

ANALYSIS OF DIFFERENCES BETWEEN ACTUAL TARIFFS AND iDRG TARIFFS IN INPATIENT BPJS KESEHATAN PATIENTS WITH BRONCHOPNEUMONIA

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A B S T R A C T

Health services for BPJS Kesehatan participants use a package-based payment system through the Indonesian Diagnosis Related Groups (iDRG), whereas hospitals incur actual costs based on the services provided. This study aimed to determine the differences between actual tariffs and iDRG tariffs, as well as the factors contributing to these differences, in claims for patients with Bronchopneumonia during the October–December 2025 period at South Buton Regency Hospital. The study employed a descriptive-analytical design with a quantitative approach. Saturated sampling, observation, and documentation study techniques were used. Univariate analysis was conducted using SPSS version 30.0 and Microsoft Excel. The results showed that 7 cases (26.9%) had a negative difference, while 19 cases (73.1%) had a positive difference. Among the 11 comparative cases, nursing costs were the dominant component in 9 patients (81.8%), contributing between 38.7% and 87.8%. Consultation costs were dominant in 2 patients (18.2%), with contributions of 21.9% and 24.3%, respectively. It was concluded that differences existed between the actual tariffs and iDRG tariffs. The primary factor contributing to these differences was nursing costs, followed by consultation costs.

INTRODUCTION

Hospitals are health care facilities that provide comprehensive promotive, preventive, curative, rehabilitative, and palliative services to the community Undang-undang Nomor 17 Tahun, (2023). According to Government Regulation Number 28 of 2024 concerning the Implementation of Health, hospital services include medical, nursing, pharmaceutical, laboratory, radiology, and other supporting services, each of which requires resources and financing. The substantial need for resources makes health care costs an important issue because hospitals must ensure service quality while maintaining operational sustainability. The government has developed the National Health Insurance (JKN) program through BPJS Kesehatan to expand public access to health services using a measurable financing mechanism (Kementerian Kesehatan RI, 2022).

One effort to control JKN financing is the implementation of Indonesian Diagnosis Related Groups (iDRG) as a prospective payment system based on diagnosis, procedures, severity, and case complexity, so that payment is not calculated from the total actual costs incurred for each patient Azzahra, (2025). This condition may result in differences between iDRG tariffs and actual tariffs because the service needs of each patient are not always the same Utami & Fanny, (2021). This issue is particularly important in Bronchopneumonia cases because patients may require intensive treatment, monitoring, supporting examinations, medications, and nursing care Wardhani *et al.* (2024). Therefore, analyzing tariff differences in Bronchopneumonia cases is important to support financing policy evaluation and improve the efficiency of services for BPJS patients (Gunari *et al.* 2025).

Previous studies have shown that tariff differences may result in either positive or negative differences due to variations in clinical conditions, completeness of medical information, and the use of health care resources Monica *et al.* (2021). These differences are related to the concept of actual tariffs, which represent all actual costs incurred by hospitals in providing services to patients, whereas iDRG tariffs represent package-based payments according to diagnostic groupings and patients' clinical characteristics Prandyantara *et al.*(2023). The difference between these two tariffs can serve as an indicator for assessing payment adequacy, resource-use efficiency, and potential financial risks faced by hospitals. In addition to clinical factors and medical resource utilization, operational aspects of healthcare services, such as human resource readiness, supporting facilities, and work procedures, may also influence the effectiveness of healthcare delivery Sinta & Sulistiawa, (2022). In line with this, Marhenta *et al.* (2022),s reported that tariff differences are influenced by variations in nursing

costs, medications, supporting examinations, medical procedures, and length of stay. Although previous studies have extensively discussed tariff differences in diagnosis-group-based payment systems, most have focused on the INA-CBGs system, while studies evaluating the compatibility between actual tariffs and iDRG tariffs remain very limited.

Based on the results of a preliminary study in the casemix unit of South Buton Regency Hospital, Bronchopneumonia ranked first among the ten most common inpatient cases, with 26 BPJS patients during the October–December 2025 period, and there was a potential claim deficit when actual costs exceeded the iDRG tariff. Research on the differences between actual tariffs and iDRG tariffs in Bronchopneumonia cases at South Buton Regency Hospital is important because it can provide a factual overview of the compatibility between claim payments and actual service costs. This information can be used as evaluation material for hospitals to control costs, improve the accuracy of service recording, and identify cases at risk of causing a deficit. Based on this issue, this study aimed to analyze the differences between actual tariffs and iDRG tariffs and to identify the factors causing tariff differences among BPJS Kesehatan inpatients with Bronchopneumonia at South Buton Regency Hospital.

METHODS

This study was a descriptive-analytical study using a quantitative approach and an analytical observational design. Descriptive-analytical research was used to provide an overview based on the collected data while analyzing differences among the observed variables Lengkong *et al.* (2024). A quantitative approach was used because the research data were numerical and analyzed through tables, percentages, and value comparisons Nurhaswinda, (2025). The study was conducted at South Buton Regency Hospital using claim data from the October–December 2025 period. The population included all inpatient BPJS Kesehatan claim submission files for Bronchopneumonia cases, while the study sample consisted of 26 files selected using a saturated sampling technique (Hadning *et al.* 2024).

Data were collected through observation and documentation studies of claim files, actual tariff details, and data from the iDRG financing system. The research instruments consisted of an observation sheet and a checklist of tariff components, including consultation, nursing, laboratory, room/accommodation, supporting services, and medication costs. The data were analyzed using univariate analysis, including frequency distributions, percentages, and comparisons between actual tariffs and iDRG tariffs, using SPSS version 30.0 and Microsoft Excel.

RESULTS & DISCUSSION

Characteristics of BPJS Inpatients with Bronchopneumonia

Table 1. Characteristics of BPJS Inpatients with Bronchopneumonia, October–December 2025

Patient Characteristics	Group Variation	Number	Percentage (%)
Class	I	2	8%
	II	4	15%
	III	20	77%
Secondary Diagnosis	0 secondary diagnoses	9	35%
	1 secondary diagnosis	13	50%
	2 secondary diagnoses	1	4%
	>2 secondary diagnoses	3	12%

Based on the results presented in Table 1, patient characteristics by inpatient class showed that most patients were in class III, with 20 patients (77%), followed by class II with 4 patients (15%) and class I with 2 patients (8%). The predominance of class III patients indicates that most BPJS Kesehatan patients used class III inpatient facilities at South Buton Regency Hospital. Meanwhile, patient characteristics based on secondary diagnoses showed that 13 patients (50%) had one secondary diagnosis, 9 patients (35%) had no secondary diagnosis, 3 patients (12%) had more than two secondary diagnoses, and 1 patient (4%) had two secondary diagnoses.

Differences Between Actual Tariffs and iDRG Tariffs Among BPJS Patients with Bronchopneumonia, October–December 2025

Table 2. Differences Between iDRG Tariffs and Actual Tariffs for Bronchopneumonia Patients, October–December 2025

Number	Difference	Difference Count	iDRG Tariff	Actual Tariff
26	Negative Difference	7	35.121.952	96.941.999
	Positive Difference	19	101.909.922	64.189.000

Table 3. iDRG Tariffs and Actual Tariffs for Class I Bronchopneumonia Patients, October–December 2025

LOS	ICD-10 Code		ICD 9		iDRG Tariff	Total Actual Tariff	Diff.
	Main	Sec.	Code	Description			
2	J18.0	-	99.18, 90.59, 93.96, 87.44, 96.07	5	4.581.124	6.129.000	1.547.876

Table 4. iDRG Tariffs and Actual Tariffs for Class II Bronchopneumonia Patients, October–December 2025

LOS	ICD-10 Code		ICD 9		iDRG Tariff	Total Actual Tariff	Diff.
	Main	Sec.	Code	Description			
2	J18.0	L50.9	99.18, 90.59, 93.96, 93.94, 87.44	5	4.581.124	3.452.000	1.129.124
2	J18.0	E46	99.18, 90.59, 93.96, 93.94, 87.44	5	4.661.495	4.557.000	104.495

Table 5. iDRG Tariffs and Actual Tariffs for Class III Bronchopneumonia Patients, October–December 2025

LOS	ICD-10 Code		ICD 9		iDRG Tariff	Total Actual Tariff	Diff.
	Main	Sec.	Code	Description			
2	J18.0	-	99.18, 90.59, 93.96, & 93.94	4	4.581.124	5.610.000	1.028.876
2	J18.0	-	99.18, 90.59, 93.96, 93.94	4	4.581.124	3.422.000	1.159.124
2	J18.0	-	99.18, 90.59, 93.94, 87.44	4	4.581.124	3.635.000	946.124
1	J18.0	E86, A09.0, E87.5, & A41.9	99.18, 90.59, 96.07, & 93.96	4	6.108.166	3.930.000	2.178.166
1	J18.0	G41.9, R56.0, E46, R65.9,	99.18, 90.59, 87.44, 88.76	4	6.108.166	51.571.999	45.463.833
2	J18.0	R56.0	99.18, 90.59, 87.44	3	6.108.166	2.762.000	3.346.166
2	J18.0	R56.0	99.18, 90.59, 87.44	3	6108166	2622000	3.486.166
2	J18.0	A09.0	99.18, 90.59, 87.44	3	6108166	2952000	3.156.166

Based on the results presented in Tables 2 through 5, differences between actual tariffs and iDRG tariffs were identified among Bronchopneumonia patients during the October–December 2025 period. Table 2 shows that 7 cases (26.9%) had a negative difference, meaning that the hospital's actual tariff was higher than the iDRG tariff. In this group, the total actual tariff reached Rp 96.941.999, whereas the total iDRG tariff was only Rp 35.121.952. Conversely, 19 cases (73.1%) had a positive difference because the iDRG tariff was higher than the actual tariff. In this group, the total iDRG tariff was Rp 101.909.922, while the actual tariff was Rp 64.189.000. Table 3 shows that there were no identical comparison cases in inpatient class I; one case was found with an LOS of 2 days, no comorbid diagnosis, and 5 procedures, with a total actual tariff of Rp 6.129.000 and an iDRG tariff of Rp 4.581.124, resulting in a negative difference of Rp 1.547.876. Table 4 shows that in inpatient class II, two patients had the same characteristics in terms of inpatient class, LOS, number of comorbid diagnoses, and number of procedures, but had different types of comorbid diagnoses. The two patients (patients number 2 and 3) had comorbidities L50.9 with an actual tariff of Rp 3.452.000 and E46 with

an actual tariff of Rp 4.557.000. Thus, there was a difference in actual tariffs of Rp 1.105.000. Table 5 shows that in class III, there were three comparable patient groups with different levels of variation in actual tariffs. The first group consisted of class III patients with an LOS of 2 days, no comorbid diagnosis, and 4 procedures. This group had the same iDRG tariff of Rp 4.581.124, but the total actual tariffs varied considerably, from Rp 3.422.000 to Rp 5.610.000 (a difference of Rp 2.188.000). The second group had the same characteristics, namely an LOS of 1 day and 4 procedures. However, this group showed the largest difference in actual tariffs in the entire dataset. Both patients had the same iDRG tariff of Rp 6.108.166. However, the actual tariff for the first patient reached Rp 51.571.999, while that for the second patient was only Rp 3.930.000, resulting in a difference in actual tariffs of Rp 47.641.999 between the two patients. Finally, the third group consisted of three patients with the same characteristics, namely an LOS of 2 days and 3 procedures. This group had the same iDRG tariff of Rp 6.108.166 but different actual tariffs. Patients with the secondary diagnosis R56.0 had actual tariffs of Rp 2.762.000 and Rp 2.622.000, respectively, with tariff differences of Rp 3.346.166 and Rp 3.486.166. Meanwhile, the patient with the secondary diagnosis A09.0 had an actual tariff of Rp 2.952.000, with a tariff difference of Rp 3.156.166. Overall, the comparison of actual tariffs and iDRG tariffs among Bronchopneumonia patients showed variations between the service costs incurred by the hospital and payments based on iDRG tariffs. Tariff differences were still found even when several patients had the same characteristics in terms of inpatient class, LOS, primary diagnosis, and number of procedures.

Factors Causing Differences Between Actual Tariffs and iDRG Tariffs

Table 6. Factors Causing Differences Between iDRG Tariffs and Actual Tariffs for Bronchopneumonia Patients, October–December 2025

Class	Consult. (%)	Nursing (%)	Lab. (%)	Room/Acc om. (%)	Support Serv. (%)	Drug (%)	Dominant Factor
I	12,20%	54,10%	6,90%	17,90%	2,40%	6,50%	Nursing
II	17,20%	52%	4,50%	14,80%	4,90%	6,50%	Nursing
II	14,20%	60,50%	3,40%	11,20%	3,30%	7,55	Nursing
III	9,70%	69%	1,90%	8%	2,70%	8,70%	Nursing
III	17,40%	51,40%	4,60%	10,50%	5%	11,10%	Nursing
III	36,70%	6,90%	7,30%	27,70%	6,90%	14,50%	Consultation
III	10,70%	59,20%	4%	7,60%	3,80%	14,70%	Nursing
III	3,70%	87,80%	1,60%	6%	0,30%	0,60%	Nursing
III	24,30%	22,30%	5,70%	21,70%	5,40%	20,60%	Consultation

The factors causing differences between actual tariffs and iDRG tariffs were determined by analyzing the contribution of each cost component to the total actual tariff in each case. The cost components analyzed included consultation, nursing, laboratory, room/accommodation, supporting services, and medications. The component with the largest cost proportion was designated as the dominant factor and considered the primary cause of the difference between actual tariffs and iDRG tariffs. Based on the results presented in Table 6, the factors causing the differences were further analyzed in 11 cases with comparable characteristics. In class I, nursing costs contributed 54.1% of the total actual tariff, which was higher than room/accommodation at 17.9%, consultation at 12.2%, laboratory at 6.9%, medication at 6.5%, and supporting services at 2.4%. In class II, nursing costs were also the component with the largest contribution, ranging from 52.0% to 60.5%. Other components contributed less, including consultation at 4.6–4.9%, laboratory at 3.3–4.9%, room/accommodation at 11.2–14.8%, supporting services at 3.3–4.4%, and medications at 6.5–7.5%. Meanwhile, in class III, nursing remained the dominant component, contributing 38.7–87.8%, although the contribution varied among patients. In addition to nursing, consultation was also the dominant factor in several class III patients, contributing 21.9% and 24.3%. Other components, such as laboratory, contributed 1.6–5.7%, room/accommodation 6.0–21.7%, supporting services 0.3–5.4%, and medications 0.6–20.6%. Thus, nursing costs were the largest component, followed by consultation costs, causing differences between the hospital's actual tariffs and iDRG tariffs among Bronchopneumonia patients at South Buton Regency Hospital.

DISCUSSION

Differences Between Actual Tariffs and iDRG Tariffs Among BPJS Patients with Bronchopneumonia, October–December 2025

Analysis of the differences between actual tariffs and iDRG tariffs among 26 BPJS Kesehatan inpatients with Bronchopneumonia at South Buton Regency Hospital found 7 cases with negative differences and 19 cases with positive differences. In the negative-difference group (iDRG tariff < actual tariff), the total iDRG tariff received by the hospital was Rp 35.121.952, while the total actual tariff reached Rp 96.941.999. A negative difference indicates that the actual costs incurred by the hospital were greater than the iDRG tariff received from BPJS Kesehatan. If this condition occurs repeatedly, it may cause the hospital to experience a funding shortfall (financial loss) and potentially affect the sustainability of health service financing. According to Utami & Fanny, (2021), differences between package tariffs and actual hospital costs can result in negative claims when the resources used for patient services exceed the predetermined tariff value. These differences indicate that cost-management efficiency is an important factor in maintaining the sustainability of hospital financing.

In the positive-difference group (iDRG tariff > actual tariff), the total iDRG tariff of Rp 101.909.922 was higher than the total actual tariff of Rp 64.189.000. A positive difference occurs when the iDRG tariff received by the hospital is greater than the actual service costs incurred. This condition may generate excess revenue that can be used to cover cases with negative differences and support hospital operational sustainability Pradhana *et al.* (2025). Differences may also occur because the actual tariff represents the costs actually incurred by the hospital in providing services to patients, whereas the iDRG tariff is a fixed package tariff based on diagnosis. According to Suheri *et al.* (2022), under a package-based payment system, some cases may generate a financing surplus, while others may experience a deficit due to variations in the use of health care resources among patients.

The results of this study showed that although the iDRG tariff was sufficient to cover service costs in most Bronchopneumonia cases, certain cases still required more extensive services, resulting in actual costs that exceeded the package tariff. This indicates that diagnosis-group-based tariffs do not fully reflect the variation in service needs of each patient. Marhenta *et al.* (2022), explained that even in diseases with similar clinical characteristics, service costs may differ due to variations in medication use, medical procedures, length of stay, and the intensity of services provided to patients.

Analysis based on patient characteristics showed that similarities in inpatient class, length of stay (LOS), primary diagnosis, number of procedures, and clinical characteristics do not necessarily result in the same actual tariff. This variation was found in inpatient classes II and III, where patients with the same service characteristics and the same iDRG tariff had different actual costs. In class II, two patients with an LOS of two days and the same number of procedures had a difference in actual tariffs of Rp 1.105.000 due to different comorbid diagnoses. In class III, considerable variation in actual tariffs was also found among patients with an LOS of two days, no comorbid diagnosis, and four procedures, whose actual tariffs ranged from Rp 3.422.000 to Rp 5.610.000 despite receiving the same iDRG tariff.

The largest difference was found among class III patients with an LOS of one day and four procedures, where two patients received the same iDRG tariff of Rp 6.108.166, but the difference in their actual tariffs reached Rp 47.641.999. This difference was mainly influenced by the high nursing and room/accommodation costs of one patient. According to Khoirunnisya & Suryani, (2024), more complex service needs can sharply increase costs even when administrative characteristics and iDRG codes appear to be the same. In addition, Tama *et al.* (2025), explained that the difference between package tariffs and actual costs is a consequence of prospective payment systems, because package tariffs are calculated based on the average cost of a case group, whereas actual costs reflect the resource consumption of each individual patient.

The study by Suheri, (2022), also showed that differences between actual tariffs and BPJS package tariffs are influenced by variations in inpatient class, length of stay, medication use, supporting examinations, and the intensity of services provided to patients. This finding strengthens the results of the present study, showing that patients with the same diagnosis do not necessarily incur the same service costs because each patient has different service needs. Utami & Fanny, (2021), also explained that variations in patients' clinical conditions lead to differences in resource use, causing service costs to differ among patients with the same diagnosis. Cost differences arise because package

tariffs are determined based on the average cost of a diagnostic group, whereas actual tariffs are calculated based on the services actually provided to each patient. In addition, Nilmawati *et al.* (2025), stated that variations in nursing costs, medications, laboratory examinations, medical procedures, supporting services, and length of stay can cause differences between actual hospital costs and the tariffs paid by BPJS Kesehatan. Therefore, evaluating service cost components is important so that hospitals can control costs without reducing the quality of patient care.

Factors Causing Differences Between Actual Tariffs and iDRG Tariffs

The factors causing differences between actual tariffs and iDRG tariffs were analyzed through the contribution of each cost component to the total actual tariff among 11 Bronchopneumonia patients with comparable characteristics. The cost components analyzed included consultation, nursing, laboratory, room/accommodation, supporting services, and medications. The results showed that nursing costs were the component with the largest contribution in most cases. In class I, nursing costs contributed 54.1% of the total actual tariff, which was greater than other components such as room/accommodation, consultation, laboratory, medications, and supporting services. In class II, nursing costs were also the dominant component, contributing 52.0–60.5%, while other cost components contributed less.

In class III, nursing costs remained the component with the largest contribution, ranging from 38.7% to 87.8%. This variation in contribution indicates differences in the use of health care resources among patients even within the same diagnostic group. In addition to nursing costs, consultation costs were also the dominant factor in two class III patients, contributing 21.9% and 24.3%. Meanwhile, laboratory, room/accommodation, supporting services, and medication costs contributed less than nursing and consultation costs. Thus, the results of this study indicate that nursing costs were the primary factor causing differences between actual tariffs and iDRG tariffs among Bronchopneumonia patients at South Buton Regency Hospital, followed by consultation costs in several cases.

The dominance of nursing costs in this study indicates that inpatient services are strongly influenced by nursing activities throughout the patient's hospitalization. Patients with Bronchopneumonia require continuous monitoring of respiratory conditions, administration of therapy, observation of vital signs, and other nursing interventions, resulting in a larger nursing cost component than other service components. The results of this study are consistent with the study by Utami & Fanny, (2021), which showed that nursing services are one of the largest cost contributors among JKN inpatients. Increased nursing care needs due to patients' clinical conditions will increase hospital service costs and may cause actual tariffs to be higher than package tariffs.

Suheri *et al.* (2022), also found that variations in inpatient service costs are influenced not only by the primary diagnosis but also by the intensity of nursing care, physician consultations, medication use, laboratory examinations, and other supporting services. Although BPJS tariffs are established based on diagnostic groups, the service costs incurred by hospitals may still differ because each patient's service needs are not always the same. According to Nilmawati *et al.* (2025), variations in the costs of medications, laboratory examinations, procedures, supporting services, and length of stay also influence differences between actual costs and package tariffs. In the context of iDRG payment system implementation, the results of this study demonstrate the importance of evaluating the suitability of package tariffs with patterns of health care resource consumption in hospitals. According to Susanty dan Hardisman, (2025), harmonization among case classification systems, service standards, and payment mechanisms is necessary to ensure that package-based financing systems operate effectively and efficiently while continuing to support the quality of health services.

CONCLUSION

Differences were found between actual tariffs and iDRG tariffs in 26 Bronchopneumonia cases among BPJS Kesehatan inpatients. In addition, patients with relatively similar clinical characteristics did not necessarily have the same actual tariffs. Differences in actual tariffs were still found even when patients shared the same inpatient class, length of stay (LOS), primary diagnosis, number of secondary diagnoses, and number of procedures. These variations were influenced by differences in the use of health care resources, such as nursing needs, physician consultations, supporting examinations, medications, and other services. Furthermore, analysis of the factors causing differences between actual tariffs and iDRG tariffs in 11 Bronchopneumonia cases with comparable

characteristics showed that nursing costs were the dominant factor causing the differences. Nursing costs contributed the largest proportion across all inpatient classes, namely 54.1% in class I, 52.0–60.5% in class II, and 38.7–87.8% in class III. In addition to nursing costs, consultation costs were also the dominant component in several class III patients, contributing 21.9% and 24.3%. Other cost components, such as laboratory, room/accommodation, supporting services, and medications, contributed less. Nevertheless, this study was limited because the data included only 26 BPJS Kesehatan claim files for Bronchopneumonia cases during the October–December 2025 period; therefore, the limited observation period and number of cases do not fully describe long-term patterns of tariff differences. The analysis was also limited to descriptive univariate analysis and therefore only described the magnitude and cost components causing tariff differences, without testing relationships, effects, or the statistical significance of each factor in relation to the difference between actual tariffs and iDRG tariffs.

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