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 KATLEGO MOTHUDI, BHT
	MR CHARLTON MORUVE
	DR HLELI NHLAPO
	MR CONNIE BAKKES
	MS MICHELLE BENEKE
	MR ERIC RANTSHO

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.
2. Since this is a true reflection of the record and it is transcribed as heard, grammatical errors may occur because of role-players speaking throughout.

PROCEEDINGS ON 30 JULY 2019

PROCEEDINGS RESUME

MS BAKKES You can call me Bakkes I am from the HFMU.

MR RANTSHO: Eric Rantsho Shared Services.

MS BENEKE: Michelle Beneke from the BHF.

CHAIRPERSON: Okay so is it Mr Mothudi or Dr Mothudi? All right so Dr Mothudi let us take your oath at this point because my understanding is you will be leading the presentation for BHF?

DR MOTHUDI: Yes.

CHAIRPERSON: All right will you then take, what do you prefer an oath or an affirmation?

DR MOTHUDI: An oath is fine.

CHAIRPERSON: All right so will you then say after me I and then announce your name?

DR MOTHUDI: I Katlego Mothudi.

CHAIRPERSON: Swear that the evidence that I shall give.

DR MOTHUDI: Swear that the evidence I shall give.

CHAIRPERSON: Shall be the truth.

DR MOTHUDI: Shall be the truth.

CHAIRPERSON: The whole truth.

DR MOTHUDI: The whole truth.

CHAIRPERSON: Raise your right hand and say so help me God.

DR MOTHUDI: So help me God.

KATLEGO MOTHUDI: d.s.s.

CHAIRPERSON: Thank you. So when you are ready you can get started.

DR MOTHUDI: Thank you very much Chair. Our submission which we'll, which I will read from in the later part of the discussion was centered largely around two areas which we deemed to be of, of interest to this inquiry. The first point is around the practice code number system and then the second element is around the health forensic management unit but we, we thought as we were sitting from yesterday here there are just some additional comments that we should make, that we have packaged into the presentation. You would have the slides, but we will submit them to you, they were not part of the original submission. Secondly, we, we were advised that it would be advisable to lump the BHF and HFMU presentations together and so the, the Dr Nhlapho will later take about [indistinct] specific details.

CHAIRPERSON: All right then maybe at this point if Dr Nhlapo will be speaking let me just take his oath so that we don't have to do it before he speaks. Dr Nhlapo will you then say after me I and then your name?

DR NHLAPHO: I Hleli Nhlapho.

CHAIRPERSON: Swear that the evidence that I shall give.

DR NHLAPHO: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

DR NHLAPHO: Shall be the truth.

CHAIRPERSON: The whole truth.

DR NHLAPHO: The whole truth.

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

DR NHLAPHO: So help me God.

HLELI NHLAPHO: d.s.s.

CHAIRPERSON: Thank you yes Dr Mothudi?

DR MOTHUDI: Can I maybe also advise that at least Mr Moruve and Miss Bakkes will be joining in the presentation. I don't know if it would be convenient maybe to swear them in?

CHAIRPERSON: Yes it will be I just want to make sure that everyone who does speaks does so under oath.

DR MOTHUDI: Yes.

CHAIRPERSON: So that later on there can be consequences.

DR MOTHUDI: Ha-ha.

CHAIRPERSON: Sorry what is your name?

MR MORUVE: Charlton, Charlton Moruve.

CHAIRPERSON: Surname?

MR MORUVE: Okay.

CHAIRPERSON: So Mr Moruve will you then say after me I and then your name?

MR MORUVE: I Charlton Moruve.

CHAIRPERSON: Swear, swear that the evidence that I shall give.

MR MORUVE: Swear that the evidence that, that I shall give.

CHAIRPERSON: Shall be the truth.

MR MORUVE: Shall be the truth.

CHAIRPERSON: The whole truth.

MR MORUVE: The whole truth.

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

MR MORUVE: So help me God.

CHARLTON MORUVE: d.s.s.

CHAIRPERSON: And then is it Miss Beukes?

MS BAKKES Bakkes.

CHAIRPERSON: Bakkes all right.

MS BAKKES Yes Chair.

CHAIRPERSON: All right will you then say after me I and then your name?

MS BAKKES I Connie Bakkes.

CHAIRPERSON: I swear that the evidence that I shall give.

MS BAKKES Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

MS BAKKES Shall be the truth.

CHAIRPERSON: The whole truth.

MS BAKKES The whole truth.

CHAIRPERSON: Raise your right hand and say so help me God.

MS BAKKES So help me God.

CONNIE BAKKES: d.s.s.

CHAIRPERSON: Thank you very much yes Dr Mothudi?

DR MOTHUDI: All right thank you Chair. This is the, the shopping list for, for our discussions this afternoon. We, we gleaned some of them from the discussions emanating from yesterday and even today. Just maybe to, to bring perspectives from, from our side on, on some of the general discussions. So we'll go through some of the definitions and then some key points from yesterday and then we'll go through our submissions and just to conclude on, on our experience and the complexities of investigations. So I think just to introduce ourselves BHF is a member association, a voluntary organisation which is not for profit for health care funders. We largely represent medical aid schemes, administrators as well as managed care organisations from South Africa and seven other South African countries largely in the South African development community. What we do we, as an industry body we represent member's interest. So we articulate issues of, pertaining to health care policy through lobbying and advocacy. So we will of, review of maybe regulatory matters that are pertinent to the operation of the organisations that we represent. We also look at trends in the industry, this with the view of advising our members to, to make sure that they refine their, their practices to, to events. We also look at engagements, we're very active in terms of education and training. There's a large part of that leadership that we, we play in to, to

enhance skills and knowledge. By, by so doing we're guiding our members through, through this processes. There's a bit of more detail in the slide that you can have, have a look at. The reason that we, we are part of this process as I have articulated we, we do have a vested interest as the BHF. Being in the medical industry and also being cognisant of, of the nature of the industry. We, we are guided by what the act prescribes because that's what our members around there. So issues that were discussed this morning around section 59 of the act, section 66 and other relevant parts of the act that talk to claims, processing and benefit assessment would thus, thus form a large part of the interest. But what of significance are the losses that are made by the schemes through the claims processes. To this end the, the, there is that focus which we have participated in through the HFMU. Our view on fraud, waste and abuse is that this is an, an industry issue. We, we advocate for a non-competitive outlook that there should rather be collaboration among all the stakeholders because it's a common problem. It does affect us entities in various manners, but it is an industry issue. As a result BHF has for a while acted as a repository for, for data and we, we have been a player which does not have a vested interest in that, we do not administer any claims or participation of any benefits to, to members. We, we are cognisant of the fact that it is a very complicated environment and I think some of the, the slides later on will go into detail. So there's quite a number of stakeholders that are involved in this. If you're looking at from a patient's perspective Dr

Kabane will talk about the triangle that involves the member on one hand, the funder and the practitioner with the links not being as straightforward as they should be, but the patient is directly linked to the medical aid. The other players, we've got the regulators, switching companies that facilitate schemes payments and other people that look at management of the benefits including managed care entities. From the health care service providers side they are also regulated but there are many disciplines as well. Whether you're talking from the supply side of devices, technologies, other secondary providers like [indistinct] pathology and radiology, pharmacy etcetera. And overseeing this are your regulators but we also have involvement of law enforcement in professional bodies. We, I think somewhere in our submission we talk about some of the formalised collaborations that we have tried to seek in the last year or two with bodies like the SAU, the MP, etcetera because we do realise that it's not just an issue that the industry can handle to finality on, on its own. So it's really a, a very involved and complicated environment just focusing on fraud, waste and abuse. I think to articulate this and there's been quite a number of questions around definitions like what is relevant and what are the roles of the various players. I think it's important for us to go back to defining what the business of a medical aid scheme is. In as much as there's this transactional nature between the various entities. Members pay contributions. There are claims processes when they seek health care services. The main thing is that the scheme defers costs for

the scheme or for the beneficiary in exchange of a particular contribution. But the main thing is around the relevance of the health care service and in this we, we, we, we, we would include one of the components as being the affordability component that in terms of adjudicating what relevance is the issue of cost should never be far away. The issue of best practice should also be considered when you're looking at relevance of the product that are deployed in this and one of the responsibilities of the administrators usually articulated in the contracting process is that they must make sure that are the claims that are paid for by the schemes are validated. Now the process of validation is quite involved. It starts from even saying is the member the correct one that is registered. Secondly are they the correct one when they are seeking health care services and then the other back office elements that I touched on issues involving coding, there was a bit of talk, I've got a slide on that where, which is part of that validation process to make sure that the service that is paid for is actually a relevant health care service. There, there was also a question earlier around on what fraud, waste and abuse are and I think at the time when the, the act was contemplated some of this elements were not clearly defined but I think over the last decade or two we've had a bit of clarification on what they are. Now if you look at this slide in terms of the, the intend to deceive. I think it was correctly articulated fraud is illegal, is a criminal offence and there is intention to misrepresent facts at the prejudice of one party. Now when you look at its relationship to

waste and abuse the intention to deceive actually decreases when you move from fraud and you go upwards to, to waste. In terms of what abuse is we, we generally define it as inconsistency with best practice. So when you have inconsistent delivery of services which departs from sound medical practice then it is deemed to be abuse. I will have some examples that I will show you. In terms of abuse I think the, the, the sort of waste, the key word there is excessive, is over utilisation of services. So there is no misrepresentation but there might be addition of unnecessary elements of health care that are included in that transaction or contact and that is deemed to be wasteful. Some of them are and there are examples, I think Connie in her presentation will touch on some of this abuse. So when we look at fraud for example you could have double billing for the same patient or a recent example that we looked at is the, the health care practitioners who would have their own practice number from a solace practice and they are also part of a group. I consult and they put a claim not just on their solace practice number but also on the group. By that they are misrepresenting the facts. There could be false claims, so a member did not attend to the physician, but they sent in a, a claim. One, one other method which is very common now [indistinct] where they sent somebody back with a backpack carrying a lot of cash collecting names and, and membership numbers. They, they pay out the, the money and then they submit this as if those people that they collected the cards for actually consulted and then we've got also the issue of cash loans where

somebody comes into a practice and say I need a certain amount of money and then they submit a claim as if they attended to them for medical consultation in exchange for, for cash. And as you can see those are blatant methods where there is misrepresentation of the, the facts. The other ones where I think sometimes there is a bit of difficulty in interpreting whether they, they lie and we found that the abuse and wasteful component probably from the majority of, of these unnecessary claims. Examples are you are billing for unnecessary services when you could be having a real consultation but then your consultation evolves into other areas that are inconsistent with best practice. For example a person complains of a particular ailment but without any reasonable argument you include other things that you are not really screening for, that should not form part of the, part of the consultation. The other one is inappropriate use of coding and there are two examples here where you have unbundling of codes. Now unbundling of codes is where there is a definition in the coding manual of a particular procedure. Let us say it is repair of a shoulder, of a frozen shoulder for example there would be a particular code but you know that in the course of you attending to that person there are many other steps that you would engage in to achieve your process and then you bill for each of those little steps which accumulatively, cumulatively then give you more manual claim than when you just use one particular code. So upcoding when you are doing a minor procedure, but you know it would not pay you as much as it would be when you use another

code that is similar but not of a procedure that you, you conducted. The other one is around waste for example unnecessary admissions. Maybe a common example is somebody's benefits should have run out, but you want to run a number of tests, but they still have their in-hospital benefits intact. You admit them unnecessarily for the benefit of running those tests. The person needs the tests, but you are incurring other costs that should not have been had you been more, more careful. There are issues around doing procedures for convenience if you are an obstetrician for example you've got a high patient load. You don't want to be woken up on a Saturday night. It takes less for you to plan caesarean sections and do it on a particular day rather than allowing a person to do, to go into natural labour. That saves you time, but it is a bit more expensive because it involves longer hospitalisation and other procedures that you might not have necessarily needed to, to, to engage in. Now in terms of the approach to fraud, waste and abuse as an, as an industry, as entities I think it's important to look at interventions just like you would in any risk mitigation. So we believe that as part of your, your governance framework fraud management should actually be developed into those processes. And we've just given here a framework that many people deploy to find this gauge. So you, you'd have policies that talk towards fraud prevention and there are monitoring elements, there's investigation, there's prosecution and all of this you want them to lead to deterring perpetrators to, to committing fraud. The elements that are required

as we've said are around collaboration. We should not look at it as, as area for competition or that's, that's our approach. So there's a lot of information sharing, data sharing and [indistinct] on top of that in terms of the, the joined action. So the, if you remember the, the three slides I showed you the various players. You can see how they actually fit in. The role of the BHF is really around fraud detection. We do assist the various entities to strengthen their, their policies in terms of monitoring and prevention but we are not involved in the actual investigation. We leave that to the entities that participate in the [indistinct] renewal structure. In terms of coding I think we do recognise that this is a highly technical area. But it's, it's central to the work that you do in terms of fraud management. In as much as there are many methods from a health care practitioner perspective in the South African context there are probably maybe three coding systems that they should be familiar with and let me deal with those first before I, I spent time on, on the slide. The first one is the ICD10 code. The ICD10 code is really just a diagnostic, in fact we, we will soon be moving into ICD11 coding and on it, it is just a diagnostic method and it is written into the act. It is a requirement that when you submit a claim it must be accompanied by a relevant ICD, ICD 10 code. The second code that practitioners use or are confronted with are, are those that are, are contained in the RPL. There was a bit of discussion around it yesterday. The custodian of the other coding system, which is used popularly in South Africa, in South African medical association they do have

codes very similar to what is contained in IPL, but I've got more, more codes. The definitions are very similar. There are some differences but not, not to a large extent and these are procedure codes. So when you consult that consultation will have a particular number that dictates what the code is. If you apply or give an injection or anything else, whether you have to suture a laceration there will be a code that are, is linked to that. This codes are dvivided by discipline so you will have dental codes, you'll have codes for physiotherapists etcetera and the other significant thing is that even within those disciplines that use similar codes you might find that there will be different monetary values attached to the codes. So a specialist for example will still use code 1090 for consultation but the quantum would be slightly higher and that is determined by what they call relative value units. Which takes into consideration the scope as well as the complexity of the work related to the qualification. So that will be the procedure codes. The US have got a similar system called the CPT coding and this is owned by the American Medical Association and they have got three categories. The one that is similar to the RPL is category one that talks to procedures etcetera and the last one which we did not include here are the NAPI codes and then the ATC classes mostly for medicines and material and from a health care provider prospective those are, are the ones that they would use. When you look at the administrators and other suppliers' hospitals, they will use a lot more the CPT codes and they also develop a lot of in-house

codes depending on their reimbursement models, etcetera. But I don't want to complicate the discussion because it's not that relevant to the discussions. So when you look at how coding is central to fraud, misuse and abuse and also to validation of claims it is important that when somebody submits a claim the various codes actually talk to one another. When you've got a diagnostic code that says this person has got an abscess the procedural codes that are attached to that claim must actually talk to the diagnosis and that's part of the validation that if a scheme for example receives a claim that says abscess but the codes do not talk to that, that might necessitate the scheme or administrator reaching out to the provider and say justify what you said or it might be even rejected off hand. So, so it's quite complex but I think in our environment there are specific codes that the industry uses and we, we, we I think there is consistency in that regard.

ADV WILLIAMS: Dr Mothudi may I ask you, you mentioned in passing and you didn't go into detail, but you said that some of the schemes have produced their own in-house codes, did I hear you correctly?

DR MOTHUDI: Yes.

ADV WILLIAMS: I suppose my question is, is there amongst members consensus, across the board, in relation to what procedure code should be used for particular procedures? And I ask the question because so far, the evidence we've heard suggests that there are numerous codes and you seem to be confirming that to the

extent that you say that schemes are producing their own in-house codes. So perhaps you could just clarify that?

DR MOTHUDI: So to, to the extent that there is involvement with external stakeholders they would at least be guided by the contractual arrangements with the stakeholders. Let me give you an example. If for example one administrator has an alternative reinvestment mechanism with the hospital code for example. In the contract they would then agree to the reimbursement model. I think they also agree to what codes form part of that agreement. If you are going to bundle let's say certain procedures. There's one, let me give an example of, of a group that uses let us say hip and joint procedures as part of bundle payments. In that, in the contract they would say this particular procedures we'd reimburse them at this rate and this is included, these codes are included in this arrangement and then we cover this either based on, on the value or, or time and, and other requirements in terms of the agreement. But in terms of the, the industry as I said there is a, a general usage of RPL. In the background back offices they do use their CPT codes in as much as there is no industry standard on or industry guidance on how to use this. There is general usage of, of a certain number of codes.

ADV WILLIAMS: So the, the example you gave in relation to the hip and joint's alternative reimbursement mechanism is, is interesting but it does seem to suggest that it's a quite unique to reach agreement as to which codes should be used because here's

specific procedures as I understand it but what I'm really trying to understand and it's the second answer that you gave, the second part of your answer. Is there, the IPL we heard yesterday has been declared invalid but it's still in use. The schemes seem to have developed their own procedural codes [indistinct] code which mirrors the [indistinct] and otherwise not. I am just trying to understand from a provider perspective we heard evidence yesterday of providers had their codes challenged. How will they know which code to use with such diversity in this current environment?

DR MOTHUDI: So I think the challenge around IPL were articulated yesterday around the uncompetitive nature from, from bargaining perspective. What has happened since is that obviously each scheme implement its own tariff file and the majority of this tariff files would be based on, loosely on IPL. A number of the professional societies whether you are the South African Society of Anaesthetics or Optometrists they would then also issue their file to their members. Some of the societies have got formal relationships with the schemes and they would enter those into the scheme's tariff file if there is such relationship. So from, from those health care practitioners that are organised into societies there are an industry standard that would come from the societies part. In terms of them being adopted by the schemes there's usually engagement at a scheme level. But if you examine the various tariff files of the different schemes there isn't that much of a difference in terms of the codes that are contained in there. The major difference I think from

around 2009 has been around the cost or the price attached to each tariff file but even having said that you find that this could be no more than 10 to 15% difference expect, except when you have specific reimbursement arrangements that are based on networks or DSP arrangements.

ADV HASSIM: Would you say that, for a moment what I hear you saying is that there are, there's not that much of a difference between the schemes and there are industry standards but would you, would you agree with for example the submission by the competition commission that there needs to be a uniform coding system or do you, or do you think that's just unnecessary?

DR MOTHUDI: Ja it, we agree that there should be a uniform coding system, it would definitely reduce the complexity and fragmentation.

CHAIRPERSON: Just where are the problems concentrated? In fraud, in abuse, in incorrect coding? You see I mean, what is the impact of this improper usage of codes?

DR MOTHUDI: So it would be difficult to say in terms of each element that I've mentioned what the contribution is. Largely we, we estimate, and I think Dr [indistinct] made the same submission this morning that we estimate the impact of fraud would be as much as 15% of your claims exposure, total claims exposure. Now to the extent that the three elements we still think that the majority fraud forms maybe a smaller part in comparison with, of the other two.

CHAIRPERSON: Yes.

DR MOTHUDI: So the, the challenge's really around the waste and abuse, but we'd lump them together because the processes are safe.

CHAIRPERSON: Cause you see in your affidavit in paragraph 15 you say that fraud, misuse and abuse within the medical aid scheme environment is significant, it is being estimated that 28 billion, so this is 6 billion more than the estimate by the CMS is paid by medical schemes paying claims that amount to fraud, waste and abuse. Now the problem if you look at that is that you don't actually know how much of it is deliberate, how much of it is just mismanagement by schemes themselves and how much of it is abuse, in other words negligence and carelessness which is three times you described. Which is why in the morning I tried to understand how do we distinguish this three terms and how do we account for each of those terms separately. Because when you, when you, when I listen to people this morning I end up not being sure if the view from the regulator and from the industry is that there is 28 billion rands that gets lost because Drs are misbehaving or there is 28 billion rands getting lost because the systems are dysfunctional?

DR MOTHUDI: Ja I think, I think it's an important point and I think it's important to acknowledge that schemes are different would have different capacities in terms of how they, they manage their processes. There are also different methods brought in by the

different administrators. You, you in as much as the industry is not very big, I think you've got twenty something odd administrator and managed care service providers. Obviously, they would have as part of their armoury unique propositions so there's no standardisation on, no the back-office applications. However I think the, the, there are certain things that we, we would all do in terms of validations. Now we, we talk about fraud, waste and abuse as if its static, it also evolves because as soon as you switch off one tap, perpetrator find another. Just like in any criminal activity. So there is a need for people to be agile and develop. Unless you are a very large administrator and you are able to invest a lot of capital into your methods you are almost always catching up. In our dis-, I am somebody just like I'm also looking at the global view. Even countries that are deemed to be a bit more developed than us are still fighting this. Then the, the quantum of money lost is still staggering. So we, we have to recognise that the method used by the perpetrators are also evolving while we're still looking at what is required in terms of the basics, there are newer things that are happening. What, what we decided as part of the collaborative effort is to make sure that we share information on all this methodologies, so as the industry moves forward ja.

CHAIRPERSON: I mean how much of this amount, whether it's 28 billion or 22 billion, how much of that is fraudulent conduct and how much is carelessness?

DR MOTHUDI: Chair so in all honesty there is, there is

no exact science which can make us reach to that conclusion. It's mostly estimates. Even in territories where they've developed complex reporting systems for determining fraud, waste and abuse what you end up with is an estimate because if it was so easy to determine it, it would be easy to actually get rid of it but we are left with estimates which are made from sampling and scientific analysis so we cannot really give you an exact answer of where things lie.

CHAIRPERSON: I mean even if you work on the estimate what is your estimate on fraud because what I want to distinguish is how much of this is attributable to deliberate conduct by service providers.

DR MOTHUDI: So in the US where they did some extensive studies, they found that it's between 3 and 6 %.

CHAIRPERSON: 3 or 6%?

DR MOTHUDI: Yes and then the rest would be waste and abuse.

CHAIRPERSON: So would you say that, that figure of 3 and 6% would also be applicable here?

DR MOTHUDI: I have no reason to believe why not.

CHAIRPERSON: All right so out of this 28 billion we can say that it is as low as 3% that is deliberately, 3 and 6% that is the result of deliberate misconduct by service providers?

DR MOTHUDI: Yes.

CHAIRPERSON: All right. Now when you talk about abuse and waste. I mean one of the things that I looked at when you were

presenting earlier is that it looks like the causes of the waste are not attributable to medical practitioners, they are also attributable to schemes.

DR MOTHUDI: Ja so in our discussion of fraud we acknowledge that it would not, it would be unfair to say its only health care practitioners. We do recognise that there's a lot of collusion that happens. There are instances where schemes and administrator employees would be part of the syndicates maybe even trustees for example or even boards. So it is not just practitioners and one of the elements that makes management challenging is because of the collusion. So there will be collusion between members beneficiaries and practitioners, collusion between practitioners as well as scheme or administrator employees.

CHAIRPERSON: Yes and what have you found is the contribution of the schemes?

DR MOTHUDI: I think that as well we cannot give an, an outright estimate.

CHAIRPERSON: All right thank you; you can continue Kerry.

ADV WILLIAMS: Can I just follow up on that to say if that's your estimate of fraud in relation as a percentage or a proportion of fraud, misuse and abuse what, what, what where does the race profiling sit in your understanding of what happens?

DR MOTHUDI: So.

ADV WILLIAMS: Because now for example you, you let

me say it more precise. You provide a platform for sharing information and systems in order to validate claims and to pick up FWA behaviour. What are your findings in relation to race profiling?

DR MOTHUDI: So mean to the extent of our knowledge and belief the, the, from our side we do not have any evidence of that. In fact our submission with regards to the two elements that I alluded to in terms of managing the practice code numbering system one there is no capturing of information that denotes race or anything that can be used for that kind of profiling. Secondly in terms of the data sharing arrangements there is no provision for, for race demographics.

ADV WILLIAMS: So but could, could there be a proxy used so it wouldn't be outwardly a factor of race or in which information of race, that particular demographic information is requested but where geography or names are available, are known.

DR MOTHUDI: That would be [intervenes]

ADV WILLIAMS: In the investigation process.

DR MOTHUDI: Ja that would be pure conjecture on my part whether people would be able to use names I don't think that would be a valid assertion on my part ja.

CHAIRPERSON: So what do you mean it would be conjecture, you cannot tell from a name whether someone is black or white?

DR MOTHUDI: Some people no.

CHAIRPERSON: Can you just tell me something else then,

in your own report, which is the, the attached to your submission you say that you submit statistics to the CMS on geography? So which means you actually know what the geographic distribution of medical practitioners is throughout the country.

DR MOTHUDI: Yes, yes.

CHAIRPERSON: And now you also say you submit names of suspended service providers?

DR MOTHUDI: Yes.

CHAIRPERSON: So can you not tell from the suspended service providers whether or not the majority is black or white?

DR MOTHUDI: I think it would be dangerous Chair. I mean if you see a Dr Jones does it mean that the Dr is white or black? We, we cannot.

CHAIRPERSON: But I'm asking you if you know the names of all the suspended Drs is it not easy to tell whether the majority of the suspended ones are black or white?

DR MOTHUDI: I cannot answer that positively sir.

CHAIRPERSON: All right thank you can continue.

DR MOTHUDI: Okay so, the with regards to maybe the, the suspensions that you are referring to with the practice numbers, this comes as a result of noncompliance issues with regards to either not paying the prescription for that year or for not registering with the relevant authority. So there is no filtering or profiling there? It is just a list of people who did not requirements for registration get.

CHAIRPERSON: Thank you.

DR MOTHUDI: So we've touched a bit on PCNS. I think yesterday there was a comment from the, the competition commission regarding where PCNS is placed. I do go into a bit of detail in the submission around the relationship between PCNS, BHF and CMS and I also, there, there is confusion about what the role of the BHF is and all I wanted to, to explain here is that our role is purely administrative in terms of registration of providers. There is a prior licencing or accreditation process by the relevant bodies and we then register them on the PCNS so that they can claim from, from schemes. The PCNS is a product that is under the auspices of the Council for Medical Schemes and they had contracted the BHF to, to run it. There was a, a question around whether the savings that accrue from FWA interventions are passed on to beneficiaries and I think the, the indication was that they, they are not. I do not know this if we can truthfully say that it never happens. What we can say is that some schemes as it have demonstrated in any of their interventions that provide savings, some of the schemes have demonstrated that they can pass them on. One specific example is where a scheme has implemented what we call an efficiency discounted option or ADO which becomes a sub option and that sub option with the same benefits, the only difference is that there is care coordination in, in terms of the beneficiaries choosing health care practitioner that would be the primary contact. Secondly agreeing to be part of a network. There are schemes that have reported that they have made a lot of savings. The first manner is to

of, of passing the savings is to offer that same benefit option at a lower premium. I think they've reported I think 10 to 15% discount on that, that sort of option. And we just brought this up to say that the issue of passing on savings cannot be just be a discarded or lumped into one basket of, of it not happening in any respect. In terms of [indistinct] and I'm just going to go quickly.

CHAIRPERSON: I mean the point that was made by the commission is that the premiums are constantly going up even when we are told that there is so much saving made from FWA.

DR MOTHUDI: Ja no, no we do acknowledge that we just wanted to pick on a specific example where there were savings and there has been prove that they are passed onto members. Ja. So in terms of prevention I'm just going to go quickly on this. Obviously, there are elements of education that are required for the beneficiaries. I think the, the issue of insufficient communication resulting in information asymmetry has been muted and then also it's important to have internal controls as part of that broader policy of FWA strategy and also I think you've also mentioned around efficiency of the systems that are, are deployed by the schemes. That is important. There is a bit of detail, but I'll just rush through this. I think they will be addressed again towards, towards the end. Okay. So there I think we've already touched on some of the elements we, we in our submission we, we positioned the BHF as an industry broadly and also what, what it, what it does for the members. Paragraph 5 talks about where the practice number is, is

positioned, this is coded in regulation 5(e) of the medical schemes act that is a requirement in the submission of claims, that a practitioner number is, is quoted. I've also talked about the relationship between the CNS and the BHF relating to the practice code numbering system and the contractual arrangements that were entered into in 2003. Maybe to, to the question around whether there is potential information that can be passed on that has got racial information we thought we, we should just give a bit of detail around what the processes are around the practice number. So we, we have included I think it is in paragraph 11 we, we have included the form that health care practitioners fill in and the information that is captured and it does not include any reference to, to race. The practice number comprises a couple of digits and this operates as an unique identifier for the health care service provider and what it refers to among other things are the provider's discipline and sub-disciplines but there is no specific reference to, to race. Paragraph 13 then talks to how we then disseminate information to the schemes and administrators. There is a file that is distributed on a daily basis which includes the name of all the service, health service providers, they are registered, their practice numbers, whether they are part of a group or they are in a solace practice and this as well does not contain any racial information. To this extent we, we have actually provided a report from an independent audit that was conducted last month when this inquiry was being contemplated and its included in the, in the submission for, for your, for your reading. I

think I will maybe just before I pause we, we, we have note reference to the, the global community. The BHF is part of an organisation called the Global Health Anti-Fraud Network and in there, there are a number of propositions participating in various territories. There, there is an European component that around 2004 got together, they had representation from about 28 European countries that started developing this common standard risk measurement and they do this on an annual basis. So some of the figures that, that we mention and [indistinct] mentions are actually from publications from, from that area. That they say there is fraud exposured regardless of how resourced you are. At minimum you have about 3% exposure but most of us will be around 6% for those entities that have got more structures or minimal investment it can be up to about 15, 15% and this is captured in, in this. So just some figures. We, we talk about the 4 billion that we are, sorry 28 billion then that we are exposed to. Reports from the USA around 2011 talk about tens of billions of dollars that are lost there due to fraud. The, the [indistinct] estimates that globally there is about 260-billion-rand exposure to, to fraud. In the national health system in England the estimated loss is about 1 billion pounds lost every year. Unfortunately we do not have those definite figures for SADEC, but the figure is around anything from 3 to 15, 15% of your, of the claims exposure.

CHAIRPERSON: Sorry I just want to continue with the understanding this racial profiling issue. The, my understanding of

this report by the internal auditor is the, it is an attachment to your appendix 2?

DR MOTHUDI: Yes.

CHAIRPERSON: Now if you look at page 10. So you say that I mean if you look at the actual information you have which is demographic, age, frequency, geographic, number of active and limited service providers participating discipline, number of new registrations per providers, number of providers renewing their PCN registration, number of suspended providers, number of providers updating their details, number of group practices. Then you look at your overall conclusion. I know you said that the suspended practice is not related to section 59 per se, if you look at your overall conclusion BHF does not perform racial profiling on ESP's allocated at practice code number even though we have confirmed that PCNS data does include information relating to race, ethnicity, religion or religion.

DR MOTHUDI: I think this.

CHAIRPERSON: This does not however stop members from drawing racial conclusions from data provided. For example your using names and surnames. So the information relating to race, ethnicity and religion is available and it can be used to draw conclusions based on names and surnames for racial conclusions.

DR MOTHUDI: Ja sir I think there is a typo there it should say does not include. I think we; we can correct that.

CHAIRPERSON: Does not include?

DR MOTHUDI: Ja it does not include.

CHAIRPERSON: Ja but then the second line the conclusion is still that inference can be drawn from the available data.

DR MOTHUDI: Ja.

CHAIRPERSON: Using names and surnames. But you deny that a name and a surname can be used to draw a racial conclusion.

DR MOTHUDI: Ja I'm saying my, my personal view it would be very difficult to do it, but it does not stop anybody from drawing inferences.

CHAIRPERSON: [Intervenes] you're saying here we should insert not.

DR MOTHUDI: Yes.

CHAIRPERSON: Where it says the data does include information.

DR MOTHUDI: Does not include yes ja.

ADV WILLIAMS: Would you be willing to share the statistical information with us?

DR MOTHUDI: Yes.

ADV WILLIAMS: [Intervenes]

DR MOTHUDI: Yes.

ADV HASSIM: Great. And page 12 of the internal audit report again says even though we've confirmed the PCNS data does include information related you're saying that there's.

DR MOTHUDI: Yes.

ADV WILLIAMS: Just on that sharing of statistical information with us we'll send a letter following up but just to ask are you able to [indistinct] that information so that it separates out group practices and individual practitioners?

DR MOTHUDI: Yes, it's possible.

ADV HASSIM: Okay. Can I ask a follow-up? For example under suspended providers how is your statistical information compiled? Is it just practice numbers? How, how do you compile that number of, of suspended providers? Is there a way to look beyond practice numbers, at the names for example of the suspended providers?

DR MOTHUDI: So, so the file, the line with the details of the active providers and suspended providers are exactly the same. The only difference is that there's an indicator that one is suspended and the other is still active. So all the information that you find on an active provider would be available on a suspended provider.

ADV WILLIAMS: And just to clarify that point because there's been some talk of suspension today as well, when you speak about suspended providers what are you talking about?

DR MOTHUDI: We mean that they did not renew their practice numbers. So, it's completely different from suspended. What schemes do they normally use the term blocked to say that this provider is blocked from direct payment so for our use it's just that practice number has not been renewed and we pass on that

information to the scheme.

CHAIRPERSON: All right thank you who will be the next presenter?

DR NHLAPHO: That's me chair.

CHAIRPERSON: Thank you.

DR NHLAPHO: Thank you very much for the opportunity. I think I; I must just give a, a background having been involved in the fraud, waste and abuse business. A lot has been said but I want to take us back to where the issue, the real issue sits to find ourselves in this problem, in this particular problem. Medical aid premium as we know it that members pay every month to belong to a medical scheme it remains a grudge purchase, it remains a grudge purchase and it will be so for the foreseeable future. The issue as well as the issue of entitlement. People pay a premium and, in their minds, this is their money you know. They, I mean they forget that this is paid in lieu of medical expenses especially future ones because in the medical aid industry the young and healthy who belong to the medical aid are subsidising the old and frail. So that's the nature of, of the base that we are dealing with, but I mean the people on the ground don't see it as such. If I've got benefits for 2019 January to December and I don't use them come the end of the month I must make a plan to get as much as I can. Thus we find ourselves having to deal with the issues of fraud, waste and abuse. So that's, that's the basis for all the issues and the problems that we find ourselves in and I mean that talks to what needs to happen for, from us as

funders and administrators in terms of member education. I think we should go out there at all times and not stop to educate the members that actually a medical aid premium, the purpose of it is to deframe medical cost when you need that. Until such time we'll still sit with the problem of between the 22, 25 and 23 or 28 billion that gets lost through fraud, waste and abuse. Coming back to the health forensic management unit. The unit was established in 2003. It is a unit that was established by member schemes and administrators and manage care organisation within who are members of the board of members of health care funders. The need arose from the realisation that health care fraud was becoming, health fraud, I mean health care fraud, waste and abuse was becoming a big issue. Not only in South Africa, I mean if you read the journals elsewhere in member, in member states that we, we, we, we do business with you'll realise that it's not unique to South Africa. It's, it's all over the place for the same reasons of entitlement and the grudge purchase. In, in my submission in annexure 1 it gives the names and the companies that are involved in the unit that has found the HFMU. It stands as the, all the participants that are active in 2019 they are all listed under annexure A. The main core purpose and objective of this particular unit was to come up with a unified approach in combatting fraud, waste and abuse in, in the health care space or environment. What happens is almost all the, the member schemes and administrators I mean they've got their own forensic units that do the operations from their,

I mean from their respective spaces. HFMU does not conduct any investigations. It's just a forum where different administrators and medical schemes come together to share their experiences in terms of what they pick up when they do their analytics, their respective analytics. It, it is important to also realise that you cannot fight the scourge of this fraud, waste and abuse use in, in silos. You need to go elaborate and work together in order to see the exact picture of what is happening because I mean you know experience has, has shown us that people, people submit claims differently to medical schemes, to different medical schemes because of their experience of knowing that this scheme is very active when it comes to you know the analytic tools that they use are more effective than the others. So you'll, you'll get a different experience when we meet and collaborate on, on, what we, on what is picked up on the ground. So this has, I mean the unit itself consists of a working group that deals with the operations, you know the operations from different member schemes as well as the steer com, the steering committee that function as, as an advisory. To make sure that I mean all member you know participants behave in a certain way that is acceptable. I've got annexure B where I've given the panel the code of conduct expected from the participants. If you agree or your happy as an organisation or as the medical scheme administrator and managed care about everything else that is, is expected as a code of conduct or ethics. That I mean if I want to belong in this organisation this is how I should handle myself or you know treat the

data and information in, in that particular way. You then sign and become a member that those people, that, that annexure A all the organisations that are listed there have signed to this code of conduct that makes sure that we use a standard, you know a standardised format. No one goes out and does his own thing in his corner whilst claiming to belong to this particular unit. And then we, we also I mean in our operations there's a portal, a BHF portal where we you know the data is all shared. I mean everyone brings the data, we belong I mean we believe in the, I normally call it you bring and braai. For you to participate you must also bring your, like share your information with us in order for us to share information with. So it's a collaborative united way of sharing information to, to, to look at.

CHAIRPERSON: Is this your view as well that there's no racial profiling?

DR NHLAPHO: Very much so.

CHAIRPERSON: Okay.

DR NHLAPHO: Very much so and Chairperson I, I.

CHAIRPERSON: I've asked this morning why is it only black Drs that are complaining? What is your answer to that?

DR NHLAPHO: You know I look at, I mean I look at the demographics you know we, we, I mean most of our colleagues I mean I'm an ex practising Dr myself, I mean most of if, if you look at, at, at the distribution of, of our colleagues there's more Drs, I mean there's more black Drs, Indian Drs than any other, any other, any

other race.

CHAIRPERSON: There's what?

DR NHLAPHO: I.

CHAIRPERSON: There's more what?

DR NHLAPHO: More black.

CHAIRPERSON: There's more black Drs?

DR NHLAPHO: In the townships I mean where most of the member schemes that are represented here belong. I can share with you as well that recently I attended a, a talk from the Health Professions Council where they gave their statistics I mean it was, I mean it was it, it, it, it was not a surprise to me that in their own experience they get more than let us say white complaints, you know complaints from white Drs by patients more than black. But I in my own view I take it that maybe it's because you know some racist or racial groupings, they know their rights more than the, the others. Maybe that's where that experience comes from.

CHAIRPERSON: Sorry just to take you back to this specific one. Why do we have more complaints from black medical practitioners against medical schemes? You say that is because of the black distribution of Drs in the townships?

DR NHLAPHO: That's my own experience I mean I might be wrong; I can't put my head on the block. It's just a, a thought that comes to mind when I think about why should it be because I'm as black as they come and for me to, to be I mean profiling people on, on race that will be injustice to the [intervenes]

CHAIRPERSON: No the complaint is not that you are profiling people. It's that the schemes are profiling people on race. Now why, why is it relevant that there are more black Drs in the townships to the question of racial profiling?

DR NHLAPHO: I wouldn't I mean I wouldn't really like I say I wouldn't, I, I don't have an answer to that, as to why that ascertain comes about. Because in my own space when I deal with, I mean profiling Drs I don't look at the race, I look at the practice number. The practice number is the one that I mean comes forward first before I, I get to know that this Dr Jones he is actually black, he is not white. So to me race, race issue I don't know where it comes from. I've never experienced it; I don't practice it.

CHAIRPERSON: I'm saying.

DR NHLAPHO: And that's fact.

CHAIRPERSON: No I understand that. But I mean your answer I'm trying to get you to explain what is the relationship between the distribution of black Dr's in the townships and racial profiling. Why did you give that answer?

DR NHLAPHO: It is because my thinking is they tend to see more of people that I mean belong to medical schemes. I mean black people are more in the, are in the majority in South Africa, so obviously the more consultations will be from them. That's, that's my own maybe thinking with my little knowledge of issues.

ADV HASSIM: So are you saying that there are more black members of medical schemes than white?

DR NHLAPHO: I tend to believe so because I mean if you look at the sizes of the townships obviously there's more people in the townships than in the, I mean in the, in the suburbs and I mean most of these people of late I'm talking of late, yes in the 2000's and later they happen to belong to medical schemes. They have medi-, I mean they, they pay premium to belong to medical schemes.

CHAIRPERSON: All right thank you.

ADV WILLIAMS: May I just take you to your submission?

DR NHLAPHO: Yes.

ADV WILLIAMS: To try and understand a bit more how you work?

DR NHLAPHO: Yes.

ADV WILLIAMS: So I see that the HFMU was established in August 2003 so.

DR NHLAPHO: Yes.

ADV WILLIAMS: You've been around for a while.

DR NHLAPHO: Yes.

ADV WILLIAMS: And I can see your membership in your submission as well.

DR NHLAPHO: Yes.

ADV WILLIAMS: Then I could see that a lot of schemes that are alle-, allegations have been made against are in the HMU.

DR NHLAPHO: HFMU yes.

ADV WILLIAMS: Sorry the HFMU and also the other, there seems to be other members like forensic service providers and non-

schemes and non-administrators.

DR NHLAPHO: Yes.

ADV WILLIAMS: All right.

DR NHLAPHO: We do have members like I said my annexure A I mean have got a list of everyone that is a member of HFMU family.

ADV WILLIAMS: I see they provide organisations like [indistinct] so I presume preferred provider negotiations is also a [intervenes]

DR NHLAPHO: Yes.

ADV WILLIAMS: Okay.

DR NHLAPHO: [Intervenes]

ADV WILLIAMS: So that is how HFMU works.

DR NHLAPHO: Yes.

ADV WILLIAMS: And I understand also that you distribute these reports to your members, and you've included a redactive copy of such reports, it's out in full I think but I'm interested in, in the reports why is entitled investigations.

DR NHLAPHO: Ja what I'm gonna do Chair I'm, I'm covering the, the aspects that I'm covering. That particular one of the portals my colleague will, will deal with that in, in and will expand on that particular one.

ADV WILLIAMS: Okay may I just ask the question then you can decide between you who's supposed to answer it. The reports currently redacted but it looks like you name the actual

providers when you share the information.

DR NHLAPHO: Yes, yes.

ADV WILLIAMS: Okay so you will have a name and a surname.

DR NHLAPHO: Yes.

ADV WILLIAMS: But we are yet to tell anyone whether that will indicate that you can determine race by virtue of a surname but you will name everyone, all your membership will get a copy of this provider who has been investigated for fraud, waste and [intervenes]

DR NHLAPHO: That's the purpose of the unit.

ADV WILLIAMS: Ja.

DR NHLAPHO: I mean it's a, that is when I give you my, the objective of the unit it's a unified approach.

ADV WILLIAMS: Yes.

DR NHLAPHO: Which involves everyone involved in the, in the unit itself.

ADV WILLIAMS: Then I presume what I'm summarising is uncontroversial so and just facts.

DR NHLAPHO: Ja.

ADV WILLIAMS: So my question then is so you do name the providers, so then there's this network that has the names of providers across the network who are being investigated. Now what do the, what does the network do with it? Do they, do they treat that as a red flag and then investigate themselves?

DR NHLAPHO: Yes what happens is you know when we

share the information like when, when scheme A brings something that they've picked up with the, a certain provider. They just give you a practice number to say this practice number we found one, two, three. Please go and check for yourself. What I think I've said it in my submissions, we, its totally unacceptable for any of the participants to come into the unit or into the meeting, get a practice number and just flag a person just from having heard his or her name or her, I mean the practice number in the, in the, in the meeting.

ADV WILLIAMS: Sure.

DR NHLAPHO: What that means is you must go back to your for-, I mean your forensic unit and do your own investigation on that particular practice.

ADV WILLIAMS: Sure. And from what I understand in the report, you can please correct me if I'm wrong.

DR NHLAPHO: Ja.

ADV WILLIAMS: You aren't, it's an investigation that's, is it the results of the investigation or the fact of the investigation that you are sharing with others?

DR NHLAPHO: It's an experience of a participant about that particular practice. If I've picked up, that I mean I'm receiving hotlines or this about this practice who I mean where members themselves are claiming that they've received remittance advices from the schemes and they never saw, they don't know that particular dot. So I mean as a participant will come and say we've

received these allegations please go and check if that's the experience you also you know getting out there. I mean and if you look at the, the, the, the undertakings that one goes through to belong to, to, to this unit I mean it's, it's, it's a whole list you can see. If, if you don't agree to any of these undertakings then you don't belong in.

ADV WILLIAMS: Sure.

DR NHLAPHO: And there's lots of confidentiality and respect for.

ADV WILLIAMS: Sure I'm just interested to understand how this works in practice. So just to go back to this, this question. When you share the information about the investigations you've given us examples where one investigation experience says we identified 59 days based on abovementioned assumptions whereby the service provider exceeded their available consulting hours. So is that a, was that a, is that a finding or is that an investigation? That's what I'm trying to understand. Is that a recordal of an investigation or was it a finding? That's the first question.

DR NHLAPHO: It, it, it's a trend. Ja it's a trend but let me just give you a perspective to this you know so that when I make an example then you understand. There are disciplines where procedure codes are time based. That when you use this particular code you must have consulted with that person for an hour.

ADV WILLIAMS: Sure I don't want to interrupt you because I don't want to be rude and be fair to you and tell you I am

also asking the question.

DR NHLAPHO: Yes.

ADV WILLIAMS: My concern is, my question is are you worried about a snowballing effect? And the accuracy, what is the accuracy of what is in this list? Because the, the concern would be that if the experience or the trend described here is then treated by your members as a reason to investigate people then you, it snowballs. If you get what I'm saying because those, those providers are then flagged as potentially problematic by your full membership, do I misunderstand?

DR NHLAPHO: No you misunderstand this way because I mean the purpose of, of, of that flagging doesn't mean it doesn't give anyone authority to, to go and flag. I mean you must go and do your own investigation yourself. It is only after you've done your own investigation where you can take a decision.

ADV WILLIAMS: Do, sorry do you know how the, your members use this information? I think that's probably the better question.

DR NHLAPHO: No I, I wouldn't, I wouldn't clearly say I know everything that they do with it.

ADV WILLIAMS: Okay.

DR NHLAPHO: It's just, you know it's just an alarm to say guys it's a flag you know watch.

ADV WILLIAMS: Sure.

CHAIRPERSON: I mean there are two ways in which you

can approach it. The one is what you are doing, which is red flags, let's guys everyone must be aware. The other is that I've investigated, and I found them guilty therefore you must know about you. What is the point of red flagging someone who has not been found guilty?

DR NHLAPHO: I think you know the, that's the beginning of.

CHAIRPERSON: Yes [intervenes]

DR NHLAPHO: That's the beginning of, of how we do things. You flag a person then you go, you go and do the analysis.

CHAIRPERSON: What's the point of telling everyone else? Because you yourself are not sure.

DR NHLAPHO: Ja but I mean to me it for, for the industry that's how we understand collaboration to mean.

CHAIRPERSON: No you can collaborate after you found me guilty and tell me that I'm a problem because you've satisfied yourself that I'm a problem.

DR NHLAPHO: From the beginning no one is said to, we don't make any allegations.

CHAIRPERSON: Yes [intervenes]

DR NHLAPHO: The flag, the flagging doesn't mean somebody is guilty.

CHAIRPERSON: But the fact that I.

DR NHLAPHO: It just means please go and check, I mean go and check your statistics and see if my experience is, is the

same as yours.

CHAIRPERSON: But what is the point of doing that? Whether you're saying to them about that person.

DR MOTHUDI: Chair can I come in please?

CHAIRPERSON: When Mr Nhlapho is finished you may.

DR MOTHUDI: No I just wanted to respond to that but.

DR NHLAPHO: I think what each scheme and what each individual administrator see is only a portion of their data. So it's difficult for them to make any conclusions or to easily come up to finality to say this person is guilty, like you are saying. So the point of flagging is trying to have a better view of the practice, the provider how he practices throughout the whole day. Because it's very difficult. You can say I have claimed four hours from you envi-, from my administration environment, yet the other administrators there. So the way the portal works it has various forms. The actual questions which can be asked of a provider but the reason for flagging is you only have access or a small view of what's happening because of the datas that you have available to yourself. If you could see what's happening all around it would be easier to come up with a conclusion and then get, get to that point.

ADV WILLIAMS: I take your point in relation to, I'm trying to understand your point actually and I speak out loud as I do so. The difficulty with I suppose, the difficulty about sharing information in this way is that the schemes, some schemes have big data, they have their own big data and they can use their algorithms to flag

practitioners almost blindly using you know whatever factors that they put into the algorithm or that are put into the algorithm. So that's relative neutral assuming none of the factors are race based. But where you are naming providers and their experience of them or the trends that then involves some human intervention and cross-checking and I'm just not sure that is as neutral in terms of how it's used as an algorithm you know one in one in a large piece of data, that's the concern. Because I am worried that real people will look at this and make assumptions around guilt in relation to it even though there's not a finding of guilt there.

DR NHLAPHO: So what is very important in our environment is getting to a point of guilt is so, so difficult. I think in the last presentation you will see that when Connie gives a representation and the difficulty is you saw the stakeholder map, it's very complex, there are many players and the funder is a third party who comes in to play and have a only seen, a small section. So even in our environment when we see a flag, we know that it doesn't really mean much until you've gone on to investigate. So the participation agreement is very specific to say you cannot go on and act and even the pro-, the users they know it when you see what we call an outlier it does not mean anything. All it means is you need to understand what's going on with the practice. Because getting to a point of guilt in our environment is very, very difficult.

CHAIRPERSON: Now you see the problem I think that's what we're trying to understand clearly about the use of this data,

with the names and surnames. I know that you feel names and surnames tells you nothing about race, but we can debate that later. But the point of it is that the name is now out and the person has been flagged. What schemes do from what we've been told, I mean they are still gonna come and explain is that on that basis of information they can trigger an investigation and once an investigation is triggered one of the preliminary steps is to block or put someone on direct payment. So it is not as if the information is neutral information that cannot be used. It is information that can in fact be used even as a trigger for an inquiry into that person's practice.

DR NHLAPHO: I think we are missing each other. From what you've just said right now I think that would be the whole point. The only thing is when you get the information it does not mean that you have to go and investigate. First thing is does it affect you, is the provider claiming in your environment or not, are you seeing the same trend? In some cases where we have been speaking to schemes, they actually say no this provider and this trend is not affecting us. It's not a concern to us, so it's quite a process for someone to actually end up being investigated. Being flagged on its own does not even give you any basis to go and investigate because if I was a scheme and I see that someone has been flagged I cannot take that to the provider and say you are flagged by that scheme so I want to start investigating you. It does not really work like that.

CHAIRPERSON: Ja.

DR NHLAPHO: There's no basis for anyone to do that.

CHAIRPERSON: This is the point Dr Nhlapo says they have no control over what the participants do with the information.

DR NHLAPHO: So they would have no basis because if the provider is not claiming from that scheme for instance the fact that is clear that he is flagged somewhere else, it does not give you any basis of investigation. What will you go to and say you have a done in the environment, or you cannot accuse him of anything? It is up to the scheme to check the trends that are being flagged.

CHAIRPERSON: Yes.

DR NHLAPHO: And verify if the same is even happening in their environment and then make a decision as to what to do. It is not like a flag is an automatic thing for everyone to start an investigation.

ADV HASSIM: Can I probe this from a different angle and that's from your standard operating procedure document. Maybe we can understand it through that prism. The first thing I, I would like to understand in case, in case I have misunderstood is each from you. HFMU is a collaborate effort, it's a place in which there's information sharing, in which patterns and trends are picked up and that permits all of the participants to refine their own processes of investigations, am I right on that? So schemes and administrators, individual schemes and administrators have their own.

DR NHLAPHO: Way.

ADV HASSIM: Investigative processes, it's not the HFMU that does it, it just an information sharing platform. The HFMU okay. So there's a standard operating procedure that you have right? And in your standard operating procedure under 3.1 you talk about the grounds for an investigation and you say before an investigation is started it is necessary to ensure that the investigation is reasonable. This is to ensure that innocent individuals are not investigated. Can you explain to me how that would take place? How would you establish reasonable grounds and how would you know that, whether somebody is innocent or not until you have conducted an investigation? I have several follow-up questions. So ja.

MS BAKKES: Chair thank you I think my colleagues are all looking at me once you touch the investigation field. On a lighter note trusting a blonde I am not so sure whether that was the best decision. Ha-ha. But I think Chair if I may I think what the problem is here is in terms of the standard operating procedure that was a recommended process that we developed over the years to our participants. So that we have had many complaints before in terms of illegal probing, illegal entrapments, we've seen the news, been there, done that, so we've actually required and identified the need to develop a process that we, it's, it's not an enforceable process, it's a recommendable process to our participants.

ADV HASSIM: I want you to continue and I want to cut

you short. I just want to ask in relation of your point to probes. Is it, are you saying there has been illegal probing and entrapment?

MS BAKKES: Allegations Chair so I mean I'm coming from sorry I need to say this, probably from a South African Police background, as well as an NPA background and 20 years' experience and 11 years' now in the health care environment. So definitely there was allegations, were allegations. If there's any happening now I hope and pray they not part of the HFMU division because it's not allowed in terms of the SLA agreements that we have signed now and developed and that is not recommended to our participants. So it is illegal for any HFMU participants to, to adapt any illegal processes like illegal probings and or entrapments and I think you will appreciate the word probing and entrapment is actually a criminal process in terms of the section 252(a)'s. So obviously you know we would not encounter in that processes and procedures and we would require our participants, participants to be complying to all legislation.

ADV HASSIM: And you're saying your, the participants at HFMU has signed a service level agreement?

MS BAKKES: yes.

ADV HASSIM: And with HFMU which [intervenes]

MS BAKKES: They do Chair.

ADV HASSIM: Have you provided us with the service level agreement?

MS BAKKES: Yes as part of our submission is.

ADV HASSIM: Okay so now I understand that.

MS BAKKES: It is.

ADV HASSIM: And I understand the standard operating procedures that are the guideline for your participants but what I want to know is, so if this is the guideline what happens if they don't follow this guideline?

CHAIRPERSON: Can you also explain what you do with people who have done illegal entrapment? We've had lots of complaints yesterday about people who were entrapped and illegal probes, people posing as patients, but it turns out they were probes.

DR NHLAPHO: I think we've never; we've never received any, any complaint of that nature from a, from a service provider or anyone towards or to a, a HFMU member. If that happens, I think we won't take it very lightly. We can even fire that person. We can fire that organisation from, because we don't want to be tainted. The reason why we went up, out there to draw up this standard process and ethics and conduct was for that reason to say if you, if you want to belong here you sign here you belong, you live by the bible that we all live by. And I mean, I think we, I think BHF has gone you know, has gone to an extent to make sure that all these guidelines that are here, are within law. That it has been, I mean it has been tested by the independent legal firm to make sure that all the things that we say in here can stand legally.

ADV HASSIM: Thanks I presume that if you do come across those allegations here, you would investigate them, if it is in

relationship to your [indistinct].

DR NHLAPHO: Yes.

ADV HASSIM: If it's in relation to new participants.

DR NHLAPHO: Without doubt.

ADV HASSIM: In 3.2 of your standard operating procedure you, it states that the investigation must be conducted in a short, in a shorter period of time as possible especially in cases where payment is suspended. So these guidelines anticipate a scenario where payment is suspended to a service provider whilst an investigation is ongoing. What do you understand by this phrase you use payment has been suspended? Do you understand it to mean that the health service provider is no longer receiving direct payment and that payment is being made to the members rather? Or, do you understand it as payment is suspended meaning, meaning it's blocked, that that service provider blocked. How should we understand that phrase in your guidelines?

DR NHLAPO: You know, I mean, I think to the panel lets go back to the CMS's earlier, you know, submission. The payment, I'll tell you of what my thinking and my sharing with my colleagues within the HFMU is. When it comes to the, paying the service, I mean, paying the provider or the member within seven, I mean, within 30 days. If there's a reason from the fund that you believe that all is not well with the behaviour of the practice, it doesn't mean payment mustn't be done. The payment must be done to the member. But in the main what we've experienced is the providers

are the ones that come and say please, go through with the investigation, don't pay the member, wait for the investigation, just do your investigation expediently so that we can sort it out. That's the request that comes from them. Because once you pay the member the next stop is Pick n Pay, they never come to the doctor to pay the doctor.

ADV HASSIM: So, when you use in your document suspension of payment you are talking about suspension of payment to either the provider or the member?

DR NHLAPO: Yes.

DR MOTHUDI: I think another, can I, can I just say. One of the elements, I can't remember the section. That, I think it is still 59 I don't know which sub section. They are supposed to pay within 30 days. But if you find anything untoward you can then have a period of 60 days while you're investigating but after having notified the member and... (intervenes)

DR NHLAPO: And the doctor, ja.

DR MOTHUDI: So, in that space that could also qualify as suspension of payment.

ADV HASSIM: So, that would be an application of Regulation 6? That would be... (intervenes)

DR NHLAPO: Ja.

ADV HASSIM: Regulation, that's where you get that from, right. So, it's your understanding that Section 59(3) is to be read with Regulation 6? Is that right?

MS BAKKES: Chair, I would like to explain a little bit more in detail if I'm allowed to. So, we do come from the governance requirements in terms of where you identify any risk exposure to any fraudulent or waste and or abuse claims. Where the medical schemes are then required to mitigate that risk. Part of the analysis, the data analysis, and we're going to touch on the investigation side thereof. Part of the data analysis. So, we find two processes when you conduct the data analysis where this information comes to your knowledge. So, if either claims that have already been paid, where we then only have Section 59(3) to recover whatever funds we then identify to be fraudulent. And or some of those claims are in process of being paid. So, obviously to manage our risk exposure we would place a hold on that claims, but then that is where Regulation 6 come into as we are obliged by law to pay within 30 days. So, Regulation 6 would require us to then to serve a notice to our service providers and or members. And require them and inform what we are busy with. What we found and give them the opportunity to explain... (intervenes)

CHAIRPERSON: Respond.

MS BAKKES: ...to respond. And then, I think that is where Dr Mothudi then mentioned then we have another 60 days period for them to respond and for us to finalise our investigation. And then, to release and pay and or to take them on whatever punitive measure the medical schemes or the administrators have in term of then their forensic findings. So, I think you can combine

combine regulation and 59(3) in terms of claims already paid versus Regulation 6, *ag*, section, sorry, Section 59(3) versus Regulation 6 which we requires then claims that's still due to be paid. I mean, there's no ways that a scheme may release and pay claims if they have a suspicion that there's fraudulent based and or abused claims. I think that would be gross negligence or, from their perspective. So, I would like to explain then that process in terms of how we then place claims on hold. Blocked, Madam Chair, so you used the word blocked. I know of experience and of information... (intervenes)

ADV WILLIAMS: I'm going to interrupt. When you say we, you, I'm just getting kind of confused here. Because... (intervenes)

MS BAKKES: Chair, from HFMU perspective. So, I'm... (intervenes)

ADV WILLIAMS: So, but you aren't a medical scheme or administrators.

MS BAKKES: I'm HFMU. So, from reports that we receive. So, I'm with HFMU since 2008.

ADV WILLIAMS: Sorry, but you're describing the Section 59 and Regulation 6, I don't understand HFMU to be implementing those sections.

MS BAKKES: No, not implementing. So, the... (intervenes) ...standard operating procedure was drafted based on that information on... (intervenes)

ADV WILLIAMS: Okay, thank you. Thank you.

CHAIRPERSON: All right, can we, let's move on. I think, Dr Nhlapo, you still have points to make and then if you do maybe... (intervenes)

DR NHLAPO: No, I think I was going straight to, to my ANNEXURE C on the portal.

MR SHELTON: Ja. Thank you, Chair. I'm going to give you a summary of how the portal works. I think we've already described it. So, there are several features. In terms of the information -- I'll start with the data analytics. When a funder tries to detect fraud, they look at their claims data and this links into what was, what we presented earlier around the coding. Some codes have to be consistent with the, the ICD claim code has to be consistent with the procedure codes. Some procedures are imposable on (indistinct) and some procedures are imposable on young children for instance. So, schemes can actually deploy some analytics. They can do some trend analysis.

There's some providers who decide they may become busy one specific day of the week for instance. That would just be an outlier, it's unusual behaviour. And then, using that information they start asking questions why is this happening and so on. But it does not really mean that they've started a full-on investigation. It's just understanding the trends that the data is showing you. Then, there is an element of data sharing, where you actually share simple data across multiple funders. Like administrators can combine data from several schemes and pick up wider trends as opposed to smaller

schemes where they do not have a big data set.

So, like you were mentioning, with the bigger data set your capacity to identify fraud or outliers increases. But as long as you don't have a full data set, you are always limited in terms of what you can pick up. If a provider is out to defraud schemes, you can actually design and do false claims in a way that you know all the funders will not will pick you up. I'll do just enough to make sure that this administrator will not identify me as an outlier. So, it's important to share data so that funders are able to pick up all these trends across various claims submitted by almost all industry participants. My next slide actually talks to the type of information which is sent on HFMU. So, there are generally three categories.

There's one where funders share information on completed cases where they have conducted a full-on investigation and they've come onto a conclusion. They can share the information with other funders so that as they are processing their claims, if the same way of defrauding the scheme starts happening in their environment, they're able to pick it up collectively. So that at least you don't have to exhaust resources doing the same investigation from all schemes every time, that would, that is the whole point. And then there's notifications.

Where funders may pick up some trend which are funny, maybe abusive, not necessarily fraud. Where they can verify with other funders is this what is happening in your environment. Has anyone ever investigated this and actually come up with an

explanation of what's happening? And the other one it's where they can ask each other questions. I think we had one case where one funder asked whether a certain beneficiary was registered on any other scheme because there was some missing information. So, the way the portal works it's almost a platform where funders are able to help each other in terms of fraud waste and abuse. And it takes away the duplication of effort. It would be very costly for the industry to try and do all these detection and analysis at each funder. So, the portal actually aids that part. Then, we did talk a bit about the legal opinions. The HF went to length to try and look at whether... (intervenes)

ADV WILLIAMS: (indistinct).

MR SHELTON: Yes.

ADV WILLIAMS: (indistinct). Just to match what you're saying in your slide presentation. If you wouldn't mind going to the previous slide. I just want to match what you're saying with the documents we have before us. So, you've provided us with a alert email. It, and we chatted about it already, but it only seems to provide sections for the investigation and notifications.

MR SHELTON: Yes.

ADV WILLIAMS: So, am I correct this alert goes out with just the notifications. In other words, just information to other funders on the trends.

MR SHELTON: Uh-huh.

ADV WILLIAMS: And investigations which is something

different which is about the investigations currently being undergone by your members that is being shared. Is that right?

MR SHELTON: Yes. So, there are two types of reports that are sent out to members. So, the, an alert it's just is there to notify all participants that there is some new activity on the portal. And then there is regular reports which are more comprehensive. So, what you have is an alert. It just means, what tells me is it was generated after something, some new information was loaded on the portal.

ADV WILLIAMS: And so we don't have a copy of the regular reports which are sent out. Is that correct?

MR SHELTON: No, we didn't get them.

MALE SPEAKER: No, but I'm told it's not... (intervenes)

MR SHELTON: You can. ..it's not, it's not being submitted... (intervenes) You can get it. ...but we can submit one.

ADV WILLIAMS: Thank you very much, we'll follow up on that.

MR SHELTON: Okay. So, some of the legal opinions that we have got relate to competition law. And the question is, is the sharing of such information uncompetitive? And the legal opinion that we did receive was it's fine, especially because it's open for everyone to participate. And what you are trying to do is actually in the interest of promoting efficiency in the industry. And then in terms of protection of personal information. This relates to the provider information because that is what is mostly shared.

We also got an opinion that the way we have structured the HFMU and how it works, it's also fine from that standpoint of view. And these ones can be provided if, if required. Then, Dr Hleli mentioned a lot about the participation agreement, so it's not a loose environment where people will just come, and they can irresponsibly use the information. We are very strict on how people use the information on the portal as explained earlier on. So, I won't spend much time on this slide. Just to add that there are some schemes which do provide data.

We've also signed an NDA in relation to how that data is used on the portal. I'll talk more into that. So, the portal is deployed in two phases. The first phase is just sharing of information. So, this is the information which I did discuss. And what the portal ends up looking like it becomes a library because there are so many notifications about several cases that are loaded with details as to what is happening with specific providers. So, it makes it a bit difficult to use for our members, hence the genesis of phase 2. And phase 2 seeks to be also more proactive in that it tries to identify trends. Not when someone has really picked up something wrong. Because it has got a data analytics element and it's also linked to phase 1.

I will take you through the data that I'm talking about. So, this data it relates to a specific activity of each provider on a single day. And the whole idea from getting this data is seeing how busy providers are in a single day. From a more consolidated data set

rather than looking at data which sits in one administration platform or one small scheme for instance. So this is the way we explain it. When a scheme looks at its own view it only sees the tip of the iceberg. So, they can do so much analysis, but it's based on a very small data set. When you combine it you are able to see the whole iceberg.

So, when you pick up your outliers it's more accurate and it's more informed from the data sharing. And this data sharing it's linked to the cases which are loaded just to help someone using the portal to see what is relevant to me and what is not relevant. Because there are, providers do not claim from all seven claim schemes. They claim from certain schemes maybe because of location of the provider and where the members are. So, the notifications and the cases which are loaded, all of them do not relate to all funders. There are some which are specific to certain schemes.

So, the sharing of data also enables the funders to identify what you call the network analysis. Where we are able to pick up beneficiaries who are actually working in cahoots with fraudulent providers. Which is a bit useful because it's difficult to pick it up from a small data set if that is happening. But when you have a bigger data set it makes it easier for schemes to pick this up. And when they do, they investigation they're a bit more pointed. So, going back to the point which you've raised earlier, it's not about us doing the investigations, but it's just us facilitating that process to

say if there are any red flags it should be raised, ja. At least with a bit of more signs. Much like the data set so that the investigators can go and put their efforts where they are more relevant.

So, there are, there are reports which are provided which you have mentioned. And these reports provide almost a summary of what has been happening and they are tailored to each specific scheme so that they know where their highest risk lies and where to place more efforts when it comes to the investigations, especially for the forensic unit. I think my presentation is done. I will have to hand over to Connie.

CHAIRPERSON: Thank you. Just, this is something called fraud alert. Now, it's a HFMU alert report fraud waste and abuse. Is this what, I mean it contains both notifications and investigations. Would it be a typical alert, it would be in exactly this format? It's ANNEXURE C.

MR SHELTON: Yes, that’s correct.

CHAIRPERSON: All right. I mean, this is what I would receive as a participant to the portal?

MR SHELTON: Yes.

CHAIRPERSON: All right. Thank you. What, what's the position now, Dr Ndlovu, are we, who's next?

DR NDLOVU: Connie is the next.

CHAIRPERSON: All right.

DR NDLOVU: And the last.

CHAIRPERSON: Ms Bakkes.

DR NDLOVU: Ja.

MS BAKKES Chair, thank you. Yes, this is the most difficult part. And just, maybe just to inform the panel that this is a very high-level processes that the HFMU has and actually developed and that form part of our standard operating procedure. So, what we will present to you now is more of our experience coming through all these years in the HFMU and receiving all the reports and the facts that we receive. And then, just also to inform the panel a little bit more in terms of how the processes, the investigation processes are being managed within the healthcare industry.

So, then I'm going to start off with what we then call the preliminary analysis process. And then, obviously, the data analysis reports is a preventative measure. So, we have various prevention strategies that form part of your governance procedures. Obviously, you would know that the medical schemes as any other company in South Africa are governed by legislation to manage fraud and defraud and corruption policies, processes and prevention is part thereof.

As a prevention strategy then we develop this data analytics reports. It's a fact throughout the years that where a scheme would be defrauded by a service provider where we would then place that provider on hold and investigate the provider. Obviously, that provider makes his bread and butter from the fraudulent activity and then he would move on to other schemes. And we found as the

processes that the other participants then would be hammered in terms of fraud waste and abuse if we do not share this information. So, the sharing of information was actually also a prerogative or a strategy that came from SABRIC, the banking industry. Where they have their data portals, where they share their banking accounts, identity theft accounts and information like that.

So, within the healthcare industry we identified this need to create this data portal then. Where we share this information so that where we, some of our schemes identify the fraudsters it's a fact that it's, you know, that they would move on. We call it actually migrate to other medical schemes and defraud those medical schemes.

CHAIRPERSON: How is it perpetrator trade are identified?

MS BAKKES Chair, so obviously through various processes. So, we've got the data analysis processes where the medical schemes, especially the bigger medical schemes and or their administrators actually purchased software. We call it the healthcare claims data analysis software that we have. Very expensive software that we purchase and use for data analytics. And it would actually compare service providers against their peers. It would compare providers geographically. It would compare providers within the same disciplines. And then these software would actually, as Shelton has identified or informed the meeting that they would identify your high-risk claimers. And from our high-risk claimers that is where we would then conduct a preliminary investigation.

CHAIRPERSON: And how is that software populated? I mean, presumably, if you say that it will produce comparison on a geographic same discipline. So, it is populated by some data.

MS BAKKES It is, Chair. So, obviously, it's the claims data of the medical schemes. Shelton already also explained that where you analyse the claims data of one scheme you can only see the claims of a provider from within one scheme. If you combine the claims data of 15 medical schemes, you can actually see the *modus operandi*, the conduct of that provider over 15 schemes. Then, obviously, it would identify the very high-risk claimers through that processes. I hope and pray that our medical schemes and or their administrators will bring specific cases to this, to this investigation panel. So that you can actually see that exact examples of their profiling reports which is very interesting for you to see. Thank you. Chair, can you just... (intervenes)

CHAIRPERSON: And who can give us those?

MS BAKKES Sorry, Chair.

CHAIRPERSON: You say we should ask the schemes, I thought it's one of your...

MS BAKKES They are, Chair, but we haven't prepared any examples. So, as of the HFMU I think we would be overstepping our boundaries. So, we would rather give it to our participants to provide such reports to the panel. I think it would be also better to, to hear these reports first-hand than secondary information coming from us. Chair, thank you. Then the preliminary

analysis process, you've asked how we identify. So, it's either through whistleblowing, hotlines, through this analysis methods that we have. The data analysis software is a very mathematical process. Where it actually compares values and claims and the amount of hours, Dr Hleli also referred to the hours available per day on the service providers.

And then combining all the scheme's information you can actually see how many hours this provider is claiming for. Some of these providers would actually render, I mean, 48 hours of services in a 24-hour day, which is really impossible. So, you would see the trends from all of those data analysis processes that we have. And it is all forming then of how we institute this investigation. So, you must remember that claims payments are electronically through EDI system and we are talking big data, huge data claims that's coming in per day per provider per member per medical scheme, etcetera. So, it's really, claims are paid within 30 days.

So, we pay claims believing that it is honest and true and that it's legitimate claims. So, and that is exactly, it's only through these prevention and or identification prevention strategies where we then identify high-risk claims. When and if we identify these high-risk claims, that's the first time where human intervention then actually comes into. So, only if and when the high-risk claims are identified. So, the human intervention is actually the amount of high-risk claims information that we receive per day. Unfortunately, it does not allow us sufficient time to investigate everything and all that we would like

to investigate.

So, sometimes I realise that, you know, we wish we can extend that 30 days to 60 days, you know, just to give us more time to make sure that the claims that we pay are valid claims. But then within the preliminary analysis process we have data analysts and they are expert forensic data analysts and paid quite high salaries. Wherein they conduct the human intervention that we talk of. And where they then identify or analyse the claims behaviour by these high-risk claimers. The data analysts would actually create their findings reports and the findings reports would identify the erroneous and or irregular claiming patterns, Chair, which was referred to initially.

So, I remember in the 2008, 2009 period it's only soon thereafter where we developed a definition for fraud waste and abuse. And previously, and I think with the regulator that drafted the Medical Schemes Act at that stage the only terms that were used were irregular and or erroneous claims. So, I don't think that there should be a discrepancy in terms of what they actually refer to as erroneous irregular versus fraud waste and abuse. I think that they, the regulator, the writer of our legislation actually implied that whenever a claim is invalid that that would form part of irregular and or erroneous claims.

And as we have recently defined it with the part of fraud waste and abuse. When our data analysts then compile their data analysts reports, they would also establish the monetary value which

is very important for us. I would like to touch the soft, medium and hard cases a little bit later. But then in terms of our punitive measures that we then take thereafter, it would all depend on the monetary value of our cases after that analysis report has been drafted. Establishing the *modus operandi*. Chair, you have asked the types of trends and cases that we face, and I've listed a few here. And I do apologise our training normally is a day long and I was told that unfortunately you do not have a day for this presentation. But I've quickly listed a couple of the *modus operandi* matters that we are currently faced with.

So, first of all and very known in the field is the cash and or the groceries that's issued by service providers. Our members would actually walk in and receive cash and or they would buy groceries. And whereas the service providers would then put claims to the funders and claim either for consults and or for medicines issued. They would buy groceries at pharmacies and they would put in claims as if medication was issued. Another *modus operandi* method that we have is where they would claim for services, but none of that services were actually rendered. And my colleague next to me is actually from the dental discipline.

So, where he would actually find where the providers would place gold into our members' teeth and obviously, we do not pay for gold implants we only pay for the dental processes. A third *modus operandi* matter that I've actually identified or that I would say that is more of a priority trend that we're facing, is duplicate claims where

they would merely change the date, or they would change a dependent code. It's either the member or the wife or the children's dependent code. Or they would just change the type of service that was provided.

So, they would maybe claim multiple claims on one person that they actually saw. The fourth trend -- please stop me, Chair if you want some more or more explanation on this. I'm going to highlight just quickly. We, it's a trend that we call upcoding. We find that especially where they distribute medication where they would actually distribute Disprins, but would claim Comprals from us. So, it's what we called upcoding. So, they would claim the more expensive product, but then actually distribute the least, the lesser value of medication. Chair, the fifth one I need to make to mention of because coming with the NHI I see this as a huge risk to the whole of South Africa and this is actually where we are dealing the boot-stock sales. A boot-stock is actually referring to a car, car as a boot.

So, the trend that we see is where the syndicates would actually purchase or buy up expired medication from government hospitals, from pharmacies or whatever, it's expired medication. They would actually repackage it. Would actually repackage it and redistribute it. Medication is legislated by the Medicines Act and distribution of some of these medications is legislated and you need to keep book and records thereof if and when you sell this. So this is what we're calling boot-stock sales where they actually then

distribute expired medication. I can name a couple of recent investigations that we were informed of on the HFMU floor. We have a recent case of an occulist which sells prosthesis eyes from the boot of his car.

So, Chair, you would realise that this is a surgical process and that would requires you to go into a theatre to place in a prosthesis eye. So, but this specific person is actually selling prosthesis eyes to members from his boot. Chair, I'm not so sure, there are many examples, but you can just imagine what we are faced out there. And this small number of human intervention investigations it seems small and insignificant, but the monetary values thereof is very high to medical schemes and the risk exposure. And then, I think that our investigation processes are limited, and I would like to go, if we're finished on this one, maybe to the full investigations and to tell you a little bit about the challenges that we face in the field.

ADV HASSIM: Thank you. This is very illuminating. This is out and out fraud within FWA. So, as a percentage of all your investigations what would this out and out fraud constitute? And sorry, and the other thing is that... (intervenes)

MS BAKKES Chair, ja.

ADV HASSIM: ...I want to just, so, and you made a point about the monetary value. Are you saying that while this might be a small percentage of overall FWA, the monetary value of these, these examples is a lot higher than what is lost through based, based and

abuse?

MS BAKKES Chair, I'm going to give you my honest opinion because, and I'm talking from experience in terms of only 11 years in this field. Any statistics provided to this panel I think would be thumb-suck. Because the statistics that we provide you are actually the statistics identified and comes from historic analysis and or historic experiences. But how do you know whether you are defrauded or not? How do you know how much your fraud exposure is? And how do you know if you close one risk gap or *modus operandi* trend how many other trends there are not. I mean, talking about... (intervenes)

ADV HASSIM: (indistinct) relate to whatever. I'm just saying off a hundred investigations, how many would there, of that how many would be of this type? How many would result in findings of this type of fraud?

MS BAKKES Ja, I'm going take, I'm going to... (intervenes)

DR NHLAPO: You know, it's quite a challenge to give the exact, the exact figure. Because I mean we, I can admit that we, it's a big challenge to quantify the, I mean, the monetary value of fraud in South Africa. You know, considering all the limitations that we have. But maybe I can share with you, I happen to, with Dr Mothudi, we went to France last year to the European Anti-Fraud Conference. I'm just going to read for you so that I don't miss anything. It's just a one, one paragraph:

"Fraud affects every country and every sector. According to PKF in the United Kingdom financial cost of healthcare fraud report of 2011, the results collated over 12 years from across the globe show that $415 dollars US, that is over 4 trillion, 4 trillion is lost through fraud. This would be enough to provide clean safe water around the globe, bring malaria under control in Africa, provide diphtheria and or, tetanus and petasos vaccine to 23.5 million children under one year old who are currently not immunised. Quadruple the budget of world health organisation and the United Nations Children's Fund with a surplus of over 320 billion."

That's how, how big this is. Unfortunately, I'm quoting statistics from countries that have done so much work on the subject than where we are.

CHAIRPERSON: So, I mean we do have an estimate of 3 to 6% of the entire FWA that is attributed to fraud. So, perhaps you could take us through. I just want to understand your modality of how you do an investigation. I think you were going to take us through that, to those steps, ja.

MS BAKKES Chair, thank you. Chair, thank you. So, so I... (intervenes)

ADV WILLIAMS: Just to be clear, not to interrupt but you're speaking on behalf of kind of, on your knowledge of the general practice in the industry, particular your membership, is that right? When you describe these modalities.

MS BAKKES Chair, no, it's actually as part of HFMU and the data and information we share.

ADV WILLIAMS: So, HFMU itself is conducting investigations?

MS BAKKES No, no, not conducting investigations, Chair.

ADV WILLIAMS: This is what I'm asking, sir.

DR NHLAPO: This is the information that comes through when we, you know, we collate information. It's not to say we are actively doing investigations. This is what the members bring back to the... (intervenes)

ADV WILLIAMS: Ja, the evidence that Ms Bakkes is giving goes to how investigations are conducted. So, I'm just trying to understand where she gets that information from. So, is it from what you know of your... (intervenes)

DR NHLAPO: As I said.

ADV WILLIAMS: ...how your members are conducting investigations?

DR NHLAPO: As I said, Chair, HFMU is made out of

medical schemes, administrators, managed care companies. So, the representatives that you see here that represent HFMU, except the BHF officials, come from medical schemes, they come from managed care, they come from administrators. So, we've got all, all of us within HFMU we've got our personal experiences that we can share. This is what she's trying to do now.

CHAIRPERSON: Right, thank you. I mean, we can take that this is the model of how it should be done. And then, whether schemes deviate from that we'll deal with that under schemes. But I still want you to explain to us how exactly it is done.

MS BAKKES Chair... (intervenes)

MR SHELTON: Chair, sorry. Can I just come in to explain? So, Connie does the trustee training for BHF at Wits on fraud waste and abuse. She's also part of HFMU. So, we think that some of the information that she shared for the trustee training will be quite relevant for you. So, she's speaking from experience of having gone through the investigation process and she... (intervenes)

ADV HASSIM: We're not questioning that, ja.

CHAIRPERSON: No, I mean, no one says that says that she's not, she's not an expert. We... (intervenes)

MR SHELTON: I'm just explaining why she's here and why she's giving that talk on behalf of HFMU.

CHAIRPERSON: All right. Thank you very much that's helpful. Perhaps we should now get to the heart of the issue.

MS BAKKES Thank you, Chair. So, it's clear that I'm not the expert.

CHAIRPERSON: Ja.

MS BAKKES Just the information carrier. Chair, thank you very much. So, just to, before I finalise preliminary analysis. So, to us after we've developed this findings report based on the findings that we have and remember that's the very first stage. If and when we come to our knowledge that something has taken place. From this findings report, and the best way that I could explain this process followed from here after is to try and explain to panel that we then divide these matters into soft, medium and hard matters.

And I think the metrics, there's no metrics in terms of what is soft and what is medium and what is hard but I'm going to try and just place it how -- and it would, it would differ from scheme to scheme and I think from administrator to administrator. But then, in terms of our standard operating procedures and as our discussions goes and explanation goes in the HFMU. So, what we've defined the soft cases then to be are the first-time offenders or transgressors, not offenders, please don't get my word wrong there. It would be first-time transgressors, small values, human error, administration mistakes. It would really be the very smaller group of involved service providers.

Obviously, our response methodologies to this group would be more a softer approach if I may then use that same term. And

then we would group the medium transgressors, would be maybe a second-time offender, still a small monetary value involved in the audit findings. You know, it would depend on the disciplinary and or the *modus operandi* that was used. Obviously, we will not accept any fraud as either soft or medium transgressors. Fraud, in terms of this country and I think in each and every scheme and as well as the Medical Schemes Act has got a zero tolerance for fraud policy. So, we would definitely regard fraud then as your hard transgressors, your hard targets.

So, obviously, our response methodologies against your hard targets would be much more detailed investigations. So, and that thing carries me to my next slide in terms of the full-scale investigations. So, obviously, we cannot be seen to waste time, effort, resources, money on either soft or medium targets as the actual full investigations of your hard targets, your criminal cases, and I'm going to come to the details required if and when we go the criminal route. It's of, to such an extent that it takes a lot of time, a lot of effort and a lot of resources to actually then go into your full-scale investigations. May I continue... (intervenes)

CHAIRPERSON: Yes, please.

MS BAKKES ...Chair? Thank you. So, obviously, if and when we go into our full-scale investigations it would be those perpetrators or transgressors that we've identified where we have fraud, clear fraud involved. The data analytical processes are of such nature that they can identify pure fraud from the beginning.

And those are the cases that we would then immediately go into our full-scale investigations. And I really hope and pray that our medical schemes and their, and or their administrators will bring some examples to you in terms of such hard reports that they then draft. But, Chair, obviously the full-scale investigations, and this it cold involve not just service providers but also members and or internal personnel.

So, where you have these full-scale investigations your investigation methodology that you would then take on would depend on your *modus operandi* and your involved perpetrators. So, obviously, if you have internal personnel involved, we would have as part of our full-scale investigations obtain our personnel files, the job descriptions. You know, the, if there's companies involved the company's registration details. Credit records is important for us because there's a motive behind the conduct of these transgressors. Criminal records also very important to us. You can imagine what a process and time it will take to gather this type of information that you require for a full-scale information, *ag*, investigation.

Then, Chair, further processes would then require field investigations. So, we have clarified and cleared in our standing operating procedure how, and that’s a recommended process, how we would like our HFMU participants to act ethically within the legal requirements, within the criminal processes and procedures. And that standard operating processes is exactly drafted for that

purposes. Where we then prescribe and or recommend what we regard as ethical conduct during these investigations. The physical evidence that we obtain, Chair, so I've identified to you the example of this occulist with the prosthesis eyes.

So, you can realise the need for the patient files. Because if he actually provides the services from the boot of his car, how good is his patient files, how good is his administration processes. So, there's a reason, a legal reason why would want these patient files, why we would want proof of the services delivered. And that for the reason is either to validate the claims to see whether it's either valid claims or not. Chair, I would like to say that in some cases and instances we were actually provided with patient files, with proof. And then obviously the matters were closed. And none came from that because even where the proof is being provided then no further action is required. It's not everyone that always ends up in the criminal court.

So, it would depend on whether they cooperate and work with us in terms of to validate the claims. Validation of claims is a governance requirement by the board of trustees which are empowered and then escalated then down to its, the schemes management. And obviously then that's the reason why we have forensic investigation firms and or the administrators that does this type of investigations. And it requires an experienced field of skill to investigate healthcare fraud related matters. I come from that area, I had 20 years of experience and I need to tell you this, Chair, and I

unfortunately walked into, first time in the healthcare environment and they were talking HPCSA, AMCS and ICD (indistinct). And the language that are used in the healthcare environment is such a closed language that within the SAPS environment and the NPA prosecution environment, it takes quite time for us to explain our matters to our investigators in the SAPS environment and the NPA environment for them to be able to prosecute our cases.

The collusion between member and providers actually complicates our investigation extremely. Because it's very difficult to prove the non-service provider, especially if they collude together and say that it's actually being provided and or they confirm their services and or services rendered. So, you can imagine how difficult it is for a full investigation to actually be completed and to be ready. So, Chair, I mean fraud, we all know it's, you need to prove the elements of fraud, the intent. You need to prove intent. You need to prove it's illegal. You need to prove the value of a case whether it's a potential value, obviously, and or actual value.

So, actual value would be where claims are already paid, and losses sustained. Potential values would be where some of those claims which has not yet been paid and we have placed it on hold, that would be the potential losses sustained. We have challenges in the criminal registration area in terms of the jurisdictions, where do we report our cases. So, we are referred hence and forth from station to province to station because where has the fraud actually been committed. By receipt of the administrator, by the scheme

where the scheme's head office is or where the service provider's practice is. The problem is, is where the service provider is providing services from the car of his boot, how do you identify the police station where you report your cases?

And then we have further challenges in terms of the monetary value of our cases. So, you would know that the districts court has got a limit of the monetary values versus the regional courts versus the high courts. So, and in terms of the monetary values of our cases, so we had this debate with the NPA for ages in terms of a charge would be a consultation R350,00, R400,00 or are we allowed to put all the claims and monetary values together. And can we say, okay, it's 4 million, 5 million please can we go the high court.

So, we have many challenges in the field of reporting criminal cases. And then, up and above these challenges the skill and experience by our SAPS police investigators are our biggest challenge currently. As the investigation you would regard that we do data analysis and we do the data analysis reports but we're not allowed to conduct an investigation on the police's behalf. And where you have this, exactly this occulist trend that we face here, further investigation is needed. Maybe cameras, maybe video cameras, definitely maybe a probe or an entrapment and that would require a Section 25(2) process through the police. For them to understand our healthcare environment, it's very difficult to explain to them, you know, what is requirement in terms of these full

investigations.

Chair, I'm thinking, I haven't noted everything down. I'm not so sure, we also, I've said we have polygraphs and fingerprints there, that would be where we have internal personnel involved. Access to certain areas which is not allowed. We, a delegation of powers in terms of we had an internal employee many years ago. Reported at the HFMU who lifted the hold, *ag*, who lifted the limits, the benefit limits on a specific benefit for a period for a friend of his to put through his claims. So, you can imagine if you lift the benefit and then put the benefit limit back, so it's an IT required process where you need to have all of the IT specialists extracting that information as to who accessed or when accessed or when the hold was lifted and when it placed back.

So, it is very time consuming to do the full investigation processes. And unfortunately, Dr Mothudi there successful because you see that there are successful cases part of the HMFU reports as well. And maybe, Chair, if we have had four or five successful cases in this year it would be a overstatement. Our cases take extremely long, especially if and when it reach the prosecution stage. Postponement after postponement, I think there's nothing new to the challenges... (intervenes)

CHAIRPERSON: What's (indistinct) of an investigation between the time you start. I mean, there are two periods. There's one where you start your own until you've got enough of a case to prosecute it.

MS BAKKES Case, yes.

CHAIRPERSON: And then there's the time after the NPA, then no one knows what happens there. It... (intervenes)

MS BAKKES Chair, if I may, I may but, may I name two cases but, I mean, this is from my own personal experience. We have a current case where the bogus doctors were involved. Our doctor appointed two overseas doctors, not registered at all and they practiced from his rooms. He himself pleaded guilty. Even with the guilty pleadings it took us five years and we were in Garankuwa court based on the logistic area where his practice was established.

CHAIRPERSON: Yes.

MS BAKKES And he was sentenced, and part of his sentence is to now witness, testify against the two bogus doctors. Unfortunately, he did not adhere to his penalty. And so, we rearrested him again.

ADV HASSIM: When, when was the re-arrest?

MS BAKKES He was rearrested June, July, June, July and now we're appearing in court again. So, but within that five years of case postponements I closely appeared in Garankuwa court between 20, 25 times. So, you can imagine if you take your investigative, your experienced data analysts and they're very highly paid people from their daily work to appear at these court proceedings. It's day after day, postponement after postponement, it's huge. Up and above the criminal investigation required from SAPS. We had a matter that was reported in 2013 to SAPS, it's now

2019.

The doctor actually provided us with an affidavit of his own where he admit that he paid members cash, 72 members involved. And the investigation to obtain and finalise the chain of evidence, he even provided us with the deposit slips how he paid these members. So, you can imagine it's bank account details everything that's required to complete the chain of evidence. So, since 2013 the investigation is now being finalised and were going to go to the NPA only this year. So, even the criminal investigations sometimes takes three, four, five years to obtain everything that's required to prove healthcare fraud. It's not as easy as everyone thought. I mean, the commercial crime units are very skilled investigators. Unfortunately, that is where I come from.

So, when I entered the healthcare environment it's a different ball game in terms of what is required and the processes skill and expertise. That analytics is not an understandable trend within the criminal and prosecution aspects. So, if and when we have data analytics report we also need to explain to our prosecutors in terms of how did we come to those findings. I'm told that I'm already saying too much, Chair.

CHAIRPERSON: All right. Thank you. No, I still want your SOP because what's important about it is that we need to be able to say to schemes that this is the recommended SOP. We want to know if there are variances with it. So,... (intervenes)

MS BAKKES: Only one.

CHAIRPERSON: But we, I think you've submitted it, it's somewhere here.

MS BAKKES Yes.

CHAIRPERSON: Yes. All right, that's wonderful. So, that's the SOP for investigations.

MS BAKKES Yes, Chair. We... (intervenes)

CHAIRPERSON: Now, just tell me something. At what point now do schemes suspend membership prior to the completion of the investigation?

MS BAKKES Chair, suspend membership?

CHAIRPERSON: No, I mean suspend, block the doctor or block a service provider. Suspend payments and benefits.

MS BAKKES Chair, maybe I should, if I can... (intervenes)

CHAIRPERSON: I mean, where does that feature in your SOP?

MS BAKKES There's a, yes, Chair, there's a difference between block, there's a difference between place on hold, there's a difference between are we leading to the response methodologies in terms of indirect payment and... Maybe I should continue with my next slide so that I can explain to the panel in terms of then the response strategies and what we then do in terms of that. Because it would explain to them on hold and block. If you would allow me, Chair. Thank you.

Chair, obviously, after conducting our analysis reports and or

our investigations, then based on whether we have soft, medium or hard targets the response methodologies would actually then prescribe in what processes the schemes and or their administrators can follow. And again, it would differ from scheme to scheme and or administrator to administrator. So, what we would see is the administration action and that's the acknowledgement of debt, Chair. So, we've heard the Council of Medical Schemes stating this morning that there's nothing forbidding medical schemes and or their administrators to have an acknowledgement of debt.

In my view, and I think from the HFMU perspective we regard this as a, and let me just continue. As a contractual commitment I would say because it is in writing. It would be a contractual commitment that we would obtain between provider and the medical scheme and or their administrator involved. And the purpose for this acknowledgement of debt, the main purpose for this is to recover the funds. And I would like to compare this to the trust account of an attorney. I mean, if any of the trust account's funds are stolen your main purpose is to recover the funds. You can see our challenges that we have in trying to go the criminal route.

So then, you know, there's very little other routes that's left for us. So, the acknowledgement of debt. Obviously, Chair, we absolutely do not, we're not -- how can I say. We don't agree that if they use bully tactics or enforce this process on service providers. That is completely unethical and unacceptable and the HFMU participants are not allowed to use that bullying tactics and or

processes. And in terms of acknowledgement of debt they can choose whether they want to have the Section 59(3) where we just recover then from any future claims and or whether they want acknowledgement of debt.

I have seen a contract of an acknowledgement of debt where they even take into consideration the National Credit Act regulations. In terms of how much you can afford and whether it's fine with the service provider and affordable by the service provider to pay back the claims. You can imagine if you have 2, R3 million of debt owed to a scheme based on whatever behaviour that, you know, you can't immediately pay that back. So, there must be some sort an agreement, a contractual agreement between the funder and the service provider.

DR NHLAPO: Chairperson, through you.

CHAIRPERSON: Yes.

DR NHLAPO: If I may just add before she passes on to the next item. In the main what I'm talking now or what I'm sharing with you it's fact. In the main what, what you see when you get to that administrative action is the provider himself or herself coming or asking for a meeting where he brings his legal representative or the association, the, I mean, the representative where he belongs. And it's them who asks for this, it's not the scheme. I've got several cases that I can share with the panel. Where it was the lawyer agreeing with the, I mean, with the client to say I've, and I've wronged the scheme I'm prepared to pay, they must just tell me how

much. But when it comes out there it's like people are coerced and forced. I mean, we've got documentary proof that we can share with the panel.

CHAIRPERSON: Ja. Well, that will be helpful. I mean, we obviously need to look at the problem from all of its sides.

DR NHLAPO: Ja, we can share that.

CHAIRPERSON: So, if you've got those examples that would be helpful.

DR NHLAPO: Ja.

CHAIRPERSON: Thank you.

MS BAKKES I'm thinking too much, Chair. Thank you very much. I would like to continue then. Obviously, just I see it is not stated on these slides but then the difference between block and place on hold. So as have I explained that if and when these service providers come to our attention you would have claims already paid and or claims in process. Claims in process would be placed on hold and that is where the Regulation 6 the 30 days then, the notice period comes in and that whole process must take place to our service providers. And it is regulated in terms of that. Blocked claims, Chair, and the example, I would like to name, name a pharmacy many years ago, 2008, 2009, it's actually a non-existent pharmacy, we actually inspected the premises and it's non-existent. Pendula Pharmacy, I don't know if anyone, Pendula pharmacy it's non-existent.

So, we would block claims completely to that pharmacy.

Unfortunately, we already lost a couple of millions between the HFMU participants over a few months, three, four months period. And only after we visited the premises and we have and find no premises that we could block payment to these people. So, I would like to differentiate between blocked as non-existent service providers completely and or identity theft you would know is where people steal another person's practice. We have nurses that's not working currently at all, but they've got practice numbers.

So, we would have health and wellness service providers that would use their practice numbers for illegal claims placed against us. And those are blocked practice numbers. So, it's completely illegal non-existent services provided and we need to block them. Because even if you place them on hold or in, it doesn't matter you can't place them on indirect because then it means they can still claim from the schemes. So, that's a clear difference between blocked and placing on hold. That would be for based and abused response. Chair, then the... (intervenes)

ADV HASSIM: Now, how long would you place on hold?

MS BAKKES The, Regulation 6 only prescribe 30 days in terms of whether a claim then must be paid and or if not paid in 30 days then the notice must be served to that service provider and or the members. in terms of what you've identified and found and give him then the, I think the next the following 60 days process for him to provide his proof of validation of the claims. So, I think it's only allowed to be placed on hold for 30 days, pending then them to

validate their claims. Obviously, I can assume, Chair, that if they don't provide the proof how can you then release and pay. I mean, how can you validate a claim release and pay if there was no validation provided to validate the legitimacy of that claim.

So, I do, I've heard of instances where you now mentioned that they complained that they were placed on hold for extended periods. But then obviously if they'd provided and cooperated with the investigators that wouldn't have required that period to be placed on hold. Because then somewhere these schemes needs to make a decision as to then what should happen with this provider.

CHAIRPERSON: So, according to your own SOP, I mean, we understand your relationship you don't administer this process but this is designing an SOP. No one should be put on hold for longer than 30 days.

MS BAKKES 30 days, preferably. And the Regulation 6 says that within that 30 days they need to inform the provider and or member if there's an investigation. And then that regulation then requires, I think a further 60, 60 days period for them to, and communicate and correspond and validate the legitimacy of the claim. So, Chair, I would, I would say then at least within three months period this process needs to be finalised. But now, obviously, if you have a provider that doesn't come to the party then what do you do then.

And I think, I'm not speaking on behalf of the schemes and maybe the schemes and or their administrators can then give you

more information as to what they are then supposed to do or what they are doing.

CHAIRPERSON: Yes. And then on the blocking side, I mean, I understand on the putting someone on hold, 30 days but at most 90 days for the whole process to be finalised.

MS BAKKES That's according to the regulations and the legislation, yes.

CHAIRPERSON: I mean, you discuss with the schemes what they actually do in practice.

MS BAKKES Yes.

CHAIRPERSON: And then on the blocking side to say that must be in clear cut cases of fraud... (intervenes)

MS BAKKES Definitely.

CHAIRPERSON: ...like a non-existent practice.

MS BAKKES Definitely, Chair. But I think the service providers may, may not know whether they are blocked or placed on hold and maybe complaints could be that they were actually placed on hold and or they would say that they're blocked but actually only placed on withhold. So, I'm not so sure how the message would come to them and how they would know whether they are blocked or placed on hold. So, I'm not clear on the communication from the medical schemes and or their forensic stakeholders how that would be communicated to these service providers.

ADV HASSIM: It may be that the, sometimes there's a distinction without a difference. Because to be placed on indirect

payment means that your patients must pay you up front and then be reimbursed by the scheme. Is that not what it is? So, how would, how would the patient get the service then?

MS BAKKES: Chair, we don't block patients from going to that provider, we place claims payment on hold. So, patients can continue to see that provider, pending then the investigation. So, we don't... (intervenes)

CHAIRPERSON: Sure.

ADV HASSIM: Sure, sure but what I'm saying is that your definition, the way you explain it s that the provider will not be paid directly, the member will be paid.

MS BAKKES No, not in this instance. Chair, so I'm coming to indirect payments which is different.

ADV HASSIM: I thought we were talking about indirect payments.

MS BAKKES No.

ADV HASSIM: Okay, no.

MS BAKKES Ja. No. This is, this is where we conduct the analysis process still and is in process and then we decide to place on hold to mitigate the risk and or where there is clean cut fraud, we definitely block them, so no claims go through. Chair, then we get to the indirect payments. So, let me try and explain to you the indirect payments. So, obviously, where we have no proof of actual fraud being committed it's difficult to prove the elements of fraud and or abuse. The only alternative than that we have, not only

alternative one of the response methodologies that we have is to place the services providers on indirect payment. This will break the collusion relationship between member and provider. You can imagine if providers give members cash for services actually not rendered and they would claim from us.

These members are actually poor if I may say so, in need of cash. If you then place the service provider on indirect payment, it's a response strategy to then break the collusion relationship between member and provider. Because if you pay the member which is an obligation from the Medical Schemes Act that we pay claims and pay members in terms of that. I think it's a choice that we pay by EDI we pay the providers. So, then if you break that relationship between provider and member, the member if you pay him, he's going to use the money because he needs the money more than the provider and he's not going to pay the provider.

Which is a problem to the member and provider but that is a fraud prevention strategy then for us. And that's the only method if and when we use the indirect payment is to break that collusion relationship between provider and member. So, we can choose, Chair, either or indirect payment. We're not enforcing all of these response strategies on the people. So, it would depend again and that's where we come to the soft, medium and hard targets. The last one that we have there is remove from networks. Chair, you mentioned before and you asked questions about the networks, DSP networks... (intervenes)

ADV HASSIM: Sorry. Just on indirect payment. You say to break the collusion between members and providers. So, you would use indirect payment in instances where the abuse or that was at play was of that nature. Would you, as opposed to for example using indirect payment as a response to a coding irregularity.

MS BAKKES Chair, so from experience I can't say that just on a coding error you would place the service provider on indirect payment. That's why I say that we do classify them between soft, medium and hard. It would depend on the transgression whether you place them on indirect payment. So, to me it won't be just a coding error and I do think that your investigation report, you analysis report outcomes would prescribe the response strategy that you would follow. I can unfortunately not speak on behalf of medical schemes and or their administrators. I can just speak on behalf of the process that we currently use. Does that answer you?

CHAIRPERSON: Thank you. And then there is a, the last one which is the removal from a network.

MS BAKKES Yes.

CHAIRPERSON: Ja.

MS BAKKES Chair, so obviously that's just another fraud waste and abuse response strategy. It's mitigating the risk. We obviously do not want to have providers on our networks that's fraudulent and or abusers of our systems and processes. So, we then would actually as part of our fraud prevention and a strategy,

mitigation strategy remove them from our DSP provider networks. Just in terms of a DSP provider network, anyone can apply it's not just closed. Any provider can apply to be on the DSP networks of any scheme and or administrator and or I don't know who else manage these DSP networks.

But then obviously your DSP networks on application would also go through a vetting process. So, I know that some of the administrators and or medical schemes and their vetting process is actually performed by BHF themselves. Wherein they vet service providers. Not DSP service providers but in terms of if and when they apply to be registered. The PCNS would then assist the schemes and or their administrators where they would allow these providers to be part of their DSP networks. Many of the DSP networks would be informed by information like geographical areas where there's a need of services by your members.

It would look at disciplinary logistics in terms of if they're in a rural area how far are they from a service provider. So, many of the DSP providers are actually determined by aspects and or requirements in that it is not just, you know, a nonsensical reason for having a DSP provider network.

CHAIRPERSON: Thank you. You have another slide to go through.

MS BAKKES Chair, that concludes the investigation part of it. Then we look at the monitoring just conclude the circle of life in terms of fraud management. The very last stage would be

then the monitoring of these fraud waste and abuse transgressors and or, you know, when you identified a first offender you must make sure that, you know, it doesn't happen and he doesn't transgress the conduct again so that he doesn't become a second offender or third offender. And or that he doesn't flow from soft, medium to a hard target.

So, our monitoring would definitely include then all the reports that we share with each other, the fraud waste and abuse reports. Industry reports, we receive industry reports from the Council of Medical Schemes when they have their investigation outcomes. HPCSA would also place monthly reports on their Website in terms of service providers which they found guilty and or suspended, sentences that they've issued. So, obviously, from this monitoring perspective we also look at all these reports. The prosecution is also very important in terms of the proof required and for any future cases that we are preparing for it. If we made a mistake once you don't make the mistake a second time so you need to make sure that you then close any gap or loophole created in a lost matter in a criminal prosecution.

So, Chair, there's many ways to monitor progress and successes in this area. And then our fraud waste and abuse reports are only one method for our, especially the smaller schemes to make sure it's a prevention strategy and that, you know, they don't loose monies to fraudsters which are actually identified by the bigger schemes in using this analysis software that we have. Very

expensive, I hope our administrator would come and give you their cost regarding the purchase of software like that. Because the smaller schemes unfortunately cannot afford it, absolutely not. Even the bigger schemes are, it's too expensive. So, we opted for the administrator.

So, where an administrator would manage 15, 16 medical schemes they would purchase the software and provide it. In the past as a key performance indicator, if we have 5% of our claims analysed for healthcare fraud waste and abuse it would be a lot. With the software that we have we can analyse 100% of the healthcare claims that goes through that software to then be validated and or processed for any high-risk claimers through that data analysis software. Chair, that concludes my... (intervenes)

CHAIRPERSON: Thank you.

MS BAKKES ...presentation. I'm not so sure there's any questions.

ADV WILLIAMS: Ms Bakkes, just one last question from my side. If you are an investigator in a scheme or administrator, and I understand you have been and you have experience of this space. When you receive, the HFMU, alerts or a report what practically do you do with it?

MS BAKKES Am I allowed to answer this? Chair, I'm just worried that I, if I'm allowed to answer the question. I am worried because my medical scheme is, should not be involved but I'm talking on behalf of administrator and experiences. So,

obviously, you need to analyse your own claims when you receive this information. You are not allowed to act at all. And to red flag or highlight or anything the words that I heard from the panel before, it's completely unacceptable and unethical to act based on the fraud waste and abuse reports.

You are required first and that's the service level agreement that we signed with all participants. You are required first to analyse you own data. Based on your own data you're allowed to act. And then only on your own data if there are any erroneous or irregular claiming patterns or high-risk trends that you identified, are you then allowed to then put that whole process to start. With the preliminary phase, a full investigation phase and a whatever is required.

ADV WILLIAMS: So, what do you look for in your own data?

MS BAKKES Sorry?

ADV WILLIAMS: What do you look for in your own data?

MS BAKKES You look for a similar trend and or you look at your claims data for that service provider. So, it assist us to cut time short. So, if you would look at Dr Hleli you would look at, the trend would be analysed. So, you mentioned before that it's said that -- what was the trend that we identified in this previous report but you would actually look at that codes and at that trend within your claims data and then you would identify whether there's any erroneous or... (intervenes)

CHAIRPERSON: Ja. I mean, your point is that they

shouldn't slavishly follow what they got from you they must... (intervenes)

MS BAKKES No, definitely not, yes.

CHAIRPERSON: ...they must forensically investigate what they get.

MS BAKKES Definitely, Chair.

CHAIRPERSON: And yours may just be a pointer but it's the first pointer.

MS BAKKES Yes, Chair. They're not allowed to act on our information provided and that's where Dr Hleli said it's a bring and braai process sort of. You bring your own data as well, you know, while you receive this information, but you are not allowed to act based on the data received from the HFMU reports. You must investigate and analyse your own claims data first for any erroneous claims or irregularities. Only then if you do find something are you allowed to act based on that.

ADV WILLIAMS: So, just, so if for example this report says Mr X for example here it's services not rendered but Mr X is being investigated for services not rendered, do you go to your claims data and look for Mr X?

MS BAKKES I assume that would cut on time, yes, Chair. It would definitely. I mean, to investigate 5 000 Mr Xs, I mean, if you don't know the practice numbers then obviously it would assist you to cut shorter on time to investigate Dr Xs claims. But you're not allowed to act. Only and if and when you find

something erroneous and irregulars are you then allowed to act against Mr X.

CHAIRPERSON: I mean, that is the big benefit of the information sharing.

MS BAKKES Exactly.

CHAIRPERSON: That it gives you the red flag.

MS BAKKES Yes.

CHAIRPERSON: But from there you must do your own work.

MS BAKKES Own work, yes, Chair. Thank you.

CHAIRPERSON: No, I understand. All right, thank you. Dr Mothudi you brought your colleagues here, so I presume that this is the end of their presentation. All right.

DR MOTHUDI: Thank you, Chair.

CHAIRPERSON: All right, thank you. One.. (intervenes)

DR MOTHUDI: Chairperson, just in closing, it would be injustice to close, especially on the HPC, I mean, on the HFMU's side without giving you the main principle and objective of the HFMU. In the final analysis with all what has been said, rehabilitation is one of the main things that we push. We've got, I mean, the country needs healthcare providers, we can't be kicking or sending them all to jail. Rehabilitation, if those that have, I mean, are serious are about their profession and they want to mend their ways, by all means. So, rehabilitation is one of the things that we, we also are pushing.

CHAIRPERSON: Thank you very much. All right, while it remains of me then to thank you for coming and presenting, it's certainly been opening, and we understand the structure better now because of your presentation. You might be called again, and you might be sent letters requesting for further information. So, if you don't mind continuing your spirit of cooperation with the panel.

DR MOTHUDI: It's a pleasure.

CHAIRPERSON: Today's session is then adjourned. We will reconvene tomorrow at 10 o'clock. Who's coming tomorrow?

PROCEEDINGS ADJOURN

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