THE COUNCIL FOR MEDICAL SCHEMES (CMS)

INQUIRY UNDER SECTION 59 OF THE MEDICAL SCHEMES ACT

HELD AT

BLOCK A, ECO GLADES 2, OFFICE PARK, CENTURION

27 JANUARY 2020

DAY 15

PROCEEDINGS HELD ON 27 JANUARY 2020

ADV TEMBEKA NGCUKAITOBI: Good morning and thank you for coming. This is the Section 59 of the Medical Schemes Act Inquiry. We are commencing the final phase of the public hearings which will be held this week by listening to the evidence of medical schemes and medical schemes administrators.

This morning will be a presentation from POLMED followed in the afternoon by a presentation from Bonitas. I presume we have representatives from POLMED.

ADV NKOSINATHI WISEMAN BHUKA: Yes.

ADV TEMBEKA NGCUKAITOBI: Thank you. If you can switch on your microphone.

ADV NKOSINATHI WISEMAN BHUKA: That is correct Chair, thank you.

ADV TEMBEKA NGCUKAITOBI: Thank you very much. So, the procedure we have been following is that we take an oath or an affirmation to those people who will be speaking because the evidence is given under oath. And are there any objections to taking the prescribed oath?

ADV NKOSINATHI WISEMAN BHUKA: No objections Chairperson.

ADV TEMBEKA NGCUKAITOBI: Who will be speaking? Who would be presenting, speaking and giving the testimony?

ADV NKOSINATHI WISEMAN BHUKA: Chair, I would be doing the presentation and I will take the oath. I do have two colleagues whom I may want to confer with from time to time. But for the purposes of the record I will be doing- running the presentation. Thank you Chair.

ADV TEMBEKA NGCUKAITOBI: No that is fine. Will you take the oath

then and say after me? I and your full names. I, your full names?

ADV NKOSINATHI WISEMAN BHUKA: I Nkosinathi Wiseman Bhuka.

ADV TEMBEKA NGCUKAITOBI: Hereby swear.

ADV NKOSINATHI WISEMAN BHUKA: Hereby swear.

ADV TEMBEKA NGCUKAITOBI: That the evidence I will give.

ADV NKOSINATHI WISEMAN BHUKA: That the evidence I will give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

ADV NKOSINATHI WISEMAN BHUKA: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

ADV NKOSINATHI WISEMAN BHUKA: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

ADV NKOSINATHI WISEMAN BHUKA: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: Will you raise your right hand and say, so help me God?

ADV NKOSINATHI WISEMAN BHUKA: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. Sworn in. So, Mr Bhuka you can take us through. I see we have a couple of documents from you and we have a slide presentation.

ADV NKOSINATHI WISEMAN BHUKA: That is correct Chair. Chair, if I may, we do have a bundle that I would like to hand to the Panel as well as the Secretariat which I will be talking through in terms of our presentation.

ADV TEMBEKA NGCUKAITOBI: Yes Mr Bhuka.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair, if I may start by just reflecting on a few preliminary points or opening remarks as it were just for the purpose of reflecting on how they may have assisted

or hindered in terms of our preparation for these proceedings.

Chair without much delay I would like to start by first just apologising that we- our PO who would have been here but for the other prior commitments could not join us, is out- she is out of town. And therefore, she would have loved very much to be here. She very much respects these proceedings however, at the time of getting the confirmation of this date and the time she was already out of town and therefore she could not make changes in terms of that schedule. Thank you Chair.

ADV TEMBEKA NGCUKAITOBI: That is fine. Presumably you have the full mandate?

ADV NKOSINATHI WISEMAN BHUKA: Chair thank you. I certainly have a full mandate Chair. So, I will- sorry, I will proceed on that basis.

Chair, the next point I want to just reflect on briefly is the issue of the engagements with the Secretariat to the Panel. We have had time issues in terms of receiving notices that are less than the times- thank you.

ADV TEMBEKA NGCUKAITOBI: I did not realise that you cannot see.

ADV NKOSINATHI WISEMAN BHUKA: We have had notices Chair that were less than the times required in terms of the terms of reference of the Panel. And further to that we have had situations where the communication has not been sent to the correct people within the scheme and therefore either that communication then delayed in term of being attended to or there were certain dynamics that led to the preparation not being as utmost as you would have wanted it to.

Chair, we had prepared in terms of for purposes of assisting the Panel a timeline in terms of the events that talks to what I am right now reflecting if the Panel would like to have that, we can hand over that for the

purpose of the panel. But we do not want to make it a point so as to delay and detract these proceedings but we do want to reflect that it is and was a concern for us.

ADV TEMBEKA NGCUKAITOBI: Alright, you can hand it up. If you have got three copies for the panel, that is fine otherwise give it to the Secretariat.

ADV KERRY WILLIAMS: May I ask a further question just in relation to your procedural concerns? Can you explain to us how or if you have been prejudiced and then how we can cure that prejudiced? Because we obviously this is your evidence. There may be opportunities to supplement your evidence if you need. But I do not think we should let it hold us up. We just like to know what is the prejudice you have experienced if any and how we can cure that?

ADV NKOSINATHI WISEMAN BHUKA: Thank you. Chair, so as I said for example the PO would have loved to be here to address certain points and that could not happen and therefore, I have the necessary mandate to address those.

What can cure the prejudices that we have had to encounter because of those problems is Chair among other things we have indicated that to some extend on certain things we would be pleased to have an opportunity to address those by way of written submissions or depending on how the Panel wants to proceed by way of heads of argument on certain items. But we are saying Chair is that it would not be ideal for us to request for that for any reason this process be detracted or delayed. But as long as we can have an opportunity to amplify certain of the things that because of those problems we could not adequately or utmost put the

necessary preparations and records for.

ADV TEMBEKA NGCUKAITOBI: Thank you. I think it is now time to move to the presentation.

ADV NKOSINATHI WISEMAN BHUKA: I will move to the presentation Chair in terms of your instruction. But there were some other few points but I will ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: No, I am not overruling you- your points. I thought you explained the prejudice and how you suggest we can cure it. We will obviously factor that in. But if you have got a further preliminary point, by all means raise it.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair.

ADV TEMBEKA NGCUKAITOBI: But I would like you to focus on your presentation. I think that is why you are here this morning and you have two hours.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair, maybe- I will quickly gloss through on some of the preliminary or opening remarks. As I said Chair, the idea is to assist the Panel so that some of these things- the Panel is well versed of when it goes about its process of deliberating and taking certain progress steps on some of this.

Chair, one of the things for example that I would like to pose as a matter of the preliminary points is the complaints that were referred to POLMED for purpose of response in preparation for these proceedings. Chair, there were a number of concerns with that process. First, the complaints were a conflation of complaints against a number of schemes which effectively means that certain information relating to other schemes was exchanged with POLMED probably and duly. And certain of the

information relating to POLMED to the extent that is similar that is the same bundle or the same pack that we received was also sent to the other schemes. It may well be that POLMEDs information has been then referred to other schemes so the complaints compilation process for purpose of schemes to respond was also a problematic issue.

Chair, without further ado I will now go to our presentation. Chair, just to indicate that our presentation will focus on the correspondence we have received from the Secretariat in terms of the issues we are requested to respond to or to address and so we will take those issue and we will try and dissect for the purpose of the Panel to the best in terms of how we can respond to them. If you can go to the next slide Connie.

Chair, we will start with the composition of POLMED. POLMED is a non-profit entity I suppose like any other scheme in terms of the regulatory regime. It is a closed scheme Chair and it was found in 1981 at the time as a service benefit in terms of the Police Services Act. And it was later then registered with the Council in 2000 to be exact as a medical scheme for purposes of the regulatory regime of the Medical Schemes Act.

Chair the scheme only caters for members of the Police who are appointed in terms of the Police Service Act. And you will appreciate Chair that there are certain other members within the Police Service who are appointed in terms of other laws. So those would not fall within the purview of the cover of POLMED.

Chair, we the scheme has got two benefit options and probably this is one of the highlights or the prominent points about the scheme.

The two benefit options, one option is the Aquarium Option which is a basic option. And then Chair the second option is the Marine Option which is a more enhanced option which caters for a more sickly members in terms of managed disease programs and so on. Thank you, Connie, next slide.

Chair, I am now going to deal with the governance of POLMED. We have Chair at POLMED a 14-member board and the board are composed of members who are elected by members of the scheme as well as members who are designated or appointed by the National Commissioner. The split Chair is into half, in other words, the Commissioner appoints 7 or designate seven of those members and the member elect the other 7. We have Chair on the slide there on the screen the actual board members just for the appreciation of the Panel.

Further to that Chair, the board has got board subcommittees. We have an Audit and Risk Committee and Chair if I can briefly just talk about that. The Audit and Risk Committee is one of- is an independent committee, it is chaired by an independent non-elected, non-designated or non-appointed chair. The rest of the committees Chair are- the members are the members of the board as it were. Our Audit and Risk Committee Chair, it sits with all the risk and audit issues. It gets reports from among others the fraud, waste, abuse component of the management of the scheme.

We also Chair have got a Clinical Governance Committee. The Clinical Governance Committee Chair looks at specifically the clinical issues, the benefit designs and it approves all matters that relates to those things. So, in terms of the internal processes we will have certain processes that

lead to either certain proposals that must then be taken to that committee for purpose of approval.

Then Chair we have got a Legal Ethics Complaints and Dispute Resolution Committee. Chair, this committee looks at issues such as the ethical conduct within the leadership or the governance of the scheme. It looks at complaints so in other words once a complaint has been taken through the internal operational management issues and there is still no resolution, then a complaint would be referred to that committee for final decision before then the matter can be referred to Council.

We then Chair have also an Investment Committee. This committee looks after the scheme's investment in terms of which portfolios the investment statement compliance with the regulations in terms of which assets the schemes may be allowed in terms the regulatory regime to invest in.

And then Chair we have got an HR Ramco Committee. That committee Chair looks at all your HR issues, your remuneration both at board level up to the staff level. It will look at issues such as the policy for purpose of remuneration. It will look at what must be tabled with the AGM in terms of the board's remuneration. So that committee Chair is responsible for the entire functioning of the scheme. Okay Connie.

Chair we then have an Executive Committee of which I am a member of. Chair the Executive is headed by Ms Neo Khauoe as the Principle Officer whom as I have indicated Chair already that she could not join us today. We then have the Chief Legal Officer which is myself, Advocate Nkosinathi Bhuka. We then have the Chief Financial Officer Chair, Mr H Heunis du Plessis. We have got a Chief of Corporate Services Chair, Mr Mashudu Sadiki and then we have the Chief Operations Officer Dr Jaco

Makkink.

In terms of portfolios Chair, the operations look specifically at communication with members, at issues of clinical management, relationship with networks and designated service providers. So that would be the portfolio that is covered by the Chief Operations Officer.

The portfolio that is covered by the Chief of Corporate Services would be your system issues, IT, safety, analytics. So that would fall under that portfolio.

The Chief Financial Officer Chair looks at the financial health of the scheme.

And then the portfolio that is covered by the Chief Legal Officer includes public policy, legal advisory, litigation, regulatory compliance, risk management, fraud, waste, abuse management. So that would be the functions that are covered by that portfolio. Hence our being mandated to come and respond to these proceedings today.

Chair, I now deal with just briefly the business model. If I may start briefly just with the contributions Chair? You will see that in terms of contributions the employer contributes 75% towards the contribution pool of the scheme and members contribute by way of direct monthly deductions or debit order and so on 25% towards contributions. So, there is a large exposure to in terms of how the department has structured its budget and it effects in terms of the employer contribution how the scheme budgets.

Then Chair, I want to take you to the split in term of membership. I did indicate Chair earlier that the membership is specifically members who are appointed in terms of the Police Service Act. So, we have

continuation members which are members who either have been retired or have been medically boarded and so on so we describe those as continuation members. So, they will continue to be members of the scheme and therefore pay the necessary contributions and be covered by their employer contribution in terms of the split that I have indicated earlier.

Then Chair you have serving members. Our serving member ratio is about 82%. Now those are members that are in force as we speak that are busy with operations as we speak. So that is the kind of pool that our scheme covers.

Then just in terms of the outsource model Chair. We have outsourced the administration Chair. We have outsourced the administration to Medscheme. We have outsourced Managed care to Medscheme. We have outsourced Optical Benefit Management to PPN. And we have outsourced Medical Emergency Services to Netcare 911.

ADV KERRY WILLIAMS: Mr Bhuka, may I interrupt you there? I understand that you outsource your fraud, waste and abuse function. Does it get outsourced through the Administration or your Managed care component?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. It is outsourced through the Administration component.

ADV KERRY WILLIAMS: So, there is an administration contract in place between you and Medscheme.

ADV NKOSINATHI WISEMAN BHUKA: That is correct.

ADV KERRY WILLIAMS: Which determines how Medscheme conducts the fraud, waste and abuse monitoring it etcetera.

ADV NKOSINATHI WISEMAN BHUKA: That is correct.

ADV KERRY WILLIAMS: And can you tell us what exactly that contract says please?

ADV NKOSINATHI WISEMAN BHUKA: Chair, we – among the slides there is somewhere where we make reference to the relationship- the structure of the relationship. But in terms of the actual detail as in per clause by clause, I do not think Chair we will be able to go through that. It is something that we can if the Panel is comfortable address by way of a written or heads submission. But in the presentation, there is some slides that talk to them, general design and the structure of the relationship. If that pleases the Chair.

ADV KERRY WILLIAMS: Just a follow up question. Go ahead.

ADV ADILA HASSIM: Sorry, have you provided us with the contract?

ADV NKOSINATHI WISEMAN BHUKA: No, we have not placed the actual contract in the bundle.

ADV ADILA HASSIM: Can you provide us with the contract please?

ADV NKOSINATHI WISEMAN BHUKA: Chair, we have looked at that. The contract Chair contains certain information that may necessarily be confidential in terms of the relationship that exist between the parties. However, if that is indicated Chair, if we have to make a submission by way of heads or written submission, we can address that through that- in that way.

You will recall Chair that once the Panel has completed its work, the total record of the proceedings may at some point be a public record information and hence our submission that Chair it would be better if we address that by way of a written submission or heads of argument and we

address the specific question that relate to the contract and the terms thereof.

ADV KERRY WILLIAMS: My follow up question is, I am not sure I understand why that contract would be confidential. So perhaps you can expand on that now.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair, as I have indicated so there may be certain details that are necessarily a proprietary or commercial information of the parties. And to that extend there may well be information and Chair because we are not prepotent to present specifically on the contract.

I cannot take you through that right now but all I am saying is that at a principle level, there may well be information that is propriety, that is commercial. That before we then determine how to present the necessary records to the Panel and to what extend and what protections we may seek if we do that. It would be better if then we do that by way of written submission.

ADV TEMBEKA NGCUKAITOBI: Alright, thank you. You say there is a part in your submission where you are going to deal with the contract.

ADV NKOSINATHI WISEMAN BHUKA: Chair yes, there is a part in the presentation where I deal with the general design of the contract. But it does not talk to clause by clause … (intervenes)

ADV TEMBEKA NGCUKAITOBI: No, no, that is fine. I understand. Can I suggest you do this? We will come back to these terms of the contract and the basis and which you claim confidentiality. But take us through then the other parts of your presentation then we will revisit this topic when you are dealing with the contract. Let us see how much you are

disclosing in your presentation.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Alright the next slide.

Chair, then this slide just talks to the member profile in terms of who exactly is covered by the scheme. You will see Chair that in terms of principle members we have in excess of 170 000 principle members both serving as well as continuation. We have Chair in excess of 110- the exact is 111 003, 111 000 adult dependants Chair. You will see child dependants we have got about 219 000. The number of beneficiaries in total is just over half a million to be exact 508 000.

If you look Chair at the family size rate, we have got about- that is now a covered family, the principle member as well as beneficiaries, we have got an average of 2.86 of the family size. Chair if you look at the age of the kind of members, we have you will see that we probably have an aging scheme. The average age being 44 years and if you look at the average age of beneficiaries you look at about an average of 29 years. If you look Chair at principle members that exceeds 60 years, you look at about 10.5% of the scheme so it is really an ageing scheme so to speak. Chair we have also breaking down into ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: Just out of interest here, why is it an aging scheme? Because you are a closed scheme, you only allow membership to Police and your split is 82 18 so you would expect that the 82% would be young and fit and healthy.

ADV NKOSINATHI WISEMAN BHUKA: Chair I think maybe the context would assist in answering that question. Chair among other things the design of the medical aid for purposes of the policy I have indicated Chair

it was initially or it was started as a Service Benefit. Now it is one of the attractions into the Police force. If you look at the general- I am going to call it pay levels within the Police force you will realise that medical aid becomes one of the most attractions.

And what that means is that then you have a situation where once the person is in the attrition in terms of people exiting or leaving is very low which means the only time you have new members is when each and every year the government announces the number of recruits that are going to be added. But in terms of those exiting it is very slow so hence then you see that there is a sense of I am called maturity or ageing in terms of the members. Because members remain up until either retirement or they are medically boarded and those kinds of situations. So, I think Chair that is the reason why you have the scheme sitting at that average age in terms of membership.

ADV TEMBEKA NGCUKAITOBI: Is this a reflection of the composition of the Police force, that we have got an aging Police force? You do not have to answer that. Move on.

ADV NKOSINATHI WISEMAN BHUKA: I was about to say Chair that I do not have the mandate to respond to that. But thank you Chair. So that is just- I think Chair the importance of reflecting on the member profile just to appreciate the enormity of the population group that the scheme has to cover and has to cater for. Thanks, colleague, the next slide.

Chair, this slide deals with, just slightly reflecting on what I call the economics of the scheme. You will see, Chair, we have the red line on top which goes slightly on top of the other lines, that red line just reflects on the health care cost inflation. And you will see Chair that

is already higher than, although it fluctuates, but generally it is higher than the other lines and that is health care cost inflation.

Then Chair, you have the ordinary inflation which is your purple line which is slightly below the red and the blue line which gives you a comparison when you look at the health care cost inflation versus ordinary inflation, what schemes have to contend with in terms managing their financials.

Then Chair, you have your blue line which talks to the increase in the total subsidy, the total subsidy is, Chair, the contribution by the employer that I had referred to earlier. So, that tells you, if you look at how that subsidy increases versus the inflation you will see that it is very much lower than what the inflation is. Which means, all the time the scheme has to play catch up, in terms of the cost of health care that must be provided to members. That is the importance of the message that we are trying to draw on that slide. Thank you.

Chair, this slide deals with performance of the scheme over time. It deals, Chair, with the blue line which simply reflects the claims ratio. If you look at the, what colour is that? Orange. That orange line reflects the solvency. Now will recall Chair, that in terms of the Medical Schemes Act, schemes have to retain a certain level of solvency and some schemes are slightly above that level and some schemes are below. So we measure our performance in terms of the claims ratio as well as our solvency to say, how far are we from the regulatory prescribed solvency ratio as well as how far are we in terms of our claims ratio? In other words, do we have more claims than the contributions and if so, how are we managing that?

But, I think Chair, the one particular point I want to emphasise for purposes of this presentation is the yellow line, Chair. That yellow line talks to the non-health care cost ratio. If you look at around from 2012 when the scheme was around 6.5 of the non-health care cost, the scheme has managed in all the years up until when you look at last year where the scheme is sitting at about 3.5 non-health care cost. I think that is a reflection of how the scheme is focussing all the resources of the scheme towards meeting the health care requirements of members and attributing as little as it can towards non-health care costs. And I think that is an important thing to reflect on, Chair. Colleague? Thank you.

Thank you Chair. Chair, this slide Chair is ...

ADV TEMBEKA NGCUKAITOBI: Sorry, just to explain, I mean, the non-health care ratio, so it has been declining since 2012 where it was 6.5%, now it is standing at 3.5%. What are these non-health care costs and why are you paying for them?

ADV NKOSINATHIS WISEMAN BHUKA: Thank you Chair. Chair your non-health care costs, it's your costs that relates to things for example, like salaries, administration, systems, infrastructure. So, it is costs that are not expended for the purposes of meeting member health requirements but Chair, if one has to be technical, there is a particular formula that the regulatory regime has put in place in terms of computing as well as delineating the specific items that will be counted as non-health care. If the commission, if the panel wants a further amplification on that, we can reflect on exactly that regulatory regime

to say, of the listed items and of the specified computations, what can we avail to the panel and what the panel would require.

But I am just giving a very high level now without reflecting on the particular formula that is prescribed by the law.

ADV TEMBEKA NGCUKAITOBI: So if you just look on administration alone as a component of the non-health care costs, what is the proportion of that that you are paying every year?

ADV NKOSINATHIS WISEMAN BHUKA: I didn't get the question Chair?

ADV TEMBEKA NGCUKAITOBI: How much are you paying? I mean if you are looking at that 3.5% how much of that would be administration costs?

ADV NKOSINATHIS WISEMAN BHUKA: Maybe let me just confer with my colleague. I am not sure if I am in a position ....

ADV TEMBEKA NGCUKAITOBI: ... to answer.

ADV NKOSINATHIS WISEMAN BHUKA: To accurately respond to that.

ADV TEMBEKA NGCUKAITOBI: No, that is fine. I just want to get the figures to see how much you are, when you say administration, I mean, do you include the cost of administering the scheme which is the cost that you would pay to Medscheme?

ADV NKOSINATHIS WISEMAN BHUKA: May I proceed Chair?

ADV TEMBEKA NGCUKAITOBI: Yes, indeed.

ADV NKOSINATHIS WISEMAN BHUKA: Thank you. Chair, as I understand, the 3.5 includes the cost of administration but Chair, as I have indicated, I am advised that we would rather talk to the formula that is provided by the regulatory instrument so that if there is a

particular line that must be drawn on that specific item, then we can reflect on that. But, as general principle my advice is that the non-health care cost would include the cost of the administrator.

ADV TEMBEKA NGCUKAITOBI: Now, how much would you take out of that 3.5% as the administration costs? Is that information, you don't have it with you now?

ADV NKOSINATHIS WISEMAN BHUKA: That is correct, that is the information I don't have.

ADV TEMBEKA NGCUKAITOBI: Well you can reflect and then in due course submit it. Thanks. Carry on.

ADV NKOSINATHIS WISEMAN BHUKA: Thank you. Chair, this slide, it's a claims analysis. It looks very busy but all it indicates or shows is the areas or categories in terms of claims where the scheme is facing a larger burden compared to other claim categories. You will see for example, if you look at medicine, which is the very first item in the year 2019 the scheme had about R753 million on claims, when you compare to the 2018 where the scheme had about R1 3 000 000. But if you look at the change between the two years, Chair, all it means is that there was a change of 36%. Now that shows you the movement in terms of the claims from one year to the next. But this slide Chair, all it shows is which area the scheme is really burning in terms of claims and what are the comparison from the previous year to the current year in terms of the progression of those claims. And the last ...

ADV TEMBEKA NGCUKAITOBI: Sorry, just to make sure I understand this. The total amount, is it the amount paid or is it the amount claimed when you say claims analysis?

ADV NKOSINATHIS WISEMAN BHUKA: It would be the amount paid, Chair.

ADV TEMBEKA NGCUKAITOBI: So in 2019, you paid R7.2 billion?

ADV NKOSINATHIS WISEMAN BHUKA: Yes. That is correct Chair.

ADV TEMBEKA NGCUKAITOBI: Yes. And in 2018 you paid R7.1 billion?

ADV NKOSINATHIS WISEMAN BHUKA: That is correct Chair.

ADV TEMBEKA NGCUKAITOBI: Now how does that link to the budget of R7 billion because then that is R100 million and R200 million that seems to be out of sync there? In other words, why do you pay more than is budgeted?

ADV NKOSINATHIS WISEMAN BHUKA: Thank you Chair. Chair, so if you recall Chair, at some point I spoke about claims ratio and I indicated that the claims ratio is the ratio of claims versus the contributions.

Now, we pay more because there would be more claims than the contributions received. So, in other words, we may get a certain lump sum in terms of the employer contribution, we have got a certain amount of contributions from members but, at a certain point then those contributions don't meet the amount of claims we receive at the time and hence at times then schemes will then for example, tap into the reserves that I think I reflected on previously when I spoke about the investments.

So, you find those schemes employ various mechanisms so, it would be tapping into the reserves, it would be employing certain managed care costs, ah sorry, processes to manage costs. So, all those processes

will then put the scheme in a space where the scheme will either recover in a particular period in the year or the scheme then will have to reflect that as, in other words, if your claims ratio is 103 for the particular financial year it means that you've had 3% more than your contributions in your claims in the particular financial year.

ADV TEMBEKA NGCUKAITOBI: Okay, I understand. Now, just to understand the categories; that means you've spent, your highest cost is hospitalisation. In 2018 your hospitalisation costs were R2.5 billion and in 2019 they were R2.7 billion. So there are a lot of people who sleep in hospital.

ADV NKOSINATHIS WISEMAN BHUKA: Chair, it is one of the high costs, so again, it is a matter that is managed through various processes, among those processes is a hospital network arrangement where the scheme would agree with certain groups of hospitals about how to manage admissions and about how to manage the process of attending to the patient once he is admitted. But, yes it is, hospitalisation is one of the high cost drivers for our purposes.

ADV TEMBEKA NGCUKAITOBI: Where is this fraud, waste and abuse because you see from this table there is nothing that accounts for it? Instead, you are paying a lot of money for sending people to hospital.

ADV NKOSINATHIS WISEMAN BHUKA: Thank you Chair, Chair if I may proceed? So, Chair, the reason why the hospitalisation is highlighted in yellow in terms of that slide is that there was a particular call it, spike or increase, in that period. But if you look at the other categories, medical specialists, pathology and radiology which are in red, what it means is that those have been constantly the higher or the

bigger areas of burning. Now, what the scheme has done with the hospitalisation is that it has, as I have indicated, implemented a cost management program with the hospitals. But still, you will see that with the pathology and the specialist and radiology we still have got higher costs.

So, Chair, what this means is that the fraud/waste/abuse component is something that is picked within the processes of examining these claims. So, remember when the analytics are done by our teams and they look at certain claims, for example, the increase in the hospital claims then they start interrogating to say, at what point in time do we really experience those spikes or that increase and once they have picked that up then they will say what is the history, how much has the change been? What is the cause?

So, it would be in those instances where one would pick up that there are some unusual claims. Similarly, with the specialists, pathology and radiology, the fraud/waste/abuse is not going to be a component that is a stand-alone, but it is a component that is discovered when one does analysis of these high cost claims, either hospital admissions or the other categories. So, Chair, what I am saying is, you are not going to see fraud/waste/abuse as a stand-alone item in this list.

ADV TEMBEKA NGCUKAITOBI: I understand but, I mean, what we know from you have shown us is that you have a budget of R7 billion, you spent R7.2 billion, so, that is fine you have explained where the R200 million is going to come from. But, the problem I am trying to tease out is that, what I can see from the slide, and I know you say that

historically if you drew the data from maybe 2015 I will find that hospital costs are lower than they are.

But, on what I have now, is that your major expense is hospitalisation. From what we have heard in the evidence here, is that the problem is individual practitioners. They are the ones responsible for FWA, but, this is not proven by the presentation you have given because if I want to know what is the area where I can save money as your scheme, it will be in hospitalisation – not in the individual practitioners - even if I accept your explanation that the FWA is hidden in pathology and radiology and medical specialists or general practitioner.

But general practitioner is not a big risk. In fact, what you have got here is green, 0.3%. The biggest risk you have is hospitalisation. I mean, so, that is what I am struggling with to understand. Anyway you may not have the full details. You don't have to, if you have an explanation you can give, but if not, move on.

ADV NKOSINATHIS WISEMAN BHUKA: Chair, if it is acceptable to the panel, it is one of the things we can amplify in terms of our written submissions. Thank you.

ADV TEMBEKA NGCUKAITOBI: Thank you. Just when you think about amplifying I do want to see how much exactly you are paying which is classified as FWA. We have been sitting here and each person who is on the side of this debate, we are spending as the schemes, R28 billion every year on FWA but there is not even an item on your presentation. You are the first scheme to present but there is a zero item on FWA so it looks like actually there is no money being

wasted on FWA. But you say it is hidden somewhere but if you can also just de-couple it from the other expenses.

ADV KERRY WILLIAMS: And to add to that, I would assume it would be in the amount that Medscheme pays back to you which is declared to be FWA. But, I would like to understand that, yes.

ADV NKOSINATHIS WISEMAN BHUKA: Thank you Chair. Chair, there is a slide that talks specifically to the fraud/waste/abuse figures as picked from the analytics. So, later on as I go on with the presentation, we will get to that slide.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV NKOSINATHIS WISEMAN BHUKA: Thanks colleague. Chair, this slide, the next slide, that is now slide 11 just talks to our process in terms of managing fraud/waste/abuse. First from a policy point of view, we recognise fraud/waste/abuse as a very significant risk to the financial stability of the scheme as well as the industry. The board takes a particular fiduciary duty to manage that process, or to control that process. You will recall Chair that I mentioned among the committees of the board, there Fraud and Risk Committee. That committee deals with the monetary computation and reflection in terms of what fraud/waste/abuse is costing the scheme.

I also, when I was talking about governance of the scheme, I spoke to the Legal Policy and Ethics Committee, that committee specifically reflects on issues of the actual content of what constitutes either fraud or waste or abuse and what process must be followed in terms of intervening on those things. Chair, the scheme has adopted a zero

tolerance towards dishonest activities whether by the member or by service providers towards the scheme.

The BOT which is our Board of Trustees has developed an anti-fraud and corruption policy as I have indicated, Chair. And among platforms that deal with the implementation of that policy, we have got a Fraud Forum which then reports, as I have indicated, to the Audit and Risk Committee as well the Legal and Policy Board committees for purposes of decision making.

Chair, we, so as I have indicated Chair, the function itself is outsourced and therefore it has been delegated, if one may use the phrase to the administrator through the outsource agreement which I have, the panel has requested we make available. We also have got a whistle blower or hotline and investigations platform where members as well as service providers can then alert the schemes to certain of the things that they pick up in the industry. And this is just a policy view in terms of how the scheme looks at fraud/waste/abuse.

ADV KERRY WILLAIMS: May I ask a question about this? What monitoring does POLMED do of Medscheme's activities once it is outsourced?

ADV NKOSINATHIS WISEMAN BHUKA: Thank you Chair, Chair the monitoring is set out both in terms of the policy that I have indicated as well as the contract. We have service levels that are built into the contract in terms of what the scheme must account for, within which times. However, if the question is about the mandate itself, the mandate is a broad or generic mandate that says, you are accredited by the Council, you will act in accordance with the law in terms of what the

law requires for purposes of recovery of fraud/waste/abuse. Therefore we are giving you a mandate to do that to the extent that you comply with the law.

If there is anything that is outside that mandate or is extraordinary, then we will then certainly have an extra specific and pointed mandate specifically for that outside-the-law, extraordinary intervention that Medscheme may want to employ in a particular circumstance.

ADV KERRY WILLIAMS: Mr Bhuka can I ask you then just to, have you got a copy of our bundle in front of you?

ADV NKOSINATHIS WISEMAN BHUKA: Yes, I do Commissioner.

ADV KERRY WILLIAMS: Okay, great, I am glad to hear that. Can I just ask, does the scheme mandate Medscheme to write to providers in the name of the scheme. So, does POLMED mandate Medscheme to write to providers in the name of POLMED?

ADV NKOSINATHIS WISEMAN BHUKA: Chair, the question goes into the substantive content of the contract. Let me, as I have indicated, the scheme gave Medscheme a mandate to recover fraud/waste/abuse on behalf of the scheme but as I understand the question, if Medscheme writes, does it write on its own capacity as an agent that is outsourced to do this work, or does it write as it is writing in the shoes of the scheme? I think it would require one to go into the construction of the contract.

But, I think Chair, the point is Medscheme has got a mandate and that mandate empowers them to do the recovery of fraud/waste/abuse and to the extent that they act outside that mandate whether by way of communication of by way of interventions, then, at that point in time,

through our platform such as the Fraud Forum and the policies that we have, we will then intervene.

ADV KERRY WILLIAMS: Mr Bhuka perhaps I can assist because we don't have to look at the contract to understand the answer to this question, I think. Could you turn to page 91 of your bundle?

ADV NKOSINATHIS WISEMAN BHUKA: Our bundle or the panel's bundle?

ADV KERRY WILLIAMS: The panel's bundle, *ja.* And as you know we have received numerous complaints and we have thousands of pages of correspondence before us from various administrators and the providers. So this is just one of the many examples. It is a relatively unusual example but I want to ask you about it. So, you can see it is a letter written by Medscheme on a Medscheme letterhead.

It is signed by one of Medscheme's forensic analysts, Themba Matchaya, and it is dated 16th of May 2019. And it starts with,

> 'Dear Miss Khanyane'

And it says, this is now on a Medscheme letter it says,

> 'We, POLMED, have undertaken an analysis of your previous and current claiming patterns submitted by… '

The practice number, so it says, 'We POLMED' so they are writing as if they are you. Is this mandated?

ADV NKOSINATHIS WISEMAN BHUKA: Chair, Medscheme will write in its own name, in its own capacity as a mandate agent. So, I am not sure how that, I can only say probably it was an error because when Medscheme is not sure of their mandate, they will inform us and we will write either directly to the complainant and say Medscheme has got a

particular mandate, we are please asking you to co-operate with them or we will write to Medscheme and say we have received this particular complaint from the complainant saying that you are not applying the recovery process as they would understand in law and therefore we are asking you then to explain to us.

So, it is as you say Chair, it is unusual that the letterhead of Medscheme would say, 'We POLMED'. I am not in a position to explain how that was ...

ADV TEMBEKA NGCUKAITOBI: No, I think the real question I think, everyone can see what the letter says, I think the real question is, is that mandated or not?

ADV KERRY WILLIAMS: Sir what percentage of your FWA Investigations are made of black practitioners?

ADV NKOSINATHI WISEMAN BHUKA: I couldn't get the question?

ADV KERRY WILLIAMS: Your FWA, your Fraud, Waste and Abuse Investigations or prosecutions, what proportion of that is made up of black practitioners.

ADV NKOSINATHI WISEMAN BHUKA: Chair, we have no computation of those numbers, sorry we have no computation of those numbers, because in our mandate, in term of the contract to Medscheme we have nothing that suggest that they, they must do the analysis to that level of detail. It may have been an oversight on our part not to specify that, but we have, we have construction or computation of specially the race profile of the complaints.

ADV KERRY WILLIAMS: Have you requested that of Medscheme subsequent to the complaints been made about these allegations of racial

discrimination by schemes. Have you requested that information from your administrator?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Yes we have had conversations after the commencement this enquiry, we had then requested that Medscheme looks in this statistical issue it might not necessarily be what the practice was, but even if it is statistical computation to say, are you able to, from you analytics pull a data that suggest claims or affected members or Service Providers by race profile. There are amongst other things and they were very willing to co-operate to assist in that regard, but amongst the things that they have highlighted as the difficulty is that often if they rely purely on the name or those other assumptions like where the person is, in term of location it does not always give the accurate reflection of whether the person is a black person and therefore whilst they can give us an assumption from the data, but it may not necessarily be accurate.

But yes, we have requested and we are in the process of engaging them to at the very least pull a statistical analyses that tends to give a picture in that regard.

ADV TEMBEKA NGCUKAITOBI: When did you ask them?

ADV NKOSINATHI WISEMAN BHUKA: Chair thank you. Whilst we do not have the exact dates or times that conversation may have taken place around, towards the end of last year, when we first got, when we got the first request from the Secretariat to address the panel as a scheme on the enquiry.

I will not have the exact dates, but it was more towards when were preparing to appear before the panel here.

ADV TEMBEKA NGCUKAITOBI: Yes, now the enquiry I mean has been long going, it started in the middle of last year. The allegations of racial discrimination are old, I mean they come from 2014. So why have you not done anything about them since them?

ADV NKOSINATHI WISEMAN BHUKA: Chair as I have indicated, so when we had engagements with Medscheme on this issue, their response was that claims are processed on the basis of practise numbers, and top of that as I have indicated the medical, Medscheme as an entity does not keep a particular categorisation of what is the race of the person, be the Service Providers or member who has submitted a claim at the time. So at the time when we had that conversation, purely as a Relationship Management issue we were satisfied that the practice numbers do not necessarily give an accurate proposition of what race may have been either of the member or of the Service Provider.

But we heightened a request and hence I have made a reference to a statistical data. So we heightened the request when the enquiry started and we became aware that we may, we be required to come and present before the Inquiry. We then heightened that request to say that we understand that you have told us that this process is based on practice numbers and so on and therefore you are not in a position to give us an accurate sense of what races are at play.

However, can you look at you statistical base and say is there any pointer that can assist you to, even if it is a deductive exercise, to do that exercise where you say there may be certain people either because where they are located or because of the names or because of any other identifier where you can say, even though the practice number tells you,

does not give the race, but when look at those identifiers that can assist you, so that is what we asked further, after the conversation was initially that based on the practice numbers it is impossible to deduct that information.

ADV TEMBEKA NGCUKAITOBI: Okay my understanding then is that your answer is; you asked them earlier for a racial breakdown, and they told you it is impossible to compute.

You asked them again and they said they would do it, but by reference to other factors.

ADV NKOSINATHI WISEMAN BHUKA: Chair, as I say we did not ask it for purposes of accounting to any authority. It was a Relationship Management issues to say what trends are you picking? At that point in time we threw it in as one of the issues we want them to analyse for us, but we are not preparing for any accounting to any authority. But when this process started and we were made aware that we may have to explain how we do certain things, then the conversation took a little higher note and said, even if by way of systems process you are not in a position you are not in a position to give a particular detail.

Are there any pointers that can assist you to give us a certain statistical picture, and so it was only at that point when we asked for it for the purposes of accounting or for the purposes of reporting.

ADV TEMBEKA NGCUKAITOBI: No, I appreciate that. I just want to know, when you first asked them as a matter what you call a management exercise, when was that?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair I would not be able to recall the exact time, but we have, the Fraud Forum for

example, we sit together with Medscheme. We analyse all complaints that come in, they will say, this are the recoveries we are busy with, and these are the trends we are picking. These are the issues we are having, either co-operation or lack of co-operation. These are the matters we may have to litigate and so on and so. During those monthly and quarterly reporting relationships or forums, that is when some of these questions will come up, and as I say it is a group of people. It may not necessarily be because they are preparing for a certain process.

One of the persons in the meeting might ask but it looks like all this complaints that we are receiving are a certain type. Are you able to pick up why is that trend and so on. But it will not be a pointed question that they must account to.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV KERRY WILLIAMS: I am sorry by when, but now you have requested it as I understand and you will provided with some report from Medscheme. Do you know when you will be provided with that report?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. As I understand Medscheme will be presenting the later or tomorrow, I cannot remember when, but however to the extent of what they have given us in term of a response to that, it is something that we can also add into our return submissions, but as it is right now we do not have that statistical data.

ADV TEMBEKA NGCUKAITOBI: Were you asked the matter as at the end of last year, and you asked them in order to help you make a presentation, your presentation is today. That is the point my colleague

is trying to understand. If you ask you in order to help you to present today then they clearly have not complied with your instruction.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Yes I note, I take note of the question and as I have indicated to the extent that it is going to assist the panel we can insist on that statistical analyses to the extent that they can get us and we can attach it to our return submission. I take note of the time lapse that you are referring to Chair and certainly we can remedy that by insisting on, if there is any data they may have that they can avail us.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV NKOSINATHI WISEMAN BHUKA: Just one last thing on that. We would like that, thank you very much, but is it not incumbent upon Polmed regardless of the existence of this enquiry to satisfy itself that there is any racial discrimination taking place, even if it is, however it might be. Whether it is indirectly or whether you know about it, if you, is it incumbent upon the scheme itself to make sure that that is not happening. Regardless of this enquiry.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. So Chair as I have indicated it was exactly on that reflection in the past we have heard a conversation, it was precisely that assertion that whilst it may not necessarily be a conscious practise but there may be certain towards that, and to the extent that there are those pointers is it something that needs a certain intervention, so that conversation did take place as I say. But the conversation when it took place at the time, it was not for the purposes of accounting to any authority or instrument or platform. It was purely to say what is the picture we are getting.

We called a *modus operandi*. What is the picture we are getting, but after the initiation of this process that is when we realised that maybe we should have the question may be even more potently.

ADV TEMBEKA NGCUKAITOBI: I suppose the accusation of racism is directed at Medscheme. So you then say go and investigate yourselves. Whereas I think the point that is being raised is that the Legislative of Duty rest on you as the scheme. There is no role for administrators in the Act.

The role is for the schemes. So since at least 2014, according to what we know there has been accusations of racism against Medscheme. At some point they must have come to your attention as you say in Management meetings. The question I suppose as well, if there racial discrimination by your Administrator you are liable for that. Isn't it in those circumstances then your duty to satisfy yourselves that your Administrator is perpetrating racial discrimination. I think that is the large point that has been canvassed with you.

We appreciate the answers you have given, you asked a question and did not get a proper answer and then you followed up which was sharpened by the existence of this enquiry. But this enquiry is really irrelevant to the question as to whether there is or there is not racial discrimination, because regardless of our existence you still bear a duty under the law to make sure there is no racial discrimination. So if an allegation is made I suppose the point is, is it not your duty to make sure it does not happen, especially in relation to your own Administrator.

So, I suppose that is really the thing. Where I am asking you to reflect you. I mean if you cannot that is fine. I also want to just ask you

something which you can reflect on which is that, what is your sense of your ability to hold Medscheme responsible in terms of the contract?

Do you get the sense that they have too much power, they are not accountable or do you get the sense that you are the scheme can in fact hold them liable. I am the sense that you can say to a Service Provider, I mean an advocate I provide services. When an attorney says I must give them a report, I try to give them a report on time, otherwise I will get fired. But the idea that you have asked twice for information of this importance, and until you have given your presentation it has never been given to you. I mean is it yourself that you in fact do have the leverage over Medscheme or do you think that they are just too powerful, they are not accountable?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair I am confident that we have the leverage, I am confident the necessary power over Medscheme. To the extent that we may not have not driven certain things it may well be a reflection on us not following up on certain things or in terms of further information to the extent that they may have responded and we want something further. So I am confident Chair that we have the necessary power over the Medscheme.

The contract allows us to exercise that power and to the best of my re-collection they have not willingly refused to execute an instruction based either on the genital mandate as contained in their contract or on a specific mandate as I have reflected that there may be times we have to give a specific mandate. So I have no doubt Chair that we will get the necessary response.

ADV KERRY WILLIAMS: Just another factual question. I mean does your contract require Medscheme not to unfairly discriminate.

ADV NKOSINATHI WISEMAN BHUKA: Chair, thank you. So as I have indicate Chair do not start think about the exact direct content of the contract, I am not sure it specifically deal with that hence I have indicated that when we submit, when we make the return submissions on the contract as was requested earlier we can then reflect on those specific issues that the panel would want us to pointedly address. So the direct answer Chair, is that I cannot recall if it specifically talks about containment of racial discrimination.

ADV TEMBEKA NGCUKAITOBI: Alright carry on. We have diverted you from your presentation. At some point you are still going to tell us the mechanics of the contract in terms of how it works and then you will also explain what exactly you say in confidential about it.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Connie the next slide. Chair thank you. So this is our slide 12 in terms of our presentation. This slide deals with, you will recall that I have said we have got a particular process in terms of which we account and we manage Fraud, Waste and Abuse. So the very first top is just a reflection or the confirmation that we have outsourced that function to Medscheme.

Then as we have now been discussing the contract. We have service level agreement agreement. We have got the sanctions policy. The sanctions policy deals specifically with what interventions may be employed in what circumstances which those two instruments, the service level agreement and the sanctions policy guide Medscheme's mandate in

terms of what they may or may not do in the process of recovering Fraud Waste Abuse.

We then have monthly and quarterly forensic reports that come from Medscheme to the scheme Polmed, so they report to us monthly as well as quarterly. We also have got the Management Committee meetings.

ADV KERRY WILLIAMS: Tell us what is the contents of those reports. The monthly and quarterly reports.

ADV NKOSINATHI WISEMAN BHUKA: Thank you, Chair. So the reports as I have indicated we account to two committees audit and risk as well as legal and policy in terms of the board committees. So the report for the purposes that it must go and get approval at the computation of the quantum of Fraud Waste Abuse. So they will tell us how many cases that they are dealing with, what are the values of each of those cases, what is the total quantum in terms of those cases combined. How much they are in a position to recover, or they have already recovered, so the report for purposes of the Audit and Risk committee will focus purely on the monetary values.

Then the report for the purposes of the Legal Policy and Ethics Committee will focus on the actual mechanics. So in other words what is the nature of the conduct that we are dealing with in terms of this Fraud Waste Abuse. What is the frequency of occurrence. In other words are we dealing with the same person over a number of times and so on.

So Legal Policy and Ethics Board Committee will then be interested in that in that kind of reporting. So the report is structured in that way, in terms of for whom is it being prepared.

ADV KERRY WILLIAMS: Will the Legal Committee be concerned with the manner of investigation and whether the, there is fairness in the manner of investigation of the Fraud Waste and Abuse.

ADV NKOSINATHI WISEMAN BHUKA: Thank you, Chair. Chair that committee, although it is never a specific item in the reporting but in the nature of the interrogation that that committee exercises when it gets that report I would imagine it is something that is something that is in their purview that would ask for.

So far what the committee has asked for is, is issues such as the nature of the conduct, which entity has it been referred to, in other words either for criminal investigation or Health Professions Councils, and that said what is the frequency. What have you done in terms of trying to engage or recover from that Service Provider.

So I do not recall a specific question that said how did you actually investigate. I do not recall that question.

ADV KERRY WILLIAMS: Just a few further questions on this Legal and Ethics Committee. What it discusses and what it might direct or not direct Medscheme to do.

So an issue in this inquiry has been Medscheme requesting patient confidential information from providers. So, patients files or notes. I would like what Polmed position is on that. Does it mandate Medscheme to request patient files from the doctors in order to conduct their audit.

ADV NKOSINATHI WISEMAN BHUKA: Thank you, Chair. Chair, it is possible that they would, they would do that. The scheme rules allow for, the scheme rules allow for such information to be requested for purposes

of forensic investigation. So, to the extent that Medscheme does it within, how it is described in the scheme rules, they would, they would do that. I do not know if the Chair wants me to rule the rule.

ADV KERRY WILLIAMS: What, we have a copy of the rule. Where are you pointing us to so that we can be sure we are on the same page?

ADV NKOSINATHI WISEMAN BHUKA: It is our Bundle Chair, slide 21.

ADV KERRY WILLIAMS: Can you explain to me why you think that entitles Medscheme to access patients confidential information?

ADV NKOSINATHI WISEMAN BHUKA: Chair if I may just read the rule.

> "The scheme shall have the right to obtain any relevant medical and or financial information concerning a member or beneficiary that may be deemed necessary from the supplier of health, care, goods or services. Including medicines, or any other person that has such information under his control, and shall disclose such information to the authorised personnel or medical advisor of the scheme."

Our reading of that rule Chair is that it obliges the person who may have the relevant information to be more exact to use the phrase of, of, the confidential information, to the extent that it is required for purposes of ...[intervenes - break in recording]

Well I doubt I will be done in 30 minutes with the remaining component of my presentation. So, I was thinking that maybe we address a lot more by way of the written submissions. Then I run through the principle issues on each slide so the Panel may formulate ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: The fault is really not yours. It is ours. We are the ones asking the questions. But I am happy for you to supplement but the engagement is also crucial as part and parcel of our own understanding. Let us see what we can do in 30 minutes. If it becomes intolerable then we will revisit it at that stage. But you have the right to supplement for as much as you can.

But I do not want to do is to give you permission to abandon your oral presentation in order to give us written presentation which cannot be questioned. You see what I mean? Alright, so are you happy to take 10 minutes and then consult with your team.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair.

ADV TEMBEKA NGCUKAITOBI: Thank you.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Thank you, we are resuming. The last question was to try and reconcile page 90 with page 21 in terms of which rule is actually applicable.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair the quick answer to that is that page 90 is a clause in the application form- membership application form so that is a consent and declaration. So, in other words when the member signs the scheme membership form there will be one- there will be this provision as one of the provisions in the membership form that says the member must give consent for the scheme to do what is set out in rule 20- in slide 21. So, slide 21 is a rule in the rules book of the scheme and page 90 is a provision in the membership

form of the scheme which translates that rule into a specific undertaking at a membership stage.

Then Chair, if I may proceed? So, I was still addressing Chair the slide on- slide number 12 on our bundle and I was just taking the Panel through the processes that we are employing as well as the forum or platforms that are at play within the policy space to manage fraud, waste, abuse.

And when the question came, I was specifically addressing the management committees that are there which is the Fraud Forum where we get these reports, monthly reports as well as quarterly reports in terms of what Medscheme is busy with in terms of the recovery process. What investigations are they busy with, at what stages are those investigations and whether or not they have recovered or they are in the process of recovering. So, they will account those and then the finance committee will also be one of those committees where for purposes of the financial values of the various claims, they will also report to say what are the monetary values that are involved in that process. And Chair … (intervenes)

ADV ADILA HASSIM: Sorry, Advocate Bhuka, could you provide us with a copy of a monthly and a quarterly report to the scheme?

ADV NKOSINATHI WISEMAN BHUKA: The actual monthly or quarterly report.

ADV ADILA HASSIM: Not every single one but one or two so we can see what it looks like.

ADV NKOSINATHI WISEMAN BHUKA: I- yes. Thank you Chair. Then Chair the- as I have indicated the board committee meetings, I think

through the questions I think I have already reflected which of those committees looks at what so I will not repeat that exercise.

ADV KERRY WILLIAMS: Before you move from the slide, you said something earlier about the SLA and the Sanctions Policy to guide the forensic process that is on side. You said specifically that you do guide Medscheme's forensic process. How do you guide it?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair you will recall that I first spoke about the mandate and that mandate is based on the accreditation that Medscheme has as an administrator and that mandate is based on the Sanctions policy. So, in other words, when we give them the mandate, we look at what the law allows them to the extent that they are accredited. We also look at in terms of our own as POLMED, our Sanctions policy, what sanctions may be imposed in what circumstance.

So we do not guide Medscheme in term of running the investigation but when they report, when they account we monitor and hold them to account based on those service levels that are in the contract also based on whether or not they have applied the Sanctions policy as it is set out in our policy. So, we do not tell them what to do at what stage of the investigation.

ADV KERRY WILLIAMS: Okay so I understand you do not guide them in an investigation. You exercise no control over the way they conduct their investigations. Is that- would that be correct?

ADV NKOSINATHI WISEMAN BHUKA: That is correct Chair.

ADV KERRY WILLIAMS: Okay. So, what does the Sanctions policy do? What input do you have there?

ADV NKOSINATHI WISEMAN BHUKA: Chair, so I have indicated the Sanctions policy it is also a slide here in the presentation. It talks to what sanctions we may impose. If you go to page- slide 15, sorry, of our bundle Chair. So, if you look at ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: Maybe start at page 13, does it not?

ADV NKOSINATHI WISEMAN BHUKA: Yes, thank you Chair. So that process sets out the sanctions that we impose. So, Sanctions policy, if I can Chair direct to you specifically to page 15. So, you will see their professional sanctions is effectively when we require the Medscheme in term of the mandate to refer certain matter to the professional body for further investigation.

Then your criminal sanctions would be where we require the administrator to refer the matter for purpose of criminal investigation either to SAPS for purpose of criminal investigation and further processing. If you look at page 60- sorry, slide 60, it talks about administrative functions- sorry, civil sanctions and this is where we may then have to litigate in Civil Court for purpose of recovery. So those would be your civil sanctions.

Then you have got your administrative sanctions which talks to things such as putting the service provider on hold, indirect payment and so on. So that whole detail is set out in the Sanctions policy and this is what we when Medscheme accounts either in the monthly or in the quarterly meeting, these are the things we test against what they have done.

ADV KERRY WILLIAMS: Can you give us a practical example of when you might have found when they did not do something and you held them to account?

ADV NKOSINATHI WISEMAN BHUKA: Chair, thank you. Ja, I will struggle to have something of- I include it as part of the written submission, that is the best I can do.

ADV NKOSINATHI WISEMAN BHUKA: Would it be fair to say, if you cannot recall it that it does not happen very often?

ADV NKOSINATHI WISEMAN BHUKA: Yes Chair. It does not happen very often that they act outside the Sanctions policy.

ADV TEMBEKA NGCUKAITOBI: Who is being sanctioned here? It looks like you are sanctioning the member as opposed to the service provider. Because it says, Termination of Membership, Reporting the Member to the Employer. And those are the sanctions you are talking about. It is not sanctions under the contract as against your own service provider.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair it is both. We apply the Sanctions policy for purposes of both the member and the service provider hence if you look at slide 16 when it deals with administrative sanctions, those are sanctions that would specifically apply to the service provider.

ADV TEMBEKA NGCUKAITOBI: I see.

ADV NKOSINATHI WISEMAN BHUKA: Putting on hold, indirect payment and so on. So those would be specific to the service provider. But that said Chair, this is an overall of all the sanctions both a member as well as a service provider.

ADV TEMBEKA NGCUKAITOBI: Can you just explain what we have come across in relation to Medscheme is that there are instances where they write a letter to the service provider and in that letter, they tell the service provider that their relationship has been suspended even before

an investigation is undertaken. Do you sanction that or are they doing that on their own?

ADV NKOSINATHI WISEMAN BHUKA: Let me just try and understand Chair. So, what I understand you to be saying is that Medscheme would say to a member, your … (intervenes)

ADV TEMBEKA NGCUKAITOBI: Your service provider.

ADV NKOSINATHI WISEMAN BHUKA: Sorry, to a service provider, your payments have been suspended. So, in other words the scheme is not going to pay.

ADV TEMBEKA NGCUKAITOBI: They will say, we suspect allegations of wrongdoing. We are suspending payments and please provide us with the historical data going back three years. Now what I am asking you is, the suspension of payments prior to completion of investigation, is that sanctioned by you or is Medscheme doing that on its own?

ADV NKOSINATHI WISEMAN BHUKA: Chair, that would be provided for in the mandate or in the process. One of the things that one may remember in terms of this- the recovery fraud, waste, abuse recovery process is that payments are made in good faith. So, in other words you get a claim today, you take payment. The analysis in term of the analytics takes time after.

Now what would happen is that say if we have received a certain badge of claims from a particular service provider over a period say 6 months or whatever the case may be and we have paid those. But on badge number 7 when we do the analytics, we realise that but there is something that is not- is out of the ordinary based on what we have always there to within term of that analytics. Then at that point in time Medscheme will then

advise the service provider that we have picked up these inconsistencies or problems and can you get an explanation. Member explains and Medscheme ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: No, I am talking about prior to the issue of the explanation.

ADV NKOSINATHI WISEMAN BHUKA: Mm-hmm.

ADV TEMBEKA NGCUKAITOBI: What you do as- let us take your example. You have got 6 payments, badge number 7 you pick up problems.

ADV NKOSINATHI WISEMAN BHUKA: Mm-hmm.

ADV TEMBEKA NGCUKAITOBI: What I am asking you is what we have seen here is that there are instances where Medscheme at the time you pick up the problem, suspends payments to a service provider. And then says give us information to investigate the previous 6. Now I am asking if that procedure of suspending payment prior to completion of investigation is sanctioned by you?

ADV NKOSINATHI WISEMAN BHUKA: So Chair, yes, the process of suspending payments before investigation is- I just want to be sure that I am responding to the correct question, is something we would sanction but it would not be a suspension on the particular- the best way Chair is to explain it by way of the example I was trying to give.

So, if we have received a claim and we have paid that claim and Medscheme then on a further claim realises that there is something that is not adding up, they would not just suspend as I understand it, the claim. First, they would correspond with the service provider to say, we are not happy with this. What I have seen in certain occasions Chair is a

member would contest that, so in other words, Medscheme will write and say, the 2 3 things are not making sense … (intervenes)

ADV TEMBEKA NGCUKAITOBI: No, no, I appreciate that but that goes into another category where they have engaged with a member and prior- after engaging with the member they were not satisfied with the explanation.

I am talking about where it is the first time that a service provider has been identified as allegedly having committed an FWA and at that point they are already told that no further payments will be made. I am asking if that procedure, there is many many numerous examples. I just want to know from POLMEDs point of view if that procedure is sanctioned?

ADV NKOSINATHI WISEMAN BHUKA: No.

ADV TEMBEKA NGCUKAITOBI: It is not sanctioned?

ADV NKOSINATHI WISEMAN BHUKA: No, it would not be sanctioned without that prior engagement of requesting explanation.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV KERRY WILLIAMS: Thant answer is still not clear to me. So, it would not- it is not sanctioned. So, when is being placed on suspension when direct payment sanctioned by you?

ADV NKOSINATHI WISEMAN BHUKA: Chair, as I have indicated, direct suspension or any other of the administrative sanctions it would be after for purposes- if it is a sanctioned intervention, it will only be after Medscheme has requested a certain response. That response either came and was not satisfactory alternatively that response came but contested the assertions of Medscheme. And then at that point then

Medscheme may apply whichever of the sanctions as per the Sanctions policy.

But I am saying that we would not sanction or we would not authorise maybe to so that language is clear, we would not authorise an imposition of a particular sanction where there is- it is the first time Medscheme receives a claim and they pick up a problem with that claim and they immediately put the person on suspension without communicating with that person.

ADV KERRY WILLIAMS: So, you agree the provider must be given a form of a hearing? They must be given opportunity to state their position before being put on indirect payment?

ADV NKOSINATHI WISEMAN BHUKA: Yes, I agree Chair.

ADV KERRY WILLIAMS: Thank you.

ADV ADILA HASSIM: Sorry, and then in order for the service provider to avoid being placed on suspension, the service provider would have to provide the information that is being requested, the patient information? Is that right?

ADV NKOSINATHI WISEMAN BHUKA: That is correct Chair. So, in order for the service provider to be placed on suspension or any other of the sanctions that may be applicable because remember suspension may just be one.

ADV ADILA HASSIM: I know but what period of time must the service provider- so the information that is requested, how far back in time may it go?

ADV NKOSINATHI WISEMAN BHUKA: Chair the information that may be requested as I have said Chair, we use or Medscheme rather uses a

certain analytics and if they pick up that of the 6 claims already that we have paid out there is this particular problem that they have picked up actually started from claim number 4. Then that would be from when the sanction will be imposed.

So, there is no uniform or generic rule that says we will start from 3 years back or that kind of thing. It is going to be dictated by the analytics in term of where do they show reasonably the particular conduct to could have started.

ADV ADILA HASSIM: And that could be more than 3 years.

ADV NKOSINATHI WISEMAN BHUKA: It is possible.

ADV ADILA HASSIM: And that is sanctioned by the scheme to go back more than 3 years?

ADV NKOSINATHI WISEMAN BHUKA: It is possible.

ADV TEMBEKA NGCUKAITOBI: Can you just explain where in the contract between the scheme and the service provider do you require service providers to keep records for more than 3 years?

ADV NKOSINATHI WISEMAN BHUKA: Chair, for purpose of accuracy it is something I can also address in the written submission. However, I am certain and I am aware that in the rules as well the communication to the service providers, we do make the point in terms for how long the records or the data may be kept. But for purposes of not misleading the Panel I will not give you the exact preposition in terms of exactly what do we say and what time do we give. But certainly, we do.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. So, I was just finishing up that so … (intervenes)

ADV ADILA HASSIM: Sorry Advocate Bhuka, and how much time is the service provider given to provide that information before being placed on direct suspension?

ADV NKOSINATHI WISEMAN BHUKA: Chair, the service provider would not- again there is no uniform time to say please all service providers must respond within 14 days or something like that. There is a particular engagement where Medscheme will say, in order for you- for us to process your claim further we need you to assist us with the following information or concerns that we have with your claim.

It may well be that the service provider is going to say, I do not have that information readily available give me a week or give me a month because the records are not sitting with me. So, there is no uniform rule where we say every service provider must respond within a particular number of days. It becomes a matter of engagement.

ADV TEMBEKA NGCUKAITOBI: If you look at page 67 of the Commissions bundle. Let us use that is an example that is … (intervenes)

ADV NKOSINATHI WISEMAN BHUKA: Page 60 Chair?

ADV TEMBEKA NGCUKAITOBI: 67 of the Commissions Bundle. The Panel's bundle.

ADV NKOSINATHI WISEMAN BHUKA: Yes, I see that Chair.

ADV TEMBEKA NGCUKAITOBI: We do have an example of what this looks like. At 68.

ADV NKOSINATHI WISEMAN BHUKA: Yes Chair.

ADV TEMBEKA NGCUKAITOBI: At the board, it says that kindly note that should the information requested not be submitted within 10 working

days. And the letter itself is dated the 13th of May and the deadline is the 27th of May. And the request is for information between January 2016 and March 2019. So, they are asking for data that goes beyond 3 years and then they say you must bring it in 10 days' time. In circumstances where we are not even sure whether information lies.

Now from a- the perspective of the doctor, this is like a sword hanging over his head. That if I do not supply this, I am going to be put on indirect payment. Now is this the sort of thing that you encourage Medscheme to do?

ADV NKOSINATHI WISEMAN BHUKA: Chair, thank you. Certainly, the time does look very short given the extend of the data or records that are required. It- I can imagine one of two things Chair and one is that if there was a prior conversation where there was understanding that this information is readily available, in that circumstance it may have been reasonable to give that timeframe. But if this was the only and the first conversation or exchange, yes, it does look unreasonable the timeline.

ADV TEMBEKA NGCUKAITOBI: Sir, we were trying to debate with you earlier about what exactly is the hold that you have over Medscheme because I think there have been 3 questions that we have asked and where you have- kindly and not that it is criticism but it is the right thing. Where you say, well that seems wrong or that seems unreasonable. It is exactly this sort of thing where which take me back to answer- to asking what hold do you really have over Medscheme? It looks like they just have free reign.

I mean you take the example you have given where they give the service provider an unreasonable period to collect material that- I mean if you

ask me what I did in 2016, I have no idea what I did in 2016. I mean no reasonable person should be put through this. You paying these people every month, why are you not disciplining them?

ADV NKOSINATHI WISEMAN BHUKA: Chair, thank you. As I have indicated it is certainly not a free reign. I have indicated Chair that there are various instances or platforms where Medscheme must account.

Now if we take for example this particular cases that you are referring to, it may well be that when we look at our records there has been- because now we only referring to this letter as an isolation. We do not know what is the context. What is the total composition of the record? It may well be that Medscheme had advised us that, this is the situation we are having and based on this this is the conversation we have had with the particular service provider. In those instances, we may have said, I am saying we may because I do not have now the full context of the file in terms of what this is related to. We may have said either that process or that timeline is wholly unreasonable, please give the service provider a lot more time.

I am for example Chair aware that in certain instances where you have these kinds of concerns where either the timeline or the information requested because sometimes the service provider is, we even contest the necessity or the relevance of the information requested. In those instances the service providers have come to the scheme and say, we are having the particular engagement with Medscheme and they are requesting 1, 2, 3 and we feel that it is either unreasonable or it is not going to assist or they are simply what using the power or- and we would intervene in those and engage Medscheme.

And if we find that what Medscheme has requested and we will ask Medscheme also to send us the records of what communication they have sent to the service provider. And if we find that that communication or engagement was beyond what the mandate- what mandate they have in terms of the contract. We will certainly intervene and either reverse what they have done. We also in term of our service level contract we have got what you call penalties so if they have done certain things outside the contract, we can also apply penalties.

But all I am saying Chair, I am trying to explain Chair is that the picture painted by these letters in their isolation, yes, it may suggest either an unreasonable or unconscionable conduct. But if this picture is placed within the context of whatever file that one may have been dealing with at the time, you might find that there has been prior conversations where either something has been referred to us for intervention and we have either ruled, to use the phrases loosely, in favour of Medscheme or in favour of the service provider.

But I cannot with the conscience in my mind agree that or say that we are giving Medscheme free reign, certainly not. If you look at sometimes the complaints, they have about the penalties we apply on certain things, it cannot be free reign.

ADV ADILA HASSIM: Advocate Bhuka, you said that you as POLMED do not sanction, do not permit Medscheme to place service providers on immediate suspension.

ADV NKOSINATHI WISEMAN BHUKA: Without prior (indistinct microphone)

ADV ADILA HASSIM: Yes. So on in the same example, if we take the same example which goes- covers a period of more than 3 years request information within 10 days. But it also says in the same letter, please be advised that your payments are currently suspended and will remain suspended until the requested documents are received and reviewed and a thorough analysis has been concluded.

So, this is an example of immediate suspension. This is a letter that starts off informing the service provider that the medical schemes have determined that it is now necessary to do this analysis and until the analysis- information is received, the payments will be suspended- are currently suspended. So, this would be contrary to what you just said earlier, that you do not permit immediate suspension without prior engagement?

ADV NKOSINATHI WISEMAN BHUKA: Thank you, Chair. I think Chair as I have indicated, if one has had a full record of this file and say this letter was the first communication that ever took place between Medscheme and the service provider, then I can take the point.

But all I am saying is that right now all I have is this letter. I do not know whether there was any other conversation before this letter was exchanged between Medscheme and the particular service provider. So, it is difficult for me to say, yes, they have acted outside their mandate in terms of the administration contract.

ADV ADILA HASSIM: I accept that you need to look at more than just this letter in relation to this example. When this file was provided to you last year to respond to the complaints, you would have picked up that the letter says it is immediate suspension. Did you then look at the context

to see what took place in relation to for example this case is not the only- there are several examples like that in this bundle.

Did the scheme look at the context to see whether this was above board and in line with the rules that you permit the administrator to comply with?

ADV NKOSINATHI WISEMAN BHUKA: Chair, if you look at our bundle at the back of our bundle Chair, we have got a spreadsheet which sets out the complaints that were specifically referred to us for purposes of direct or point at response. If it is one of those, it will then be covered in term of that spreadsheet in term of the history of the matter. If then it is not then ... (intervenes)

ADV ADILA HASSIM: It is.

ADV KERRY WILLIAMS: And there is a further similar letter for Kwazwayo which is also covered in your spreadsheet. There is the exact same letter, page 32 and 33 of the bundle.

ADV ADILA HASSIM: And for Kanyanye.

ADV NKOSINATHI WISEMAN BHUKA: I am trying to see them on the spreadsheet.

ADV TEMBEKA NGCUKAITOBI: It is number 8 from the top, that is Ms Mapumulu.

ADV NKOSINATHI WISEMAN BHUKA: Okay.

ADV TEMBEKA NGCUKAITOBI: Let us just focus on Ms Mapumulu for now. Where is the answer that you say will give us the full context?

ADV NKOSINATHIS WISEMAN BHUKA: ... and to read through the spreadsheet in terms of the columns where it would give me some

historical context. Period of investigation, so this was in 2019. It's a tricky one Chair, sorry.

ADV TEMBEKA NGCUKAITOBI: Look there is nothing tricky because - unless you have something you mean when you say it is tricky? But I mean, we are not trying to trick you. That is what I am trying to say.

ADV NKOSINATHI WISEMAN BHUKA: My apology for that.

ADV TEMBEKA NGCUKAITOBI: *Ja.* But what we are trying to understand as you would have seen. I asked a general question about what you allow Medscheme to do and you have made it clear that you don't allow them to suspend as the first port of call prior to enquiring and then I asked a general question about the timing and you have again admitted that that period is short.

But your broad answer was, I need to investigate the matter. The problem with that, I mean I would have accepted it. If you want time to investigate, fine. But the problem is that this was given to you for a thorough review so that you can respond to this. This is what you have responded. Now we have read this spreadsheet. There is no answer to the spreadsheet.

And the fact that there is no answer is not because you didn't have time. You've had enough time to investigate and provide an answer. The best that you could do is to write cryptically, 'awaiting outcomes of investigation'. That is just unacceptable.

ADV NKOSINATHI WISEMAN BHUKA: Yes, Chair, sorry Chair. Thank you Chair, I take the criticism Chair. As I understand this is one of complaints that we received on the 22nd of January. It was not in the

last year's bundle. So, with that kind of time and the number of complaints that we had to go through.

ADV TEMBEKA NGCUKAITOBI: I mean, but then I don't want to get into a debate with you about the facts about when you received this but our understanding is that this came to you last year already and the fact that you say that you got it in January is untrue. But there is no point in you arguing with the panel. You are here to give evidence. What are you suggesting now exactly around this issue because what we are trying to do is to understand what is happening here. Medscheme has done two things, on your own version, which are not in accordance with what you expect them to do.

They have given a service provider too short a period for an unreasonably wide range of information. They have suspended them before they have conducted an investigation. You have investigated it and the best you have come up with is that it is awaiting an investigation. So, is your point at this stage that you still want to look at this further and then come with a better, more improved answer or what are you suggesting?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair, if it may please the panel, may I request that I then include this in my written submission and amplify my responses because I don't want to give the panel an inaccurate response on the matter so I would rather satisfy myself of the exact facts and address that question.

ADV TEMBEKA NGCUKAITOBI: Just tell me, in terms of the way in which you relate with Medscheme, do you, I mean I know they submit monthly and quarterly reports and they call them forensic reports and

we have not seen what that report looks like. But do you actually deal in those reports on a case by case basis where you go through each letter? For instance, there are so many of these letters from Medscheme which say, 'we have detected a problem, you are hereby put on indirect payment, give us information' covering a range of schemes.

Now, if it was wrong to do that as you have testified, this would have been picked up quite early in those management meetings. What I am struggling with, why has it not been picked up? Why should it require us, as the panel, to point it out to you today, the 27th of January, on things that have been happening for years? So, clearly someone is not reading it, or if they are reading it, they just don't care.

ADV NKOSINATHI WISEMAN BHUKA: In terms of the report, Chair, I had earlier indicated the report from Medscheme will deal with two things, depending on which committee we are preparing for. If it is preparation for the Audit and Risk the focus would be on the monetary values that are involved. If it is preparation for the Legal and Policy Committee the preparation or the report would focus on the actual substance of the complaints or the investigations that are taking place. The process of investigating, Chair, you will recall that I did indicate that we don't dictate them in terms of what to do at what time in terms of the actual investigation process but what we do interrogate when we receive the reports is what is the actual problem or subject matter of the investigation. What stage or phase it is and whether or not the member is contesting that particular investigation? And what is required to get to a resolution? So in other words, if you require a

confirmation that a script was given? So is all that is required to finalise the investigation?

But, we don't Chair, get into what is your first process? Do you write a correspondence? Do you call? That process is entirely within their investigation or analytics process.

ADV ADILA HASSIM: You would have also picked up by now that a number of the service providers don't provide the information and that holds up the investigation and the reason that they provide for not giving the information is that it's confidential information of the patients and they are not permitted, in terms of their ethical codes, to release that information. Do you then engage with your members directly to seek informed consent in respect of records held by that particular service provider to break the deadlock?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair, Chair, as I have indicated yes, we do, on two occasions. The first one is a generic occasion where at membership stage when the person signs the membership form the consent is there as part of the provisions.

ADV ADILA HASSIM: Okay, I am talking about, that is what the member signs when becoming a member of the scheme, but when there is an investigation ongoing and you have requested from the service provider, your member's information and the service provider is saying that he or she cannot provide it, do you then contact the member directly to say there is an investigation and that they should release the information or give further consent to release that information.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair, yes Chair, it does happen both ways. Sometimes the member will call us directly

and say I am required to provide this information and I believe it is confidential and we will direct the member to the rules and say for purposes of verifying the claim or whatever the investigation may have been, you are obliged, based on the rules to make that information available. Sometimes it would be if the matter is referred to us directly or is picked up during the reporting discussions with Medscheme, we will be in a space where we will then ask the member to co-operate. That is the phrase we generally use with the process of investigate including where the information is required, that the member co-operates and given the necessary consent for that information to be obtained.

ADV TEMBEKA NGCUKAITOBI: The problem we have had is not so much on members, you see, members are you members and if you have signed a consent to release information that is fine. But the problem is service providers as doctors, the problem is not so much your rules, the doctors are saying under the Act and their Code of Conduct they are not at liberty to release patient information and if you want patient information, you must get it from the members, not from them.

But it is them who receive the sanction of a suspension or indirect payment because they are refusing to provide you with the information and when they refuse they say it is because we are complying with our own Act which they say enjoys precedence over any agreement between you and your members. So I think that is really the scope of the debate, is how you reconcile the clashing ethical obligations.

ADV NKOSINATHI WISEMAN BHUKA: Chair, as you have indicated, it may be a contested space between the service providers and the

schemes. We interpret the rules or the applicable provisions of the regulations in that fashion, in other words, as to empower the service provider to make that information available. If it is a service provider's contention that our interpretation is incorrect or inaccurate, I suppose it is unfortunate, it is one of those things that may delay the investigation process.

I would imagine there are certain cases where some of those contested interpretations have been referred to both counsel and appeals board for purposes of interpretation. So, I agree with you it is a contested space. That is not deniable.

ADV KERRY WILLIAMS: Mr Bhuka, can I just carry on on this point? Can you turn to page 67 and 68 of the bundle because what I am struggling to understand, our bundle, the Commission's bundle – 67 and 68 – so I have read the scheme rules on page 21 of your Powerpoint presentation and I have already given my view on that. But, what I want to ask you about now is, we have been provided with reams of correspondence written by Medscheme on your behalf and not once have they invoked the scheme rules as a basis to require the doctor to disclose the patient information.

They in fact invoke a provision of the general regulations on Managed Health Care which is regulation 15(j) and they also invoke the application for membership form, the wording in that, which I pointed to earlier. So it is very odd to me that today you are here saying that Medscheme is entitled to access patient information from doctors by virtue of your rules but nowhere in the correspondence does Medscheme mention these rules at all.

So if you turn to page 68 and this again is a letter from Medscheme written on behalf of POLMED, and in the middle of the page they say in terms of regulation 15(j) of the Medical Schemes Act regulations, a medical scheme is entitled to access any treatment record. So they rely on something completely different to what you say they should rely on. Can you explain that?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair, you will recall that when I spoke to the administration contract, the component of which is the fraud/waste/abuse process, I indicated Chair, that the contract is premised on a number of things. One, I mentioned accreditation of Medscheme, either generally as an administrator or for an accreditation for a specific function. I also mentioned our internal policies, the sanction policy to be more exact, in terms of how we expect Medscheme to implement their fraud/waste/abuse management.

I wouldn't, Chair be in a position to explain why would Medscheme choose to rely mostly on the Act rather than the rules of which the rules is a product of the Act.

To the extent that that is not contravening the mandate they have in terms of our sanctions policy as well as their accreditation status, I wouldn't necessarily contest that Chair, if I may use the phrase. So, yes it is possible they may have chosen to rely more on the Act than the rules but I am not sure if that suggests a contravention of the mandate as it were.

ADV TEMBEKA NGCUKAITOBI: Thank you. I think let's return to your slide.

ADV NKOSINATHI WISEMAN BHUKA: Sorry, I have already addressed Chair, the kind of sanctions that Medscheme would be authorised in terms of their mandate to apply in respect of various stages. The next slide, Chair, which is slide 17...

ADV ADILA HASSIM: Sorry, I am so sorry Adv Bhuka, but I don't want you to move too quickly off those sanctions because you refer to acknowledgement of debt and you say where an acknowledgement of debt is reached, a settlement is reached in terms of section 59(3) of the Act. Where does section 59(3) allow for a settlement or an acknowledgement of debt?

ADV TEMBEKA NGCUKAITOBI: You can take mine if you want, the Act. Can you just pass it on. Oh, have you got a copy? Good.

ADV NKOSINATHI WISEMAN BHUKA: Section 59(3)?

ADV TEMBEKA NGCUKAITOBI: Yes.

ADV NKOSINATHI WISEMAN BHUKA:

'Notwithstanding anything to the contrary contained in any other law, a medical scheme may, in case of

(a) any amount which has been paid... '

ADV ADILA HASSIM: Turn your mic on please Adv Bhuka.

ADV NKOSINATHI WISEMAN BHUKA: I didn't realise that it is off.

'Notwithstanding anything to the contrary contained in any other law, a medical scheme may in the case of

(a) Any amount which has been paid *bona fide* in accordance with the provisions of this Act to which a member or a supplier of health services is not entitled to; or

(b) Any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme

deduct such amount from any benefit payable to such a member or supplier of health services.'

And the question was how does that translate into an acknowledgement of debt?

ADV ADILA HASSIM: Yes. And I am just reading from your slide. You say where a settlement is reached and then you in brackets say (AOD) in terms of 59(3) then one of the following sanctions are imposed and then you list the sanctions.

ADV NKOSINATHI WISEMAN BHUKA: So Chair, the long and short of that provision Chair is that that deduction that is referred at the end of section 59(3) where it says the scheme may deduct the relevant amount, deduct such amount from any benefit payable. Our interpretation is that it wouldn't be proper to simply do the computation of what amount it is that is either paid erroneously or on any other grounds set out there. It would not be proper to then simply start deducting that.

So, in other words, once the computation has been done, an arrangement must be reached with the service provider to say, this is what we have computed, this is what we are going to deduct in terms of section 59(3). However, which way would work better or assist the service provider as well so that you can continue to do your function. So, the AOD is a way to get into implementing the deduction.

ADV ADILA HASSIM: So you are saying the AOD there is a repayment agreement, it is not a settlement off an amount that is not based on the actual loss?

ADV NKOSINATHI WISEMAN BHUKA: The AOD Chair is by its nature a settlement agreement.

ADV ADILA HASSIM: Yes, but is it for the purposes of structuring the payments going forward or is it a settlement of some amount of money but that is not based on calculation of what the loss the scheme suffered, what exact amount the scheme suffered.

ADV TEMBEKA NGCUKAITOBI: You see, I think the point Adv Bhuka is that if I claim you owe me money, or you owe me R20. You can say I don't owe you or you can say I owe you R20 or you can say yes, I owe you but it is R10. If you admit you owe me R20 then you can sign an AOD for the whole R20 but we can also sign an AOD for R10. But when we sign an AOD for R10 it becomes then a compromise. I think that is really the question about this. What you mean by an AOD is that it is not the actual amount that the scheme says is due, it may be a compromised amount?

ADV NKOSINATHI WISEMAN BHUKA: Certainly, Chair, that is correct. It may not necessarily be the amount that the scheme has asserted. It may be the amount that has been agreed after whatever the scheme have thought initially is the total value.

ADV TEMBEKA NGCUKAITOBI: Explain something to me because I am not sure if I understand this. The Act that you have just read, the section that you have just read, expressly talks about such an amount. The practice that is followed by Medscheme is that the average based

on a deduction, we looked at I think its ten, yes ten examples, they extrapolate an amount and they will do an average. And then they will go backwards and say well we think based on what we have found in relation to ten instances, we think the total amount of all of your claims is inflated by 10% and therefore pay us 10% of all of your claims and then maybe they come to R2 million claim comes to R200 000 and that is the amount you are then entitled to deduct. Is that correct?

ADV NKOSINATHI WISEMAN BHUKA: Chair if you don't mind, can you just refine your question?

ADV TEMBEKA NGCUKAITOBI: Just tell me, maybe I should ask an open question rather than a leading question. What is the mechanism that Medscheme uses according to your understanding, to arrive at an amount?

ADV NKOSINATHI WISEMAN BHUKA: Chair, I am just thinking now whether Medscheme is best placed to answer that.

ADV TEMBEKA NGCUKAITOBI: No, no, no you see I am not going to allow this because we cannot have a scheme which has a duty under the Act, because that section you've read imposes a duty on the scheme, not on the administrator, so if the administrator is acting illegally it is your job to discipline them.

So, you cannot not know the method that they use to arrive at an amount.

ADV NKOSINATHI WISEMAN BHUKA: Thank you, Chair. My apologies Chair. Maybe I had expressed my thoughts in a manner that, what I am saying Chair, I am not saying we don't know how Medscheme arrives at an amount but all we are saying is, as a matter of principle,

is it a question that, maybe let me debate that Chair. Let me just get to responding to the question. Chair, Medscheme have got a system where as claims come in between the administration function and the fraud/waste function, there will be exchange of, let's take for example, admissions. That information will be fed from the administration function to say we have got so many admissions which were referred by this particular doctor and based on that, there is an unusual amount of claims.

Now that is based on a number of things, Chair. It is based on the, I am going to call it the ordinary value of a particular service, so if for example, a particular service would have warranted a 1 day admission and the authorisation or the referral from the doctor suggests 3 days, I am just using that as an example, then that would be one form of a trigger. And the computation then would be, if it is then established that the extra two days should not have been part of the admission then that would be the computation to say ordinarily all we should have paid is 1 day, 2 days should not have been paid. It was an inappropriate admission and therefore the computation for the purpose of that admission and for fraud/waste/abuse recovery, and I am not now getting into a classification as to whether that would be fraud or waste or whatever, but I am just now referring directly to the computation, then the computation would be, you have put the scheme out of pocket in an abusive or a, whatever manner, by two days worth of admission and therefore that is the amount we are going to then pursue in terms of the recovery process.

So, what I am saying Chair, is that as we understand it, that is the process. You get those claims, they get analysed in terms of the system. Then the system will tell, either from a practice code, or from a service code point of view what would have been the ordinary or the appropriate level of payment for that particular service. And once that is done, whatever is deemed to be outside that ordinary payment level, then would be the amount that would be pursued.

ADV TEMBEKA NGCUKAITOBI: Certainly, that is how it should be done, so if I should not have been hospitalised and I am sent to hospital for five days, you have been put out of pocket for five days, correct? But that is a specific amount that the service provider is then liable for, correct?

ADV NKOSINATHI WISEMAN BHUKA: That's right.

ADV TEMBEKA NGCUKAITOBI: Yes, now any other system that doesn't track what you have described, would that be authorised by you?

ADV NKOSINATHI WISEMAN BHUKA: No, Chair. I do not recall us authorising such in the past.

ADV ADILA HASSIM: Can I ask you to have a look at page 26 of the bundle, of the Commission's bundle?

ADV NKOSINATHI WISEMAN BHUKA: Page?

ADV ADILA HASSIM: 26, and specifically at paragraph 6 where it is alleged that Medscheme acting on behalf of POLMED, called our client, this was written by an attorney, to their offices to quote, 'amicably resolve the matter'.

'Medscheme on behalf of POLMED insisted that the only way to resolve the matter was for our client to acknowledge his indebtedness to POLMED in the sum of around R300 000. There was simply no basis for paying any sum of money to POLMED but in the circumstances our client took a business decision to agree to pay them as that payment meant that some monies which were due would be paid to the pharmacy forthwith and our client would be able to submit further claims to POLMED'

Would that have been permitted by you, and what was your response to this when you received these complaints and you read this, what investigations did you or Polmed do in relation to this case, to establish whether is in fact correct and if so, what penalties would be imposed. You may also be aware that there are a number of Service Providers who have already come before us and have said that the acknowledgement of debt process is used in the cohesive manner. So, this is what this is alleging.

ADV NKOSINATHI WISEMAN BHUKA: Chair the approach of that process is used as a way to progress the dispute or the complaint between Medscheme and the Service Providers. Now it, I would not be aware if Medscheme uses it as cursive tool. All that I am aware, and I have always been informed in term of the reporting is that is a tool that is used in the negotiating where the amounts are contested, where the basis of the claim are contested. The acknowledge of debt will be used to refine and to constrain the issues that are being contested.

Eventually at a point the parties will agree and then the

arrangement in term of how the Service Provider will pay is reached. As to Chair the assertion that the Service Provider is forced to acknowledge that and to agree to a payment with no basis, I, I cannot agree to that Chair. From the response that we have received, Medscheme has often advised us of, especially the contested cases. It may well be that on those that are not contested they may have proceeded, and the matter is settled quickly.

But on the contested matters we would be informed of what the contestation is and we will be asked to intervene, and that it indicate, if we on our analyses we feel that Medscheme has acted within the mandate we will certainly endorse what they are doing. If we feel that they have acted outside the mandate, we will certainly reverse their decision or give the Service Provider a different directive in terms of how to engage with Medscheme.

Now if we are going to deal specifically with this case as to what did we do, and so on. Chair it is it would probably one of the matters that is in the list. I would imagine, in the list of complaints.

ADV KERRY WILLIAMS: It is in the list.

ADV NKOSINATHI WISEMAN BHUKA: If you look Chair at the outcomes of the investigation. A criminal case has been lodged against Mr Hlongwane, and the case number is provided there. Polmed was served with both Gauteng High Court summons and the case is set out there with the Plaintiffs count number, and what is suggest to me Chair is that if you look at those proceedings where up to either a criminal complaint has been laid or a civil proceeding has been initiated, without delving into the exact steps before those exercises I am certain that the matter would get

into those stage where we did not know that there has been a contestation.

So if we have agreed, we have accepted that Medscheme must proceed to lodge a criminal case, it means that from our own intervention we are satisfied that the particular matter warranted that it be verified and to the extent necessary that certain proceedings such as a criminal complaint should be laid.

So what I am saying to you is that I do not agree with that assertion in that letter that we would have had a situation where a, an acknowledgement of debt was used purely to extract or to extort a certain amount of money from Service Provider without basis.

ADV TEMBEKA NGCUKAITOBI: I suppose the real point is that you have described to us what your understanding is of how to implement Section 59(3) which says you must always track a specific amount against which you must measure whether or not a scheme has been, as you put it, put out of pocket. But it is always structuring an amount.

Now that is inconsistent with any system of averaging. And when I asked you know if anyone is using a system of averaging are the acting consistent with your mandate and your answer is no. Now the question here was whether or not this payment, where somebody comes to your office and they say R300 000,00 on average that is what we think. Whether that is consistent.

I think it is quite obvious that it is not consistent with the method you have described which is, you must track an amount. Now just to understand, this idea of tracks an amount as a methodology of applying section 59(3), that is what Medscheme told you it does when it tries to

recover. Have you ever satisfied yourself that in practice Medscheme does so? And they do not do something different?

ADV NKOSINATHI WISEMAN BHUKA: Chair whether Medscheme either averages or tracks a specific tracks an amount for purpose of recovery and the question is whether we have satisfied ourselves whether they do one or the other. I am just trying to recall Chair, because I am, accuracy become an important thing in responding to this.

What I am certain of Chair is that we have interrogated the amount that would Medscheme advise to us to be claimable, but as what the basis is, in other words whether they have used the averaging to the computation of that amount or whether they have the actual tracking of the particular claim, ja I would not be certain Chair that we have distinguished between those.

We have only interrogated what amount it is, and based on the report that they have given us, we would say that no that amount does not make sense, or that amount makes sense, but we never interrogated the basis.

ADV TEMBEKA NGCUKAITOBI: Thank you. You should carry on. I am told that the next presenter has arrived. If there are members of Bonitas here, they should just be patient, I think everyone can see that we are, you know in the middle of a presentation, but we will attend to them as soon as this is over. Carry on Advocate Bhuka.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair the next slide that we are going to, one slide 17 and that slide just, as I have indicated in terms of the sanctions policy it just sets out the various other sanctions that we have implemented. So, for example you will see the

number that have been referred to the Health Professions Counsel and the total value thereof. You will also see the number of matters that have been referred for criminal investigation and the total value thereof.

You will also see the last column, the number of cases that have been referred to the Counsel, Counsel for Medical Schemes and the values that were involved. This particular table Chair tracks from 2017 up to 2019. So we thought it would assist the panel just to see when we talk the relevant sanctions as to what extent, or how far some of those go, and this is just intended to assist with that frame.

ADV KERRY WILLIAMS: Thank you.

ADV TEMBEKA NGCUKAITOBI: I mean I have got a problem with this table, because especially the HPCSA table. You report for the three cases, you only have return of guilty verdict in three cases, then no-one knows what happens to the rest, and then you put an amount of twenty-six million which creates the impression that everyone there, the scheme has been defrauded to the amount of twenty-six million rands.

The same thing with 2018. You report seventeen cases. Only five are actually guilty. Same thing with 2019. Fifty-five reported but only one is guilty.

ADV NKOSINATHI WISEMAN BHUKA: Thank you, Chair. Chair the reflection on the guilty is the actual finalised matter. But the value that is reflected there is the total value of the claims in respect of all those matters.

So maybe Chair what we should have done then is to degenerate the finalised one and say the final one, what is the value and the remaining unfinalized what is the total value of the claim.

ADV TEMBEKA NGCUKAITOBI: Well I mean that would be more helpful for us, because if out of this forty-four million Rands it is actually twenty thousand rand that is implicated in the single guilty verdict and that gives a completely different picture.

For all we know all of this people could be innocent.

ADV ADILA HASSIM: The reporting has also increased quite dramatically here, and the amounts involved. Is there a reason for that? Do you know? Has it just become more fraud and waste and abuse is taking place, what is the explanation for that?

I mean for example the SAPS reported matters goes from seven and 2017 to thirty-two in 2019. For example.

ADV TEMBEKA NGCUKAITOBI: The SAPS statistics is also are also just above baffling. I mean it state seventeen cases in 2017. 2.5 million rand, but three of those have been withdrawn. No guilt findings have been made. The same thing with 2018. Twenty-six cases. I do not follow what is the point of putting all of these big numbers, because they have no relationship whatsoever with actual guilty verdicts.

ADV NKOSINATHI WISEMAN BHUKA: Chair I may respond to the question about the increase in the frequency. Yes, there is an increase in the frequency of the incidents. And yes, it is increasing every year. I mean if I reflect on a member base we, in term of now the instruction that we have received from our Legal Ethics Committee is that not only we should refer this to the specific enforcement agencies but we also need to then engage the employer about this specific cases, in terms of what interventions it can apply as an employer.

So, there is no doubt Chair, I mean if one takes some classical

examples. We have had situations where certain of the members have, Service Providers have in fact in some of the current investigations gave confirmation of those events or incidents.

So, to answer the question directly and crisply yes there is an increase in the incidents that we are facing, that it is increasing all the time.

In terms of the values. Chair I cannot say more than what I have explained to say. The values that are reflected there, they reflect the total value of the claims as they were made at the time, and yes I do concede we may, to assist the panel more, we may have done a little more in terms of delineating what is the value that have been settled or finalised, what is the value of those that are still outstanding and so on.

Maybe that further detail would have assisted more ...[intervenes].

ADV KERRY WILLIAMS: Sorry. Maybe I can throw you with a lifeline. Can I then ask you rather a different question about the money? How much in these three years, 2017, 2018 and 2019 has Medscheme paid you for Fraud Waste and Abuse recoveries.

ADV NKOSINATHI WISEMAN BHUKA: Chair if maybe we can go to the next slide, I know it may not directly answer the question, but if I can first reflect on that slide before ...[intervenes].

ADV KERRY WILLIAMS: Can I just ...[intervenes].

ADV NKOSINATHI WISEMAN BHUKA: To answer ...[intervenes].

ADV KERRY WILLIAMS: Because we are going to run short of time now. I would like to know the answer to that question, and then I would also like us to know the answer to the question, what then have you paid back

to your patients in those three years. Because this is also about the patients. So, what amounts has Medscheme paid you back for Fraud Waste and Abuse for those three years, and what amount have you paid the patients.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. Chair we do not have that level of detail here in terms of the actual claims that have been paid out as well as the actual recoveries.

What I do have Chair on slide eighteen, is a slide that demonstrates the impact of interventions that we have had. So, if you look at the first column, the column titled "prior", if you look at that, the total that shows the, what is the word. The claims that we have had before the interventions from the various Service Providers.

ADV ADILA HASSIM: Is 248 the total number of provider that you okay?

ADV NKOSINATHI WISEMAN BHUKA: 248 where are you.

ADV TEMBEKA NGCUKAITOBI: In the first one. Plus, thirty-six months, numbers of providers.

ADV NKOSINATHI WISEMAN BHUKA: Yes, those would be the Service Providers are included in this analysis. So, it is not a total Service Providers that we ever have to pay, but for the purpose of computing this analysis ...[intervenes].

ADV TEMBEKA NGCUKAITOBI: I understand what you are you are trying to say. You say prior to this it was 1.3 billion. You forecast at 1.5 billion. Actually, it came to nine hundred and fifty-six and therefore you saved yourself six hundred and forty million rand. I mean that is the point and therefore there has been a forty percent reduction because of the change of interventions.

The problem is, we do not know what this all means.

ADV KERRY WILLIAMS: Who is the author of this table?

ADV NKOSINATHI WISEMAN BHUKA: Chair this, sorry this would be an external report that we have received either a monthly or quarterly report.

ADV KERRY WILLIAMS: From Medscheme ...[intervenes].

ADV ADILA HASSIM: From Medscheme ...[intervenes].

ADV KERRY WILLIAMS: So, Medscheme is the author of this report.

ADV NKOSINATHI WISEMAN BHUKA: That is correct.

ADV TEMBEKA NGCUKAITOBI: I mean do you know what it means, because I have no idea that you had claims of 1.3 billion. You forecast that. I do not know how you forecast it.

ADV KERRY WILLIAMS: How do you forecast claims?

ADV NKOSINATHI WISEMAN BHUKA: So, the forecast here is done if, let me put it this way. If Bhuka has been claiming consistently in excess of R10 000,00 per month. I am using that as an example and a particular was applied to him then after that intervention Bhuka is now either lesser. So the forecast is, if that intervention would not have been applied, the pattern whether it was a stable pattern or a continuously growing pattern, if based on that pattern, Bhuka if he had continuing to claim R10 000,00 per month for the period under review then we would be sitting, let us say a year one hundred and twenty thousand.

But because of the intervention we have now seen that Bhuka has now reduced his claims with now actually eight thousand claims. So that is the forecast. The forecast is based is based on what the Service Providers has been consistently over the measured period had been claiming and what changed after certain interventions.

ADV TEMBEKA NGCUKAITOBI: Now I mean what does this actually mean? You see what we have looked at that very first slide that we debated is that the biggest amount of money goes to hospitalisation. What we do not know, you know your forecast, I mean I do also do not follow this. Your forecast is 1.5 and then you say, and then you deduct that and then you come to six hundred and forty.

Because that is not the actual amount, it is just the amount that you thought would be claimed. Whereas if there is any saving it is the nine fifty-six from the 1.3 and therefore it is the figure of six hundred and forty million is also a misleading figure. It is actually not forty percent because that is just a projection. It is a bit of a thumb suck projection.

But there for the less I want to understand for which year is this, because in the slide you gave, which I am trying to figure in my own head, remember you gave us the first slide. What page was this? It is at page 10. So, if you compare this your actual expenditure has increased by a hundred million. From 7.1 to 7.2 billion. So, it makes no sense for me to now see that oh no-no you have made this big savings because of some miraculous interventions, because in reality your expenses have gone up. So, what does this mean? I do not follow this at all.

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. So, Chair remember our claims process as reflected in slide number ten, reflects on all, on a number of disciplines in term of where we receive claim. In respect of which we receive claims.

Now that total is a total based on all those disciplines. Hospitalisation is, you must, you will recall Chair that for hospitalisation a member is referred by a doctor. You do not walk into a hospital and ask

to be hospitalised. So, when that analysis is done in terms of the hospitalisation and those other categories, the process is, the referring doctor, how many of these kinds of referrals have happened over a particular measured period. What is the, the generic or the period of referral that the doctor normally recommend or prescribes.

So, all those Chair, are measured based on the actual claims as a take list. Now the slide that we are dealing with, slide eighteen. The relation there is that, of all those claims that are set out in slide ten, when you apply the analytics then the analytics will pick up this issues or concern in respect of each of the items made out in slide ten.

ADV TEMBEKA NGCUKAITOBI: No, I mean this is the problem. I do not understand Advocate Bhuka. I am sorry. If I look at 2018 to 2019 in page ten, yes, each item has gone up. The biggest item is hospitalisation by approximately one hundred and seventy million. But other items, pathology, radiology, dental, auxiliary all of them have gone up by average in ten million, twenty million, thirty million.

None of them have gone down. Now I had a look at item 18. Item 18 somehow suggest that there has been a big saving between 2017 and 2019. But that is not tracked by the actual monies that you have spent in claims. Your claims have gone up. So, where have this savings been reflected in this claims?

ADV NKOSINATHI WISEMAN BHUKA: So, Chair that is what I am trying to explain. This saving is only in respect in what you would classify as Fraud Waste Abuse. So, it is not a saving on the total claims or cost exposure. It is saving of what we would have incurred or suffered as a consequence of Fraud Waste Abuse.

So that is what this slide ...[intervenes].

ADV TEMBEKA NGCUKAITOBI: No see ...[intervenes].

ADV NKOSINATHI WISEMAN BHUKA: Reflects.

ADV TEMBEKA NGCUKAITOBI: I am sorry about this. I mean maybe I am just being very slow. You see I have asked you where is Fraud Waste Abuse in slide ten? Your answer was that it factored in the expense items. So, when those items go up or down, Fraud Waste and Abuse is already accounted for there.

Now we are dealing with this, I am trying to track, and you say no-no actually this one is completely separate.

ADV NKOSINATHI WISEMAN BHUKA: Chair at the risk of debating let me try and explain it slightly different.

ADV TEMBEKA NGCUKAITOBI: So, let us take Chair for the hospitalisation, or maybe let us take medicine as an example and just uplift it.

So, we will say that our cost exposure in terms or claims exposure in terms of medicine would be the seven hundred and fifty three million that is reflected on the first item. Okay.

So that is our total exposure in terms of claims, but when the analyses are done at the time of processing those claims, because when those claims are received we do not know whether one claim is a fraud claim or is a legitimate claim, so hence that figure is a total aggregate exposure on claims.

Once those claims are received you then do an analysis. Then you separate certain things and say claim number ten of this list is problematic. Then you put it aside. Claim number 20 of this list is

problematic and then you put it aside. And that then give you what you see in slide eighteen.

ADV ADILA HASSIM: So, slide does not include ...[intervenes].

ADV TEMBEKA NGCUKAITOBI: Fraud Waste and Abuse.

ADV ADILA HASSIM: Fraud Waste and Abuse.

ADV KERRY WILLIAMS: But then you also say you experienced two hundred and ninety-six million of FWA. On the prior period or the forecast period. I am also not following if you are saying it is set aside. I am not following.

ADV NKOSINATHI WISEMAN BHUKA: Chair can I maybe make this request.

ADV TEMBEKA NGCUKAITOBI: Yes sure. What is the request.

ADV NKOSINATHI WISEMAN BHUKA: Well I, it might sound I think Chair it would assist to really articulate and maybe by way of specific examples, not examples that I am now kicking from the air, but take specific case examples and try and illustrate exactly what I am saying. Would the panel be amicable to that?

ADV TEMBEKA NGCUKAITOBI: No that is fine. Look we are going to ask Medscheme the same questions. Who prepared slide number ten? Was that you or Medscheme.

ADV NKOSINATHI WISEMAN BHUKA: It was Medscheme. It was a report.

ADV TEMBEKA NGCUKAITOBI: Okay so item ten and item eighteen were both done by Medscheme?

ADV NKOSINATHI WISEMAN BHUKA: No slide ten Chair is us. It is an internal analyses of our own cost slips.

ADV TEMBEKA NGCUKAITOBI: I see. Alright.

ADV NKOSINATHI WISEMAN BHUKA: And then slide 18 is Medscheme.

ADV TEMBEKA NGCUKAITOBI: That is fine. Thank you, so you were at item eighteen. You will supplement that in due course.

ADV NKOSINATHI WISEMAN BHUKA: That is correct Chair. And then Chair slide nineteen, just deals what we believe the empower provisions in terms of the law that assist us to manage this process. I am not sure if the panel wants me to go through those. It is purely just extraction from the Act and how we translated that into that in the rules of the scheme and so on.

If the panel would like for me to go through them I can but I think they are self-explanatory.

ADV TEMBEKA NGCUKAITOBI: I mean unless there is a point you want to put emphasis on.

ADV ADILA HASSIM: Can I ask you a question, I have read all those slides and I see your reference to the various strategy provisions. In slide twenty-four you deal with 58 read with regulations 15, 16 and 17. And then you set out the written contract. I just want to point out there that you do then refer to the contract and to the annexure A to the contract which really is quite important for us, so we will need, we will need to have sight of that contract plus the annexure.

That is the first thing because you have referred to it here and we would then need to have a look at the underlying text. And the second is, what is your interpretation of Regulation 6 as applied to Section 59 (3).

ADV NKOSINATHI WISEMAN BHUKA: Chair, if I may- maybe let me start

by saying this that the Panel has got the necessary authority to apply a particular consequence that it wants to attach to the Regulation. So, we will never contest whatever proposition the Panel may have in terms of that. I think the second point to make is that ... (intervenes)

ADV ADILA HASSIM: Sorry, Advocate Bhuka, I am not making a proposition. I actually would like to be guided by the various presenters so I am really asking you for what you propose is the correct interpretation.

ADV NKOSINATHI WISEMAN BHUKA: I just want to just read Regulation 6 first Chair, if you will allow me. Just get me Regulation 6 there. Thank you. So, Chair, if I may just read it first?

A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such members is entitled, limit, exclude, retain or withhold as the case may be any payment to such member or supplier of services as a result of late submission of or ... (intervenes)

ADV ADILA HASSIM: Read Regulation 6.2.

ADV NKOSINATHI WISEMAN BHUKA: Regulation 6.2

If a medical scheme is of the opinion that an amount statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant healthcare provider within 30 days after receipt of such account, statement or claim that is erroneous or unacceptable for payment and state the reasons for such an opinion.

Chair, the long and short of our understanding of the Regulation is that a legitimate bona fide claim must be paid within 30 days from the date of receipt. If for any reason the claim is contested, then the

verification process then may have the effect of interrupting the running of those 30 days.

ADV ADILA HASSIM: Sorry, I do not follow that answer ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: If anything, at least that phrasing supports your earlier interpretation that one is always concerned with a particular amount based on a particular claim. Anyway ... (intervenes)

ADV ADILA HASSIM: And with providing the service provider with notice and information that substantiates what you contest or disputes before placing them on- before applying sanctions basically.

ADV NKOSINATHI WISEMAN BHUKA: I am not following the question.

ADV ADILA HASSIM: You would need to give the service provider the information stipulated in 6.2 before you can apply sanctions. Is that not so?

ADV NKOSINATHI WISEMAN BHUKA: In Regulation 6.2 yes (indistinct_microphone) you will need to pay the service provider.

ADV ADILA HASSIM: Well before implement any sanction against the service provider, you would have to explain why the claim is- why claims submitted or whatever it is that is submitted by the service provider, however many number of claims it is, is erroneous or unacceptable. You have to state the reasons for that. And the service provider and the member must be afforded an opportunity to correct.

ADV TEMBEKA NGCUKAITOBI: Do you understand that provision to apply to fraudulent claims when it talks about erroneous payments? Is that the same as a fraudulent claim?

ADV ADILA HASSIM: Or unacceptable.

ADV TEMBEKA NGCUKAITOBI: Or an- yes.

ADV NKOSINATHI WISEMAN BHUKA: I understand it to include fraudulent claims.

ADV ADILA HASSIM: Okay.

ADV TEMBEKA NGCUKAITOBI: So, it applies to what we are dealing with?

ADV NKOSINATHI WISEMAN BHUKA: That is correct.

ADV TEMBEKA NGCUKAITOBI: I think my colleague Advocate Williams has one question for you.

ADV KERRY WILLIAMS: We understand that you appointed Medscheme from the 1st of January 2016. But before that Metropolitan was you administrator. Can you please explain why you changed administrators?

ADV NKOSINATHI WISEMAN BHUKA: Thank you Chair. There were two specific issues that led to changing administrator. One was there was a particular phase of engagement with CMS where a certain directive was issued and the scheme was placed in a particular space and after those then the scheme was left with a decision on whether to continue to run as normal. So that is one so one was a reaction to that.

The other one was the ordinary cost of events in that the contract was reaching its particular phase or duration and therefore the scheme was left with an option on whether or not to continue with the same service provider to the extent that the rules or the law may allow that or to go out and get a new service provider. So those were the two in principle events that informed the scheme to say, then we have reached the duration of the contract.

We have had these issues and therefore what is the next step. And the next step was, let us go through the process. Let us get a service

provider and that service provider or Medscheme was successful as that service provider through that process.

ADV TEMBEKA NGCUKAITOBI: Can you just explain the contract you have with Medscheme? Is it one generic administrator contract or is there a specific FWA contract?

ADV NKOSINATHI WISEMAN BHUKA: The current- sorry. Chair, the current contract is one generic contract. The initial engagements where that the contract was not a generic contract so there was an administration contract and the fraud, waste service was an added as one of the administrative functions that Medscheme would perform.

ADV TEMBEKA NGCUKAITOBI: And now is an FWA a simply an aspect of a generic administration contract?

ADV NKOSINATHI WISEMAN BHUKA: That is correct. As we speak, fraud, waste, abuse is purely a component of the administration service.

ADV TEMBEKA NGCUKAITOBI: And do you pay specifically for recoveries under FWA or do you pay a generic administration fee?

ADV NKOSINATHI WISEMAN BHUKA: We pay a generic administration fee- I am just trying to recall Chair now from the previous dispensation to the current dispensation whether we changed the fee structure. To the- I think current- in the current dispensation we pay the singular administration fee but I can provide the accurate in terms of the changes we made to the fee structure.

ADV TEMBEKA NGCUKAITOBI: And how do they account for recoveries? I mean is there- it is not like there is a percentage of recoveries they will be entitled to. For instance, slide 18 which says they have saved you 640 million rand, whether that is true or not, it is an open question. But will

they be entitled to a percentage of the 640 million rands that is savings?

ADV NKOSINATHI WISEMAN BHUKA: That is why Chair I am saying maybe if the Panel can allow to just check what have we changed in the fee structure. I know that there were- what I understand you to be saying is whether there is a contingency arrangement of some sort. I know there was a similar arrangement but in term of the changes we have made I would not want to mislead the Panel and say we have stuck to the original arrangement.

If the Panel can allow me to just rather give you the accurate information of what changes we have made to the extent that the Panel may require.

ADV TEMBEKA NGCUKAITOBI: Yes, I mean we do want the contract. I know that you say that you are not going to give it to us because it is confidential but we really do want to see the contract. One of the complaints and this is all a transparent process, we are not hiding anything.

ADV NKOSINATHI WISEMAN BHUKA: Mm-hmm.

ADV TEMBEKA NGCUKAITOBI: One of the complaints made is that the investigators have an improper financial motif which is why they run roughshod over rights of people. We want to know what are the incentives contained in your contract as towards Medscheme so that we can judge for ourselves whether the allegations of improper financial incentives driving the investigators are true or not.

And I have asked you now just a basic question around what is the fee structure which you cannot answer. And that fee structure has to be answered by reference to the contract not by reference to heads of arguments. So, we do want the contract.

Is there anything that you want to add to the presentation you have given so far because I do not want to cut you because this is still your time, your time has not yet ended.

ADV NKOSINATHI WISEMAN BHUKA: Chair, thank you. We have no further points that we would like to address the Panel on save Chair to indicate that as I have requested to amplify or to clarify certain of either the questions or the detail that is required in terms of a supplementary submission. That is all. Maybe one can then request- I would imagine that one would get the necessary communication from the Secretariat in terms of how that process is going to unfold.

But other than that Chair, we thank the Panel for the opportunity and we thank the Panel for also giving us an opportunity to assist or to add our contribution to the efforts the Panel is making to try and get to the bottom and the resolution of this matter. Thank you Chair.

ADV TEMBEKA NGCUKAITOBI: Thank you Advocate Bhuka. We are also equally grateful for the time you have taken together with your colleagues, pity the Principle Officer could not make it but hopefully she will make a contribution in the written submission.

Thank you, we are going to take some time. I mean we have been running this for a long time, it is now 5 minutes to 2. I am really sorry to the Bonitas representatives. So, I think- ja alright, so we are going to take 20 minutes lunch adjournment and we will resume at what 14:20. Let us resume at 14:20. Thank you.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Welcome back, this is the continuation of today's session in the section 59 panel enquiry. We are going to hear evidence from Bonitas. Can you please introduce yourselves and also let us know who the speakers are going to be?

LEE RICARDO CALLAKOPPEN: Good afternoon Chair, good afternoon to the panel. By way of introduction my name is Lee Callakoppen. I am the Principal Officer of Bonitas Medical Fund. Today with me I have got our legal representative, Anisa Mohamed as well as our Fraud, Waste and Abuse Senior Manager that is employed by Bonitas Medical Fund, that is Vusi to my left, or far left.

In terms of who will be handling our submission today is by way of a presentation that has been shared to the panel and we will be covering various elements between the three of us. From myself, the governance and oversight, as Principal Officer I am accountable to the board. From a legal perspective I will be handing over to Anisa where required and the operational detail level, Vusi that oversees the day to day management of fraud, waste and abuse.

ADV TEMBEKA NGCUKAITOBI: Let's do this, I think then let me just take the oath for everyone so that we are covered. Shall I start with you, will you say after me, I, and your full name.

LEE RICARDO CALLAKOPPEN: I, Lee Ricardo Callakoppen,

ADV TEMBEKA NGCUKAITOBI: Hereby swear

LEE RICARDO CALLAKOPPEN: Hereby swear

ADV TEMBEKA NGCUKAITOBI: That the evidence I shall give.

LEE RICARDO CALLAKOPPEN: That the evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth

LEE RICARDO CALLAKOPPEN: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

LEE RICARDO CALLAKOPPEN: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: Please raise your right hand and say, 'So help me God'

LEE RICARDO CALLAKOPPEN: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. And sorry, I didn't get your surname?

ANISA MOHAMED: Mohamed.

ADV TEMBEKA NGCUKAITOBI: Oh Miss Mohamed. Would you also take the oath or the affirmation?

ANISA MOHAMED: I am fine with either.

ADV TEMBEKA NGCUKAITOBI: With either, alright, so let's do the oath then. Will you say after me, I and your name.

ANISA MOHAMED: I, Anisa Mohamed

ADV TEMBEKA NGCUKAITOBI: Hereby swear.

ANISA MOHAMED: Hereby swear.

ADV TEMBEKA NGCUKAITOBI: That the evidence I shall give

ANISA MOHAMED: That the evidence I shall give

ADV TEMBEKA NGCUKAITOBI: Shall be the truth

ANISA MOHAMED: Shall be the truth

ADV TEMBEKA NGCUKAITOBI: The whole truth

ANISA MOHAMED: The whole truth

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

ANISA MOHAMED: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: If so, please raise your right hand and say, 'So help me God.'

ANISA MOHAMED: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you and Sir? What is your ...

LEE RICARDO CALLAKOPPEN:

VUSI MAKANDA: Vusi Makanda

ADV TEMBEKA NGCUKAITOBI: Oh yes, Mr Makanda will you then say after me, I and then your name.

VUSI MAKANDA: I, Vusi Makanda

ADV TEMBEKA NGCUKAITOBI: Hereby swear.

VUSI MAKANDA: Hereby swear

ADV TEMBEKA NGCUKAITOBI: That the evidence I shall give

VUSI MAKANDA: That the evidence I shall give

ADV TEMBEKA NGCUKAITOBI: Shall be the truth

VUSI MAKANDA: Shall be the truth

ADV TEMBEKA NGCUKAITOBI: The whole truth

VUSI MAKANDA: The whole truth

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth

VUSI MAKANDA: And nothing else but the truth

ADV TEMBEKA NGCUKAITOBI: Raise your right hand and say, 'So help me God'

VUSI MAKANDA: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. The floor is yours, you can split it whichever way you wish.

LEE RICARDO CALLAKOPPEN: Thank you so much Chair, Chair just by way of opening, I would like to thank the board for allowing us to be here today to make our submission on the section 59 investigation. It is important for us in terms of the approach that we are taking today as to provide full context for the panel to be able to arrive at their conclusion around this investigation.

Chair, just a few housekeeping issues that I think is quite important to put forward. The issue, and it is not that we desire a remedy associated with it, but we would like to for the record just formally bring it to the Chair's attention and that is when the investigation originally commenced and when there was information shared that we were one of the medical schemes that received information of other schemes, confidential information around those members in our actual bundle.

We did inform the secretariat around our concern associated with it but we also making an assumption that the same information that was shared of Bonitas medical scheme was shared with other medical schemes. So we would just like to place that on record.

The second aspect that we would like to put forward to the panel is that based on what we will sharing today and making a representation on, is based on the guidelines provided to us that we could take on a format of submission in any form that we deemed appropriate to bring forward the matter to the panel. However, with that said, there is no information that we are not willing to share as long as we can engage with it and obviously consider the confidentiality associated thereof. So some of our information might not be forthcoming in our presentation but we are happy to take any questions during or at the

end of it because we believe we do cover a wide scope of information in the presentation.

Chair, then moving directly into the first slide, I think it is quite important to look at our agenda, we will be covering an introduction. We will be covering Bonitas in terms of an overview from a fraud, waste and abuse perspective. We will also be covering an understanding in terms of the terms of reference and then we shall be making some closing remarks.

Chair, it would be remiss of us as Bonitas medical fund not to start off with what the business is of Bonitas medical fund and in terms of our mission statement, it is to ensure that the sustainability of the scheme is always sustained while meeting the needs of our members. At the end of the day we exist for the purpose of our members. Further to that, in terms of our vision is to ensure that quality health care is more accessible and is made more affordable within South Africa and for the members that we serve.

And this is obviously of importance in relation to the impact that fraud, waste and abuse could have on the specific mission statement as well as vision statement of the medical scheme. With that said I would also like to draw your attention to a clause within the Medical Schemes Act which is section 57(6) that sets out, that says that,

> 'The Board of Trustees will take all reasonable steps to ensure that the interests of beneficiaries in terms of the rules of the medical scheme and the provisions of the Medical Schemes Act is protected at all times.'

We act with due care, diligence and skill as well as good faith. Why is this important? Because I believe that within our understanding of this investigation, it is how this is conducted and the impact on health care professionals. So we wanted to then draw the attention of the panel around our duty and the duty of specifically Bonitas medical fund and the Board of Trustees as well as our associates in terms of our service providers in terms of the behaviour associated with how we conduct business and serving the best interests of our members.

Chair, if you would allow me and this is probably common knowledge, to some of the panel members, but for the purpose of completeness, I would like to give an overview of Bonitas medical fund. The scheme was established in April 1982 primarily for Black civil servants and has successfully reinvented its image while staying true to its commitment to make the quality of health care more affordable and accessible for South Africans. Approximately three quarters of the scheme's current membership base comprises of Black people.

As at the 31st of October 2019 the scheme had over 335 000 principal members and 723 000 beneficiaries who are demographically comprises of 20% White, 5% unclassified, and 75% Black. We will later in our submission point out the relevance of the stats that we have shared. Chair, on average the scheme processes close to 2 486 000 claim lines per month. We also issue close to about 15 879 authorisations to various health care professionals as well as facilities. All these claims are paid within 30 days as prescribed by section 59(2) of the Medical Schemes Act unless these claims, identified to be erroneous or unacceptable for payment due to non-compliance with the provisions of

regulation 5 of the regulations of the Medical Schemes Act. We will discuss this in further detail to point out the relevance of it. Why is this important? This is important for us in relation to the governance and processes that Bonitas deploys and follows as we act with due care and diligence, skill and good faith as per the duty I articulated in the very first slide of this presentation.

Access to quality care remains a priority for all South Africans and that is the reason why we are sitting here today, to ensure that the South African health care ecosystem is fit to serve its members. It is no secret that the escalating health care costs and inflation are key current challenges that faces our industry as we have seen recently in the publication of the health market enquiry. To this end how we address fraud, waste and abuse and there is a distinction between the fraud, waste and abuses this panel has heard of in sitting. We as a medical scheme is quite focussed in terms of addressing this particular area.

With health care costs consistently outpacing inflation, the challenge for medical schemes is finding the right balance between providing high level of value and care for its members and dependants while managing the cost effectively. And as I mentioned, among many reasons for these high costs drivers is what we are seeing in terms of fraud, waste and abuse. Fraudulent and wasteful and abusive billing is not unique to this scheme. I don't even think that it is unique to South Africa. It is an international challenge that we are facing. This primarily manifests itself in the form of unethical and opportunistic over servicing and over charging. This unwanted practice is always to the detriment

of the collective risk pool that we have for our scheme members but also individual members who are unceremoniously find themselves running out of benefits due to service providers unlawfully depleting their benefits and we have to be mindful of this dimension.

I think, not think, but to the point on this particular slide, from various different avenues it is estimated that fraud constitutes, fraud waste and abuse constitutes about 23% of all medical scheme claims. Other stakeholders, such as the Board of Health Care Funders, the Health Care Funders Association, for example, has estimated this figure at 15% of health care spent. So dependent on who you engage, these numbers have been ranging between 15 % and 23%.

ADV TEMBEKA NGCUKAITOBI: What is Bonitas's number?

LEE RICARDO CALLAKOPPEN: Chair, at this particular point in time I cannot sit here and say to you the full ecosystem is quantified at X, the reason being is that at this particular point in time based on the information available, it would be based on the type of activities, on the type of disciplines that we have engaged on. This information I can share and we will cover on later on and it is also extensively published in our annual financial results that is published to members but I can cover that point, if we do not cover it in detail and to your satisfaction, at later slides. Thank you.

Chair, it is our submission that it is a minority and I want to emphasise this point. It is a minority of health care professionals who do not conduct themselves according to the standards expected of them. It is the fiduciary duty of the Board to ensure that members and dependants receive all access to treatment that is affordable and of the highest

quality. Medical schemes are by law required to have a solvency ratio as you have heard in earlier presentations and are probably very aware of that.

It stipulates and regulates that the Medical Schemes Act also to protect the interests of the members and if that risk pool and solvency is not protected by addressing areas such as fraud, waste and abuse or managing non-health care cost, we are placing the interest of members on the back burner and that is not the duty of the Board of Trustees that needs to discharge themselves of their fiduciary duties. Accordingly, in ensuring strict policing of fraud, waste and abuse the schemes are abiding by their legal duties.

Chair, with that said and those opening remarks I would like to move on to giving an overview, as I mentioned earlier on, it is the how and as a fully outsourced business, it is important that we illustrate to this panel in terms of the governance structures that we as Bonitas deploy in terms of managing fraud, waste and abuse. However, before doing so I see that there might be a question.

ADV KERRY WILLIAMS: It is a question on your opening remarks. You mentioned the numbers of claims you process and authorisations you give to health care providers. Am I understanding you correctly that you do that yourself as the scheme?

LEE RICARDO CALLAKOPPEN: Thank you Chair, and this is what I will be covering structure in terms of what our operating model is in the oversight so, but in answering your question in short, we are not self-administered, we rely on third parts and we utilise an outsource model so we don't do it directly, in answering your question.

ADV ADILA HASSIM: So which service providers do you use?

LEE RICARDO CALLAKOPPEN: Chair, we utilise accredited administration and manage their service providers and our current instance, it is Medscheme, however, in terms of our fraud, waste and abuse it is not exclusively just done by Medscheme, it is also done by Qhubeka Forensic Services and that allows us, and I will cover his later in the presentation as well as by my colleagues to ensure that there are checks and balances between these parties.

ADV ADILA HASSIM: So do you have contracts with both service providers?

LEE RICARDO CALLAKOPPEN: Yes, Chair, we have got contracts with both service providers. It will become clear in the next section when I cover the overview of how fraud, waste and abuse is managed by the fund. Chair, with your permission, if I may continue?

ADV TEMBEKA NGCUKAITOBI: Yes.

LEE RICARDO CALLAKOPPEN: To move onto the next section? As what I indicated before addressing some of the questions, I will be moving on to give an overview of the governance structures in relation to how fraud, waste and abuse is managed within Bonitas medical fund. Chair, I referred earlier on to the governance structures and the processes and will now focus on that detail because it is quite important for us to be able to demonstrate as a medical scheme how we go about managing it.

With that said, the scheme functions as a wholly outsourced model meaning that administration of managed health care and other core services are outsourced to various service providers. Amongst the

services outsourced is, fraud, waste and abuse management services. The fraud, waste and abuse management services are conducted by Medscheme Holdings or better referred to as Medscheme. We use their specialised software, IFM to analyse claims patterns on behalf of their clients which in this case, we as a scheme, are one of those clients. The scheme also uses independent service providers for [intervenes]

ADV KERRY WILLIAMS: Sorry, just to understand that statement, you say, we use their specialised software. So, do you use their software, do you go into their offices and use their software?

LEE RICARDO CALLAKOPPEN: No, we contract for them to utilise for the application of managing fraud, waste and abuse.

ADV KERRY WILLIAMS: Thank you.

LEE RICARDO CALLAKOPPEN: Chair, with that said also, I mentioned earlier on as part of the questions the scheme also utilises an independent service provider for whistle blower services where members of the scheme may call anonymously to report fraud, waste and abuse. Governance of the scheme's outsource model will be discussed in more detail in the slides to follow if you have questions related to that.

ADV KERRY WILLIAMS: Are you happy to make available your contracts with Medscheme and Qhubeka?

LEE RICARDO CALLAKOPPEN: Chair, yes we are willing to make that available to the panel and under strict confidentiality because we do believe it contains certain commercial aspects but it could be made available to this panel under confidentiality and direct submission.

ADV TEMBEKA NGCUKAITOBI: Just tell me is this a separate service provider because, so Medscheme does FWA and then there is another service provider which does whistle blower services? And there is an another one Qhubeka which does ...

LEE RICARDO CALLAKOPPEN: Chair, there are three distinct services. It is fraud, waste and abuse. The waste and abuse is typically covered from a Medscheme perspective and then we utilise Qhubeka for the fraudulent component and investigation which comes through from a waste and abuse perspective. Vusi, is there any clarification that you wish to add or more detail?

VUSI MAKANDA: Yes, through you Chair, the aspect that Lee is talking about is of course Qhubeka on fraud, it is Medscheme on waste and abuse but there is also an independent service provider that deals with hotlines and those hotlines would be directed to either Medscheme or Qhubeka.

ADV TEMBEKA NGCUKAITOBI: Yes, that is what I am asking. It looks like there are three contracts?

LEE RICARDO CALLAKOPPEN: Yes.

ADV TEMBEKA NGCUKAITOBI: So, who is the independent service provider who is unnamed here?

VUSI MAKANDA: That is Whistle Blowers. That is the one that I name the whistle blowers.

ADV TEMBEKA NGCUKAITOBI: No, I understand but what is the name of the company?

VUSI MAKANDA: It's called Whistle Blowers.

LEE RICARDO CALLAKOPPEN: It is called Whistle Blowers.

ADV KERRY WILLIAMS: I understand Whistle Blowers is also contracted with Medscheme, not with you, is that correct?

LEE RICARDO CALLAKOPPEN: Chair, I will have to just confirm that information. I wouldn't want to give something that is actually incorrect. Can we note that down and respond to you? Thank you.

Then moving on, the scheme has a zero tolerance approach to fraud, waste and abuse issues involving all stakeholder because bear in mind as much as we are sitting and listening to complaints lobbied by general practitioners or health care providers, this could also be in the case of member abuse.

The scheme has a fraud, waste and abuse framework as well as policies on the processes to be followed by our service providers when fraud, waste and abuse is identified and a policy in terms of dealing with the appropriate actions that may be taken having regard to this particular circumstance because every single circumstance should be considered on its merit. These fraud, waste and abuse policies, guide the schemes and contracted service providers in conducting investigations and ensure that a consolidated approach that is as cost effective as possible is followed dealing with fraud, waste and abuse while simultaneously protecting the scheme's reputation and that of its members when dealing with stake holders and particularly I want to emphasise, the health care providers as well as any other external parties.

The scheme further has a dedicated resource in the form of Vusi whose sole duty and sole job in the fund is to have oversight in the management of all associated activities in terms of fraud, waste and

abuse and the management of the contracted service providers. Chair, I think every single, not think, I know and expect that every single scheme's process is very unique to them. If I can draw the panel's attention specifically, just with a high level overview that will give some context in terms of the process that we follow in managing specifically, our providers.

To the far left you would see that we take a pro-active risk analysis and assessment and verification in terms of looking at matters that could either be fraud, waste or abuse. Those matters are firstly investigated by our different service providers and based on the information at hand and analysis that has been conducted utilising what I referred to previously, the specialised analytical solutions that these organisations have and apply in terms of doing the analysis. This is reported back to the fund and you will see in later slides when I talk about the governance structures and oversight, that we have applied within the scheme those are brought to fraud, waste and abuse committee or panel, that basically considers those specific reports or analysis and consider whether it is actionable. Whether these cases are actionable. Where we find ...

ADV KERRY WILLIAMS: May I interrupt?

LEE RICARDO CALLAKOPPEN: Sure

ADV KERRY WILLIAMS: I am just trying to understand this. These set of business processes that you are describing here, and I have read your submissions, but I am trying to understand which are your business processes and which are Medschemes? Because this suggests that you do all of this, you do the risk analysis, you do the

assessment and verification, you do the investigation and you do the reporting.

But I don't think that's right, and I am not sure I am checking, that the scheme is involved when it appears there is a recommendation approved by scheme forum. But if you could explain in this business process diagram, who does what or where the scheme actually gets involved. That would be helpful.

LEE RICARDO CALLAKOPPEN: Chair, first of all I can appreciate your concern and hopefully we can now clarify that for you. I would like to hand over to Vusi just to give you the detail in terms of the segregation of duties and what of the business processes is associated with service providers and which are the fund. However, before handing over to him the important thing is that we exercise oversight around this entire process with the service providers. But with that said, let me hand over to Vusi to give you the detail.

VUSI MAKANDA: Through you Mr Chair, this process, it is what Mr Lee has also mentioned of when he spoke about processes that the scheme has adopted. It is in our policies that it should be done that way. I will take you through that very same slide. Pro-active risk analysis is whatever Medscheme would then pick up from their analysis. Re-active hotline would be any hotline that comes through our service provider that we mentioned and of course, any other stakeholder who wants to mention anything to us, then it will be done through that.

But when it comes to assessment and verification, that is done by Medscheme or any person who then receives those kind of allegations.

That is done mainly to ascertain whether this particular matter is going to be further investigated or it can be clarified by any person or by any business unit that then has contact with that.

Now, investigate means it is either Medscheme or Qhubeka who will then conduct further investigation on that. As I said before, if it is waste and abuse then Medscheme will continue with that kind of investigation. If it is fraud then that matter is investigated by Qhubeka and then all those reports will then come to the scheme and then we will then talk about them and decide what proper action should be taken based on the merits of that particular case. I don't know whether I have clarified that to the panel.

ADV TEMBEKA NGCUKAITOBI: Yes, thanks, I just want to understand what do you do with instances of the incorrect use of codes? Are those fraud or waste or abuse?

VUSI MAKANDA: Those instances will then be adjudicated on that assessment stage and it will be Medscheme who is doing that.

ADV TEMBEKA NGCUKAITOBI: So, an incorrect use of a code is not fraud?

VUSI MAKANDA: No, it is not fraud from the onset but it depends on the complexity of that particular instance because some providers, and I am saying this , Mr Chair of having experience, having been there in that same environment. They will use that code deliberately, so knowing that it is not supposed to be like that so it depends on the complexity or the nature of that particular allegation.

ADV TEMBEKA NGCUKAITOBI: Now, I think the specific question really was, what is the role of Bonitas because you have got an

outsource agreement with Medscheme, so I think the question is, who does what? What is your role versus Medscheme's role?

LEE RICARDO CALLAKOPPEN: Chair, if I can take your question further? As a funder and responsible for the funding of health care for the members that select to be part of our scheme or fund, we are ultimately accountable to ensure the oversight in terms of the processes associated that we have outsourced to our service providers. As I articulated in my introduction, I think we appreciate that there are fraudulent, wasteful and abusive activities that can take place.

With that said, to deploy the relevant policies and frameworks in the case and having oversight that our actual service providers do it accordingly to the regulation and legislation that is set out and our role is to ensure that we are managing it. We cannot abdicate that responsibility. We ultimately have to take accountability and ensure that those aspects, or policies and frameworks are applied accordingly. I trust that that answers the question?

ADV TEMBEKA NGCUKAITOBI: So, if Medscheme picks up an allegation of something improper do they consult with you before they write the letter or do they just write the letter on the assumption that they have the mandate?

LEE RICARDO CALLAKOPPEN: Would you like to?

VUSI MAKANDA: On that aspect, Mr Chair, they will then run with the investigation that is now the first step of an action that they will be taking so it is not the scheme that will then give them that kind of a, go for this one. They will be the ones running the investigation.

ADV TEMBEKA NGCUKAITOBI: Now, if they have to decide whether, at the commencement of the investigation to suspend payments to a service provider, do they consult with you or do they make that decision independently?

LEE RICARDO CALLAKOPPEN: Chair if I may and just for the interest of time and you know to ensure that we completely answer the question we are covering this under – I think the important thing for us to pin the regulatory component to it, so we will be covering that particular question I will note it down and if we have not answered it to the level of detail at the end, because I think it's important to understand the process entered into with all due respect and we are going to cover it from a legal perspective as well. Will that suffice?

ADV TEMBEKA NGCUKAITOBI: I don't want a legal answer, I just want a factual answer. Medscheme has decided that it wants to proceed, my understanding is that they can do that on their own without consulting, but they want to understand whether to suspend payment prior to investigation, do they consult with you for a mandate or do they do that on their own?

VUSI MAKANDA: On that one Mr Chair they will then continue with that aspect because it is part and parcel of their assessment and investigation, but maybe to put context to that, whatever they have done in regard to that it has to be within the 30 days that the scheme is expected to pay the provider.

ADV TEMBEKA NGCUKAITOBI: I am talking about a period outside of the 30 days, and they have to make a decision should we suspend and

then ask for a recovery, whether or not they will consult with you at all, and that is really the point I am trying to understand.

VUSI MAKANDA: If it is over 30 days Mr Chair then they will have to come to the scheme to get confirmation or kind of approval to take whatever action on that particular matter.

ADV TEMBEKA NGCUKAITOBI: So all of the cases we have seen where action is taken beyond the 30 days are specifically authorised by Bonitas?

VUSI MAKANDA: It is those cases that would have been brought to the fraud forum where they will talk to it first because it is not just a matter of rubber stamping what they see, it is about interrogating the very same case and if needs be we will change the decision of their recommendation and that is what we have done in many instances Mr Chair.

MR LEE RICARDO CALLAKOPPEN: Chair also ...[intervenes]

ADV TEMBEKA NGCUKAITOBI: I understand that – sorry – I do want to just get clarity, I just want to understand at the level of Principal and if we see an instance where Medscheme has acted outside of the 30 days and they're trying to recover retrospectively, we must assume that that is expressly discussed with you and you have given an express mandate?

VUSI MAKANDA: Yes Mr Chair that is the straight answer.

MR LEE RICARDO CALLAKOPPEN: Chair also a key distinction here is that where you do find a whistleblower that has contacted us and advised us that was advised through Medscheme that there is behaviour that is considered either fraud, waste and abuse in

circumstances such as that Medscheme would probably suspend as well, to stop the bleed, but start the process of an investigation, so there is a distinction that must be taken between the different providers in terms of the fraud, the waste, the abuse and whistle bellowing. It is very similar and not to draw an inference around it if you tomorrow would phone in your bank and say I believe there is fraud on my credit card would they suspend it immediately or go and check first? It will be stopped then investigated because the member has phoned in and said I am blowing a whistle that there is monies being given, and in those instances, but it will be discussed as well.

So one needs to contextualise each case by case, and in ...[intervenes]

ADV TEMBEKA NGCUKAITOBI: But what does that mean practically? Does it mean that the only instance that you are aware of where a suspension takes place prior to investigation a whistle blower in instances?

MR LEE RICARDO CALLAKOPPEN: Well Chair the point I am trying to bring across around it is that in the pack provided I think there was about 23 cases, one would have to look at the merits in terms of how that matter has come through, was it through an analysis of trying to establish if there's fraud, waste and abuse, was it a whistle blowing tip off that is significant where we had to suspend, so I am setting out the principles as what you indicated for each one but we could go into merits of each case if you want to refer to the bundle.

ADV TEMBEKA NGCUKAITOBI: No, I want understand how you work in relation to your relationship to Medscheme or Qubeka for that matter,

and I tried to get the principle, whether your intervention was no, no, no it is only in those instances where there is a whistleblower where suspension will be made, the example of a bank, but are you saying that as a matter of principle it is only where there is a whistleblower that you suspend before investigation?

MR LEE RICARDO CALLAKOPPEN: Chair to the best of our knowledge that is the instances where we do the suspension when there is whistle blowing, unless you know Vusi from an operational perspective but in instances and to the best of my knowledge it is in cases where we have whistle blowing where we have to stop bleed of significant risk to the fund and to the members.

ADV TEMBEKA NGCUKAITOBI: So if we find instances where there is no whistleblower but there has been as suspension you should assume that the service provider acted on their own without a mandate.

MR LEE RICARDO CALLAKOPPEN: I believe that would be the exception to the rule. Chair if you ...[intervenes]

ADV TEMGEKA NGCUKAITOBI: Ja, please.

MR LEE RICARDO CALLAKOPPEN: If I may proceed. Chair just to pick up in terms of where I left off I indicated that the scheme has a zero tolerance to the approach in terms of fraud, waste and abuse. I also refer to the fact that the scheme has a dedicated resources as I indicated earlier on in terms of managing these activities.

However with that said I think, and it's quite small in terms of the presentation, but I think it is reasonably expanded in the written submission that we did, at a macro level, and in terms of our duty under the Medical Schemes Act Chair we've set out the governance structures

associated and I would like to stop just for a few minutes and unpack this for you, to demonstrate in terms of the relevant structures that we have put in place to ensure that activities and one such activity in terms of how we manage fraud, waste and abuse and our service providers is applied within Bonitas Medical Fund.

Starting on the left of the slide, as we all know there is governing legislation and regulation which we will cover after the next few slides, there's the Act, there's the Scheme Rules, there's good corporate governance principles that we shouldn't forget about such as King for additional guidelines that we consider as a medical fund, further to that there is also the aspects of common law.

How we have structured in terms of it we have got a Board of Trustees that is all elected and independently elected by our members. These trustees serve a five year term and more importantly they undergo aspects to ensure that they are fit and proper and that they are able to be accountable to the members.

The Board of Trustees have also created various sub-committee structures and those sub-committee structures inclusive of our audit and risk committee as well as a risk – various other sub-committees is all governed under Committee Charters to ensure that they discharge themselves of their duties.

Further to that myself as Principal Officer and that of the Executive Team is to ensure that the relevant policies, procedures, frameworks and mandates are actually implemented and that our service providers, keeping in mind we are a wholly-owned – we are at an outsourced model that we are actually able to execute against that,

and that is managed under strict aspects, such as Service Level Agreements as well as various forums that is in place.

Why is this important? The structure within Bonitas Medical Fund is to ensure that there's proper oversight and adherence to specifically this governance structure that is currently being displayed, and fraud, waste and abuse because of the financial and reputational risk that it has both on service providers as well members, we have deemed it important enough to appoint a senior manager that is solely accountable just to ensure that it is managed. That member of staff is here with us present today, as indicated earlier on, but is also supported by a number of other scheme staff such as a General N Manager for Operations, COO, a CFO as well as a General Manager for Governance Risk and Compliance, to ensure that we have the relevant skills, competencies to manage all our service providers as best as possible.

Chair with that said we would like to move on to understanding in relation to the terms of reference that brought us into the room today, and I would like to start in terms of handing over to our legal representative, Anisa Mohamed, that will set out specifically the legislation and the claims associated process.

Thank you.

MS ANISA MOHAMED: Mr Chairperson through you, thank you so much. We as ...[intervenes]

ADV TEMBEKA NGCUKKAITOBI: Ms Mohamed can I ask you do you think that Regulation 63 applies to instances of fraud?

MS ANISA MOHAMED: I will – just let me refresh my memory a

second, I have it in front of me. It could be, although I fail to see how you are going to rectify a fraudulent claim, if the suspicion is correct.

The question under 5 and 6, Regulations 5 and 6, I think are quite important to contextualise where the elements of administrative compliance allow for the payment of the claim to be made within the 30 day period as envisaged by Section 59 become pre-emptory and at what point it becomes discretionary, in other words where Regulation 6 might come into play.

Now if one contextualises and you know I am going to take it that the panel has read these regulations *ad nauseum* but for us it's important to understand or to at least set out our understanding of where we see the claims process coming through in order to give effect to the rights of people who may be impacted by claims not being processed within a 30 day period as is envisaged by the Act.

Now Regulation 5 sets out really what is an administrative requirement for what is to be a valid claim, and generally speaking if a claim passes a Regulation 5 muster that means that the claim would then be ripe for payment within the 30 day period that the Act envisages.

However what becomes quite clear is that if one looks at Regulation 6 it doesn't simply say that a claim that is not compliant with Regulation 5 can be sent for rectification, it goes slightly wider than that and says that if a claim is erroneous or unacceptable as a payment then an opportunity for rectification must be given.

Now for example unacceptable for payment could also be that the member has simply run out of benefits. Yes, technically speaking

there should be a right to rectify a claim like this, but how do you rectify something when you have run out of benefits, it simply is a situation that has occurred as a result of the use and regulation 6 under those circumstances then becomes completely useless.

ADV TEMBEKA NGCUKAITOBI: (Inaudible – microphone off)

MS ANISA MOHAMED: Well that presupposes that you have the evidence that the claim is fraudulent at the time when the claim is submitted, or certainly you have a reasonable suspicion which would cause you to reject the claim at that point.

ADV TEMBEKA NGCUKAITOBI: (Inaudible – microphone off)

MS ANISA MOHAMED: Well the point of the matter is as I said to you bright at the beginning how do you ask a person to correct a fraudulent claim, surely it in itself then lends to the reasonable interpretation that it cannot be corrected, because the claim in itself is fraudulent.

ADV KERRY WILLIAMS: Here you are separating out fraud from waste and abuse?

MS ANISA MOHAMED: Yes but the question was specifically on fraud. You know obviously wasteful, or for example take a designated service provider who is contracted to bill at a particular rate and fails to do that so I mean all you do under those circumstances, it could be possible abuse there, but there is a rectification mechanism because you would send the claim back under regulation 6 and simply say you've billed at the wrong tariff, please bill at the right tariff, which would then trigger a payment.

So one does have an opportunity to determine whether it is rectifiable under 6 which then makes this incumbent or not – for example

a clearly fraudulent claim which would render regulation 6 then supercilious under those circumstances.

ADV TEMBEKA NGCUKAITOBI: (Inaudible – microphone off)

MS ANISA MOHAMED: Yes.

ADV TEMBEKA NGCUKAITOBI: (Inaudible – microphone off) so the terms used by the Act is erroneous or unacceptable for payment whether those are regarded at Bonitas as wide enough to encompass fraud?

MS ANISA MOHAMED: Mr Chairperson with due respect I would suspect that no fraudulent claim is ever acceptable for payment, if one wants to look at the – so the regulation is drafted fairly widely and I think would in our view encompass possible fraudulent payments.

ADV TEMBEKA NGCUKAITOBI: If it encompasses fraudulent payments why is it never followed?

MS ANISA MOHAMED: I beg our pardon, I didn't …[intervenes]

ADV TEMBEKA NGCUKAITOBI: If that regulation encompasses fraudulent payments why is it in none of these 23 instances that we have found implicated Bonitas has that regulation ever been followed?

MS ANISA MOHAMED: I am not quite sure why – Mr Chairperson I would have to look at a specific instance but …[intervenes]

ADV TEMGEKA NGCUKAITOBI: Well instances were sent to Bonitas, because I mean if that is the regulation that must be followed I mean the question really is why has that never been followed by Bonitas.

MS ANISA MOHAMED: Mr Chairperson that's what I am trying to understand, I am not sure why you say it has never been followed, so if we go back to the administration process and this is not the FWA process, so just when a claim comes in purely as a normal claim, as the

two million odd line items that come in every month, they go through the process, they get shifted in terms of five, they are checked for accuracy and whether there is benefit, if there is it gets loaded for payment, if not it goes into, this is an automated system, it goes into the regulatory 6 provisions, it is rejected with the correct code for whatever, for example – let's go back to the example I gave you, the incorrect tariff is given, so if you look at 6, 6 says you must be given an opportunity to correct it and you must be given reasons why it was rejected in the first place, so when you go back to that on any statement it will go back and it will say this claim has been rejected for Code whatever, 47, so you look at the key 47 says run out of benefits by way of example.

Now I am going to use the run out of benefits again as an example, yes Regulation 6 says used, in other words it is rejected, there is an opportunity to correct but factually because the member has run out of benefit there is no practical way to correct it, therefore the claim process, the claim adjudication and repayment process stops at that point.

So it is not to say that Regulation 6 is not used, it simply means the outcome is for practical reasons stops at a point prior to the correction action having been taken because it's an impossibility, so I am not quite sure whether that perhaps puts things into context, and I mean that would happen with every single claim, it is not just the FWA claims that go through this process.

ADV KERRY WILLIAMS: So if it comes to your attention at some point that a health services provider has been submitting claims that are

erroneous say over a period of time and so you find that you actually are – you have suffered a loss in the amount of – a certain amount, say R100 000, then what do you do?

MS ANISA MOHAMED: Well I think this is ...[intervenes]

ADV KERRY WILLIAMS: Now you have got another claim that comes from the same service provider, now what do you do?

MS ANISA MOHAMED: Okay now what you first of all have is you have your regulation 6, so let's take a situation, let's go back to the example where the provider was billing at the wrong code, but for some reason the system didn't pick it up, so he should have been billing at R100 per visit, he's been billing at R200 per visit, and this accumulates over a period of time and when the audits are done you see hang on a second, this chap has billed at the wrong tariff, we have actually got a contract with him that he should be billing at R100, he has not.

We approach him and we say listen you know we have actually overpaid you, either make good or we then under certain circumstances where either through consent or using the statutory right of set-off under 59(3) that the over-billing would then be set-off against future claims, so under those circumstances that would probably be happened, because you pick up the pattern of incorrect or erroneous billing post the 30 day period, so in other words payment has already been made. If it is within the 30 day period remember you can at least stop the payment get it fixed and then just pay the correct amount, but if it happens outside of that period one ...[intervenes]

UNIDENTIFIED SPEAKER: (Inaudible – microphone off)

MS ANISA MOHAMED: Well if it's on code oh ...

UNIDENTIFIED SPEAKER: (Inaudible – microphone off)

MS ANISA MOHAMED: Well first of all and I think on the irregularity I am going to hand over to Lee for purposes of the practicalities of that particular payment, but just on the irregularity bear in mind that in terms of Regulation 6 if you fail to within the time stipulated in Regulation 6 refer an erroneous payment back to the service provider for rectification. All that happened is that the burden of proof to show that that is indeed erroneous after the fact lies with the scheme, yes. But it means that were we to claw it back under 59(3) and we were to be challenged it simply means that the scheme must be able to back up what it's done, in other words the onus shifts, it does not deprive the scheme of its statutory right to claw back but it better make sure that it has the facts to back it up.

UNIDENTIFIED SPEAKER: (Inaudible – microphone off)

MS ANISA MOHAMED: Well the point of the matter is if no one asked the question what am I justifying but if I am challenged I would submit then that under those circumstances the scheme would have to back it up, if it cannot then obviously the ruling would fall in favour of the service provider.

ADV TEMGEKA NGCUKAITOBI: Ja, but why do you say that no one is challenging is because the doctor refuses to pay, the only difference is that you have the capability of enforcing payment because you are in control of the payment, so you say that no one is challenging it, doctors are always challenging, all of the cases we have here the doctors are refusing to pay, they deny that they are lying.

MS ANISA MOHAMED: Mr Chairperson I am speaking of a specific

instance where Regulation 6 is being utilised and I am saying to you under those circumstances were a service provider to challenge the scheme as to why in the next month we did not pay a valid claim but set it off against a claim that was paid erroneously in a previous month we would have to show that doctor where the calculations which show that – you know he has already been paid in a previous month in circumstances where he was not entitled to that payment. I mean if it goes to a dispute and I mean there are various dispute resolution mechanisms including you now appeals before the appeal committee, well first of all the Registrar and then the appeals committee or directly to a court, all I am saying is that under those circumstances wherever it is challenged if Regulation 6 was not invoked timeously the scheme would simply bear the burden under those circumstances to show that it was entitled to claw back the funds as contemplate in terms of 59.

ADV TEMGEKA NGCUKAITOBI: But why would he take the money first and then prove the case later?

MR LEE RICARDO CALLAKOPPEN: Chair the picture with all due respect that is painted in my simple mind is as a ...[indistinct] you know we're withholding us, come and challenge us until you can prove it. I need what we need to see into context when a claims come in, is that yes that claim goes through an adjudication system and regulation is applied. However as part of my administration agreement and probably applicable for most medical schemes is that one of the services that we have is a dedicated health provider call centre. In this case through Medscheme and it is based in Durban.

This is a call centre that purely deals just with healthcare

providers and specifically the administrative staff and what we have seen of late bureaus that acts on behalf of these practises that actually deals with asking questions around codes and BMB's etcetera.

So even before the first – and we have multiple payment runs, healthcare professions are given a dedicated area where they claim or query what they have submitted versus what is going to be paid to them, and then later on in this process chain you still have what we see in the fraud, waste and abuse side of it where questions can be asked around it, so it is not that money is just withheld unilaterally and you know we will sort it out, at that particular point in time already when monies is withheld I can only accept, and Vusi can confirm it I know, that we have already started engaging as the reason why we are offsetting and in all probability that is an acceptance that says yes I have utilised the wrong code, yes I have been paid more, set it off and we can get into – I think we cover that detail a bit later on in the presentation as well, but it doesn't happen as an event and here is your claim, it hasn't been paid and you were overpaid and we withhold, there is a robust engagement process and what we try to illustrate through the governance structures, our frameworks, our policies, that we will make available, that it is not just you know what you are guilty and let's deal with you afterwards.

I know in many instances that is how things are conducted within South Africa, but that is certainly not the case and could probably be the exception to the rule where there are cases such as that, and we are happy to take learning from it.

ADV TEMGEKA NGCUKAITOBI: No you see what I am trying to get to is that what we know from Ms Mohamed is that if you fail to do your job in

the 30 days the onus shifts to the scheme. What that means is that you must prove your case before being entitled to deduct, but in practice you deduct before you can prove your case, now that is what I am trying to get my head around.

MR LEE RICARDO CALLAKOPPEN: Chair with that said as well in terms of that you must first – you have got a certain amount of time etcetera, when we do engage and commence a process where we either believe that there is either fraud and perhaps we should start at the back, abuse, waste or fraud, there is an engagement around it, and yes there is letters written, in our instance directly from Bonita's that the administrator writes on our letterheads to those providers, and because of the urgency that we know goes along with it, we must not forget that that healthcare provider is there to serve a member in need of health services, right, and we as a medical scheme deem it very important that our member gets the access to healthcare, so yes we will probably say do it within seven days, or do it within, but it is to stress the urgency of ensuring that that member, that child, that family member, receives the services that is right for them, keeping in mind that if we perpetuate bad behaviour we will be setting a tone where monies can just be utilised abusively and at the end of the day affects members from a contribution perspective, is that not a challenge that we face as South Africans in terms of the cost of healthcare and it is not what we do, I firmly believe and the ethos that we drive, it is how we go about doing it, and yes if you look at one written submission that says you know it is – I can confidently say that our processes is to guard against that.

ADV KERRY WILLIAMS: Perhaps I can ask a question of Mr Makanda,

could you take us back to your presentation to that governance slide, and please can you make the presentation available to the panel because we don't have copies of this, but the governance slide on your presentation or the business process slide that has been referred to. That slide ja, I'm sorry I do not understand still the details of the oversights that you do or don't exercise over Medscheme, so I am trying to understand that in much greater detail than we have managed to cover so far.

Before I ask open-ended questions I just want to ask I understand you do allow Medscheme to write on your letterhead to providers?

MR VUSI MAKANDA: That's correct.

ADV KERRY WILLIAMS: Now why do you do that?

MR VUSI MAKANDA: It is also to – it is just to identify ourselves and separate ourselves from what Medscheme is doing, because a letterhead that we gave them it is exactly what we would want it to be as per the policy that we expect them to apply on our behalf.

ADV KERRY WILLIAMS: Do you approve those letters?

MR VUSI MAKANDA: No we don't approve the letters, but we look at the standard letter up front before we deploy to them to distribute to their service providers. The reason why we are not ...[intervenes]

ADV KERRY WILLIAMS: Just hold on, you have signed off on a standard upfront letter that they are supposed to send?

MR VUSI MAKANDA: Yes.

ADV KERRY WILLIAMS: What does that letter say?

MR VUSI MAKANDA: It depends on the information that we would have been requesting from the service provider. A typical example to

you Mr Chair if they just want to verify services then the letterhead will have a topic that says verification of services and then we will stipulate these are the cornerstones of your content of the letter that will have to go, but as for what goes in there in detail with regards to that specific service provider it will be what they would have identified in their processes of investigating a service provider.

ADV KERRY WILLIAMS: So you don't really have any influence ultimately on what goes into the final letter?

MR VUSI MAKANDA: No we don't. What we do have is the standard, the format of what that letter should encompass or include. Typical example Mr Chair is – okay, let me rather clarify it this way, if the services were not rendered at all and Medscheme has picked up there are five members from whom services were not rendered then we do not have details of those five members because Medscheme would have had that information, but if it is for what the format of that letter should be it would be what Bonitas has given Medscheme to use when they interact with service providers.

ADV KERRY WILLIAMS: Will you give us all your pro-forma letters that you have instructed Medscheme to send?

MS VUSI MAKANDA: Yes, certainly, we can always provide that.

ADV KERRY WILLIAMS: How many are there?

MR VUSI MAKANDA: I think we have got three that I can think of now but if there are more than that we will provide everything to the panel.

ADV KERRY WILLIAMS: And do you mandate Medscheme to request patient information from the providers? Do you mandate Medscheme to request patient information from providers?

MR VUSI MAKANDA: And Mr Chair in the processes that we have said they must use. Bus as for what details are, they then requesting in there as I said we are not privy to every detail that they will be requesting from the service provider.

ADV KERRY WILLIAMS: So, what is the answer to my question?

MR VUSI MAKANDA: When it comes to member information, it depends on what that information is and for what purpose that information is requested.

ADV KERRY WILLIAMS: So, do you mandate Medscheme to request confidential patient files and notes in order to verify that services were provided?

MR VUSI MAKANDA: We do not mandate them as such Mr Chair but what we do is that they will then of course request those kinds of information depending on the investigation that they are conducting.

ADV KERRY WILLIAMS: So, you do not mandate them to request that type of information?

MR VUSI MAKANDA: No.

ADV KERRY WILLIAMS: Yes, you do not or yes you do?

MR VUSI MAKANDA: No, we do not.

ADV KERRY WILLIAMS: Okay, you do not.

MR VUSI MAKANDA: Yes.

ADV TEMBEKA NGCUKAITOBI: Sorry, in the standard letters that you prepare for Medscheme, none of them authorises Medscheme to request confidential patient information?

MR VUSI MAKANDA: As I said Mr Chair, the form- the standard letters are not detailed to say this is what you will have to send if we request

this kind of information. The kind of information that gets requested from service providers depends on the allegation that was investigated.

So, we cannot in any way have a Performa letter upfront to say this should be the way that you are requesting that information. It is what the investigation has then identified which we then want clarity from the service provider.

ADV ADILA HASSIM: I think that question is that it is- so it is not about what specific whether it is your blood results or that or what. But confidential patient information.

MR LEE RICARDO CALLAKOPPEN: Ja.

ADV ADILA HASSIM: May be requested. In order- I mean how do you verify what you are investigating? So, in your Pro forma letters, does it have a section that deals with requesting patient information and then saying under what rules the administrator may request such information.

MR LEE RICARDO CALLAKOPPEN: True.

MS ANISA MOHAMED: Mr Chairperson.

ADV TEMBEKA NGCUKAITOBI: Yes.

MS ANISA MOHAMED: Perhaps if I could just try and reframe this and understand what we getting at. From my understanding of the processes. So, when the investigation reaches a particular point which necessitates for example information as to whether the services were properly rendered which may consist of clinical information.

That information can be requested. Remember this is not the administrator requesting the information, it is the scheme requesting the information. Hence, the approach that the scheme has taken it is the practicalities which are outsourced but the scheme remains ultimately

responsible and accountable and exercises oversight as to what is ultimately received and requested from members. And by the ... (intervenes)

ADV KERRY WILLIAMS: Sorry Anisa, I need to understand that. So, you do mandate Medscheme to request patient- confidential patient information?

MS ANISA MOHAMED: The scheme requests it yes.

ADV KERRY WILLIAMS: So, well the- we have got contradictory answers here. It is unclear to me because the letters are written on your letterhead.

MS ANISA MOHAMED: Correct.

ADV KERRY WILLIAMS: By Medscheme which you do not approve but the Pro forma kind of instructions ... (intervenes)

MS ANISA MOHAMED: No, no, no. I think there is a bit of confusion.

ADV KERRY WILLIAMS: I think really speak to your personal knowledge. Do not speak to what you understand Medscheme does. It is what you instruct Medscheme to do. I am really trying to understand your personal knowledge.

MS ANISA MOHAMED: Certainly. What I am trying to just perhaps put forth is when the- remember there is various stages of the investigation. And normally it starts off with Pro forma letters however as engagements occur the type of correspondence that gets exchanged gets more and more pertinent.

So, to my knowledge it would be exceptionally rare to shoot off the very first letter asking for confidential information. It would simply be setting out we are doing a verification. This is the type of information that prima

facie come to our view. We would like to engage with you to understand the type of services that you require. If the engagement is positive, one need not necessarily then ask for confidential information.

It just depends and I think that is part of the problem is that it is quite new on stand- depending on the type of case that you are dealing with, you may or may not ask for the confidential information. If it is required from what I understand ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: I think there- sorry Ms Mohamed. I mean ... (intervenes)

MS ANISA MOHAMED: Is then the decision is taken ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: We do need a straight answer. I mean I am sorry ... (intervenes)

MS ANISA MOHAMED: Well I am about to.

ADV TEMBEKA NGCUKAITOBI: To interrupt you, ja.

MS ANISA MOHAMED: Yes, I am about- from what I understand is that that is brought to the fraud forum which is where the scheme sits and that information is then debated at the fraud forum. And the go ahead to ask for that information is then specifically given on a case by case basis. That is my understanding. So yes, it is been given but it is not as Advocate Williams says sort of a blanket approach. It is on a case by case where necessary that the authority is then given.

ADV KERRY WILLIAMS: Who sits on the fraud forum? Because you say, as you understand.

MR VUSI MAKANDA: I chair the fraud forum and Medscheme and other stakeholders are also sitting in the fraud forum.

ADV KERRY WILLIAMS: Okay. Just quickly, I am not suggesting there is

a blanket approach. I understand the nuance. But I am understanding- what I am trying to ask is where the determines there is a need to request that you mandate Medscheme to request it.

MR VUSI MAKANDA: Yes, we do.

MR LEE RICARDO CALLAKOPPEN: Yes.

ADV KERRY WILLIAMS: And on what basis do you do so?

MR VUSI MAKANDA: Mr Chair it would be on the basis of the case itself as I said before. Before we request or do anything, there is a background investigation that has been conducted. And I want to distinguish between the confidential information and any other information that gets requested from the provider. The reason why I am doing it ... (intervenes)

ADV KERRY WILLIAMS: Before you go there.

MR VUSI MAKANDA: Yes.

ADV KERRY WILLIAMS: We- I mean you will be aware having sat through many of these proceedings that one of the issues is legitimate claims that providers make potentially around protecting the patient confidentiality and they cannot get consent from their members.

So, you mandate Medscheme to ask for this information, the provider says no we cannot get consent. There seems to be a legitimate deadlock there. But it is still used as a reason to place providers on indirect payment and suspend payments and that creates a difficulty which I am trying to probe.

MS ANISA MOHAMED: So if I might Mr Chairperson. I am sure many other schemes have pointed you to the fact that member consent is given regarding the accessing of clinical information in the application forms. Because clinical information again is not only needed for the investigation

of fraudulent claims, it is required for things like authorisations to see if the member have sufficient benefit whether the procedure is covered by the member's benefit. So, there is many instances where clinical information is required.

Having said that, booklet 9 of the HPCSA booklets which set out professional conduct, it says that if a member has consented, service providers are enjoying to give that information. So, the very professional body that has oversight over the service providers and presumably who the service providers are afraid to antagonise by giving this information actually says you must give that information when members have consented.

If I might draw the analogy, remember the information is that of the members. It is the member's information. It is not the providers information. It is a bit like legal privilege. It is the client's information. It is not the lawyer's information. So, where a member has consented and it would be absurd for a member not to consent because inherent to the processing of claims for which there is an insured benefit requires ... (intervenes)

MR LEE RICARDO CALLAKOPPEN: The information.

MS ANISA MOHAMED: The insurer to know whether that claim is covered or not. It is inherent to the entire model. So, there would be an absurdity to say, well you can use it here but if you investigating me for fraud, then you cannot.

So, it is a bit strange but the ultimate legal test is yes, the member has consented. The professional body says where the member has consented you must give. So, I fail to see where the prohibition comes and it is not

like this is supposed to be publicised, it is used for very particular purposes … (intervenes)

ADV ADILA HASSIM: Try to assist this by taking you to a specific example.

MS ANISA MOHAMED: Okay.

ADV ADILA HASSIM: Can you have regard to page 468.

MS ANISA MOHAMED: Okay.

ADV ADILA HASSIM: Of the Panel's bundle.

MR LEE RICARDO CALLAKOPPEN: It must be that page. Let me just quickly.

MS ANISA MOHAMED: Is that the table of?

ADV ADILA HASSIM: No.

MS ANISA MOHAMED: No, 468?

ADV ADILA HASSIM: Ja.

MS ANISA MOHAMED: Okay, I will page if that helps looks like that.

ADV ADILA HASSIM: It is a letter on the Bonitas.

MS ANISA MOHAMED: No, we have got a list, a table.

MR LEE RICARDO CALLAKOPPEN: A table with chargeable codes.

ADV ADILA HASSIM: Okay, let us go ahead, once we locate the correct document then we will get back to this point.

MR LEE RICARDO CALLAKOPPEN: Okay.

ADV TEMBEKA NGCUKAITOBI: Yes. Thank you. You were still on the terms of reference.

MR LEE RICARDO CALLAKOPPEN: Yes Chair. So, we have wanted to set out the importance in terms of the various regulation which Anisa has covered. Sorry, I just want to get my bearings Chair because we went

slightly off track.

So, Chair as mentioned earlier in the discussions thus far the abovementioned policies have been adopted by Bonitas (indistinct) we act without fear, favour or prejudice and rely solely on the facts when deciding on fraud, waste and abuse matters. I do appreciate that in the absence of having had sight of our fraud, waste and abuse policies as well as frameworks which we have given an indication that we will share confidentially with the Panel. This will become clearer in terms of the detailed how we conduct it and what is in scope and what is out of scope. But I trust that we have addressed some of the questions.

We constantly strive to act to fairly, transparently and within the boundaries of law at all time and that is our formal submission and can go on record in that regard. Both our internal as well as our external auditors use to monitor these policies and interpret and apply consistently. So, we are not as a scheme and would provide as judge and jury. We also have oversight from our independent auditors to help us to ensure that we do not and yes there might be deviations but that those deviations are addressed as promptly as possible in accordance to the applicable charters that we have within the scheme.

Further to that as stated in the sanctions document, Bonitas reports or abhorrent healthcare professionals to the Health Professional Council as well as other bodies. And to that point from the beginning of 2016 when we contracted Medscheme as well as Kubeka, we reported close to about 62 cases to the Health Professional Council of South Africa and 19 cases to the South African Pharmacy Council.

Of the 62 cases reported to the Health Professional Council of South

Africa, only 11 cases have been finalised to date. Cases reported to the SAPC, unfortunately nothing has been adjudicated in that regard. We also reported over 44 cases to the South African Police Services and of that 44 cases, 7 healthcare practitioners have been found guilty of fraud by various courts in the country. The sentences impose from and vary from imprisonment terms to fines to suspended sentences. The importance that I wish to highlight with this particular slide is that we followed due legal process in arriving at the process and addressing the (indistinct) of fraud, waste and abuse.

Chair, and then moving to the particular point that was raised in terms of the terms of reference and the respondent complaints that we had. The schemes have taken a view to corporate with the Panel as what I indicated in my opening statement without jeopardising its position in matters which may be served or be served- serving before the courts or any lawful tribunal at this particular point in time. It must be noted that the schemes submission and presentation made to the Panel as well as the schemes responses to the complaints that were levelled against the scheme by HCP or complainants are made strictly without prejudice and to any of its rights. And the scheme reserves its right to end at it anytime should it become necessary.

However, for clarification and to the points to the questions raised we would like to respond formerly. And the question that was raised by the actual tribunal was that medical schemes conduct profile based racial terms only on Black and Indian doctors that are audited. And the point around it in our formal submission is that we refute that claims as Bonitas and hopefully through the illustration and the submission that we have

made through this presentation, we are able to demonstrate that we do not do any racial profiling towards Black and Indian doctors in any form.

ADV TEMBEKA NGCUKAITOBI: Have you had a look at the racial statistics of the people investigated on your behalf either by Kubeka or by Medscheme?

MR LEE RICARDO CALLAKOPPEN: Chair, no, we have not for the very reason that I demonstrated is that how we conduct ourselves is based on practice numbers. I have satisfied myself as Principle Officer and that of the Management team that we have relooked in terms of what is the process followed and the tools utilised by the service providers that we give.

So, we have not directly gone and looked at the racial profiling or the race composition of the doctors that was subjected to fraud, waste and abuse. At this point in time ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: How do you know then that there are no racially biased outcomes if you have not asked for the information?

MR LEE RICARDO CALLAKOPPEN: Ja. Chair to the point around it is that we investigate and what we demonstrated based on the merits of the data available to us to either establish whether there is wasteful behaviour, abusive behaviour or fraudulent behaviour associated with it. I also at this particular point in time I alluded in my opening statement when I referred to the demographics of the Bonitas membership, they had close to 75% of our members are African in terms of ... (intervenes)

ADV ADILA HASSIM: What does that have to do with the service providers?

MR LEE RICARDO CALLAKOPPEN: The point I am trying to infer around

it ma'am is that yes, they were utilised potentially and it is inference it is not statistically based but utilised doctors of similar racial background and in areas where those doctors are, it is an inference it is not statistically based. However, with that said we are focusing in terms of understanding the behaviour of the claims submitted for our members and ensuring ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: What I do not follow is how can you come and refute racial outcomes when you have done absolutely no enquiries with the service provider that does the investigation on your behalf?

MR LEE RICARDO CALLAKOPPEN: So when I indicate that we have done nothing, we have investigated that is why we are able to demonstrate through our structures, through the policies and the application of it, through the oversight of our committees that our approach has been factually based in terms of looking in relation to regulation and legislation that we do not focus and ask go and look at a specifically set of doctors.

ADV TEMBEKA NGCUKAITOBI: And how can you come here and draw inferences that Black patients will go to Black doctors just on a thumb suck without doing any investigation?

MR LEE RICARDO CALLAKOPPEN: Chair, it is any area that I- that is why I say it is not based on any statistical research or anything such as that. But it is an area that probably requires a bit more of an investigation and looking into ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: You have done zero investigation and yet you come here, you say to us there is no racism and then after that

you make a racially loaded statement.

MR LEE RICARDO CALLAKOPPEN: Chair, with all due respect and I am happy to withdraw the comment. The point I am trying to make is that Bonitas as a medical fund through their service providers do not conduct themselves and refute the statement that our practices in business is that that is racially based.

ADV ADILA HASSIM: I think that there are two things that do not really comes to your systems that you have been emphasising.

MR LEE RICARDO CALLAKOPPEN: Yes.

ADV ADILA HASSIM: Because we accept them already.

MR LEE RICARDO CALLAKOPPEN: Okay.

ADV ADILA HASSIM: So, you are beating a dead horse but you are not helping us because you are not answering the direct question. The two things have one, that there is no question that fraud, waste and abuse must be investigated and that the impact of fraud, waste and abuse is to the detriment of the members of the medical schemes.

MR LEE RICARDO CALLAKOPPEN: Yes.

ADV ADILA HASSIM: No one has ever questioned that. That is not up for debate.

MR LEE RICARDO CALLAKOPPEN: Ja.

ADV ADILA HASSIM: It is a duty on the medical schemes to protect their members interest and of course it is a constitution obligation and you to ensure that health services are properly provided. That is not even ... (intervenes)

MR LEE RICARDO CALLAKOPPEN: Debatable.

ADV ADILA HASSIM: That is really not up for debate.

MR LEE RICARDO CALLAKOPPEN: Ja.

ADV ADILA HASSIM: Certainly not with this Panel.

MR LEE RICARDO CALLAKOPPEN: Yes.

ADV ADILA HASSIM: The second thing that is not- that we have not- that you keep speaking about but we have not really disputed with you, is that you use practice numbers in your approach to investigations and that you do not look at race in the way in which you embark upon your investigations. Or in a way in which targets for investigation are identified.

The question to you is that how do you explain a racially biased outcome if you have not looked and asked your service provider what the outcome is of investigations in relation to Bonitas itself?

MR LEE RICARDO CALLAKOPPEN: Mm.

ADV ADILA HASSIM: So how do you explain that? How can you say there is not any race bias at play if you have not looked at your outcomes?

MR LEE RICARDO CALLAKOPPEN: Ja.

ADV ADILA HASSIM: Outcomes versus intention.

MR LEE RICARDO CALLAKOPPEN: Ja. Chair, thank you very much for clarifying it and I am glad that we view it similar what is not in dispute. Because I think many a times we sit and we listen to this and ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: We do not really have the time. Could you just answer the question please?

MR LEE RICARDO CALLAKOPPEN: Right. But to answer that question Chair through you, is that we have set aside ourselves in terms of our

governance and our processes. We do take the point that we probably require a more intensive review from a racial perspective from the service providers but at this point in time we have not gone to that extend nor were we expected to present that particular answer.

I have on several occasions Chair with all due respect written to the Secretariat over the last 6 weeks requesting if there were particular questions to be answered that we could adequately prepare for. At this point in time we prepared based on what we as fund team discharging ourselves of our fiduciary duty to ensure that no such actions take place. However, I do take note that that answer requires or question requires a factual based answer and by all means as a scheme, we will probe that further.

ADV ADILA HASSIM: Because the duty that rest upon you is not only a duty to investigate fraud, waste and abuse in the interest of your members. But it is also to ensure that your company through your agent or directly is not perpetrating racial discrimination.

MR LEE RICARDO CALLAKOPPEN: Most definitely and we do not condone as a fund any racial discrimination. And where we find and you will see it in the closing statement of our written submission that we will take the necessary action where it is found to be the case by a service provider. Because as a fund we do not however in terms of the current practices that our structures, our policies, our frameworks are geared towards insuring that does not take place.

ADV ADILA HASSIM: It may not be and you will not know if it is actually effective and it is ensuring against as you say because you have not looked at what does it produce.

MR LEE RICARDO CALLAKOPPEN: Chair, point taken. Thank you.

ADV ADILA HASSIM: Okay.

ADV TEMBEKA NGCUKAITOBI: There were questions that my colleague wanted to pose to Advocate Mohamed but we lost the page numbering.

ADV ADILA HASSIM: So, it is the pages that I have flagged in red, I am told. If you just look at one letter.

MS ANISA MOHAMED: Right.

ADV ADILA HASSIM: The one that is dated the 3rd of July 2018. Are you there?

MS ANISA MOHAMED: We are.

MR LEE RICARDO CALLAKOPPEN: Yes, we are.

ADV ADILA HASSIM: Okay. So, the one dated 3rd of July to a- yes to a service provider. It begins with, undertaken an analysis based on our provisional desktop audit. To date it has become necessary to verify the validity of certain services claimed on behalf of our members. And then you say, find hereunder a list of the members and the services. And then you say that you request information in relation to a list of patients.

MS ANISA MOHAMED: Mm-hmm.

ADV ADILA HASSIM: 13 patients, their blood request form and the copies of the results of the blood request.

MS ANISA MOHAMED: Mm-hmm.

ADV ADILA HASSIM: That must be provided and then you say, as per the advice of HPCSA you should obtain the necessary consent from the above patients to share their clinical records with our unit.

MS ANISA MOHAMED: Yes.

ADV ADILA HASSIM: So how does that square with what you are saying

which is that they do not need to get consent from the members because the consent has been provided already.

MS ANISA MOHAMED: Chairperson, please give me a moment. I am just looking at the overall.

ADV TEMBEKA NGCUKAITOBI: Sure.

ADV ADILA HASSIM: There are two questions in relation to that letter. One is in relation to that consent which you say they must go to the members. The service provider must get from the members. And the second is advising the service provider that these payments are currently suspended. So, you are suspending it while you are attempting to verify the claims.

ADV TEMBEKA NGCUKAITOBI: Can we take 10 minutes?

MS ANISA MOHAMED: Yes Chair.

ADV TEMBEKA NGCUKAITOBI: Because we were meant to finish by 16:00 but it is still going on. So, you can take time if you want.

MR LEE RICARDO CALLAKOPPEN: Thank you Chair.

ADV TEMBEKA NGCUKAITOBI: Thank you.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Thank you. Maybe we can just focus on the question by Adv Hassim?

ANISA MOHAMED: Thank you Mr Chairperson, so I have consulted very, very briefly with client and some of the administration staff that we have here and I am informed that, you know, that this is not a standard letter. What had happened in this interaction is that there was a debate going backwards and forwards where the service provider

claimed he did not have the right, notwithstanding the scheme asserting that they have got consent from the member, that he did not have the right independently to supply the information sought and as a result thereof this paragraph seems to have made it into various iterations of ongoing reminders and correspondence.

But from what I gather it was not a standard letter, it was peculiar to the circumstances of this matter.

ADV ADILA HASSIM: But the sentence says that the HPCSA has advised that the service provider should get the consent from members.

ANISA MOHAMED: I take the point,

ADV ADILA HASSIM: So they are the custodians of the ethical code for the service providers, so obviously their interpretation is that individual consent has to be obtained from the members for this purpose and that the blanket consent that they provided is insufficient.

ANISA MOHAMED: Well, I can't speak to that. I do believe though the fact that the scheme had, from what I gather from booklet 9, is that the blanket consent would be sufficient because of the nature of the type of relationship that the scheme has with members. And that was by extension then said, for particular purposes where schemes request those information, it should be forthcoming. Whether the debate also went because part of it was, because if you look at the end of that sentence, it says,

'We act as the managed health care organisation'

And whether the schemes consent, presumably was not sufficient to cover that particular element, or that particular, you know, link in the chain. As I say we consulted very, very briefly on this, I don't have

anything further to add other than to perhaps postulate that that might have been a factor also.

ADV TEMBEKA NGCUKAITOBI: Yes, I think let's proceed with the slide presentations.

LEE RICARDO CALLAKOPPEN: Thank you very much.

ADV KERRY WILLIAMS: Sorry, may I just ask one follow up question on this, sorry Chair. Can you just point us to where in your rules the patient consents to disclose information?

ANISA MOHAMED: It is actually on each of the, when members sign up.

ADV KERRY WILLIAMS: Sorry, it is on the –

LEE RICARDO CALLAKOPPEN: Application form.

ADV KERRY WILLIAMS: So where is that form? Where is a copy of that form?

ANISA MOHAMED: Well there is a form per member. We can make our pro forma available to you because it is on every single printed form so when the member signs to apply to become a member of Bonitas, part of that is the consent.

ADV KERRY WILLIAMS: You don't have that wording readily at hand today?

ANISA MOHAMED: I will pull it up for you right now.

ADV KERRY WILLIAMS: Okay and while you are doing that, could you also point us to, I have booklet 9 here, we have looked at it, I don't see where booklet 9 says what you say it says, so if you can point us to that as well please.

ANISA MOHAMED: I'll do that.

ADV KERRY WILLIAMS: Thank you.

LEE RICARDO CALLAKOPPEN: Thank you Chair, to move on to just the terms of reference, I have covered the first point. The second point that was raised was whether medical schemes demand member's patient confidential records when verifying the claims. Chair, we did cover it in previous, but for the purpose of going on record, want to read it to you in terms of our submission.

> 'The scheme respects the confidentiality of members and patients information disclosed to treating health care professionals. When claims are submitted by the HCP it is done with the ICD -10 codes detailing the relevant diagnosis and the treatment plans to be employed. Motivation for pre-authorisation contains very detailed clinical information about the condition, surgery and/or treatment of the member when pre-authorisation is requested. Verification of the services can be confirmed using other means other than the confidential information that is suggested. The scheme service providers have confirmed the verification of services does not only rely on confidential information of the members or patients other than for the purpose of unlocking member benefits, entitlement and processing thereof.'

And Chair, the other question that was asked by the panel, was medical schemes conduct illegal probes and are guilty of entrapment techniques. Bonitas medical fund's submission or response to this point is the scheme does not conduct any illegal probes in any form of entrapment. The scheme service providers have also confirmed to us

that they do not conduct probes, not do they use hidden cameras or entrapment of HCP's. However, they confirmed that they do conduct unannounced visits to health care professionals and this they have gone on record to provide to us when we engaged on the subject matter.

The next question that was also asked to us was medical schemes do not report HCP's to the appropriate regulatory bodies and the law enforcement agencies. In terms of the scheme's response is that fraud, waste and abuse matters has reported arrant HCP's to both the Health Professions Council, the South African Pharmaceutical Council as well as SAPS, as well I indicated in terms of the type of statistics I presented in one of the aforementioned slides, the scheme cannot overemphasise the challenges that we encountered with the mentioned regulatory bodies and the South African Police Services in ensuring that the reported cases are investigated and finalised promptly. So this is a challenge that we experiencing as a fund.

And then finally, the question was posed to us in terms of medical schemes unlawfully being bullied or unlawfully bully health care professionals to sign acknowledgement of debts or AOD's without any legal basis. Our response formally in that regard is that all the health care professional providers are invited at a particular time at the AOD meetings and are advised up front in terms of their rights and their right to legal counsel or representation of their choice. In instances where there is no legal representation and the health care professional elected to enter into the AOD with the scheme, the HCP does so voluntarily and without any coerced in any manner or form.

It must be stressed that the health care professionals are informed of their rights to legal representation and we have this on record from our service providers when we looked into this matter and these allegations.

Then Chair, moving on really to the last slide of our submission and our response, it is the following: The scheme has an escalation process where any person who feels aggrieved at any given time by the conduct of our scheme service providers while conducting an investigation, to directly approach the scheme for any intervention. The scheme remains open to engage with any such person with an aim of equitably resolving any issues or disputes that is brought to our attention.

The scheme further wishes to submit to the panel that it remains committed in working with the health care industry to get rid of fraud, waste and abuse to benefit the scheme and its members and all South Africans. The scheme remains committed to the Constitution and any other laws of this country. And then in closing Chair, we would like to reiterate that in employing advanced and robust techniques many persons who have sought to defraud the scheme and its members have faced the consequences of doing so as has been by the outcomes of certain trials brought before our courts.

The scheme would urge the panel to weigh up the interests of justice and the ordinary consumers who fall victim to some of the behaviour that we have seen coming forward in this industry. The scheme does not tolerate any form of racism and objects to any allegations that it indulges and/or supports such practices. I also in this point and not in my written submission, take cognisance of the points raised by the

panel members and yes, we will be taking this further, we do not see this as a conclusive matter and we look forward to the report and the outcome that this panel will submit.

In our view, in so far as it may pertain to the scheme, there is no basis to hold that the scheme, that the Bonitas medical fund specifically, employs racist practices in its business environment. It is certainly not something that the Board or myself or any management condones that there should be racists. Especially, in how far we have come as a country and to that point we give the commitment to address any of the findings that may be forthcoming from this panel. Thank you.

ADV TEMBEKA NGCUKAITOBI: Thank you, can you just tell me how do you decide on the amount to be recovered?

LEE RICARDO CALLAKOPPEN: Chair, are you referring ...

ADV TEMBEKA NGCUKAITOBI: In the section 59(3) implementation.

LEE RICARDO CALLAKOPPEN: Chair, in terms of the amount to be recovered, obviously this is based on the analysis in terms of where we have investigated and we have considered in terms of where there is actions that requires an amount. So it is based on the factual computation that is considered based on that analysis that is performed. And,

ADV TEMBEKA NGCUKAITOBI: How is the computation done?

LEE RICARDO CALLAKOPPEN: And also taking into consideration what is then presented to a provider because that computation could result in a provider, when engaged, pointing out to probably an error or oversight on their behalf and a correction thereof so it is through and engagement to get to a final number.

ADV TEMBEKA NGCUKAITOBI: How do you compute the amount?

LEE RICARDO CALLAKOPPEN: Chair, it is done through the actual claims adjudication process that our service providers obviously go through in terms of looking at the detailed claims by line item, by code in terms of, it's a very complex process which personally as principal officer I can share at this particular point in time the level of detail for you but I am happy through the oversight that we provide through the committee and the policies associated that it articulates that process for us.

ADV TEMBEKA NGCUKAITOBI: Alright, but you personally don't know?

LEE RICARDO CALLAKOPPEN: I personally am not an expert in that field Chair.

ADV TEMBEKA NGCUKAITOBI: Alright, no, thank you. The other thing I just wanted to get clarity on is how much do you pay per annum in claims?

LEE RICARDO CALLAKOPPEN: Chair, I can quickly draw up information and I can share that with you to give you a factually based number but it will be based on the 2018 results.

ADV TEMBEKA NGCUKAITOBI: Yes, no, it doesn't matter which, I mean maybe if there is an escalation, it won't be more than 10%. And how much of that do you say is ascribable to FWA?

LEE RICARDO CALLAKOPPEN: Chair I have noted those two points, can I suggest that other two questions may be answered and then I can come back to these two for you. Thank you.

ANISA MOHAMED: Mr Chairperson, I have the one for Adv Williams there, I am just waiting for the reference to the HPCSA booklet to come through but I have got the 2017 application form which I believe is still current. Section 11 of that, talks to the protection of information, in other words, the scheme's undertaking to keep member information confidential and I just want to highlight this, I will make the form available

> 'We will only use your information for the following purposes, underwriting, assessing and processing medical services claims, fraud prevention and detection, statistical analysis, audit and record keeping, compliance with legal and regulatory requirements verifying your identity. We may share your information with the service providers for the purposes of processing and rendering services to you.'

And then, regarding the reciprocal consent that is required for this, it is found in section 12, and it says,

> 'I authorise my and my dependant's health care providers to disclose information to Bonitas and its contracted service providers and partners, provided that the information is treated as confidential.'

Which is why I read the confidentiality obligations of the scheme.

> 'I agree to provide Bonitas with any medical or historical information and grant Bonitas access to medical information reasonably required relating to a specific ailment, disease, disorder, condition or disability.'

So there is other but those go specifically to the clinical data and the consent both to service provider, health care service providers as well as the member's own undertaking to then facilitate the information.

ADV TEMBEKA NGCUKAITOBI: How long should doctors keep their records for?

ANISA MOHAMED: I understand it is six years from the HCPSA guidelines but I can find that reference for you.

ADV TEMBEKA NGCUKAITOBI: So you rely on HPCSA guidelines, not on the specific rule that applies in relation service providers.

ANISA MOHAMED: No, we refer to the HPCSA guideline. If you just give me a moment, I will then find the appropriate booklet for you.

ADV KERRY WILLIAMS: While you are looking for that, Mr Makanda, can I ask you a question? Just because I still am struggling with understanding how Bonitas interacts with Medscheme and how much oversight you have over Medscheme's conduct. We of course haven't seen your contract so we can't use that, so we are relying entirely on what you tell us today for the moment but how many people do you manage in your team as head of FWA operations?

VUSI MAKANDA: At Bonitas, which is the Head Office, its only myself, there is no one else. And then at Medscheme I think it is 54 people that operate under, on that division only.

ADV KERRY WILLIAMS: So you are solely responsible for all FWA activities at Bonitas?

VUSI MAKANDA: Yes.

ADV KERRY WILLIAMS: Okay and how often do you meet with Medscheme then in terms of performing

VUSI MAKANDA: Oversight.

ADV KERRY WILLIAMS: Oversight and engagements. *Ja.*

VUSI MAKANDA: We have two stand out meetings on a monthly basis that we sit and in those meetings it is either the fraud forum or the one on ones that I have with them and in those meetings it is there where we go through every other things that we believe we should get clarity on, including specific cases.

ADV KERRY WILLIAMS: Okay.

ADV TEMBEKA NGCUKAITOBI: I mean this oversight, how does it actually work you see because as you have testified, you have no insight into specific letters that go out, that is all administered by Medscheme. So you have a general conversation every fortnight?

VUSI MAKANDA: It is not a general conversation Mr Chair. It is specific to certain cases that have been brought to my attention for example, or cases that Medscheme would want to relay to me for approval.

ADV TEMBEKA NGCUKAITOBI: So it is either they have come to you or Medscheme has decided which cases should be discussed?

VUSI MAKANDA: I have got my own cases that I would just want them to give me clarity on and I think it is only fair that I explain this thing. The amount of cases that they carry on a monthly basis, it cannot be possible for me to have an oversight on each and every one of them, hence I am saying it is only those cases that then they would feel it warrants my intervention and then I will intervene on those. Including those that myself, I will pick and choose which case I should ask them

how far they are and then I will have an oversight on those kind of cases.

ADV TEMBEKA NGCUKAITOBI: I think we should appreciate that it should be quite a taxing exercise. And what is the average cases that they are carrying per month that you say it is impossible for one individual to have and in depth oversight of.

VUSI MAKANDA: From what I have been told and what I have seen on the system, because I also have access to the system that they use, it is anything up to say, 100 per analyst.

ADV TEMBEKA NGCUKAITOBI: So Medscheme's own analysts are handling 100 cases per month? Each analyst?

VUSI MAKANDA: Depending on the volumes that would have come for that particular month, but it varies. I cannot sit here and say it is 20 cases, it varies depending on how many cases were then spit out by the system and the hotlines that they receive for that particular month.

ADV TEMBEKA NGCUKAITOBI: And then how many analysts would then report to you?

VUSI MAKANDA: As I said, Mr Chair, I don't, there's no analysts reporting to me. I get the reports from the head of that unit which is the General Manager and he is the one reporting to me, telling me exactly what is going on. As for the analysts, it is Medscheme and their supervisors and everybody else who is there who then manages them

ADV TEMBEKA NGCUKAITOBI: I just want to understand, I mean if you have one analyst, a hundred cases, I mean even for that specific analyst who is doing 100 cases, that is a big job.

VUSI MAKANDA: It is.

ADV TEMBEKA NGCUKAITOBI: And there is a big scope for mistakes. And then to multiply those, maybe there are say, four analysts. That is 400 hundred cases already. And that is what you have to contend with every month.

VUSI MAKANDA: Mr Chair, it is not 400 cases that I sit with as a person. As I said, I manage the manager who manages those cases. It is those that they would then come to me for an approval that I will overlook and for those that I will pick and choose depending on what I want to achieve for that particular question or kind of case that I want clarity on.

ADV TEMBEKA NGCUKAITOBI: And in an average meeting how many cases would you be able to look at specifically?

VUSI MAKANDA: Okay, in – I always have say 4 to 5 hour meeting with the head of that unit and within that meeting, because we are not only discussing cases, we can discuss up to 10 to 20 depending on the volumes that we would have agreed upon up front.

ADV TEMBEKA NGCUKAITOBI: So the overwhelming really just is the baby of Medscheme?

VUSI MAKANDA: If you take that 100 and then the 20 that we are looking at then yes, the 80 could be then what Medscheme is handling on their own.

ADV ADILA HASSIM: And those that you are discussing in these meetings are those cases that require specific decision making oversight by you?

VUSI MAKANDA: Yes.

ADV ADILA HASSIM: And do you know the names of the service providers who are implicated when you are having those discussions in the meetings?

VUSI MAKANDA: Because I would ask questions as to who this provider is, where is it, and what are the issues, then I will get to know who the provider is.

ADV TEMBEKA NGCUKAITOBI: Will the analysts know the providers? That is the source of your information.

VUSI MAKANDA: Exactly.

ADV TEMBEKA NGCUKAITOBI: *Ja.*

ADV KERRY WILLIAMS: And in terms of the 22 or 23 complaints that Bonitas has responded to, do you recall those being discussed at any of your meetings?

VUSI MAKANDA: Yes, Mr Chair, I recall quite a number of them having been discussed in those forums.

ADV KERRY WILLIAMS: And was Dr Kalanda discussed?

VUSI MAKANDA: No, Dr Kalanda was not one of them.

ADV KERRY WILLIAMS: Who or which providers were discussed or which complainants were discussed?

VUSI MAKANDA: For example, the City Hospital matter was discussed, the matter of NC and HCPA it was discussed and Clean Path, it was discussed.

ADV KERRY WILLIAMS: Sorry, how could the matter of the National NCPA, that was I understand, a submission, unless I have got it wrong, it wasn't a complaint, I mean sorry, it wasn't a product of an investigation?

VUSI MAKANDA: It was reported because there was a process that was already on play. That is why they had to report as to how far that matter is.

ADV KERRY WILLIAMS: So, three of them?

VUSI MAKANDA: Yes, Mr Chair.

ADV KERRY WILLIAMS: Thank you.

ADV ADILA HASSIM: Sorry, one last question Mr Makanda, does Medscheme also provide monthly and quarterly reports to the scheme?

VUSI MAKANDA: Yes, they do.

ADV ADILA HASSIM: Can you provide that to us? A sample of those.

VUSI MAKANDA: Yes.

ADV ADILA HASSIM: Thank you.

LEE RICARDO CALLAKOPPEN: Chair, if I can then move on to your question? The question poses the claims value paid. The point was at 20, in the last financial year, it was close to R13.9 billion that we paid keeping in mind that in 2019 we have seen a steep increase in terms of utilisation cost, so *ja* it would be significantly higher than the R13.9 billion.

Your question that you also asked is, how much is fraud, waste and abuse, Chair, to the point of what we have reported in, since we started in 2016, about R297 million and this is as at the end of 2018, we calculated close to about R297 million quantified due to fraud, waste and abuse. We recovered only close to about R84 million. However, what is quite important for us is on the waste and abuse side of it, ...

ADV ADILA HASSIM: Just a moment, that is for 2018

LEE RICARDO CALLAKOPPEN: That was as reported in our financial statements at the end of 2018.

ADV ADILA HASSIM: For the period 2018? For the financial year ending 2018?

LEE RICARDO CALLAKOPPEN: Correct.

ADV TEMBEKA NGCUKAITOBI: And in terms of the financial structure that you have designed with Medscheme, are they entitled to a percentage of that R84 million?

LEE RICARDO CALLAKOPPEN: Of the R84 million?

ADV TEMBEKA NGCUKAITOBI: *Ja.*

LEE RICARDO CALLAKOPPEN: Chair, they get paid on a per member per month fee. Apologies, just give me a second. Chair, what I have just been advised from my counsel perspective, is that we are subject to certain confidentiality associated with it however, I am happy to make a written submission to the panel directly just for your info than to go publicly in terms of how the commercial arrangement is arrived at.

ADV TEMBEKA NGCUKAITOBI: Thank you, unless there are any further points from your side, this will conclude the inquiry. It just remains of me to thank you for the time spent in preparing and appearing and putting up with our questions and we are looking forward to your supplementary submissions.

LEE RICARDO CALLAKOPPEN: Chair on behalf of the panel and on behalf of Bonitas medical fund, thank you very much and thank you for affording us the opportunity and we will in due course try to answer all the particular questions that was raised in our supplementary submission. Thank you very much and all the best with your process.

ADV TEMBEKA NGCUKAITOBI: Thank you. The enquiry is adjourned. We are resuming tomorrow at 10 am.

INQUIRY ADJOURNS TO 28 JANUARY 2020

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TRANSCRIBERS CERTIFICATE FOR

THE COUNCIL FOR MEDICAL SCHEMES (CMS) INQUIRY UNDER

SECTION 59 OF THE MEDICAL SCHEMES ACT

HELD AT

BLOCK A, ECO GLADES 2, OFFICE PARK, CENTURION

DATE HELD : 2020-01-27

DAY: : 15

TRANSCRIBER : C M LEHMANN; B DODD; D BONTHUYS

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