FRAUD, WASTE & ABUSE SUMMIT

28 FEBRUARY - 1 MARCH 2019 SANDTON CONVENTION CENTRE

CMS Council for Medical Schemes

Fraud Waste and Abuse

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28th February 2019

"Partnership towards curbing fraud, waste and abuse"

#fwasummit

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Background and Context

- Annual claims paid out by schemes in **2017; R172bn**
- Rejected claims in **2017 (R29bn)**
- ± 15% of all claims due to Fraud, Waste and Abuse **(R25.8bn)**
- If **ALL** claims were paid out **(R201bn)** and proportion of FWA **(R30.15bn)**
- Stagnant membership at **8.8m**
- New members and dependents lost by schemes exceeds new members
- Fraud Waste and abuse major contributor to annual member contribution increases
- Less members remaining in schemes and less potential members joining
- Overall scheme sustainability in question

Fraud, Waste and Abuse: Member

- Fake ailments
- Membership substitution
- Dual membership
- Service provider-hopping
- Altered invoices
- Identity theft
- Collusion with service providers

Fraud, Waste and Abuse: Service Provider

- Claims for services or goods not provided
- Use of membership card by non-members
- False claims
- Over-billing
- Falsification of patient information
- Miscoding
- Supplying non-medical goods and services
- Admitting patients for non-existent ailments: Kick-backs from hospitals and specialists
- Supplier induced demand
- Collusion with members

Complaints against schemes and Administrators

- Variety of methodologies and systems for fraud detection
- Variety of approaches in managing alleged fraud, waste and abuse cases
- Coercion of Service providers to sign Acknowledgement of Debt
- Claw backs in addressing alleged cases of Fraud, Waste and Abuse
- Abuse of Section 59 of MSA
- Use of hidden cameras, seizure of patient records, intimidation and disruption of clinical practices
- Use of sting operations and entrapment of health professionals
- Failure to report fraud and corruption under Section 34 of the Prevention and Combating of Corrupt Activities Act 2004

Other Complaints:

- From members that service providers are claiming from them accounts that have been rejected by schemes
- Service providers that their claims are not paid by schemes
- Service providers that their claims are paid directly to members
- Scheme and administrators that service providers are presenting allegedly fraudulent claims
- These complaints are increasing in their quantities and the sums involved
- That CMS is not executing its regulatory mandate
- Members and their beneficiaries **ARE** the ultimate victims of these practices

CMS: Mandate

Section 7

*a. Protect the **interests of members** at all times*

b. Control and co-ordinate the functioning** of schemes in a manner that is complementary with **National Policy

*d. **Investigate complaints** and **settle disputes** in relation to the affairs of schemes as provided for in the Act.*

*f. **Make rules** that are not **inconsistent** with the Act, for the purpose of its **functions a**nd the exercise of **its powers***

CMS: Mandate

Section 5(1)(d):

A person who has at any time been convicted of fraud, whether in RSA or elsewhere, is disqualified to be a member of Council.

Section 16

Makes provision for the reporting of practitioners involved in improper and disgraceful conduct to be reported to the relevant statutory body and the NPA, where a criminal offence has occurred

Section 29(2)(c):

A scheme is entitled to terminate or suspend the membership if a member submits fraudulent claims or commits any fraudulent act in terms of the Act.

CMS: Mandate

Section 59 (1-3)MSA:

(1) Dictates that a service provider shall provide a member or beneficiary with an account/statement of services provided. And also Makes reference to information to be presented in a claim

*(2) Indicates that a scheme shall when it is presented with an account for services rendered in line with the MSA and the scheme rules; pay to the **service provider** or **member within 30days** of receipt of the account*

***3a**. Any amount paid bona fide in line with the MSA, which a member or service provider is **not entitled** to; or*

***3b**. Any loss which is sustained by a scheme through **theft, fraud or negligence** and which comes to the notice of the scheme; will be deducted from the member or supplier.*

Coding Systems: "*At the core of Fraud Waste and Abuse lies coding and billing abuses*"

- ICD 10 , 11, ICHI: WHO and NDOH custodian; CMS co-ordinates private sector
- ATC and DDD: WHO custodian
- CPT: SAMA
- PCNS: CMS custodian; BHF contracted implementer
- NAPPI: Mediswitch

NO REGULATIONS and NO CONTROL

Fraud Prevention and Detection

- Acknowledge that large schemes and administrators have sophisticated systems for fraud detection
- Acknowledge and support industry representative efforts (HFMU)
- Smaller schemes do not have this capacity
- CMS does not have this capacity
- Competitive nature of the industry does not allow for free sharing of information
- Inconsistent and often illegal processes or practices in dealing with alleged fraudulent service providers

What does CMS want to do?

- Co-ordinate industry efforts aimed at the reduction of Fraud, Waste and abuse as mandated by the Special Investigations Unit (SIU)
- Co-ordinate the development of industry-wide definitions, standards, code of best practice and a Charter
- Act as a central repository for information that needs to be shared on proven fraudsters
- Co-ordinate the establishment of industry-wide representative structure
- CMS will not be assuming the role of schemes or administrators
- Support establishment of a central coding authority
- Co-ordinate training of Law enforcement agencies on the MSA, Regulations
- Publish reports on Fraud Waste and Abuses in the sector

Journey: 2018

- Appointment of Dr Mini as chairperson in November 2017 started the conversation
- Fraud Waste and Abuse as a priority was supported by key stakeholders that we consulted (NDOH, Treasury , WHO, World Bank, Portfolio Committee on Health)
- This priority was also endorsed by regulated entities in the roadshow that we started in February 2018
- SIU mandated the CMS to co-ordinate Fraud, Waste and Abuse as part of the National Anti-Fraud Forum: Health Sector
- We convened a steering committee (BHF, HFA, SIU, HPCSA, HFMU) in 2018, which supported the idea of a Summit
- The Steering Committee developed and project plan and deliverables for this summit

Journey: 2019

- The Steering committee under the leadership of the CMS is responsible for the co-ordination and organization of the Summit
- This Fraud Waste and Abuse Summit is funded largely by the Council for Medical Schemes, Board of Healthcare Funders and the Health Funders Association
- It is programmed to take place over the next one and half day
- In the lead to the summit, we have attempted to put together a programme that allows for as many stakeholder voice as possible to be heard
- This is an inaugural Summit and we hope this will be established as an industry Annual event

Immediate Key Deliverables For The Summit

- Fruitful and Constructive discussions on combating FRAUD, WASTE and ABUSE
- Industry Charter on FRAUD, WASTE and ABUSE signed by a significant number of stakeholders
- Industry agreement on the key definitions related to FRAUD, WASTE and ABUSE

Medium to Long term Deliverables

- Industry agreement to develop industry standards and best code of practice on FRAUD, WASTE and ABUSE
- Industry agreement to establish a representative structure to co-ordinate and address FRAUD , WASTE and ABUSE issues in the medium to long term
- Agreement to hold this Summit on an annual basis

Conclusion

- Key documents adopted at this Summit will remain in operation until changed by another Summit
- This is not the end of the process but the beginning
- Opportunities for further engagements and inputs remain open
- Processes in between Summits will be advanced through a consultative approach
- No-one should be left behind

The End!!!

Thank You!!!