Council for Medical Schemes

Section 59 Investigation

30 January 2020

A Member of AfroCentric Group

medscheme

Agenda

- **Introduction**
- **Healthcare Provider Relationships**
- **Coding and Tariffs**
  - Case examples
- **Legal**
- **Forensic Process**
- **Response to Report on Racial Profiling Analysis in FWA Cases**
- **Conclusion**

Introduction

Dr Lungi Nyathi
Executive Director: Healthcare Management

Who we are

01 Medscheme is a part of the JSE-listed AfroCentric Group

02 CMS accredited – medical scheme administration and managed care

03 Level 1 B-BBEE

04 Serving 15 of 76 medical schemes in SA – 3.7 million lives

05 Comprehensive suite of services include healthcare forensic analysis

06 Provide healthcare forensic analysis to 1.9m lives

Why we exist

- Sustainability of healthcare
- Maximising the value of the healthcare Rand
- Strategic purchasing
- Well-functioning healthcare system
- Affordability
- Quality & healthcare outcomes

What we do

43 200
Phone calls
EVERY DAY

256 350
Member/provider emails sent
EVERY DAY

183 730
SMS's sent
EVERY DAY

519 840
Claims processed
EVERY DAY

R36.9 billion
Value of claims processed
EVERY YEAR

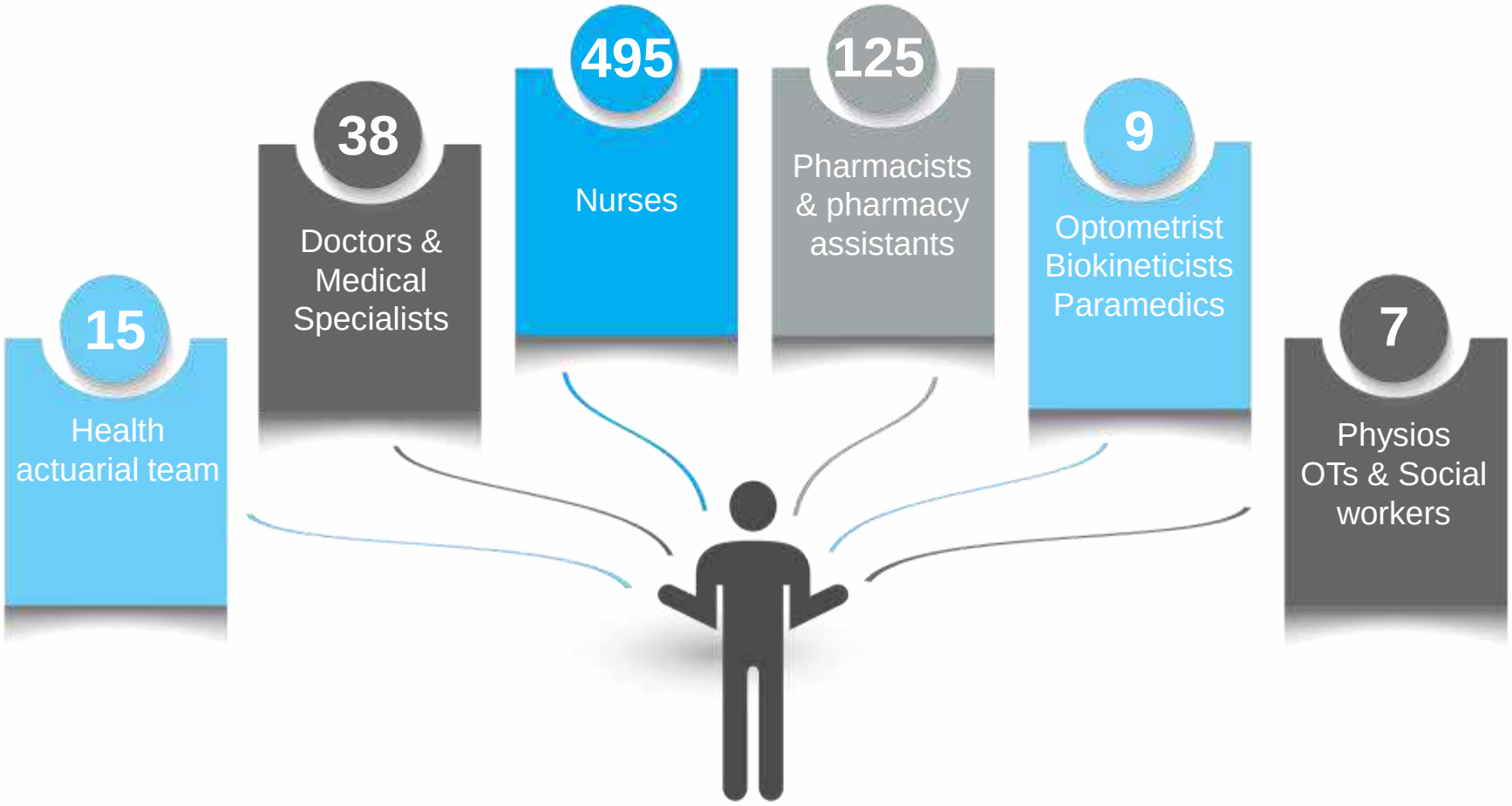
7.87 days
Claims received to paid

12 300
Mobi statements sent out
EVERY DAY

2 200
Member cards distributed
(including E-cards) EVERY DAY

7 935
Hospital authorisations
EVERY DAY

Expertise


15
Health actuarial team
38
Doctors & Medical Specialists
495
Nurses
125
Pharmacists & pharmacy assistants
9
Optometrist Biokineticists Paramedics
7
Physios OTs & Social workers

Thandi – our typical medical scheme member

Thandi is a 35 year old mother to two children
1 year old Lethabo and 6 year old Mpho
*She earns **R24 380 per month***
She lives in Soweto

FWA is an international phenomenon

OVERUTILISATION, WASTE AND ABUSE OF MEDICAL SERVICES: A GLOBAL PERSPECTIVE, SOLUTIONS AND THE SOUTH AFRICAN CONTEXT

CAPE TOWN

The Annual BHF Southern African Conference

Convergence 2030 - Healthcare Re-imagined

Nir Kaminer

Medical Reviews International (Ireland)

MEDREV MEDICAL REVIEWS INTERNATIONAL

Global Overutilisation and Inappropriate Care

- Total knee or hip replacement 26%
- Total knee replacement 34%
- Hysterectomy 20% (Taiwan)
- Hysterectomy 13%
- PCI (angioplasty with stent) 30%
- PCI 20%
- PCI 16%

Hospital admissions, extended stay, LOC:

- 18%–25%
- 33%
- 47%
- 19%
- 57% of patients received inappropriate antibiotics

6.2 million/year are medically unnecessarily (from 29.7 million)

Number has doubled globally since 2000

Qualitative Overutilisation Examples

- "There is no medical explanation for two thirds of all surgeries (...) many surgeries are only executed so that hospitals can earn money"
- In 10 years >50% of retired population will have an artificial knee or hip

- Private vs NHS patients:
- 3 times as likely to have knee surgery
- 8 times as likely to have shoulder surgery

- More than 30% surgeries are not medically necessary
- Highest rates: highest profit margin surgeries (Hip prosthesis, knee prosthesis, and knee arthroscopy)
- Decreased reimbursement rates INCREASED number of surgeries by 25%

* Uwe Deh, Executive Director of the AOK-Bundesverband in "Spiegel"

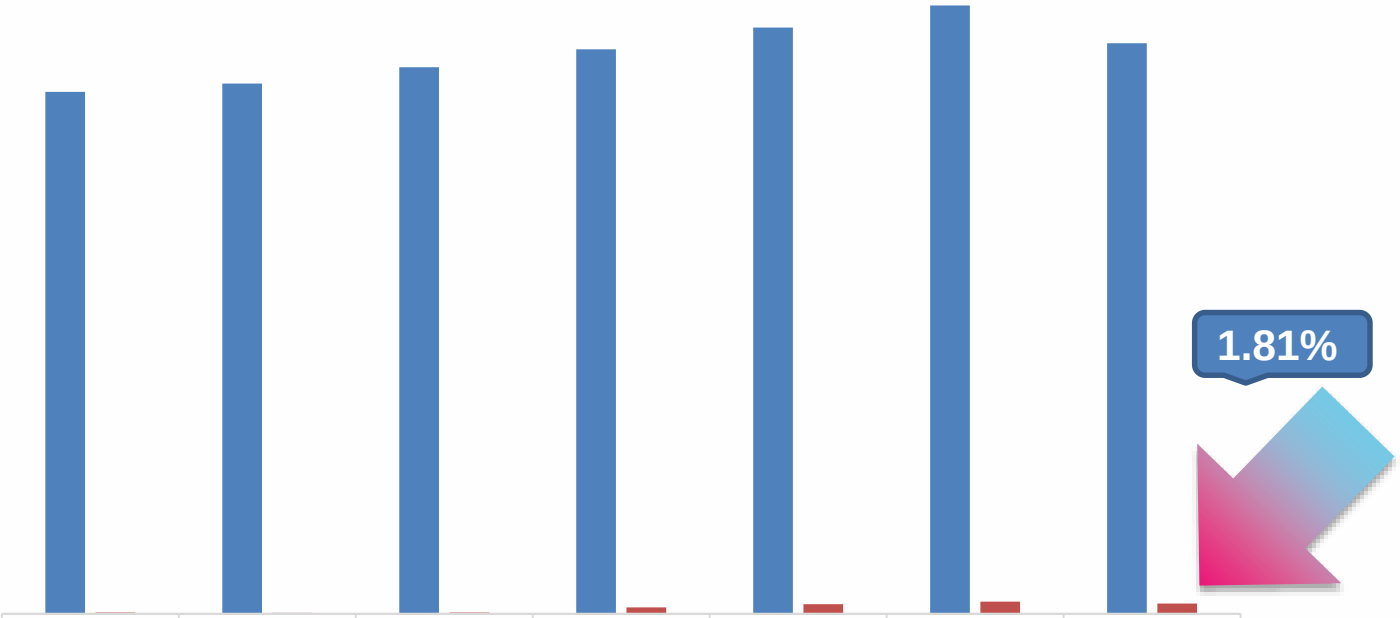
Provider pricing context

Changes by different regulatory bodies to various aspects of healthcare pricing

- 2003 – Competition Commission: Removing Collective Fee Negotiations
- 2008 – HPCSA: Removal of Ethical Tariffs
- 2010 – Department of Health – Invalidating National Health Reference Price List (NHRPL)
- 2013 – Council for Medical Schemes – Payment of Prescribed Minimum Benefits (PMBs) at invoice price
- 2018 – Council for Medical Schemes – Forensic audits

Current industry impact

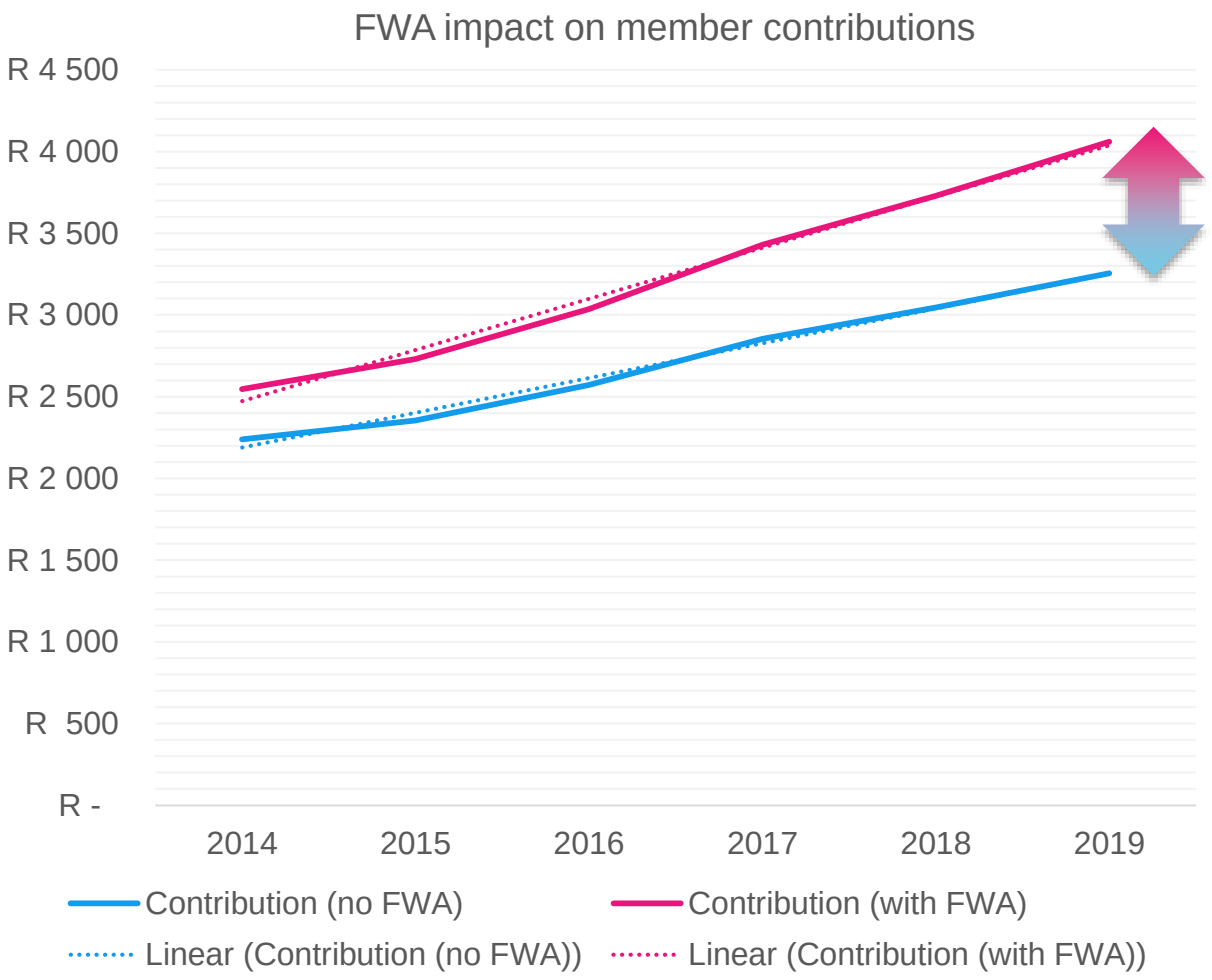
ONLY 1.81% of all claiming providers have forensic findings



	2013	2014	2015	2016	2017	2018	2019
Providers Claiming	35 854	36 424	37 528	38 761	40 253	41 772	39 178
Providers with forensic findings	80	72	90	440	660	830	710

Providers Claiming Providers with forensic findings

Small percentage - big money



Thandi would have been able to pay for BOTH of her children to be on medical aid

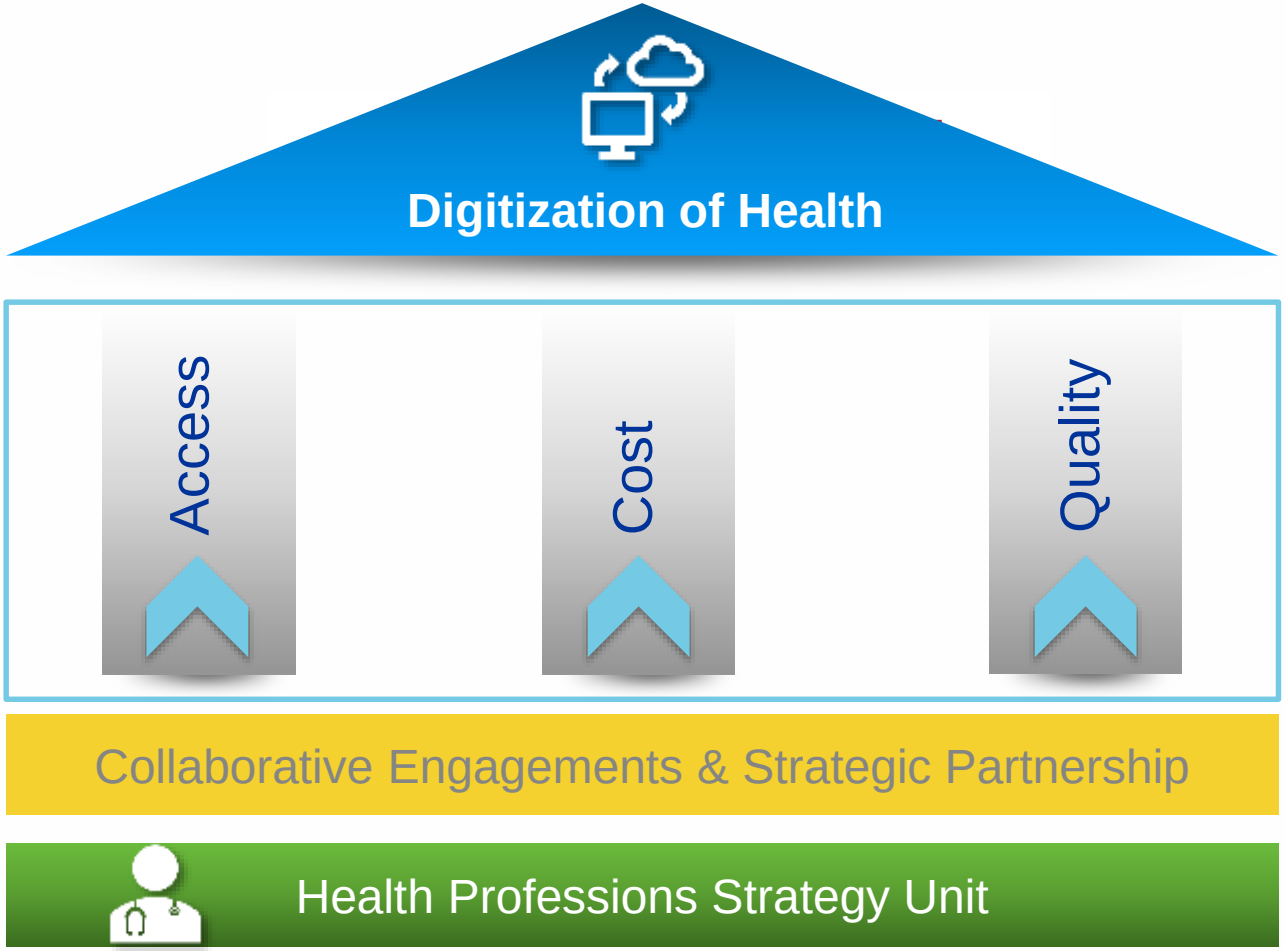
Savings = Healthcare

27 910 Wheelchairs	1 641 997 Flu vaccines	10 896 Tonsillectomies
17 024 Diabetics can have insulin for a year	10 344 HIV+ people can have ARVs for a year	431 270 GP consultations
5 819 Hospital admissions for normal deliveries	2 645 Hospital admissions for Congestive Heart Failure	4 608 Hospital admissions for Diabetes Mellitus
3 264 Hospital admissions for Mental health	6 405 Injury / Trauma Medical stay admissions	4 056 Hospital admissions for Pneumonia

Healthcare Provider Relationships

Dr Claude Ndlovu
General Manager: Healthcare Provider Relations

HP Engagement Framework



HP Engagement Model

Professional Associations/ Societies

Regulatory Bodies

HPCSA
Health Professions Council of South Africa

CMS
Council for Medical Schemes

Foster a collaborative environment

- Forums – Quarterly meetings
- Clinical Coordinating Committees

Communication

- Regular communication with doctors ad professional associations

Positive Positioning of client schemes

- Supporting CMEs and Sponsoring Up-skilling Workshops

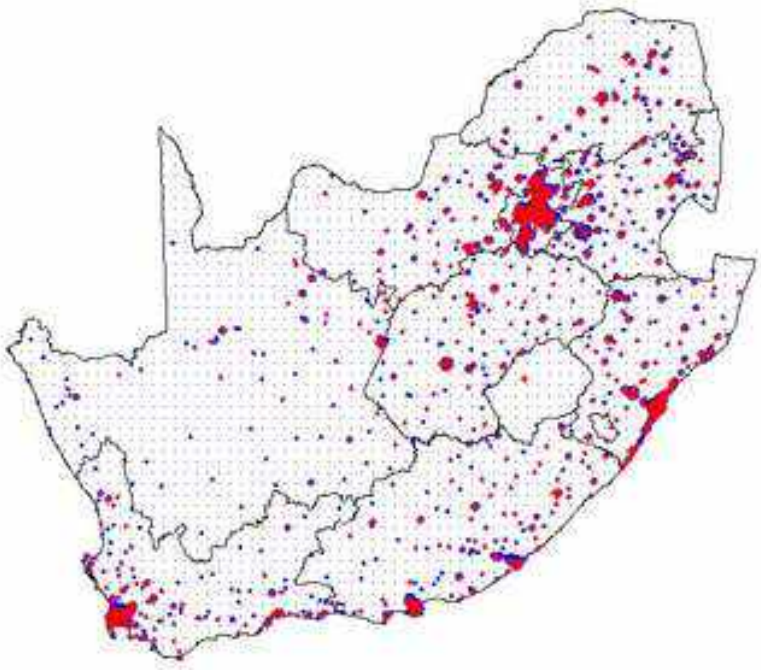
Build Relationship with all critical stakeholders

- Practice Management platforms, Bureaus, Vendors and Switches

Family Practitioners | Specialists | Allied professionals

Strategic Pillar: Cost effective Access

Geo-mapping of network doctors to membership



97,6% of members are within 10kms of a network FP

- **83%** of all doctors are on the network

Scheme with Specialist Network

85% of members are within **30km** of the nearest network Specialist, and **70%** of cost incurred within network

Channels of Engagements

- Practice Liaison Consultants
- Dedicated HP Contact Center
- Dedicated teams for escalations

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Contracting and Networking

Protecting schemes
PMB payment at cost

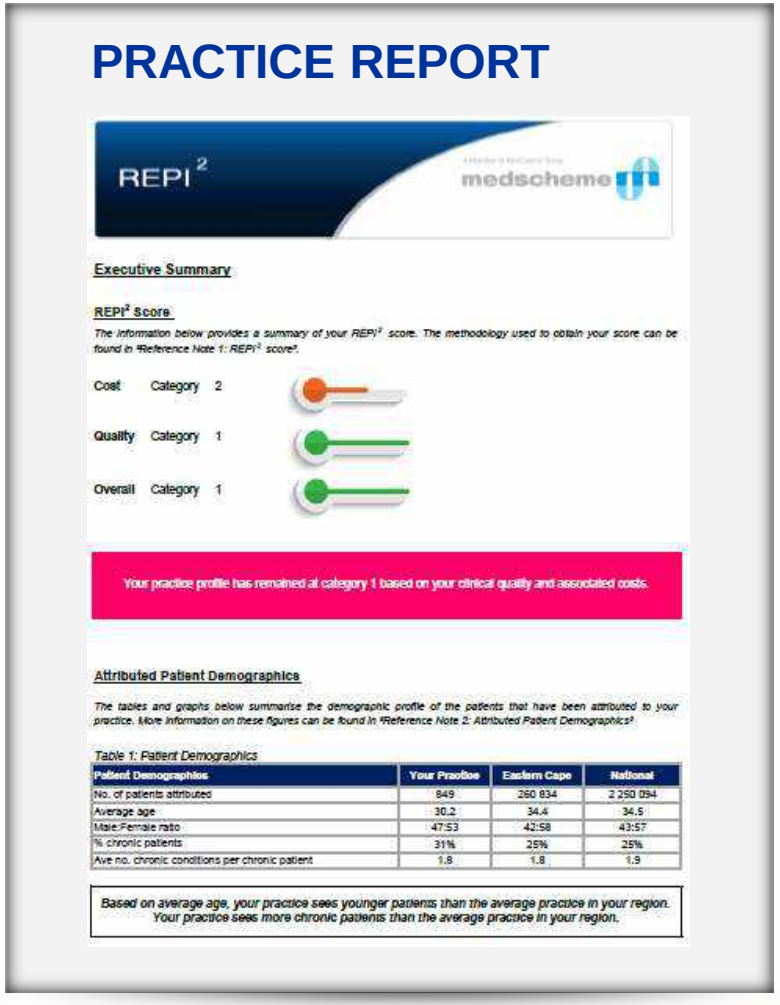
Protecting members
Out of Pocket payments

Strategic Pillars: Cost and Quality

Data communication and information sharing with doctors

A key facilitator for outcomes

- Affordability of healthcare services
- Sustainability of member funds
- Facilitating clinical peer review
- FP Up-skilling
- Best practice
- Peer to peer engagement
- IPA engagement



PRACTICE REPORT

REPI 2

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Executive Summary

REPI² Score

The information below provides a summary of your REPI² score. The methodology used to obtain your score can be found in 'Reference Note 1: REPI² score'.

Cost Category 2

Quality Category 1

Overall Category 1

Your practice profile has remained at category 1 based on your clinical quality and associated costs.

Attributed Patient Demographics

The tables and graphs below summarise the demographic profile of the patients that have been attributed to your practice. More information on these figures can be found in 'Reference Note 2: Attributed Patient Demographics'.

Table 1: Patient Demographics

Patient Demographics	Your Practice	Eastern Cape	National
No. of patients attributed	849	260 834	2 250 094
Average age	30.2	34.4	34.5
Male:Female ratio	47:53	42:58	43:57
% chronic patients	31%	25%	25%
Ave no. chronic conditions per chronic patient	1.8	1.8	1.9

Based on average age, your practice sees younger patients than the average practice in your region. Your practice sees more chronic patients than the average practice in your region.

Clinical quality of patient treatment

Quality indicators monitored per medical condition

Measure	Actual Last Quarter	Actual This Quarter	Trend
Diabetes			
Adherence to chronic diabetes medication	59%	53%	↓
HbA1c coverage	56%	74%	↑
LDL coverage	66%	76%	↑
Monitoring nephropathy	0%	0%	→
Annual retinal examination	12%	8%	↓
Aspirin coverage (patients over 30 years old)	41%	42%	→
Statin Coverage (Diabetes type II)	66%	62%	↓
Diabetes related hospital admissions*		8%	
Asthma			
Adherence to chronic asthma medication	61%	73%	↑
% non-registered patients claiming B2 agonists/steroid/combo inhalers	3%	4%	→
% registered asthmatics claiming for B2 agonist inhaler only	45%	75%	↓
Asthma related hospital admissions*		59%	
Cardiac			
Adherence to chronic hypertension medication	65%	65%	→
LDL coverage (Ischaemic Heart Disease (IHD) and Hyperlipidaemia (HYL))	75%	87%	↑
Aspirin coverage (IHD)			
Monitoring nephropathy (Hypertension)	0%	0%	→
IHD related admissions (IHD, HYL, Diabetes Mellitus)*		20%	
Depression			
Adherence to chronic depression medication (registered patients only)			
Mental Health related hospital admissions (all patients)*		11%	
Preventative			
Pap smear coverage in past 12 months	8%	13%	↑
HIV testing prevalence: 16 - 65 year olds	7%	8%	→

** These measures are not based on peer benchmarks but are risk-adjusted for the profile of patients that you see*

Coding and Tariffs

Dr Gregory Pratt
Clinical Advisor: Healthcare Forensics

Coding - using RPL/SAMA

Translation
Medical services into billing codes for invoices

History
Long and evolving

SAMA
Published guide largely the industry standard

Context
Codes are valid only in context due to healthcare complexity

No training
Practitioners receive no formal coding training during student or State years

Word of mouth
Relying on colleagues, bureaus when opening a new practice

Societies
Provide guidance but membership is voluntary

FFS incentives
Fee for service environment with higher value codes and PMBs

Coding – framework for forensic audits

Relative Value Units (RVUs)
Codes linked to RVUs determining
- Base level of funding
- Scheme rates
- Scheme costing impact
- New codes proposed

Appropriateness
Matching funding to complexity and time spent

Aim
Pay valid claims

Billing vs funding rules
Medical schemes bound by CMS registered option rules

Consistency
SAMA explanatory notes used as reference

Code irregularities
Examples
- Up-coding
- Unbundling
- Padding
- Manipulation
- Over-charging

Coding – billing profile and audits

Good faith payment
High volumes and time restrictions

Retrospective
Analysis, audit to confirm validity

Patterns and anomalies

Codes

- Combinations, bundles, multiples
- Number, repetition of codes
- Inappropriate diagnostic codes (ICD10)
- NAPPI codes - No price checks and large discounts to practices

Code rules not applied by providers

- Mutually exclusive
- Inappropriate combinations
- Maximum limits
- Disallowed contexts (severity, lavage, wounds)

Findings

- Frequent use of specific or unusual medicines
- Hours per day
- Excessive, unnecessary diagnostic tests
- High cost appliances
- Higher cost, frequency or time spent than peers
- Unusual age band serviced
- Higher admission rates
- Expected treatment not conducted
- Higher frequency of dental fillings or fillings on previously extracted teeth

Lack of Ethical Limits

- R212 000 per hour (surgeon)
- R75 000 (49 min, plastic surgeon)
- R45 000 (32 mins in theatre – dermatologist)
- R525 hearing aids billed at R12 000
- R6 050 Laser fibre billed at R160 000

Medscheme forensic unit advised by…

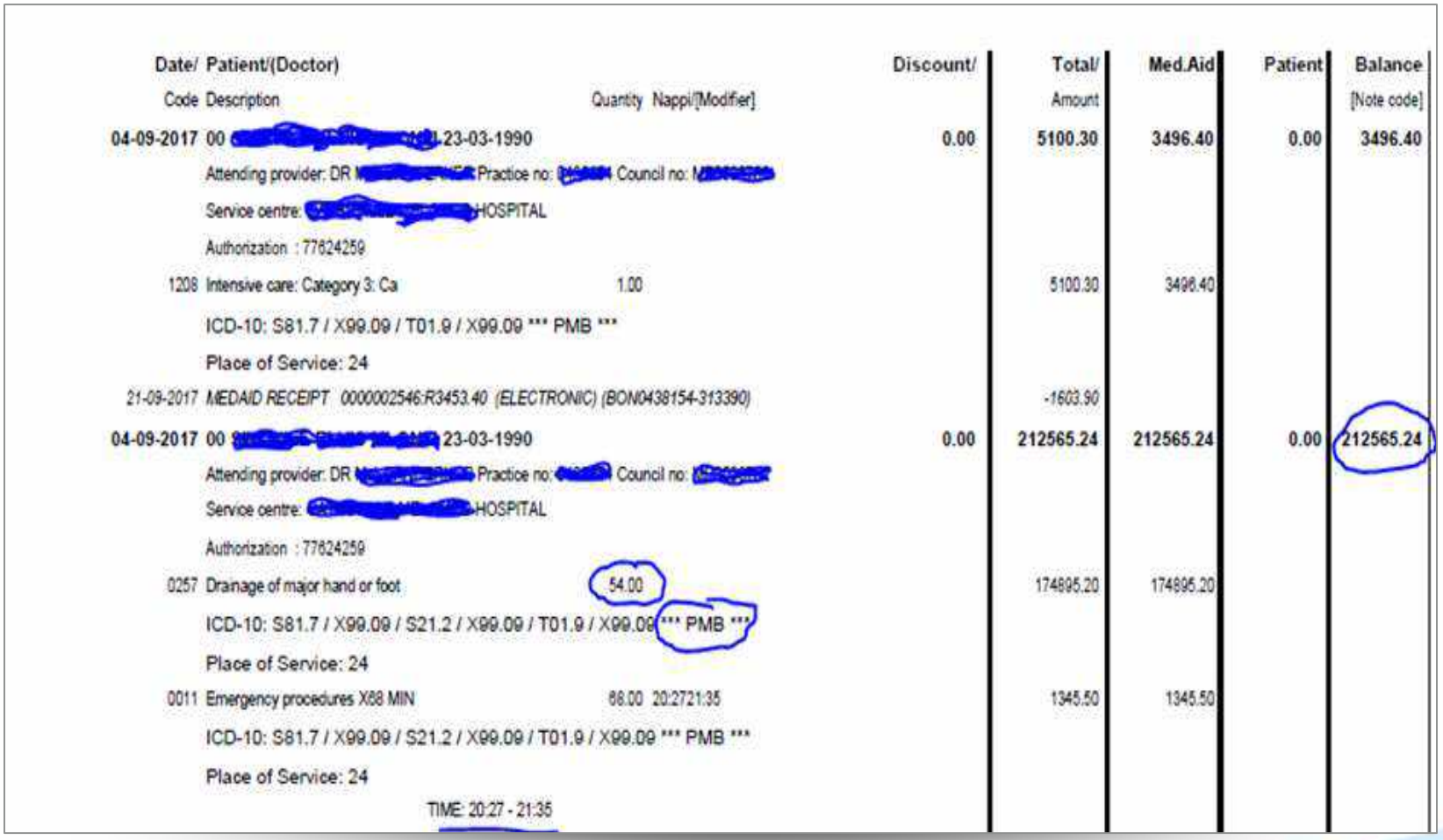
1. South African Society of Gynaecologists (SASOG)
2. Ophthalmology Management Group (OMG)
3. Surgicom (Society for surgeons)
4. SA Society for Anaesthesiologists (SASA)
5. Psychiatry Management Group (PsychMG)
6. SA Audiology Association (SAAA)
7. SA Association for Social Workers in Private Practice (SAASWIPP)
8. Occupational Therapy Association of SA (OTASA)
9. Dermatology Society of SA (DSSA)
10. Cardiothoracic Society of SA
11. Renal Care Society (Clinical Technologists)
12. SA Renal Society (Nephrologists)
13. Association of Plastic, Reconstructive and Aesthetic Surgeons of SA (APRASSA)
14. SA Society for Otorhinolaryngology
15. Radiological Society of SA (RSSA)
16. SA Urological Association
17. SA Society of Physiotherapy
18. Psychology Society of South Africa (PsySSA)
19. South African Orthopaedic Association (SAOA)
20. Society of Medical Laboratory of South Africa (SMLTSA)
21. SA Heart Association

Case examples

Example of over-charging through code abuse

Surgeon billed **R212 565 for 68 minutes** in theatre

Expected full payment as PMB



Date/ Code	Patient/(Doctor) Description	Quantity	Nappi/[Modifier]	Discount/	Total/ Amount	Med.Aid	Patient	Balance [Note code]
04-09-2017	00 [redacted] 23-03-1990			0.00	5100.30	3496.40	0.00	3496.40
	Attending provider: DR [redacted] Practice no: [redacted] Council no: [redacted]							
	Service centre: [redacted] HOSPITAL							
	Authorization : 77624259							
1208	Intensive care: Category 3: Ca	1.00			5100.30	3496.40		
	ICD-10: S81.7 / X99.09 / T01.9 / X99.09 *** PMB ***							
	Place of Service: 24							
21-09-2017	*MEDAID RECEIPT 0000002546:R3453.40 (ELECTRONIC) (BON0438154-313390)*				-1603.90			
04-09-2017	00 [redacted] 23-03-1990			0.00	212565.24	212565.24	0.00	212565.24
	Attending provider: DR [redacted] Practice no: [redacted] Council no: [redacted]							
	Service centre: [redacted] HOSPITAL							
	Authorization : 77624259							
0257	Drainage of major hand or foot	54.00			174895.20	174895.20		
	ICD-10: S81.7 / X99.09 / S21.2 / X99.09 / T01.9 / X99.09 *** PMB ***							
	Place of Service: 24							
0011	Emergency procedures X68 MIN	68.00	20:2721:35		1345.50	1345.50		
	ICD-10: S81.7 / X99.09 / S21.2 / X99.09 / T01.9 / X99.09 *** PMB ***							
	Place of Service: 24							
	TIME: 20:27 - 21:35							

Example of high cost billing

Dermatologist billed R44 011 for 47 minutes in theatre

Wart removal

R14 545 added because patient was overweight

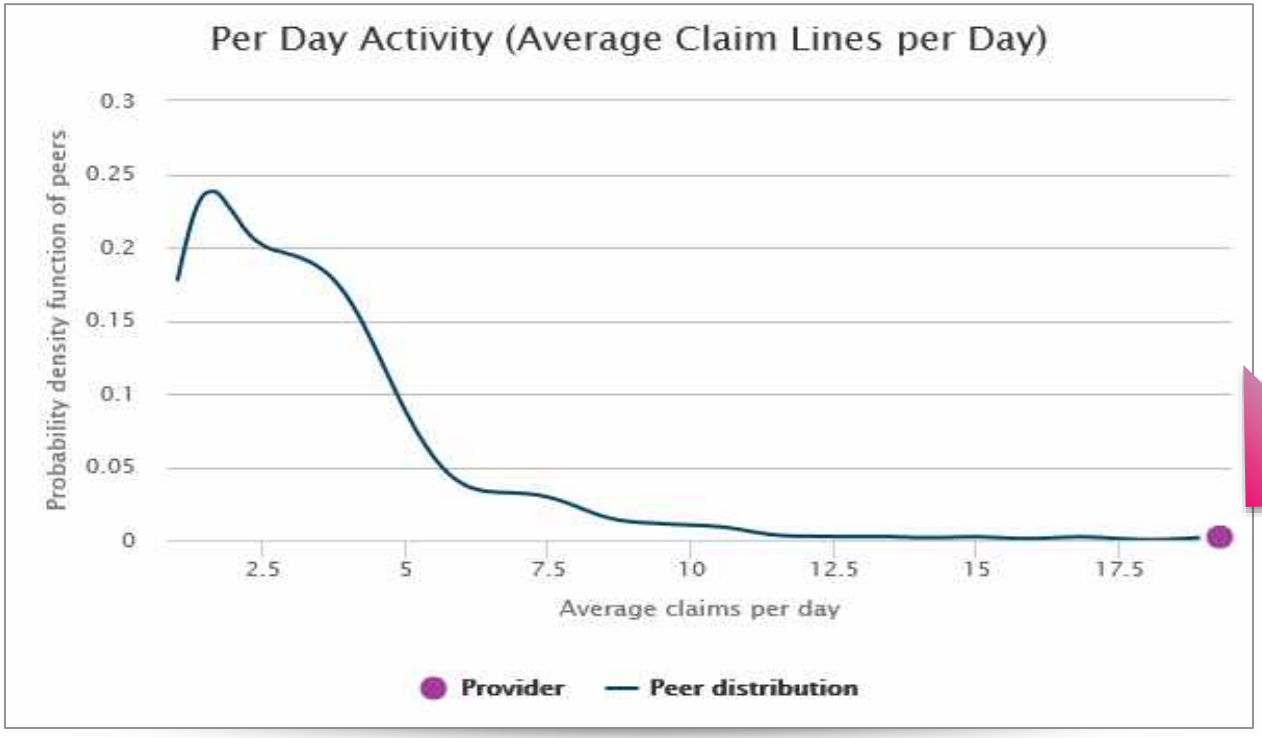
Date	Patient	Code/Nappi	Particulars	Units/Qty	Patient Amt.	Med Aid Amt.	Journal	Payment Received
2017/03/24	00-[redacted] DOB:20/11/1964	0173	FIRST HOSPITAL CONSULTATION Authorised: 76901793 ICD-10 Code: B07	1.00		442.91		
2017/03/24	00-[redacted] DOB:20/11/1964	0145	VISIT AWAY FROM DOCTORS ROOMS Authorised: 76901793 ICD-10 Code: B07	1.00		147.81		
2017/03/24	00-[redacted] DOB:20/11/1964	0245	REMOVAL OF BENIGN LESION BY CU ICD-10 Code: B07	1.00		292.53		292.53
2017/04/21	00-[redacted] DOB:20/11/1964	MP						
2017/03/24	00-[redacted] DOB:20/11/1964	0246	REMOVAL OF BENIGN LESION BY CU Authorised: 76901793 ICD-10 Code: B07	100.00	28 875.55	215.26		215.26
2017/04/21	00-[redacted] DOB:20/11/1964	MP						
2017/03/24	00-[redacted] DOB:20/11/1964	0018	SURGICAL MODIFIER FOR PERSONS WITH A BMI Authorised: 76901793 Ht:1.65 Wt:115 BMI:42.24 ICD-10 Code: B07	1.00		14 545.41		

Current	Patient Amt.	Med Aid Amt.	Journal Amt.	Payment Received
R 44 011.68	28,875.55	15 643.92	0.00	507.79

Total Due R 44 011.68

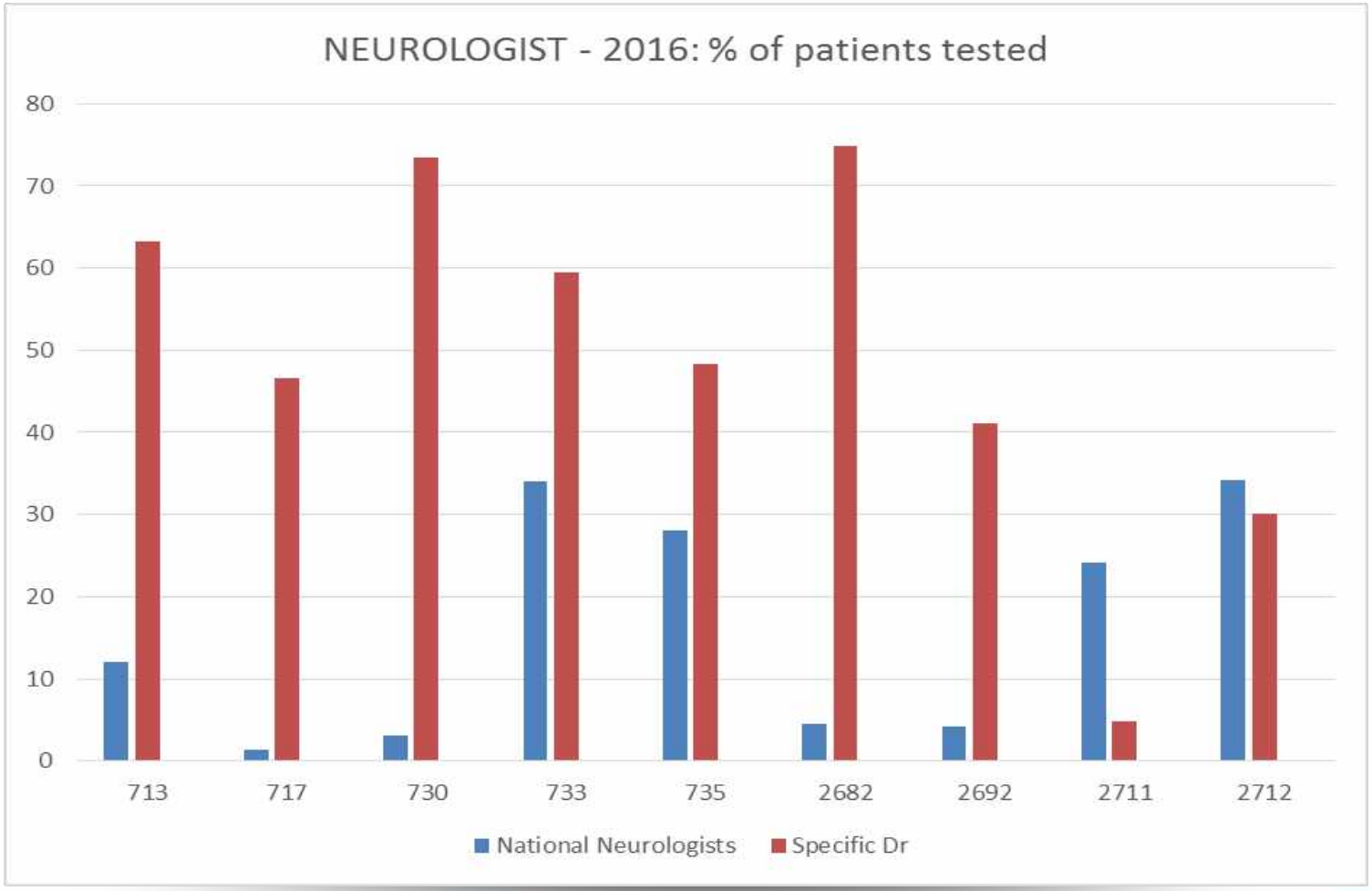
Example of high cost code abuse

Dermatologist



Example of irregular test rates

R30 million paid in 18 months



Example of up-coding

Plastic surgeon billed **R74 921 for 49 minutes** in theatre

78y old lady - referred for removal of 4 cancerous skin lesions

Pre-authorization granted for removal of 4 lesions, with wide excisions and skin flap repairs, costly codes quoted, was authorized

Patient not informed of cost upfront

Post-op inquiry:

- Pathology lab report confirmed only **4 very small lesions** removed – **major flap reconstructive surgery therefore highly unlikely**
- Dr refused to supply operative report to confirm work done
- Medical Society confirmed large costly codes were inappropriate – grossly overcharged; HPCSA case lodged
- Dr suing patient after scheme reduced funding portion

Challenges: cannot confirm work done if records not supplied, rely on Dr information at pre-auth, patients uninformed of cost consequence

KEY MESSAGE

If the post-op inquiry was not done, the discrepancy would not have been found.

Example - Pattern of false claims

Radiographer

The table below summarises the top diagnoses:

ICD10	Description	Number of instances	% of Total Benefit
K59.0	Constipation	1171	87.13
K59.9	Functional intestinal disorder, unspecified	170	12.65
Totals		1341	99.78%

87% of patients had 'Constipation'

39101 - Trans-hepatic; percutaneous biliary tract
39043 - Facial bones and/ orbits
39111 - Ribs
39093 - Intravenous Study, biliary tract
39089 - Hypotonic Duodenography
39049 - Mastoid: Bilateral
39013 - Skeletal survey over 5 years old

All patients got the **same set** of X-rays

Referring Dr on claims denied seeing any of the patients - no consults

Claimed R890 000 in around 7 months - 1 scheme

Findings: Patients consulted at Wellness days at work - no X-rays taken

Example - Waste in medical appliances

Orthotist

- Served patients mostly at Wellness Days
- Supplied most patients with **knee braces and compression stockings**
- No referrals/oversight from medical practitioners
- No objective diagnostic testing to confirm medical necessity
- Supplier induced demand
- Patients oblivious of costs – not informed
- **Claimed R2.55 Million in 9 months**
  - **R154 023 on a single day for 23 members = R6700 each!**
- R1.43 Million for knee braces alone.

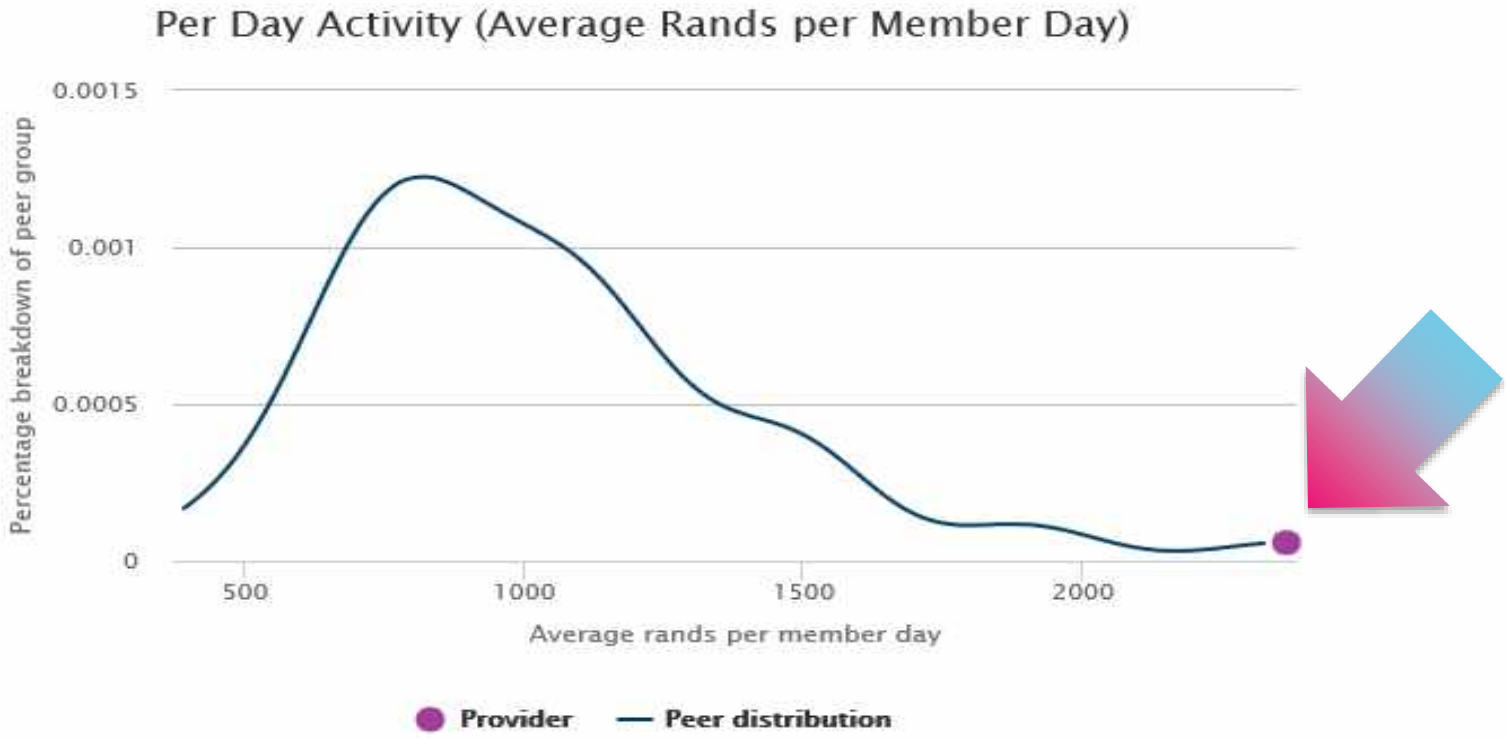
Challenges:

- Claims do not indicate place of service
- Codes are valid but retrospective pattern shows abuse
- Cannot put individual benefit sub-limits on each of 25 000 medical appliances on the market

Example – Excessive testing - before

Pulmonologist

November 2016



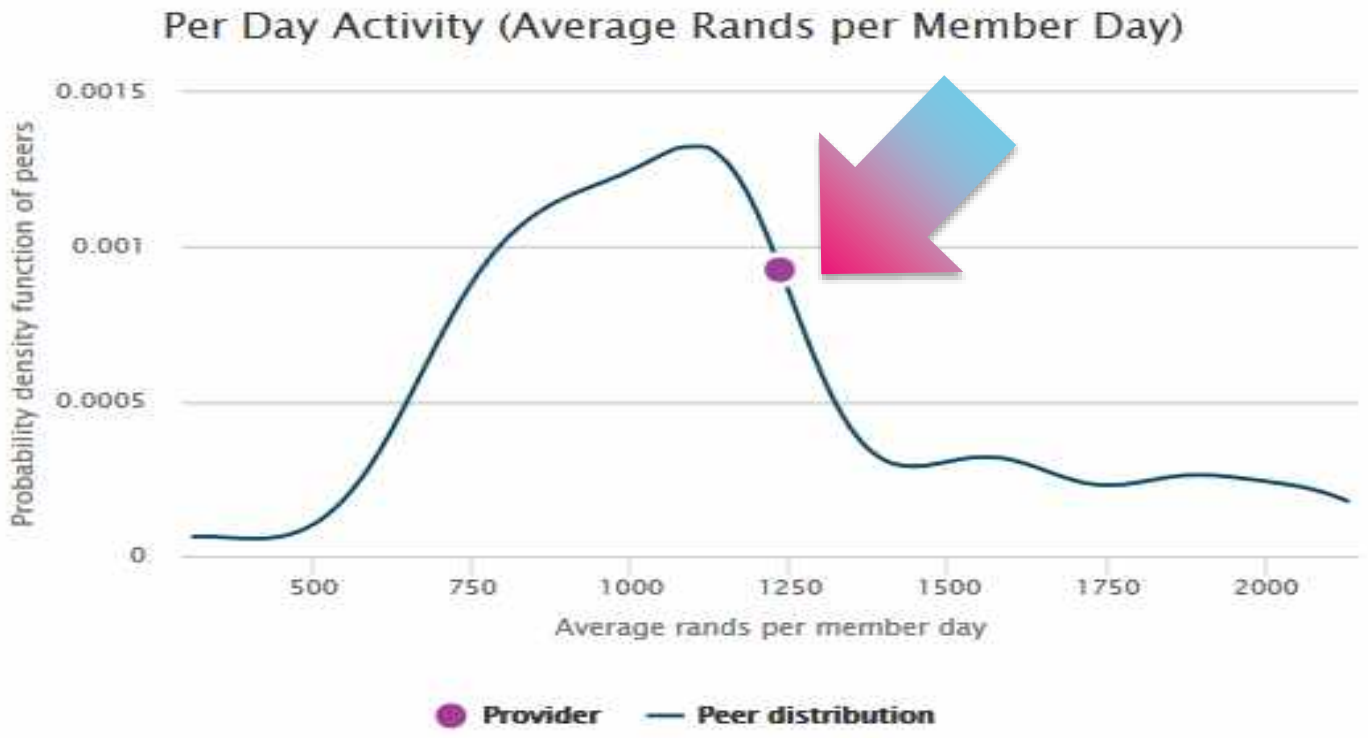
Performed complex lung functions on 56% of patients - 30% of income

R 1.96 million charged in 20 months

Example – provider behaviour change

Pulmonologist

October 2019



Lung functions on 54% of patients - now only 16% of income

R 1.09 million charged in 25 months – Reduced cost impact

Legal

Ms Lerato Sikhakhane
Senior Legal Advisor

Medical Schemes Act 131 of 1998 (the Act)

Section 2 – Application of Act

Section 32 – Binding force of rules

"The rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming."

Section 59(2) of the Medical Schemes Act

59(2) Charges by suppliers of service -

A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Regulation 5 and 6 of the Medical Schemes Act

Regulation 5 - Prescribes particulars to be reflected in a statement or account contemplated in section 59 (1)

Regulation 6(1) - Prescribes periods when a section 59(2) accounts, or statements contemplated in shall be valid for payment

Regulation 6(2) - Process to be followed when a section 59 (2) account or statement in is erroneous or unacceptable for payment

Regulation 6(3) - The member's or supplier's right to an opportunity to correct a section 59 (2) erroneous or unacceptable account or statement

Regulation 6(4) - Onus of medical scheme to prove that a section 59 (2) is not valid for payment

Regulation 6(5) - Information that must appear on a section 59(2) account or statement once an account or statement has been corrected and the medical scheme has honoured the payment of that account

Section 59(3)

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

(a) any amount which has been paid bone fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or

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

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

Advocate C Loxton SC

Section 59(2) and (3) are closely linked and must be read together.

- The right to deduct monies as provided by section 59(3) is conferred upon medical schemes post the section 59(1) and (2) period (read with regulations 5 and 6).
- This right is linked to their obligation to pay accounts submitted within 30 days in good faith because on face value the account or statement complies with the particulars in regulation 5.
- Section 59(3) is a remedy upon which schemes must rely on, when they deem that the payment erroneous (should not have been paid in the first place within the 30 days and regulation 6 period.)
- Right to deduct when claims have been submitted in bad faith to which a member or a supplier of service is not entitled.

Advocate C Loxton SC

What does Section 59(3) legally permit medical schemes to do?

- Section 59(3) legally permits medical schemes to adjudicate whether a supplier of service is entitled to payment of claims submitted.
- Deduct amounts paid in good faith in terms of the provisions of the Act, when the amount was in fact not due.
- Deduct from any benefit payable to member or supplier of health service

Advocate C Loxton SC

“Notwithstanding anything to the contrary contained in any other law…” that:

> “Section 59 (3) should prevail over other laws, including the common law, particularly in relation to the burden of proof which might otherwise lie upon the medical scheme in a claim for repayment of monies erroneously paid.”

Advocate C Loxton SC

Burden of proof for Medical Schemes

1. Overpayment must have been in good faith.

2. Overpayment must have been made in accordance with the provisions of the Medical Scheme's Act.

3. The member or supplier of health service in question must have not been entitled to the payment.

Advocate C Loxton SC

> *deduct such amount from any benefit payable to such member or supplier of health service*

Wholly inconsistent with an intention on the part of the Legislature that the medical scheme in question is obligated to go to a court of law in order to prove its claim against the member or service provider before it is entitled to off set the overpayment against any benefits due.

Case Law

- Mokwena and Others v Government Employees Medical Scheme [2017] 3196/2017 ZAFSHC
- Medscheme Holdings (Pty) Ltd and another v Bhamjee [2005] 4 All SA 16 (SCA)
- South African Police Service Medical Scheme v Registrar of Medical Schemes, Council for Medical Schemes and Dr C Paynee CMS52609
- Yarona Healthcare Network v Medshield (1108/2016) [2017] ZASCA

Other remedies

Section 16. Cases of improper or disgraceful conduct

Whenever it appears to the Council -

(a) that the conduct of any person registered under any Act of Parliament which regulates the professional conduct of any health care supplier constitutes improper or disgraceful conduct relating to a medical scheme, the Council shall; report this matter to any body or organisation which has jurisdiction over the person concerned; or

(b) that an offence has been committed,

the Council shall refer the matter to the National Prosecuting Authority.

Other remedies

Section 29(2) (c) and (d)

"A medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependants, except on the grounds of -

…

(c) submission of fraudulent claims;

(d) Committing any fraudulent act;

Additional consequences to section 59(3)

Section 66 - Offences and penalties

(1) Any person who -

(b) makes or causes to be made any claim for the payment of any benefit **allegedly due in terms of the rules** of a medical scheme, knowing such claim to be false;

(c) knowingly makes or causes to be made a **false representation of any material fact** to a medical scheme, for use in determining any right to any benefit allegedly due in terms of the rules of the medical scheme;

(d) having knowledge of any fact or the occurrence of any event affecting his or her right to receive any benefit in terms of the rules of a medical scheme, and who fails to disclose such fact or event to the medical scheme with the intent to obtain from the medical scheme a benefit to which he or she is not entitled **or a larger benefit than that to which he or she is entitled**;

(e) renders a statement, account or invoice to a member or any other person, knowing that such statement, account or invoice is false and which may be used by such member or other person to claim from a medical scheme any benefit **or a benefit greater than the benefit to which he or she is entitled** in terms of the rules of the medical scheme;

shall, subject to the provisions of subsection (2), be guilty of an offence, and liable on conviction to a fine or to imprisonment for a period not exceeding five years or both a fine and imprisonment.

Additional consequences to section 59(3)

Section 66 - Offences and penalties (continued)

Section 66(2)

No contravention or failure to comply with any provision of this Act shall be punishable under subsection (1) if the act or omission constituting that contravention or failure to comply with any request or requirement is punishable as an offence under the provisions of any other Act of Parliament which controls the professional conduct of any health care provider.

Forensic Process

Mr Paul Midlane
General Manager: Healthcare Fraud and Abuse

Why healthcare is different
Fraud Waste and Abuse

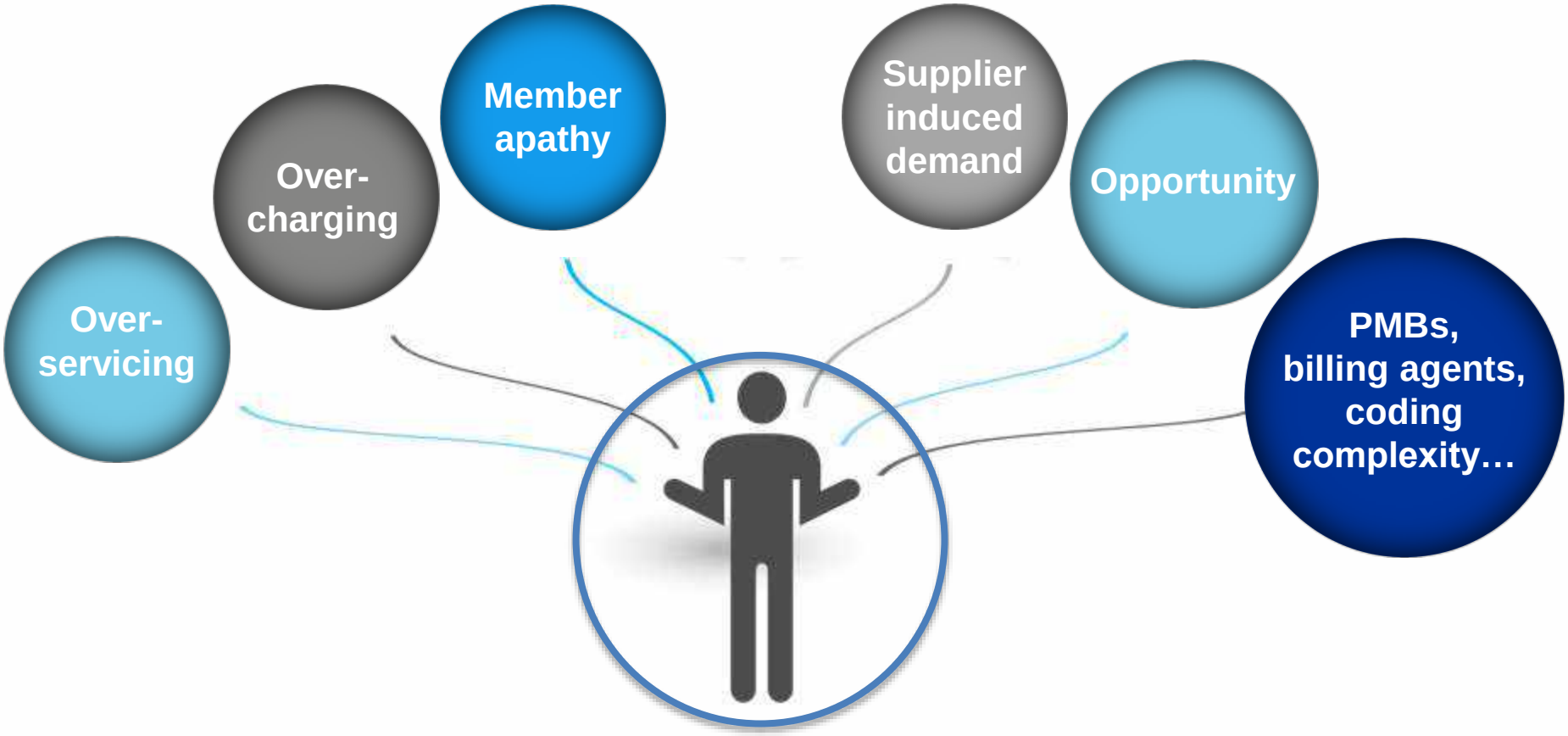
Knowingly submitting, or causing to be submitted, false claims or an intentional misrepresentation of the facts in order to access payment of a benefit to which you would otherwise not have been entitled.

INTENTIONAL

- *Claims paid within 30 days*
- *Emotive in nature*
- *Huge volumes*
- *Paid in good faith*
- *Hard to prove intention*

The claiming for healthcare treatment and services that are not absolutely medically necessary, including any form of over-servicing or over-charging of a patient, and that may objectively be considered as not adding clinical value to the patient and/or as unethical or unconscionable or contrary to best practice and/or evidence-based medicine principles.

Factors driving of Fraud Waste and Abuse



Medscheme Forensics Department

Healthcare Forensics (51)

General Manager

Internal Investigators X 3

Clinical and Functional Support X 5

Data mining

Data reporting and statistics

Clinical interpretation and quantifications

Improvements Admin + MHC = FWA Steering Committee

External clinical engagement with providers and clients (incl HASA, SAMA, IPA's, Specialist forums)

Governance and Operational Support X 7

Quality Assurance

Reporting

Communication – articles, case studies, awareness and training

Case Management – CMS / Civil / Criminal / HPCSA / SAPS *(where applicable)* / blacklisting / vetting

Fraud Risk Management – Policies, Processes

Medical Professionals X 15

1 x Manager

13 x Analysts

1 x Investigator

Pharmacies X 12

1 x Manager

9 x Analysts

2 x Investigators

Facilities X 8

1 x Manager

6 x Analysts

1 x Investigator

Forensic validation and recovery process

Identified practices / facilities / pharmacies using predictive analytics and tip-offs

Application of relevant clinical, financial or institutional principles

Desktop verification and validation (10 days) | Physical verification of services

Quantification of irregularities

Further provider engagement

Notify provider of irregularities and provide opportunity to respond within further 10 working days

If no response received, or response inadequate, recovery loaded and offset against future valid claims

Continuous monitoring of claims going forward

Further transgressions to result in suspension of payment and further sanctioning

Current scheme remedies available

FINANCIAL

- Voluntary repayment (AoD or payment plan)
- Section 59(3) MSA – Statutory off-setting (current & future claims)
- Civil sanctioning

PUNITIVE

- Section 59(2) MSA – Indirect payment
- Regulatory body reporting
- Criminal sanctioning
- Membership termination
- Network removal

HPCSA sanctions

Dr X – ran an illegal abortion clinic

MP 0497525/1259760 - COUNT 1

THAT you are guilty of unprofessional conduct or conduct which, when regard is had to your profession, is unprofessional in that on or about February 2015 you acted in a manner that is not in accordance with the norms and standards of your profession in that:

1.1 you were found guilty at the Johannesburg Magistrate Court and sentenced to pay a fine of R20 000.00, for operating an illegal abortion clinic;

1.2 you employed unregistered persons.

The Respondent was found guilty and the following sanctions were imposed:

Five (5) years suspension, wholly suspended for three (3) years on the following conditions:

That the Respondent is not found guilty of a similar offence.

HPCSA sanctions

Mr Y – all claims submitted were false

PT 0072346/2105946

THAT you are guilty of unprofessional conduct or conduct which, when regard is had to your profession, is unprofessional in that you rendered or caused or permitted to be rendered on your behalf and in respect of your patient, an account/statement wherein you charged and/or attempted to recover the amounts specified in the said account/statement in respect of professional services allegedly rendered by you on or about March 2009, whilst –

a) none of the professional services were rendered by you; and/or

b) you were not entitled to payment of any of the amounts specified in the said account/statement; and/or

c) the said account/statement was drafted in a manner that was inaccurate or incorrect.

The Respondent paid an admission of guilt fine in the amount of R20 000.

HPCSA sanctions

Dr Z – found guilty of 10 individual counts of fraud

MP0482129/5473152 Counts 1 - 10

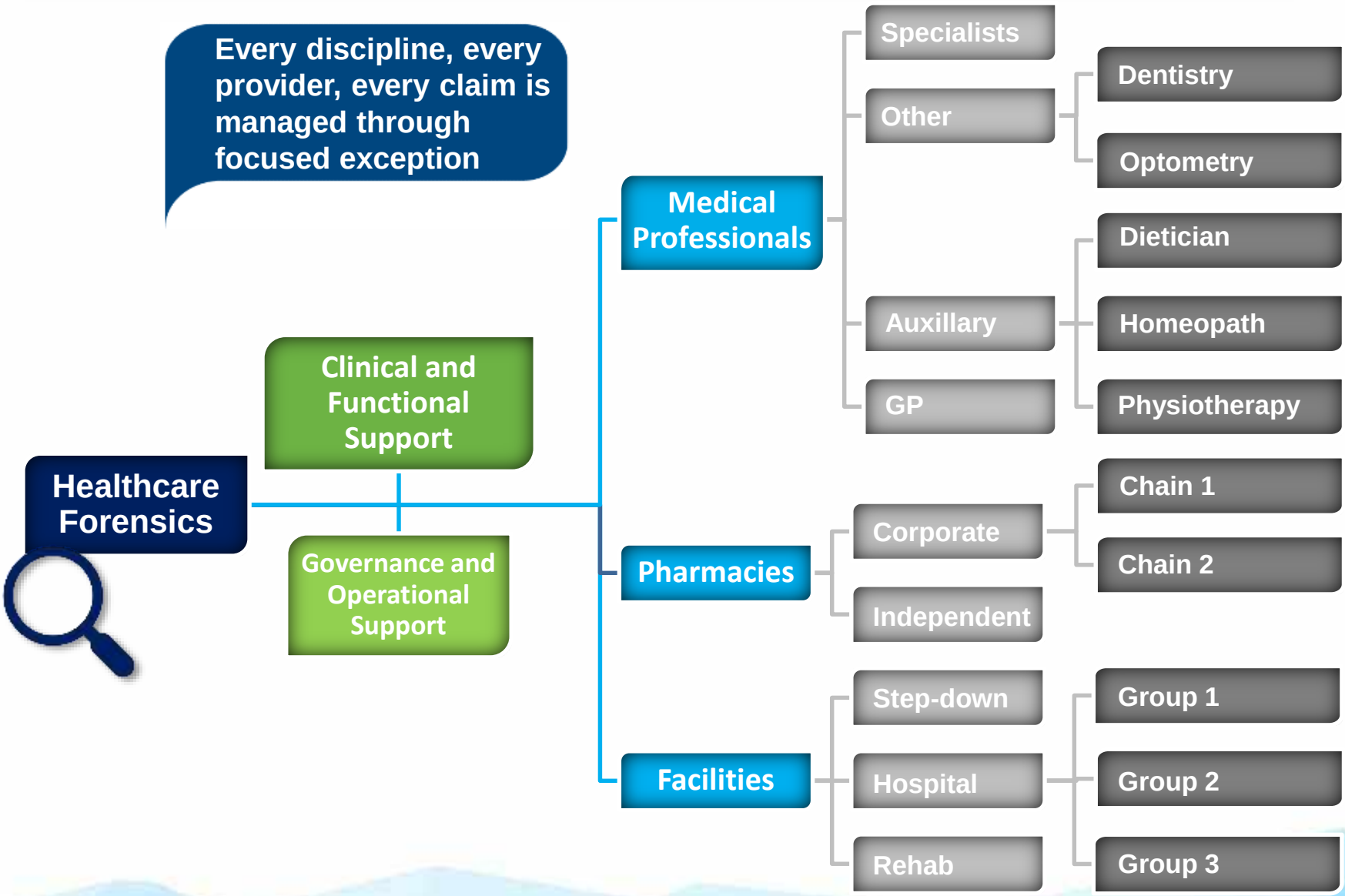
THAT you are guilty of unprofessional conduct or conduct which, when regard is had to your profession, is unprofessional in that during the period mentioned you and/or your practice rendered statements of account to a Medical Aid Scheme, in respect of persons mentioned for professional services rendered whilst you knew and/or ought to have known that, no professional services were rendered to persons mentioned by you and/or your practice.

The Respondent was found guilty on all counts and the following sanctions were imposed:

- ***In respect of count 1: Ten thousand rand (R10 000) fine and furthermore, he was suspended from the register for a period of five (5) years, wholly suspended for five years, on condition that the Respondent is not found guilty of a similar offence during the period of suspension;***

- **Suspension was suspended**

2020 and beyond - dedicated teams per discipline



Response to Report on Racial Profiling Analysis in FWA Cases

Mr Paul Midlane
General Manager: Healthcare Fraud and Abuse

Context of cases in relation to providers paid

	2013	2014	2015	2016	2017	2018	2019
Practices Paid	35 854	36 424	37 528	38 761	40 253	41 772	39 178
Providers with FWA findings	80	72	90	440	660	830	710
% Cases vs Claimed	**0,22%**	**0,20%**	**0,24%**	**1,14%**	**1,64%**	**1,99%**	**1,81%**

Findings based on two questions

1. Is there an explicit racial bias in the algorithms and methods used by Discovery Health, GEMS and Medscheme to identify FWA?
2. Are the outcomes of the FWA process racially biased? In particular, were Black providers identified as having committed FWA at a higher than expected rate?

Observations on terminology - Bias

Racial Profiling: *"The act of suspecting or targeting a person of a certain race on the basis of observed or assumed characteristics or behaviour of a racial or ethnic group, rather than on individual suspicion."*

Bias (Colloquial): ***"****Disproportionate weight in favour of or against an idea or thing, usually in a way that is closed-minded, prejudicial, or unfair."*

- Subjective to the institution or individual
- Explicit (intentional / conscious) or Implicit (unintentional / unconscious)

Bias (Statistical): *"A feature of a statistical technique or of its results whereby the expected value of the results differs from the true underlying quantitative parameter being estimated."*

- Objective based on factual results
- Intent or causality is irrelevant

Question 1 is looking for 'colloquial' bias in the processes and systems;
Question 2 is looking for statistical bias in the outcomes of FWA findings

Methodology Used

Question 1

Medscheme is satisfied with the analysis performed in interrogating whether our forensic processes and systems contain any form of racial profiling or explicit racial bias in their design or implementation

Question 2

a) We **appreciate the difficult task** in attempting to assign race to private healthcare practices

b) The DoH; HPCSA; CMS; Provider Associations and the Report itself confirmed that the **racial demographic is unknown**

c) Using **surname as proxy** for race appears to be the only logical way of attempting to reach some form of indication

Methodology Used

The methodology used however is insufficient for purposes of reaching factually accurate conclusions for purposes of this investigation:

Juristic entities

- Payment demographic of Medscheme includes many juristic entities that have no racial identity. Pharmacies; hospitals; pathology labs; nursing agencies; rehabilitation and step-down facilities; emergency services and even large group practices;
- It is Dr Kimmie's view that these organisations were defaulted to 'Non-black' to ensure any detected statistical bias is as conservative as possible;
- Medscheme however believes this significantly dilutes the underlying baseline population against which the racial allocation of FWA cases is compared;
- **Juristic entities should have been excluded** from the surname based racial classification prior to any comparative analysis;

Use of geographic information

- Annexure C to the Report "*Fiscella – Geo-coding and surname analysis*" recommends combining both sets of data to arrive at a more comprehensive results;
- Geographic location of practices were provided as part of our submission to the RFI.

Response to finding 1 – No explicit racial profiling

“There is no evidence of explicit racial profiling in the design or implementation of systems used to identify potential FWA cases by Medscheme.”

- Medscheme agrees with this finding

What about implicit racial bias?

The Report does however limit the Finding to '*explicit racial profiling*'.

By implication Medscheme still has an onus to prove that there is no implicit racial profiling or racial bias in our forensic work.

Implicit Bias: *"The unconscious attribution of particular qualities to a member of a certain social group."*

Sources of detection (pg 8 of Main Submission):

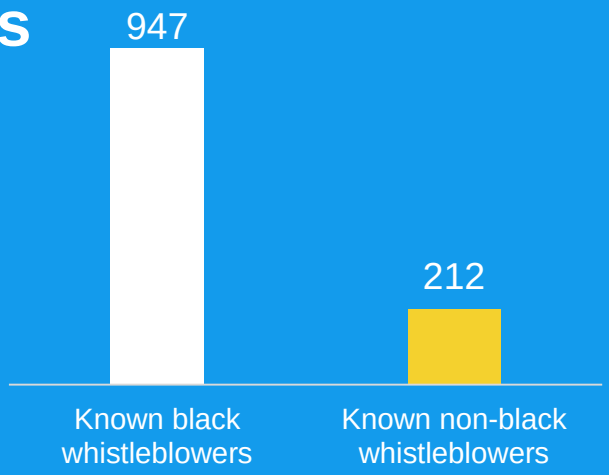
Compulsory *(tip-offs and external referrals)* vs Proactive *(analytics):*

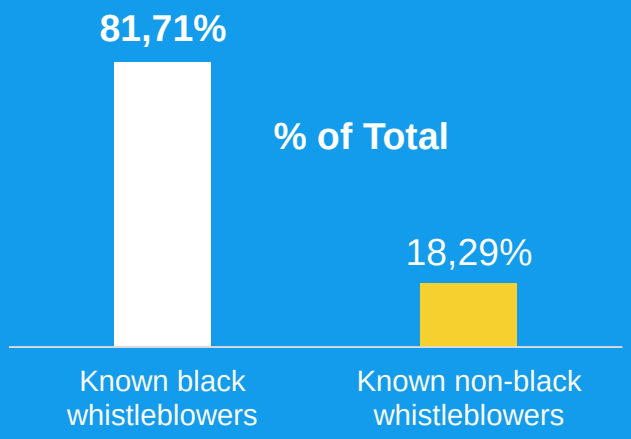
FWA Identification Method	***Proportion Identified***
Proactive analytical detection	*47%*
Tip-offs and referrals	*53%*

53% of all cases with forensic findings originated independently and Medscheme have no influence or control over their source. There is no possibility of implicit racial profiling by Medscheme Forensics in these in these cases.

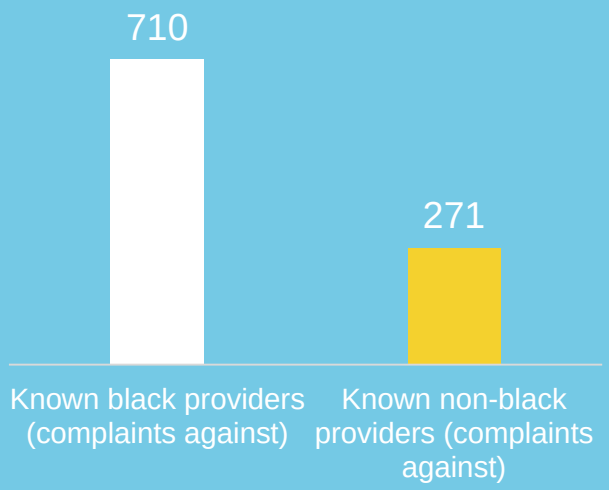
Whistleblowing statistics

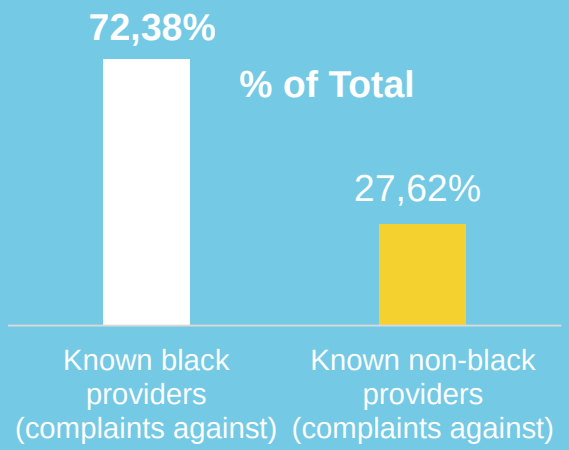
Whistleblowers





Providers
with whistleblower complaints





No evidence of implicit racial bias

The most fair and objective way of measuring whether implicit bias exists in the remaining cases identified proactively, would be to compare those racial outcomes against the racial outcomes of the compulsory cases, using the same classification assigned in the Report.

Medscheme have taken the liberty of performing such analysis with the following outcomes *(the R outputs are included in our written response)*:

- Removing the compulsory FWA investigation cases (whistle-blower and industry referral) reduced the risk ratio from **3.29 to 2.99**.
- Running only for compulsory FWA investigation cases (whistle-blower and industry referral); the risk ratio increased from **3.29 to 3.74**.
- The statistical racial bias is proportionately higher in the compulsory FWA cases over which Medscheme have no explicit or implicit influence.

Based on the inherent neutrality of the compulsory cases, one can factually conclude that the cases identified proactively through data analysis display no empirical evidence of disproportionality based on race when compared to the independent baseline.

Other factors reducing potential implicit racial bias

Medscheme is Level 1 B-BBEE – Shareholders / Board / Management / Staff is racially diverse with no one particular race dominant in the formulation or execution of Company policies; procedures; contracted services and core values

The Medscheme Forensic team is racially diverse with **over 72% of the 51 employees being 'Black'**. During the expert testimony of Professor Melissa Steyn on 'Critical Race Theory' presented on 18 October 2019, Prof Steyn mentions the United Nations Report titled *"Preventing and Countering Racial Profiling of People of African Descent – Good Practices and Challenges"*. One of the recommendations made in the UN report *(paragraph 47 page 29)* to assist Law Enforcement Agencies in avoiding potential implicit racial profiling is the following: *"Agencies should also develop recruitment and retention strategies that promote a diverse workforce reflective of the populations they serve."* The racial demographic of the forensic team mirrors this control

Medscheme uses predictive analytics software **developed outside of South Africa and deployed internationally**. The mathematical algorithms are not designed by Medscheme and we do not exercise any influence or control over the risk scoring outputs.

All these factors further reduces the potential for implicit racial bias to occur within the detection and investigation of healthcare fraud, waste or abuse.

Response to Finding 2 – statistically bias outcomes

"There is clear and strong evidence of racial bias with respect to the outcomes of FWA processes as implemented by Medscheme"

- Medscheme finds the analysis incomplete and lacking in certain critical data that would arrive at a more accurate result
- The proportionality utilized to determine '…higher than expected rate…' requires greater precision and consideration of context
- Without the application of risk adjustment factors, applicable to the specific baseline population under review, one cannot deduce whether the results indeed indicate statistical bias

Proportionality (higher than expected rate)

The testimony of Adv Trengrove SC indicated that for discrimination to exist, the outcomes of an administrative action or process must disproportionately impact one race or ethnic group over another

The challenge with the analysis performed in the Report is that the objective criteria for 'proportionality' is not established. For statistical bias to occur, the '*quantitative parameter'* upon which the FWA outcomes are to be measured must be clearly defined

Good fraud risk management is guided by the relevant risk exposure (operational; financial; reputational) to the medical scheme. FWA outcomes are never by chance, but always based on the specific conduct of the individual or entity under investigation

Therefore from a forensic perspective, cases should be proportionate to the relevant risk exposure to the medical schemes, whilst from the perspective of the Report, cases should reflect proportionately only to the number of practitioners paid

Proportionality (higher than expected rate) cont..

A practitioner who has only submitted 1 claim in the past 5 years is a significantly smaller risk than a practitioner who submits 100 claims a day. If one practitioner was Pink, and the other Blue, you cannot expect the likelihood of a forensic investigation to be proportionately equal to either colour at 50%. The expected fair proportion must be adjusted for the particular risk exposure (risk adjustment).

Only once proportionality is accurately defined can any form of statistical bias or disproportionality be determined

Risk adjustment

COST and UTILISATION are key factors when assessing risk exposure

The more claims a scheme receives from a practice, the higher the utilisation factor
The more a practice charges for its services, the higher the cost factor.

When either or both of these factors unexpectedly increase, the associated risk exposure is directly proportional to the increase. Unjustified utilisation is deemed *over-servicing* and unjustified costs is deemed *over-charging*.

Utilisation and Cost of a practice is determined by many internal and external factors specific to that practice, for example:

- Membership demographic of the scheme members they render services to;
- Geographic location;
- Size of the practice;
- Availability of similar skills, services and products;
- Relationship with a medical scheme (network, DSP, direct payment);
- Nature and necessity of services or product;
- Quality of services rendered;
- Degree of ethical behaviour employed by the practice.

Example 1 – Utilisation risk

Findings of Report in respect of disciplines with high statistical bias:

	Providers			Risk				
	N	FWA	Black	All	Black	Not Black	RR	p-value
Social Worker	1,249	147	641	11.8	20.4	2.6	7.77	4e-21
Psychologist	4,740	137	1,010	2.9	8.1	1.5	5.51	3e-27
Registered Counsellor	690	134	293	19.4	32.8	9.6	3.42	4e-13

Once basic Utilisation figures are applied (number of claim lines):

Row Labels	No. of Claim Lines	% Split	Practice type
81	**241100**		
2017	**125483**	**100,0%**	
Black	90409	72,0%	
Not Black	35074	28,0%	
2018	**115617**	**100,0%**	
Black	88440	76,5%	
Not Black	27177	23,5%	*Registered Councellors
86	**1283905**		
2017	**631175**	**100,0%**	
Black	257359	40,8%	
Not Black	373816	59,2%	
2018	**652730**	**100,0%**	
Black	259320	39,7%	
Not Black	393410	60,3%	*Psychologists
89	**325493**		
2017	**154734**	**100,0%**	
Black	113369	73,3%	
Not Black	41365	26,7%	
2018	**170759**	**100,0%**	
Black	125532	73,5%	
Not Black	45227	26,5%	*Social Workers

Example 1 – Utilisation risk

	Assumed 'Black' Risk Proportion in Report	Assumed 'Black' Risk Proportion - Utilisation	Percentage increase in Risk Proportion
Social workers	51%	73%	22%
Psychologists	21%	40%	19%
Registered Counsellors	42%	74%	32%

The difference in proportion percentages once risk adjusted for claim volumes is statistically significant and material. The risk exposure and likelihood of detection is much higher the more claims a practice submits.

Example 2 – Cost risk

Applying basic Cost adjustment (amount paid per practice):

Row Labels	Value of claims		% Split	Practice Type
81	**R**	**129 726 949**		*Registered Councellors
2017	**R**	**65 926 021**	**100,00%**	
Black	R	48 652 874	73,80%	
Not Black	R	17 273 147	26,20%	
2018	**R**	**63 800 929**	**100,00%**	
Black	R	48 845 572	76,56%	
Not Black	R	14 955 357	23,44%	
86	**R**	**973 032 466**		*Psychologists
2017	**R**	**470 742 989**	**100,00%**	
Black	R	222 899 607	47,35%	
Not Black	R	247 843 383	52,65%	
2018	**R**	**502 289 477**	**100,00%**	
Black	R	229 091 381	45,61%	
Not Black	R	273 198 096	54,39%	
89	**R**	**168 001 653**		*Social Workers
2017	**R**	**74 999 035**	**100,00%**	
Black	R	60 356 277	80,48%	
Not Black	R	14 642 758	19,52%	
2018	**R**	**93 002 618**	**100,00%**	
Black	R	74 309 497	79,90%	
Not Black	R	18 693 121	20,10%	

Example 2 – Cost risk

	Assumed 'Black' Risk Proportion in Report	Assumed 'Black' Risk Proportion - Utilisation	Percentage increase in Risk Proportion
Social workers	51%	80%	29%
Psychologists	21%	46%	25%
Registered Counsellors	42%	75%	33%

The difference in proportion percentages once risk adjusted for claim values is statistically significant and material. The risk exposure and likelihood of detection is much higher when the value of the claims submitted by a practice increases.

Critical observations from examples

1. The above ratios are calculated using the Report's own surname based race classification, which defaulted 'Unknowns' to 'Non-Black'. There is a strong possibility that the number of 'Black' providers who actually claimed from Medscheme in the data set is higher, thereby directly increasing both cost and utilisation percentages;

2. In line with the observation in point 1, none of the calculations in Example 1 or 2 change the allocated race classification of FWA cases. Therefore for purposes of calculating the Risk Ratio as utilised in the Report, the proportion of 'Black' providers will go up significantly as the baseline denominator, but the FWA numerator will remain exactly the same. What this practically means is that once a specific risk adjustment factor is applied, the Risk Ratio will decrease radically. The more factors applied, statistically the reduction in Risk Ratio will occur in multiples;

3. Amongst those 3 disciplines alone, Medscheme paid those **6,679 providers** over **R1.2 billion** and processed over **1.7 million claim lines** over a 2 year period. This is why claims are paid in good faith and only analysed retrospectively for irregular patterns.

Example 3 – Subjectivity of assigning surname

"*Among **Pharmacies** the lack of name data results in the default classification of Not Black being applied in more than 80% of cases. Even with this default categorisation those Pharmacies classified Black were almost three times more likely to be identified as FWA cases*."

Using the same race classification from the data, and applying the total paid to those practices, this was the result:

Row Labels	Total claim lines	% Split		Value of claims	Percentage Split	Practice Type
60	**80784125**		**R**	**18 037 030 991**		*Pharmacies
2017	**38926791**	**100,0%**	**R**	**8 729 293 251**	**100,00%**	
Black	1346324	3,5%	R	264 268 378	3,03%	
Not Black	37580467	96,5%	R	8 465 024 873	96,97%	
2018	**41857334**	**100,0%**	**R**	**9 307 737 740**	**100,00%**	
Black	1857969	4,4%	R	333 305 785	3,58%	
Not Black	39999365	95,6%	R	8 974 431 955	96,42%	

As all 'Unknown' entities were defaulted to 'White', in the pharmacy race classification it reflects that approximately only 3% - 4% of claims received and their corresponding financial value (R600 million out of R18 billion) were from 'Black' pharmacies. This can never be the case and shows the inherent subjectivity of attempting to use surname as a proxy for race.

The baseline denominator would be inaccurately low, thereby unfairly reflecting a Risk Ratio that is completely wrong.

Conclusions

Finding 1

There is no evidence of either explicit or implicit racial bias and/or racial profiling in the design or implementation of forensic work conducted by Medscheme.

Conclusion to Finding 2

1) The finding that there is significant and consistent statistical racial bias in the outcome of FWA cases conducted by Medscheme Forensics is not conclusive based solely on the analysis performed in the Report. The Report is neither correct nor incorrect, but merely incomplete. Without proper risk adjustment based on comprehensive datasets combined with an evidence-based and accurate baseline comparison against which a dis/proportionate outcome (or "…*higher than expected rate*…") can be measured, Finding 2 cannot be accepted in its current form. It will take a much deeper and more thorough analysis to properly determine whether the outcomes of FWA cases disproportionately impact one race of healthcare practitioners more than another.

Conclusions (continued)

2) Even if one were to assume that Finding 2 is sufficiently accurate and indicative of statistical racial bias in FWA outcomes, the outcome is not as a result of Medscheme's FWA processes;

3) To determine the root causes of any potential statistical racial bias in FWA outcomes, one would have to perform a much wider and in-depth academic study, taking into account multiple external factors that may influence such outcome. The socio-economic circumstances of a practice or its patient base may for example play a noteworthy role.

Conclusions

Dr Lungi Nyathi
Executive Director: Healthcare Management

Summary

All claims are paid in good faith.

The sustainability of our healthcare industry is fundamental.

Schemes and administrators have a fiduciary responsibility to protect member funds

FWA findings involve less than 2% of providers.

FWA has a material impact on members.

Medscheme does not racially profile providers.

Recommendations

Preventative measures

- Expand practitioner training and engagement
- Implement HMI findings:
  - Platform for fee and coding discussions
  - Building blocks for Supply-Side Regulator
  - Moving away from Fee-for-Service to risk sharing models
- Expanded use of technology to verify services

Improved collaboration

- Participation on CMS FWA work streams and Summit:
  - Finalise Code of Good Practice
- Focus on SIU healthcare sector anti-corruption forum
- Collaboration with Office of Health Standards Compliance