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ABSTRAK

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Pencegahan Kecurangan (*Fraud)* sesuai dengan Permenkes No. 36 Tahun 2015 tentang Pencegahan Kecurangan (*Fraud)* dalam Pelaksanaan Program Jaminan Kesehatan pada Sistem Jaminan Sosial Nasional di Rumah Sakit X

xii + 143 halam**an + 8 tabel + 9 gambar +7 lampiran**

Perubahan pola pembayaran menggunakan *CBG* menyebabkan perubahan proporsi penerimaan rumah sakit serta perubahan beban resiko keuangan, hal ini yang mendorong timbulnya potensi fraud. Tindakan *readmisi* di Rumah Sakit X berkisar 29,35% pasien rawat jalan dan 3,6% pasien rawat inap mendapatkan perawatan lebih dari 1 (satu) kali dalam periode 1 (satu) bulan serta belum terciptanya kebijakan pencegahan kecurangan di Rumah Sakit X sebagaimana diamanatkan dalam Permenkes RI No. 36/ 2015. Lima tahapan formulasi dilakukan untuk merumuskan kebijakan, pada penelitian ini hanya melakukan 2 (dua) tahap formulasi yaitu fase pertama berupaya untuk mengidentifikasi tujuan dan program pencegahan kecurangan di Rumah Sakit X dan fase kedua formulasi yaitu menganalisa kelengkapan informasi.

Jenis penelitian ini adalah kualitatif dengan menggunakan wawancara dan diskusi mendalam. Informan utama dalam penelitian ini adalah lima koder dan unsur pengambil keputusan. Teknik analisis data dengan analisis konten, meliputi wawancara dengan informan diolah kemudian dilakukan analisis data.

Hasil penelitian menunjukkan masih lemahnya pemahaman petugas pelaksana tentang tindakan kecurangan, hal ini ditunjukkan melalui jawaban responden yang memiliki interpretasi berbeda maksud tindakan kecurangan JKN berdasarkan Permenkes No. 36/2015 serta belum adanya *atensi* dari pengambil keputusan terkait sistem pencegahan. *Atensi* dapat diketahui dari perhatian utama pengambil kebijakan hanya pada permasalahan pengkodean diagnosa yang memiliki *over cost* dan juga belum adanya pembaharuan SK Pengendali Asuransi sejak tahun 2013. Untuk mewujudkan sistem pengendalian efektif yang mampu mencegah, melaporkan dan memperbaiki potensi kecurangan di Rumah Sakit X dengan cara menciptakan program pencegahan dan deteksi dini berupa pendidikan anti fraud, investigasi internal melalui analisa data klaim dan program tindakan pelaporan dan pemberian sanksi. Diperlukan kelengkapan sistem berupa tim pencegahan kecurangan dan pedoman pencegahan yang berisi literature review, daftar tindakan yang dianggap potensi fraud, aspek pencegahan, deteksi dan penindakan serta petunjuk teknis pencegahan *fraud*, monitoring dan evaluasi serta pelaporan.

Penelitian ini merekomendasikan untuk menerbitkan SK Tim Pencegahan Kecurangan , merumuskan draf final pencegahan kecurangan agar dapat disahkan menjadi pedoman pencegahan kecurangan, pengembangan sistem informasi untuk analisa data klaim.

Kata kunci : Formulasi Kebijakan, Pedoman Pencegahan Kecurangan, Fraud
Kepustakaan: 52 (2000-2015)

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ABSTRACT

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Fraud Prevention based on the Health Minister Regulation Number 36 in 2015 about Fraud Prevention in the Implementation of the Health Insurance Program on the National Social Insurance System at X Hospital

xii + 143 pages + 8 tables + 9 figures + 7 appendices

The change of a payment pattern using CBG causes the change in the proportion of hospital income and the change in burden of financial risk that will lead to fraud. Readmission to X Hospital was approximately 29.35% of patients at outpatient unit and 3.6% of patients at inpatient unit who got treatment more than one in a month. In addition, there was no policy which referred to the Health Minister Regulation Number 36/2015 to prevent fraud at X Hospital. Five steps of formulation were conducted to arrange the policy. In this study, two of these five steps of formulation namely identifying objectives and a program of fraud prevention at X Hospital as the first step and analysing completeness of information as the second step were conducted.

This was a qualitative study by conducting indepth interview. Main informants consisted of five coders and decision makers. Data were collected using a method of content analysis.

The result of this study showed that the implementers did not really understand fraud activity. Each officer had different interpretation in defining fraud of JKN based on the regulation. In addition, decision makers did not pay attention to this problem. Attention could be identified from the main attention of policy makers that only focussed on a problem of coding diagnosis which had over cost. The Insurance Control Decree have not been renewed since 2013. To realise the effective control system that could prevent, report, and improve a potency of fraud at the X Hospital, it was conducted by creating a program of prevention and early detection like education of anti-fraud, internal investigation through analysing claim data, reporting, and punishing. There needed to complete system like a team of fraud prevention and a prevention guidance that consisted of a literature review, a list of actions categorised as fraud, aspects of prevention, detection, action, a technical guidance of fraud prevention, monitoring, evaluating, and reporting.

The Decree of a fraud prevention team needs to be released. A final draft of fraud prevention needs to be arranged in order to be legalised to be a guidance of fraud prevention. In addition, information system needs to be developed to analyse claim data.

Keywords : Policy Formulation; Guidance Of Fraud Prevention, Fraud
Bibliography: 52 (2000-2015)