Australian Government

Department of Health

Senate Community Affairs Legislation Committee – Inquiry into the Health Insurance Amendment (Compliance Administration) Bill 2020

AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH SUBMISSION

November 2020

Introduction

The Department of Health (the department) provides the following submission for the consideration of the Senate Community Affairs Legislation Committee Inquiry into the Health Insurance Amendment (Compliance Administration) Bill 2020 (the Bill).

This submission should be read in conjunction with the revised Explanatory Memorandum which sets out the policy context for the Bill's impact on practitioners.

This submission provides some background on the department's health provider compliance framework, the necessity for this Bill and the safeguards in place for practitioners who are subject to an audit under section 129AC(1) of the *Health Insurance Act 1973* (HIA).

Background

The department is responsible for protecting the integrity of Australia's health payments system. It does this through prevention, identification and treatment of incorrect claiming, inappropriate practice and fraud by health care practitioners. The majority of practitioners do the right thing, but in the few cases where non-compliance occurs, it is important that timely and effective action is taken to recover Medicare benefits that should not have been paid.

Services that attract a Medicare benefit are listed as individual items in the Medicare Benefits Schedule (MBS). A claim for an MBS benefit is submitted to Services Australia for payment. Under the *Health Insurance Regulations 2018,* a claim for Medicare benefits must, at a minimum, include the following information:

- the MBS item number that relates to the service, or a description of the service sufficient to identify the item that specifies the service;
- the patient's name;
- the practitioner's name or practitioner's provider number;
- the date on which the service was provided;
- the amount charged and total amount paid in respect of the service.

Under the Medicare arrangements, responsibility for correct claiming rests with the health practitioner providing the Medicare service. The practitioner is the only person who can determine that a Medicare service was delivered in accordance with the requirements of the MBS. A practitioner is granted a provider number on the clear expectation that their services will be billed correctly to Medicare.

Compliance activities and compliance powers under the HIA

The majority of the department's compliance activities focus on encouraging voluntary compliance through provider education, feedback to professional colleges, and letters targeted to practitioners with unusual or unexpected claiming or diagnostic requesting patterns.

Practitioners are encouraged to check MBS claims made under their provider number for accuracy and can contact Services Australia to make a claims adjustment if an error is found. Where practitioners are unsure of the legislative requirements of MBS items they can seek advice directly from the department through our AskMBS email service.

The department has three main mechanisms available to address significant and persistent non-compliance:

1. Recovery of debt under section 129AC(1) of the HIA – where a person, usually the practitioner, is found to have made a false or misleading statement by submitting claims for MBS services that did not meet legislative requirements;
2. Referring a practitioner to the Director of Professional Services Review under section 86 the HIA to determine if a practitioner or corporate entity has engaged in inappropriate practice;
3. Preparation of briefs of evidence for alleged fraudulent claiming and referral to the Commonwealth Director of Public Prosecution.

Section 129AC(1) – false or misleading statement

Under the current provisions of section 129AC(1) if, as a result of the making of a false or misleading statement, an amount paid, purportedly by way of benefit or payment under the HIA, exceeds the amount (if any) that should have been paid, the amount of the excess is recoverable as a debt due to the Commonwealth from the person by or on behalf of whom the statement was made.

A false or misleading statement can occur when a practitioner or someone authorised to act on their behalf submits a Medicare claim where the legislative requirements were in fact not met.

Examples of non-compliance for which a debt can be recovered under section 129AC(1) providing the appropriate processes are followed to determine there is a debt include:

- When a GP submits an MBS claim and receives benefits for a higher priced consultation item to prepare a chronic disease management plan but does not prepare a plan;
- Where a specialist submits an MBS claim for a higher priced consultation item, but the patient does not have the required referral from a GP; and
- Where a practitioner makes multiple claims for the same service.

As noted above, the vast majority of practitioners aim to do the right thing. Last year the department undertook less than three hundred audits of practitioners delivering Medicare services. However, the powers under section 129AC(1) are essential for the Commonwealth to recover incorrectly claimed payments and ensure the sustainability of the Medicare program. The powers protect patients too. In circumstances where the number of services per patient are limited (for example, mental health services provided by psychologists and other allied mental health practitioners), incorrect claiming can prevent/delay patients' access to vital services. It is essential to address these situations, to ensure that the MBS continues to operate for the benefit of the Australian community.

Proposed amendments in the Bill

The section 129AC(1) provisions were introduced in 1985, and were designed when all Medicare claiming was paper-based. The Bill modernises the circumstances in which the Commonwealth can recover a Medicare benefit or payment from a person when it should not have been paid under the HIA. The Bill makes minor amendments to the HIA to clarify that a Medicare benefit or payment can be recovered as a debt due to the Commonwealth in circumstances where an incorrect amount is paid as a result of a person giving false or misleading "information", whether or not the information was intentionally incorrect. The false or misleading information can be in a document, or statement, or in any other form.

This amendment supports current, emerging and future technological advancements to electronic Medicare claiming by focusing on the giving of false or misleading information, rather than the form in which this false or misleading information is submitted to Services Australia, such as via a "statement".

A comparison of the current provisions and the amendments in the Bill are at Attachment A.

Manner of identifying audit cases, the procedural fairness steps taken during the audit process and method for recovery of debts under section 129AC(1)

The HIA and the amendments in this Bill do not permit the automation of compliance outcomes or raising of debts and in no way use algorithms to generate debts. All decisions are made by departmental officers with appropriate senior executive level oversight.

The department has an established, comprehensive process for identifying cases of suspected non-compliance. The department identifies potential cases of non-compliance by staff receiving and evaluating tip offs or by analysing practitioner claims data. Other staff then assess this information to identify possible compliance concerns and determine, through consultation with medical advisors and other departmental subject matter experts, whether they present as potential cases to be pursued further. As a further safeguard, risk analytics staff extract and analyse additional claims data to confirm these initial assessments. Once a case has been validated as a potential compliance concern, the department officers talk to medical advisors and other subject matter experts and consult with peak bodies and other health sector stakeholders to determine the appropriate compliance activity. Cases identified as appropriate for audit are forwarded to the Audit team for action. This entire process is overseen by governance bodies, established to oversee and endorse the progression of a case through identification, validation and treatment.

Once a case has been identified for an audit, the Commonwealth can only establish that a debt exists under section 129AC(1) if there is evidence to support that finding. However, before making that debt decision the practitioner will be afforded procedural fairness. Before a delegate of the Chief Executive Medicare (CEM) can provide a notice to claim an amount as a debt under section 129AC(1), a practitioner is, and will continue to be provided with the CEM's preliminary view of the debt decision as a procedural fairness step. This step gives the practitioner an opportunity to be heard and respond to the CEM on the issues before a decision is made.

The CEM's preliminary view of decision includes the proposed debt amount, the evidence being relied on and the reasons for the preliminary view that false or misleading information

has been given, which resulted in the Medicare payment being paid, and a schedule of the services that were claimed and the Medicare benefits that have been paid. The practitioner is then given an opportunity to make submissions and provide any additional information about the CEM's preliminary view of a debt decision. Also, if the CEM does make a debt decision, the HIA gives the practitioner an opportunity to seek an internal review of that debt decision under section 129AAJ."

The department's debt recovery arrangements are also measured in their approach by considering the practitioner's individual circumstances when seeking the recovery of debt. Once a notice to reclaim an amount as a debt is sent to the practitioner, the department makes every reasonable attempt to make contact with them to determine how the debt will be repaid, including implementing a repayment plan if required. In a small number of cases where the practitioner refuses to pay, is not contactable, after multiple attempts via varied channels, or defaults on a payment arrangement, there are a number of legislative information gathering and debt recovery powers with strict limits that can be employed.

Impact of the Bill on patients

The Bill does not adversely affect patients.

Impact of the Bill on practitioners

The Bill does not impose additional requirements on practitioners, who are currently responsible for ensuring that their Medicare claims are correct.

The Bill does not increase the debt recovery powers of the Commonwealth, nor does it increase the scope of compliance activity by the Commonwealth. This Bill is linked to the modernisation of the existing provision to enable it to function as intended, taking into consideration digital Medicare claiming channels.

The Government acknowledged the increase in the role of practices, corporate entities and hospitals in the billing of MBS services on behalf of individual practitioners by introducing the Shared Debt Recovery Scheme (SDRS) in 2018 with the support of the Australian Medical Association. Under the SDRS, if a practitioner has an employment or other contractual arrangement with an organisation (for example a practice), and is found to have made a false or misleading statement, and it is reasonably believed that the organisation contributed to the circumstances that led to the making of the false and misleading statement, the debt may be shared between the practitioner and the other contracted party.

The Bill also amends the false or misleading statement provisions under the SDRS so that if a practitioner has an employment or other contractual arrangement with an organisation the debt as a result of the giving of false or misleading information can be shared between the parties. No other changes to the SDRS have been made.

The table below describes the key concepts underpinning the recovery of debts under section 129AC(1) of the HIA.

Key concepts in the current provisions of the HIA	Amendments in Bill
Practitioner is primarily responsible for the claims made under their provider number	No change

It is considered a false or misleading statement whether the statement is intentionally incorrect or not	No change – false or misleading information includes information which is not intentionally incorrect
The department will pursue a person other than the practitioner in instances of fraud.	No change

Attachment A

Comparison of the current false or misleading statement provisions and the proposed amendments in the Health Insurance Amendment (Compliance Administration) Bill 2020.

The table below shows the current provisions and the new provision if the Bill is passed by parliament. The amendments in the Bill are in bold in the second column

Current provision	New provision
129AC Recovery of amounts overpaid etc. and administrative penalties False or misleading statements (1) Where, as a result of the making of a false or misleading statement, an amount paid, purportedly by way of benefit or payment under this Act, exceeds the amount (if any) that should have been paid, the amount of the excess is recoverable as a debt due to the Commonwealth from the person by or on behalf of whom the statement was made, or from the estate of that person, whether or not the amount was paid to that person, and whether or not any person has been convicted of an offence in relation to the making of the statement. (1AA) Subsection (1) does not apply to an amount if subsection 129ACA(1) applies to the amount.	129AC Recovery of amounts overpaid etc and administrative penalties False or misleading **information** (1) Where as a result of the **giving of false or misleading information**, an amount, purportedly by way of benefit or payment under this Act, exceeds the amount (if any) that should have been paid the amount of the excess is recoverable as a debt due to the Commonwealth from the person by, or on behalf of whom the **information was given,** or from the estate of that person, whether or not the amount was paid to that person and whether or not any person has been convicted of an offence in relation to the **giving of the information.** **1AAA for the purposes of subsection (1), it is immaterial whether the false or misleading information is given:** **(a) In a document; or** **(b) In a statement; or** (c) **In any other form.**
129ACA Shared debt determinations Making shared debt determinations (1) If: (a) as a result of the making of a false or misleading statement, an amount paid, purportedly by way of benefit or payment under this Act, exceeds the amount (if any) that should have been paid in respect of a professional service rendered, or purportedly rendered by a person; and	129ACA Shared debt determinations Making shared debt determinations (1) If: (a) as a result of the **giving of false or misleading information,** an amount paid, purportedly by way of benefit or payment under this Act, exceeds the amount (if any) that should have been paid in respect of a professional service rendered, or purportedly rendered by a person; and

(b) the Chief Executive Medicare (the ***CEO***) makes a determination under subsection (2) in relation to the amount; the excess (the ***recoverable amount***) is recoverable as a debt due to the Commonwealth from that person (the ***primary debtor***) (or from the estate of that person) and another person (the ***secondary debtor***) (or from the estate of that person) specified in the determination.	(b) the Chief Executive Medicare (the ***CEO***) makes a determination under subsection (2) in relation to the amount; the excess (the ***recoverable amount***) is recoverable as a debt due to the Commonwealth from that person (the ***primary debtor***) (or from the estate of that person) and another person (the ***secondary debtor***) (or from the estate of that person) specified in the determination. **129ACA(1A)** **For the purposes of subsection (1), it is immaterial whether the false or misleading information is given:** **(a) In a document; or** **(b) In a statement ; or** (c) **In any other form.**
129ACA Shared debt determinations Making shared debt determinations (continued) (2) The CEO may make a written determination under this subsection in relation to an amount if: (a) notice has been given under subsection (7) in relation to the recoverable amount to the primary debtor and the secondary debtor; and (b) any of the following apply: (i) the secondary debtor employed or otherwise engaged the primary debtor to render professional services of the kind mentioned in paragraph (1)(a); (ii) the secondary debtor had an arrangement or agreement with the primary debtor relating to professional services of that kind; (iii) the secondary debtor is a person in a class of persons prescribed under paragraph (9)(a);	129ACA Shared debt determinations Making shared debt determinations (continued) (2) The CEO may make a written determination under this subsection in relation to an amount if: (a) notice has been given under subsection (7) in relation to the recoverable amount to the primary debtor and the secondary debtor; and (b) any of the following apply: (i) the secondary debtor employed or otherwise engaged the primary debtor to render professional services of the kind mentioned in paragraph (1)(a); (ii) the secondary debtor had an arrangement or agreement with the primary debtor relating to professional services of that kind; (iii) the secondary debtor is a person in a class of persons prescribed under paragraph (9)(a);

(iv) the secondary debtor is not a person in a class of persons prescribed under paragraph (9)(b); and (c) the CEO reasonably believes the determination should be made having regard to the following: (i) whether the relationship of the secondary debtor with the primary debtor was such that the secondary debtor could have controlled or influenced the circumstances that led to the making of the false or misleading statement to which the debt relates; (ii) whether the secondary debtor directly or indirectly obtained a financial benefit from the making of the false or misleading statement; (iii) whether any other factors in all the circumstances of the case make it fair and reasonable for the determination to be made.	(iv) the secondary debtor is not a person in a class of persons prescribed under paragraph (9)(b); and (c) the CEO reasonably believes the determination should be made having regard to the following: (i) whether the relationship of the secondary debtor with the primary debtor was such that the secondary debtor could have controlled or influenced the circumstances that led to the **giving of the false or misleading information** to which the debt relates; (ii) whether the secondary debtor directly or indirectly obtained a financial benefit from the **giving of the false or misleading information;** (iii) whether any other factors in all the circumstances of the case make it fair and reasonable for the determination to be made.
129ACA(6) (6) An amount is recoverable under subsection (1) whether or not: (a) the amount was paid to the primary debtor or secondary debtor (or the estates of those persons); and (b) any person has been convicted of an offence in relation to the making of the statement.	129ACA(6) (6) An amount is recoverable under subsection (1) whether or not: (a) the amount was paid to the primary debtor or secondary debtor (or the estates of those persons); and (b) any person has been convicted of an offence in relation to the **giving of the false or misleading information.**