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SUBMISSION

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AMA submission to proposed amendments to Health legislation to improve Medicare integrity

Consultation closes 7 Mar 2025

Via APH: upload

Introduction

The Australian Medical Association (AMA) appreciates the opportunity to comment on the proposed Health Legislation Amendment (Improved Medicare Integrity and Other Measures) Bill 2025 (the Bill) referred to the Community Affairs Legislation Committee.

This submission comments specifically on the provisions relating to proposed amendments to the *Health Insurance Act 1973* (the Act) to improve Medicare integrity. Furthermore, the AMA acknowledges the broad and multifaceted changes contained within the proposed amendments and will restrict our input to those changes concerning Medicare Benefits Schedule (MBS) compliance and integrity specifically.

The AMA supports greater vigilance against the potential for, and incidences of, genuine fraud occurring in the claims system. We have been very clear in our communications about not tolerating fraud, and in supporting the role of doctors in the stewardship of healthcare resources. We draw a careful distinction here between deliberate fraud and inadvertent non-compliant MBS billing. As the Philip Review highlighted, "a significant part of the leakage in the Medicare payment system stems from non-compliance errors rather than premeditated fraud."[1] Where fraud does occur, medical practitioners are sometimes themselves victims, such as when their Medicare provider number is used by the perpetrator without the medical practitioner's knowledge or consent.

The AMA emphasises the importance of maintaining a clear legislative demarcation in the powers conferred on each regulatory body engaged in governing practitioner use of the MBS having regard to their distinct and complementary roles.

We acknowledge the Department of Health and Aged Care's (the department) willingness to engage with the AMA in managing MBS compliance issues and more recently in their efforts to identify and

[1] Philip (2023), Independent Review of Medicare Integrity and Compliance. Page 5.

address fraud. As such, we support the intentions of this Bill. Some of the proposed changes are reasonably straightforward, such as reducing the timeframe for making Medicare claims (from two years to one year). The AMA considers this a reasonable measure to minimise incorrect and fraudulent claims and enable recourse, when necessary, within a more appropriate timeframe.

However, we have some concerns with aspects of the current drafting which may have unintended outcomes. The provisions that we have concerns about were not specifically recommended by the Philip Review. They were added to the Bill on 5 February 2025 and passed by the House of Representatives on the same day. Accordingly, there has been very limited opportunity to comment on them.

It is essential all proposed legislative changes achieve the balance intended to resolve cases of Medicare integrity without constituting an overreach of delegated and complementary authority.

Proposed changes

Investigative powers

The proposed amendments aim to broaden and update investigative powers to ensure consistent and effective use across health benefits schemes and include additional offences under the Criminal Code such as money laundering, forgery, and identity fraud.

Coercive powers to search premises and seize data can significantly impact an individual's privacy. The AMA acknowledges the Bill intends to balance additional powers with appropriate safeguards, including restrictions on when warrants may be issued and guidelines regarding officer conduct.

However, the AMA is concerned this balance has not been achieved and requires further evaluation. The amendments support the extension of investigatory powers without providing sufficient limitations to the circumstances and persons to which collected evidence may be employed. It is essential these powers should only be exercised when Chief Executive Medicare has formed a strong view noncompliance or fraud may have occurred, with strict application within the scope of that individual case.

New section 129AACA (Notice to give information etc. relevant to Act administration)

Currently Chief Executive Medicare has the power to require providers to produce documents where they:

- have a reasonable concern that an amount should not have been paid; and
- have taken into account advice given from a medical practitioner employed by the department about the types of documents that may be relevant.

New section 129AACA gives Chief Executive Medicare (or their delegate) the power to issue a written notice requiring any person to provide “relevant material” within a specified period (which must be at least 21 days). The term “relevant material” is very broad (emphasis added):

> *In this section, relevant material means information, a document or a thing that is relevant to the administration of this Act and* ***includes*** *information, a document or a thing that relates to:*
>
> *(a) compliance with a requirement under this Act or an instrument made under this Act; or*
>
> *(b) an amount paid under this Act; or*

(c) a person's entitlement to a benefit or payment under this Act.

Unlike the existing provision, there is no limit on who a notice can be given to. As drafted, the Chief Executive Medicare (or their delegate) can use this provision to obtain files from a doctor's medical defence organisation or lawyer. Unlike the existing provision, there is no prohibition on issuing notices to patients (cf section 129AAD(8)). The only requirement is that the Chief Executive Medicare (or their delegate) reasonably believes that the person has the information. Unlike a warrant or subpoena, there is no requirement for the Chief Executive Medicare (or their delegate) to explain (or even consider) why they need or want the information.

Failure to comply is a strict liability offence with a maximum penalty of 30 penalty units (around $10,000) for an individual and 150 penalty units (around $50,000) for a corporation (section 129AACB). Most medical practitioners and hospitals operate via corporations. Legal professional privilege and the privilege against self-incrimination are not defences.

We understand this power is intended to improve the department's ability to obtain information about potential fraud and support cost-recovery essential to protect the MBS system's sustainability. The material obtained will invariably include personal information, such as records of treatment, correspondence with providers, clinical records, and billing records.

The Revised EM (page 90) acknowledges that, because disclosure is required by law, new section 129AACA will override the obligations that doctors and hospitals would otherwise have under the Privacy Act to maintain patient privacy. We appreciate that:

- Section 129AACA(1) provides that if the relevant material contains clinical details relating to an individual, the notice must nominate a specified APS employee within the department who is a medical practitioner.
- Statutory secrecy provisions will continue to apply to the information collected by the department.

However, we also expect the department to put in place processes to ensure this power is used appropriately, and that medical practitioners, hospitals, patients, and MDOs are not directed to produce personal information unless the department believes that the information is relevant to an investigation. In introducing this amendment, the government relevantly stated (Hansard, 5 February 2025, page 89) that:

> *These amendments insert additional integrity measures into the bill, which also implement the findings of the Philip review into Medicare integrity. They make several changes to the Health Insurance Act 1973. They improve existing powers to obtain information about potential fraud and noncompliance and enable the recovery of amounts if they should not have been paid…*
>
> *These changes will enable appropriate inquiries to be made about Medicare payments if available information suggests potential noncompliance or fraud. If payments are found to be incorrect, amounts could be recovered…*

The Philip Review did not recommend any specific amendments to this provision.

Section 129AACA is not limited to circumstances where Chief Executive Medicare has formed a view that there has or may have been a potential noncompliance or fraud. As drafted, Chief Executive Medicare (or their delegate) need only reasonably suspect that the person has documents relevant to

the administration of the Act. Unless they do not participate in the MBS (which is rare), all medical practitioners, all hospitals, all health funds and all patients have information relevant to the administration of the Act. Therefore, as currently drafted, Chief Executive Medicare (or their delegate) could directly or indirectly require production of the clinical records of every Australian.

Amendments to section 106ZPQ(2)

Under subsections 89B(2) and 105A(2), any person may be required to produce documents relevant to:

- the director of PSR's review of the provision of services by a person; or
- the referral made to the committee,

within the period stated in the notice (which must be at least 14 days).

Failure by a person (other than a person under review (PUR)) to comply is an offence with a maximum penalty of 30 penalty units (around $10,000) for an individual and 150 penalty units (around $50,000) for a corporation (section 106ZPN). Most medical practitioners and hospitals operate via corporations. A PUR who is a practitioner (i.e. an individual) can refuse to comply but will be disqualified from further participation in the MBS (section 106ZPM).

Existing subsection 106ZPQ(1) states that a person cannot refuse to produce documents on the grounds that it may incriminate them. This expressly overrides any common law privilege against self-incrimination. For example, the documents may provide evidence that the person has done something (or failed to do something) which was:

- contrary to their Medicare obligations under the Act; or
- may result in them being struck off or disciplined by the Medical Board; or
- negligent; or
- defamatory; or
- a breach of contract or consumer laws; or
- criminal.

Existing subsection 106ZPQ(2) balances this by providing that documents that are compulsorily produced under subsection 106ZPQ(1) are:

> *not admissible in evidence against the person in:*
>
> *(a) any criminal proceedings other than proceedings for an offence against section 106ZPP (False or misleading documents); or*
>
> *(b) any civil proceedings other than proceedings before a Committee or the Determining Authority.*

However, the proposed amendments to subsection 106ZPQ(2) expand the circumstances in which such material can be admitted as evidence to include:

- proceedings for an offence against subsection 106ZPN(1) (failing to produce documents or give information);
- proceedings to recover an amount that is: (i) recoverable under this Part as a debt due to the Commonwealth; or (ii) otherwise required by or under this Part to be repaid to the Commonwealth; and

- any other proceedings in relation to compliance with a requirement in Part VAA (sections 79A to 106ZR).

Moreover, new subsections 106ZPQ(3) and (4) allows the information (or further information generated as a result of that information) to be used in any proceedings brought by Ahpra or the Medical Board under National Law where information has been passed on by the director under subsection 106XA(2) or 106XB(2). Subsection 106XA(2) relates to "a significant threat to the life or health of any other person". Subsection 106XB(2) is any failure to comply with professional standards. For example, it could be poor record keeping or being rude to a patient or another staff member. There is no requirement that the non-compliance be substantial or life threatening.

These changes substantially expand the circumstances in which a person (other than an individual PUR) can be compulsorily required to produce the evidence that is used to convict them or otherwise pursue them. This includes scenarios where a person provides information requested as part of proceedings against someone else. For example, a GP cannot refuse to produce information requested by PSR (as part of a case against a non-GP specialist) on the basis that the information may be used in a case against the GP. In short, the GP does not have the right to remain silent.

This is another instance where a careful balance must be struck. The imposed limits to these privileges must be necessary and demonstrate proportionality in maintaining both the integrity of the MBS system and ensuring patient safety.

In introducing this amendment, the government relevantly stated (Hansard, 5 February 2025, page 89):

> *Further changes will remove some restrictions on the admission of information obtained under the Professional Services Review agency's notice to produce powers as evidence in proceedings, including proceedings under the Health Practitioner Regulation National Law. The existing restrictions will no longer apply in respect of prosecutions related to a failure to produce documents, proceedings to recover debts relating to the Professional Services Review scheme and some other proceedings relating to noncompliance. The restrictions will also not apply in respect of documents produced to PSR under notice and passed on to the Australian Health Practitioner Regulation Agency, AHPRA, or a national board under certain provisions in the Health Insurance Act or information obtained or generated by AHPRA or a national board from its own investigation triggered by documents produced to PSR under notice. This will enable AHPRA and associated health practitioner boards to use PSR related material to trigger their own investigation into allegations involving risks to patient safety. This will also allow AHPRA and health practitioner boards to admit evidence in national law proceedings if it was referred to them under the legislation for the reasons of a significant threat to life or health or noncompliance with professional standards. These changes are required to ensure all appropriate steps are taken to protect patient safety and that the existing requirement to refer the information to AHPRA and health practitioner boards is not frustrated.*

As noted above, the changes are not limited to scenarios of patient safety. Where it is determined the clinical practice or other behaviours of a PUR under investigation for MBS non-compliance poses a threat to the public, the AMA agrees the PSR can and should share this information with Ahpra. This is already provided for in section 106XA. However, the changes go beyond this and expand Ahpra's ability to use information compulsorily provided by the PUR to take action against them.

We note these amendments will only apply to proceedings instituted on or after commencement of the amended Bill. The Revised EM argues (page 23) that:

> *In addition, the amendments will only apply to permit the admission of the relevant information as evidence in criminal or civil proceedings instituted on or after commencement. This is another safeguard to ensure that people providing information in response to notices under subsection 89B(2) or 105A(2) will be aware of the circumstances in which the information can be used.*

However, the AMA is concerned Sections 89B and 105A contain no requirement for the department to warn people the information they disclose may be used in this way. Moreover, if a person (other than an individual PUR) chooses not to disclose information (on the basis that it may be used in subsequent proceedings) they will be committing an offence. Unlike an encounter with the police (where a person is warned of the consequences of waiving their right to remain silent), in this case the person will be fined $10,000 or $50,000 if they "choose" to remain silent.

We emphasise the impacts of these legislative changes in practice will extend well beyond the policy intent. If these changes are upheld, it will be absolutely necessary to monitor how the new legislated requirements interact with existing principles and overlapping spheres of authority to ensure practitioner integrity is truly balanced with that of the MBS system.

Recovery of overpayments

The AMA also has some concerns regarding amendments to section 129AAK of the Act, which introduce new powers for the department to recover overpayments, complementary to existing powers under s129AC and 129AD. Unlike existing sections 129AC and 129AD, there is:

- no ability for a shared debt determination;
- no requirement to prove any wrongdoing by the practitioner; and
- no requirement to prove that the practitioner received any of the money.

The only requirement is that an amount was paid that should not have been paid. While section 129AAK will be subject to internal review, an entirely innocent practitioner is unlikely to succeed on review if they cannot demonstrate that the amount was validly paid.

The Revised EM states (on page 93) that (emphasis added):

> *Under those provisions, an amount could be recovered from a practitioner (that is, the person who rendered the service, **or is identified in the claim as having done so**) where Medicare benefit was not payable because:*
>
> - *the requirements under the Health Insurance Act in relation to the practitioner, the service, or the rendering of the service were not met;*
> - *a contract between the practitioner and the Commonwealth was breached; or*
> - *the practitioner was disqualified at the time of the service.*
>
> *This recognises that many requirements in the Health Insurance Act in relation to the entitlement for a Medicare benefit are dependent on compliance by the person who renders the service. Where a practitioner has not complied with relevant legislative requirements, it is **arguable that** the practitioner's conduct is the reason for which the Medicare benefit was not payable and it would be unfair for the eligible person to be left out-of-pocket as a result. Further, recovering the amount from*

*the practitioner **may be justified** in circumstances where the practitioner indirectly benefits from the payment of the Medicare benefit, through the payment of fees for service.*

Many of these scenarios are reasonable. The AMA agrees, in cases where the practitioner is responsible for the non-compliance, it is fair to recover the amount from the practitioner and prevent the eligible patient from being left out of pocket. By extension, the Commonwealth's scope to recover unauthorised payments should exclude no one.

The AMA is concerned about the ability to recover from a practitioner (or their estate) purely on the basis that they were identified in the claim form as having rendered the service.

The practitioner named on the claim form may be an employee who has left the medical practice or could be the victim of a fraud (e.g. by non-clinical staff member of the practice or a hacker). For these circumstances, it is important the legislation allows and supports every effort to clarify whether the owner of the provider number associated with an instance of fraud was in fact the beneficiary of the overpayment.

In cases of genuine fraud, this expansion to the department's powers to recover overpayments under the Act must also be construed as an initial step that may lead to further legal investigation. If at any stage of implementation the legislative changes do not operate according to this distinction, they should again be brought under review to protect both patients and practitioners.