Australian Government
Department of Health and Ageing

DEPUTY SECRETARY

Mr Elton Humphery
Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Mr Humphery

Inquiry into Compliance Audits on Medicare Benefits

I refer to your letter of 25 March 2009 inviting the Secretary of the Department of Health and Ageing, Ms Jane Halton PSM to provide a written submission to the Committee on issues which may be of relevance to the above Inquiry.

On 23 April 2009, Mr Tony Kingdon, First Assistant Secretary, Medical Benefits Division sought an extension for the lodgement of the Department of Health and Ageing's (DoHA's) submission.

Attached is DoHA's submission in response to your invitation. It should be read in conjunction with:

- the Exposure Draft for the Health Insurance Amendment (Compliance) Bill 2009 (Attachment A) and the accompanying explanatory material (Attachment B) together with;
- the Privacy Impact Assessment (Attachment C) and the information sheets distributed to stakeholders (Attachment D).

I look forward to meeting with the Committee at the Hearing for the Inquiry this Wednesday, 6 May 2009.

Should you have any queries, please do not hesitate to contact Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Branch on (02) 6289 6945 or email samantha.robertson@health.gov.au

Yours sincerely

David Learmonth
Deputy Secretary
4 May 2009

MDP 84 GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 4288 Facsimile: (02) 6285 1994

Australian Government

Department of Health and Ageing

Submission to the

Senate Community Affairs Committee

for the

Inquiry into Compliance Audits on Medicare Benefits

---

1. Introduction

On 19 March 2009, the following matter was referred to the Community Affairs Committee for inquiry and report by 15 May 2009:

> *Any Government proposal to implement the Government's announced 2008-09 Budget measure to increase compliance audits on Medicare benefits by increasing the audit powers to Medicare Australia to access the patient records supporting Medicare billing and to apply sanctions on providers.*

On 25 March 2009, Mr Elton Humphery, the Secretary to the Community Affairs Committee invited the Secretary of the Department of Health and Ageing (DoHA), Ms Jane Halton PSM to provide a written submission to the Committee addressing the issues which may be of relevance.

The submission is in response to this request and should be read in conjunction with:

- the Exposure Draft for the Health Insurance Amendment (Compliance) Bill 2009 (Attachment A) and the accompanying explanatory material (Attachment B);
- the Privacy Impact Assessment (Attachment C) and the information sheets distributed to stakeholders (Attachment D).

2. The Current Context

2.1 Roles and Responsibilities

Under the Administrative Arrangements Orders, the Minister for Health and Ageing and the Department of Health and Ageing (the Department) administer health and ageing policy and legislation, including in relation to the Medicare Benefits Schedule (MBS) and the *Health Insurance Act 1973* (HIA). The Minister for Human Services and the Department of Human Services (DHS) are responsible for the development, delivery and co-ordination of government services, and development of policy on service delivery and administration in relation to the *Medicare Australia Act 1973*.

In accordance with section 5(1) of the *Medicare Australia Act 1973* (MAA), the functions of the Chief Executive Officer (CEO) of Medicare Australia include medicare functions conferred on the CEO by or under the HIA.

The Department's role is to provide policy advice on the MBS and to manage legislative amendments to the HIA, while Medicare Australia is responsible for conducting activities to ensure that services comply with the legislative requirements of the MBS.

2.2 The MBS

Medicare is a universal health scheme which was introduced in 1984 to provide affordable, accessible and high-quality health care. In the 2007/08 financial year, over $13 billion was paid in patient benefits associated with nearly 280 million Medicare transactions[1].

The Medicare scheme is funded from a special appropriation and is demand driven. It provides financial assistance to eligible people who incur medical expenses in respect of specified professional services rendered by eligible qualified medical practitioners, participating optometrists, eligible dentists and eligible allied health workers. Medicare benefits are currently available for over 5,700 specified services[2].

Under current arrangements patients are entitled to a rebate of 100% of the Medicare schedule fee for GP consultations. For all other consultations covered under the MBS, the patient receives 85% of the schedule fee from Medicare if the service is provided out-of-hospital or 75% of the fee if the service is provided in hospital.

There are currently three main methods of claiming under Medicare:

- the patient can assign the right to the payment to the practitioner, if the practitioner agrees to accept the Medicare rebate as full payment for the service;
- the patient can pay the doctor's account and then claim the benefit from Medicare;
- the patient can claim from Medicare for the unpaid account and receive a cheque made out in the practitioner's name. The patient then gives the cheque to the practitioner, plus any balance still owing (the patient may have to pay the difference between the benefit and the total fee charged at the time of service.

2.3 Process for developing MBS items

The items of medical services and the schedule fee applicable to each item are set out in tables prescribed under sections 4, 4A and 4AA of the Health

[1] Department of Health and Ageing 2008, *Annual report 2007-08*, DoHA, Canberra, pp.73 & 76..
[2] As at 1 May 2009 there are 5,767 services listed on the Medicare Benefits Schedule.

Insurance Act 1973 (HIA)[3]. These tables of services are listed in the Medicare Benefits Schedule (MBS)[4].

The medical profession plays an important role in ensuring that the MBS remains reflective of current medical practice. Professional stakeholders are generally consulted during the development of new MBS items and the review of existing MBS items. The descriptors for MBS items are agreed with the profession before they are introduced.

New medical technologies or procedures must be assessed by the Medical Services Advisory Committee (MSAC) before they can be publicly funded. The MSAC is an independent scientific committee which advises the Minister for Health and Ageing about whether new medical services should be publicly funded based on an assessment of their safety, effectiveness and cost effectiveness, using the best available evidence. The MSAC undertakes a rigorous and transparent assessment of new medical technologies in consultation with the applicant[5].

The established mechanism for reviewing MBS items which no longer reflect current medical practice is the Medicare Benefits Consultative Committee (MBCC). The MBCC is an informal consultative forum established in September 1989 by agreement between the then Minister for Health and Ageing and the Australian Medical Association (AMA) to facilitate discussion on reviews of the Health Insurance (General Medical Services Table) Regulations. Representation is drawn from the Department of Health and Ageing, Medicare Australia, the AMA and relevant craft groups of the medical profession. There are separate processes established for reviewing Medicare items relating to the Health Insurance (Pathology Services Table) Regulations and the Health Insurance (Diagnostic Services Table) Regulations.

2.4 Growth in usage of the MBS

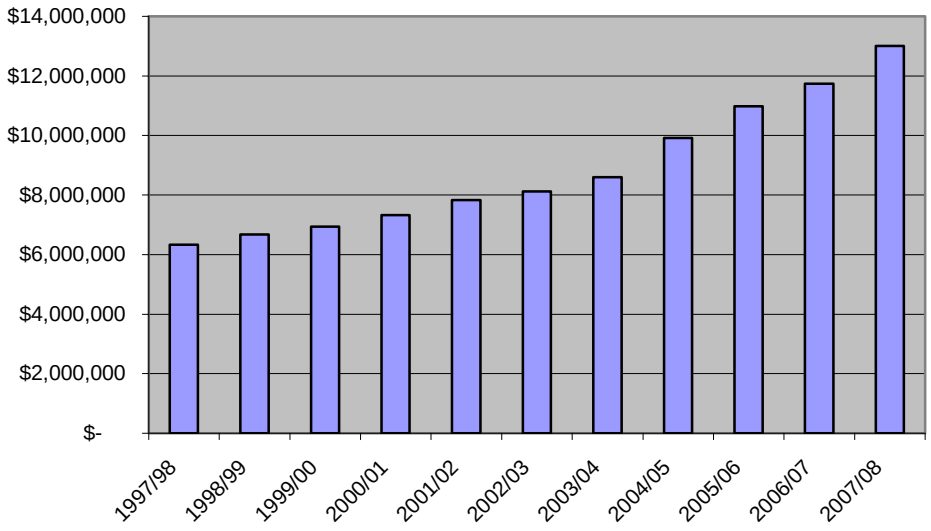
In the past decade:

- expenditure has more than doubled from $6 billion in 1997-98 to over $13 billion in 2007-08 (Chart 1)[6];

[3] The relevant tables are the Health Insurance (General Medical Services Table) Regulations, the Health Insurance (Pathology Services Table) Regulations and the Health Insurance (Diagnostic Imaging Services Table) Regulations.
[4] The MBS is provided free of cost to all practitioners on a CD and is available online at www.mbsonline.gov.au. Practitioners may also purchase a hard copy of the MBS.
[5] The MSAC website at www.msac.gov.au contains all the information required in making a submission to the MSAC under the link "MSAC Application Process". The MSAC application forms and guidelines are available for download from the website.
[6] Dept of Health and Ageing 2009, Medicare Statistics – December Quarter 2008, Table A4 Benefit Paid, DoHA, Canberra, viewed 30 April 2009, <http://www.health.gov.au/internet/main/publishing.nsf/Content/medstat-dec08-tables-a.

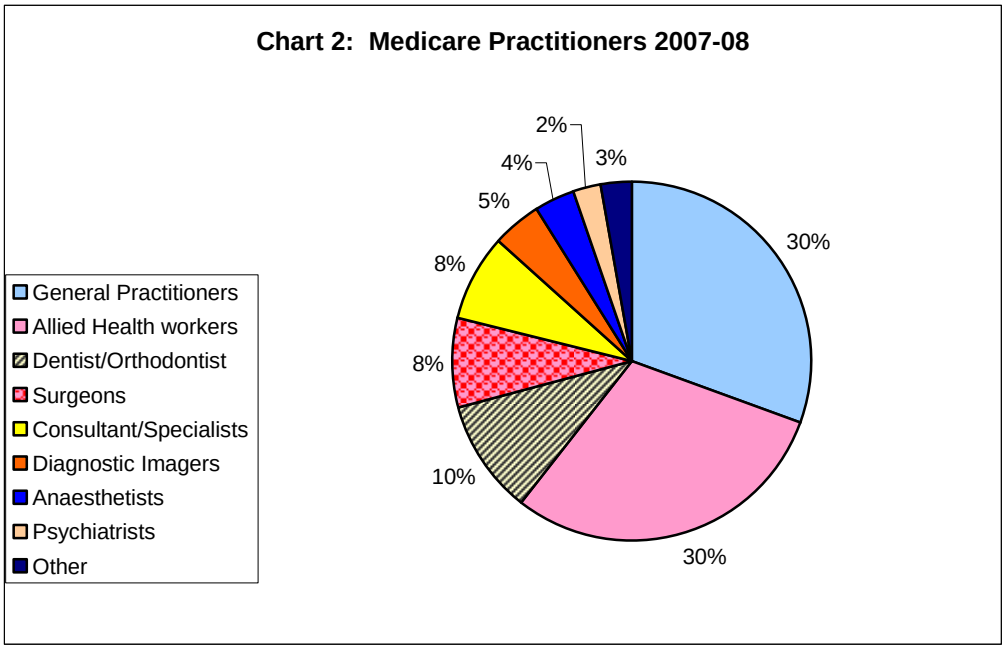
- the number of services claimed has grown from 202 million to nearly 280 million annually[7];
- the number of practitioners who can provide Medicare-eligible services has increased from 44,500 to over 80,000[8]; and
- new groups of practitioners such as allied health practitioners may now provide Medicare-eligible services (Chart 2). This group includes aboriginal health workers; audiologists; clinical psychologists; diabetes educators; dieticians; exercise physiologists; mental health nurses; occupational therapists; psychologists; social workers; and speech pathologists.

Chart 1: Medicare Benefits Paid by Finanacial Year, 1997-98 to 2007-08



[7] ibid., Table A1 Number of Services.
[8] Unpublished data.

Chart 2: Medicare Practitioners 2007-08



2.5 Addressing existing risks to the integrity of the MBS

There is a multilayered approach to activities to protect the integrity of the MBS. The scheme must be flexible enough to enable practitioners to exercise reasonable clinical and professional judgement and benefits to be paid with minimal up-front verification so that individuals can access affordable health services when they need them.

Ongoing risks to the integrity of the MBS are managed through traditional compliance activities which are complemented by a peer review scheme. This approach provides coverage across the continuum of the three types of behaviour which pose a risk to the integrity of the MBS. These are fraud; incorrect Medicare payments; and inappropriate practice. These risks are managed through criminal investigations and administrative audits, undertaken by Medicare Australia, and peer review to investigate potential inappropriate practice administered by Professional Services Review (PSR).

Medicare Australia advises that expenditure associated with incorrect Medicare payments constitutes the greatest risk to the integrity of the Medicare scheme. A key weakness of current arrangements is that there are broad legislative powers in place to deal with criminal activity and inappropriate practice.

2.5.1 Fraud

Fraud occurs where an individual seeks to obtain a Medicare benefit by intentionally falsifying facts and/or documents. Medicare Australia has broad powers under the *Medicare Australia Act 1973* and the HIA to investigate potentially fraudulent activity[9]. When there are reasonable concerns that a fraud has been committed, Medicare Australia has powers to conduct searches and seize clinical records. Administrative staff employed by Medicare Australia who are involved in criminal investigations may view any of the information obtained in the course of these investigations.

The incidence of fraud is relatively minor. Medicare Australia advise that in the period 2006-07 to 2008-09, a total of six practitioners have been successfully prosecuted.

When a medical provider is convicted of fraud against Medicare, the CEO must refer the provider to the Medicare Participation Review Committee (MPRC) (Part VB of the *Health Insurance Act 1973*). The MPRC has the power to suspend a convicted provider from the Medicare program for a period of up to 5 years.

2.5.2 Incorrect Medicare Payments

Incorrect Medicare payments occur when a practitioner makes an unintentional false or misleading statement that results in a Medicare benefit payment being made that is greater than the benefit which should have been paid in respect of a service.

When Medicare Australia identifies a potential threat to the integrity of the Medicare scheme, it notifies the individual practitioner about the concern. Medicare Australia gives the practitioner the details of the service(s), explains the concern being audited and asks the practitioner to supply documents or information to substantiate the service(s).

However, Medicare Australia has no power to require a practitioner to cooperate with an audit request. If a practitioner refuses to respond or cooperate voluntarily, Medicare Australia is not able to proceed with the audit and is unable to verify the Medicare benefit amount paid in respect of the service.

[9] Such as sections 128A, 128B and 129 relating to false and misleading statements and Part IID of the *Medicare Australia Act 1973*.

2.5.3 Inappropriate Practice

The concept of 'inappropriate practice' is defined in section 82 of the HIA as conduct in connection with rendering or initiating services that would be considered unacceptable to the general body of a practitioner's professional colleagues. It is a determination that can only be applied to a practitioner once they have been reviewed by PSR[10].

The object of the PSR Scheme is to protect the integrity of the Commonwealth's medicare benefits and pharmaceutical benefits programs and, in doing so it:

- protects patients and the community in general from the risks associated with inappropriate practice; and
- protects the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

Essentially, the PSR Scheme ensures that the Commonwealth does not subsidise medical services which a practitioner's peer group determine are not clinically relevant[11]. It is the clinical relevance that differentiates inappropriate practice from incorrect Medicare payments or fraud.

When Medicare Australia forms the view that a practitioner may have engaged in inappropriate practice, they may make a request for the Director of PSR to review the matter.

It is not Medicare Australia's role to make determinations about inappropriate practice.

Sections 89B and 105A of the HIA provide the Director and the PSRC with powers to require the production of documents relevant to the Medicare services under review. The Director and the PSRC may issue a notice requiring relevant documents, including clinical or practice records, to be produced to the Director, the PSRC or a nominee of the Director or PSRC. The notice may be issued to the person under review or any other person. The Director, PSRC or the nominee may retain, inspect and make a copy of these documents as required. The nominee does not have to be a medical or other practitioner and may be administrative staff employed by PSR.

---

[10] Reviews of potential inappropriate practice in relation to Medicare-eligible services are investigated by PSR. PSR is an independent body established under the Act to administer the PSR scheme which is set out in Part VAA of the HIA. PSR is part of the health and ageing portfolio.

[11] The PSR scheme is described in Part VAA of the *Health Insurance Act 1973*. Further information on PSR is available at http://www.psr.gov.au.

Once a PSRC has made a finding of inappropriate practice the Determining Authority (DA) imposes an appropriate sanction[12]. Sanctions may include reprimand and counselling by the Director, repayment of Medicare and/or Pharmaceutical benefits and partial or full disqualification from Medicare and/or the PBS for a period of up to three years. In the case of a negotiated settlement with the Director, the DA is required to ratify any sanctions agreed to by the practitioner. The DA is the only body with the legal authority to make a final determination.

If a practitioner has received two final determinations of inappropriate practice the Director of PSR must refer the practitioner to the Medicare Participation Review Committee (MPRC) (Part VB of the HIA). The MPRC has the power to suspend a practitioner from the Medicare program for a period of up to 5 years.

2.6 Compliance activities for the MBS

Compliance activity is one mechanism by which risks to the integrity of the Medicare scheme are managed. The compliance program for the MBS has two purposes:

- it provides a level of assurance for Government and taxpayers that public revenue is being expended on services which are provided according to the relevant legislation; and
- the outcomes are used to review and improve the design of health policies and programs, including clarifying and refining existing MBS items.

Compliance activities largely focus on post payment verification of key risks associated with incorrect Medicare payments and fraudulent activity. Consideration is given to whether a service was provided and whether the Medicare item billed reflects the service provided. However the activities underpinning administrative audits rely on voluntary compliance by practitioners. Practitioners are not required to produce any documents or information to verify that a service has met the legislative requirements. This places a significant restriction on the current compliance program for the MBS.

[12] The DA is an independent body also established under the Act.

3. The Increased MBS Compliance Audits Initiative

3.1 Overview

The Increased Medicare Benefits Schedule Compliance Audits (IMCA) initiative was announced in the 2008-09 Budget as part of the Responsible Economic Management package.

The IMCA initiative has three components which are:

- an increase in the number of compliance audits undertaken by Medicare Australia each year from 500 to 2,500;
- a requirement that practitioners produce evidence to substantiate a Medicare benefit paid in respect of a service when audited by Medicare Australia; and
- a financial penalty for certain practitioners who are not able to substantiate a Medicare benefit paid in respect of a service.

The increase in the number of compliance audits conducted by Medicare Australia each year did not require amendments to the HIA and took effect from 1 January 2009.

Legislative amendments to the HIA are required for the other changes and are contained in the draft Health Insurance Amendment (Compliance) Bill 2009.

The IMCA initiative enhances the compliance program for the Medicare scheme by providing a mechanism to enable the medicare benefits which are paid in respect of professional services to be substantiated.

This initiative addresses weaknesses in the current process for managing the risks associated with incorrect Medicare payments. It does not include measures relating to inappropriate practice or fraud.

3.2 Why are these changes necessary?

With over $13 billion of public revenue being spent annually on Medicare services, it is reasonable for the Government and the Australian public to seek an assurance that those services comply with the requirements of the relevant legislation.

It is the Department's view that most practitioners who provide Medicare services try to provide services which correspond to the requirements of the

legislation. The proposed legislation is not targeting these practitioners. Rather, it is concerned with the minority of practitioners who do not take appropriate care when billing Medicare-eligible services and/or do not voluntarily comply with compliance audit requests.

Medicare Australia has advised that although the majority of practitioners voluntarily comply with a Medicare Australia request to provide information during a compliance audit under existing arrangements, this occurs in an *ad hoc* manner. During 2007-08 around 10% of practitioners provide information from a patient medical record in excess of what is required to fulfil the audit requirements, while around 20% refused to provide any information at all. As a result these audits were effectively halted as no further action was able to be taken[13].

If permitted to continue, this could have a significant negative impact on public revenue. It could lead to a situation where a significant proportion of Medicare payments which are identified as being at risk of being incorrect are not able to be verified.

This draft Bill addresses the current weakness in activities designed to address key risks to the integrity of the Medicare scheme by establishing a simple, cost effective administrative mechanism to deal with incorrect Medicare payments which constitute a substantial risk to Medicare expenditure. It is intended to provide an incentive to practitioners to ensure that the Medicare services they provide meet the requirements of the legislation.

3.3 Notice to produce documents

The proposed legislative amendments will provide Medicare Australia with authority to give a notice to produce documents to persons to substantiate a Medicare benefit paid in respect of a service and the person will be required to comply. This may involve the disclosure of information from a patient medical record to Medicare Australia.

Maintaining the privacy of patient medical records is very important. The Department and Medicare Australia have worked closely with the Office of the Privacy Commissioner throughout the development of the IMCA initiative. However privacy issues must be balanced against other important public interests such as the protection of public revenue and the promotion of the efficient administration of government programs. Consequently, Medicare Australia's compliance audit program will continue to target services which are

[13] Except where Medicare Australia identified grounds for referral to PSR or for criminal investigation.

identified through a risk assessment process as at medium to high risk of not being paid correctly.

The proposed legislation clarifies the obligations of practitioners in relation to compliance audits conducted by Medicare Australia while placing limits on Medicare Australia's access to this information by:

- setting out the circumstances under which a person is required by law to provide information to Medicare Australia – that is when a person is issued with a notice to produce documents;
- requiring Medicare Australia to have a reasonable concern in respect of specified services and to explain this in the notice to produce documents;
- limiting the information which Medicare Australia may require in response to a concern, to that which is relevant to the concern identified in relation to the specified service(s);
- providing a person who is given a notice to produce a set period of time in which to respond – that is, not less than 21 days; and
- requiring the notice to produce to indicate how (and where) the information is to be supplied to Medicare Australia.

The proposed legislation does not provide Medicare Australia with any powers to search any premises or seize any records. The draft Bill leaves it up to the person who is given the notice to determine what information they have available which may substantiate the Medicare benefit paid in respect of the service. This is intended to minimise the impact on practitioners by allowing them to supply relevant information from the most convenient documents available to them. Stakeholders have indicated that practitioners have different records management practices and that the compliance audit process needs to allow for these differences. The Department was also concerned that specifying the different kinds of information and documents that a practitioner might use to substantiate a Medicare benefit paid in respect of a service, would create additional red tape for practitioners.

The proposed legislation does not prevent a practitioner from informing individual patients that information from their medical record has been provided to Medicare Australia during a compliance audit for the purposes of substantiating a Medicare benefit paid in respect of a service.

A Privacy Impact Assessment (PIA) has been prepared on the potential impact of the proposed amendments (Attachment B). The PIA will continue to be

updated throughout the implementation and ongoing management of the IMCA initiative.

The Department is working closely with Medicare Australia to ensure that stringent safeguards are in place to protect health information provided during compliance audits. It is intended that health information collected during the course of administering the MBS will be governed by existing section 130 of the HIA and by the *Privacy Act 1988*[14]. This is the same protection currently provided to information supplied by practitioners during PSR reviews.

Penalties, including fines and up to two years imprisonment, may apply to any Commonwealth officer, including Medicare Australia staff, who breaches their obligations under section 130 of the HIA, and other statutory sanctions may also be imposed where personal information is misused.

3.4 Administrative penalty

The Bill contains an additional financial administrative penalty for practitioners who are unable to substantiate a Medicare benefit paid in respect of a service. At present, when a Medicare benefit exceeds the amount that should have been paid in respect of a service, the practitioner is asked to repay the amount. However the incorrect payment does not incur a penalty. This does not provide any incentive for practitioners to ensure that the legislative requirements for the Medicare items paid in respect of the services they provide are met.

The MBS supports a large number of services across a wide range of medical and allied health professions. Individual compliance audits may be conducted in relation to incorrect payments for relatively small amounts of money (less than $500). However, when these incorrect payments to individual practitioners are multiplied across a professional group, the aggregate amount of money involved can be substantial.

With over 80,000 practitioners providing Medicare services each year, small amounts of money which are paid out to individual practitioners when they should not have been paid can quickly add up to large amounts of taxpayers' money.

If individuals receive a Medicare benefit amount that is not payable for a professional service over repeated instances the behaviour can become habitual

[14] Section 130 of the HIA prohibits any Commonwealth officer from giving out personal information which has been acquired under the HIA to any other person, except in the performance of their statutory duties and functions or where the individual has authorised the release of that information. Statutory exceptions also enable information to be released in other limited circumstances (such as where there is an imminent threat to a person's life or health).

and the system can lose its integrity. This can have an ongoing and increasing negative compliance impact on the entire community.

The financial administrative sanction is intended to address this weakness in current arrangements by providing a simple, transparent system to address incorrect payments. Clearly the prospect of repaying an amount of money and an additional financial penalty provides an incentive for practitioners to ensure that the Medicare services they provide comply with the relevant legislative requirements.

It is proposed that a base penalty amount of 20% will be applied to debts in excess of $2,500 or a higher amount if specified in regulations. The regulation making power will enable this threshold to be adjusted upwards in response to increases in the schedule fee for Medicare services. It will also mean that practitioners who owe a small amount of money will not be subject to a financial sanction. The $2,500 threshold is based on an analysis of Medicare Australia data which indicates that this is the point at which mistaken claims may become routine, or reflective of poor administration or decision making. In 2007-08 only 36% of practitioners who were required to repay money, repaid an amount of more than $2,500.

The Bill allows the base penalty amount to be reduced or increased according to specified circumstances. For example, if a practitioner admits to causing an incorrect Medicare payment to be made prior to any Medicare Australia compliance contact, the base penalty amount is reduced by 100%. This means that the practitioner will only have to repay the amount which was paid incorrectly — no additional penalty amount will be payable. This is intended to provide an incentive for practitioners to make an early admission to Medicare Australia if they become aware that they have caused an incorrect Medicare payment to be paid.

However, if a practitioner fails to respond to a notice to produce documents and the amount of the services specified in the notice is more than $2,500, the practitioner will be required to repay the full amount of the services and an additional penalty amount. However the base penalty amount is increased by 25% because the practitioner did not respond to the notice. This is intended to provide an incentive for practitioners to respond to a notice to produce documents.

Medicare Australia already has a significant range of educational resources available to practitioners including e-learning modules, face-to-face educations sessions and paper based materials. Practitioners found to have caused an

incorrect payment to be made under the proposed legislation will have access to these resources to ensure they understand how to use the relevant Medicare items correctly.

4. Conclusion

The IMCA initiative will:

- address existing deficiencies in the compliance program for the Medicare benefits scheme by providing a simple, cost effective administrative mechanism to deal with incorrect Medicare payments which constitute a substantial risk to Medicare expenditure;
- assist in clarifying the obligations of both Medicare Australia and practitioners in relation to the substantiation of Medicare payments; and
- introduce a simple administrative penalty system which will be an effective deterrent to combat incorrect Medicare payments.