SECTION 59 INVESTIGATION

DATE: 2019-07-30

HELD IN: IMBIZO BOARDROOM,

COUNCIL FOR MEDICAL SCHEMES OFFICES, CENTURION

PRESENT:	**ADV TEMBEKA NGCUKAITOBI - CHAIRPERSON**
	ADV ADILA HASSIM - PANEL
	ADV KERRY WILLIAMS - PANEL
	DR SIPHO KABANE, CMS
	DR HLELI NHLAPO, HFMU
	MR PARESH PREMA
	MR SIBONELO CELE
	MR DANIE KOLVER

In Living Colour

011 708 7451

CERTIFICATE OF VERACITY

I, the undersigned, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the conversation:

Section 59 Investigation

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Notes:

1. This is a verbatim transcription and transcribed without the benefit of any documentation for the verification of spelling of names and places.
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PROCEEDINGS ON 30 JULY 2019

CHAIRPERSON: Good morning, we are scheduled to start day number two of the public hearings into Section 59 of the Medical Schemes Act. We have received an email version of the submissions by the Council for Medical Schemes. We had expected to also get a printed version to facilitate our lives. I am told that it is being printed as we speak, but we want to really start on time. So I think we will carry on, and then as soon as the copies are available, they will be given to us. So who will be speaking on behalf of the council?

DR KABANE: Thank you Chairperson, I will speak on behalf of the council, but I also have a team of members that will speak to certain technical areas of the presentation here.

CHAIRPERSON: Alright, can we do this. I need to then administer the oath for everyone who will be speaking, because we are trying to take this as evidence. Shall I start, how many other people are speaking other than you Mr Registrar?

DR KABANE: It's six.

CHAIRPERSON: Six, alright. Look, we will have to take a joint oath, otherwise to do it six times that's not going to work. Okay, so will you just say after me I, and then mention your name? You can, ja, in any order, anyone, ja.

MR CELE: Sibonelo Cele.

CHAIRPERSON: Thank you.

MR LETSOALO: John Letsoalo.

CHAIRPERSON: Yes.

DR KABANE: Sipho Kabane.

MR PREMA: Paresh Prema.

MS PHASWANE: Thembikile Phaswane.

MR KOLVER: Danie Kolver.

CHAIRPERSON: Swear that the evidence I shall give.

MS PHASWANE: I swear that.

CHAIRPERSON: Ja, it's fine.

MS PHASWANE: I swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

MS PHASWANE: Shall be the truth.

CHAIRPERSON: The whole truth.

MS PHASWANE: The whole truth.

CHAIRPERSON: And rise your right hand and say; so help me God.

MS PHASWANE: So help me God.

CHAIRPERSON: I think we'll have to do it six times. So say after me; I swear that the evidence I shall give.

MR KOLVER: I swear that the evidence I shall give

CHAIRPERSON: Shall be the truth.

MR KOLVER: Shall be the truth.

CHAIRPERSON: The whole truth. MR KOLVER: The whole truth.

CHAIRPERSON: And raise your right hand and say; so

help me God.

MR KOLVER: So help me God.

CHAIRPERSON: And then, I swear that the evidence that I shall give.

MR PREMA: I swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

MR PREMA: Shall be the truth.

CHAIRPERSON: The whole truth.

MR PREMA: The whole truth.

CHAIRPERSON: And then raise your right hand and say; so help me God.

MR PREMA: So help me God.

CHAIRPERSON: Dr Kabane, I swear that the evidence I shall give.

DR KABANE: I swear that the evidence I shall give.

CHAIRPERSON: Shall be the truth.

DR KABANE: Shall be the truth.

CHAIRPERSON: The whole truth.

DR KABANE: The whole truth.

CHAIRPERSON: And raise your right hand and say; so help me God.

DR KABANE: So help me God.

CHAIRPERSON: Thank you. Yes, and then you say after me, I swear that the evidence that I shall give.

MR CELE: I swear that the evidence I shall give.

CHAIRPERSON: Shall be the truth.

MR CELE: Shall be the truth.

CHAIRPERSON: The whole truth.

MR CELE: The whole truth.

CHAIRPERSON: And then raise your right hand and say;

so help me God.

MR CELE: So help me God.

CHAIRPERSON: Thank you Mr Cele. Will you say after me, I swear that the evidence that I shall give.

MR LETSOALO: I swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

MR LETSOALO: Shall be the truth.

CHAIRPERSON: The whole truth.

MR LETSOALO: The whole truth.

CHAIRPERSON: And then you raise your right hand and say; so help me God.

MR LETSOALO: So help me God.

CHAIRPERSON: Thank you. Dr Kabane I will leave it up to you to structure your presentation and to just lead us. The way we've been running these hearings is that you speak, we don't have a specific time that is uninterrupted, but either me or my colleagues will question you, and if there are documents that we require we will ask you to produce them in due course. But feel free then to take us through your presentation.

DR KABANE: Alright, thank you Chairperson. Basically the structure of the presentation is I'll give a brief introduction and background, and then some high-level comments around the

Section 59 regulatory actions, and then my colleagues will deal with the specific areas. We'll have Mr Paresh talking to benefits and rules, Mr Danie Kolver talking to the accreditation, and Ms

Thembikile Phaswane talking to adjudication of complaints. Mr Sibonelo Cele will deal with inspections and investigation, and then Mr John Letsoalo will take us through litigation and appeals. Then I will close with some concluding remarks including talking to waste, fraud, waste and abuse and what CMS is doing to, you know,

mitigate against that here.

So Chair we've got a written document here, and the intention is not to read word by word here. But one will, you know, where we think it's important, you know, go into details. But there will be areas where we try and move quicker here. Just by way of introduction, I think it's important that the Council of Medical

Schemes is noted as the statutory regulator of medical schemes, medical schemes administrators, managed care organisations, and medical scheme care brokers, and that we perform this regulatory mandate in line with the Medical Schemes Act of, number 131 of 1998.

So our submission is done by myself and the team in

representing the statutory regulator here. Just a few comments in terms of how this investigation came about. Between the 6th and 15th of May in 2019, this year myself, the Chairperson of council Dr Mini, and the Minister of Health Honourable Minister Dr Aaron Motsoaledi at the time, convened several engagements, and at the heart of these was a request by the

National Health Care Professional Association, together with other service providers. Part of the engagement was including these allegations and complaints of racial profiling, bullying, blacklisting, which were being levelled against the medical schemes and administrators.

I think point four of that part, which is articulated in page three, goes into detail in terms of the allegation, and I don't want to repeat these here. But I think it is important that, you know, these allegations have been dealt with by CMS on its day to day regulatory efforts, and it became more important for us to institute this investigation because of the fact that these were now in the public domain, and they were including a racial element to it. So it became important as a regulator to ensure that there's an investigation put in

place here to address these allegations. So basically the industry

that we regulate contributes about 4.5% to the overall GDP in the country.

Which is part of the expenditure on health, and basically as I said, we regulate schemes, administrators, brokers and managed care organisations, and this we do in the protection of interest of 8.8 million members and beneficiaries. Currently we've got 78 schemes,

26 administrators, 15 managed care organisations, and more than 10 000 brokers here, and we regulate these in support of our members. Just a brief about the industry itself, in 2018 alone the claims that were paid out in the medical schemes industry were at the level of about R172 billion, and when you look at all schemes combined, they've got reserves that are sitting at R62 billion.

Just a bit of background around CMS and its function, CMS is a public institution established in, under chapter three of the Schemes Act 131 of 1998, and its key functions are stipulated in Section Seven of the Act. Namely to protect the interest of beneficiaries at all time, to control and coordinate the functioning of the medical schemes in a manner that is complementary to the national health policy, to make recommendations to the minister on criteria for measurement of quality and outcomes of relevant health services provided for by schemes, and other services as the council may from time to time determine.

Investigate complaints, settle disputes in relation to affairs of medical schemes provided for in this act, collect and disseminate information about private health care, make rules not inconsistent with the provision of this act for the purpose of performance of its function and the exercise of its powers. Advise the minister on any matter regarding the medical schemes and perform any other functions that would be conferred to the council by the minister. So this is really what sits in Section Seven and constitutes the mandate of the council. Chairperson, I just want to talk to some high-level comments in terms of Section 59, regulation five and six, and these are captured in our document as pages five, six, and seven.

Then I'll hand over to my colleagues here. So basically when you look at Section 59, its main purpose is to guide charges by suppliers of service, and that first part, the first section here then, it talks about the supplier of a service that has been provided to a beneficiary rendering an account directly

to members. Here this is where part of the problem sits because it doesn't make any

reference to the service provider, and I think part of this triangular relationship between supplier, member, and service provider is what is being articulated here.

You'll hear my colleagues talk about the case law, which basically indicates that whilst there's a contract, or agreement between the supplier and the member, as well as the member and the service provider, this does not automatically apply to the suppliers of the service, and the scheme. So in a sense we believe part of the problem sits there. The second clause there talks to the 30-day rule, and basically says that once an accountant has been

rendered and its, its correct there's no issues, it needs to be paid

within 30 days of being received here. I think the interpretation there across the board is, one could say almost uniform. But it is the third clause there that is often a point in dispute here, and this relates to the fact that this section actually allows that if the scheme have paid you in good faith as a service provider, and after some times make a decision that you're not entitled to the amount, or this amount is a loss to the scheme due to theft, fraud and negligence.

It is empowered to deduct such an amount, you know, from

the service provider. Now the issues that come from this here, is that firstly it's not prescriptive in terms of how far back a scheme may go,

or an administrator may go to offset this loss, and secondly it's not clear how a scheme would actually arrive at this point that, you know, the money that they have been, they have paid is basically the service provider is not entitled to. Or that there's fraud or negligence,

you know, related to this, and these things are some of the issues that have led to the investigation itself here, and we hope that out of this we'll be able to get a clear way in terms of how this should be dealt with. The next part that I want to talk to is regulation five

[intervenes]

ADV WILLIAMS: Dr Kabane, may I just flag a question for you and your team? Not necessarily to address now, but because you have been touching on the legislation and the regulations, it obviously is going to be discussed throughout these hearings. But

I'm interested to know if you have any specific views on the meaning

of the words in both Section 59(3), and regulation, excuse me, and

regulation six. So you will know that 59(3) allows the schemes effectively to, the wording, I will read it for convenience, it is to claw back amounts that have been paid *bona fide* in accordance with the act to which a member or supplier of healthcare service, and the

wording is "not entitled". So I'm interested in your views on what that might mean.

Then the second question is looking at regulation six and trying to understand whether it's intended to implement Section 59(3) or not. Regulation six uses slightly different words, and places

constraints on how schemes should pay accounts, and note what

they call erroneous or unacceptable payment. So again, slightly different wording, and we're just, or I'm certainly interested in understanding if the CMS has any views on that, and if that, any clarity comes out of your rulings. Thank you.

DR KABANE: Can I just ask whether you want the answer now, or right at the end after we've made [intervenes]

ADV WILLIAMS: Completely up to you, whatever's convenient?

DR KABANE: Ja, okay ja, I'll suggest that we make the presentations and if it has not come out clearly, we can then zoom in and come and answer that.

ADV WILLIAMS: Thank you Dr Kabane.

DR KABANE: Alright thank you, and then if you look at regulation five. This addresses itself to the accounts by suppliers of service, and without going into the detail of what sits in there, in my mind I think this is all the information that needs to be addressed when an account is being rendered, for it to be considered by a scheme for payment. Basically if you look at regulation six here, it talks about the manner of payment of benefits, and this is where we also have a lot of, you know, interpretations within the industry. Because if you look at that first clause there here, which talks about how a scheme, you know, is, can basically, is not entitled to limit, exclude, etcetera, etcetera.

If you look at that last part of that sentence, it actually addresses itself mainly to the timing of when this can be done, and there's an interpretation that it also then, you know, also means that schemes are entitled to, you

know, limit, exclude, retain, you know, in relation to scheme payments here. If you look at the second section of that regulation here, it basically talks about the erroneous and unacceptable, claims that are erroneous and unacceptable, and it seeks to explain how these need to be handled between the scheme, the service provider, and the member here. And one is not certain whether schemes actually do inform members, and you know, service providers that there's a problem with a certain claim, and whether they do this within 30 days.

Because if they don't do that then basically it means they're in violation of that section of the act here. There's also the, the third clause here which talks about an opportunity being given to service providers and members to correct problematic claims that have been

put forward. Whether these are erroneous or unacceptable, and

basically, you know, talks about giving them an opportunity to correct these, and allowing them to re-submit so that these gets paid here. The big question is, you know, do schemes adhere to this, and the administrators, and basically what also happens when a service provider either is not informed, or is not cooperating with this here.

We're hoping that we'll get clarity in terms of what is recommended on the way forward here. Chairperson, on page eight

…[intervenes]

ADV WILLIAMS: Sorry, sorry Dr Kabane. Will your team be addressing the experience of the CMS in enforcing and monitoring compliance with regulation six, and whether schemes do comply or not?

DR KABANE: Yes, they will give input in that respect.

The last part that I wanted to talk to Chairperson, sits in page eight, number five there. We also believe that, you know, a board of trustees can't be excluded from these allegations that we are currently dealing with, because we believe that in terms of good governance, and the Schemes Act, and its regulations they've got a certain responsibility, and I think this investigation would need to also look at, you know, the board of trustees here. Now in terms of our understanding, it's that the medical schemes are not expected to negligently find claims even when there's a reasonable suspicion of irregularity.

We also believe that the board of trustees of the medical schemes, in terms of Section 57(4)(c), need to ensure that there's proper control systems that are employed by, and on behalf of the medical schemes. Again we also believe that schemes and administrators through their board of trustees, in terms of Section 57(6)(a), need to take all reasonable steps to ensure that the interest of beneficiaries in terms of the rules of the medical schemes, and the provisions of the act are protected at all times. Basically we expect the boards of trustees to ensure that, you know, the entities that they govern comply with all the sections, I mean comply with the provisions of Section 57.

We also believe that this is the part that enables schemes to be able to reverse claims, because the argument there is that they are protecting member interests. Chairperson, I will then hand over to my colleague, Mr Paresh Prema, to take us through the benefit and rules.

CHAIRPERSON: Thank you. Mr Prema?

MR PREMA: Thank you Chairperson. My section deals

with the rules that medical schemes need to register in order to operate. I'm responsible for advising and recommending those changes to the registrar, and the operation of Section 31 of the Medical Schemes Act. So in terms of the Medical Schemes Act, Section 31 deals with amendment of rules, the requirements of those amendments, and the submission of those to the office, and the criteria in which the registrar would have to apply in order to register, or not register a medical scheme rule. It, the main provision relied on by the registrar is that, to ensure that the rules must, or an amendment to the rules must not be unfair to members, or inconsistent with the Medical Schemes Act, in registering those rules.

There are further provisions in Section 31 which I'll deal with briefly during my submission. In terms of the Medical Schemes Act, rules, medical schemes require rules to be registered, in order for them to be governed in terms of those rules, and Section 29 of the Medical Schemes Act sets out the provisions that need to be contained in those rules. A particular section that deals with benefits itself is section 292, which speaks to the manner in payment of

benefits, according to a scale or tariff, recommended guide, an specific directives prescribed in the rules of the scheme.

Insofar as the office is concerned in giving guidance to schemes as to the contents of their rules, based on Section 29,

there's a guidance document called the model rules, which we publish for schemes so that the interpretations of the sections can be put in their rules that are acceptable for the registrar. However the model rules are a guide, and if schemes submit rule amendments that are different and are not unlawful, they are also registered by the registrar, as long as they speak to the functioning of the scheme in terms of Section 29.

We have to have that in case of different elements, and different schemes having different, for example, restricted schemes may have rules relating to the eligibility of membership to a scheme.

So model rules go more in terms of the normal day to day operations of a scheme, and general governance of the scheme. How AGM's, when they're set up, quorums, and things like that which give guidance to schemes. In terms of Section 31, it states that schemes can only operate rules if they are approved by the registrar.

So if they do not submit an amendment and operate a rule that is not approved by the registrar, that is, those rules are invalid, and once they are registered, they are binding to the medical scheme in terms of Section 32. There are, and in as far as this investigation goes, there are certain elements and some rules, in some schemes, that deal with Section 59 and the payment of claims,

which are different to, or add additional requirements by the scheme in paying those claims, and instances it's more to deal with the relationship between the scheme and the provider.

As the registrar mentioned earlier, the Section 59 provision only deals with a member supplying the statement to the scheme requiring payment, and not the provider doing that. So in instances where schemes have further rules dealing with the payment of claims around Section 59, it deals with how the provider does that, and I'll give an example of where we have a concern with one of, one format of the rule that we have currently in one of the schemes, and how we are dealing with that going forward.

So there are a few small restricted schemes, and a large open scheme that deal with these claims, and the treatment of the scheme submitted by providers. The rules that deal with these,

speak to the scheme investigating of finding concerns with the

claims that deal with putting the scheme at risk, and that's the term that is used by schemes in the rules. So if the scheme finds a provider putting the scheme at risk, then the rules deal with the remedies in that regard. It goes on, the rules go on …[intervenes]

ADV WILLIAMS: Mr Prema, may I interrupt you just to pause, because what you're saying is significant certainly, and I would like to understand it better. So are you saying some of the scheme rules actually set out rules which govern the service providers in the scheme, so don't govern the relationship between the scheme and the members, and my first

question in relation to that is; do you consider that then to be binding on the service providers?

MR PREMA: No, it's not a rule that binds the service provider, but it's a rule which governs how the scheme will treat payments to those providers. So if the scheme, so if reading of the rules says if the scheme investigates a provider, and in the next section, and based on justifiable reason has cause that this provider has put the scheme at risk, will then determine on, determine the way in which the scheme reimburses that provider.

ADV WILLIAMS: Yes, I think I am understanding you. I suppose just what I'm trying to understand further is, the provider's not necessarily in a relationship, legal relationship with the scheme, so I'm interested to understand how the provider gets, is bound by the rules of the scheme, and if there's any thinking around that, if this is determining how Section 59 investigations are managed by schemes?

MR PREMA: Yeah, so as far as we're aware in terms of the rules, it guides how the scheme would review and decide on the payment to those providers, but it doesn't bind the provider in terms of any arrangement or any form of negotiation with the provider. But our concern with the provision is what is a result of the scheme doing that investigation, and the issue is not that it's a widespread, there is a handful of, or up to six schemes that do that. Which there is a process in which we embarked on to deal with

those, but ja.

ADV WILLIAMS: And just to reflect what you're saying, so you're saying it's a form of internal governance that's displayed in the rules?

MR PREMA: Yes.

ADV WILLIAMS: Okay, thank you.

ADV HASSIM: Sorry Mr Prema, I'm going to interrupt you as well.

MR PREMA: Yes.

ADV HASSIM: Are there any rulings, or any precedents that flesh out what is meant by the phrase; "putting the scheme at risk"?

MR PREMA: Yes, so that is, that is what has raised the concern from our side, and as such we've taken certain steps to deal with this specific rule. My colleague from the complaints unit will also deal with the implications and the concerns that this, that we have with the rule, and the implication of the rule itself. So that's, so further on in my submission we'll deal with now the problem relating to this rule, but essentially, it's that. To say that if the rule states that if the provider is found to put the scheme at risk, and the scheme has justifiable reason, or probable cause, then the further concern we have is, the rules states that the scheme will stop paying the provider. That is a concern for us, and it wasn't an issue because this rule was registered in 2010, and when we found the practice in the way in which the schemes apply the rule, we then requested the

schemes to change the rule. So Section 31(4) of the Medical Schemes Act is a provision that allows the registrar to write to the scheme, to instruct it to change the rule in the manner indicated by him. The problem is though, that is then a decision that can be

appealed by a medical scheme, if they're in disagreement with the director.

ADV WILLIAMS: Sorry, which medical scheme is this? CHAIRPERSON: They asked not to mention names of

schemes.

MR PREMA: Oh, apologies, okay.

CHAIRPERSON: Carry on Mr Prema.

MS HASSIM: Sorry, sorry maybe this isn't, why can't you mention the scheme? Is it not a matter of public record, the rules and rulings in relation to it?

(simultaneous speaking).

MR PREMA: Maybe later as part of the final [intervenes]

(simultaneous speaking).

CHAIRPERSON: You made the request not to mention the schemes.

MR PREMA: Yes.

CHAIRPERSON: So carry on, we will discuss it with you later.

MR PREMA: But my, I think the point I want to make

is, it's not a widespread rule. It's a handful of schemes. It's not, if

you're looking at a practice across the industry, it's not based on this rule specifically, but as part of the investigation, it's a good opportunity for us to raise our process, our concerns, and how we attempt to try to deal with these matters that come on, and these are matters that we deal with on a day to day basis as the regulator. Because we deal with rules and changes to rules, amendment to rules, and when we find rules that are applied in an inconsistent way, or inconsistent with certain provisions of the act, what is the remedies that we have to deal with those.

So as far as this investigation is concerned, that's the only provision that we find that we have a concern with relating to specifically payment of providers. What is important with this rule is, it says it gives a discretion to the scheme to identify providers that may put the scheme at risk. But it doesn't go further to qualify what,

how is that determined, and it mentions probable cause or justifiable

reason, and then on that basis stop payment. That is our concern with the rule, and it's been picked up in all other processes in the office where the scheme uses that to not pay, or find that the investigation has revealed certain risks that the provider poses to the scheme, and as such payment being stopped.

The, further on my submission I talk about when it was registered. At that point it was, the rule was approved in order for the scheme to manage its risk, but they, the intention was for the scheme to do it on a case by case basis, not a blanket process. It's meant to deal with providers, and those are very few and far between that may pose a risk to the scheme. But we have identified these in 2015, that they need to be

changed. We've written to them. The scheme has appealed that decision and based on our process going forward we may need to approach the matter at the courts in trying to get the schemes to reverse that.

CHAIRPERSON: Just tell me, the relationship between the service providers and the schemes, that's regulated by a contract, they call them the DSP's, do you have any role to play in setting the terms of that contract?

MR PREMA: No, in terms of the Medical Schemes Act, they, the schemes, if they choose to appoint a DSP, may appoint a DSP but not contract, the word contract is not in the Act. It says you may nominate or appoint a DSP. We've had recent court judgements where it said that, that would imply that there is an agreement, and

we would want to see an agreement between the scheme which

nominates a DSP. But in the absence, or if the scheme does not want to enter into a DSP agreement, a supplier may submit a claim, and the scheme is required to pay, especially if it relates to prescribed minimum benefits.

CHAIRPERSON: I'm talking in instances where there is an agreement, what is the role, what is your regulatory function in looking at the terms of that contract?

MR PREMA: We don't have any function in terms of that contract, because there isn't a, it's not related to the rules specifically. Where those contracts come into play, or arrangements, is the level of benefits that are paid to a DSP versus a non-DSP.

That's where the rules would apply in terms of those arrangements.

CHAIRPERSON: So your understanding of your role is you are enforcing the Act and the rules, and you have nothing to do with the contract?

MR PREMA: We don't have any role in the contracting specifically with those.

CHAIRPERSON: Alright, thank you.

MR PREMA: Okay, so the approval, again we get, based on our request to the schemes to amend the rule, the appeal has been lodged and there was a process around that which we are busy engaging in, so it's not concluded. But we have, our concern is even though the scheme has its right to appeal the decision, it's important for us in terms of what the fiduciary duties of trustees are in put, applying a rule in the manner in which it gives them discretion to determine whether a provider will be paid or not, and also whether that is in the best interest of members in the cases where it's applied in a way that is unfair to those providers.

As far as the other medical schemes are concerned, we are in the process to require them to remove those rules and apply Section 59 strictly. There is also a provision in the rule which says, which I didn't mention earlier, which says that if the scheme has found a provider to do that, they will notify the provider, and in instances like that put the provider up on a list of providers that they have stopped paying. We've not seen that list, and we're not aware

of this scheme, this particular scheme doing that. But it's a provision also that is concerning for us, and that's why we've asked the scheme to remove that.

ADV WILLIAMS: Is that a list that's available to all medical 5 schemes?

MR PREMA: So in terms of the rules, they've put in the provision to say they will create a list, and they will publish the list for schemes, but we've not seen that list, especially related to this particular scheme itself, or the other ones that are, that we found to have a similar provision. But we've not seen that list, we've not seen them publish any list of that sort for those schemes concerned.

CHAIRPERSON: Thank you, are you finished here?

MR PREMA: Yes.

CHAIRPERSON: Thank you, one of you still needs to answer Ms William's question about what is the linkage between Section 59 and regulation five and six, because the two concepts that are used in the two are different. But maybe that's not you.

Okay, so who is next?

MS WILLIAMS: Tembeka may I, sorry …[indistinct 00:40:12], can I just ask a further question? Just to clarify this information that you're giving us. It occurs to me that whether or not there are provisions in the schemes rules about how they manage their Section 59 investigations and claw-backs is actually immaterial, because it could be in the scheme rule and then you have visibility of it, but if not because it's an internal governance issue, it may not

be and then you don't have visibility of it, would that be a fair comment?

MR PREMA: Yes, yes it will.

CHAIRPERSON: Who is next?

MR KOLVER: Thank you Chair. Danie Kolver, I'm the general manager in the accreditation unit of the Council for Medical Schemes. Our function Chair is to accredit medical scheme administrators, healthcare brokers, and also managed care organisations. The registrar referred to the distinction between registering medical schemes, and the accreditation functions which we derive from Section 58 of the Act as an authorising clause. Which in this particular instance, insofar as administrators are concerned, is read in conjunction with chapter six, in other word regulation 16 to 27 of the regulations published in terms of the Medical Schemes Act.

Chair, I think it's relevant to mention that the accreditation function, or administrators are accredited by the Council for Medical Schemes itself. There's no delegated function to either myself or the registrar, or anybody else. It is a council function, and I think it's also relevant to note that Section, oh excuse me, regulation 17, insofar as accreditation standards are concerned, that those were developed over time, and as we speak we're busy with the, the fifth addition, the fifth revised addition of the accreditation standards which have been developed over time at this particular stage.

Our founding regulation, insofar as the application of

standards is concerned, emanates from regulation 17(2)(f), for

foxtrot, saying that; such information as the council may deem necessary to satisfy it that such person as an administrator, A; is fit and proper to provide admin services, it has the necessary resources, skills, capacity and infrastructure to render the service, and thirdly is financially sound. Chair, a number of, there are a number of accreditation standards that are applicable to

administrators, and insofar as this investigation is concerned, I may just for context mention that on claims paying ability, now what is important here is that there are several standards that apply to, in assessing the ability that administrators and self-administered schemes, because self-administered schemes perform the admin functions from within their own resources.

So it's their own abilities, skills, capacity, but also infrastructure that enable them to comply with the legislative

requirements, and this obviously includes Section 59 insofar as

healthcare providers, and it may touch on the question Chair, that you raised earlier on the contract. Because Section 59, insofar as this is concerned, the accreditation function is concerned, would apply to when a healthcare provider renders an account, by virtue of Section, regulation five and six. There are other instances where accounts are not rendered, where contracts may come into, may come into play.

But insofar as claims payments are concerned, or claimant of, payment of claims, there Chair we have, we have 23 standards for instance, to check the ability of an administrator, or a selfadministered scheme, to do that. It's not a detailed audit, but we look at the ability of those entities to be able to

pay that. Then there's a further standard to suggest that, just to give you an idea, that if claims are, have to be reconciled and have to be paid in accordance with scheme rules. In respect of beneficiaries entitled to receive those benefits, and for instance if there are discounts received from providers, or negotiated, then those discounts go back to the schemes and not to the administrator or utilised for any other purpose.

The there's a further requirement, it's also incorporated in terms of the standards, and that is to say the, they must have the ability to produce at least monthly reconciliations between the operating and financial management systems, including but not limited to contributions, claims, and savings accounts. Then another,

I think for context, is also a standard that says the administrator has

in place processes for the early detection and mitigation of irregularities and illegal acts by employees, members and providers. So obviously irregularities is not limited to, and we refer here to irregular claims as well, because I believe there may be claims which are paid erroneously, which may be irregular.

Not necessarily in a fraudulent manner, but irregular by virtue of, you know, what was previously discussed in Section 59, Section 59(3). So Chair the, again [intervenes]

CHAIRPERSON: Sorry Mr Kolver, the terms fraud, waste and abuse, how do we define them?

MR KOLVER: Chair, I'm not a lawyer, can I [intervenes] CHAIRPERSON: I just want a functional understanding. MR KOLVER: I believe the generic reference to, to

fraud is a deliberate act.

CHAIRPERSON: Ja.

MR KOLVER: It may be seen by me as a layman, as a layperson, to be a deliberate act to defraud a medical scheme, or, but I think what is also important is, and the standards are framed along that basis to say, well it's not necessarily providers. You know,

because irregular claims, or an irregular act, a fraudulent, wasteful or abusive payment of, may also relate to, for instance, a member. It may be member-inspired, which quite often, which quite often happens. Wasteful and abusive may be inconsistent, in my view, with the rules of the medical scheme in, for instance, the event that

there may not be a limitation on for instance the number of, of, of consultations, or of medicine dispensed, and so on and so forth.

It may be, and I think it's very relevant to also mention to yourselves that, you know, many of these claims are, must be gender sensitive. In other words, the system must be able to identify

claims with regard to gender, or to children versus adults versus, you know the elderly, elderly people. Dental, you can't, it must be capable of identifying a claim instituted by whoever for one tooth having been extracted on a, for three, on a third occasion. You know that kind of thing.

Chair I think in conclusion, I think the registrar made

reference to the role that the, that the board of trustees and the scheme should play in identifying and managing, appropriately managing, claims payment and mainly reports, and I think there's lots of scope for improvement as it relates to that. Because if we analyse the agreements between medical schemes and their administrators, there are, and we do focus on that as part of the accreditation function, to scrutinise the contracts for administration. And to ensure that there are service level agreements in place, that there are appropriate penalties in place for non-compliance. But I think also moreover, to focus on the kind of reports, and the frequency of reports as it relates to a variety of aspects covered during the process of administering the affairs of a medical scheme, to provide that necessary feedback to the board of trustees via the principle officer, and for appropriate detention and management to

be, to be given to that aspect. Thank you.

ADV WILLIAMS: Mr Kolver, the way I understand your evidence is that as part of the accreditation process, you do scrutinise the administration contracts between the schemes and their administrators. I mean, to accredit and administrator

[intervenes]

MR KOLVER: That's correct.

ADV WILLIAMS: You scrutinise those contracts.

MR KOLVER: Very much so, ja.

ADV WILLIAMS: And I also understand that it is the administrators that are often applying Section 59, on behalf of the

schemes, but nevertheless doing the active work in relation to it. So are you, do you see in these contracts provisions which determine how Section 59 will be applied?

MR KOLVER: Yes Ma'am, the service level agreements would *inter alia* provide for, if we go through the standards, it's to say well, are eligible claims being paid within a period of 30 days as provided for in the Act. Furthermore how they deal with unacceptable accounts in the event that accounts are rendered for payment, how they deal with that. But also a fundamental aspect thereof would be to notify members, because there is a regulation, I think it's in five or six, where it says that the members must be advised of how a particular claim, you know, claims payment advice, how a particular claim has been handled. Date of service, date of receipt, date of payment, or if there is rejected, or queried, then on what basis is it being queried, and then allowing for sufficient time.

I think the registrar made reference to that, of resubmitting such an erroneous claim for payment within the prescripts. But on average, yes provision is made in the service level agreements for the kind of reports that need to be submitted to the client schemes.

CHAIRPERSON: So tell me, one of your standards is that an administrator should have an early detection method for claims that will not be, that will either be fraudulent, abusive, and wasteful?

MR KOLVER: Yes.

CHAIRPERSON: Now do you review these accreditation agreements on a regular basis? Because the reason I'm asking you

this, maybe you can comment on this, is that we've listened yesterday to doctors complain that; we submit an invoice, it's paid, and then three years later we are told that there was something wrong with it. And yet, an administrator has come to the CMS, got through the system on the basis that they have an early detection system, but it turns out they don't. But they still got the accreditation.

MR KOLVER: Chair I believe identifying unacceptable claims may likely take place on a retrospective basis, because I believe an administrator or a medical scheme may pay a claim *bona fide*, when it received it, within a period of 30 days. And however, it may become clear when they do a retrospective review of claims payments, that erroneous, erroneously so [intervenes]

CHAIRPERSON: No, I understand that.

MR KOLVER: Ja.

CHAIRPERSON But I mean take the examples we were listening to yesterday, it's three years after the event and I'm now told to go and find my clinical notes, patients are gone, I don't even have any connection with them. But your own standards for accreditation is that it must be early detection.

MR KOLVER: Yes, yes.

CHAIRPERSON: So why are they getting through the early detection system, if their systems are only retrospective?

MR KOLVER: Ja, Chair I think it's for that reason why I

strongly, you know, suggest that, you know, that entire arrangement ought to be more carefully looked at and managed by a board of

trustees, by a principle officer. To avoid a situation, and I'm sorry I didn't, I didn't listen to all of the testimony that was submitted to you yesterday, but to avoid that kind of thing. To focus more on the early detection it's safe to say [intervenes]

CHAIRPERSON: No, I'm asking about, I'm asking about CMS, your accrediting people, on the basis that they are required to have a system that will ensure early detection, and they come back to you and they ask for accreditation, you still give it to them?

MR KOLVER: Chair yes that may be. Although from an accreditation perspective, I think it is important for us, for accreditation purposes, to say do they have the ability to actually do that, and then obviously one would, one would believe, or variably believe that it is dealt with by an administrator, like for instance the ability of, you know, claims payments within the prescribed period of time, and how they deal with it as a *modus operandi*. Or the manner in which they do it.

CHAIRPERSON: But why do you believe that when the evidence shows that they don't? You say that I variably believe that they do it, and then there are people saying actually that's not what happens.

MR KOLVER: Chair I believe that is, that is perhaps an area which between the accreditation process and the auditing, auditing process of, you know, the statutory audit of medical schemes and of administrators, ought to be scrutinised in order to, you know, to verify the detail, to investigate, to inspect the detail as

opposed to us checking for the ability and you know, to see that systems are functional, that the processes are in place without necessarily going into detailed, into detailed audits. We're not shying away Chair, from the, that responsibility. In fact it may be an area that we, from our perspective, we can maybe increase or enhance by taking samples to verify that particular aspect.

CHAIRPERSON: Thank you.

ADV HASSIM: It's related to the question my colleague has posed to you, can you, what is the responsibility of the CMS in relation to administrators? What regulatory oversight are you entitled to perform?

MR KOLVER: I just want to make sure if I understand the question correctly, the responsibility of the CMS towards administrators?

ADV HASSIM: In exercising its regulatory oversight over administrators.

MR KOLVER: Right, that fundamentally forms the, is derived from the accreditation standards, and the accreditation process. For instance, if an administrator upon application is, for accreditation, is found not to be compliant with any of these standards, then what we, what we ordinarily do is to invoke, or to propose to council that restorative suspension takes place upon, upon the applicant not being able to comply with a particular, with a particular standard. I think also what is, as part of our regulatory function, is that we conduct on site investigations, or inspections at

the facilities of administrators, mainly to test the ability, to look at the processes. Particularly since we're talking, Chair, about of different systems that need to, that need to interact. Because you would have a financial system. You would have a database, a member management system and to integrate the two to ensure that, you know, they comply and that's quite an intensive process carried out by staff in the accreditation unit during the on-site investigations, and that's to say do they, because the arrangement or the regulatory provision is seen that they must comply with the accreditation standards and with the relevant legislation throughout a period, the period of accreditation. And we have the ability for instance if there are complaints lodged as it relates to treatment of whatever, whichever aspect by a particular administrator to investigate same and to look *ad hoc* at areas of concern.

MS WILLIAMS: And I'm not sure if I missed it, but how often do you review the accreditation approval of the administrators?

MR KOLVER: Every two years.

MS WILLIAMS: Every two years.

CHAIRPERSON: Thank you. Oh, yes, Dr Kabane.

DR KABANE: Ja, Chairperson I just wanted to add to the answers here. Because I don't want the investigation panel to leave this discussion thinking that CMS is actually doing an excellent job in terms of, you know, regulating through accreditation. We do have severe resource constraints. In my initial presentation I mentioned that we've got 26 administrators and as it has been said

here, we accredit them for a 2-year period and then they re-apply. Now what happens in-between their accreditation? Is that because of resource constraints? We can't go to every entity that we have accredited, and check whether they are compliant, you know, with all the standards that we have been giving them. What, how we do this is more on a sample basis or where there has been complaints to the CMS and we have to go to the scheme either to do an inspection and to check whether you know, those systems are in place.

So it may well happen that once you've accredited an entity in between those accreditations, you know, these systems are no longer in place and it may also happen that you know, the schemes and these administrators do things that we are not aware of as a regulator and only pick it up when we are doing the re-accreditation.

So there is a gap there and part of it, it's, you know, the human resources and the systems that we would need to actually do, you know, almost on a continuous basis a follow-up on all of these accreditation entities between those two points at which we do accreditation. I just wanted to expose that gap that we hope moving forwards, we'll also be addressing.

CHAIRPERSON: Thank you. I think [indistinct - 1:03:49.7] he wants to [indistinct - 1:03:51.0].

MR KOLVER: Chair, can I just refer to the earlier question about going back three years?

CHAIRPERSON: Yes.

MR KOLVER: To investigate unacceptable behaviour

and to then deal with it retrospectively. I believe that investigations of this nature are not necessarily carried out by administrators in total, because I believe that schemes have the ability and they perhaps do appoint investigative teams, forensic auditors and so on to actually do that. That function *per sé* is not specifically accredited as part of an ordinary administration agreement. But I think also the, what administrators may likely testify before you, going forward, is that they have the ability to, for instance, collate claims on, you know, on a collective basis, because they may, they administer, you know, a number of schemes and medical schemes collect big data and as part of that accreditation or the process of verifying claims looking for unacceptable behaviour, in whatever way, shape or form, enable them to, from a collective or a collation of data of all medical schemes under administration, may point to certain, may point to certain unacceptable behaviour collectively, which, Chair, the question you posed, will by enlarge be retrospective in nature.

CHAIRPERSON: Alright. Thank you.

MS WILLIAMS: Sorry. Mr Kolver. [intervenes]

Mr Kolver, can I just take you back to this, the question I flagged earlier because I think it's quite important to understand the accreditation division's view on the interaction between Section 59(3) and Regulation 6. So we had a short exchange where, it seems to me, that you were saying those accreditation agreements are approved on the basis that they implement Regulation 6 to the extent that, for example, schemes might be required to determine if

a claim is erroneous or I think the other word is [intervenes]

MR KOLVER: Unacceptable.

MS WILLIAMS: Unacceptable within 30 days. And then you suggested that's, that certainly is in the KPI's, I think you said. Or something along those lines. Or you check the agreements that this is the case. But you haven't explained to me, and then you said, and you see that as implementing actually 59(3)(A) not being entitled to the benefit. But you haven't explained if the provision

which is about fraud, theft, misconduct, is also governed by those 30, that 30-day rule and the 60-day rule. Sorry, my question is now not entirely clear. But it's, what is the accreditation division's view on

the meaning whether Regulation 6 fully implements Section 59(3)? That's really what I'm getting at.

MR KOLVER: I think the short answer to that is that there is a statutory obligation to pay valid claims within a period of 30 days, and then if that doesn't take place, is how in a different way are those claims that are not capable of being paid, dealt with.

MS WILLIAMS: But should fraudulent claims be dealt with at, as claims which are irregular? That's what I'm trying to understand.

MR KOLVER: Fraudulent claims in our experience is, you know, once identified, then obviously it must be dealt with in accordance with practices in place. And by enlarge you may find; you may find different medical schemes having different policy

[intervenes]

MS WILLIAMS: So, if that's your interpretation, if that's the CMS's interpretation of section, then that does outlaw retrospective audits, as I understand it. Because it will place an obligation on the schemes to recognise irregular claims within 30 to 60 days. And I'm talking now about fraudulent claims.

MR KOLVER: Yes. No, I wouldn't be in a position to comment, you know, on that because I think, you know, with jurisprudence having being developed over time, I think my colleague dealing with explaining, you know, complaints and related to that may be better positioned to express views on that.

CHAIRPERSON: Your function is accreditation. I mean we're trying to tease out whether regulation by accreditation could not be one of the options available.

MR KOLVER: Correct, ja.

CHAIRPERSON: Alright. Thank you. You are finished with your presentation?

MR KOLVER: I'm finished with my presentation. CHAIRPERSON: Thank you. Who is next? Alright. Sorry, just remind us your name?

MS PHASWANE: Thembekile Phaswane.

CHAIRPERSON: Phaswane?

MS PHASWANE: Yes.

CHAIRPERSON: Alright. Yes, thanks Ms Phaswane. MS PHASWANE: Mine is to take you through the role of complaints adjudication. In so far it relates to complaints by

healthcare practitioners in the application of Section 59 by medical schemes. What we have, just at the onset Chair, is just to indicate to the panel that with regard to racial profiling, CMS does not have, does not keep statistics in terms of the complainants, whether their racial background or ethical background. We just process complaints as they come in. We don't classify them in terms of race. What we looked at, we looked at the allegations that are brought before the

Registrar's office and to indicate whether are those allegations matters that are provided for in the Medical Schemes Act.

Some of the allegations that are brought to CMS indicates that medical schemes have arbitrarily suspended the audit, I mean the payment of claims by healthcare practitioners that they ask to pay certain amounts of money to the medical schemes and they regard this as unlawful or unjustified. In the letters that they send to CMS, as

attachments to the complaint, they indicate that medical schemes

have written to medical practitioners to indicate that there are certain billing anomalies that were found or there're a number of suspicious claims that were submitted to the medical schemes for payment to which payment was already made to the healthcare practitioners. And it will go as far as indicating now that the medical scheme is conducting retrospective review of all the claims for a particular period and then they are required then to submit information to the medical scheme relating to those claims that are under scrutiny or that are being audited.

Questions that should be posed or evidence that would be

asked by medical schemes and administrator to the healthcare practitioners that he provided us: Consultation hours in respect of this number of patients or claims? The location of your practice. What are your operating hours? Purchase of consumables. Equipment. What's your qualification? If you've got locums indicate their names and how many do you have them in your practice. What's the time that you spent consulting each patient? What are the hours that you are working per day? What are the, where can we get clinical notes.

Some medical practitioners will co-operate and submit information as requested by medical schemes. Some will refuse. Some will submit incomplete information to the medical scheme.

And medical scheme will indicate that they won't be in a position to conclude the audit in the absence of all the information that they've requested from the medical practitioners and then once they are resisting or uncooperative, that's then that they'll be given further correspondence indicating that direct payment to relevance to those practitioners will be suspended, pending finalisation of the audit. So what we looked into as a unit, we looked as is there any contravention of the medical schemes act in the manner in which the medical schemes or administrators have conducted themselves in suspending payment and also withholding payment and not even paying claims moving forward. So before we even issue a ruling in those complaints, we refer those matters obvious to the medical scheme as prescribed by the

legislation for comments. Once we get comments, we'll go through the information. If there's further

information that is required, there'll be ongoing engagement between our offices and medical schemes and administrators relating to those particular matters.

Once we issue a ruling, we'll take into consideration a number of issues that were raised as well as information that is before CMS. So in all our rulings we always clarify the legality of medical schemes or administrators conduct in withholding payment and offsetting the value of the alleged irregular claims, against the ones which are owed to the medical scheme. And you'll find that in certain instances, the information that is sent to CMS and to the medical scheme, we find that it doesn't match the claims that were submitted that time. Just to give you example of the number of issues that we've seen before us.

We'll find certain medical practitioners, dentist in this instance, where they've inserted jewellery in the teeth of members, but claimed for a benefit that is covered in the rules of the medical scheme. We'll find that payment was made in respect of those but there's evidence and there's affidavits to show that services that were rendered are not those that are provided for in the Medical Schemes Act, but payment was made.

Going to [indistinct - 1:14:32.2] the issue of Regulation 6, whether it applies. Medical Scheme have got 30 days to pay the claim. Once they look at the claim as it stands, it looks as if the claim is valid, but those affidavits would show that services that were rendered were not those that should have been funded by medical scheme in those instances. In certain instances, non-members are treated but the claim will be submitted as if a member of a

medical scheme was, receive services from that medical practitioner. We know that if you're a non-member there's no way that the claim can bear the details of a member. Then it's a collusion between a member and a healthcare practitioner in those instances. [Intervenes]

CHAIRPERSON: According the CMS, why does a scheme need 30 days to pay a claim?

MS PHASWANE: Why does it need 30 days?

CHAIRPERSON: Yes, the Act says it must be paid within 30 days. But I mean, don't they need the 30 days to verify the validity of the claim?

MS PHASWANE: They have to do that and then pay within that particular period. If the scheme, if the claim hits the medical, the medical scheme maybe day five after the treat, after the date of receiving services, then they've got a 30 days from that particular date at which it was received, to pay the claims. And we know once they make the payments, there're a number of human errors that happen to find that they've paid the claim but due to these retrospectives then, validation of claims they found that erroneous claims because the shortened timeframe within which they should pay. So there are those instances where they've paid the claim but where that claim was not supposed to be paid.

CHAIRPERSON: Ja. I mean what's your experience on this? Do the schemes actually properly verify the validity of the claims in 30 days or do they just take it at face value?

MS PHASWANE: Not in all instances, Chair.

CHAIRPERSON: So what do you mean?

MS PHASWANE: Some claims, you'll find that they're proper. They are paid correctly but some they are not paid correctly. You see even other complaints not relating to Section 59. If there was a claim that was supposed to be paid, but there was an admin error at that time, but the claim will be paid. Later on they reverse [intervenes]

CHAIRPERSON: Ja, I understand. I'm asking a different question. I mean if the purpose of giving the scheme 30 days is to validate the claim and to make sure that it's the correct and accurate claim, what is your experience as CMS? Do you find that schemes in fact use that 30 days to validate the claim or do they just pay the claim with very superficial validation and then investigate afterwards? MS PHASWANE: It's both Chair. It's both. It's a combination of both. You'll find in the responses that we get in complaints, it's only then that it's an oops, oh, we've made an error. Now are going to reprocess. So [intervenes]

CHAIRPERSON: So they don't actually, properly scrutinise the claim in that 30 days?

MS PHASWANE: Not in all instances. Hence, the evidence that is before us.

CHAIRPERSON: Yes.

MS WILLIAMS: Ms Phaswane, is it permissible for a scheme to impose restriction on the payment of a supplier pending an investigation?

MS PHASWANE: I think it's permissible Chair. Because it's those risk mitigation measures that the medical schemes supposed to have.

MS WILLIAMS: But I need to understand that more. Why is that so and in that scenario there's no finding by the scheme that there was an erroneous payment, an unacceptable payment, a fraudulent claim or whatever the case might be. They're simple saying, we think there might be an issue, we want to investigate. In the meantime we're not going to pay your claims. That's permissible?

MS PHASWANE: It is permissible Chair, because even though there may not be a finding at a particular time, it's those instances where audit is not yet concluded. There's evidence but they need to make sure that they wrap up the entire investigation. Hence,

I've made an example that we've had, even before us we had affidavits showing that services were not rendered at the time but the medical scheme is withholding payment because it's calling upon all the information that will enable them to conclude that exercise and reach finality, then make payment. So it's reasonable to suspend,

pending finalisation. Once [intervenes]

MS WILLIAMS: And how long should that investigation last? Is there a limit to how long that investigation will be?

MS PHASWANE: That's the gap in the legislation. There's no timeframe whatsoever. But please note [intervenes]

MS WILLIAMS: So, if they take six months to wrap up the

investigation and that the conclusion of the investigation, they find

that there was no irregularity, what happens then?

MS PHASWANE: Then they need to release the funds that are due to, for payment to the service provider.

MS WILLIAMS: So the, sorry, so the six-month period in which they were not paying claims, they will now pay the claims?

MS PHASWANE: They have to pay those claims which are [intervenes]

MS WILLIAMS: And the burden of the interim period will then be on the supplier for having to, the burden then is on the supplier. Is that right?

MS PHASWANE: Yes.

CHAIRPERSON: I mean, this is the point, is it not? So for six months you are sitting there as a GP, you are not getting paid and then you are told that you might be paid after six months and the CMS thinks there's nothing wrong with that?

MS PHASWANE: Remember Chair, audit has to be concluded. And the legislation does not even provide a timeframe. So CMS cannot say that six months is unreasonable, but we've made a pronouncement in the number of rulings. Especially where audit took over a year. Where we say that it's unfair to prolong this audit. Audit must reach finality at certain stage. Because we cannot withhold payment or say that you're investigating indefinitely. So a period of one year, that's why we made a pronouncement, a ruling, say that this period it's unreasonable. But where

25 I'm sitting, six months, and it also depends on the cooperation of the healthcare provider. If they don't

provide that information, because in many instances I'm busy, I don't have time, I'll get back to you. Then it delays the actually conclusion of the investigation of the claims audit.

CHAIRPERSON: Ja. What is the authority that you relying upon that entitles the scheme to terminate payment pending the outcome of the investigation?

MS PHASWANE: There're a number of judgements by our courts as well as the appeals board. I'll name two cases which were held at appeals board. Which, those two cases are very important, because they've overturned the decision that were made by the council, the appeals committee. There's one case relating to Polmed versus Dr Paine. The second one relates to GEMS versus Council for Medical Schemes and [indistinct - 1:21:37.0] Pharmacy. In those judgements, the appeals board made it clear that in the absence of contractual relationship with the scheme, the supplier has no right to insist on direct payment by medical scheme. So, in our rulings, we don't depart from those judgements as well because they are president setting. They overturned the ruling of appeals committee saying that the scheme is correct under this instance, hence we rely on them then in arriving at our decisions.

MS WILLIAMS: Sorry, that's quite important. You're talking restriction in the sense of direct payment. So, you're saying that it's, that would be permissible, but would it be permissible to completely suspend claim, payment of claims?

MS PHASWANE: Remember when they suspend payment

of claims, they pay members instead of you as a certain provider.

There are rules [intervenes]

MS WILLIAMS: Is that a fact?

MS PHASWANE: Yes.

CHAIRPERSON: Well, I mean you know, yesterday we heard evidence here that what schemes do is that they will not necessarily put you on direct payment. They will simply block the service provider completely and they tell the patients that you are not to use that service provider because he is blocked. So when we say, what authority do you rely upon that a scheme is entitled to suspend a service provider, we're not asking you the same thing as what

authority exist for direct payments. So, is there anything that allows the schemes to suspend a doctor or a medical practitioner, including informing their patients that they are blocked?

MS PHASWANE: Well, the issue of blocking, I think it's a issue that was dealt with by our compliance unit. I think Mr Cele will be addressing that because they've dealt with one big medical scheme where it's blocked a healthcare practitioner. But in respect of the complaints that we've dealt with, those ones that I was relying, I was making reference to, it is when they are just suspending payment at the time but paying members. But doctors will insist on direct payment. Don't pay members, because it's difficult for me to recover the moneys. Pay me directly where they are compelling medical schemes to fund them.

MS WILLIAMS: Sorry, I just need to clarify this, because

that is the language that's used and, in the evidence, that's been provided to us. Letters that are sent to medical schemes, is that they are told that payment will be suspended. Suspended. And you are saying we are to interpret that payment will be suspended. Payment in respect of claims from you practice will be suspended meaning that that means members will be paid directly and not the practice.

MS PHASWANE: That's why I sighted those judgement, Ma'am, because I was referring to those in particular. I can continue now.

CHAIRPERSON: Yes.

MS PHASWANE: Lost my train of thought. But in certain instances you'll find that in the rulings that were made by the office, we make it clear that where a medical schemes cannot verify the claims, which are under audit, then there was no basis for medical schemes to release payment, due to the failure of healthcare provider to provide that information that will enable proper validation of claims. However in certain instances, you'll find out that even though we're making a pronouncement on funding decisions, but there are issues that are raising complaints that relates to the role that should be played by other statutory organisation or other societies of that complainant. Example: with clinical psychology or psychologies in general. Where medical scheme will dispute the length of notes that are indicated during consultation. Where they say that we won't fund you because you just submitted a one liner in this particular consultation. Your records are not detailed enough. You know? The information is not clear.

What we are saying as an office, we are not in a position to adjudicate on those issues. Medical schemes should go a step further and consult the society of psychologists for example, to make a pronouncement on that matter. Then CMS will come at the tail end of that to make a determination whether funding should have been made or not. Because you can't say now, because the notes that

were written on the date of consultation are just one liners, therefore the amount that they've claimed doesn't correspond with that. We can't make such pronouncement. That's why I said that refer it to other organisations then. In certain instances when it's come to the issuing of codes, billing, we say that HPCSA must play a role.

The matter must also be referred to HPCSA. HPCSA must look into this coding disputes, make a pronouncement, then it will come to CMS at the tail end of that dispute. Because there's no way

that you can say medical scheme release payment or the doctor, you are entitled to payment in the absence of information because now we'll be encroaching on the role that should be played by other regulators or societies of this healthcare practitioners.

MS WILLIAMS: Sorry Ms Phaswane, how do you deal with the complaints by suppliers who say that they are requested to provide confidential information in violation of their ethical codes? How do you deal with that where members have already signed an agreement with the schemes that they may access confidential health records?

MS PHASWANE: We've gone through the terms of the

application form, Ma'am, in detail, to see what exactly has members concerted into? You'll find that they are informing medical or they giving the medical scheme the right to request confidential and private information. You can give it to, in this instance, to a medical scheme, to an administrator. However the use of that information must be relevant to the issue in dispute. In this instance, it's payment of claims. But you'll find that the issue now relates to healthcare professions councils where it says that you need to get the members consent. Meaning that there must be another consent where the member may be, submits in writing to indicate that I allow you as a medical scheme to share this information or to disclose.

So there are just those. Because I know that there was also a view which was shared by the Registrar earlier, saying that medical practitioners are not supposed to disclose information without the written consent of patients. So, those are the two areas. The contract that the member has entered to, gives the scheme and administrators the permission to request information and to use it for the purposes of administering the claims. But another organisation, meaning that they need to have another written consent. So those are the two areas which we're like dealing with as an office.

MS WILLIAMS: Sure. No, and I appreciate that there are lines between you as the regulator and the HPCSA and their ambit of regulation, but you have oversight of the rules, over the rules that members and, that members signed. Right? With the scheme and

they sign as part of their membership of the scheme that they consent to the provision of that information. Do you have members who later then complain when they are asked to provide that information? Have you had those complaints from members of medical schemes?

MS PHASWANE: No. We don't have that. We don't have them where they say that they've never concerted, not before us.

MS WILLIAMS: No, I'm not saying the complaint that they've not consented. But I'm saying, have members complained about having to sign that type of consent as part of the application [intervenes]

MS PHASWANE: No, Ma'am.

MS WILLIAMS: To be a member the scheme?

MS PHASWANE: No.

MS WILLIAMS: There'd me none of those complaints?

MS PHASWANE: Yes. None. In conclusion [intervenes]

MS HASSIM: Now, sorry, may I also interrupt you there. Just to go back to your comments in relation to dealing with complaints about claw backs when there's a coding issue. So where a provider might complain that money was, he or she was required to pay back money where he or she might have used the incorrect code. Please explain how you deal with those sorts of complaints?

MS PHASWANE: What we've done in respect of those, we arrange with Health Professions Council that we'll be referring those to them so that they go through them because they've got a mandate in respect of

the codes to come back to us. But unfortunately there were delays in respect of that area, even escalated it to the Registrar saying, that he, can you please take it further with HPCSA, because we need to resolve a number of complaints which pertains to the coding disputes. What happens in those areas we find that we don't

get a response, hence the escalation that we've done as a unit. Because we find that they were creating a lot of backlog for the unit because you couldn't resolve them.

Saying that we need a view from HPCSA, and doctors will tell us that, but we're never trained on coding. Hence, I use this code.

They've been paying this code. It only came to my attention at this time that now, I'm not supposed to code in this way but on the other way. Hence, we say that HPCSA is the right forum to make a pronouncement on those matters.

MS HASSIM: So we heard evidence yesterday from the Competition Commission that there are numerous codes that are being used. So, I am surprised that it goes to the HPCSA, because I wasn't aware that they were responsible for a code that was in use.

MS PHASWANE: Yes, there are different codes, Ma'am, that are used, and they come from different, different institutions. South African Medical Association also publishes a coding, billing manual where medical practitioners referred to as to how they code. So there are just many codes in the industry by different societies and other societies will come out

with their codes as well. So the coding issue is just all over the show. We don't have a coding authority at this stage because there's currently a gap in the system. Hence, the CMS under

the Registrars, where they made a proposal that we need to have coding authority as a country due to these anomalies relating to codes.

Every society comes up with codes and expect medical schemes to fund. Medical schemes say no, we don't recognise that particular billing manual, but we rely on that manual. So that's why

[intervenes]

MS HASSIM: Sorry to interrupt. Is it fair to say that it's impossible for you to resolve a coding dispute then?

MS PHASWANE: In certain instances we do. Because we rely on the NHRPL which was the coding, I'll call it a guideline, that was issued to the industry until it was repelled, and it was outlawed when the matter went to Court.

CHAIRPERSON: Thank you. Do you still have more to say? Or can you wrap up?

MS PHASWANE: Ja. Just to wrap up. There're some concerns that we've noted as a complaints unit, relating to the Section 59(3) complaints. We noted that some decisions to complaint, to commence rather, deducting amounts which are allegedly owed to 20 medical schemes are not preceded by transparent and credible

investigation. We'll find that that there's a letter that is send, but you could see that there was just no evidence coming from that or, two, in certain instances there's no detailed report found that on factual evidence of the irregularities and the quantification of those amounts are always not clear. Medical scheme will just give you that it's estimated that service provider X owes us this amount. When we ask them for quantification, that's where the problem lies.

It appears that in certain instances it's a thumb suck. Lastly, we were also concerned where investigations were prolonged and appeared to run indefinitely and then we're advising those rulings that such investigations should be expedited and brought to finality sooner due to the time that has lapsed from the time in which they started with the investigation until the member, the doctor complained to CMS. That concludes my presentation.

CHAIRPERSON: Thank you. What's going to happen now this side? Mr Letsoalo and Mr Cele, how are you going to deal with your presentations?

MR LETSOALO: Thank you Chair. Chair, I'll just take you through the, some of the litigation and appeals that we've had as the office of the Council for Medical Schemes.

CHAIRPERSON: And you are in legal?

MR LETSOALO: Legal yes, that is correct Chair. We've

also made available some of these copies of all this judgement and rulings for ease of reference. I'll not go much into detail but just to highlight one of the standout cases which, to a certain extent, deals with the problems surrounding Section 59. And that was an SCA judgement, Sechaba Medical Solutions versus Sikete. And this particular judgment, Chair, it provides circumstances to which how the relationship of a scheme and a service provider should be. We've chose this matter for one reason. Some of the matters that were decided in the appeals committee and the appeal board, they are subject to the SCA. So, when we look at the authority in relation to how the relationship of the scheme and the service provider ought to be dealt with, we are mostly guided by the SCA judgement.

Chair, in short, and I'll take you through the comparison of what the position is. The [intervenes]

CHAIRPERSON: [indistinct - 1:36:53.7] you something. I mean yesterday we heard evidence that the CMS is not enforcing its own rulings and the schemes are treating CMS contemptuously. What is your comment on that?

MR LETSOALO: Chair, I think that particular question will depend on the ruling which sits within body. It may be a ruling which sits within the Registrar's office, which may be appealed by a scheme to the appeals committee, which will in effect suspend that particular provision. It will also depend whether that ruling is it a ruling of the appeals committee, being appealed to the appeal board. So Chair, the, that

particular evident has to be factualised to the extent that where would that ruling be coming from? Would it be coming from the

Registrar's office? Because if it is appealed then it is suspended,

unfortunately there's an express provision under the Act which says the Registrar, or their office cannot do anything.

So just to contextualise that particular predicament, it will depend upon where the ruling is sitting within the internal remedies or the internal forums within the Council for Medical Schemes.

CHAIRPERSON: So the perception yesterday, I mean I just want to give you a chance to deal with it, that some medical practitioners perceived the CMS as toothless because it's giving rulings that are not being enforced. You say that is, that that is sometimes the consequence of a legislative enactment because even

if you've given a ruling, it cannot be enforced until the appeal is finished.

MR LETSOALO: That is correct Chair. I think just to give context. If you look at the ruling that is made by the Registrar and you look at the particular provision that relates to an appeal of the

Registrar's ruling, the act is clear to say that particular decision, it's suspended pending the finalisation. So, it is regrettable that there would be that particular misconception that we may be toothless, but it is because of the express legislative terms of the particular act.

CHAIRPERSON: But I mean the other complains that you

are not enforcing your own rulings.

MR LETSOALO: I, Chair, I think that again becomes a problem because if there is a blatant statement to say we're not enforcing our rulings, I'll have to stand by my earlier submission that I made to you Chair, to say it depends where the ruling sits. If it sits within the Registrar's office and it's appealed to the appeals committee, unfortunately it is a legislative issue because there is an express suspension of the decision. However, when the matter sits within the appeals committee, to the appeal board, we've had challenges, but our view has always been, where there's a latitude to enforce, our compliance and investigation unit will issue those direct,

or those penalties. However, where there's an express like in this particular case on the Registrar's ruling, unfortunately we'll particularly submit that there may be that conception that we are unable to act but it is because of the challenges that we face in terms of the legislative terms that we have currently.

CHAIRPERSON: Yes. But what do you do with this? So, you make a ruling that a member must be, sorry, a scheme must honour a particular account or a relationship with a service provider.

They don't want to and there's no appeal. What is the actual mechanism that you have to force the scheme to comply?

MR LETSOALO: No, thank you Chair. I think that is quite an important question. That question sits with our enforcement and compliance team. I think my colleague, after my presentation to you, he'll probably touch on it as to what are the steps. But one of the thing is they'll normally issue; they can start even imposing penalties under Section 66 of the Act because of non-compliance. But now the challenge becomes when the scheme files an appeal, then it means, you know, the particular ruling is suspended. So, that is some of the challenges that we see from a regulatory perspective.

CHAIRPERSON: How many penalties have you imposed for breaches of Section 59?

MR LETSOALO: Chair, I think my colleague [intervenes]

CHAIRPERSON: Oh, it's not with you, okay, it's with Mr Cele. Alright.

MR LETSOALO: It's with Mr Cele actually.

CHAIRPERSON: Anyway. Carry on. You were telling us about the SCA judgement.

MR LETSOALO: Yes, Chair. The, we chose this particular judgement because I mean it's the SCA judgement. We don't have the latitude of other matters that sits within the CC or other jurisdiction. But what this particular judgement has said that the liability of schemes does not exist in substitution for the liability of a member but as an [indistinct - 1:42:20.8] to it. This was in reference with Section 26(1) of the Medical Schemes Act which says: Upon the contractual relationship of the scheme and the member, the scheme then assumes liability in favour of the member. So, the SCA saw the liability of the scheme towards to the service provider, not existing without the contractual relationship with the particular member. So absent the member, then the liability of the scheme towards the service provider will fall away.

So that's how the SCA saw this relationship. And they went further to say Section 51 of our Act recognises that a healthcare service provider will ordinarily render its account directly to schemes, which is the normal practise. And the Court said this is for this reason why it obliges service providers in addition to furnish account and statement directly to members. And the Court went on to say they also recognise that schemes may pay service provider directly. And this is important because when you look at Section 59(2) it says, the member or. So it envisages a situation where the scheme can pay either the member or the scheme. So, at present, Chair, the point of

departure in terms of looking as to 59, these are the words which was used by Judge Wallis, was to say this can only be because the claim of service of the service provider must arise in circumstances where the service provider was entitled to advance that claim against the medical scheme and the scheme was obliged to pay for it.

So, the current position within CMS in terms of interpreting 59 is to ask ourselves, did this particular claim arise where the service provider was entitled to advance that claim against the scheme and the scheme was obliged to pay. This is fundamental Chair, because it says to us as the office, if the claim ought not to be paid by the scheme, there can be no claim that the service provider could force the medical scheme to pay. So, by understanding how this particular provision says to us, is to say, if the claim that is been brought by the service provider, it arises in a circumstances where the service provider was legitimate to advance that particular claim and that claim was correct to the medical scheme. Then the medical scheme is obliged to pay.

However, the fundamental question Chair, which comes to mind is, the court did not pronounce on the issue relating to 59 to 20 distinguish between whether or not, a member or the service provider. There have been conflicting interpretation on this particular judgement. Some other people when they read the judgement, they felt it went on to attach the proposition that a scheme has an obligation to pay directly. But we as the office, we say this to say if the

service provider lodges a legitimate claim, which in any event that particular liability ought to have been attracted in an event of a member, then the scheme is obliged to pay.

But the Court did not go as far as to say to us, or to give us an insight that indeed, the word “or” under 59 meant that they can either pay the service provider or the member. The only thing that we know is when that particular claim is legitimate and the service provider was entitled to advance it, the scheme is obliged to pay. But [intervenes]

CHAIRPERSON: What is your own interpretation as the regulator?

MR LETSOALO: As the regulator Chair, our interpretation is the terminology used under 59, to say “or”, it suggest to mean the [intervenes]

MS WILLIAMS: You mean 59, subsection 2?

MR LETSOALO: 59 Subsection 2, thank you. So or in our interpretation meant the scheme can pay either the member or the service provider but there is no definitive obligation in terms of 59(2), to say the scheme is obliged to pay a service provider. It only envisages a dispensation that it can either be this or this. Unfortunately. And even if you go under the regulations under 5 and 6, there’s not even that [indistinct - 1:47:36.4] term which requires a scheme to pay direct.

MS WILLIAMS: But the scheme would be liable to pay the

service provider where the service provider has supplied a service to a member of that scheme. Is that not so?

MR LETSOALO: That will be correct. Because the, in terms

of this particular judge, it means that particular claim was legitimate, arose even in circumstances where the service provider was entitled to advance that particular claim, and the scheme was obliged, meaning the claim is valid. In that particular case, then the scheme will be obliged to pay. The question now backs and unfortunately, you know, even if you look at this particular judgement, one never gets to understand whether does it mean direct. We can only go as far as say the scheme will then be obliged to pay in terms of the SCA judgement. Whether or not direct or not, it may be an issue for interpretation and argument or I'll be it, if we had the sentiment of the Constitutional Court, whom would have probable come out clearly to tell us whether direct or not in terms of the, or as used under 59(2).

MS HASSIM: Mr Letsoalo, I'm not sure how this impacts our interpretation of 59(3). I mean I understand there's some, there're differing interpretations of this Sechaba judgement and, but I'm not sure how it affects 59(3) or what the submission is that you're making in relation to 59(3).

CHAIRPERSON: What I'm not also not sure about is exactly how have you interpreted the judgement for 59(2) purposes? I mean, we, I understand that any judgement is open to several interpretations, but you are the regulator, you must bring certainty to the industry. What do you think it means?

MR LETSOALO: No, thank you Chair. I think for us as the regulator 59(2) means exactly what I've already submitted. It means when a service provider advances a claim to the scheme, in

circumstances where the service provider had the legitimate right to do so, and that particular claim was valid, it means the scheme had the obligation to pay it. I'll be it, direct or not. At that particular point the scheme [intervenes]

MS WILLIAMS: What do you mean or be it direct or not? Maybe that's where the confusion is. Obligation, if the service provider submits a claim to the scheme for services provided to a member of that scheme, why should the scheme not pay the service provider?

MR LETSOALO: I'm using [intervenes]

MS WILLIAMS: Is that direct payment? Is that what you understand to be direct? What would indirect payment be to this service provider?

MR LETSOALO: Indirect will mean the scheme will elect to pay the member. So what I'm saying is, when the service provider advances the account to the scheme, under 59(2) it's clear, and the wording was used, for the purposes that the scheme has an election to pay the member or the service provider. If the dispensation did not envisage an election, it will have been a member. But it went on to say, or a service provider. So the intention foresaw that the member could get the services and they could pay for themselves, meaning the scheme has to reimburse. Or the member could to attend to the service provider and the scheme would pay direct to the service provider. Hence, I'm using the word, direct. Our interpretation, as I've alluded earlier, is that when the service provider advances a claim, in

circumstances where that particular claim was valid and there was an obligation to pay, the medical scheme has an obligation to pay.

The problem and the difficulty that we sit with is, we don't have the benefit of another judgment which has come and informed us as to the wording under 52 it says or. Does it mean you can do it direct or you choose? But by the wording and by wording of the word

"or", for us it will mean it's some form of an election.

MS WILLIAMS: Okay. So, it's not clear how that relates to what the scheme may or may not do under 59 subsection 3. Right? There're two distinct scenarios there. The 59(2) which says it may pay the supplier or the member. Why would that, let's just clarify that. We know that Section 26 of the Medical Scheme Act, obliges the scheme to assume liability for benefits that have been granted to the member, for want of better word. So if a supplier provides the service, the

scheme is obliged to pay the supplier upon presentation of an

account. Isn't that so? It may be that a provider says to its own patients that we don't want to submit claims to the schemes. We want you to pay upfront. You may then claim from your scheme. So 59(2), the "or", permits the member then to submit the account to the scheme for payment.

Isn't that the extent of 59(2)? Why is there such a controversy over direct or indirect payment? That's my first question. And the second question is what does it matter anyway in so far as Section 59 subsection 3 goes, for our purposes?

MR LETSOALO: I think [intervenes]

CHAIRPERSON: You don't have to answer all of these questions yourself. There are many people at the CMS. I think we're just teasing out various ways of looking at the problem. So, don't make it your problem. If you are finished with what you have to say, just let us know and move on to other topics. So, but the choice is yours.

MR LETSOALO: No, thank you Chair.

MS WILLIAMS: As long as someone in your team answers.

MR LETSOALO: No, like I've already said, Chair, I've made all these judgements available for you. Just for your consumption. So that will be the end of my presentation. Thank you.

CHAIRPERSON: Thank you Mr Letsoalo. Mr Cele. MR CELE: Good morning Sir, thank you. There have been several questions that have been asked. I think probably it might be best to address them at the end, once I've set out what we've seen and what we understand to be the true scenario out there. Firstly, we, in our processes we have had to investigate the allegations of noncompliance or contravention of Section 59. And in our approach, we have looked at this from the definition of the business of medical scheme. If you look at Section 1, it speaks to the undertaking of a medical scheme. Liability associated with rendering a relevant health service. And I'm skipping other words, by any supplier or group of suppliers of a relevant health service or by any person in association with or in terms of an agreement with a medical scheme. It will

become relevant later to see the obligations and the relationship between a supplier and a medical scheme. Because there is a question whether is there a relationship, and the submission is that there is a relationship that is established in terms of the act and in

terms of the rules.

If you go to Section 26(1)(B) it speaks to liability for and guarantee the, and the, and guarantee the benefits. Basically the full reading of the section says: Any medical schemes registered under the Medical Scheme's Act, shall assume liability and guarantee the

benefits offered to its members. And the word that has to be probably noted in that [indistinct - 1:57:09.2] the entire act, is [indistinct - 1:57:11.8]. You see it Section 1 in the business of a medical scheme. You see it here in Section 26(1)(B). I will take you to 26(4)(A). It speaks on limitation on use of medical scheme funds. It says: No

amount shall be debited to the account contemplated in section,

subsection 1(C) other than payment by a medical scheme of any benefit payable under the rules of a medical scheme. Again, it speaks to the business of the medical scheme. It says, what may or may not be used for by funds collected from members.

If you then go to Section 59(1), the understanding is that 59(1) speaks to an obligation to render a statement. That is the extent of the importance of Section 59(1). Ordinarily in terms of the law you're only obliged to issue a statement to one party and here the section is obliging provision of a statement to more than one party by a supplier.

59(2), the obligation to pay a benefit. Firstly, it requires an assessment of a claim and payment within 30 days. It also allows for calling for correction of the submission within 60 days. Failure to question within 30 days shifts the onus of proof to a medical scheme in the event of a dispute, and again the [intervenes]

MS WILLIAMS: [indistinct - 1:59:18.1] regulation 6?

MR CELE: Yes. If you read the wording of Section 59(2), it again speaks to a payment of a benefit. It does not speak to a payment of a claim, and I think that is an important distinction.

Because the payment obligation is of a benefit not of a statement or a claim as such. Reading that together with 6, Regulation 6, Regulation 6(1) is a prohibition on the scheme, to limit any payment as a result of a late submission. Beyond that the regulation is of no use unless it's a late claim. Basically you can't limit payment, exclude payment unless it's later than 4 months. It doesn't speak to whether it is erroneous, or it is fraudulent or as such.

ADV HASSIM: Sorry Mr Cele, I don't, I really don't want to interrupt your flow, I just quickly, you are confirming then that the understanding of the Council is that Regulation 6 gives effect to Section 59(3), (2) and (3), is that right? It's an implementation of Section [intervenes]

MR CELE: Correct, yes. ADV HASSIM: 59(2) [intervenes]

MR CELE: Yes.

ADV HASSIM: And 3?

MR CELE: Yes. The provisions of Regulation 59(3)

are basically provisions for set-off and that is where we, we, we then find problems because that's where you start seeing investigations and recoveries that have given rise to this investigation. In terms of Section 59(3) the medical schemes may deduct money from benefits so if a medical scheme is enforcing or is acting under the provisions of Section 59 it can only recover from benefits that are payable, which is distinct from recoveries in certain instances where you go to the provider and say put it back, that is distinct.

The provisions of Section 66, and I am jumping in between sections, so if I'm losing you please advise so that I don't become a scatterbrain too much, they seek to address false claims, false misrepresentation and omissions in regard to payment of benefits.

Basically, in terms of Section 66 that is rendered a criminal offence. The provisions of Section 66 are applicable to any person so it, it, it basically covers members and providers as such. Now, before getting into the issues of, of, of what we have seen on Section 59, I want to go-, take you to the concerns that have been raised by healthcare professionals with CMS and have been investigated by CMS.

One, there has been, there have been allegations that medical schemes earned through their administrators, they use entrapment to investigate possible fraud. That there is an extrapolation of the extent and value of alleged fraud waste and abuse / corruption that is used to determine recoverable amounts. In other words, there is intern exercise where a

scheme establishes how much exactly do you owe, they will come up with a

"guesstimation", for lack of a better word. Thirdly, there is an allegation of cohesion of service providers to sign acknowledge of debt agreements.

And lastly, there is blacklisting or blocking of service providers from providing any health service to members of medical schemes. We have conducted broad investigations that have covered more than 50% of the industry by size of medical schemes and, and, and administrators that we have looked at. The broad findings that we, we, we have noted is that the practices alleged exist and they are being practised. They are in contravention and are inconsistent with the provisions of Section 59 and the Regulations. What has been noted is that it raises issues of selfhelp, due process or lack thereof, rule of law, adjudication or resolution of legal disputes as envisaged under Section 34 of the Constitution.

Medical schemes in justification for their methods, used to fight this alleged fraud, waste and abuse which, I may add quickly that we agree it exist, it's, it's, it's a real, it's a real scorch in the industry. Besides high volumes of claims and the litigation delays that would attach to implementation of recovery processes envisaged under Section 59 if these provisions require use of summons to recover among other means.

ADV WILLIAMS: Mr Cele, can I ask you, I understand your evidence to be that you've conducted inspections in relation to over

50% of the market and you found abuse, well let's not use the term "abuse", you found breaches of Section 59 and Regulation 6, Section 59(3) in particular. Presumably as a result of those inspections you've requested remedial action. Could you share with us what remedial action you've requested?

MR CELE: Can I just address it towards the end?

ADV WILLIAMS: Thank you.

MR CELE: As I was saying the, the reality is that on the other hand, on the other hand the findings have confirmed that service providers do submit fraudulent claims against medical schemes and some of these providers are repeat offenders and to the same medical schemes, which is an area of concern which I will try and address later. Now, there, there is also other issues that, that, that in the investigations we came across. There are certain rules that have been registered that enable medical schemes to block or, or attempt to recover funds in, in, in a manner that is inconsistent with Section 59.

The Registrar has-, and the Council have only two options. One is to persuade the medical scheme to amend the rules and it is not always easy to, to, to obtain such relief and in, in some way I will try and address this because as part of the remedial attempts in-, during the investigations we have attempted to get a medical scheme to amend these rules and they have held fast to the view that the role should persist. Alternatively, the Council can approach

court in terms of Section 51(1)(5)(c) to amend the rules of a medical scheme through court because the unfortunate situation is that once the role is, is registered the Registrar is unable to reverse such a role absent a court process.

There was a question asked about the, the rules and whether they are binding. If you look at Section 32 of the Medical Schemes Act it reads that the rules of a medical scheme shall be binding on any person and the on any person is applicable in this instance because it is in addition to members of a medical scheme to officers of a medical scheme. So it's broader and wider than just members

strictly who [intervenes]

ADV WILLIAMS: May I just interject for a second there just so I understand, why, why the remedial measure to amend rules either via persuasion or court application where there is a breach of the section where conduct is in breach of the Act, is it not

appropriate to enforce compliance in another way? Why the rules which are, seem peripheral actually? This must be evidence of potentially, in some instances evidence of the breach.

MR CELE: If, if you can just take me through that again, I think I am missing your question?

ADV WILLIAMS: My apologies. No, I am trying to understand, so I understand you are answering the question what remedial steps you've taken in relation to enforcing your findings and inspections and I understand you found that there was a breach of Section 59. The obvious ex-, example, and I don't know the facts of

your case but the obvious example being-, having to sign an

acknowledgement of debt doesn't comply with Section 59(3) because that only allows deduction. So there's a clear breach of the Act that you found, as I understand it. So, is there not a mechanism to require the schemes to comply with the Act which doesn't involve a change to their rules?

CHAIRPERSON: Why don't we instruct the scheme to breaching the Act?

ADV WILLIAMS: Why not charge them with an offence under Section 66?

MR CELE: It becomes a debate basically because [intervenes]

CHAIRPERSON: Why is it a debate? What, what is the problem that you are facing that makes it impossible to tell the scheme that it must stop breaching the Act.

MR CELE: Taking you to Section 66, the directives that the Registrar may issue are only [inaudible-2:12:00] in terms of our Act to obtain information and basically if there is no provision of information to impose penalties in terms of Section 66(3). So absent that, the Medical Schemes Act does not provide at all for imposition of penalties for non-compliance with the Medical Schemes Act. In other words, the only available options is you, you refer the matter to the NPA in terms of Section 16 read together with Section 66 alternatively, you follow the provisions of Section 26, you suspend or you cancel registration of a medical scheme which takes it to the extremities of the provisions of the Act.

There isn't a workable and enabling provision that allows a scheme to continue operating and allows the Registrar to, to, to compel compliance in this instance where there is resistance.

CHAIRPERSON: Sorry, that is the point we are trying to understand. Why don't you write a letter to Scheme X and say that your acknowledgments of debts are illegal, stop them?

MR CELE: In, in, in respect to the alle-, to the investigations that I've just referred to, there is a rule registered. We said this rule is inconsistent with the Medical Schemes Act and, and the regulations thereto. The response is the Registrar has registered the rule and that rule is in effect and that's it, we will live by that rule so the next step is then to proceed by way of Section 51 to set rule aside before we can do anything really.

CHAIRPERSON: No, no, forget about the rule, the rule as Ms Williams points out might be a manifestation of a breach. What is an issue is that the conduct of the scheme is breaching the Act? You are responsible to enforce the Act. Why don't you tell the scheme to stop breaching the Act by stopping their AOD's?

MR CELE: The, the, the, the nap of it is every time we tell them they should stop what they are doing and there is a rule in place, their responses who are empowered in terms of our rules to, to, to conduct and manage the affairs of the medical schemes as they are. Maybe there is a limitation on our side in how we have sought to direct medical schemes to, to, to stop using AOD's as such. However, as I was saying earlier, why does it become a

debate? Medical Schemes have argued that where there is consensus between a supplier and a medical scheme that there is a liability.

Acknowledgement of debts *per se* are not unlawful or in contravention of any Medical Schemes Act provisions as such. The issue arises where there is a dispute or there's an allegation of cohesion made against the medical scheme and, and, and that issue only arises when someone comes up to us and says I was "cohesed" actually, there wasn't mutual agreement. So in that regard, one of the recommendations that have come up as a result of the investigation is if medical schemes must establish a liability.

Someone else independent of medical schemes should be able to determine that there is a liability owed and basically serve as an arbiter between the two parties and be an objective determinant of whether there is a ground of an acknowledgment of debt or not.

Absent that, we are unable to say out and out acknowledgements of debts are unlawful *per se* and more so when they are saying we are not necessarily relying on Section 59 as such but if we believe that you owe us and we seek to recover such, we should be entitled to so do.

CHAIRPERSON: For me to understand this and maybe it is a systemic problem, your feeling is that the Act doesn't give you enough administrative role to regulate the schemes. I mean, we put in an example of an AOD that is regularly used but your feeling is that it may be illegal. As a hypothetical scenario, you say you've got no power under the Act to instruct the schemes to comply with the Act.

MR CELE: Maybe the response should be more nuanced. The AOD *per se* is not our view that it's, it's illegal as such.

CHAIRPERSON: Yes.

MR CELE: However, how it is utilised and how it manifests has proved to be illegal in certain instances or unlawful in certain instances. To the extent that it is used under cohesive circumstances but other than that on its own, we do not hold the view that an acknowledgement of debt is an impermissible instrument.

CHAIRPERSON: In those instances of an abuse of an otherwise lawful instruments, why are you not stopping them? I am trying to understand what exactly is the limitation that you are perceiving.

MR CELE: The limitation is that inasmuch as you may instruct a medical scheme not to, to enter into AOD's under cohesive environment, we are unable to observe and, and regulate that because they entered without our absence, without our observation and without our supervision. If there is an environment that can be created that can enable that kind of supervision, then yes, an instruction to say stop entering into cohesive AOD's can be ultimately enforced but as is it comes to us as an after effect when there is a dispute. I am hoping I'm coming through on this.

CHAIRPERSON: No, no that's fine. I'm, I am not making a judgment. And then in relation to the rules that are inconsistent with Section 59 where you have established for yourselves that they are inconsistent, why are you not stopping that?

MR CELE: Why have we not approached court to set those rules aside, is that the question?

CHAIRPERSON: There are many options available from a remedial point of view but all I'm asking is why do those rules still exist even though you've taken the view that they are illegal?

MR CELE: Some of those rules we have sought to have them deregistered or, or, or scrapped. The medical schemes involved have taken us on appeal on those and we have failed basically to, to, to set them aside. The next option, and this is on counsel's-, senior counsel's opinion obtained recently, I think it was in April this year, is that we should proceed by way of Section 51(1) of the Medical Schemes Act and that is the next step to set aside the rules that have been already registered. The alternative is, in terms of Section 31 we can and are rejecting such rules when they are being registered for the first time.

ADV HASSIM: This last part of what you said seems that it won't have much of an impact on any of this because I don't imagine there many medical schemes that are being registered now, are there, are there many new applicants for registration?

MR CELE: No. However, annually medical schemes tend to submit rules and they can amend rules at any point in time.

ADV HASSIM: But you are saying that that's not really effective because if it's an existing medical scheme you can't say [inaudible-2:21:21], you can't-, you feel that you cannot impose a threat of deregistration because it would be going too far. Is that right?

MR CELE: Yes, the, the, the challenge that we have is the multiplicity of medical schemes with such rules already registered may make it not easy to, to, to deal with it.

ADV HASSIM: Okay, okay. I, I don't want to labour that. I think you've answered my colleagues on the rules and whether or not we, we are not expressing a view at this point about whether that's the correct interpretation of how to deal with rules that are in contravention of the Act. But let's take another example. You have submitted to us that Regulation 6 is, gives effect, is intended to give

effect and to implement Section 59(3) that-, am I right? So,

Regulation 6 places onus on the medical scheme once a certain

time period is up to prove that that liability it one, that it exists, that it is a clear liability, sorry not a liability, it's a clear erroneous whatever the issue is, whether it is an erroneous payment or unacceptable payment that the basis for which they have established that, the grounds for which it is unacceptable.

They would have to also properly quantify what the extent of the unacceptable payments are, right? The onus would be on the scheme, is that so? Now, we have heard complaints that there is no onus that is discharged. That onus is not discharged by the medical

scheme that action is taken against a supplier without having met that onus of proof. So that would be a contravention of the Act and the Regulations, isn't that so? Yes?

MR CELE: Yes, that is correct.

ADV HASSIM: That is now-, I am not talking about rules, I am just talking about that conduct. What do you do then in the face of that contravention by medical schemes?

MR CELE: This is where we get presented with a dispute between a provider and a medical scheme alleging that I am being compelled to, to, to pay an amount that is not proved and that is a contravention with or without rules. As a matter of law an obligation to or an, an obligation or a liability to someone must be established.

ADV HASSIM: But my question is how do you then enforce the Act and the Regulations where the medical schemes have not assumed that burden of proof?

MR CELE: Usually it manifest itselves-, itself as a-, an acknowledgement of debt between a medical scheme and a provider which creates a different scenario because, is CMS in a position to adjudicate then an acknowledgement of debt and the question of whether it's legal or not.

ADV HASSIM: Sure. I've heard on the acknowle-, so let's say there's no acknowledgment of debt because there are cases where the supplier has refused to sign an acknowledgement of debt. So what, what do you do then?

MR CELE: Eh [intervenes]

ADV WILLIAMS: Sorry and, and this is related to the, the-, because what we've heard is that the schemes will, you've spoken about direct and indirect payment but where there is a blocking of a particular provider, it means that the members cannot use the services of that provider. So it would affect the members too. So what, what then does the Council do to enforce the Act and the

Regulations under circumstances where there hasn't been an AOD that complicates matters?

MR CELE: In those instances, we have had instances where a provider has refused to pay-, to, to, to sign an acknowledgement of debt, the medical scheme has virtually blocked such a provider and informed members that if you access health services from Provider X, we will not pay you. And, the members have accessed services from such a provider and attempted to claim

and have been refused reimbursement because they would have paid upfront to the medical service provider and will then take an invoice, go to a medical scheme and say, I saw Doctor X and he treated me or she treated me for this condition, here is my claim, and they have refused.

In those instances we have intervened, and medical schemes have ultimately paid. However, because they are case by case in nature and they do not come to us until a member complains. It becomes a painstaking exercise to enforce and medical schemes, unless in good faith, they start complying without us enforcing or, or, or supervising such

blocking, it becomes a tenuous exercise how we can ensure that every time such a claim is presented to a medical scheme it's paid. We have elected and we have warned medical schemes that this is a contravention, they do pay because they appreciate that it is a contravention.

However, the problem is that systematically if you get every day a claim and go in to a service provider it must always come to us and we must always on a repetitive basis issue directives to mean: But you've said that the schemes acknowledge that it's a contravention of the Act and the Regulations?

MR CELE: Yes, they do because they ultimately also do [intervenes]

ADV WILLIAMS: Do the schemes not take the view that in fact there isn't an onus of proof on them to establish that there is an unacceptable payment, that the payment that they made was unacceptable?

MR CELE: In the cases that we have investigated, when the schemes have-, after having blocked the provider they haven't taken that issue. All they have said is, we have warned you not to use such a provider, in future we will not be able to pay if you access services from that person, however, when the claim goes in again, they still pay because they understand inasmuch as they can hold that position, it's more a persuasive position really than a regulatory provision or a compliant provision. But that is the problem that we have that schemes are taking that leeway.

CHAIRPERSON: What authority do the schemes have to tell members not to use particular service providers?

MR CELE: In certain instances in terms of the rules, they do provide for blocking of providers [intervenes]

CHAIRPERSON: So the [intervenes]

MR CELE: In instances [intervenes]

CHAIRPERSON: … of the scheme?

MR CELE: Yes, in terms of the rules of the scheme. In certain instances where there isn't such, they, they block without relying on anything and, and, and basically, it's non-compliant with their own rules, it is non-compliant also with Medical Schemes Act.

ADV WILLIAMS: The first function of the medical-, of the Council is to protect the interests of the members of schemes to protect the beneficiaries, that's the first function, responsibility of the Council. In your investigations, have you found, what are your findings in relation to the impact on members of, of this conduct?

MR CELE: The, the impact is one, access to, to, to health is impacted on because instead of going to the closest service provider members are forced to either access it fr-, away from where they ordinarily would access healthcare from. Secondly, in disputes between services providers and medical schemes there is apparently little regard for the benefit-, beneficiaries and the question on benefits that are payable, rather the focus is on conduct of a service provider even in cases where a patient has sought and obtained healthcare cov-, I mean healthcare benefits.

Merely because there is a dispute such beneficiary is then affected and this is more than one beneficiary, it could be several beneficiaries that fall under a similar or one administrator that sees several-, that has got a broad spectrum of medical schemes because you then have that provider being flacked across all medical schemes. So this impact moves beyond just one medical scheme vis-à-vis one provider but it's wider and has a hallow effect on, on beneficiaries beyond medical schemes, beyond one medical scheme that may have an issue with such a provider.

ADV WILLIAMS: Thank you.

CHAIRPERSON: Thank you. You can wrap up if you-, there are any aspects that still need to be dealt with and then Dr Kabane can conclude.

MR CELE: One other thing that probably is important for our purposes because inasmuch as you make findings that there is apparent fraud by providers as well and by members in certain instances, in terms of Section 16 and in terms of Section 66 there is limitations on what CMS may do about that. In regard to providers, in terms of Section 16 and 66 the Medical Schemes Act-, the Medical Schemes Council and the Registrar may only report such providers to organisations that have got jurisdiction over such people and it's referred to as improper, disgraceful or improper or disgraceful conduct, which speaks to conduct that may not constitute fraud but it's unacceptable and probably would fall within the ambit of what we call "waste and abuse".

CHAIRPERSON: Thank you. So Dr Kabane, I think you,

you mentioned at the beginning that you would want to come back after all of your presenters.

DR KABANE: Yes, thank you Chairperson, and I'm not going to read everything. I just wanted to, to make a few points around fraud, waste and abuse, that it is a major problem in the country. There is an estimation that up to 15% of all claims are associated with fraud, waste and abuse and our own calculations based on claims that have been paid out is that this amount may sit between 22 and 25 billion per annum and basically these are resources that are supposed to be directed at providing quality services to members that are now being diverted to other parties here.

We, we understand that, you know, members of schemes or service providers, either on their own or in collusion, are actually

responsible for these fraudulent activities. But we are also concerned about the behaviour of the schemes and the administrators in the manner in which conduct themselves where there is a suspected fraudulent transaction because we believe that they've, they exceed their mandate. And I think it, it is very clear to us that where there's a dispute between the scheme and the service providers, the ultimate victim is the member of the schemes, either through lack of access to the service or basically through exorbitant co-payments that sometimes lead to the "impoverisation" of members where there are catastrophic expenditures.

So, so I just wanted to make the point that CMS has long foreseen this problem and as early as February this year, we convened a summit where we brought all the key stakeholders in to try and get to the bottom of how

we can prevent and reduce fraud, waste and abuse. And the result of that was a summit and, and the products of that summit was the key definitions that have been agreed upon that are related to fraud, waste and abuse as well as a chapter which we have attached as part of our submission and this chapter talks to the key principles that the signatories you know, committing themselves to and these are largely anti-fraud, waste and abuse.

And basically the next step would be to develop clear codes of good practice for all the key stakeholders around fraud, waste and abuse. And we are hoping that through this exercise, when we see recommendations, they will start to talk to that because we believe that in the absence of clear rules on how the different parties should conduct themselves, we get a lot of these different interpretations and people playing outside, what is acceptable, what is legal and what is ethical. So, so we are hoping that, you know, through these recommendations we would be able to construct these codes of good practice.

You know, by way of conclusion, I just want to say that I hope through our presentation we've been able to demonstrate that whilst we've currently used what sits in the Act and Regulations, there are clear discrepancies in terms of how we should actually be operating in an environment where you know, there is empowerment to the regulator in terms of a clear Act and Regulations. And we believe that we've also demonstrated that Section 59 together with this Regulation 5 and 6 is problematic in the way that it sits right now and clearly something needs to be done to provide more clarity.

And, and I think some of the inputs have made reference to, to some of the key areas that I just wanted to emphasize. Firstly, when there's a suspicion of a fraudulent claim, you know, what kind of processes allow schemes, administrators and service providers including the members, to get an engagement so that there's a proper confirmation of that diagnosis. And also how to proceed once that fraud is detected because whilst the rules and the laws and the

Regulations clearly say, if there's fraud, it needs to be reported to the responsible authorities.

Clearly, within the industry, there is collusion between fraudulent service providers and the schemes and administrators where they sign these acknowledgements of debt when in fact those cases should have been referred to, you know the, the, the law enforcement agents. We also are hoping that we need to clarify the areas that are problematic around at what stage should an audit be conducted; how should it be done and what rules should be followed. We also think it's important to address this issue of guaranteed exclusive payment by service providers because, because I think it's, it's common cause, I mean I'm not a legal practitioner, but I think if you are a general practitioner and you provide a service to a patient in good faith and you provide a legitimate claim to a service provider, you expect payment, you know that should be made direct.

So [indistinct-2:40:36] and say, under what circumstances should this be done here? Are they certain additional things that services providers need to do so that this is guaranteed and it's exclusive? I also think the, the issue of clawbacks needs to be closely examined because they just seem to be

unlawful and are not governed by any, you know rule or legislation and I think we need to, to put that to an end. But CMS, Chairperson, is looking forward to the recommendations and we don't think we are angels in these discussions because clearly there are certain things that we should have done but we will away the recommendations and implement them. Thank you.

CHAIRPERSON: Thank you Dr Kabane. It remains of me then to thank you Dr Kabane and your team for your input this morning. It's certainly been very enriching and enlightening. Of course it has not been, I mean we don't hold back but that's the nature of the animal. Thank you. The session is adjourned until, I think half past one.

PROCEEDINGS ADJOURN

END OF AUDIO