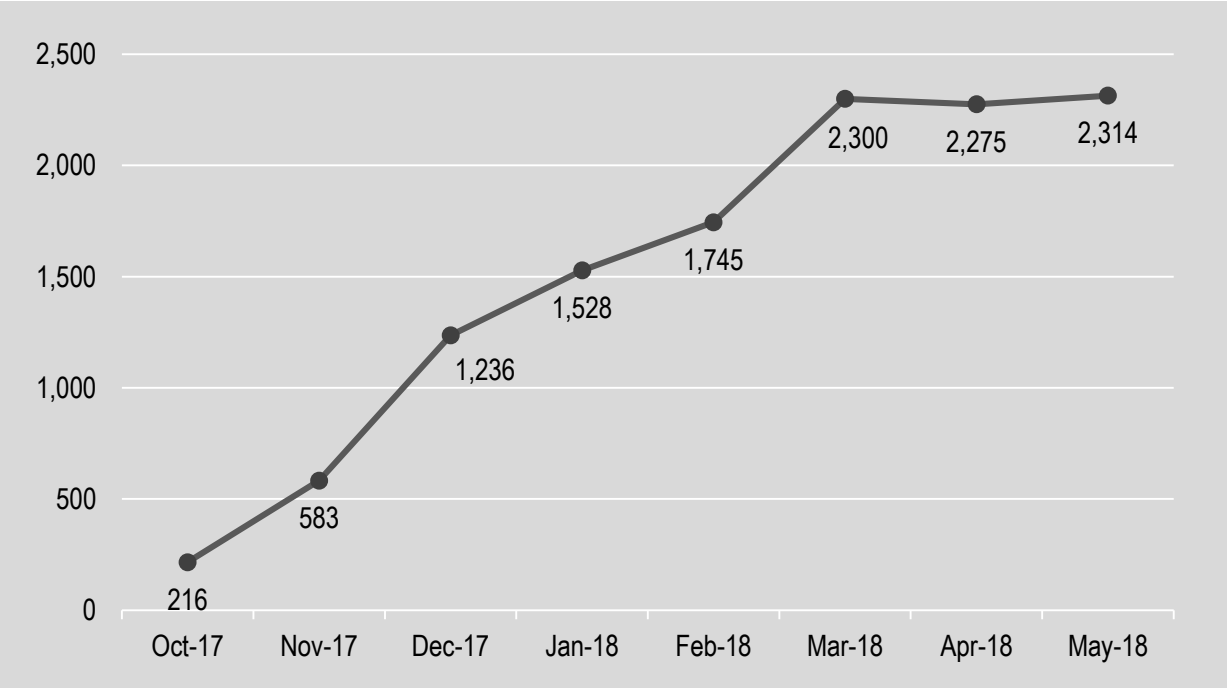
comparing targets vs actual performance, before-and-after indicators, and/or other types of statistics or measurements.

The following table describes the difference between the old verification system and VEDIKA.

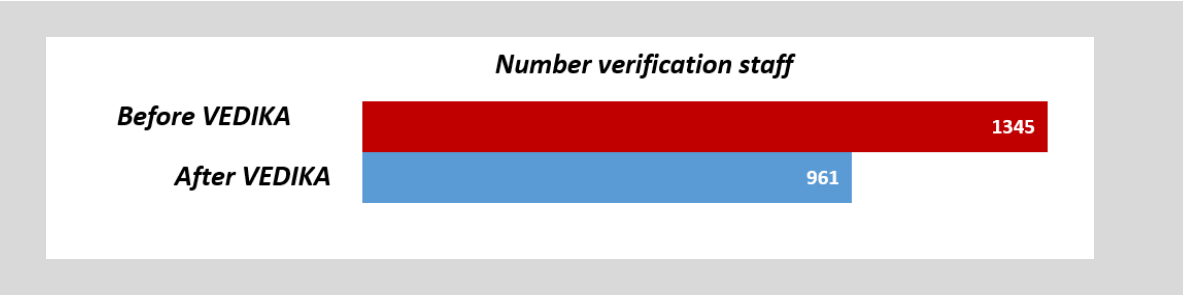
No	Description	Before VEDIKA	VEDIKA
1	Participants eligibility checking	BPJS Kesehatan staff Health facility staff	Health facility staff
2	Information and complaints handling	BPJS Kesehatan staff Health facility staff	Health facility staff BPJS Care Center (hotline service)
3	Verification location	Health facility	BPJS Kesehatan branch office
4	Claim verification process	All claims are manually verification	Sampling claim, digital verification with system filtration
5	Claim submission time	Unstandardized, can be partially submitted daily or weekly	Monthly minimum claim submission must be 75 per cent of the number of cases
6	Information system	Localized and limited IT support, mostly manual verification	Centralized and verified using IT logic
7	Time required from verification to payment	Varies across health facilities, average of 45 days	15 days

Results in implementing VEDIKA:

1. The number of health facilities which applies VEDIKA reached 100 per cent in May 2018. The increasing number of health facilities using VEDIKA is shown by the following graph:



The number of staff needed for verification has been reduced significantly:



Lessons learned

Based on the organization's experience, name up to three factors which you consider as indispensable to replicate this good practice. Name up to three risks that arose/could arise in implementing this good practice. Please explain these factors and/or risks briefly.

Three indispensable factors to be considered to replicate this good practice:

1. Provider support is important to implement a new management claim system.
2. Mutual trust between the social protection organization and the providers is important so that both parties shall correct payments in cases of incorrect claims.
3. Commitment to continuously seek innovation to improve claim quality and the payment system.

Three risks to be considered in implementing a digital claim verification:

1. Disparity between the IT capacity of the social security organization and the partner health facilities.
2. Since 70 per cent of claims are only digitally checked, a robust fraud prevention system is a must.
3. Coding agreements must be implemented at the highest level to minimize disputes at the branch office level.