Australian Government
Department of Human Services

The Secretary
Joint Committee of Public Accounts and Audit
Suite R1.108
Parliament House
CANBERRA ACT 2600

Dear Secretary

Further to your letter of 23 September 2014 regarding the response to JCPAA Report 445 – recommendations 5, 6 and 7 to Department of Human Services, please find attached the department's response to those recommendations.

If you wish to discuss this further, please contact Kerryn Vine-Camp, General Manager, Debt, Appeals and Health Compliance on 02 61331057 or by email at kerryn.vine-camp@humanservices.gov.au.

Yours sincerely

Barry Sandison
Deputy Secretary
Health, Compliance and Information

19 March 2015

EXECUTIVE MINUTE

on

JOINT COMMITTEE OF PUBLIC ACCOUNTS AND AUDIT

REPORT No. 445

Regional Cities Program, KPIs and Medicare
Chapter 4 – Medicare Compliance Audits

General Comments

The Joint Committee of Public Accounts and Audit (the Committee) and the Australian National Audit Office (ANAO) Audit reports into Medicare Compliance Audits and the Integrity of Medicare Customer Data are significant to the department. They have set clear direction on a number of specific changes to business processes to strengthen government performance measurement and reporting, and provided opportunity for the department to review current administrative methodologies and approaches.

Progress Report on Key Recommendations

Recommendation No. 5 **paragraph 4.41**

The Committee recommends that the Department of Human Services report to the Committee, no later than six months after the tabling of this report, on its progress towards implementing the Auditor-General's recommendation that it develop a methodology to monitor outcomes and report on the effectiveness of Medicare compliance audits. The report should include any decisions or other progress made in regard to measuring savings from behavioural change.

Greater focus on governance

The key focus of the department's health payments compliance programme is to protect the payment integrity of the Medicare programme (which includes payments under the MBS, the PBS and all other health related programmes and incentives). Since the tabling of the ANAO report, the department has revised the governance, and reporting arrangements to government of its compliance programme, including redefining key activities in relation to performance measurement where audits and reviews are exclusive of general education and targeted feedback letters. These changes took effect from 1 July 2014 and address several concerns raised by the ANAO. Under these new arrangements the department completed 3,979 audits in 2013-14 of which 2,873 where MBS specific. As at end January 2015 the department has undertaken 2,219 audit activities of which 1,767 are MBS specific.

Greater performance monitoring

The department is working to codify the principles of an outcomes reporting framework for Medicare compliance activities. The framework details an agreed set of robust methodologies to calculate direct savings (debts raised) and indirect savings (from behavioural change). An accompanying evaluation strategy will be finalised by end June 2015. Other aspects of integrity such as accuracy and quality as well as assessing compliance activities against their original objectives will be covered by the evaluation strategy.

With the implementation of the *2008-09 Increased Medicare Compliance Audits* (IMCA) measure, government expected an average of approximately $37 million in savings per year (combining the value of debts raised from compliance activities of $6.5 million and resultant behavioural change of $30.3 million).

The department's performance in direct savings (debts raised) has been steadily improving since the conduct of the ANAO audit. As at 31 December 2014 total debts raised from MBS compliance activities specifically targeted at health professionals, excluding, Chronic Disease Dental Scheme (CDDS) and the Child Dental Benefits Schedule (CDBS) is approximately $3.4 million.

In relation to behavioural change, the department has validated a sub-set of previous compliance activities against relevant methodologies to measure their effectiveness. Preliminary analysis from general compliance audits conducted in the 2013-14 financial year demonstrates the department has met this behavioural change target of $30.3 million. Performance of other health compliance activities are also being assessed and show similar strong results of improved performance with compliance activities influencing and changing behaviour.

External validation of these methodologies and associated analysis will be completed by the end of the 2014-15 financial year. Feedback from the external review will allow the department to further improve its compliance activities and the associated monitoring of outcomes.

The department is working with the Department of Health to establish a formal reporting mechanism by the end of the 2015-16 financial year to ensure accountability back to the policy department.

Recommendation No. 6 **paragraph 4.43**

The Committee recommends that the Department of Human Services undertake a cost-benefit analysis of its Medicare compliance activities to ensure more effective targeting of significant compliance risks to the Medicare program and increase the cost effectiveness of its compliance approach.

Greater targeting of resources and increasing cost effectiveness

The department has improved its risk identification and risk prioritisation business processes to more effectively target significant compliance risks, through the introduction of improved risk pre-assessment processes, introduction of systemic reviews, and strengthened governance to review new and emerging risks. This change took effect from 1 July 2014.

The 2014-15 work programme focuses on targeted high risks and work continues on areas where further analysis is needed to fully understand the nature of other risks. The following eight priority work areas have been identified this financial year: Child Dental Benefits Schedule, Health Support Programmes, Diagnostic Imaging, Pathology, Specialists, General Practitioners, Public Fraud – Medicare, and the Pharmaceutical Benefits Scheme. The analytical work will continue to grow departmental expertise in this area and provide opportunity to identify changes in claiming activity.

Each priority work area can have multiple elements that are of concern which in turn will result in additional sub-risks being identified and targeted as appropriate. Having targeted treatment strategies to address risks is a key component of the department's overall compliance approach and assists with allowing the sharing of learnings from each compliance intervention and the more effective targeting of resources.

The department is also exploring the further use of alternative treatment mechanisms to improve the efficiency and effectiveness of compliance activities. Trials using behavioural insights techniques will commence by end June 2015 to increase health professional and public awareness of compliance and legislative obligations.

Being able to target high risk areas and choose from a range of treatment options ensures that the department is maximising the return on the government's investment in the compliance programme. The department is confident that it will be able to demonstrate that the direct and indirect return to government from its 2014-15 work programme will exceed the cost of the compliance activities.

Greater data analysis

The department is proactively engaging with a diverse range of stakeholders, particularly in the private health industry to investigate practices to identify a more mature, enterprise level approach, to addressing fraud and non-compliance. Specifically the department is consulting with Private Health Australia and individual private health insurers. A key achievement in this was in April 2014 the establishment of an ongoing relationship with an industry leader in data analysis.

These consultations have identified that industry best practice is using enterprise approach to fraud detection and prevention. This approach uses a range of sophisticated modelling techniques that apply algorithms or analytics rules to large data sets to instantaneously provide business intelligence at the claim, provider, business entity and network level. Such systems identify outliers or variants in claiming patterns and/or relationships and include predictive modelling to identify new or emerging risks or trends.

To maximise the value of this activity, the department is trialling these various approaches across its work programme and introducing measurement techniques to ensure that outcomes are accurately stated. This activity will bring together all elements of the work underway to improve the efficiency and effectiveness of the department's health compliance activities and is expected to be completed by 2015-16. It will also be influenced by broader research.

Examples of the above are trials being conducted on:

- software and claims analytics platforms using a sub-set of rules to identify risk through anomalous claiming patterns.
- alternative software and claims analytics tools and platforms used by the financial sector domestically and internationally.

Results from these trials has matured the department's considerations and led to additional trials and analysis which is ongoing.

The outcomes of this work will provide the department with significantly improved data analysis capacity, leading to better case selection for treatment and further improved returns to government.

Greater efficiency in business processes

The department will complete an independent assessment of its compliance business processes, across all parts of the compliance workflow by end May 2015 Outcomes from this independent assessment will be implemented to ensure quicker completion of some current compliance activities, including automation of some processes. The findings will also help the department further improve its measurement of outcomes.

Summary

The specific changes outlined above demonstrate the department's progress in strengthening its performance measurement and reporting capability. Whilst this is a process of continuous change and enhancement, the improvements already achieved respond directly to the recommendations and key concerns expressed by the ANAO and the JCPAA with regard to Medicare compliance activities.

Recommendation No. 7 **paragraph 5.28**

The Committee recommends that the Department of Human Services report to the Committee, no later than six months after the tabling of this report, on its progress towards implementing the Auditor-General's recommendations in terms of undertaking targeted, risk-based data integrity testing of Medicare customer records; better managing duplicate and intertwined records; and reviewing existing entitlement types and implementing controls to ensure that only those customers eligible to receive Medicare benefits can access them.

Risk-based data integrity testing

The department has undertaken data integrity testing to further improve the completeness, accuracy and reliability of Medicare customer data. A suite of reports to support the detection and resolution of data integrity issues have been implemented and are being run on a monthly, biannual and annual basis.

To date, the department has conducted the following data integrity testing:

- Analysis of inactive Medicare customers over 90 years of age has been completed. 325,146 customers who have not claimed Medicare and have not had an eHealth record since September 2013 have had their Medicare record end dated. The department also confirmed that these customers had not had any interaction with other health programs administered by the department, including the Pharmaceutical Benefits Scheme (PBS) and Department of Veteran Affairs (DVA) programs since September 2013.
- Investigation of 54 customers with first name anomalies (for example, individuals with only one name or unusual first names) has been completed. All issues identified with these records have been resolved.
- A review of other integrity anomalies has been completed. This included 963 customers having the word 'baby' in their name. Of these records 960 have been verified as being correct with three records of concern awaiting a response from the parents.

- A review of 14,529 customers with eligibility periods exceeding policy parameters has been undertaken. As part of this review it was identified that existing policies and procedures needed amendment to include all periods of appeal, which has occurred, and this resulted in 14,371 records being appropriate. The remaining 158 customer records either had their entitlement updated or their record end-dated after their visa information was confirmed with the Department of Immigration and Border Protection.
- A further analysis project, examining inactive Medicare customers aged over 85 and under 90 years of age, will commence in June 2015.

Managing duplicate and intertwined records

The department has investigated the 18,000 possible duplicate records identified by the ANAO. 13,000 where confirmed as not being duplicates. The remaining records were confirmed as duplicates and were resolved by merging the duplicate records into one single customer record.

There is an ongoing programme of work to monitor and address possible duplicate Medicare customer records. This includes an automated ICT process that runs daily to assess customer records and flag possible duplicates for investigation. Flagged records are then assessed by a dedicated team and actioned further as required.

The department has been progressing work relating to intertwined Medicare customer records since June 2013. This work has focused on identifying, analysing, investigating and resolving records. Work has also been undertaken to understand the causes of why intertwined records occur and to develop mechanisms to mitigate the risk of future intertwined records being created.

Data mining experts were engaged by the department in May 2014 to proactively identify potential intertwined records in the Medicare consumer directory.

Since July 2014 an intertwined record referral form has been available to allow staff to escalate suspected intertwined records directly to a specialist team. This team is responsible for the management of all duplicate and intertwined cases through to resolution.

In September 2014 Medicare staff have been provided with updated training and reference material. The training outlined the department's approach to managing intertwined customer records and was designed to reinforce staff awareness on the prevention of intertwined records.

System enhancements were implemented in September 2014 to highlight and contain possible intertwined records in the Medicare consumer directory during investigation.

As at 8 February 2015, there were 307 cases of potentially intertwined Medicare customer records out of approximately 24 million consumers enrolled in Medicare. Of these:

- 170 cases have been closed which comprised 81 cases confirmed as not intertwined and 89 cases of confirmed intertwined records.
- 137 known possible cases remain outstanding.

The resolution of intertwined records is a complex and time consuming manual process. Resolving cases of intertwined records requires methodical and careful investigation. Older cases of intertwined records will take some time to resolve. There will need to be an ongoing programme of work to continue to identify and manage intertwined records. Data integrity

activities undertaken by the department will continue to be refined over time and minimise the occurrence of intertwined records occurring.

A working group was established in early 2014 to oversee resolution and improved management practices related to duplicate and intertwined records.

Reviewing existing entitlement types and implementing controls

The department has undertaken a review of Medicare entitlement types based on feedback from the ANAO of possible errors. Medicare entitlement types that are no longer current have been removed from drop down selection menus within enrolment screens. Where appropriate, business rules have been amended and descriptions improved.

Business rules for all Medicare entitlement types have been reviewed. The department is strengthening the accuracy of the enrolment procedure by implementing additional system checks to assist staff when selecting eligibility and residency documentation.

Staff reference and training material that supports the Medicare enrolment process, including eligibility and residency documentation required for each Medicare entitlement type, is continuing to be reviewed and updated. As at 16 February 2015, 72 per cent of relevant staff guidance material has been reviewed, updated, consolidated or deleted. Additional resources have been allocated to this task and the review of the remaining reference documentation is expected to be completed by March 2015. eLearning training material will be reviewed once the relevant eReference guidance material has been updated with an expected completion date of June 2015.