

The Council for Medical Schemes'

CMS News

Issue 1 • June 2018

NATIONAL HEALTH INSURANCE:
Enhancing CMS ' capacity

STAKEHOLDERS' VIEWS ON FRAUD

- **Defining fraud, waste and abuse**
- **Killing the goose that lays the golden egg**
- **A threat to the future of healthcare**
- **Collaboration and analytics vital**

Fraud in the medical
schemes industry



EDITORIAL

Fraud in the medical schemes industry has been under the spotlight for some time, with key role players in the industry intensifying their efforts to deal with the scourge. More schemes are turning to big data analytics to uncover patterns and trends on member and provider behaviour, all in the quest to keep the issue of fraud, waste and abuse under control.

The big question is whether the industry is winning on this one. What is now emerging is that there is general consensus regarding the need for collaboration in order for the healthcare sector to effectively and efficiently address the issue.

Whether fraudulent activities are committed by the medical scheme members, or healthcare service providers, individually or acting in collusion; it is ultimately the members collectively, who bear the brunt in the form of increased monthly contributions as schemes try to mitigate the effect of the loss suffered.

One of the negative effects of the escalating premiums due to fraudulent activities, is the issue of affordability; with the private healthcare sector gradually becoming inaccessible to people who may no longer be able to afford the premiums. The resultant domino effects are immense on numerous fronts.

In this edition, we take a closer look at how the different medical schemes and other entities are dealing with the issue of fraud, waste and abuse in their own environments.

We trust that this edition will help to further stimulate debate on collective intervention on this issue going forward, using available industry expertise and resources - **Editor**



How to choose a Medical Scheme

- Identify a few schemes and request information on their benefits, contributions, limitations and exclusions.
- Find out what the scheme's reserves are (solvency ratio), and non-healthcare expenditure, to ensure that the scheme is in good financial health.
- Read up about prescribed minimum benefits (PMBs) and Designated Service Providers (DSPs).

If you are already a member:

- Read all the material such as options to change benefit plans.
- Understand what is covered by the benefit option that you choose, in order to ensure that you are sufficiently covered when you need to receive medical treatment.
- Remember that it is not compulsory to use a broker, but if you do, ensure that they have been accredited by the CMS and that your selection of a scheme is based on informed consent.

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Enhancing CMS' capacity for operation in the NHI environment

Dr Clarence Mini assumed leadership of the CMS Council following his appointment by the Minister of Health, Dr Aaron Motsoaledi. CMS News sat down with the good doctor to get some insight on the direction in which the new Council seeks to drive the CMS.

A medical doctor by vocation, Dr Clarence Mini previously fulfilled the following roles: chairperson of the Board of Healthcare Funders of Southern Africa (BHF), board member of the Government Employees' Medical Scheme, principal medical officer for the Port Elizabeth Municipality, national director for Family Health International and national coordinator and deputy national director of Management Sciences for Health.

He has served as co-chairperson of the National AIDS Convention of South Africa (NACOSA). NACOSA wrote the first National HIV/AIDS Plan for South Africa in 1994. He has also served on the committee of inquiry into the National Health Insurance (NHI), the board of directors for the Hospice Palliative Care Association and as an executive director of the MESAB Palliative Care Initiative.

He was part of the team that wrote the latest HIV/AIDS National Strategic Plan, the past president of the Gauteng Medical Association and the chairperson of the Gauteng Health Facility Accreditation Committee.

In addition, he served as a member of the board of the Institute for Human Evolution at Wits University and as a trustee of St Andrew's School for Girls.

He has been a member of the Johannesburg Mayoral AIDS Council, chairman of the board of directors for Africa Health Placements and corporate affairs executive for Thebe ya Bophelo Healthcare Administrators.

// *As a regulator, the CMS has an integral part to play in helping to shape the new healthcare landscape as envisaged by the Minister of Health, Dr Aaron Motsoaledi.*

Dr Mini shared some of the CMS's key focus areas for the next five years

Part of the new trajectory adopted by the CMS for the next five years involves a deeper level of engagement with stakeholders for improved collaboration on key issues affecting the industry, including the role that the industry must play in the National Health Insurance (NHI) environment. Since March 2018, we have embarked on a roadshow where we have one-on-one meetings with medical schemes and other entities involved in the healthcare sector.

Among others, the purpose of these meetings is to gain insight on some of the challenges that schemes are grappling with in the provision of private healthcare services for members; as well as to get to know about some of the innovative solutions that schemes are working on to provide improved healthcare services to beneficiaries of medical schemes.

It is our belief that effective and efficient regulation of the industry requires a deeper understanding of what is happening at scheme level. By the end of the first quarter of the 2018/19 financial year we would have visited a total of 25 entities, including 17 schemes.

We want to work together with stakeholders to deal with problematic issues such as the escalating health costs, largely due to fraud, waste and abuse.

Working together with the BHF, which is currently responsible for the PCNS, we believe that we will be able to deal with the issue of abuse which is exacerbated by the use of multiple PCNS by most rogue practitioners. We want to work with the BHF to make it a requirement for practitioners to have only one PCN allocated to them.

Care coordination for members

The issue of care coordination is one of the areas that we aim to facilitate better management of, to bring it in line with best practices in the world. We want the

General Practitioner (GP) to be the first port of call when a member is sick, instead of the member going directly to visit a specialist without a referral from the GP; often with very high costs involved.

Although this forms part of the prescribed minimum benefits (PMBs) review process; our aim is to ensure that in the interim, each scheme should offer at least one benefit option that is focused on primary healthcare for members; as part of general improvement of healthcare management and cost containment.

Cumulatively, the high healthcare costs are borne by medical schemes members in the form of increased premiums. We believe that care coordination will assist to significantly bring down the cost of healthcare service delivery, and thereby ease the burden for the member.

Establishment of a central coding authority to strengthen member protection

The issue of coding is an important feature in the healthcare sector to ensure appropriate billing processes, fraud prevention, and member protection. There is a need for a central coding authority for the sector to address the current situation where we have various codes located with different stakeholders; with no final arbiter for coding disputes.

The CMS is seeking to engage the World Health Organisation (WHO) on issues of coding in order to build capacity towards the establishment of a central coding authority for the healthcare industry. Collaboration with WHO will also focus on enhancing the CMS' capacity to deal with the Diagnosis Related Groups (DRGs).

Prescribed minimum benefits review

Our intention is to ensure that primary healthcare is embedded in the PMB package. The system is currently hospital-centric, with schemes mostly paying when a member is hospitalised. It is imperative to be broad-



mindful on the issue of the PMBs, in order to curb fraud, wastage and abuse. We need to isolate and expose the culprits.

We are saying that the CMS cannot fight the issue of fraud alone, we need formidable partnerships to win the fights against the rogues.

Enhancing the CMS's technical capability

As a regulator, the CMS has an integral part to play in helping to shape the new healthcare landscape as envisaged by the Minister of Health, Dr Aaron Motsoaledi.

Against this background, it is very important that the technical capability of the CMS is enhanced. The budget needs to be drastically overhauled for effective and efficient supervision of the industry.

We want to enhance our Research, Monitoring & Evaluation capability by expanding the unit. Our plan is to establish a Policy unit that will enable the CMS to provide support for the National Department of Health in its direction on future policy initiatives.

Going forward the CMS will also focus much effort on the fight against fraud, waste and abuse. While the larger schemes have the required capability to deal with fraud; it is not so with the smaller schemes.

Working together with the industry, we want to enhance capacity for the CMS to be able to deal effectively with the issue, as part of building a healthy industry for all.

Negotiations are currently under way for the CMS to partner with the BHF's Forensic unit in this regard.

COMING SOON



Medical Schemes



Fraud Conference

Gauteng
October 2018

Venue to be confirmed



THE ASSOCIATION OF CERTIFIED
FRAUD EXAMINERS (ACFE)
SA, HEALTH CARE FORUM

Medical Schemes Fraud, Waste and Abuse

Have you ever overheard someone towards the end of the year, say that they should quickly go and “stock up” to use the last of their medical scheme benefits for the year? This is not fraud, it is waste and abuse. Analysing and unpacking the difference between fraud, waste and abuse, will assist to create a better understanding for all role players in the healthcare industry, including the members and beneficiaries of medical schemes and health insurance products.

What is fraud?

Fraud refers to an intentional deception, misrepresentation, false statement(s) or false representation of material facts with the knowledge that the deception could result in unauthorised benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person’s own benefit or for the benefit of some other party.

Healthcare fraud is one of the fastest growing crimes in South Africa today. Classified as a white-collar crime, healthcare fraud eats up huge amounts of money from the South African economy each year. One expert puts the figure at R930 million per annum, and postulates that the poor conviction rates are partially to blame for the rise in this type of crime.

The fundamental problem in healthcare is that nobody is measuring the collective losses, and the quantum is just an estimate of losses across the entire sector. Professor Jim Gee, Partner and Head of Forensic, Cyber and Counter Fraud Services at Crowe Clark Whitehill LLP, and Visiting Professor and Chair of the Centre for Counter Fraud Studies at University of Portsmouth (UK), likens the common practice of merely directing counter fraud activities towards fraud detection, to “chasing the smoke and not going for the fire”.

This he says, results in a partial resolution of the problem, which leaves the door wide open for other potential risk areas, which may not be easily detected at times.

Factors influencing fraud, waste and abuse

What is abuse?

Abuse in this regard refers to practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to a medical scheme, or in reimbursement for services that are not medically necessary.

The elements of waste and abuse are as harmful as the effect of fraud, and both have a direct impact on other medical scheme members, including the viability of the private healthcare sector and that of the economy.

What is waste?

Waste refers to the extra costs incurred when healthcare services are overused, or when bills for services are prepared incorrectly. Unlike fraud, waste is usually caused by mistake rather than illegal or intentionally wrongful actions.

It may still not be common knowledge, but healthcare fraud, waste and abuse affect all healthcare insurers in South Africa, and as a result the solvency ratios of many medical schemes have been negatively affected.

What is collusion?

Collusion in this regard refers to a secret or illegal cooperation or conspiracy to deceive others.

Collusion between healthcare service providers and medical scheme members is the same as fraud as it contains the elements of intent, deception and undue benefit. The sad reality is that fraud, including the abuse and waste of benefits, and any other collusive behaviour, have a negative impact on the benefit pot of a medical scheme – the same benefit pot on which all the members belonging to the scheme rely on should they require unexpected, costly and life-saving medical treatment.

What kind of action is classified as fraud, waste and abuse?

- Allowing your healthcare provider to charge for services they did not provide;
- Loaning your medical scheme card to unregistered dependants, i.e. friends and family members;
- Providing your medical scheme or policy details to a healthcare provider for the purpose of submitting false claims in order to obtain a percentage of cash for the healthcare provider upon payment of the false claims by the medical scheme or insurer;
- Buying non-medical goods with your medical scheme card from doctors and pharmacies;
- Being admitted to hospital for a non-existent ailment in order to benefit from the cash payment from your insurer.

The list above is not exhaustive, but if it feels wrong or feels like a “white lie”, don’t do it! Participating in these acts ultimately leads to increased contributions for members of medical schemes or medical insurance policy holders, due to the financial burden placed on the insurers.

Some examples of healthcare fraud categories include, but are not limited to the following:

- Fraud by medical scheme members: fake ailments, membership substitution, dual membership, doctor hopping, false or altered invoices and identity theft.
- Fraud, waste and abuse by healthcare professionals: misuse of practice number, servicing non-members using the details of registered members, claiming for services not rendered, over-servicing, merchandise substitution, script alterations, claiming for expensive branded medicines and dispensing the cheaper generic equivalent and reckless billing methods.

Fraud affects every country and every sector. According to the PKF (UK) Financial Cost of Healthcare Fraud Report of 2011, the results collated over 12 years from across the globe show that 415 billion USD (over R4 trillion) is lost. This would be enough to provide clean, safe water around the globe, bring malaria under control in Africa; provide the Diphtheria, Tetanus and Pertussis vaccine to 23.5 million children under one year who are currently not immunised; quadruple the budget of the World Health Organisation (WHO); and the United Nations Children’s Fund (UNICEF); with a surplus of over 320 billion USD (over R3 trillion).

South Africa is not immune to this problem. Role players in the healthcare environment recognise that it is a serious issue and one that has far reaching consequences which includes the reduction in the availability and quality of patient care.

How often have you heard people say that they do not have healthcare cover, because they simply cannot afford it? While this is probably a reality for many South Africans, who truly cannot afford the monthly contributions for even the most basic cover, there are many others who can afford the top plans. The truth is that a large percentage of healthcare policy holders see their monthly contributions as a grudge purchase. Very often, this mindset leads policy holders, their dependants, and their healthcare service providers to developing a sense of entitlement and this is where the fraud, waste and abuse begins.

A common comment from the members is “I contribute a lot of money to the healthcare insurer every month, so I can use my available benefits as I see fit”. Education, especially for the members and their dependants, is very important in this regard. The likelihood is that once all role players fully understand the negative impact of fraud, abuse and wastage on the cost of healthcare, we will begin to see some positive change in behaviour.

A case study

One medical scheme reported that a member recently complained about a Dietician who submitted a claim on his membership number for a two-hour session, following the member’s participation at a health and wellness day arranged by his employer. The member was only at the Dietician’s tent for about 5 minutes. The investigation showed that the Dietician submitted claims on the membership numbers of ALL the employees of that employer; and the medical scheme would not have known about it if it had not been for the member who checked his statements and reported the discrepancy to his medical scheme. The Dietician had been remunerated by the employer for the services provided during the health and wellness day; and was not supposed to submit claims for the individual members. She did not even render services for all the employees on whose behalf she submitted claims.

One member’s vigilance and enquiring mind saved the medical scheme concerned, some money in this instance. Imagine the ripple effect if all members and policy holders behaved in the same manner.

The responsibility of combating fraud, waste and abuse lies squarely on the shoulders of all role players in the healthcare sector, including healthcare providers, regu-

lators; members of medical schemes and health insurance policy holders; as well as members of the general public. This is very important seeing that every role player suffers the consequences of increasing healthcare costs, one way or the other.

Medical scheme members and healthcare insurance policy holders are the first line of defence against unscrupulous healthcare providers. By examining correspondence from their medical schemes, especially statements about claims that were received and paid out, members are able to alert their schemes or insurer about any suspicious claims. In this manner, forensic departments of medical schemes were able to uncover many fraudulent claims. Even if your suspicion does not result in a fraud investigation, your vigilance and engagement with your scheme can help to curb the cost of incorrect claims submitted by healthcare providers, due to administrative errors.

The Association of Certified Fraud Examiners (ACFE) SA is aware that sanctions imposed on offenders in the healthcare sector are not tough enough; and that this results in repeat offenders who continue unabated with the same modus operandi, or simply change tactics to avoid detection. It is very important for the healthcare industry to create more visible policing, and to inculcate a culture of zero tolerance to fraudulent behaviour. We have found that one of the biggest deterrents to fraud, waste and abuse is to make it known that one is actively acting on every instance of fraud that is detected. As indicated, education, training and awareness go a long way in curbing the abuse of healthcare benefits and, as such, it is important that any approach towards fraud management must incorporate the awareness and education component.

The ACFE SA Healthcare Forum was established to develop an accredited training course for healthcare investigators. The Steering Committee of the Healthcare Forum has also been tasked with ensuring that the course and the academic standards link back to the ACFE Code of Ethics, at the same time adhering to the SAQA requirements and the ACFE SA Training standards. Fighting healthcare fraud, waste and abuse is one of the top priorities of the members of the ACFE SA Healthcare Forum; and we would like to encourage all players in the healthcare sector to put in place a series of measures, to ensure that their businesses are fraud resilient.

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Collaboration and analytics vital in combatting medical scheme fraud



DR KATLEGO MOTHUDI

MANAGING DIRECTOR

BOARD OF HEALTHCARE FUNDERS

Healthcare fraud is a serious and growing industry challenge that comes in many different guises which include: over-billing for services or supplies; falsifying patient data to obtain payments from medical schemes; referring patients to specific specialists or hospitals in return for kickbacks; as well as misrepresenting diagnoses and miscoding of claims to obtain payments or more money than is justifiable. In some instances, medical scheme members and service providers collude with healthcare practitioners in acts of medical aid fraud.

Healthcare fraud directly impacts the quality and cost of care that a patient receives, and can put patients' lives at risk when they are exposed to treatment or procedures that are not medically warranted.

Medical aid fraud is a complex form of financial fraud to detect, monitor and prevent. This is exacerbated by the fact that fraud detection and mitigation across the medical schemes industry is fragmented. It is essential that the individual efforts of schemes and administrators are consolidated in an industry-wide central database to facilitate collective use and analysis of data, as it is done for example, in the banking sector.

A key reason for the reluctance to share data between schemes and administrators is that fraud management ultimately becomes a factor of competition. Schemes and administrators that are more adept at detecting and mitigating fraud will enjoy lower operating costs and thus have a greater competitive advantage. This silo approach however only serves to transfer fraudulent activity between schemes, rather than resolve it.

The solution to the problem of fraud in medical schemes can only come about when as an industry, we finally decide to work together and take the competition factor out of fraud management. We need to recognise medical schemes fraud for what it is - a fundamental threat to the financial integrity of medical schemes and healthcare providers, as well as the industry's ability to provide healthcare services to the more than nine million people who depend on medical schemes. When you consider that a R160 billion industry is losing at least R10 billion to fraud every year, it becomes very clear that the current lack of collaboration between schemes and administrators on fraud mitigation could see the industry heading into the intensive care unit (ICU).

The prevalence of healthcare fraud in South Africa

Estimates of the prevalence of healthcare fraud in South Africa are anywhere between 5%–15% of the total healthcare expenditure in terms of fraudulent claims. It should also be noted that the majority of healthcare professionals abide by the highest standards of integrity and patient care, and that fraud is conducted by a limited number of individuals. However, the actions of a limited few can have significant consequences for patients, funders and healthcare professionals. It is for this reason that emphasis is placed on close collaboration among healthcare professionals, medical schemes, professional bodies, as well as medical scheme members to eradicate fraud in the healthcare sector.

On an individual level, medical schemes continue to deploy tools and systems which help mitigate the impact of healthcare fraud, as well as detect any anomalies for further investigation. In instances where schemes suspect wrongdoing, a case is lodged with the various professional councils and with the South African Police Services (SAPS). In many instances however, the sanctions from the councils are not a deterrent; and criminal proceedings typically take a long time, with considerable delays in the investigation of cases, and ultimately prosecution of perpetrators.

Investigating and prosecuting healthcare fraud is challenging and long-tailed at best. In many instances, we see medical schemes struggling to get convictions due to the complexities around investigating and proving the fraudulent activity. The result is that the industry is often saddled with dealing with repeat perpetrators who game the system by simply moving on to the next medical scheme once their activities are discovered. Healthcare providers are also not without risk in this regard. The reality is that if the funding industry ultimately shrinks, the private supply industry will shrink along with it.

Factors that contribute to the challenges in fraud detection and mitigation include the sheer volume of medical aid claims; the lack of information sharing and pooling of resources between industry players, and a lack of meaningful prosecution and stringent sanctions for fraudsters.

The BHF's contribution towards dealing with fraud in the industry

The Board of Healthcare Funders (BHF) is able to bring companies with horizontal relationships together to focus on the issue of fraud as an industry, and not as competitors. By bringing the data together from all role players in one central repository, we have access to industrywide data and analytics that provide significant economies of scale and a helicopter view of the actual state of fraud prevalence.

Medical Schemes through the BHF's Healthcare Fraud Management Unit (HFMU) are also able to engage with various stakeholders and law enforcement bodies to assist in building capacity to properly investigate and prosecute healthcare fraud cases more successfully, and as a criminal offence.

The benefits of participating in the HFMU includes but is not limited to working within a strict legal framework to ensure a fair and transparent approach; no duplication of efforts; collaboration with professional and international bodies; a more streamlined process on criminal matters due to newly formed relationships with institutions such as the Special Investigating Unit (SIU), the Health Professions Council of South Africa (HPCSA) and various prosecuting authorities; as well as regular training workshops.

Fraud is a significant problem for the various sectors, and the healthcare funding industry is no different. Fortunately, medical schemes and administrators already collect vast amounts of data that can be used in the fight against fraud. To benefit from the true potential of data and analytics in fighting medical fraud, it is essential that every role player commits to sharing relevant data, investing in skills and resources, and collaborating on best practices.

Given the significant rewards of minimising fraud losses for schemes, members and healthcare providers; the commitment towards collaboration is something that every scheme, administrator and healthcare provider should be willing to make.

Funding industry related fraud: Killing the goose that lays the golden egg



LERATO MOSIAH

CHIEF EXECUTIVE OFFICER

HEALTH FUNDERS ASSOCIATION

With annual contribution collections amounting to billions of rands, medical schemes are seen as fair game when it comes to fraud, misuse and abuse of their funds. While the exact extent of the problem is difficult to quantify with any certainty, experts estimate that the cost of fraud and other wastage runs into tens of billions of rands annually.

What is certain, however, is that this inappropriate behaviour, perpetrated by a minority of individuals across the spectrum of members; industry employees; and healthcare service providers, negatively affects every single member of a medical scheme by pushing up contribution premiums and making access to healthcare difficult for those who need it most.

There are numerous causes for the high levels of fraud and abuse in the healthcare industry. One of these is the fact that medical scheme premiums are often perceived as a 'grudge purchase' and members therefore feel justified in inappropriately exploiting the schemes' funds. What members do not realise is that the funds belong to all the members on the scheme, and when they are abused, it is their fellow members who are negatively affected.

While fraud and abuse can never be justified, industry experts agree that there are several systemic issues which create a conducive environment for inappropriate behaviour to occur. A key culprit is the fee-for-service system which creates a temptation to over service and over charge. This effectively reduces the funds available for member benefits, as well as to fund increases in pro-

vider tariffs. Examples in this regard include incidents where some healthcare providers' daily bills for patients reflects more hours than there are in a day; and where some specialists include intensive care unit (ICU) modifiers for all admitted patients.

The challenge of managing fraud is to some extent also made worse by the misinterpretation of the principle of open enrolment, a cornerstone of the Medical Schemes Act that is intended for the protection of members. In this regard schemes are compelled to re-admit members who have defrauded a scheme through, for example, non-disclosure or claiming fraudulently for benefits. While the scheme may have other recourse, such as through the criminal justice system, it is common knowledge that legal processes are often protracted. This forces the scheme to use funds for legal fees that would otherwise be used for member benefits.

It is comforting to note that fraud detection is becoming more sophisticated, resulting in more fraud and abuse incidents being uncovered. This is borne out by the fact that systemic issues, such as upcoding, which has always been rife, is now being more effectively uncovered and addressed.

Certain types of fraud are notably on the increase. These include syndicated fraud, where a group of healthcare service providers work together to defraud a scheme; as well as fraud committed by scheme members, which often increases as economic conditions become tougher.

Common types of fraud and abuse Prevention and Investigation

Some of the most common incidences of fraud and abuse encountered by schemes include:

- Member non-disclosure, where members do not disclose pre-existing conditions to the scheme.
- Obtaining sunglasses where prescription spectacles have been claimed for.
- Claiming for fillings when cosmetic dental work has been performed.
- Ordering of unnecessary blood tests.
- Pharmacies claiming for medicines but dispensing groceries and other non-medicine items.
- Kickbacks for referrals.

While fraud and abuse affect all schemes across the board, the types of fraud and abuse, are not generic and differ according to the dynamics within the scheme.

In cases of fraud where members and healthcare providers act in collusion, we often encounter, for example, more cases of cash and groceries being claimed as medicine in a scheme with mostly blue-collar workers; whereas in a scheme with more affluent members we may see more cases of rhinoplasty (nose job) claimed as a deviated septum.

How are medical schemes dealing with the problem of fraud?

Most schemes will agree that prevention is better than investigation; and that the most constructive approach to dealing with fraud and abuse by healthcare service providers is not punitive but rather to correct the behaviour within the realm of what is legal, ethical and possible.

Where a scheme has lost money, it is the schemes duty to recover it as the funds of the scheme belongs to all the members and therefore what has been stolen is members' money. However, simply recovering the money defrauded from the scheme in the first place provides no disincentive to prevent fraudulent behaviour. Many schemes have therefore implemented processes which commit the healthcare service provider to reform and monitors their claiming patterns going forward. Where appropriate, schemes also submit complaints to industry regulatory bodies.

Where the inappropriate behaviour in question meets the criteria identified in the Prevention and Combating of Corrupt Activities Act, i.e. it falls within the definition of 'fraud' or 'extortion' and involves an amount of R100 000 or more, schemes are obliged to report the matter to the police.

When it comes to prevention and investigation, 'big data' is the buzzword. Schemes report that their ability to collect data has improved, and back-end technology has evolved to enable easier and quicker detection. New technology, such as sophisticated analytical tools, is being used to provide a bigger picture and to mine and analyse the data more effectively.

This new, sophisticated technology enables real-time mining of data, which allows schemes to track and monitor member and provider profiles in real time, and thus more effectively identify fraudulent behaviour. Real-time tracking is also resulting in a decrease in the quantum related to fraud as perpetrators are identified immediately and schemes are thus able to take prompt action.

Methodologies for monitoring and identifying fraud are constantly evolving. These include using social media as well as combining claims data with other related data sets.

Working together to foster ethical behaviour

It is now evident that the single, most effective tool for combatting fraud and abuse is for the industry to work together in creating a culture that fosters ethical behaviour.

When a health professional acts inappropriately, his/her peers must speak out against it and the regulatory authority must take swift and effective punitive action. Similarly, when a medical scheme member commits fraud, the Regulator must support the scheme in its attempts to protect the remaining members' funds.

Schemes must also take responsibility by communicating with their members and healthcare service providers regarding the issue of fraud. It is important for schemes to ensure that their members, and the healthcare professionals servicing their members understand what constitutes inappropriate behaviour, and the consequences which may result from such conduct.



Fraud in Medical Schemes

– MMI’s perspective

CORRIN HOLGATE

HEAD: HEALTH INVESTIGATIONS UNIT

MMI HEALTH

A simple internet search on the phrase “fraud in medical schemes”, in South Africa exclusively, returns nearly a million items related to fraud in medical schemes demonstrating that this is a complex, dynamic subject. The purpose of this article is to share information on how MMI Health as an administrator, is tackling this complex subject.

The extent of fraud, waste and abuse in the medical schemes industry

We are often asked to quantify the extent of fraud, waste and abuse in the industry. Articles on the subject locally and abroad quantify healthcare fraud at anywhere between 5% and 20% of claims. The quantifications vary due to the complexity of the definition of what should be included in the definition of fraud, waste and abuse, as well as the different administra-

tors’ approach regarding what is included. Some calculations include claims rejected up-front which may in other environments be classified as mistake and errors, or automatic rejections as part of the functions of an administrator. Both instances could be argued to have an element of fraud, waste and abuse.

What is clear about this issue is that the different benefit options available in medical schemes; the variety of products in the insurance and health market; the implementation and interpretation of the prescribed minimum benefits (PMBs) legislation; as well as the size and sheer volume of claims handled by the sector make the industry vulnerable and susceptible to fraud, waste and abuse. In addition to the complex environment mentioned above, the tariff codes charged by providers are often confusing, not related to the condition or health as an outcome and are often not scrutinised or understood by the members of a medical scheme. It is

essential to strategically and pro-actively manage these risks.

Preventing fraud, waste and abuse

Some of the challenges of fraud, waste and abuse can be minimised by product design and the strict management and implementation of rules based on the benefits, according to the intended design.

These include initiatives where members are empowered and incentivised to make the right decisions on benefit options; and providers are contracted by the medical scheme to ensure predictable delivery. This approach minimises the incidents of fraudulent behaviour by any stakeholder in the system. The end result is that the levels of fraud in the majority of our schemes will be reduced.

Despite everything that is done up-front to prevent fraud, waste and abuse, some claims submissions contain a component of fraud, waste or abuse. Momentum Health has invested in analytics capabilities to assist with the identification of fraud, waste and abuse.

This includes the development of artificial intelligence models to assist with the early identification, and case management of high cost outlier cases. We have also introduced a world-leading software tool which uses behavioural analytics to identify healthcare providers and members exhibiting suspicious behaviours, indicative of fraud, waste and/or abuse.

This tool assists us to detect anomalous behaviour by a service provider, when compared to previous performance, or in terms of the norms of other healthcare providers in the same discipline. Early identification and resolution of issues of waste and/or abuse with the affected provider can save the scheme money, and ensure that services are not compromised, while at the same time ensuring that the issue of skills shortages is not aggravated.

Coupled with the implementation of a clear policy regarding the treatment of fraud, waste and abuse, the provision of a dedicated hotline for reporting possible fraud, waste and abuse is another essential initiative for dealing with the issue.

Awareness and education campaigns among healthcare providers and scheme members are also important. We have numerous examples of matters where healthcare providers have identified and reported cases of fraud, waste and abuse.

In one case a member permitted a third party to use the medical aid card of a beneficiary. This was identified early by the hospital and the third party was moved to an alternative facility for treatment. The costs were recovered and no loss was suffered. In a separate case, costs of R1.6 million accrued when third party fraud was identified. In this case, membership was terminated and legal action was initiated to recover the money from the terminated member.

All cases of fraud, waste and abuse are investigated by a dedicated and experienced team comprising clinical, investigative, legal, accounting and data specialists. Where necessary, the expert advice of the professional bodies or associations and subject matter experts is sought prior to finalisation of an investigation.

Where fraud is identified, we report the perpetrators to the South African Police Services and unprofessional conduct is reported to the relevant regulatory body. It can be frustrating when matters that are reported are not pursued. In one particular matter, we received a tip-off through the whistle blower hotline regarding collusion between members and pharmacies who were submitting claims for medication in exchange for providing cash to members on a large scale.

These matters were investigated and reported to the South African Pharmacy Council and South African Police Services. No action has been taken yet against the perpetrators.

What more can be done to combat fraud, waste and abuse?

We are active supporters of the Healthcare Forensic Management Unit established by the Board of Healthcare Funders for the purposes of facilitating industry collaboration in combating fraud.

Strong collaboration is required with law enforcement agencies, the prosecuting authority and the regulatory bodies. Most administrators and medical schemes will agree that they have had limited, if any, success prosecuting medical scheme fraud. This is understandable when the law enforcement agencies are faced with other more urgent crimes. However, in order to tackle the scourge of fraud in the healthcare sector, and support industry initiatives, these organisations will require dedicated, specialised and capacitated teams to deal with this issue.



Fraud threatens healthcare's future

DR JONATHAN BROOMBERG

CHIEF EXECUTIVE OFFICER

DISCOVERY HEALTH

The majority of healthcare professionals are honest, hard-working, ethical people who deliver excellent service to their patients. Yet, a minority knowingly commit abuse and fraud against medical aid schemes, resulting in hundreds of millions being lost by schemes every year. These healthcare professionals are effectively stealing from their own patients, who bear the brunt of increasing medical aid premiums every year.

Healthcare fraud has devastating financial and personal effects. The financial loss is only one part of the story. The other part is the human face of the fallout - individual victims of healthcare fraud who have been exploited; whose health or medical records have been compromised; or whose legitimate insurance information is used to submit falsified claims.

A global scourge

Economies the world over are bracing themselves against sky-rocketing healthcare costs linked to the explosion of non-communicable diseases as a result of poor lifestyle choices; the high cost of new medicines and technologies etc. all exacerbated by fraud and corruption. It is estimated that the United Kingdom's publicly funded National Health Service¹ loses £1.25bn (1% of the NHS budget) every year to fraud committed by patients, staff and contractors.

According to the US National Health Care Anti-Fraud Association², healthcare fraud is impossible to accurately quantify, ranging from \$80 billion to over \$200 billion in that country. Ongoing investigations are crucial to deal with this undefined menace. In July 2017, the United States' Federal Bureau of investigation announced a 'Historic Nationwide Health Care Fraud Takedown'³ involving charges levelled against 400 people who allegedly made false filings worth about \$1.3 billion.

Given the scale of international healthcare fraud and its cumulative effect on the quality of the provision of healthcare services, it is essential that government agencies and private insurers work closely to combat this crime.

Millions recovered from South African fraudsters

In South Africa, Discovery Health has invested substantially in fighting the scourge of healthcare fraud. Between January 2016 and September 2017, Discovery Health recovered almost R850 million in fraudulent or inappropriate claims, mainly from healthcare professionals. Significant behaviour change is often seen after fraud intervention. From 2012 to 2016, reductions in potentially fraudulent behaviour by healthcare professionals, resulted in avoided fraudulent claims of approx-

¹ <http://www.bbc.com/news/health-41824180>

² https://www.nhcaa.org/media/127538/nhcaa_ushealthcaresystem_2017.pdf

³ <https://www.fbi.gov/audio-repository/ftw-podcast-health-care-fraud-takedown-071317.mp3/view>

imately R3.9bn – the so-called ‘halo-effect’ of visible fraud investigations and counter measures.

Even with these large recoveries and fraud-avoidance efforts, we believe that this is only the tip of the iceberg, and that fraudulent activity and billing abuse most likely costs medical aid schemes several billion rands per year. These precious funds could be used to pay for critically needed benefits, or to keep premiums more affordable.

Big data analytics expose fraudsters

Discovery Health’s efforts to expose fraudsters who perpetrate these crimes include the deployment of a specialised team of over 75 analysts and professional investigators as well as a proprietary forensic software system that uses sophisticated algorithms to analyse claims data and identify any unusual claim patterns. Invaluable tip-offs from whistle-blowers also help to identify fraud.

With the aid of advanced big data analytics platforms, sniffing out claims that may stem from fraud, waste or abuse is no longer as tedious and time-consuming as it used to be in the past. Our access to real-time, or near real-time data, has made all the difference, both in helping investigators to identify fraudsters and also to contact witnesses who might provide evidence against a corrupt health professional or other fraud suspect. When hundreds of millions of transactions can be organized in a way that identifies patterns of fraud, the suspected perpetrators of that fraud are no longer able to hide.

Discovery Health’s forensics team conducts over 3000 fraud investigations every year. On average, every month, over 200 in-depth healthcare fraud investigations are conducted in the field and almost six million claims are reviewed. In carrying out anti-fraud activities, Discovery Health adheres strictly to the highest standards of fairness and to all applicable legislative requirements. Our processes have been reviewed in detail by external legal experts, and have also stood the scrutiny of the courts.

What happens to members and medical professionals involved in fraud?

When fraud is identified and proven, Discovery Health reclaims funds obtained fraudulently by members and healthcare providers, and which are owed to the medi-

cal scheme. When appropriate, the scheme terminates memberships of clients and payment to healthcare providers; and formal charges are filed with the South African Police Services.

Discovery Health also submits formal complaints against healthcare providers to relevant industry bodies including the Health Professions Council of South Africa (HPCSA) where appropriate. The HPCSA has jurisdiction to fine, or suspend a healthcare professional according to the merits of the case. There has been industry-wide concern that fines handed down to perpetrators of fraud; sometimes guilty of multiple counts of fraud, are not harsh enough. If fraudulent practitioners faced harsher sanctions, such as suspension from practice, this would serve as an effective deterrent against fraud.

Understanding the different forms of healthcare fraud

A common fraud incident involves a pharmacy supplying members of medical schemes with non-claimable items such as baby formula, nappies, cosmetics and shoes but submitting claims for prescription medicines.

A particular pharmacy was found to have dispensed multiple high-cost items to individual families, during one year:

- A family claimed 19 thermometer units, with another family claiming 14. These cost approximately R3200 each.
- A family claimed four swivel bath chairs, costing approximately R2000 per unit. Two of these were claimed on the same day, and another two within a day of one another.
- A family claimed 11 nebulisers.
- A family was identified for claiming wheelchairs from a well-known pharmacy chain every year since 2014 and obtaining this under different entities on the policy to bypass the limit rules. There are seven children on the policy but not one appears to have any clinical reasons for the wheelchairs.

In another example, a General Practitioner who was often absent from his private practice allowed a male nurse to treat his patients. The General Practitioner would then claim for the consultations. A patient rightfully reported this to Discovery Health.

Sometimes pharmacies or doctors dispense generic medicines, yet claim for higher-cost original medicines. Further examples of irregular activity have included a sudden, 36-fold increase in patients seen by a particular GP in a month, with an increase of 884% in fees claimed. In another case, 58% of total patients in the practice were seen on a Monday. Our investiga-

tion revealed that the GP was supplying fraudulent sick notes. In a case of the so-called “code-gaming”, 44% of a certain speech therapist’s ICD codes related to unspecified pain treatment, which should be very rare in the context of a normal speech therapy practice.

Hospital cash plan fraud, a lucrative scam

Hospital cash plans are sold by insurance companies and provide beneficiaries with a lump sum if they are hospitalised. These cash plans are intended to help cover the shortfall a patient might face if the costs associated with their hospital admission are not fully covered by their medical scheme.

Discovery Health has identified doctors who admit healthy patients to hospital for extended periods, then submit false claims on their behalf to both their medical scheme and their cash plan provider. The “patient” then splits the cash lump sum paid out by the insurer with the doctor. Both the medical scheme and the cash plan provider are left out of pocket in this regard.

Healthcare fraud eats away a medical scheme’s solvency ratio and drives up premiums

The burden of funds lost as a result of fraud would be significantly more serious in the absence of a rigorous approach to investigating potential fraudulent behaviour and dealing decisively with fraud when it is identified.

Without the active intervention of Discovery Health to recover fraudulently claimed funds, we estimate that the Discovery Health Medical Scheme’s solvency ratio would be far lower than its current level of almost 27%; and that premium increases would be substantially higher as well, harshly impacting members’ pockets and access to quality healthcare.

Alongside a host of other local medical aids and their administrators, Discovery Health is working closely with the South African Medical Association and other industry bodies to ensure a zero tolerance for fraud, and to ensure that all perpetrators are brought to book.

Healthcare fraud is not only a grave injustice perpetrated against innocent medical aid members, driving up premiums and depriving them of much needed benefits, it is also a criminal offense that tarnishes the good name of honest healthcare professionals, and of the private healthcare system as a whole.

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Reduce fraud, waste & abuse to sustain healthcare

ANTHONY PEDERSEN
CHIEF EXECUTIVE OFFICER
MEDSCHEME

Private healthcare is a privilege few could afford without medical aid or health insurance cover. The cost of private healthcare continues to escalate with above inflationary increases year-on-year.

A stay in an intensive care (IC) ward of a hospital can quickly run into millions of rands, which few people have as disposable income. There are hospital costs, anaesthetist fees, surgeon fees, medication and a whole range of incidental expenses linked to a single health event. A 20-minute consultation with a specialist can easily cost over R1 000 per visit, excluding the potential pathology and radiology costs if you need blood tests or x-ray scans done.

Part of the cause of the challenges that we are currently experiencing with escalating costs, is that the private healthcare sector has become highly commercialised. Healthcare providers are remunerated on a fee-for-service basis, and every life is associated to a rand value.

Medical schemes pay over 92% of the contributions they receive directly towards healthcare expenses, which is phenomenal when compared to other general insurers who often spend anywhere between 10% and 20% on claims processing and administration, in a much simpler and less complex environment than healthcare.

Schemes and Administrators have to invest substantial sums of money on resources and analytical software capable of detecting irregular claims and ensuring that only valid healthcare claims by healthcare providers and facilities are paid. Through predictive analytical software and 'Big Data', Medscheme is now uncovering the real extent of fraudulent and abusive claiming; and the emerging picture is not pretty. The company has uncovered over R446 million in fraudulent, wasteful or abusive claims since 2016 with the introduction of predictive analytical provider scoring in the Forensic unit.

Opportunistic fraud and abuse is rife among healthcare practitioners and facilities, and it is estimated that at least 10% to 15% of all claims are fraudulent or constitute abuse of resources. This is a substantial amount of money that is being lost.

As is the case with any industry, healthcare fraud and abuse occurs in many creative and different ways; however, it is much harder to contain due to a variety of factors, including but not limited to:

- the volume of claims associated to one healthcare event,
- the need for quick access to healthcare,
- the emotive nature of the story linked to every claim submitted,
- the unintended consequences of prescribed minimum benefits (PMBs) and;
- the inherent assumption that a healthcare provider or facility is compelled to act in your best interest, with little consideration to potential downstream costs to the medical scheme.

The tide however is turning. It is common knowledge that only a minority of all healthcare service providers are responsible for the huge material losses suffered by medical schemes due to fraud. Of the over 25 000 practitioners, hospitals and pharmacies that Medscheme pays regularly; less than 3% have required forensic intervention by Medscheme for opportunistic or fraudulent claiming. The impact of such interventions however, has saved schemes over R270 million in a period of 18 months; and such funds can now be re-allocated for legitimate and much needed healthcare expenses, by all scheme members.

With increased awareness, more members will engage service providers and start to ask questions regarding some of the excessively high costs. This will go a long way in assisting schemes to reduce fraud, waste and abuse in the healthcare sector. The active participation of all role players will help to make healthcare services more accessible and affordable, ultimately leading to a sustainable healthcare industry.





TRENDS OBSERVED in Medical Scheme fraud

PONTSO NYATHI

HEAD OF FORENSICS

SIZWE NTSALUBA GOBODO

Fraud, waste, abuse and illicit conduct of healthcare practitioners are a major threat to the healthcare industry globally. This level of healthcare fraud affects the society negatively as it leads to higher premiums (e.g. when medical aid schemes increase premiums to recover losses incurred through fraud) and increased medical taxes, which ultimately have a negative impact on the economy. Increased awareness regarding various types of fraud affecting society is imperative for the course of fraud prevention. In this article, we look at some of the current emerging medical aid fraud trends perpetrated by healthcare providers, practitioners and

members of medical aid schemes identified from the work that SizweNtsalubaGobodo (SNG) has carried out in the industry over time.

Registered Nurses

A registered nurse is a trained person who cares for the sick, especially in hospital. Current trends in this discipline indicate that the majority of Registered Nurses are opening their own practices and rendering services to members of various medical aid schemes. In addition, Registered Nurses assist various healthcare providers

in providing treatment to patients suffering from different medical conditions. They administer medication, monitor patient recovery and progress, and educate patients and their families on disease prevention and post-hospital treatment.

Majority of Allied healthcare providers are recruiting graduates and/or elderly nurses to provide services to patients as locums, however, trends show that some of these Allied healthcare providers at times register fictitious practices using the graduates or elderly nurses' details without their consent. Consequently, claims ranging from about R800 000 and above annually, are submitted through these fictitious practice numbers.

The locum's practice number is used in an unauthorized manner, resulting in, inter alia, the following types of irregularities:

- Inflated tariff codes: submitting high tariff codes to medical schemes even though services rendered to patients were for lesser tariff codes;
- Irregular employment practices: Registered Nurses permanently employed by government institutions are opening their own practices without approval from the Department of Health;
- Collusion between nurses/healthcare providers and medical aid members: submission of claims for services not rendered and splitting the funds claimed between the member and the nurse/healthcare provider once the medical scheme pays.

Psychiatric hospitals

Psychiatrist hospitals, also known as mental hospitals, specialise in the treatment of serious mental disorders such as depression, schizophrenia and bi-polar. Psychiatrists in these hospitals treat patients with the abovementioned conditions and admit and monitor the patients. Patients are charged an admission fee, a consultation fee and fees for medication dispensed during their stay in hospitals.

Through forensic investigations on medical schemes, we identified the following trends in respect of Psychiatric institutions:

- Psychiatric hospitals admitting more patients than the approved number by the Department of Health;
- Fictitious claims through the abuse of patient files: Patient files kept at the hospitals contain certain stickers used when admitting patients. These stickers contain details of the patients admitted in hospital such as the medical aid number, admitting healthcare provider name and the identify number of the patient. Trends show that Allied healthcare providers steal these stickers and claim for services not rendered;

- Submitting claims for longer therapy sessions whereas a patient spent less time with the service provider;
- Service providers unnecessarily admitting patients for longer periods for financial gain;
- Medical aid scheme members requesting to be admitted in hospital to with the malicious intent to claim on their various hospitals cash back plans/policies; and
- Collusion between healthcare providers and members of various medical aids, by admitting members who do not have a condition that warrants an admission, thus using the hospitals as rest facilities.

Conclusion

The trends highlighted in this article occur due to, amongst others, the following fraud gaps in the industry:

- Medical aids cards used as cash card;
- Inadequate tools and methods to detect fraudulent activities;
- Perpetrators being ahead of the preventative tools and methods in place;
- Collusion between healthcare providers and employees of medical schemes;
- The reactive nature of medical aid schemes, focusing on recovery instead of prevention. The existing recovery approach also results in most of the healthcare providers/practitioners not being prosecuted for fraud once they have paid back the monies fraudulently claimed from the medical aid schemes.

There are various ways in which some of the shortcomings in the industry can be addressed which include, amongst others, the following:

- Data sharing between medical schemes, i.e. details and modus operandi of the perpetrators identified by one medical scheme should be shared with other medical aid schemes and collective action taken by all schemes to prevent the perpetrators from continuing their irregular conduct;
- Detailed background searches when registering new practices;
- Awareness campaigns on fraud, waste and abuse for healthcare providers and members of various medical aid schemes; and
- Medical aid schemes adopting a preventative approach rather than being reactive when dealing with the issue of fraud.



The Medical Schemes Act's provisions on medical schemes related fraud

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A person is guilty of fraud if a court of law can prove beyond reasonable doubt that he or she intentionally made a misrepresentation which is unlawful and caused prejudice or potential prejudice to another person. The prejudice suffered by the other person can be patrimonial or non-patrimonial.

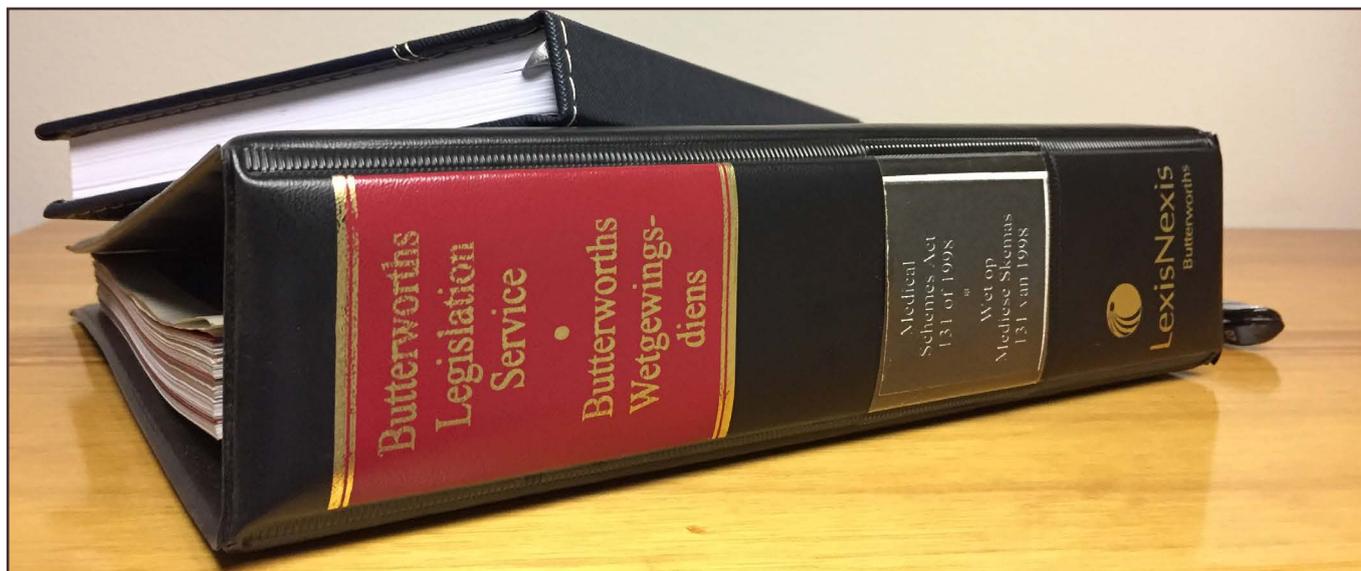
The Medical Schemes Act, 131 of 1998 (the Act) contains the following provisions relating to fraud:

- A person who has at any time been convicted of fraud whether in the Republic of South Africa or elsewhere, is disqualified from being a member of the Council - section 5(1)(d).
- 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 -

section 29(2)(c) and (d).

- A medical scheme may deduct any loss that it has sustained through theft, fraud, negligence or any misconduct from a benefit payable to a member or a supplier of health service when it comes to the notice of the scheme - section 59(3)(b).

The legal provisions dealing with the appointment of the board of trustees of a scheme does not specifically deal with fraud but it does require that a member of the board shall be fit and proper-section 57(1). If it becomes apparent that this is not the case, such a trustee will be removed in terms of section 46 or the scheme will be placed under curatorship if all the trustees stand to be removed -section 56.



Section 16 of the Act states that if fraud has been committed by a healthcare provider in relation to its dealings with a medical scheme, the Council must report the conduct to any body or organisation which has jurisdiction over the healthcare provider concerned, and to the National Prosecuting Authority as fraud constitutes a criminal offence.

Section 66(2) further provides that “No contravention or failure to comply with any provision of this Act shall be punishable under subsection (1) if the act or omission constituting that contravention or failure to comply with any request or requirement is punishable as an offence under the provisions of any other Act of Parliament which controls the professional conduct of any healthcare provider.”

This means that the Act provides certain powers to the Council and medical schemes for protection against fraudulent acts, except for the conviction of fraud, as such cases must be referred to the relevant authorities.

The Council for Medical Schemes (CMS) previously dealt with a matter in the High Court where a dependant’s membership with a scheme was terminated on the basis that there were allegations of fraud against him in his capacity as a service provider to the scheme.

The CMS ordered the scheme to reinstate the person’s membership as he had not been convicted of fraud by a court of law; and section 29(2) does not contemplate termination of membership where the fraudulent activity was not committed in respect of his membership of that particular scheme. The court agreed with the CMS in its judgment and the member had to be reinstated.

Another issue that frequently arises is where providers approach the CMS to enquire whether medical schemes are allowed to perform forensic investigations or audits on the services rendered to members of the schemes. The issue of confidentiality of patient records is also raised from time to time.

The CMS’ view is that there is nothing in the Act that prohibits these investigations provided that they are performed in a constitutionally sound manner, and in terms of an approved policy of the scheme, to ensure that the rights of all the affected parties are respected.

The affected patients will be members of the scheme which is already in possession of the personal information of the member concerned, there should therefore be no breach of confidentiality.

Medical schemes are created to assist members with the funding of healthcare claims. The Act regulates how the funds of a scheme should be treated to ensure that they are used for the intended purpose. If fraud is committed and people misappropriate scheme funds, it means that such money cannot be used to pay for important medical procedures and other lifesaving interventions, which will likely lead to contribution increases.

Against this background, it is important that fit and proper people are appointed or elected to manage the affairs of a medical scheme, and that members and providers refrain from abusing benefits.

There is a legal obligation on any party who is aware of a fraudulent act being committed to report such activity to the relevant authorities, and in this case the CMS. The industry needs to work together to combat fraud and corruption in any shape or form.

SAMWUMED

Real Heritage Real People. Real Health Care.

SAMWUMED placed under provisional curatorship

The Western Cape Division of the High Court in Cape Town recently placed the South African Municipal Workers Union Medical Aid Scheme (SAMWUMED) under provisional curatorship following a successful application by the Acting Registrar of the Council for Medical Schemes (CMS), in terms of Section 56(1) of the Medical Schemes Act, No. 131 of 1998 (the MS Act), and Section 5(1) and (2) of the Financial Institutions (Protection of Funds) Act 28 of 2001 (the FI Act).

Acting Judge Andrews ordered that Mrs Duduza Khosana be appointed as provisional curator for SAMWUMED.

The two key issues for determination by the Court in this matter revolved around

- (a) whether the current Board of Trustees (BOT) of SAMWUMED was legally constituted; and
- (b) whether the CMS has established that there is good cause to warrant the appointment of a curator.

CMS submitted that SAMWUMED is closely associated with the South African Municipal Workers Union (SAMWU); and has been affected by the internal strife that arose within SAMWU since 2016.

The CMS submitted that the strife between the warring factions has resulted in material irregularities which have paralysed SAMWU's management, including its ability to hold scheme meetings.

The regulator further indicated that the continued participation in the BOT decisions by the trustees whose membership were terminated on 4 May 2016, gave rise to a situation where SAMWUMED was unlawfully managed for approximately 20 months.

The CMS asked the Court to appoint a curator for the Scheme, as a move towards addressing the issue of the invalid BOT, and facilitate the election of a new BOT. The Court found that "the state in which the BOT is

currently functioning is not conducive and that restoration of proper governance of the scheme in compliance with the provisions of the Trust Deed and its regulatory framework is of primary importance."

Citing AJA Fourie in *Barnard v Registrar of Medical Schemes*, Acting Judge P Andrews concluded that it is in the interest of the beneficiaries of the Scheme to appoint a curator, in view of the material irregularities identified in this matter. The Court found that the CMS had established a good cause for the appointment of a curator under these circumstances.

Implications of the provisional curatorship

The curator will assume control of the business of the scheme in order to restore the scheme to proper corporate governance and to address irregularities identified by the Office of the Registrar.

The Registrar wish to point out that there is no need for ANY concern on the part of members and service providers, regarding the day to day operations of the scheme.

Advice to brokers

Brokers are strictly cautioned not to act in any manner that negatively affects the integrity of the scheme's risk pool. Any advice provided to members must be in line with the principles of good advice, and in the best interest of members.

The CMS will continue to exercise statutory oversight regarding the affairs of the medical schemes, and to ensure that the interests of members of medical schemes are protected at all times.



CMS Education & Training Plan 2018

The Accredited Skills Programme

Is aimed at Trustees and Principal Officers. Training is spread over two sessions of two days each. The programme is made up of unit standards which are quality assured by the Insurance Seta (INSETA), and registered on the National Qualifications Framework (NQF) carrying 30 South African Qualifications Authority (SAQA) credits. The Accredited Skills programme upon completion, awards 24 knowledge CPD points and 2 Ethics Continuing Professional Development (CPD) points.

Trustee Induction

Is a two day training session aimed mainly at newly appointed members of the Board of Trustees. Participation in the training is open to all schemes. Participants consists of Trustees from open and

restricted schemes. This training programme is a pre-requisite for registering for the Accredited Skills Programme.

The Advanced Broker Training Programme is aimed at Accredited Healthcare Brokers who have attended the Induction Programme of the CMS. It is also beneficial for Medical advisors, Healthcare intermediaries, Broker consultants, Client liaison officers and other employees of the medical schemes, who need to acquire an in-depth understanding of the concept of medical scheme design, as well as compliance and pricing issues in relation to medical scheme financial soundness. Participants who are affiliated to the Financial Planning Institute (FPI) can claim CPD points by attending the programme.

	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER
Accredited Skills Programme	PTA 21-22 RSVP	PTA 19-20 RSVP			PTA 4-5 RSVP	PTA 8-9 RSVP
Trustee Induction Training				PTA 13-14 RSVP	CT 11-12 RSVP	
Advanced Broker Training			PTA - 3 PE - 10 CT - 17 DBN - 24 RSVP			



How to submit a complaint to the CMS

You can submit your complaint to the CMS Complaints Unit by mail, fax, email or in person at the CMS offices from Mondays to Fridays (08:00 – 16:30), or submit online by visiting the CMS website: www.medicalschemes.com

Your complaint should contain the following details: Full names; membership number; benefit option; contact details; full details of the complaint together with any documents that substantiates the complaint.

The CMS Complaints Unit also provides telephonic advice and personal consultations, when required.

Complaints forms are available at www.medicalshemes.com

Time limits for dealing with Complaints

The CMS will send a written acknowledgement of a complaint within 3 working days of its receipt.

Within 4 days of receiving, and analysing the complaint, the CMS must refer the complaint to the relevant medical scheme for comments.

The medical scheme is obliged to provide a written response to the CMS within 30 days.

Upon receipt of the response from the medical scheme, the CMS will analyse the response in order to make a decision or ruling. Decisions / rulings will be made within 120 days of the date of referral of a complaint, and communicated to the parties.

How to avoid complaints

- Read the small print carefully when you choose a benefit option from a medical scheme.
- Make sure you have read and understood your scheme's rules.
- Study your benefit guide.
- Read all correspondence from your scheme.
- Make sure your contributions are paid in full and on time.
- Follow the correct claiming procedures or rules.
- Use your scheme's network of service providers (doctors and hospitals) for consultations and treatments to avoid co-payments.
- Ask your pharmacist for generic medication which may be cheaper and save you some money.
- Keep yourself informed on developments relating to medical scheme cover.



CMS

Council
for Medical Schemes

CMS News

COUNCIL FOR MEDICAL SCHEMES

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