Discovery Health Presentation to Section 59 Investigation Panel

Dr Jonathan Broomberg
29 January 2020

Purpose of this presentation

Discovery Health (“DH”) has made a submission to assist the Section 59 Inquiry Panel which sets out the operational and legal parameters within which DH conducts investigations into fraud, wasteful care and billing abuse (“FWA”) on behalf of client schemes. DH has also responded to complaints lodged by practitioners, observations from representative organisations and/or regulatory bodies, and data requests received from the Panel.

The purpose of this presentation is to:

- Provide context for our submissions and for the fraud and forensic activities carried out by DH on behalf of client medical schemes.
- Highlight key elements of our submissions.
- Respond to Dr Kimmie’s report and share the results of our name based analysis.
- Highlight key elements of our responses to the complaints and observations presented to the Inquiry.

List of previous submissions

Submission	Date submitted
Initial submission	19 July 2019
Data on practices & analytics	From 12 August 2019
Responses to complaints against Discovery *(34 affidavits to date)*	From 15 August 2019
Responses to allegations in public hearings (1)	2 September 2019
Data on investigations	13 September 2019
Engagement with panel expert including data and information submission	From 27 September 2019
Responses to allegations in public hearings (2)	11 October 2019
Responses to allegations in public hearings (3)	14 November 2019
Response to Dr Kimmie's report	27 January 2020

Key points covered in this presentation (1/4)

- DH invests substantial resources in tackling FWA on behalf its client schemes, and its efforts have proved effective over many years. We outline our processes in detail to demonstrate the rigour and seriousness applied to managing FWA and protecting scheme members.
  - 70% of investigations have identified material FWA irregularities, with a total saving of R7.8 billion from 2012 to 2018 (including the halo effect).
  - Without Discovery's FWA efforts over this period, members contributions would today be 14% higher in the case of DHMS.

- DH and its client schemes have never resorted to implicit or explicit racial profiling nor to any other form of racial discrimination in the process of identifying and investigating FWA, and in the processes of recovering scheme funds.

- External legal review, counsel opinion and Court judgments have confirmed that the processes DH uses in identification, investigation and recovery of funds related to FWA are fair and fully compliant with the spirit and letter of all applicable legislation.

Key points covered in this presentation (2/4)

- DH has submitted affidavit responses on 34 complaints and clear evidence of FWA has been demonstrated in 100% of these cases. In none of these cases is there any evidence of either racial discrimination or any other wrongdoing by DH. 7 complaints are reviewed in detail in the presentation.

- At no point do we include race data in any of our investigation processes.

- In order to address the allegations raised during this Inquiry, we have used a name-based classification methodology which has been subject to external review by Deloitte.

- Our analysis finds that there is no differentiation by race in the ratios of valid investigation outcomes and recovery rates for investigated practitioners. This proves that there is no evidence of bias in the investigation processes once a case is identified for investigation.

- Our analysis confirms that there is some racial differentiation in the cases identified for investigation.

Key points covered in this presentation (3/4)

- More than 50% of investigations arise from tip-offs. DH has no control over the source of nature of tip-offs. All tip-offs are investigated in the same way, regardless of race.
- The balance of the race differences in cases identified arises from the application of the DH RRT algorithm.
- The RRT uses 30 independent factors that are not linked to practitioner demographics.
- No evidence has been presented of either implicit or explicit race bias in the 30 factors used in the RRT, nor in its application, despite rigorous external scrutiny including by Dr Kimmie.
- Dr Kimmie acknowledged that the observed race differences in FWA may be due to confounding factors rather than to race being the cause of the differences.

Key points covered in this presentation (4/4)

- DH has analysed the impact of a set of confounding factors for which we have data.
- 3 of these factors explain 75% of the observed differences in FWA outcomes by race. This reduces the risk ratio from 1.36 to 1.09. This means that the unexplained race differences in FWA cases initiated is reduced to 9%.
- There may well be further confounding factors as well as other environmental factors that neither DH nor Dr Kimmie have investigated.
- There is therefore no evidence before the Panel to prove either implicit or explicit racial bias in the DH FWA processes.
- The integrity of the forensic process is key to protecting member funds and ensuring that medical scheme cover remains affordable. The Panel should not undermine these processes on the basis of unproven allegations of racial bias.

Agenda

1. **Background context on medical schemes and administrators**
2. Background to FWA and its impact on medical schemes
3. The roles and duties of medical schemes and administrators in relation to FWA
4. Background on Discovery Health
5. Discovery Health's FWA investigation, recovery and reporting processes
6. Responses to allegations of racial profiling/discrimination, unfair conduct and statements of fact made during the Inquiry
7. Responses to formal complaints submitted to the Inquiry
8. Additional case studies demonstrating the nature and impact of FWA

Key features of medical schemes of relevance to FWA processes

Not for profit entities which play a critical role in pooling risk

- Medical schemes pool risks between the young and the elderly, and the healthy and the ill.
- They are not for profit entities which must collect sufficient premiums to cover all claims and other costs, and to maintain solvency reserves.

Highly regulated industry

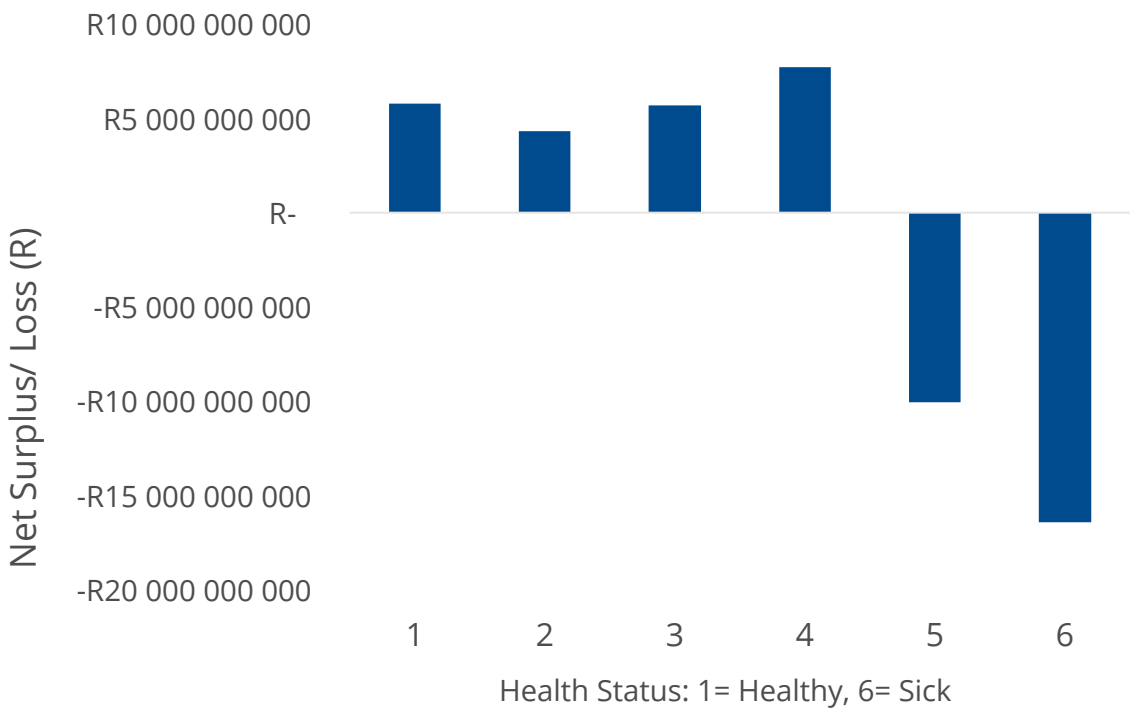
- Schemes and administrators are regulated in terms of the Medical Schemes Act, by the Council for Medical Schemes.

High claims inflation

- Medical inflation, driven by rising utilisation and claims costs, threatens the sustainability of medical scheme cover.
- FWA is an important component of rising claims costs.

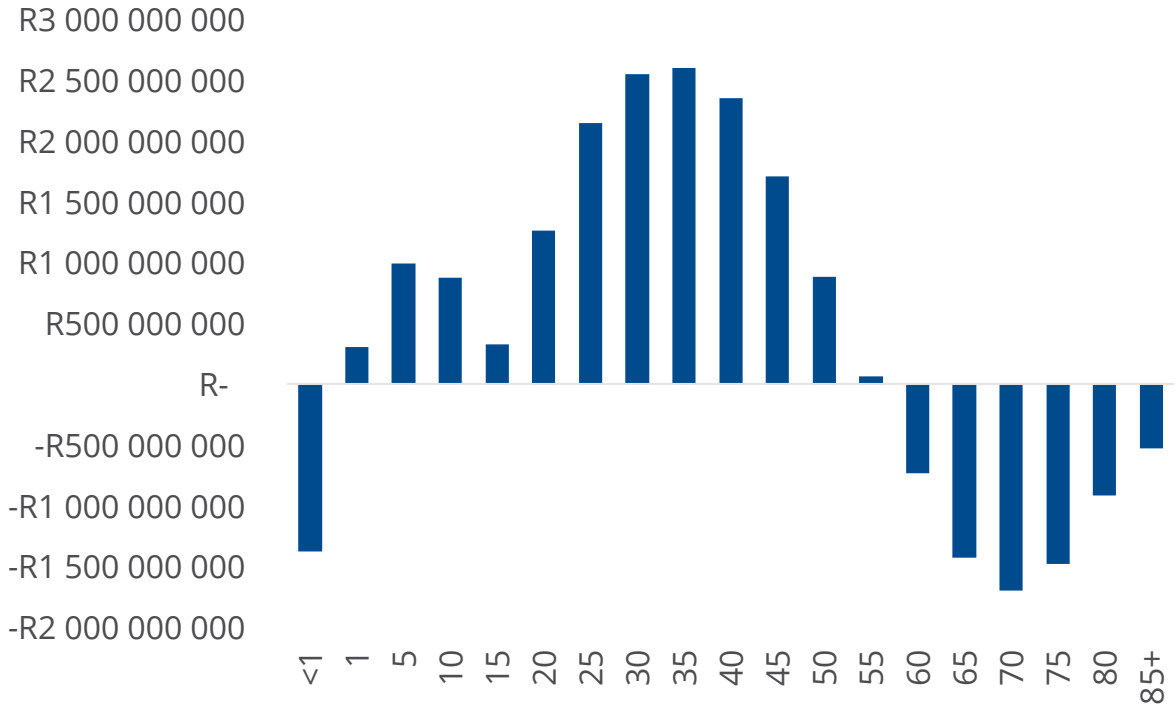
Risk pooling: schemes provide cross subsidies between the young and the old, and the healthy and the sick

Net surplus/loss by health status



Sick members with higher costs are subsidised by the net surpluses generated by healthier members.

Net surplus/loss by age



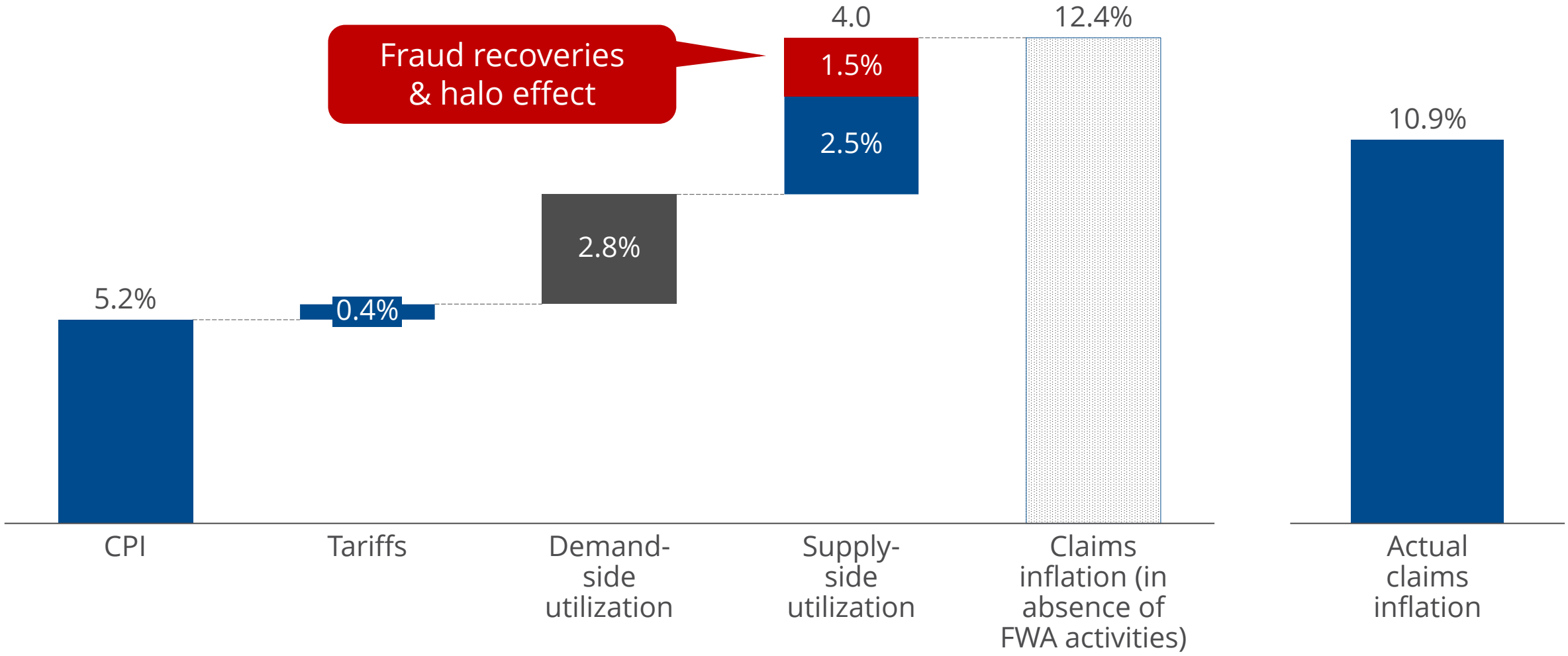
Very young (<1 year) and older members' health costs are cross-subsidised by the surpluses generated by younger members.

Implications of regulatory structure for schemes' approaches to FWA

- Medical schemes are not-for profit mutual entities, managed by a Board of Trustees who have fiduciary duty to protect member funds.
- Medical schemes are not profit making entities.
  - If the total contributions collected in a year exceed total claims and expenses, the surplus remains in Scheme reserves.
  - If the scheme incurs a loss, this loss has to be recovered through higher contributions in subsequent years.
- Trustees set annual contributions which must be sufficient to cover the claims predicted for the coming year(s).
  - If drivers of claims inflation, including FWA, are well managed, contribution increases can be contained.
  - If drivers of claims inflation, including FWA, are not controlled, contribution increases have to be higher, threatening sustainability.
- Active control of FWA and effective recoveries directly benefit scheme members.

Schemes are experiencing high medical inflation driven mainly by increasing utilisation

Average annualised inflation rates (2010 – 2018)



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8. Responses to formal complaints submitted to the Inquiry
9. Additional case studies demonstrating the nature and impact of FWA

Importance of medical scheme FWA recognised by CMS with Inaugural 2019 FWA Summit and Charter

Charter definitions

- **Fraud:** Knowingly submitting, or causing to be submitted, false claims or an intentional misrepresentation of the facts in order to access payment of a benefit to which one would otherwise not have been entitled.
- **Waste and Abuse:** Claiming for healthcare treatment and services that are not absolutely medically necessary, including any form of over-servicing or over-charging of a patient, that may objectively be considered unethical or unconscionable or contrary to best practice principles.

Stakeholders

- FWA arises from the activities of numerous stakeholders including health practitioners, crime syndicates, individual members, brokers and hospitals.
- DH data: 29% of proven fraud and billing abuse incidents attributable to health practitioners in 2018.

SOURCE: FWA Summit; Discovery Health forensics data

FWA is recognised as a major challenge for healthcare systems – in SA and globally

Global Estimates

3 – 15%

Global estimate of healthcare spend lost to FWA

$415 bn

Estimated global amount lost to FWA each year

CMS Estimates

Up to 15%

Estimated % of total claims paid by SA medical schemes due to FWA

R22 – 28 bn

Estimated amount of medical scheme members' money lost to FWA claims

DH Conservative Estimates

3 – 7.5%

Estimated share of FWA claims

R1.7bn

Estimated amount of DHMS members' money lost to fraudulent claims per year

SOURCE: Centre for Coutner Fraud Studies at the University of Portsmouth and accounting firm PKF in the United Kingdom (https://www.who.int/bulletin/volumes/89/12/11-021211/en/); FWA Summit : CMS presentation

FWA Summit Conclusions – February 2019

- Healthcare fraud, waste and abuse poses a critical impediment to efforts to make healthcare more affordable and accessible, and ultimately poses a threat to the sustainability of both the public and private healthcare systems.
- Medical schemes have a legal obligation and a fiduciary duty to protect members' funds against FWA. The execution of this duty by medical schemes is imperative for the future sustainability of the medical scheme industry.
- Provisions within the MSA, scheme rules and practitioner contracts (cumulatively read) confer on medical schemes the powers to conduct audits and the ability to withhold or recover funds paid out inappropriately to healthcare practitioners are critical tools in the fight against medical aid FWA.

SOURCE: FWA Summit

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Medical schemes have an obligation to control FWA for the benefit of their members

Medical scheme obligations

- Medical schemes are required to protect the interests of beneficiaries and to preserve scheme funds.
- Taking appropriate measures to control FWA and to recover funds clearly falls under this mandate.

Relevant legislation

- Medical Schemes Act
- Financial Institutions (Protection of Funds) Act 28 of 2001 (“FI Act”)
- King IV Report on Corporate Governance
- Common law

Medical schemes have an obligation to control FWA for the benefit of their members

Fraud-specific mandate

- CMS requires medical scheme administrators to demonstrate and maintain effective forensic oversight of claims management.
- CMS expressly recognises the lawfulness and necessity of an administrator having FWA detection measures in place.
- CMS Circular 35 of 2019 places even greater emphasis on fraud detection and forensic requirements.
- FWA Charter obligations

Implications for administrators

- DH's is mandated to control FWA and to recover funds wrongly paid out due to FWA in terms of its accreditation with CMS and its administration contracts with client schemes.

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Discovery Health

- DH is an accredited medical scheme administrator, regulated by the CMS.

- DH has 19 medical scheme clients:
  - DHMS – open scheme
  - 18 restricted membership schemes
  - 3.5 million lives under administration

- DH is appointed to provide administration and managed care services by the Boards of Trustees of each medical scheme, and operates under a formal contract with each scheme client.

Discovery Health's contractual mandate and role in FWA

- DH's contractual role is to manage the operational and administrative affairs of client schemes, including the investigation and recovery of claims paid out incorrectly due to errors or fraud.
- The obligation to manage FWA is a requirement for accreditation by CMS as a medical scheme administrator.
- The Act explicitly requires that scheme funds are utilised only for the purpose for which they are intended.
- DH employs over 4,400 people to carry out its responsibilities to its 19 client medical schemes with 3.5 million lives under administration.
- DH is paid a fixed administration fee per member of each scheme per month, and makes profit to the extent that its income from administration fees exceeds its own operating expenses. DH does not share in the surpluses of its scheme clients.

Discovery Health's contractual mandate and role in FWA

- DH's interests are aligned with its client schemes – when schemes perform well and grow, DH benefits through increased membership growth, leading to increased administration fee revenue.
- DH's revenue is not directly dependent on:
  - The financial performance of client schemes – all surpluses are retained for benefit of scheme members.
  - Whether claims are paid or not – all decisions are based on scheme rules and DH does not share in scheme reserves.
  - The extent of FWA recoveries – all recoveries are paid directly to the scheme's accounts.
- DH does not retain funds recovered from health practitioners as a result of investigations into FWA. These amounts are paid back directly to the medical schemes who have suffered losses as a result of the fraud or abuse.
- DH has no direct financial interest in FWA recoveries.

Discovery Health's commitment to transformation (1/2)

- Transformation is a key component of DH's overall business strategy.
- We focus on developing an inclusive and transformed workforce that equitably represents all sectors of society. Recruiting and retaining black South Africans in senior positions remains a key priority.
- Discovery Health's Executive Committee comprises of 63% black executives including the Chief Strategy Officer and Chief Data Officer, Chief Marketing Officer, Chief People Officer and an Executive Director.
- Further, 42% are women including our Chief Operating Officer, Chief Information Officer, Head of New Business Development, Head of Strategic Risk Management and Head of People.

Discovery Health's commitment to transformation (2/2)

- Our procurement strategy also incorporates stringent transformation principles in order to encourage transformation of our supply chain.
- 58% of DH's forensic division employees are black, and 100% of employees in the forensic analytics division are black.
- DH is accredited as a Level 1 BBB-EE contributor – the highest possible level.
- The Discovery Foundation invests approximately R30 million each year in the training of mainly black medical specialists.

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Overview of DH's claims and FWA resources and processes

- DH invests substantial resources in analysis, prevention and control of FWA.
- Resources include a full time team of 44 investigators and auditors supported by 55 actuarial, statistical and clinical professionals who support FWA activities on a part-time basis.
- Formal governance processes are in place for reporting to client medical schemes and oversight by them of all FWA processes.

Governance of FWA activities

- The entire FWA process is subject to formal corporate policies, and reviewed periodically by the DH Board and relevant Discovery Limited committees.
- Formal external reviews are commissioned from time to time.
- Cases are internally reviewed by clinical and coding specialists to avoid inappropriate or invalid investigations.
- Each case, and all associated actions, is fully tracked in the Raptor case management system.
- All investigations are directly supervised to ensure appropriate protocols are followed at all times.
- Relevant professional societies are engaged at various points in the process.

Claims processing

- Given the high claims volumes, schemes pay claims using automated, rules based systems.
- Claims are paid in good faith, on the assumption that they are accurate and valid.
- It is critical for DH (and any administrator) to ensure that all claims are paid accurately, according to the rules of each medical scheme, and to ensure that scheme funds are not lost to fraudulent claims or other abuse.
- This requires ongoing retrospective statistical analysis of claims to identify any claims errors and instances of FWA.

275,000
Claims processed per day

R300 million
Claims value processed per day

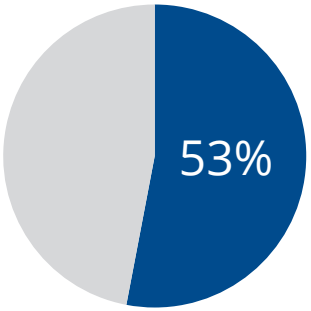
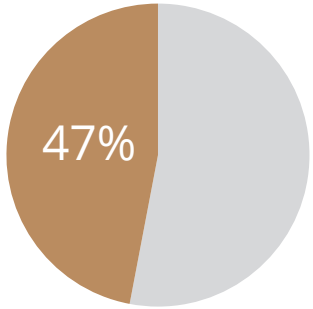
94%
Claims processed immediately

4 – 5 days
Receipt of payment

Rationale for retrospective FWA investigations and recoveries after claims payment

- Schemes are obliged to pay accounts within 30 days from receipt of the valid claim/account.
- High volumes make it impossible to verify claims prior to payment.
- Schemes typically pay the majority of claims immediately and in good faith, based on automatic adjudication using scheme rules.
- This requires retrospective claims analysis to ensure that schemes recover any invalid claims already paid out.
- The majority of health practitioners (87% of GP visits and 91% of specialist visits) are on a “direct payment arrangement” where the medical scheme pays the practitioner directly.
- This allows schemes to negotiate preferential tariffs with healthcare practitioners and to avoid any further billing to the patient.
- The direct payment model however poses risks for schemes, since the practitioner may bill fraudulently without the member’s knowledge. With appropriate FWA activities, benefits of direct payment justify the risks.

Identification of potential FWA cases

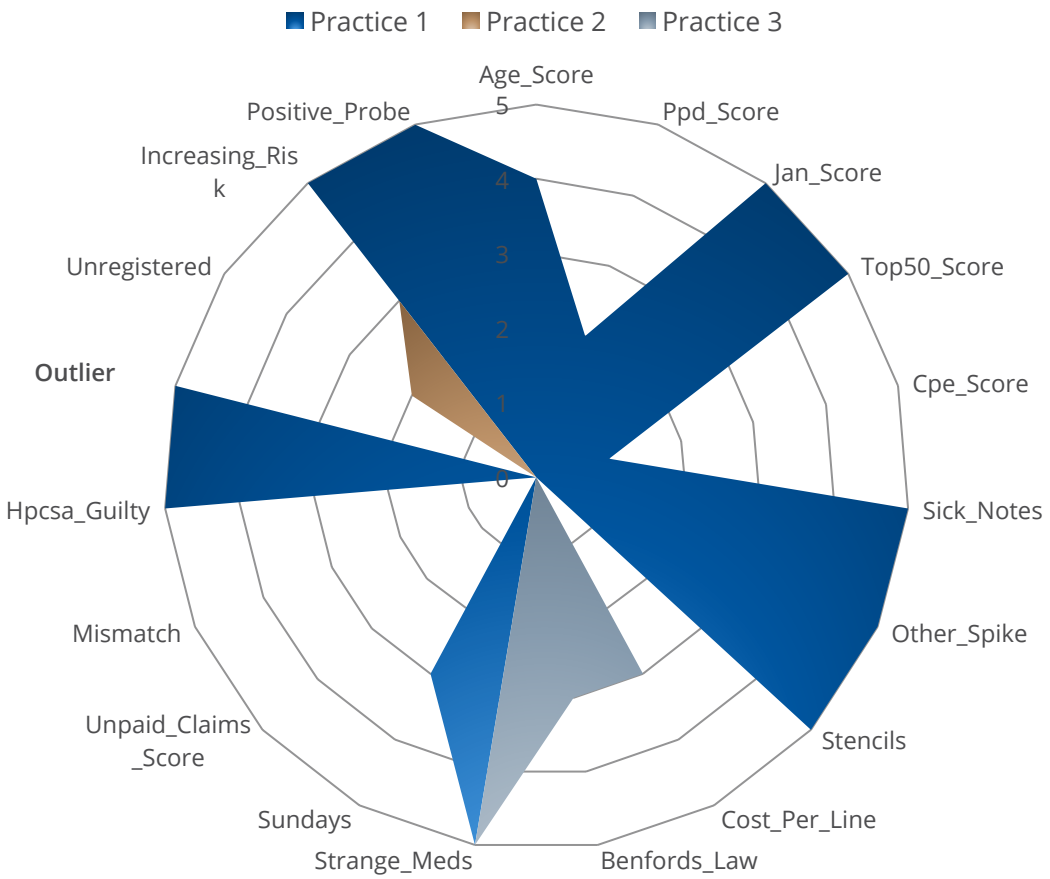
Identification method	Description	Share	Details
Tip-offs	Tip-offs come from members, other health practitioners and other stakeholders.		▪ Various whistle blowing channels are provided. ▪ Most tip-offs occur through an e-mail link provided in electronic claims statements sent to members. ▪ Tip-offs have increased to 62% of total in 2018 due to expanding tip-off channels.
Statistical analysis	Statistical algorithms and risk rating tools are applied to identify potential FWA.		▪ All claims are analysed using sophisticated data analytics methodologies, including the application of risk rating algorithms developed for each health professional practice type. ▪ DH monitors the nature, quantum and frequency of claims. ▪ The algorithmic approach seeks to identify statistical 'outliers' and claims trend irregularities.

Statistical analysis

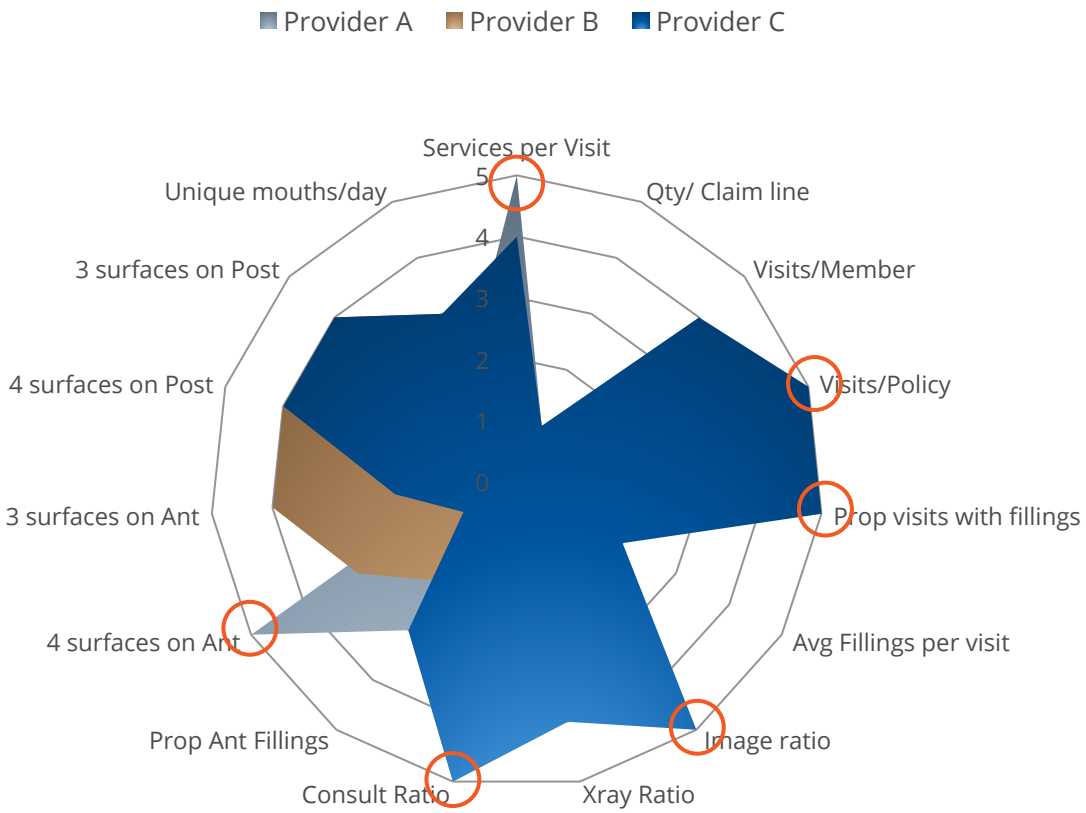
- Statistical analysis uses proprietary risk rating tools to identify practices at high risk for potential FWA.
- The inputs to the statistical analysis include 30 independent risk metrics, which are not linked to practitioner demographic factors.
- The practitioner risk rating tool then applies algorithms to identify high risk practices. It does not prove FWA but flags high risk practices or patterns.
- The tool generates:
  i. A single risk score: indicates whether there is a reason initiate an investigation.
  ii. A report: each practitioner is compared to peers for the top ICD-10 and procedure codes billed.

Examples of Practitioner Risk Rating Tool applications

Allied Health Professionals 19 Metrics



Dental 22 Metrics



Selection and allocation of potential FWA cases for further investigation (1/2)

- All practitioners are allocated a risk score through the RRT.
  - High-scoring cases have higher potential for FWA.
- New cases are loaded onto the Raptor Case Management System as existing cases are concluded.
- For any new anomalies, clinical and coding reviews are conducted. If these cases are still suspicious after this review, they are also loaded onto Raptor.
- Potential FWA cases are prioritised on the Raptor system using objective criteria without reference to race or any identity factor of the practitioner.
  - **Primary prioritisation factor:** source of the complaint, where member complaints are accorded the highest priority
  - **Secondary prioritisation factor:** potential value involved and impact on client schemes

Selection and allocation of potential FWA cases for further investigation (2/2)

- Once prioritised, cases are automatically allocated by the case management system to individual investigators.
- Allocation criteria include type of case and the workload of the investigator.
- Every case is carefully supervised and all case related actions are tracked in the Raptor system.

Investigation Process

- The mode of investigation is determined by nature of the potential FWA.
  - The majority involve direct engagement with the practice to obtain further information and to review findings.
  - Undercover investigations are reserved for small number of serious cases where this is the only method of confirming/excluding fraud.

- Direct engagement:
  - The first engagement is typically via letter requesting information and explanations.
  - This is followed by a request for a meeting.
  - The practitioner is always informed that a simple explanation for the irregularity may exist, and that they are entitled to be represented at the meeting.

Investigation Process

- Data requested:
  - Typically administrative data (e.g., appointment records, purchase orders, etc.)
  - Where clinical information is required, the absolute minimum of such information necessary for the investigation is requested.
  - The practitioner can always redact any information (s)he believes is sensitive.

- When a member applies to join a medical scheme, (s)he consents to the processing of personal information including access to information necessary to enable the scheme to verify and pay benefits as set out in the Scheme rules.

- During the initial meeting:
  - Findings of the investigation are presented.
  - Issues are discussed if practitioner is in a position to do so.
  - If not, a follow-up meeting is scheduled.

Use of undercover investigators

- DH utilises narrowly targeted undercover investigations where there is strong evidence of serious FWA activity, and where further factual information is required that is difficult to obtain by any other means.
- An investigator, posing as a patient, visits the practice to obtain information to verify or exclude the suspected fraudulent conduct.
- These investigations are conducted in line with all applicable legislation, including the guidelines in the Criminal Procedure Act.
- DH processes have been reviewed by Senior Counsel who confirmed the legality of these investigations.

Resolution and settlement of valid cases

- DH estimates the value of claims paid out on an invalid basis due to FWA based on the specifics of each case, and over an appropriate period – usually not more than 3 years.
- DH recovered funds in 71% of all valid cases over the past 8 years.
  - The practitioner undertakes to implement corrective action and to repay the amount of irregular claims to the affected medical scheme(s).
  - The settlement agreement is typically structured as an Acknowledgement of Debt (AOD) where the practice repays the settlement amount over an agreed period without interest.
  - This is easier for practitioners than insisting on full recovery immediately, and allows practitioners to pay the settlement amount over time from funds earned through ongoing claims payments.
- Recovered funds are paid to the affected scheme/s.
- Cases are reported to the authorities where appropriate and in terms of applicable legislation.
- Examples of our case-specific approaches are found in our 34 responses to complaints.

Methods for estimating value of invalid claims paid out due to FWA

Data used

- Each calculation is based on the specifics of the case.
- The aim of the analysis is to estimate the quantum of claims that have been inappropriately paid out as a result of proven FWA.
- To limit the burden of work on the practitioner, DH only requests a manageable sample of case records to further the investigation.

Process for determining amounts

- Any amounts payable back to the medical schemes involved are determined through engagement with the affected practitioner based on verified data.
- There are different approaches to calculating the amount owed.
- The general principle is to determine the approximate extent of the FWA and then to apply it to all claims over a prior period (determined depending on the case) to get to a fair settlement amount.
- The service provider is always given an opportunity to suggest possible errors in the calculation or to present their own analysis and proposals.

Estimation methodologies for different types of FWA

FWA type	Typical methodology	Alternative measures used
Claims from pharmacies or dispensing GPs	▪ The average proportion of FWA claims out of total claims is determined. ▪ That proportion is extrapolated to the full amount claimed over the period to reach a estimate of amount owed by practice.	▪ Ranking of medicines/items claimed vs peers ▪ Ethical vs generic ratio of meds ▪ Cost per prescription ▪ Cost per encounter ▪ Cost per claimant
Claims submissions for non-scheme members / sick notes	▪ Practitioner is requested to indicate the extent of the irregularities. ▪ That information is used to calculate the approximate percentage of total claims that are irregular.	▪ Visit rates of members to the practice ▪ Cost per claimant

Estimation methodologies for different types of FWA

FWA type	Typical methodology	Alternative measures used
Purchase record audits	▪ Service providers are requested to supply proof that they have purchased the items that they have claimed for. ▪ The settlement amount owed is estimated using purchases where the service provider cannot supply proof of purchase.	▪ Visit rates of members to the practice ▪ Cost per claimant
Audits for time-based coding	▪ Service providers are requested to supply information to verify claims submitted to the scheme(s) for payment. ▪ If the service provider cannot provide suitable verification, the claims paid out are recovered in full.	▪ Coding patterns of peers ▪ Average cost per encounter/cost per policy/ cost per claimant of peers ▪ Visit rate of peers

Acknowledgement of Debt (AOD) Process

- An AOD documents an admission by the practitioner that funds have been claimed invalidly and that an agreed amount is owed back to medical schemes.
- The intention is only to recover funds paid out irregularly – no penalties included.
- Intention also to ensure that the practitioner can continue to submit claims and to refund the amounts owed over a reasonable time from ongoing income.
- Practitioners are able to make a counter-proposal based on own calculations.
- Practitioners are encouraged to have representation throughout the process.
- The process is supervised and subject to documented policies.

Allocation of funds recovered during FWA processes

- All recoveries are paid directly into the affected scheme(s).
- Where applicable:
  - Claims identified are reversed.
  - Funds from savings accounts are refunded to members.
  - Limits reduced by invalid claims are replenished.
  - Risk claims are refunded to the scheme risk pool.
- Otherwise all recoveries go into the schemes' risk pool.
- Regular reporting on FWA recoveries to scheme trustees.

Costs of the investigation (1/2)

- DH's policy is to attempt to recover the direct cost incurred during undercover investigations as part of settlement negotiations with service providers.

- Investigation costs are only recovered when a service provider agrees to refund the direct cost of the investigation as part of the overall settlement reached.

- The investigation costs are determined based on the following:
  - Travel costs
  - Daily allowances for food for undercover investigators
  - Boarding for undercover investigators for out of town investigations

Costs of the investigation (2/2)

- An average cost for the above is determined each year, which is then used during the settlement process.
  - Over the past 36 months DH has recovered investigation costs in approximately 62% of cases where recoveries were made following positive undercover investigations.
  - The average investigation cost per case over this period was R4,932.

- The total value of investigation costs recovered equates to approximately 1.5% of the recoveries made on behalf of the schemes following undercover investigations over the past 36 months.

Indirect payment, suspension and blocking of practices (1/3)

Indirect payment to practitioners:

- The contractual relationship for payment is between the scheme and the member. Direct payment is a voluntary arrangement between the scheme and practitioner.
- If FWA is suspected, DH may reimburse members rather than pay practitioners directly.
- Scheme rules permit the suspension of practitioner direct payment arrangements.

Suspension of payments to practice:

- Where a practice is not cooperating with the investigation and/or where ongoing payments to a practice are deemed to pose material risk to schemes, payments to the practice may be suspended for a period until the matter can be resolved.
- Suspension may be of short duration and not affect the 30 day payment obligation as contemplated in Section 59(2) if the matter is expeditiously resolved.

Indirect payment, suspension and blocking of practices (2/3)

Suspension of payments to practice:

- Suspension may be of longer duration to protect the scheme/s from sustaining further losses through FWA until the matter can be resolved and could be coupled with set-off to recover losses as contemplated by Section 59(3).
- At any one time, 0.2% of all claiming practices are suspended.
- Suspension of payment is lifted once the matter has been resolved.

Payment block:

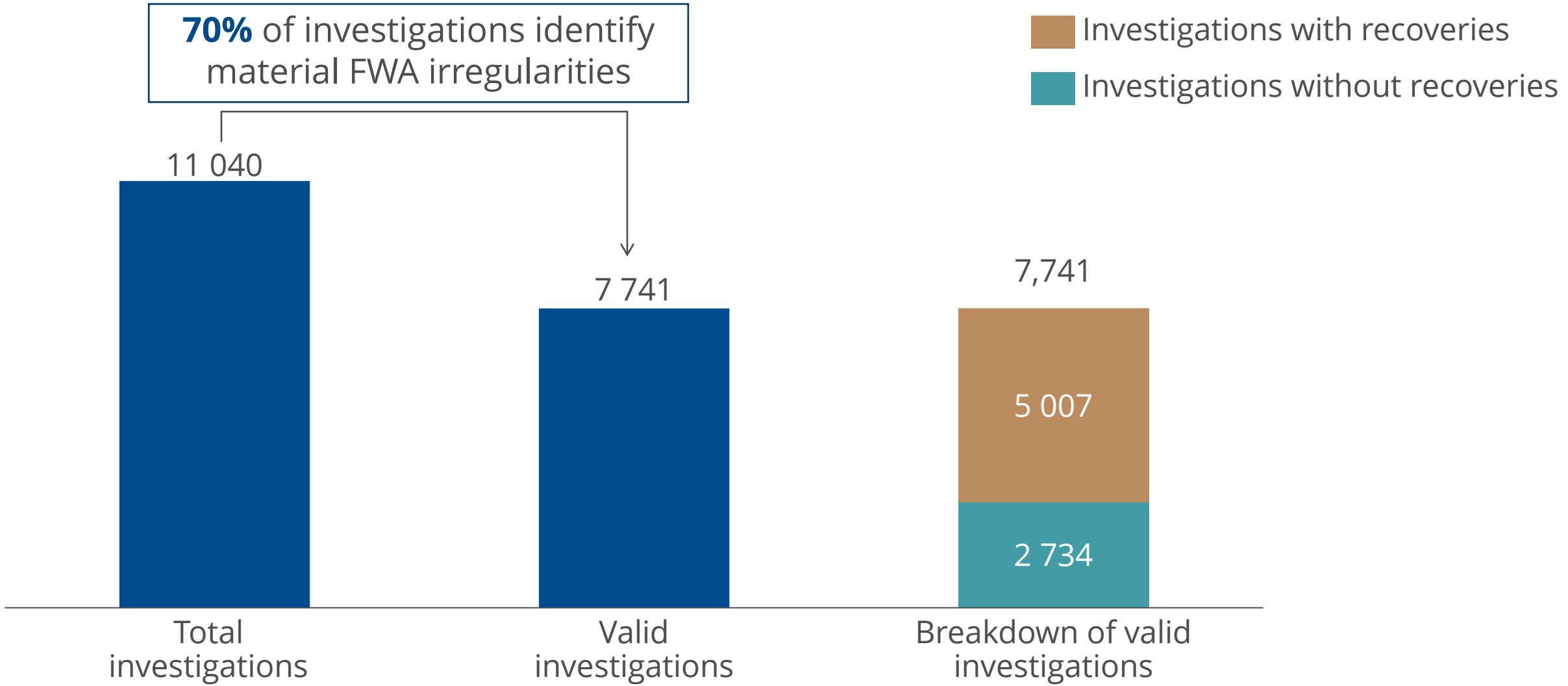
- In a small minority of cases (0.7% of all investigated cases), payments to the practice may be blocked completely.
- This sanction is reserved for practices/practitioners who persistently refuse to engage; or have engaged in very material fraud; and/or have committed repeated fraud.

Indirect payment, suspension and blocking of practices (3/3)

Administrative requirements

- Regulations 5 and 6 stipulate format and administrative requirements for claims submitted to medical schemes.
- There is an obligation on schemes to notify practitioners/members of any administrative irregularities within 30 days.
- Our legal advice is that the obligation to notify practitioners/members within 30 days does not apply to fraud or other irregular claims, and is overridden by 59(3).

Results of FWA investigations: 2016 – 2018



FWA investigations: 2018

Investigation statistics

4,195
Health practitioners investigated in 2018 for suspected FWA

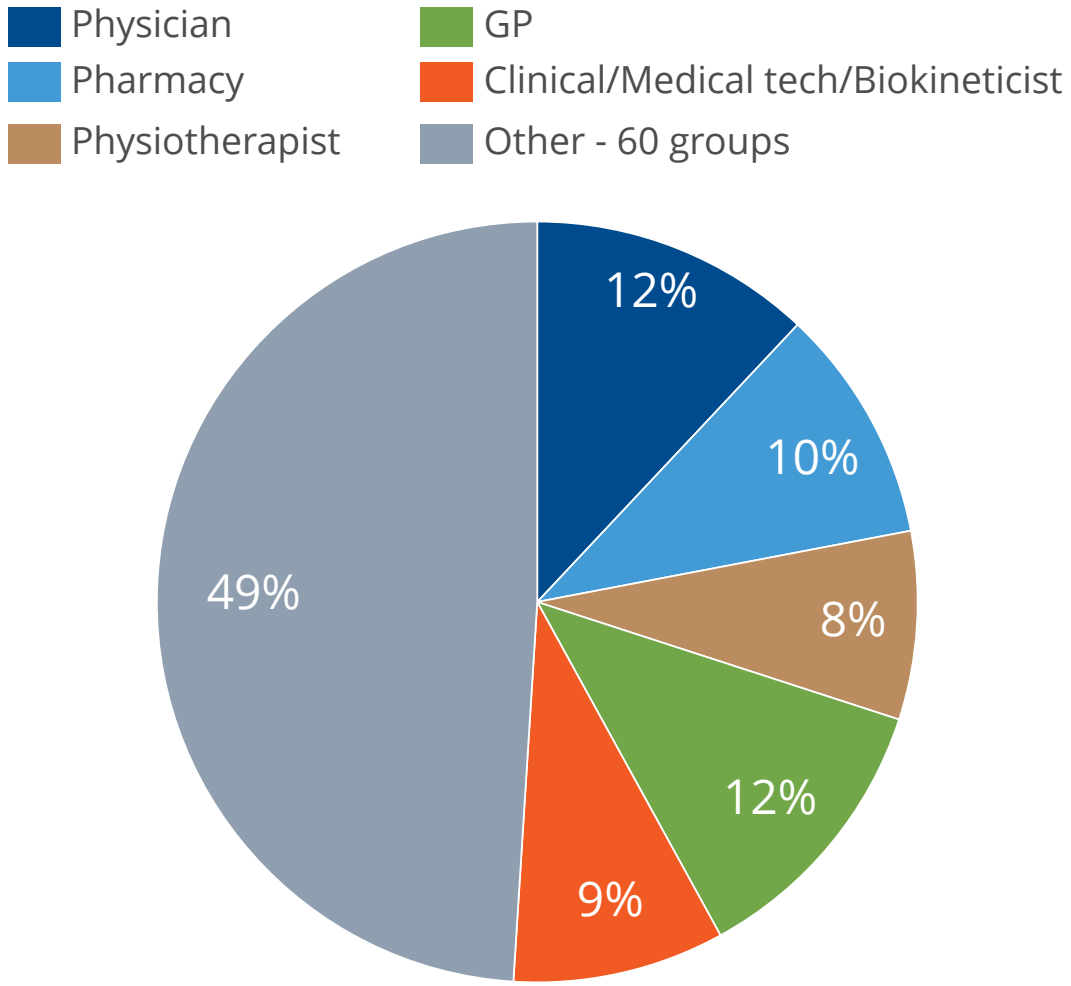
~10%
Of all professional practices were investigated in 2018

73%
Of cases confirmed as valid FWA

7.9%
Of all practices submitting claims to DH during 2018 committed FWA

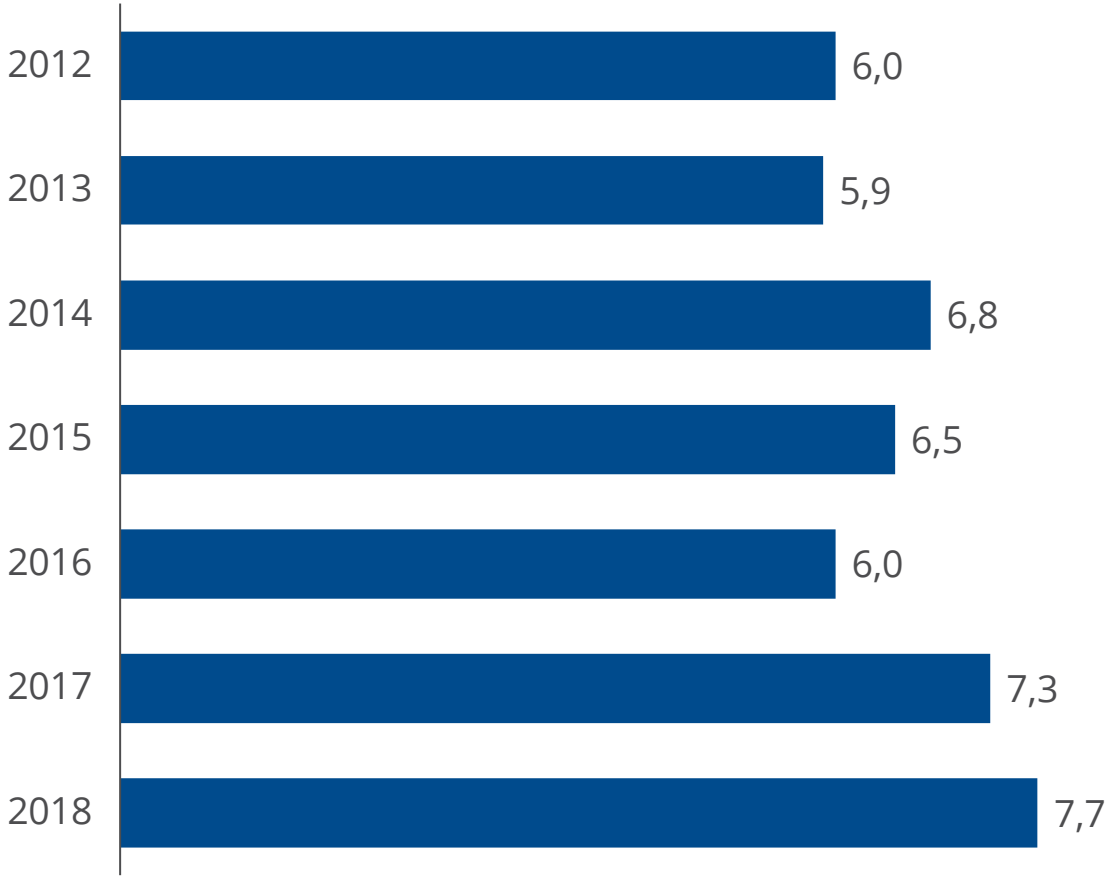
R172 million
Recovered from health practitioners in 2018

Recoveries per health practitioner discipline

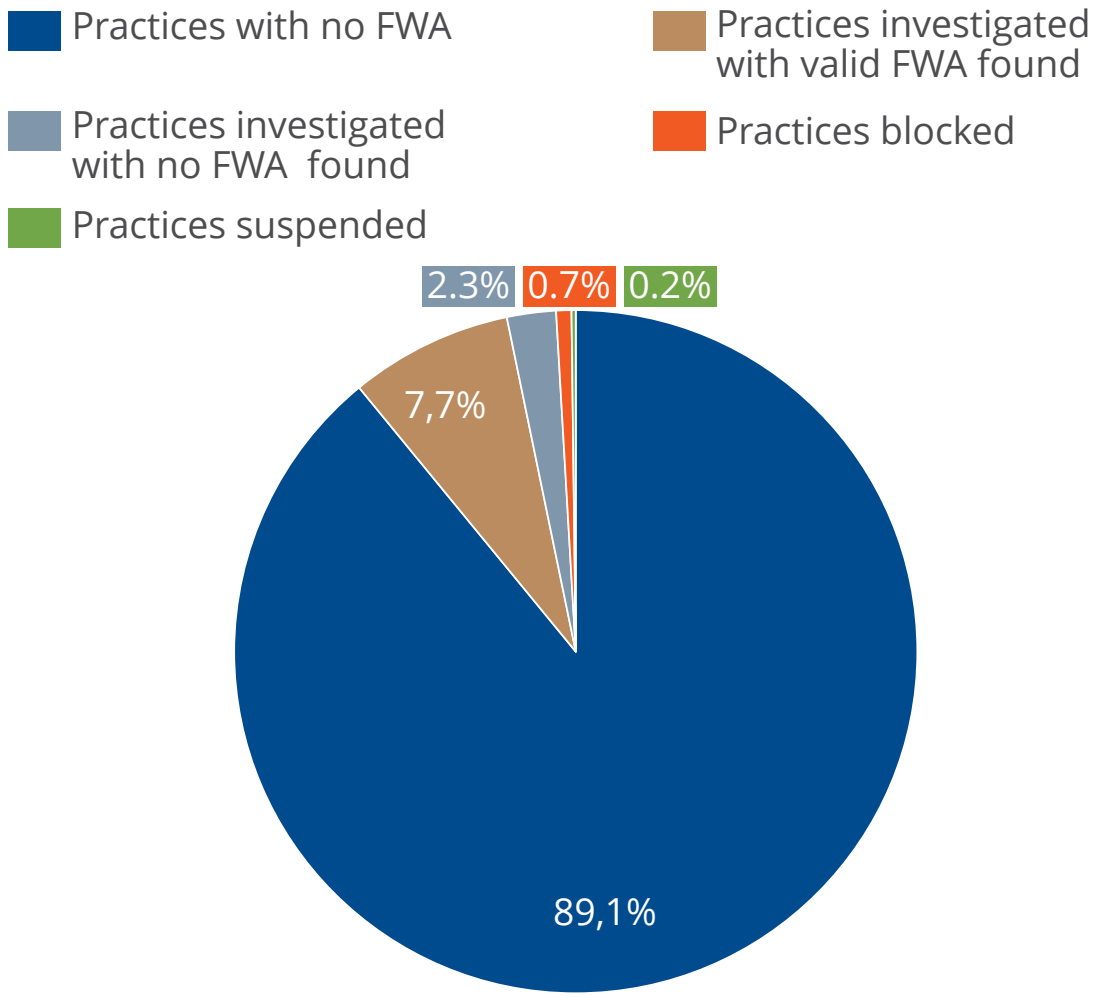


Results of FWA investigations: 2018

Share of total practices with valid FWA findings, %

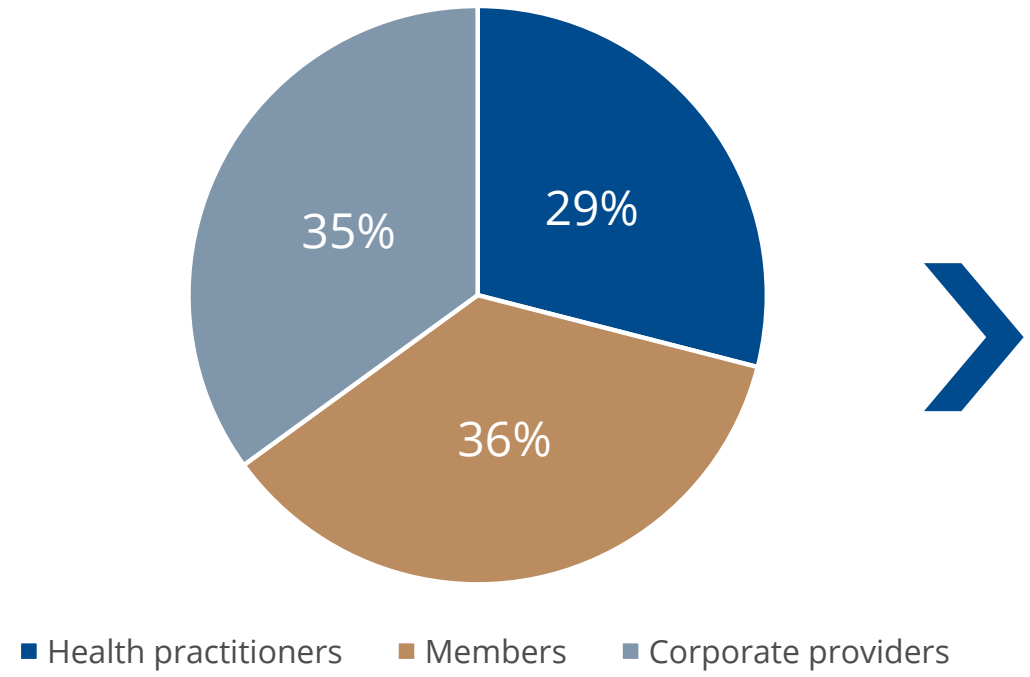


Distribution of practices by FWA status (2018)

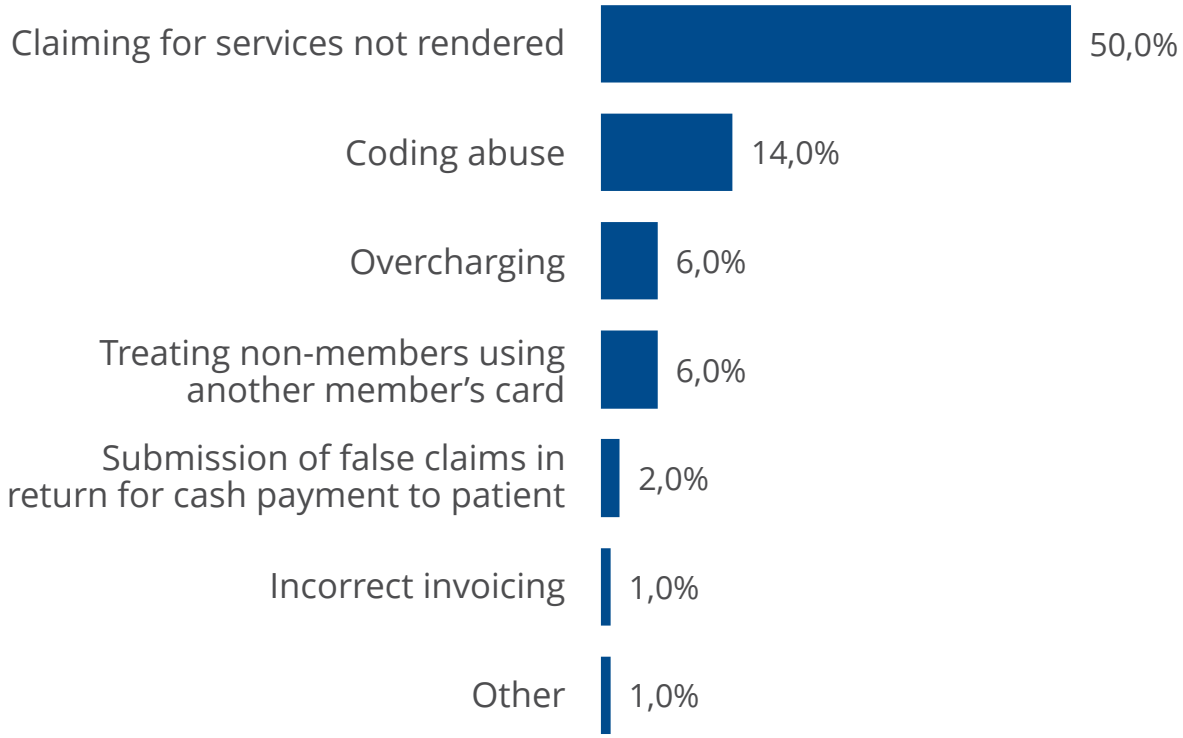


Breakdowns of FWA offences and recoveries per source

DH recoveries per source (2018)



FWA offences 2016-18

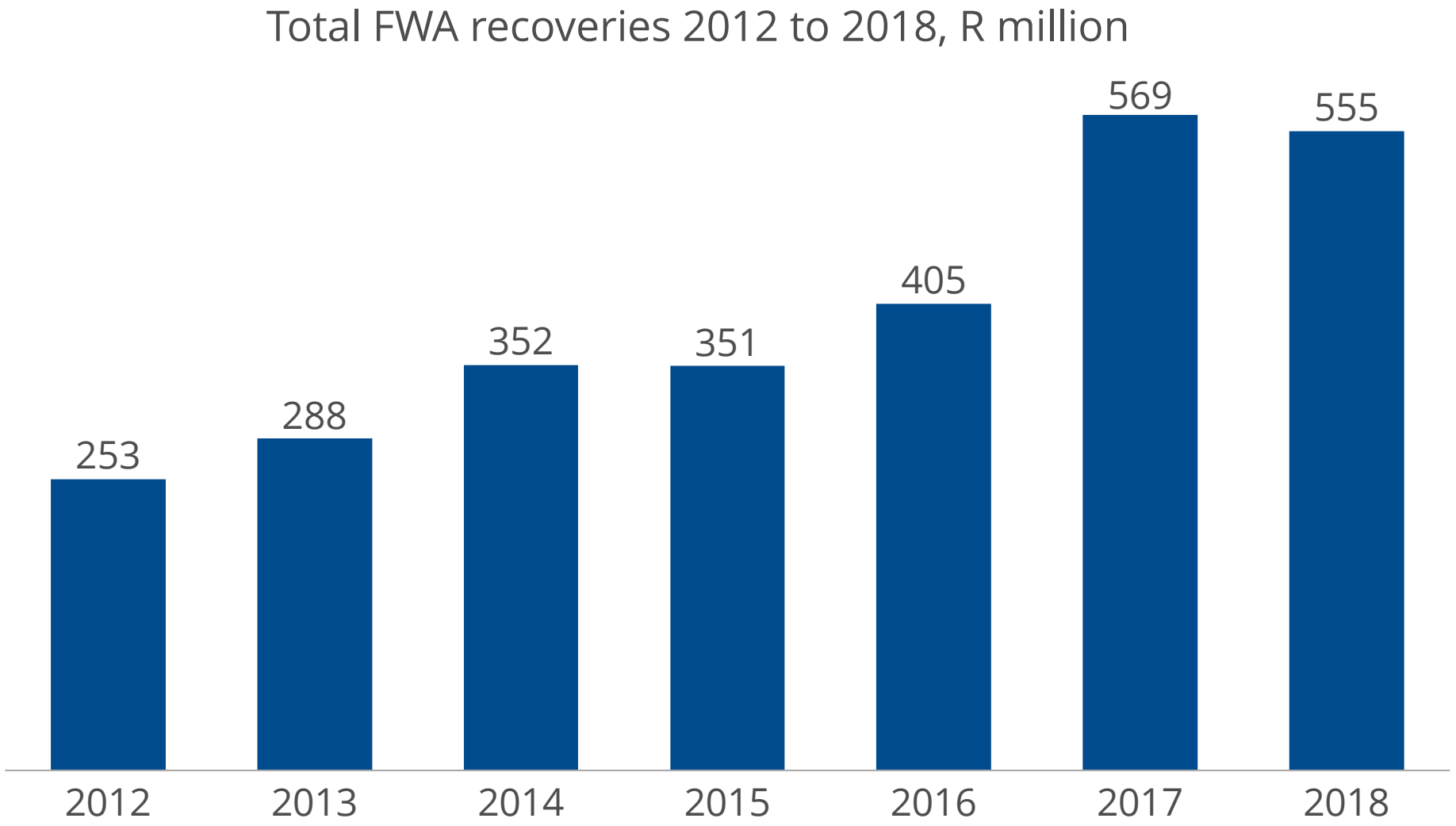


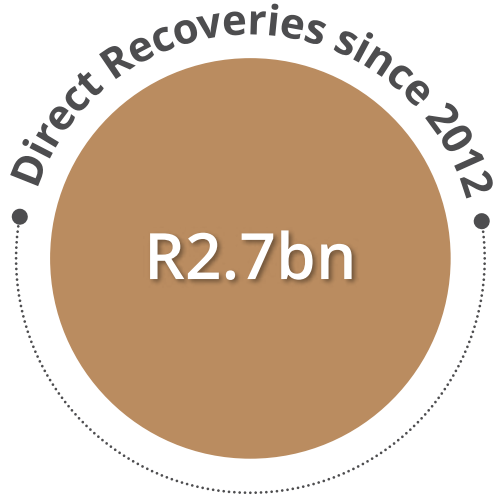
Investigations are conducted across all claiming disciplines.

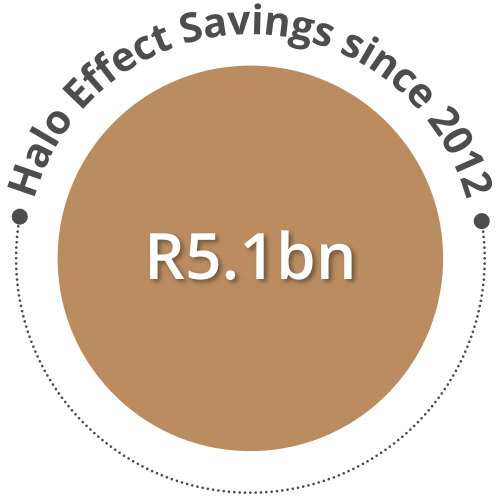
The majority of investigations are for services not rendered and abuse/manipulation of codes.

FWA recoveries achieved for client schemes: 2012 – 2018

R7.8bn direct recoveries & indirect ("halo effect") savings

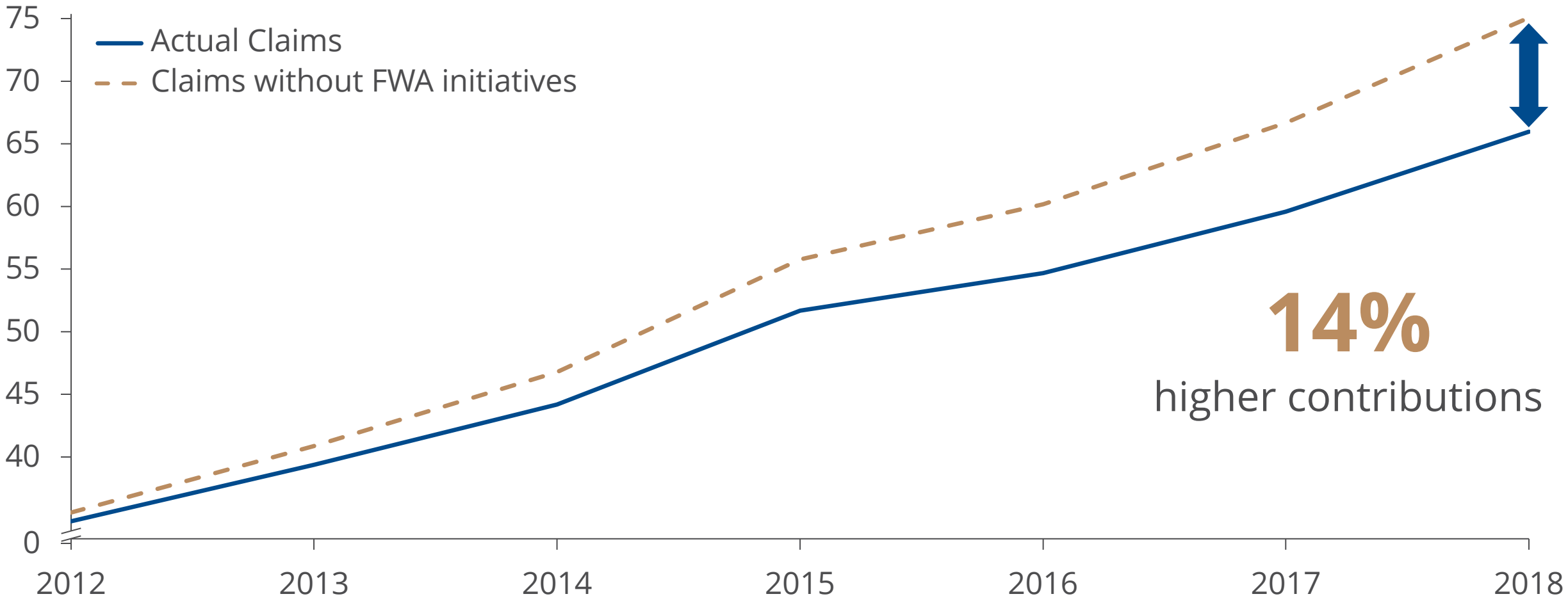






Impact of effective control of FWA on medical scheme contributions

DHMS contributions per year (2012 – 2018), R billion



Over 8 years, **DHMS contributions would have been 14% higher** without effective FWA control.

DH invests significantly in assisting practitioners with coding

- DH actively engages with all relevant health professional societies to ensure that coding standards are understood and used effectively.
- DH has a field force of ~40 employees who engage with doctors and their practice managers on a daily basis, including on coding related issues.
- A dedicated coding unit manages diagnostic and procedural codes, and deal with any escalations coming from the field force team.
- Multiple training sessions are held at GP and specialist conferences throughout the year.

Discovery Health always responds positively to requests for coding guidance or training.

Reporting of fraud to the HPCSA and SAPS

- Company policy (Discovery Health Reporting Standards) sets out obligations and standards with respect to the reporting of fraud.
- The main components of this policy include:
  - Statutory reporting obligations (including reporting thresholds and reporting process)
  - Reporting to the South African Police Services (SAPS)
  - Reporting to health professional or other regulatory bodies

Reporting statistics 2010 – 2018

SAPS

170
Cases reported to SAPS

5%
Of cases reported to the SAPS were concluded

80%
Of the concluded cases resulted in convictions

HPCSA

611
Cases reported to the HPCSA

11%
Of cases reported to HPCSA were concluded

90%
Of the concluded cases resulted in convictions, generally resulting in reprimands, fines, cautions and suspended sentences

Agenda

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6. **Responses to allegations of racial profiling/discrimination, unfair conduct and statements of fact made during the Inquiry**
7. Responses to formal complaints submitted to the Inquiry
8. Additional case studies demonstrating the nature and impact of FWA

Allegations of racial profiling and/or discrimination (1/2)

- DH has never used race or any other demographic factors in identifying or investigating potential FWA cases.

- Data analytics use depersonalised patient data and PCNS numbers only.
  - DH does not possess race or gender data on practitioners.
  - The individual identity/name or race of the health practitioner is never included in analysis.

- Harris Nupen Molebatsi Attorneys' review of DH forensic processes and systems sought to identify racial profiling or similar biases.

Allegations of racial profiling and/or discrimination (2/2)

- Key findings from the HNM attorneys' review included:
  - No evidence of racial profiling in the data analytics used by DH.
  - All healthcare practitioners are only identified by their PCNS numbers which are race and gender neutral.
  - The database to which the Risk Rating Tool ("RRT") is applied does not contain data that could result in a racially profiled outcome.
  - There is no evidence of racial profiling of healthcare practitioners investigated as a result of complaints received through tip-offs or whistleblowing.
  - There is no evidence to suggest the use of racial profiling in DH's statistical analysis to identify potential FWA.
  - Bias in the investigation processes is detectable and disincentivised.

Allegations of duress during the investigation process

- Certain practitioners have alleged that DH exerted unlawful duress during meetings, and forced them to sign an AOD.
- DH denies these allegations.
  - All practitioners are routinely informed of their entitlement to legal or professional representation at meetings and many are represented.
  - Practitioners are given full opportunity to respond to DH's allegations and information during the meetings.
  - DH investigators will always adjourn a meeting at any stage if the practitioner feels unable to respond to the concerns raised, and/or if the practitioner requests additional time.
  - The affidavits and supporting documentation in response to specific individual complaints confirm the DH approach to these meetings and investigations.

Data provided to the panel to substantiate allegations of racial profiling are based on unrepresentative and biased samples

DH conducts over 4,000 investigations per year

- HealthMan data: based on 320 investigations over approximately 8 years vs >11,000 for DH
- SAPPF data: based on 22 investigations from 2013 to 2019
- SASOP data: based on 120 cases. The period of investigation was unclear.
  - Between 2012 and 2019, DH investigated 297 Psychiatrist practices of which 60% were valid.
- SA Optometric Association data: based on 8 cases from 2019
  - From January to June 2019 DH conducted 155 investigations into Optometrist practices of which 66% were valid.
- Dental Professions Association data: based on 66 investigations in a retrospective survey that they performed on members (the period was not provided in the study)
  - In 2018 DH conducted 180 investigations into Dental practices of which 73% were valid.

Steps taken by DH to address allegations of race in forensic investigation processes (1/2)

- DH has taken the accusations of racial profiling very seriously.
- DH has initiated a series of measures to address these practitioners concerns:
  - Active participation in the CMS FWA Summit process.
  - Active engagement with the NHCPA, Solutionist Thinkers, IPAF, SAMA and UFFP directly to better understand their concerns and to agree processes to resolve outstanding issues.
  - Commissioning an independent audit by Harris Nupen Molebatsi (HNM) to assess the integrity of its forensic processes.
  - Conducting detailed analysis of DH investigation data using name-based classification methodology, reviewed by Deloitte.

Steps taken by DH to address allegations of race in forensic investigation processes (2/2)

- DH has initiated a series of measures to address these practitioners concerns *(continued)*:
  - Working with the Health Funders Association (HFA) on a FWA code of conduct.
- Following the inputs to the panel by various experts, DH recognises that it is important to assess whether there is any disproportionate racial differentiation in our forensic outcomes. Our analysis provides strong evidence that there is no unfair discrimination in our forensic processes.

DH surname analysis on FWA investigations (1/2)

Context

- DH has undertaken a detailed analysis of its FWA investigation data to address the allegations of racial profiling, and to assess if there is any evidence of explicit or implicit racial bias in forensic processes.
- The analysis has been subjected to independent review by Deloitte.

Methodology

- DH used a name-based method for data analysis since no race data is available (DH specifically holds no race data).
- The database consisted of all fraud cases for individual practices with practitioner names associated, that were closed between January 2015 and June 2019.
- A total of 7,493 practitioner investigations were analysed.

DH surname analysis on FWA investigations (2/2)

Methodology *(continued)*

- Practitioners were categorized as “Black” or “non-Black” using multiple analysts with validation checks, including an independent audit by Deloitte.
- We also constructed a comparable dataset on total billing practices paid by DH schemes for use as a denominator. This dataset has 47,133 unique practices.
- Any name based analysis methodology has significant limitations:
  - It is subjective with regard to assigning surnames to racial groups.
  - The “Coloured” population is particularly difficult to identify from a name basis.
  - Factors such as intermarriage, name-changes etc. may lead to errors.
  - The scientific literature on this subject suggests that this approach may be useful to show overall trends, but should not be relied on at level of granularity.

Results of Discovery Health name analysis (2015 – 2019)

Metric	Black practitioners (%)	Non-Black practitioners (%)	Observation
Total billing practices submitting to DH *(n = 47,113)*	37.6%	62.4%	-
Potential cases of FWA identified and investigated			
Total Investigations *(n = 7,493)*	55.7%	44.3%	Higher proportion of Black practitioners relative to ratio of claiming practices
Proportion investigations prompted through RRT identification	61.5%	38.5%	This is main source of differentiation, but: (i) No human involvement (ii) No evidence of racial bias in algorithm (iii) Largely explained by confounding factors
Proportion investigations prompted through tip-offs	49.5%	50.5%	Higher proportion of tip-offs on Black practitioners relative to claiming practices, but outside of DH control
Investigation process			
Valid investigations	74.6%	75.8%	No statistically significant difference
Recoveries made	68.6%	69.4%	No statistically significant difference

Key findings from DH's surname analysis (1/2)

Potential cases of FWA identified and investigated

- Differences in FWA outcomes by race arise from the process of identification of cases for investigation.
- More than half of these arise from tip-offs. Cases identified by tip-offs are beyond DH's control, and every case arising from a tip-off is investigated in a consistent manner.
- The balance of race differences in cases identified for investigation arise from application of DH's risk rating algorithm (RRT). Differences in these cases are the main contributor to the differences in the FWA outcomes.
  - Dr Kimmie acknowledged no explicit bias in the RRT application process.

Key findings from DH's surname analysis (2/2)

Potential cases of FWA identified and investigated *(continued)*

- The RRT uses 30 independent factors, which are not linked to demographics of practitioners.
- There is no evidence of implicit or explicit bias in these factors despite scrutiny by DH, Dr Kimmie and other external experts.

Investigation process

- No evidence of racial bias in the DH FWA investigation processes once initiated.
  - Consistent valid and recovery ratios between Black and non-Black practitioners confirm that DH's investigative and recovery practices are carried out consistently across all practitioners.

Impact of confounding factors in analysis of race bias in FWA outcomes (1/3)

- Dr Kimmie acknowledges that his results represent only a correlation between the race classifier and the FWA status and that the results provide no proof that race is a causal factor.
  - "It may be that the relationship is clarified by some intermediate confounding variable and that the causal relationship is between that variable and the outcome".

- **Example: Lung Cancer hypothetical case**
  - For example, the risk of lung cancer may be higher for males than for females (hypothetically a risk ratio of 1.5), but this may be due to the prevalence of smoking being higher in males than females.
  - Only looking at gender and not at smoking status means that the difference is attributed to the incorrect factor. It is important that multiple factors are considered to determine which are significant.

Impact of confounding factors in analysis of race bias in FWA outcomes (2/3)

- **Example: Lung Cancer hypothetical case** *(continued)*
  - This is illustrated with fictional values in the table below. Line 1 on its own looks like lung cancer is associated with gender but adding in the additional factor makes it clear that smoking is the confounding factor and gender has no influence on lung cancer risk (in this example).

Table: Lung cancer and smoker prevalence by gender (hypothetical example)

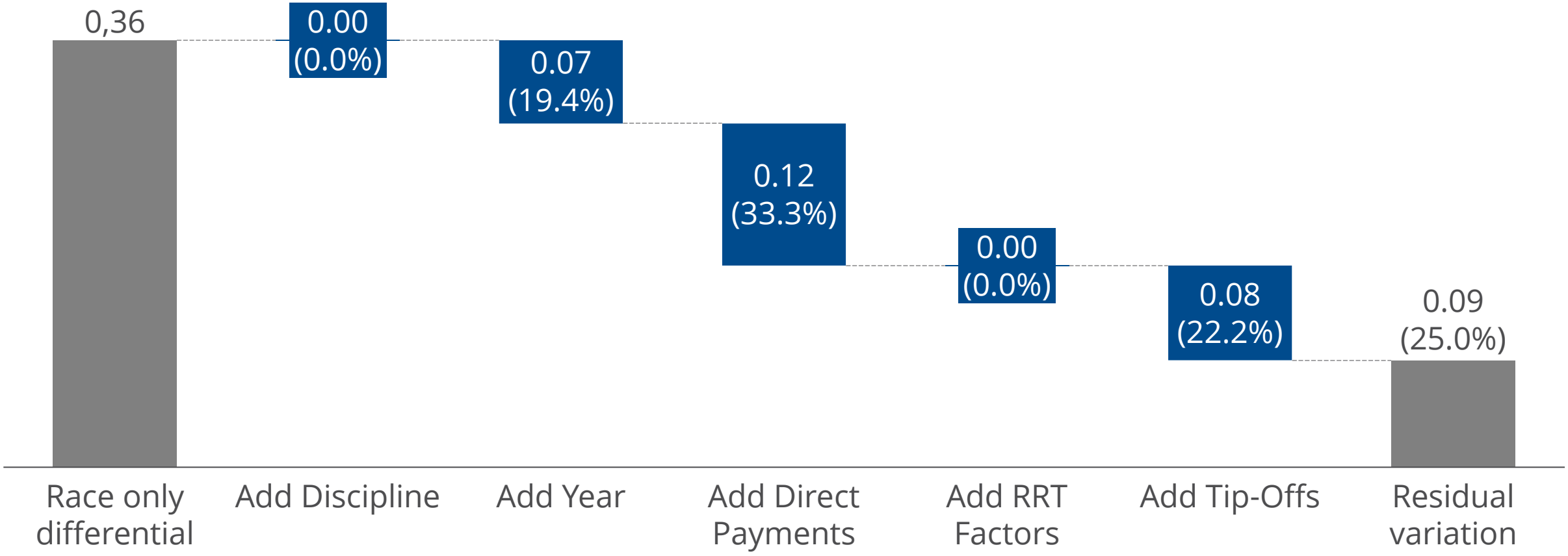
Proportions (hypothetical)	**Male**	**Female**
Lung cancer (per 1,000)	7.5	5.0
Smokers (per 100)	30	20
Percentage of smokers with lung cancer	2.5%	2.5%

Impact of confounding factors in analysis of race bias in FWA outcomes (3/3)

- Dr Kimmie did not investigate the impact of confounding factors due to lack of data.
- His results show significant variation by discipline which clearly confirms the existence of at least one confounding factor.
- DH has extended Dr Kimmie's analysis to include some potential confounding factors for which we do have data.
- This analysis confirms that the identified confounding factors reduce the differences in FWA outcomes by race by more than 75% - from a risk ratio of 1.36 to a risk ratio of 1.09.
- There could well be additional confounding and environmental factors that could explain the remaining difference.

75% of the observed race differential can be explained by a few confounding factors

Risk ratio for race, percentage point change



Race differential cannot confidently attributed to racial bias due to significant impact of confounding factors.

There is no evidence before the Panel of either implicit or explicit bias in any of DH's FWA processes

- Dr Kimmie's statement that "*The evidence of racial bias in the identification of FWA cases within Discovery Health is clear*" is not supported by the evidence.
- The evidence only suggests differences in FWA outcomes by race. Dr Kimmie has stated that it is not possible to conclude that the differences are due to racial bias, rather than due to other confounding factors that he was unable to investigate.
- We have demonstrated that 3 confounding factors can explain more than 75% of the race differences observed in FWA outcomes.
- There may well be additional confounding or environmental factors that explain the balance of the observed differences.
- While not excusing misconduct, FWA may possibly be more prevalent where practitioners treat patients facing financial hardship, as such conduct may be rationalised as benefiting the patient and not aimed at self enrichment. This would be an example of an environmental factor.
- Neither Dr Kimmie nor any other party has provided the Panel with firm evidence of either implicit or explicit racial bias in any of DH's FWA processes.

Responses to specific allegations of racial profiling or discrimination

Allegations	Response and statement(s) of fact
NHCPA: 80% - 90% of audits are conducted on black practitioners.	▪ DH does not use race criteria at any stage of FWA process. ▪ No statistically valid evidence has been submitted to support these allegations. ▪ DH analysis indicates that 55.7% of investigations are conducted on Black practitioners.
Solutionist Thinkers and HPCSA: Direct payment mainly affects black doctors.	▪ 87% of all GP visits and 91% of all specialist visits are on DH's direct payment arrangements. ▪ These arrangements are entirely voluntary.
Solutionist Thinkers: Medical schemes are "white owned".	▪ Medical schemes are owned by their members. ▪ 66% of medical scheme members are black according to General Household Survey (Stats SA, 2018).

Responses to allegations regarding demands made of health practitioners during FWA investigations

Allegations	Response and statement(s) of fact
▪ Solutionist Thinkers: Discovery demands confidential information from practitioners.	▪ Members provide consent to medical schemes to obtain the necessary data required to validate and pay claims. ▪ DH only requests information necessary to prove the service was provided. ▪ Practitioners may redact any confidential information.
▪ Solutionist Thinkers and the Independent Community Pharmacy Association: It is unreasonable for practitioners to keep records for 3 years.	▪ Professional bodies have more stringent requirements: HPCSA and Good Pharmacy Practice Guidelines require practitioners to keep records for at least 6 and 5 years respectively.
▪ Solutionist Thinkers: Doctors should have clinical discretion as to which codes to use.	▪ Health practitioners have discretion on which services to provide, but must bill with accurate coding for the services provided. ▪ Billing guidelines are regularly updated. ▪ Health practitioners use a limited number of codes and are expected to be aware of these and to use them accurately.

Responses to allegations regarding demands made of health practitioners during FWA investigations

Allegations

- NHCPA, Solutionist Thinkers: Discovery's suspension of direct payment to practitioners is unfair.

Response and statement(s) of fact

- Schemes have no obligation to pay health professionals directly.
  - The contractual relationship is between scheme and member.
  - Direct payment is a voluntary arrangement at discretion of the scheme.

- Suspension of direct payment plays several key functions:
  - It allows members to continue to see the health practitioner while FWA is being investigated.
  - It provides the member with oversight of the practitioner's billing behaviour.
  - It creates leverage to encourage the health practitioner to work with DH to resolve outstanding issues.

Responses to specific allegations regarding DH's FWA processes

Allegations	Response and statement(s) of fact
▪ Solutionist Thinkers and HPCSA: Discovery's fraud investigations are illegal.	▪ All processes comply fully with the applicable legislation. ▪ External legal review and opinion has confirmed the legality of DH's FWA processes.
▪ CMS: Estimations of amounts owed by practitioners are a "thumb-suck".	▪ DH uses a standardised and systematic approach to estimating the quantum of funds owed to client schemes. ▪ Practitioners are always able to challenge DH estimates and suggest alternatives.
▪ NHCPA: FWA recoveries are not passed back to the medical scheme.	▪ All FWA recoveries are paid directly into the bank account of the affected scheme. ▪ DH does not retain any recovered funds. ▪ All scheme accounts audited and reviewed by CMS.

Responses to specific allegations regarding DH's FWA processes

Allegations	Response and statement(s) of fact
▪ SAPPF and the Dental Professions Association: Administrators suspend payment from practices before proving FWA has taken place.	▪ Standardised policies are followed where set criteria determines whether payment to a practitioner will be suspended. ▪ Suspension of payment only occurs on a limited basis. ▪ Suspension prior to concluding an investigation only occurs in a small number of very high risk matters.
▪ South African Optometric Association: Most FWA arises from administrative errors and coding complications.	▪ 2016-2018: 50% of FWA offences by health practitioners were due to claims for services not rendered . ▪ The next largest category is incorrect invoicing (21%) followed by coding abuse (14%).

Responses to specific allegations regarding DH's FWA processes (1/2)

Allegations	Response and statement(s) of fact
▪ Adv Hasina Cassim: Forensic investigations and risk management processes are separate.	▪ This statement is incorrect and misleading. – Forensic investigations are an integral component of DH's overall risk management activities for client schemes – Statistical analysis and other elements of broader claims risk management are used throughout the forensic process. – There is intensive and regular engagement between the forensic investigators and the various teams involved in broader claims risk management.
▪ Adv Hasina Cassim: Schemes do not have the authority to investigate practitioners and scheme rules only apply to member investigations.	▪ This statement is incorrect. ▪ The MSA explicitly supports the recovery of member funds that have been obtained through FWA. ▪ This includes investigation and recover from any party to whom fraudulent claims have been paid.

Responses to specific allegations regarding DH's FWA processes (2/2)

Allegations	Response and statement(s) of fact
▪ Adv Hasina Cassim: Practitioners are justified in inflating claims because they are not adequately compensated, especially for tasks such as PMB applications.	▪ It is of grave concern that this statement, which effectively legitimises criminal conduct, could be made by an admitted officer of the Court. ▪ There can be no justification for fraud or abuse of member funds. ▪ The completion of forms for PMB purposes are reimbursed in full at cost by DH-administered Schemes by DH even though no such obligation exists in law.

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Overview of responses to complaints to date (1/2)

- To date, DH has submitted 34 affidavits to the Panel regarding complaints made during the Inquiry.

- Here we discuss only those complaints where a complainant has given oral testimony to the Panel. We have submitted formal responses to all of the complaints.

- Key observations common to all complaints:
  - None of the cases contain any credible evidence of racial discrimination.
  - In all cases, there has been a rational basis for investigation – i.e. a tip-off or an outlier in the RRT.
  - In all instances, DH has followed a fair process to ensure that procedural rights are protected at all times.

Overview of responses to complaints to date (2/2)

- Key observations common to all complaints *(continued)*:
  - Where DH has done negative cost adjustments, these could have been avoided had the practitioner given the required information in the requested time period.
  - The recovery calculations have been reasonable with reference to the details of each case. Practitioners have been allowed to repay the amount over a long period of time to ease the financial strain on the practitioner.
  - The remedial action has been appropriate, moving through proportional and graduated action.
  - Some of the complainants have committed egregious fraud, which calls in to question the credibility of their complaints.

Complaint 1: Mr A – Optometrist

Complaint

- Mr A, an optometrist, appeared before the Panel on 29 July 2019 as part of Solutionist Thinkers.
- During these submissions, a wide range of allegations were made against DH including racial profiling, illegality of DH's forensic processes, and racially discriminatory practices in forensic investigations.

Facts

- Mr A was investigated by DH on three separate occasions: 2005, 2015 and 2016.

Investigation 1: 2005

- In June 2005, DH received an anonymous tip-off that Mr A was supplying sunglasses and billing the scheme for prescription spectacles, as the cost of sunglasses is not reimbursable by the medical scheme.
- DH investigated the validity of this tip-off with two undercover investigations. The investigators were provided with sunglasses as requested, and Mr A submitted claims for prescription spectacles to DHMS for these sunglasses (a total amount of R5,069).
- DH then invited Mr A to a meeting to discuss these allegations. At the meeting, Mr A admitted that his practice performs these irregular activities, and voluntarily undertook to repay the amount of R5,069.
- Mr A honoured this repayment agreement.

Complaint 1: Mr A – Optometrist

Investigation 2: 2015

- In 2015, DH received a complaint from a member that Mr A's practice had submitted claims to DH even though no services were rendered to the member.
- While this investigation was underway, DH received an anonymous tip-off that Mr A was colluding with members of the BMW Employees Medical Scheme (BEMAS) to provide members with cash loans, grants and/or sunglasses in return for the practice submitting a claim for prescription spectacles for the same value.
- DH used undercover investigators to investigate these allegations.
- Mr A agreed to provide the investigator with cash and to recover this by submitting a claim to the medical scheme. The investigator was also supplied with a pair of sunglasses.
- Mr A then submitted a claim to BEMAS for R5,150 for prescription spectacles which was paid by the scheme. Mr A provided the investigator with cash of R1,000. No prescription spectacles were provided to the investigator.
- During a second investigation, Mr A submitted a claim to BEMAS for R5,150 for prescription spectacles. After the scheme paid the claim, Mr A provided the investigator with R2,300 in cash. No prescription spectacles were provided.

Complaint 1: Mr A – Optometrist

Investigation 2: 2015 *(continued)*

- DH invited the practitioner to discuss these allegations and evidence. At the meeting, Mr A admitted that his practice performs these irregular activities, and offered to pay back 30% of all claims submitted to BEMAS. An AOD of R1 million was signed (27% of total BEMAS claims), with a repayment term of 100 months.
- As shown in the AOD, R997,000 was to be paid directly by the practitioner to the bank account of BEMAS. An additional R3,000 was paid to DH to recover expenses associated with the probes.

Complaint 1: Mr A – Optometrist

Investigation 3: 2016

- In 2016, DH's claims analysis showed that Mr A was an outlier in respect of claims submitted for BEMAS members.
  - 96% of total claims submitted by the practice were for BEMAS, and the average cost per encounter was double that of other optometrists.
- DH requested that the practitioner submit evidence to DH to verify the BEMAS claims.
  - This evidence requested included copies of laboratory orders, invoices for all lenses claimed, and invoices for all frames claimed.
- Mr A failed to provide such evidence within a reasonable time period.
- DH then performed a recovery of R662,000 for the unverified claims submitted by the practice.
- In 2017, Mr A defaulted on his AOD of R1 million (from 2015). BEMAS instituted legal action against Mr A, but BEMAS was not able to execute judgement due to the Sheriff of the Court being unable to identify any executable assets.
- After consultation between DH and all schemes under its administration, the decision was made to cease all payments to Mr A's practice.

Complaint 2: Ms B – Social Worker

Complaint

- Ms B appeared before the Panel on 29 July 2019 as part of the Solutionist Thinkers.
- During these submissions, a wide range of allegations were made against DH including racial profiling, illegality of DH's forensic processes, and racially discriminatory practices in forensic investigations.

2015 Investigation

- Ms B was investigated by DH on three separate occasions: 2015, 2017, 2019.
- In 2015 DH's RRT system highlighted that Ms B was an outlier when compared to her peers:
  - Her cost per encounter was 97% higher than that of her peers.
  - 97.5% of her claims were longer than 80 minutes (where only 22.8% of claims of her peers were above 80 minutes).
- Claims from a social worker are time based, and billed in increments of 10 minutes after the first 20 minutes. Each higher increment results in a claim at a higher tariff.
- DH also received complaints from members that Ms B was claiming for services not rendered and for consultations of longer durations than what had actually transpired.

Complaint 2: Ms B – Social Worker

- At the meeting, Ms B explained that she had employed three locums who may have erred in the manner in which they applied billing codes.
- In addition, her practice did not have an accurate billing system in place and her clinical notes were not up-to-date to allow for the verification of claims.
- Appointing a locum on a commission basis and improper recording keeping is at best bad practice and may be in contravention of the practitioner's professional obligations.
- In order to avoid a full investigation and audit by DH, Ms B offered to resolve the matter by refunding payments received by the practice for invalid claims.
- An AOD of R58,000 (payable over 17 months) was then signed by Ms B. As shown in the AOD, this amount was to be paid directly between the bank accounts of DHMS and LA Health Medical Scheme.
- In addition, Ms B undertook in writing to improve coding and billing processes at her practice.

2017 investigation

- In 2017, DH claims analysis showed that Ms B's practice submitted claims for services which cumulatively amounted to her consulting for over 8 hours a day for members belonging to DH administered schemes.
- In addition, 83% of Ms B's claims were in respect of consultations exceeding 71minutes (compared to an industry average of 32%).

Complaint 2: Ms B – Social Worker

- DH requested to meet with Ms B in order to allow her an opportunity to verify her claims.
- Before the meeting, DH contacted several of Ms B's patients in order to better understand the practitioner's billing practices. Members confirmed that Ms B had inflated the length of the consultation when billing for services provided.
- At the meeting, Ms B confirmed that she no longer employed locums and she was the only practitioner at her practice.
- Ms B also acknowledged that her practice did not still record times of patient consultations and therefore could not validate claims submitted.
- DH found these practices indefensible given the outcomes of the previous investigation of 2015.
- Ms B insisted that she had consulted with 95% of her patients for longer than 2 hours.
- She offered to reduce her claimed consultation times, but DH found this offer unacceptable as a claim must reflect the exact time spent with patients.
- DH then suspended all direct payments to the practice, reimbursing members directly for any services provided by Ms B in the hope that members would scrutinise the time billed and to ensure resolution of the outstanding matters.

Complaint 2: Ms B – Social Worker

2019 investigation

- In March 2019, DH's claim analysis again identified Ms B as an outlier.
  - 88% of claims were for 71 minutes ore more (whereas the industry average was 32%).
  - Her practice claimed for more than 13 hours per day of face-to-face consultations with members of the schemes administered by DH only.
- DH then requested that Ms B provided information to verify these claims.
- DH warned that failure to provide this information would lead to a claims reversal of R18,600 for unverified claims.
- Ms B failed to respond to this information request.
- As a result DH blocked all payments to Ms B's practice in order to mitigate any further losses to the medical schemes and their members.
- Two months later Ms B requested that her direct funding to her practice be reinstated.
- Ms B agreed to co-operate with DH to validate her claims.
- As a result, DH agreed to lift the block on her practice and reinstate direct payment to her practice while the validation was ongoing.

Complaint 3: Dr C – Orthopaedic Surgeon

Complaint

- Dr C appeared before the Panel on 27 September 2019.
- He complained that an amount in excess of R1 million had been reclaimed from his practice unfairly and that the AOD was signed under duress.

Facts for 2018 investigation

- In 2018, DH claims analysis showed that Dr C was an outlier in terms of his peers:
  - His cost per encounter was 191% that of the industry average.
  - The percentage of income generated from Tendon Synovectomy procedures was 258% higher than that of his peers.
  - The percentage of income generated from fractures involving large joints was 300% higher than that of his peers.
  - The percentage of income generated by applying modifier 0018 (for patients with a BMI of 35 or more) was 230% higher than that of his peers. *(By using this modifier a surgeon receives an additional 50% for operating on an obese patient.)*
  - The percentage of income from charging for the use of an assistant during procedures was 140% higher than that of his peers.

Complaint 3: Dr C – Orthopaedic Surgeon

- A member submitted a complaint that Dr C had submitted a fraudulent claim on his behalf for a service that had not been rendered.
- DH sent a letter to Dr C requesting information (such as clinical notes, surgical reports, referral letters) to verify his claims.
  - Theatre records were also requested from the relevant hospital for a sample of 15 of his patients.
  - DH also invited Dr C to a meeting at DH's offices.
- Dr C refused to share his patient files with DH at the meeting. As a result, DH could not verify any of his claims.
- Dr C displayed contempt for DH professional staff during the meeting, arguing that it was unacceptable that a GP and nurse had audited his claims, notwithstanding that they were qualified coding specialists.
- Dr C's claimed that:
  - The demographics of his patients were different to those of his peers.
  - His theatre records were incorrect due to errors of hospital nurses in their recordings.
  - All BMI figures were obtained from the anesthetist's records.

Complaint 3: Dr C – Orthopaedic Surgeon

- DH contacted the hospital which confirmed that all theatre records were correct and that no assistant had been present in the surgical theatre while Dr C operated.
- DH also contacted the anaesthetist who confirmed that the claim that he had supplied BMI data to Dr C was incorrect.
- Hospital evidence further showed that Dr C had provided inaccurate information:
  - A sample of theatre records showed no records of synovectomies had only been performed in 75% of cases where Dr C had billed for the procedure.
  - Only 2 (out of a sample of 15 patients) were identified as being HIV positive, despite Dr C claiming a majority of his patients were HIV-positive.
- DH calculated that an estimated R1.3 million had been paid to Dr C for fraudulent behavior.
- DH intended to recover this amount from the practitioner.
- DH informed Dr C and his legal representative of these findings, but did not receive any response from either party.
- DH was unable to recover any funds as Dr C submitted no further claims on this practice number.

Complaint 3: Dr C – Orthopaedic Surgeon

2019

- In January 2019, DH received a tip-off that Dr C was billing under a new practice number and possibly billing for procedures that had not been performed.
- Claims analysis revealed:
  - His percentage of income generated from Tendon Synovectomies was 170% higher than that of his peers.
  - His percentage of income generated from fractures involving large joints was 560% higher than that of his peers.
  - His percentage of income from charging for the use of an assistant during procedures was 300% higher than that of his peers.
- Following these incidents, DH sent a letter to Dr C requesting information (such as clinical notes, surgical reports, referral letters and theatre records for a sample of patients) to verify his claims.
- DH then elected to suspend payment to the practice in light of the previous investigation and the failure to recover any funds arising from the invalid claims submitted prior to 2019.
- Following the suspension of payments, Dr C submitted the requested information to DH via email. DH also obtained the theatre records from the relevant hospital for a sample of patients.

Complaint 3: Dr C – Orthopaedic Surgeon

2019 *(continued)*

- DH identified billing errors from the information supplied by Dr C and the theatre records.
- Dr C admitted to these billing errors and agreed to refund the affected schemes an amount of R40,000. As shown in the AOD, this amount was to be paid directly into the bank accounts of DHMS and Bankmed.
- DH informed Dr C telephonically of the outstanding amount on his other practice number from the previous investigation of 2018.
- Dr C informed DH that his lawyer had approached the CMS on this matter and was awaiting feedback in relation to possible arbitration proceedings.
- DH then informed Dr C that due to the outstanding amount, DH would suspend direct payment to the practice, and pay members instead for any services rendered by Dr C.
- Dr C voluntarily contacted DH (on the same day) and offered to sign the AOD which he did.
- Dr C's complaint to the Inquiry is misleading in several respects:
  - He neglected to mention the DH's first investigation into his practice.
  - He did not mention that he had obtained a new practice number in order to continue submitting irregular claims.
  - He falsely claimed that he signed the AOD under extreme duress. In fact, he voluntarily signed the AOD.

Complaint 4: Mr D – Psychologist

Complaint

- Mr D appeared before the Panel on 26 September 2019.
- He complained that DH wrongfully demanded confidential patient notes which could not be provided due to patient confidentiality.
- The practitioner's refusal to share patient notes was insufficient reason for DH to suspend payments to the practice.

Facts

- In 2018, DH claims analysis showed that Mr D was an outlier in terms of his peers in relation to time based codes submitted:
  - All claims were for periods longer than 51 minutes.
  - His share of income generated from consultations longer than 61 minutes was 48% compared to a peer-based average of 22%.
  - The average income per treatment session was 136% higher than that of his peers, due to billing for longer consultations.
- Claims from psychologists are time based, and billed in increments on 10 minutes. Each higher increment results in a claim at a higher tariff.

Complaint 4: Mr D – Psychologist

- DH sent a letter to Mr D requesting information (such as clinical notes, copies of appointment diaries and verification of time spent with patients) to verify his claims.
- DH attached a list of patients to whom the requested information pertained.
- There was an email exchange between DH and Mr D where:
  - Mr D emailed DH informing DH that he would not release copies of his clinical notes without consent from his patients.
  - He stated that DH should visit his offices to inspect appointment diaries.
  - DH then responded by informing Mr D that the onus was on the practitioner to validate claims.
  - DH also advised Mr D that he could email the information requested and explained why his concerns of patient confidentiality were legally immaterial in this matter.
  - Mr D replied to this email, reiterating that DH was not entitled to the clinical information requested.
  - Mr D also enquired as to what was the nature of coding irregularities observed by DH.
  - DH responded to this email repeating that information could either be scanned or faxed to its offices. DH indicated that without the information requested, DH could not validate whether there were inaccuracies or other problems in the claims submitted by Mr D . DH confirmed that it was simply conducting a verification exercise and not actively trying to identify errors in Mr D ’s application of the billing codes.

Complaint 4: Mr D – Psychologist

Subsequent developments *(continued)*

- Mr D then contacted DH reiterating his concerns of patient confidentiality. He stated that it is DH's responsibility to contact the patients to verify claims submitted.

- After 6 months of such correspondence between Mr D and DH, DH sent a letter to Mr D stating that if the verification documentation requested was not provided, all unverified claims would be reversed by DH. Mr D was offered another 14 days to comply with this request.
- After no information had been provided, DH performed a recovery for R71,000 for unverified claims.
- Direct payment to the practice was suspended.
- Mr D claimed that DH had abused its power, reiterating his concerns of patient confidentiality and was using an "upper hand" and that he could not submit the information required without patient consent.
- DH responded reminding Mr D of their obligation to verify claims on behalf of their members.
- As no verification information was received from Mr D, the recovery of R71,000 was offset on Mr D 's account.

Complaint 5: Dr E – General Practitioner

Complaint

- No official complaint was lodged by Dr E, but he has testified to the Panel on 31 July 2019 as part of the NHCPA and made various allegations.

Facts

- In 2007, DH received a tip-off that Dr E was submitting more expensive medication than what was dispensed.
- DH used an undercover investigation, and confirmed the suspected fraudulent activity.
  - For example, Dr E submitted a claim for medication dispensed in the amount of R 236.40, while the actual value of the dispensed meds amounted to R 31.49.
  - Two of the drugs fraudulently claimed for on the undercover investigators, made up 64% of all his claims for medication.
- A meeting was held on 27 September 2007 with Dr E and he admitted to the abovementioned irregularities.
- The quantum for the irregular claims was estimated at R 70 000.
- DH and Dr E negotiated a settlement amount of R50,000 and Dr E signed an AOD for this amount payable over 16 months.

Complaint 5: Dr E – General Practitioner

- In 2016, DH's claims analysis identified Dr E as an outlier due to the medicines for which he claimed.
- An undercover investigator confirmed that Dr E was once again submitting claims for more expensive medication than what was dispensed. In addition, the investigator uncovered that Dr E submitted a claim for a non-member on a valid membership.
- A meeting was held with Dr E and his legal representative where he denied any wrongdoing, notwithstanding the fact that the medicines and claims were shown to him.
- He undertook to do his own investigation and to provide feedback. The feedback received from his attorney simply stated that they could not find any irregular claims and they refused to provide purchase invoices for the medicines for which Dr E submitted claims.
- A recovery of R 98,704 was made for the unverified medicine claims, which was offset against payments due to Dr E.

Complaint 6: Dr F – General Practitioner

Complaint

- A complaint was lodged by a 3rd party on behalf of Dr F on 21 August 2019.
- The practitioner never received a request for verification of claims submitted.
- The request by DH was not precipitated by any suspicion of misconduct.
- The practitioner was forced to sign an AOD of R1.4 million and settle this amount with DH.
- DH threatened that if the requested claims were not validated, DH would claim a refund of R266,000 from Dr F's practice.
- DH also threatened to suspend payment.
- Investigations of medical practitioners are based on ethnicity.

Facts

- DH's claims analysis identified Dr F's practice as high risk for possible FWA in 2018.
- Dr F's practice was identified as an outlier in respect of claims submitted for certain medicines when compared with other peer dispensing practices.

Complaint 6: Dr F – General Practitioner

- DH conducted a purchase invoice audit of Dr F's practice by requesting the purchase invoices of a specific list of medication.
- On 17 October 2018, DH sent a letter to Dr F requesting data to verify claims for which the practice already received payment.
- On 19 October 2018, Dr F called DH and explained that he could not provide the requested information within the 30 day time frame given by DH.
- Dr F also indicated that he would perform the audit himself.
  - For an audit to be accepted as valid, DH has to perform the audit.
  - DH responded in a letter dated 31 October 2018 to communicate this fact to Dr F.
- On 3 December 2018 DH received a letter and an invoice created by Dr F, ostensibly for medication purchased by his practice. Dr F also provided DH with an invoice for his time spent in preparation of the invoice.
- On 4 December 2018, DH responded by repeating DH's right to verify claims and rejecting Dr F's invoice as it was not from the supplier from which the practice usually procured its medication.

Complaint 6: Dr F – General Practitioner

- DH gave Dr F a further 7 days to provide the requested information failing which a recovery would be performed for the amount of R266,000 in respect of claims which could not be verified.
- Dr F was also informed that payment to the practice would be suspended pending finalisation of the matter.
- No claims verification data was provided by Dr F and payment to the practice was suspended.
- On 31 January 2019, DH sent a letter to Dr F informing him that a recovery would be actioned failing receipt of claims data within 7 days.
- No response was received to the above letter.
- On 25 February 2019, the recovery was actioned against Dr F's practice.

Complaint 7: Ms G – Psychologist

Complaint

- Ms G, a psychologist, appeared before the Panel on 29 July 2019 as part of Solutionist Thinkers.
- When Ms G engaged with DH, she was interrogated and intimidated by four males.
- She was found guilty of using incorrect codes, and had R100,000 wrongfully clawed back from her.
- She could not provide information requested to verify her claims, as information requested related to claims from three years back.
- The information she provided was not assessed by a psychologist and therefore not appropriately assessed.
- DH colluded with her attorney.

Facts

- This practice was investigated in both 2017 and 2018.
- In 2017, DH's claims analysis identified Ms G as an outlier among her peer psychologists:
  - Ms G's cost per encounter was 26% higher than that of her peers.
  - Consultations longer than 61 minutes made up 95% of Ms G's claims (opposed to 18% industry average).

Complaint 7: Ms G – Psychologist

- DH requested claims verification data for 31 of Ms G's patients (including clinical notes, copies of medical aid cards, diary of appointments or any other verification material).
- Ms G's legal representative then forwarded the requested documents, however these documents proved that the consultations were in fact less than 60 minutes per session.
- A meeting was then scheduled between Ms G and DH, where DH presented its findings to Ms G.
- Ms G conceded that the billing codes for treatment of 61-70 minute sessions may have been applied incorrectly to sessions of 60 minutes or less.
- After consultation with her legal representative, and without any intimidation, Ms G voluntarily decided to downgrade 80% of her codes for 61- 70 minutes to 60 minutes, resulting in an amount of R55,000 owed to DH medical schemes. As shown in the AOD, this amount was to be paid directly into the bank accounts of the following schemes: BEMAS, DHMS, LA Health, Lonmin, Remedi, Retail and Bankmed.
- DH offered to allow Ms G to sign an AOD for this amount to be paid over a period of 18 months. There was no intimidation during this process.
- At the meeting, Ms G also undertook to ensure that her future claims were accorded with the correct billing codes.
- During 2018, while reviewing whether Ms G had adhered to her agreement, DH found the following:
  - Billing codes for treatment for 61-70 minute sessions remained the highest code.
  - There was an increase in average number of treatment sessions of 11.9 to 15.3 per patient.
  - There was an increase in cost per encounter from R10,500 to R13,468.

Complaint 7: Ms G – Psychologist

- DH invited Ms G to a meeting and requested her to provide information to verify her patients claims.
- Via her legal representative, Ms G advised that she would not be able to provide patient information as this information was confidential. Instead, she requested that DH obtain signed consent from the applicable patients. We note that Ms G did not raise this consent issue in the prior investigation.
- In response, DH explained that it is not required in law to obtain additional consent or authorisation from members to attain information to verify claims from practitioners.
- Ms G responded stating that she did not agree with DH, and as such would not provide the information requested to verify claims.
- DH responded stating that without the information requested, it would have no option but to reverse the claims for four patients whose claims could not be verified.
- In light of these developments, DH applied a claims reversal on Ms G's account.
- Following a meeting and after lengthy consultation between her legal team and DH, Ms G agreed to sign an AOD of R120,000. As shown in the AOD, this amount was to be paid in the bank accounts of the following medical schemes: BEMAS, DHMS, LA Health, Remedi and Bankmed.
- There is no evidence to support Ms G's allegations that DH colluded with Ms G's attorney, nor that she was intimidated by DH staff during the investigation processes.

Agenda

1. Background context on medical schemes and administrators
2. Background to FWA and its impact on medical schemes
3. The roles and duties of medical schemes and administrators in relation to FWA
4. Background on Discovery Health
5. Discovery Health's FWA investigation, recovery and reporting processes
6. Responses to allegations of racial profiling/discrimination, unfair conduct and statements of fact made during the Inquiry
7. Responses to formal complaints submitted to the Inquiry
8. **Additional case studies demonstrating the nature and impact of FWA**

Case study 1: Cardiology fraud

R9 million

Identification & offence	▪ A tip-off was received regarding a cardiologist's practice conduct.
Investigation	▪ DH data showed that the cardiologist's costs per case were 43% higher than his peers, with double the number of claims for angiograms with stents compared to the national average. ▪ The subsequent investigation revealed numerous fraudulent practices: – Claiming that patients were in ICU when they were in High Care. – Submitting claims with false condition codes to ensure increased payments and to extend the length of patients' hospital stay artificially. – Manipulating dates of outpatient consultations, submitting them only once patients were admitted to hospital to increase the amounts billed per consultation.
Recoveries & reporting	▪ The cardiologist acknowledged these fraudulent activities and agreed to refund DH's client schemes an amount of R9 million.

Case study 2: Radiology fraud: Claims for misappropriated consumables and equipment

R6 million

Identification & offence	▪ A tip-off was received regarding fraudulent submission of claims by this practitioner. ▪ In addition, the statistical analysis of a radiologist's claims showed various high risk indicators.
Investigation	▪ Investigations revealed that the radiologist in question worked at various public and private hospitals. ▪ The radiologist could not produce invoices to validate certain costly consumables that had been charged for; the consumables were allegedly stolen from public hospitals and used and claimed for from medical schemes. ▪ Billing code fraud including unbundling and billing for assistants in theatre, without proof that these assistants were actually present. ▪ The radiologist also billed for certain equipment that actually belonged to the hospitals and was already included in their fees.
Recoveries & reporting	▪ Following the investigation, the radiologist admitted to the frauds and agreed to repay an amount of R6 million to the affected schemes. ▪ The matter was referred to the Health Professions Council and reported to the SAPS ▪ The HPCSA declined to prosecute and did not give reasons for this decision.

Case study 3: Pharmacy fraud

R4 million

Identification & offence	▪ A member provided a tip-off that a pharmacist had submitted claims for high-cost medicines that were never dispensed.
Investigation	▪ Investigations revealed that this pharmacy had submitted false claims with a value of more than R4 million. ▪ All claims were linked to a single member over a period of four years.
Recoveries & reporting	▪ Following the DH investigation, the pharmacist acknowledged the fraud and agreed to repay the amounts claimed fraudulently to DH's client medical schemes.

Concluding remarks (1/4)

- FWA is a serious and increasing challenge for medical schemes.
- Schemes and administrators have a clear legal and strategic imperative to tackle these practices actively.
- Failure to control FWA poses material risks to the future of schemes - higher incidence of FWA will lead to higher medical inflation, as well as to undermining integrity of the healthcare system.
- DH invests substantial resources in tackling FWA on behalf its client schemes, and its efforts have proved effective over many years.
- DH FWA activities are strictly governed by comprehensive policies, and are subject to periodic external review.
- DH and its client schemes have never resorted to racial profiling nor to any other form of racial discrimination in any of the processes of identifying and investigating FWA and of recovering scheme funds.
- No evidence has been presented to the panel to confirm the existence of implicit or explicit bias in any of DH's forensic processes.

Concluding remarks (2/4)

- External legal review, counsel opinion and Court judgments have confirmed that the processes DH uses in identification, investigation and recovery of funds related to FWA are fair and fully compliant with the spirit and letter of all applicable legislation.
- The observed differences in FWA outcomes arises from the process of identifying cases for further investigation, and not from the investigation processes undertaken once a case is flagged for investigation. This is demonstrated by the fact that the valid ratios and recovery ratios show no differentials by race of the practitioner.
- The majority of cases identified for investigation arise from tip offs, which are outside of DH's control.
- The balance of cases investigated arise from identification of potential FWA cases using the DH RRT analytics process. This accounts for the majority of the race differential identified. The RRT uses 30 independent metrics, none of which are related to the demographics of the practitioner.
- Despite scrutiny by Dr Kimmie and by two sets of external experts, there has been no evidence of any implicit or explicit racial bias in the RRT factors or its application to FWA investigations.
- There is therefore no evidence of race bias in the identification of cases using the RRT process.

Concluding remarks (3/4)

- As conceded by Dr Kimmie, the observed race differentiation does not per se demonstrate racial bias in DH's FWA activities, since there may be confounding factors which explain the findings.
- We have demonstrated that a limited set of confounding factors explain over 75% of the observed differentials in FWA outcomes by race.
- The remaining differential is approximately 9%, and may well be attributable either to additional confounding factors (measurable or unmeasurable) and/or to certain environmental factors.
- Dr Kimmie confirmed that he found no evidence of explicit bias in DH's FWA processes.
- DH has submitted 34 affidavits in response to allegations made to the Panel by practitioners. In 100% of these cases, we have demonstrated clear evidence of FWA (and in many cases, repeat offences). This undermines the validity of the allegations made by these complainants that they have been the victims of racial bias.
- For all of these reasons, we firmly maintain that there is neither implicit nor explicit racial bias at any stage in DH's FWA investigation processes, and that no convincing evidence of such bias has been presented to the Panel.

Concluding remarks (4/4)

- It is critical that the Panel's recommendations do not use unproven allegations of racial basis to undermine the ability of medical schemes and their administrators to protect the funds of medical schemes and their members by effectively preventing FWA and by investigating and recovering funds lost due to FWA.
- There is a risk of inappropriate remedies that ultimately harm members.
- DH recommends that professional societies and the regulator (HPCSA) should be more active in educating practitioners about billing practices and promoting ethical conduct.
- These bodies should also follow through on disciplinary processes to create adequate deterrents.
- DH would welcome any guidance from the Panel on how to improve its processes, and pledges to continue to be part of industry processes for developing codes of good practice, and to working constructively with relevant professional groupings on these issues.

Discovery Health Presentation to Section 59 Investigation Panel

Dr Jonathan Broomberg
January 2020