Independent Review of Medicare Integrity and Compliance

Final Report (Public Release)

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Glossary

Acronym	Full name
1LOD	First line of defence
2LOD	Second line of defence
3LOD	Third line of defence
AAA	Alternative Audit Action
ACCHO	Aboriginal Community Controlled Health Organisation
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
BID	Benefits Integrity Division
CDBS	Child Dental Benefits Schedule
CDPP	Commonwealth Director of Public Prosecutions
CT	Computerised Tomography
DoHAC	Department of Health and Aged Care
GP	General practitioner
HIA	Health Insurance Act 1973
HPOS	Health Professional Online Services
EDI	Electronic Data Interchange
MBS	Medicare Benefits Schedule
MCA	Medicare Claims Assessment
MEO	Medicare Engagement Officers
MOU	Memorandum of understanding
MRI	Magnetic Resonance Imaging
NACCHO	National Aboriginal Community Controlled Health Organisation
NCDT	Non-compliance Detection Tool
NDIS	National Disability Insurance Scheme
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
PRP	Practitioner Review Program

Acronym	Full name
PSR	Professional Services Review
ToR	Terms of Reference

Transmission and executive summary

Dear Minister,

I present my final report to you from the Independent Review of Medicare Integrity and Compliance (The Review) that you announced late last year. In this report, I outline my findings and observations of the system from my limited time conducting this Review, and outline, through my recommendations, the way forward, for your and the government's consideration.

Given the nature of this Review regarding fraud and non-compliance, and vulnerabilities of the payment system, I have been open in my dealings with stakeholders and the regulators of the system. Given the nature of some of the vulnerabilities in the system and that public discussion could see this exploited, there are some aspects of the Review which I will reserve for your confidential consideration.

Given the timeframes set for this Review, my formal consultation with stakeholders has been necessarily limited, supplemented by informal discussions with participants, and I have based most of my work on desktop analysis.

While this Review is focused on the payment system of the Medicare Benefits Schedule (MBS), my deliberations lead me to the conclusion that a sound and well-functioning compliance and integrity system for MBS payments is critical for Australians to have trust in the Medicare system overall.

To this end, I hope this Review assists in the broader reform agenda of Australia's Medicare system by providing firmer foundations for the system in which Australians can place their trust. I want to also acknowledge the openness and cooperation I have received from your department, particularly the Secretariat to this Review, Services Australia, and key stakeholders in the health system, including practitioners and peak bodies.

A great deal of attention has been drawn to the subject matter covered by this Review by public analysis of Dr Margaret Faux's work. I have had the opportunity to spend time with Dr Faux and thank her for her generosity and openness. Her work has, on one level, been a great service to the system – in shining a light on the key issue of trust in our health system.

There are significant issues raised in the current debate which highlight the complexity of this area. The evolution of the payments system over many years due to technology, changes in business models, and changes in the delivery of healthcare, has led to the lack of a system-wide perspective as ad hoc or narrow-cast changes have been made over many years.

Importantly, there are deep definitional and philosophical questions to be debated, starting with the building blocks of the MBS, namely:

- A Medicare benefit is paid to a patient, not a provider but which, for a large proportion of services, the patient assigns the benefit to the provider.
- There is a distinction between the clinically appropriate care that a practitioner rightfully determines versus the MBS requirement for payments to be made in line with specific Medicare items and the rules associated with these as detailed in Medicare item notes, and the interaction with various regulatory requirements, including those in the *Health Insurance Act 1973 (HIA)*.

The reality is that business practices, technology, and models of healthcare delivery have clouded the understanding of these foundations, and this is the frame for understanding the key issues in the current debate. It is important to distinguish between the provision and receipt of services in accordance with the MBS versus what is clinically appropriate. Similarly, it is important to distinguish between inadvertent errors that are isolated or ad hoc versus systematic and repeated error versus downright fraud. Indeed, understanding these distinctions helps one understand the breadth of estimates of non-compliance versus fraud, and the debate as to why systematic errors might be considered fraud.

- While the system is inherently complex, complexity, per se, should not be interpreted as the sole explanation for the current state of the system.
- While simplification and system changes are required as articulated in the Review, there must also be a commitment by all stakeholders to change which will bolster the integrity and compliance of the MBS.

At the core of all this, though, lies the complexity of the system, the lack of clarity of many aspects of the compliance system, the lack of emphasis in decision support pre-claims and pre-payment, and the lack of continuous monitoring.

Legislation, governance, systems, processes, and tools are currently not fit for purpose and, without significant attention, will result in significant levels of fraud.

To be blunt about this:

- **Business practice**: The controls around new business models and practices need urgent attention and tightening up.
- **Software not accredited**: To make matters worse, especially given the high volumes of claims and services provided, software for billing solutions complete an initial accreditation process which consists of a software developer interface agreement that includes supporting policies and management (e.g. integrated third party security and health and aged care web services), though these do not go sufficiently far enough to limit the opportunity for non-compliance, fraud and billing errors.
- **Diminution of individual responsibility**: Compounding this is the increasing lack of attention paid to the checking of this by practitioners who consider this an administrative burden. This is a function of the greater corporatisation of the system, inadequate education and training in the billing and compliance system, and the squeeze on time as a result of system pressures.
- **Lack of due diligence**: The lack of scrutiny by virtue of there being no continuous monitoring regime of MBS transactions means there is no meaningful way of education and re-education feedback loops to be fundamental to the system, assisting providers to make more accurate billing claims, and leaving the gate wide open to fraud. The engine which sits at the heart of the payment system is old and unable to be properly utilised for risk based or continuous monitoring activities.
- **Governance is out of date**: As the health system as evolved, governance of the compliance system of MBS payments is now inadequate – running the risk of piecemeal approaches to compliance and fraud and no holistic understanding of major trends and changes in the nature of healthcare delivery.

There are too many methodological matters to reconcile the competing views on the extent and proportionality of fraud, non-compliance, waste, low value care and the like which are key parts of the debate. However, in this Review, I propose some methodological ways forward and provide an indicative analysis, based on limited data and a conservative definition. It is not possible for me, based on the lack of available data in the system, and the timeframe for this Review, to conduct and provide you with definitive analysis of the extent of non-compliance and fraud in the system.

This analysis provides, an albeit partial, perspective that leads me to conclude that on a conservative definition of non-compliance and fraud it is entirely feasible the value of non-compliance could exist in the range of $1.5 billion to $3 billion, not inconsistent with previous studies. This comes with a significant caveat, in that there is real potential for the problem to scale to the order of magnitude in Dr Faux' analysis should effective controls, systems and education not be put in place.

It is my strong suggestion to commentators and policymakers that the actual number should not be the main subject of debate, attractive as that may seem, as the main lesson to learn from this Review is that we must focus on the structural issues and controls in the system, to build trust in Medicare and materially reduce non-compliance and fraud. To this end, some of Dr Faux's key arguments are important to take seriously as they point to vulnerabilities in the payment system.

I am also conscious that there are wider impacts of these sorts of discussions and debates and that a number of key participants in the health system have taken offence to the claims of entrenched, intentioned, and significant fraud in the system. While such impacts don't change the truth of the debate, it does remind us that the semantics and specifics of language, how we talk about these issues, and how we debate and draw on evidence, should focus on the arguments not the person and be constructive. This equally applies to those on different sides of the debate which is the subject of this Review. To reiterate, there is greater value to be gained from a focus on the structural recommendations in this Review than on the numeric value debate that has been a focus of public discourse to date. Stamping out fraud and reducing non-compliance must be the focus of system reform.

On the basis of my consultations and my experience with Australia's health system, the overwhelming majority of practitioners are well meaning and protective of the Australian health system, particularly of the care they provide to their patients.

A large part of the success and efficacy of Australia's health system, to date, is due to this level of altruistic behaviour by health professionals. That said, my Review highlights growing vulnerabilities and forces of change which could, in a short period of time, result in significant leakages, including fraud, in the system.

At present, it is my view that a significant part of the leakage in the Medicare payment system stems from non-compliance errors rather than premeditated fraud. Indeed, one could argue that there is a significant amount of 'fear' of the compliance regime, notwithstanding it is not as far reaching or effective as it could or should be in practice. But there is no room for complacency.

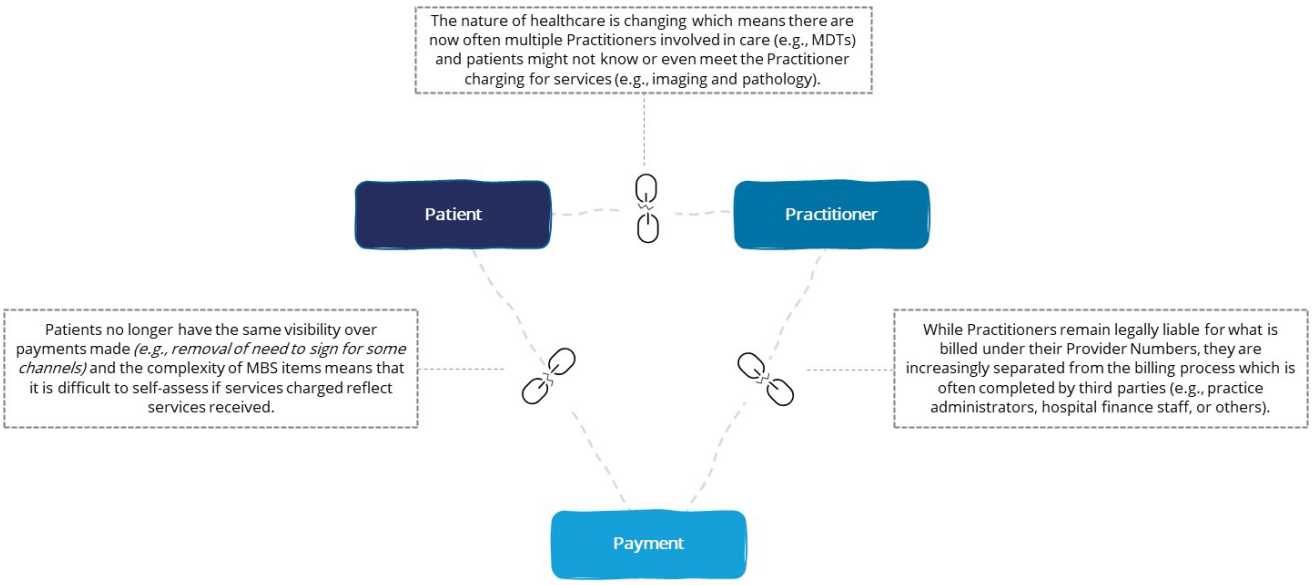
Critical to addressing this is a recognition that the legislative basis for Medicare is fast becoming out of date, unable to reflect the changing health needs and modes of health service delivery in Australia.

To ensure that this Review remained focused on the bigger picture, the following principles were developed to guide analysis of information and synthesis of consultations:

- Most health practitioners and staff within the system are dedicated to the public good and this needs to be acknowledged.
- A balance between investment in compliance activities and the protection of Medicare as Australia's universal health insurance scheme (the Scheme) and the public good and good of patients, practitioners, and taxpayers needs to be struck.
- The impacts of any potential changes on both patient outcomes and healthcare provision and the emotional and process burdens on practitioners need to be weighed against any potential negative unintended consequences.
- The money available through Medicare needs to be conceptualised as taxpayer money that must be spent in an appropriate and evidence-based way for the betterment of public health and wellbeing.
- The funding models and mechanisms of Medicare should work to incentivise best practice, support service accessibility and affordability for individuals and the community, and support health practitioners.
- Compliance and integrity activities should identify and reprimand any actors in the system who are dishonestly obtaining benefit or causing loss, and not unintentionally penalise those who are trying to do the right thing.
- As with all parts of the healthcare system, Medicare payments should be designed in a way that works backwards from patient outcomes to support the accessibility and quality and safety of health services to those that need it, especially those underserved or vulnerable populations.

Through the process of conducting this Review, it has become clear that Medicare has grown organically over time (in response to changing needs and government agendas) rather than based on clear strategy, changing demography, burden of disease and emerging therapeutics, models of care and technology. An unintended consequence of this growth over the last nearly 40 years is that there is no longer the same connection that there used to be between patient, the practitioner, and the payment (see Figure i).

Figure i: Medicare practitioner, patient and payment link



Source: Philip Review (2023).

All these changes open the door for integrity and compliance risks. When there was a clear link between payment, patient and practitioner there were inbuilt compliance and integrity checks present that protected practitioners and the Scheme. However, now that some of the fundamental assumptions about the system are no longer always true, there needs to be more consideration given to what this means for the extent, nature and type of compliance activities necessary to protect the Scheme and the practitioners who bill to it.

The compliance and integrity activities which control the Scheme not only have the capacity to influence efficient operation but also the effective and sustainable delivery of high-quality and safe healthcare.

There are a number of factors that are starting to generate **vulnerabilities** in Australia's Medicare payments system, including:

1. The **changing burden of disease** in Australia: the growth of more complex and chronic diseases is not easily addressed by the current controls in Australia's payment system.
2. The **changing nature of healthcare delivery**: it used to be the case that there was a simple relationship between provider, patient, and payments. This is no longer the case as multidisciplinary teams have formed around more complex cases, a broader range of healthcare professionals have been embraced into the remit of the Medicare system, and where the biller is not necessarily the service provider.
3. The **MBS is complex**: while health practitioners typically claim a limited number of MBS items relevant to their specific practice, there are now around 6,000 Medicare items which are not always clear to navigate and interpret. Despite the fact that peak bodies of healthcare professionals continue to be engaged in the design of MBS items through MSAC and the MBS Continuous Review, changes occur to these items at a frequency which is difficult for individual practitioners to keep up with. Indeed, I am advised that some 3,000 Medicare items underwent some change over the last 2-3 years. In this environment, communication of changes to health professionals themselves needs to improve.
4. **Corporatisation of medicine**: the growing corporatisation of medicine has further weakened the simple relationship between provider, patient, and payment. Increasingly, practitioners note that they have less and less visibility and control over what is billed in their name. Surprisingly, entities which can run medical centres do not need to be registered for the purposes of submitting Medicare claims and being paid by Medicare.
5. **Growth in billing software**: there is a rise in Medicare billing software employed in practice, yet the current accreditation processes do not progress far enough to limit the opportunity for non-compliance, fraud and billing errors.
6. **Public hospitals MBS billing arrangements are opaque**: there is increasing concern that medical specialists in public hospitals claim to have little or no visibility of what is billed in their name. This is a matter for further investigation and discussion with States and Territories beyond this Review's timeframe. This is a matter which should be the subject of further work as part of broader Commonwealth-State health reforms.
7. **Economics of medicine**: there is sufficient evidence and arguments that as the economics of practicing medicine come under pressure (namely the prolonged period of the freezing and non-increase of the Medicare rebate), there will, axiomatically, be an incentive to game or rort the payment system and/or see under billing result in under servicing of Australians and their health needs.
8. **Lack of continuous monitoring and compliance**: the current system for risk identification and analysis is predominantly project based rather than continuous and proactive. Notwithstanding the 'fear' in the system regarding compliance, a very small proportion of payments are scrutinised or systematically analysed. The lack of continuous monitoring and analysis of the 500 million transactions a year is a growing area of vulnerability.

These are significant forces at work in the health system – its evolution not matched by the policy and legislative underpinnings of the payment system. Moreover, **the current system is overly fragmented, disjointed, and lacking in contemporary tools to detect and address non-compliance and fraud, despite the best endeavours of bureaucrats, regulators, and peak bodies**.

I observe that each part of the compliance system works to maximise their remit, but there is little connectedness in the system. Policy is disconnected from payment, from risk identification and from risk treatment including compliance letters, audits and professional services review. Indeed, an important finding of this Review is that it is difficult to pinpoint who is ultimately responsible for the oversight of the operations of the compliance and integrity system of the Medicare payments system. In significant part, this reflects the administrative arrangements of the

system which have moved between agencies and departments over many years even as the nature of the health system has been evolving at pace. Not surprisingly, **governance has not kept up and has, indeed, become fragmented and disjointed**. This governance matter needs resolution and is a starting point in recommendations for reform.

In essence, my review makes the following system findings and recommended directions for reform:

1. The MBS payment system is premised on a notion of patient-provider-payment relationship which is increasingly less valid and the system of healthcare delivery is evolving at a pace which is rendering the current conception of the system, in legislation and regulatory practice, not fit for purpose.
    - The system, including legislation, and regulatory practice must recognise the new models of healthcare delivery such as greater corporatized medicine, greater use of multidisciplinary teams (adding to the complexity of billing), the emerging characteristic where the biller may or may not be the deliverer of the service, and new business models and software reducing the visibility and involvement of providers with their billing practices.
2. There is a **disproportionate focus of the systems on post-payment** with little attention paid to pre-payment, pre-claim, provider decision support for billing, or means to improve patient participation. To reduce non-compliance and fraud, clarity of the rules, and system focus on pre-claim and pre-payments is a necessity.
    - This also points to the importance, over time, of improving the stake that patients have in the billing and payment system, such as patient verification, via SMS, of services received and greater incentive to participate in their MyHealth record.
    - Moreover, greater investment in decision support for practitioners is vital as technology evolves and data sets are better able to be utilised to reduce non-compliance and fraud in the system.
3. A **governance gap** has emerged over the years. Governance must be improved to drive accountability, co-ordination, and integration in the compliance and integrity of the MBS payment system. Without more end-to-end integration and system oversight, it is hard to achieve best practice in good enforcement and compliance regimes. Ensuring that policy intent, changes in the system, feedback loops to practitioners, and risk intelligence is shared and acted upon to deliver outcomes of reduce non-compliance and fraud is paramount.
4. There is no **continuous monitorin**g of payment transactions in the system. With $38b in annual Medicare payments and more than 500 million transactions a year, it would be expected that, like what exists in financial institutions, that continuous monitoring be established. This must be given careful consideration to ensure that most payments continue to be paid at time of claim, and that those flagged, by risk, for query are resolved within 48 hours to 7 days to minimise any cash flow implications for patients and practitioners. Continuous monitoring would enable for:
    - A timely verification of payments,
    - The collection of valuable data for risk analysis,
    - A timely intervention with practitioners in treatment pathways thus reducing the cost of compliance, and
    - A better systemic education feedback loop to ensure that practitioners are better educated in close to real time on billing and care, thus reducing non-compliance and cost in the system.
5. The current **technology platform** for analysis and payments used is old and runs the risk of being unsuitable to support integrity into the future. In order to implement continuous monitoring, the 'brain' of the system needs to be modernised, and new controls, in line with a 3 lines of defence methodology, should be adopted. More effective controls means that timeliness of feedback to practitioners becomes central to behaviour change and knowledge exchange. This will require a major investment in modernising the platform and compliance tools and techniques.
6. Risk identification and treatment pathways currently rely, overly, on tip offs, outlier analysis, and the limited capacity of the department to conduct a small number of campaigns each year. Continuous monitoring and risk stratification go hand in hand with assessment of each transaction in a continuous monitoring regime. This will require significant resourcing of the department to carry out this function. I also strongly recommend that the department conduct further analysis of non-compliance and fraud, alongside considerations of low value care and waste, based on more comprehensive data sets.

7. While consultations between the department and the sector are good, they do not translate sufficiently well into proper feedback loops around education. Stakeholder involvement should move significantly more towards education than mere consultation on changes and compliance campaigns. While there are good lines of communication, these need to translate into practitioner support – through greater clarity of billing, changes and new interpretations of items, and better planning to assist practitioners when Medicare items are created or changed.
8. The Professional Services Review (PSR) regime generates significant 'fear' among practitioners despite a very small number of the practitioner population ever getting near the PSR. Many stakeholders agree it is important for there to be an effective, independent Medicare regulator, and current referrals to PSR are based on rigorous analysis of claiming behaviour of those preselected for review. But the sample size is limited by virtue of there not being any continuous monitoring of all transactions.
9. Moreover, factors such as timeliness (lack thereof) and compliance costs risk undermining support for this key integrity mechanism. Continuous monitoring and timely analysis of payments and greater emphasis on early identification of non-compliance and education will help to ensure that the pathways to the PSR are reserved for the most serious cases of non-compliance and potential inappropriate practice. Greater timeliness in identifying serious non-compliance means that concerning behaviours are addressed sooner by PSR. An anachronism of the current system is the veto power vested in the AMA on the appointment of the Director of the PSR. On account that the PSR looks across multiple disciplines, this veto approval power should be removed as part of the modernisation of the system. Notwithstanding the views of the AMA, I suggest this is a power that won't be missed (as it has never been exercised, to date, as confirmed by the AMA).
10. With around 6,000 Medicare items, which are undergoing constant change, and 14 claim channels, simplicity is a critical objective for reform. It will be important to consider reforms to Medicare items to drive simplification and clarity, and a system reduction in claiming channels is necessary. Consideration should be given to restructuring the design and composition of MBS items with a time-based backbone together with additional specific intervention and procedure codes, bundling of co-claimed surgical items to create single procedure codes, and integration of pre-claim decision support into primary care practice management software.
11. Consistent with finding (1) above, and the program of reforms outlined, legislative change will be important to facilitate the objectives of better governance, continuous monitoring, risk identification and treatment, and better capturing the way healthcare is delivered. Some legislative changes to drive better compliance are included in this Review, but more detailed consideration of legislative changes should be considered as the Government determines a course of action flowing from this Review.

In terms of the current compliance regime, it is clear that it is partial and sub-optimal in its effectiveness – significantly due to its project-based approach, ad hoc nature of inputs, over-reliance on tip offs, lack of systematic measures for continuous monitoring, and the disjointed nature of the parts of the compliance system which makes it hard to assess success or failure. Having noted that, there is much to commend those working in the system (in both the department and Services Australia) who are diligent and working with the best that they have in terms of resources, infrastructure, and tools. Importantly, though, looking ahead, serious consideration needs to be given to the emphasis of the compliance system.

A focus on these findings and the way-forward can help simplify the navigation of the system by practitioners, patients, and regulators, and lead to better outcomes in terms of fraud and errors being avoided and fraud being detected and caught.

Based on the various analyses completed to date (consultations and desktop review), and my understanding of the maturity of the system, I consider it likely that non-compliance comprises a more significant component of leakage in the system compared to fraud, however, this could change significantly if left unaddressed.

It is difficult to escape the conclusion that the vulnerabilities in the system are real and material. The nature of the solution is structural – from major investments in the payment platform to handle a workable risk-based system, to better business rules and controls, to continuous monitoring, to better governance and data sharing, to systems which provide better education and decision supports to providers, and, in the longer term, ways to bring greater consumer participation into the system (perhaps in conjunction with the Australian Digital Health Agency and the Australian Consumer Health Forum).

The way forward recommended in this Review is not easy, on account of the complexities of the system, inertia and strong positions held by regulators, policymakers, and stakeholders alike.

To illustrate, by the numbers, the current system is complex (some by necessity, some not) in 2021–22:

- 511 million transactions; there is no continuous monitoring of these transactions
- Around 6,000 Medicare items
- 176,000 practitioners who claim
- 14 different claiming channels with different levels of risk and controls.
- Less than 10% of risks brought to the attention of regulators are progressed to some sort of treatment pathway
- Only 40-60 compliance projects examining cohorts of providers are conducted each year

Add to this the changing burden of disease, corporatisation of the sector, and advances in new technology and forms of healthcare delivery, and you can get a clear picture of complexity and need for a well-functioning compliance and integrity system. Legislatively, responsibility lies with healthcare providers to ensure Medicare claiming occurring under their provider number meets all requirements, and references in this report to the complexity of the Medicare system should not be considered a legitimate excuse for systemic and intentional non-compliance and fraud.

However, there are consequences for persisting with the current overly complex, difficult to navigate system, namely that the directions for abuse of the system will escalate, that more time will be spent by providers on administration not care, that the billing system will drive clinical practice, and that underbilling in the system will shift to underservicing (i.e. practitioners will cease to pursue altruism and provide a service when they don't bill for it). In any of these pathways, the health system will be structurally diminished. If these challenges are to be addressed, then it will require the government and health sector stakeholders to work together in the design of solutions to reach the ideal future state of Medicare and Australia's health system that is more focused on addressing patient needs.

Addressing non-compliance and fraud is about trust in Medicare. Zero tolerance on fraud is hard to escape, while a tolerance of waste and errors will be a matter for government judgement and taxpayer concern.

Importantly, non-compliance and fraud impact on the quality of care that patients receive. I have been more than surprised during this Review by the lack of mention of patient experience and health and well-being during my consultations and in my review of previous analyses. All aspects of our health system must revolve around this as a matter of the culture of our health system, including deliberations on questions of non-compliance and fraud.

Yours sincerely

Dr Pradeep Philip

Head of Deloitte Access Economics

Recommendations from this Review

Recommendation	Details
Governance and structure	
Recommendation 1	Strengthen the governance model overseeing Medicare through each line of defence.
Recommendation 1.1	Introduce an expanded governance structure to embed a Medicare Oversight Committee with representation from DoHAC (chair), Services Australia, ADHA, the Digital Transformation Agency and independent experts.
Recommendation 1.2	Establish and embed working groups focused on three key areas of Medicare: 'Policy, Legislation and Program Evaluation', 'Claims and Payments', and 'Technology and Data Management'.
Recommendation 1.3	Consider restructuring the design and composition of MBS numbers with a time-based backbone together with additional specific intervention and procedure codes, bundling of co-claimed surgical items to create single procedure codes, and integration of pre-claim decision support into practice management software.
Operational processes	
Recommendation 2	Implement enhancements to the end-to-end claiming journey to strengthen the first line of defence position and enable continuous monitoring of all MBS claim transactions.
Recommendation 3	A refreshed design of key frontline operational processes, and business rules, which consider fraud and non-compliance risks is required and is urgent in order to sufficiently support the early identification and disruption of fraud and serious non-compliance. Enhanced identification of risks should be applied to disrupt fraudulent activity as early as possible.
Recommendation 3.1	More formal and deliberate feedback loops into key controls to mitigate program and integrity risks throughout the life of the MBS must be considered jointly by DoHAC and Services Australia. This involves greater integration across the various functions in DoHAC and Services Australia to build a complete end-to-end picture of compliance and appropriate data sharing.
Recommendation 3.2	A comprehensive system for continuously improving and updating education and awareness for providers regarding the application and use of the MBS must be introduced, including the involvement of key stakeholders.
Recommendation 3.3	Risk identification must be enhanced by both DoHAC and Services Australia, based on continuous monitoring; data from which will enhance detection models based on casework, intelligence and tip offs.
Recommendation 3.4	Implement more proactive identification of policy gaps to further strengthen the MBS compliance capabilities in line with the risk-based approach currently being adopted.
Recommendation 3.5	Consider the optimal operating environment to support a culture of information sharing and risk mitigation awareness across the relevant government agencies and teams, including identification of legislative and privacy-related concerns.
Recommendation 3.6	Consider expanding the use of practical case studies to support existing information and education materials available to health professionals. Closer collaboration in the preparation of education materials between government agencies and peak bodies, and an expansion of

Recommendation	Details
	the education efforts to include corporate entities and administrative staff involved in preparing MBS claims.
Recommendation 3.7	Consider ongoing tailoring of the education and reference materials available to providers and patients to support compliant MBS claiming. Ongoing participation in face-to-face seminars and education events for target groups.
Modernising technology	
Recommendation 4	Redesign of the Medicare payments system to a level of capability maturity that is commensurate with the size and complexity of the Scheme today and into the future.
Recommendation 4.1	Implement requirements for greater data checks and compliance within practice management software. This would enable closer integration of practice management software with the claims assessment rules engine to enable real-time claims assessment for providers to avoid unintentional non-compliant claiming.
Recommendation 4.2	Implement technology to enable consistent and complete pre-payment checking and validation of all MBS claims as part of the first line of defence.
Recommendation 4.3	A review regarding replacement of legacy Medicare systems, applications and databases should be conducted within 12 months.
Recommendation 4.4	Urgent consideration should be given to options for the replacement of the ageing Medicare Common Assessment rules engine to a contemporary technology infrastructure.
Recommendation 4.5	New Governance processes should be implemented (and legislative changes may be required) to expand the data exchanged between Services Australia and DoHAC.
Recommendation 4.6	Given the current lack of sufficient controls and analyses, and given the vulnerabilities in the system, DoHAC and Services Australia should conduct an urgent strategic review of current data assets and uplift of current data analysis.
Recommendation 4.7	Consider consolidation of the EDI simplified billing channel into the ECLIPSE billing channel to centralise all hospital inpatient claiming and enable data linkage to acute hospital datasets for compliance analysis.
Strengthening legislation	
Recommendation 5	Consider ongoing review of Medicare's enabling legislation and regulations to achieve the envisioned future state. Approaches employed by other regulators to ensure a consistent and contemporary approach should also be considered – including mechanisms such as statutory penalties to deter inappropriate behaviour and encourage earlier resolution of compliance cases, expansion of powers to ensure all types of serious non-compliance can be effectively dealt with and a reduction in regulation and legislation that hinders the effectiveness of compliance activities.
Recommendation 6	Remove the veto power of the AMA in the selection process of the Director of the PSR given the breadth of health professions whose registrants could be subject to a review by PSR. Additionally, the appointment of a second in charge or Associate Director could manage conflicts of interest and workloads.

1 Terms of Reference

This review has emerged from significant media attention regarding Medicare and claims about the integrity of and 'rorting' in the system. The terms of reference (ToR) that have guided the Review are:

Terms of Reference	Description
ToR 1.	Assess at a high-level, additional measures/controls for the Medicare Benefits Schedule (MBS) to reduce the risk of fraudulent billing or overservicing before payments are made. Consider measures available to slow, deter and prevent incorrect claiming such as system blocks and authorisations.
ToR 2.	Assess at a high-level, the integrity risks for the Medicare payment systems and multiple claiming channels. Consider whether some of the claiming channels are more susceptible to misuse and fraud, and steps which could be taken to minimise the risk of fraud and inappropriate practice through these channels.
ToR 3.	Develop a methodology to assess the potential value of fraudulent, non-compliant or over servicing risks in Medicare.
ToR 4.	Identify and scope opportunities for improvements in the Practitioner Review Program and Professional Services Review functions, based on an assessment of their effectiveness, transparency and independence, including addressing serious non-compliant behaviours that do not constitute fraud (non-provision) and are not considered auditable under current legislation.
ToR 5.	Review the Health Insurance Act and other associated regulations, as the service provider considers relevant and appropriate, to identify potential improvements which could be made to up-front controls for payment and options to strengthen compliance treatments and penalties for fraud, inappropriate practice and non-compliance. And consider the effectiveness of current legislative arrangements for the treatment of non-compliance by non-health provider entities. Also assess the effectiveness of recovery mechanisms for debts due to the Commonwealth, and escalation processes for repeated non-compliance.

This report does not explore these ToR individually, but instead presents an overview of the current state, key issues, and findings that have been identified to date through the Review. This approach better recognises the need to look at the Medicare integrity and compliance system as a whole and in the context of its intent and purpose. As such the structure of this document includes:

- Chapter 2: Current state analysis: which describes the current state of the MBS and Medicare system
- Chapter 3: The future state direction: which outlines a number of recommendations to address the findings and contribute to optimising the MBS and Medicare system
- Chapter 4: Implementation: which suggests a roadmap to implement the recommendations

A list of the stakeholders consulted for the Review is outlined in Appendix B.

Limitations of this report

This report has been unable to cover all aspects of the MBS and Medicare system within the bounds of the terms of reference and scope outlined above. The following should be considered when reviewing this report:

- Consideration and commentary regarding the reimbursement attributed to individual MBS items, how they relate to individual health professionals and patients has not been within the scope of this Review.
- The timeframes for this Review have led to a focus on targeted stakeholder interviews and engagement, and I am grateful for the time and effort representatives have provided to me. I have not had the opportunity for a broader community consultation and submission process.
- Data reflected in this report has been sourced from publicly-available sources as well as provided directly by DoHAC, Services Australia, and the representative stakeholders with whom I have met with through the course of this Review. I have not sought to verify the authenticity of the data and I have nominated the sources where relevant to provide transparency.

2 Current state and findings

2.1 Defining compliance and integrity in the current Medicare system

It is important to acknowledge that definitions of what is considered fraud and non-compliant activity is complex. This complexity increases when policymakers consider 'low value' care. For example, claiming a computerised tomography (CT) scan for a private patient would be considered compliant activity if the GP validly requested the scan and the Radiologist provided the services and claimed the correct MBS items. This activity would be considered low value care if the patient had already received an x-ray and magnetic resonance imaging (MRI) investigations. Table 2.2 in this section describes in more detail the variation in understanding about 'waste' or low value care and fraud or non-compliant activity.

Different stakeholders have different understandings of what is considered fraudulent and non-fraudulent behaviour and there are multifaceted interactions between intent, compliance, integrity, and clinical appropriateness that mean distilling definitions to just a simple categorisation of fraud is impossible.

Differentiating between the different compliant and non-compliant behaviours is important as there are different appropriate risk identification and treatment activities required for each behaviour. There have been a number of studies and media reports over the past five years which provide vastly different estimations of fraud and non-compliance. In part, these differences in estimates are driven by the different definitions adopted by stakeholders of what constitutes compliance, fraud and over/under servicing.

There are several dimensions to consider when defining non-compliant behaviour:

- **Legal versus illegal:** Do claims meet the legislative requirements and regulated definitions of MBS item numbers and MBS billing practices?
- **Provided versus not provided:** Were services that were claimed actually provided to patients?
- **Claimed versus not claimed:** Were services provided then claimed to MBS, or not (and if not, were these costs passed on to patients, or absorbed by practitioners)?
- **Clinically appropriate versus clinically inappropriate:** Would the services be considered clinically appropriate by a panel of relevant practitioners?
- **Intentional versus unintentional:** Are players in the system intentionally trying to claim dishonestly or are they making mistakes unintentionally?
- **Appropriate versus inappropriate:** Do choices align with the intention of Medicare and the prioritisation of people's health and wellbeing?

Using these dimensions to illustrate the spectrum of compliant and non-compliant behaviours, Table 2.1 provides a summary of types of compliant and non-compliant behaviour. Behaviour is a descriptor of the thoughts and actions of actors in the system with respect to billing. Driving factors are the reasons why individuals choose to act this way. DoHAC selectively intervenes – both by actively identifying, investigating, and treating a subset of these behaviours. This involvement is broadly outlined in the far-right column. Notably, DoHAC does not intervene in all behaviour types which could be considered 'non-compliant' (such as under-claiming).

Table 2.1: Description of the range of compliant and non-compliant behaviours

Term	Definition	Driving factors	Departmental involvement
Appropriate and compliant care	• Services provided which align with best practice care and Medicare legislative requirements	• Practitioners understand and correctly claim MBS items and those items align with clinically appropriate and required care	• None required
Underclaiming (intentional or unintentional)	• Billing behaviour which does not accurately reflect services provided	• Lack of understanding of the system and what can be claimed	• None

Term	Definition	Driving factors	Departmental involvement
		• Fear of retribution if claiming behaviour is seen to be excessive or incorrect	
Low value care	• The use of an intervention when evidence suggests it confers very little or no benefit for patients, or that the risk of harm exceeds the likely benefit, or more broadly, that the added costs of the intervention do not provide proportional added benefits	• Varied interpretation and application of the available evidence • Differing teaching and training of health professionals	• Behavioural change campaign and awareness raising letters • Investigations via the Practitioner Review Program (PRP)
Underservicing	• Services which should have been provided based on clinical needs were not provided owing to confusion or concern about what can be claimed	• Practitioner concern about compliance activities • Complexity and confusion about what items to bill • Restrictions on the number of services which can be co-claimed	• None
Overservicing (unintentional)	• Conduct in the rendering or initiating of services/prescribing that would be unacceptable to the general body of the relevant profession, or where unnecessary repetition of services occurs across the system	• Complexity of MBS items and their interpretation by health professionals • Information and data silos between care settings and health professionals • Poor understanding of item numbers and the underlying legal foundation of MBS • Lack of quality education and misinformation	• Distribution of targeted campaign letters • Possible referral and investigation by PRP
Overservicing (intentional)	• Conduct in the rendering or initiating of services/prescribing that would be unacceptable to the general body of the relevant profession • Sometimes called overservicing or inappropriate practice	• Financial gain	• Serious cases of overservicing, irrespective of intent, are assessed if identified through projects or tip offs
Incorrect claiming (unintentional)	• A service is provided but the incorrect item is claimed by mistake	• Complexity of MBS items and their interpretation by health professionals • Poor understanding of item numbers and the underlying legal foundation of MBS • Lack of integrated technology solutions to guide MBS item selection • Lack of quality education and misinformation	• Serious cases of incorrect claiming where there is reasonable concern and documented evidence are investigated if identified through projects or tip offs
Incorrect claiming (intentional)	• A service is provided but the incorrect item is claimed on purpose	• Financial gain	• Serious cases of incorrect claiming where there is reasonable concern and documented evidence are investigated if

Term	Definition	Driving factors	Departmental involvement
			identified through projects or tip offs
Non-provision of services	• Benefit is obtained by knowingly making false or misleading statement, in connection with a claim for benefit • Criminal prosecution of fraud requires intentional claiming of a service that was not provided	• Financial gain • Identity takeover	• Cases of non-provision are assessed and triaged through the Fraud Investigation Team and may proceed to criminal investigation

Source: Philip Review (2023)

The current compliance and integrity system is built around a particular definition of non-compliance which is not necessarily representative of all types of non-compliant behaviour. Table 2.2 highlights the way in which the government's definition of non-compliance differs from other commonly held definitions and views.

Table 2.2: Different definitions of fraud and how it maps to the types of behaviours

Term	Department definition	Commonwealth definition*	Academic interpretation**
Appropriate and compliant care	N.A.	N.A.	N.A.
Underclaiming (intentional or unintentional)	N.A.	Fraud and Non-compliance	N.A.
Low value care	Inappropriate practice	Non- compliance	Fraud
Underservicing	Inappropriate practice	Fraud	Fraud
Overservicing (unintentional)	Inappropriate practice	Non-compliance	Fraud
Overservicing (intentional)	Inappropriate practice	Fraud	Fraud
Incorrect claiming (unintentional)	Incorrect claiming	Non-compliance	Fraud
Incorrect claiming (intentional)	Incorrect claiming	Fraud	Fraud
Non-provision of services	Fraud	Fraud	Fraud

Source: Philip Review (2023)* Fraud against the Commonwealth is defined as *'dishonestly obtaining a benefit, or causing a loss, by deception or other means'*. The Commonwealth's position is that fraud requires intent. It requires more than carelessness, accident, mistake or error. When intent cannot be shown, an incident may be non-compliance rather than fraud (Commonwealth Fraud Control Framework 2017).** In consultations it was noted that there are a number of different definitions of 'fraud' held by external stakeholders. It appears, noting her model has not been received or reviewed, that this broad definition has been adopted and applied by Dr Faux.

The definition of non-compliance is important from two perspectives. First, it influences how we calculate the level of non-compliance and inefficiency inherent within a system. If more appropriately allocated, this 'excess' could be used to drive higher value outputs and outcomes – either within healthcare or in the public service more broadly. Refer to Section 2.9 for further detail on valuing non-compliance.

Second, the definition of non-compliance is also important to how stakeholders within the system behave. Take, for example, underbilling behaviour which is driven by a lack of understanding of the system (complexity) and fear of punishment (owing to lack of transparency in process). In time, the practitioner may begin to introduce or increase co-payments to address their funding shortfall which has implications for patient access. This behaviour drives cost-shifting within the system – from primary care to emergency care as a result of delayed time to appropriate and effective care for individual conditions. Alternatively, the practitioner may begin to underservice their patients at the expense of their clinical outcomes.

Figure 2.1 provides an overview of the definitions employed by the government in classifying subtypes of non-compliant behaviour. They are differentiated on the basis of provision and non-provision (whether a service is provided) and clinical appropriateness.

Figure 2.1: Subtypes of non-compliant claiming under current definitions

NON-COMPLIANT CLAIMING	Service provided	Service not provided
Clinically appropriate	Incorrect claiming	Fraud
Clinically inappropriate	Inappropriate practice	

Source: Philip Review (2023)

Challenges arise with the government's conceptualisation and treatment of compliance and integrity in Medicare. First, the distinction between non-compliance and compliance does vary to some degree within the Scheme itself. Strictly speaking, the boundary of 'non-compliance' is the distinction between legal and illegal application of the Scheme, noting that some treatment pathways for suspected non-compliant behaviours (the PRP and the PSR) determine 'inappropriate practice' based on a clinical rather than a legal judgement.

This interaction between legal and clinical judgement has, at times, driven uncertainty for both providers and operators of the Scheme. For example, operators of the MBS support email service 'AskMBS' report that it is difficult to provide definitive advice to providers noting that even if the advice constitutes a legally accurate definition of billing behaviour it may be deemed *clinically* inappropriate if brought to the attention of the PRP and/or the PSR.

One provider came under review of the PSR, having rendered several MBS items in excess of 98% of their peers.[1] The PSR Director's review found persistent concerns that:

- MBS requirements were not always met including that there was not always a clinical indication for health assessment services. This is an example of *overservicing*, where the service was provided to the patient and claimed correctly, however, deemed inappropriate from a clinical perspective.
- Chronic disease management service documents did not reflect a comprehensive and thorough assessment of the patient to determine their healthcare needs. Rather, a templated plan was prepared by the health professional that was either incomplete or insufficiently detailed in its observations and findings. This is an example of *underservicing*, where the chronic disease management plan was provided and claimed for, but clinically inadequate as it was not sufficiently individualised for the patient.

There are also a number of non-compliant behaviour types – including underbilling (a service is provided but the provider does not claim reimbursement) – which are driven mainly by the complexity of the system and the challenges which providers face in interpreting it. The consequences of this drive poor outcomes for both providers and patients. Indeed, even behaviour which is entirely appropriate and compliant is inefficient given the effort it takes to apply the system accurately.

Finding 1: There is a need to clearly define fraud, non-compliance and compliant claiming within the context of Medicare and have this supported by objective and measurable data captured within the system.

2.2 Vulnerabilities within the 14 Medicare claiming channels

The number and model of claiming channels has evolved since the inception of Medicare in 1984, whereby there are now 14 claiming channels that support the rebate of services across the healthcare continuum. Seven digital channels process approximately 99.7% of electronically submitted patient billed claims volumes, while seven manual claiming channels account for the approximately 0.3% remaining volume. The transition of MBS claims and billings flowing through the digitised claiming channels has enabled more efficient and timely payments. However, in some cases these channels have introduced new vulnerabilities to the integrity of Medicare that were less material and prevalent under manual claiming channels.

[1] Professional Service Review (2022), PSR Director's update for November 2022, >https://www.psr.gov.au/case-outcomes/psr-directors-update-november-2022>, accessed on 3 February 2023.

The 14 different MBS claiming channels each possess their own unique processes and steps that claimants (patients and healthcare providers) must navigate accordingly (Appendix C details all claiming pathways). A summary of claiming channels and their respective claim volumes and advantages is provided in Table 2.3.

2.2.1 Identified vulnerabilities

Almost all current claims (99.7% according to the 2021–22 volume statistics provided by Services Australia[2]) are lodged via a digital claiming channel. This explicitly supports the policy goals of equity of access to healthcare services as it minimises any potential financial burden that may be introduced due to a lag in payment of rebates, which are provided to patients as soon as the existing verification steps and checks are completed.

Most notably, the digitisation of claiming has led to:

- An increase in the convenience afforded to providers – reducing the time taken to submit bulk-billed claims manually and receive the related payment.
- An increase in service access – allowing greater equity for those patients who may have found the manual claiming pathways inconvenient and prevented them from claiming for their services or being less inclined to visit a healthcare provider in order to avoid dealing with any challenges (e.g. paperwork required to mail or fax) associated with manual claiming.
- An increase in speed of payment reimbursement – several digitised claiming channels offer payments almost immediately, with a one business day turnaround being common for patient billed claims. Patients who may have previously waited weeks, might have delayed their visit to a healthcare provider due to the burden of cost. These patients now bear that cost for only a short time.

The focus on rapid claim processing and payment has delivered a responsive MBS system, with claim channels created for specific care settings (e.g. ECLIPSE and Electronic Data Interchange [EDI] channels for hospital claims processing). However, changes to workflows, and in some cases reduced active compliance checks, have introduced new vulnerabilities that are contributing to non-compliant claiming or have exacerbated those that may have been less significant under manual claiming channels.

An unintended consequence of electronic billing has been to widen the gulf between patient participation in verification of treatment received and the service provider billing accordingly. This has further entrenched the asymmetry of information which characterises the health system – with the patient now further removed from the understanding of the payments provided for services rendered. Noting that patients can view their Medicare claims history through their Medicare online Account linked to their MyGov account. Customers can also view Medicare information in their My Health Record. However, they can only view some information and this is available only post-payment rather than prompting prior to payment.

Inherent with all claiming channels is the limited opportunity to check for clinical appropriateness of the services performed prior to payment. It is acknowledged that it is challenging to assess clinical appropriateness or excess claims on the basis of submitted data alone as multiple variables and patient factors would need to be considered.

[2] Services Australia, *Medicare Benefits Claiming*, 12 January 2023

Table 2.3: Claiming channels by volume and their associated advantages

Channel	Claim volume* (% of total claims)	Advantages
Manual claim *(comprising 7 channels)*	1.5 million (0.3% of all claim types)	• Enables optimal access to MBS reimbursement for patients who do not have reliable access to digital channels and electronic funds transfer facilities • Submission of receipt from the provider demonstrates a service has been provided to the patient • Patient has visibility of their claim verification process due to the manual nature of entry for bulk-billed items
Medicare Online	444.0 million (87% of total claims)	• Enables the payment of the overwhelming majority of MBS claims for primary care and ambulatory care settings and providers (87% as per the 2020–21 MBS volumes provided by Services Australia to the Review) • Integrated with provider's practice management systems for streamlined submission of claims. Both bulk billed and non-bulk billed services' claims flow directly from the provider to the first stage Services Australia validation checks. Claims raised by consumers flow through the provider's practice management software to verify service has been provided while a statement of claim is lodged by the practice on behalf of the patient as confirmation of submission and service provision • Enables rebates to be transferred to patients and providers within 48 hours of service via electronic funds transfer, thereby minimising any negative financial impacts for patients • Nominated bank accounts for patients and providers are used to receive the rebate payments. For patients, these are the accounts linked to their Medicare consumer records, allowing for seamless reimbursements
ECLIPSE Simplified Billing	31.6 million (6% of total claims)	(Public and private hospital claiming) • Allows for dual claim assessment and payment by Medicare and private health insurer following submission by the provider • Centralised billing management enabling all services to be claimed for an inpatient episode of care via a single submission, reducing administrative overhead
EasyClaim	24.2 million (5% of total claims)	• Accessible at point-of-sale with turnaround of payment into nominated bank accounts within two to three working days
Health Professional Online Services (HPOS)	3.9 million (0.8% of total claims)	• Webform completed by the providers with the included pre-payment checked details, and no specific software integration is required, enabling broad access to the claiming channel • Payment is made directly to the health professional's practice and their nominated bank account via electronic funds transfer for bulk billed occasions of service (within two to three working days). For patient rebates, the patient pays the practice in full (verifying service delivery), and the practice nominates the patient's bank account details attached to the claim and payment is made within one working day.
EDI (Safe File Transfer Protocol)	1.2 million (0.2% of total claims)	• Claim submissions directly from providers include a receipt of service delivery enabling a verification of service provision for a patient • Private health insurer submissions are made via EDI and occur following their review of the claim submission which provides a verification activity

Channel	Claim volume* (% of total claims)	Advantages
simplified billing		
Medicare Online Account	1.8 million (0.3% of total claims)	• Patient is required to log into MyGov and have a linked service to their Medicare online account. • If a patient submits an MBS claim directly to Services Australia, they are required to attach evidence of the receipt or invoice upon submission thereby acting as a verification of service delivery • Enables convenient and seamless claim submission by patients • Turnaround of payment into nominated bank accounts within one working day enables the policy principle of equity of access to health services
Express Plus Medicare mobile app	1.2 million (0.2% of total claims)	• Patient is required to sign into the Express Plus app and the patient must verify they are signing in to make a claim using their unique log in credentials • Patient is required to reference their receipt number for claim validation • The system only accepts claims for reimbursement if they have been paid ahead in full by the patient

Source: Philip Review (2023) *Total claims made for the financial year 2021–22 as supplied by Services Australia

A number of vulnerabilities exist commonly across the digital channels and consulted stakeholders commented on the increasing role of administrative staff and corporate entities who coordinate the collation and submission of Medicare claims via the digital channels on behalf of the individual health professionals, reducing the direct visibility they have of the claims being raised against their provider numbers.

Further to these vulnerabilities is the complexity of the technology infrastructure required to support the 14 claiming channels. Feedback was provided to me that investments are in train to uplift and modernise aspects of the supporting technology environment. Through discussions with Services Australia and DoHAC, it became apparent to me that there are a number of issues that should be addressed as a critical enabler to sustaining the Scheme into the future:

- Data and information sharing is inhibited by legislative and technological limitations. This is blunting the ability of the government agencies to proactively identify and act upon instances of non-compliant claiming behaviours.
- Complex business rules as well as system and data limitations are preventing the full implementation of new policy and legislative changes. The legacy technology that underpins the MBS payment system is limiting the ability to make reformative change regarding fraud and non-compliance (e.g. implementing pre-payment controls without significant investment in new technology and infrastructure).
- Existing systems are built around the traditional fee-for-service model with a focus on individual transactions and processes.
- There are limited analytical and reporting functionalities and capabilities to enable real-time claim behaviour tracking, analysis and flagging or to apply risk-based models to processing.

2.2.2 Duplication across channels

Comparing the multiple digital channels has revealed overlapping focus areas and capabilities. This has the potential to exacerbate vulnerabilities as well as increase the complexity and maintenance requirements of the supporting technology infrastructure and governance structures. For example, hospitals can utilise either the EDI or ECLIPSE claiming channels and both enable the involvement of private health insurers. There could be an opportunity to either combine these channels into a single channel dedicated to hospital claiming, or even further combine them into the dominant MBS Online channel to bring about consistency across all healthcare settings.

Finding 2: The existing 14 MBS claiming channels are complex and opportunities exist to reduce duplication and vulnerabilities regarding patient and provider verification, and the application of up-front claims assessment.

2.3 Governance and oversight of Medicare

Compliance and integrity activities related to the Scheme are split across DoHAC and Services Australia. At a high level, there are three key types of compliance activities undertaken in relation to Medicare:

1. Provider compliance
2. Public compliance
3. Third party compliance.

Medicare claims are processed and paid by Services Australia and the department has policy responsibility for the MBS. There were conflicting views in stakeholder consultations and documents provided as to the specific separation of delegations and responsibilities for Medicare. However, Table 2.4 provides a high-level overview of the key roles across these two agencies.

Broadly, the table shows that in addition to administering all payments, Services Australia holds some compliance and integrity functions for public and third-party compliance. DoHAC holds responsibility for provider compliance – which is by far the greatest share of all claims. The roles and responsibilities in relation to these three categories is shared across DoHAC and Service Australia and is documented in the 2021 Compliance Protocol.[3]

[3] Australian Government, *Compliance Protocol: Forming part of the statement of intent between the Department of Health and Services Australia*, July 2021

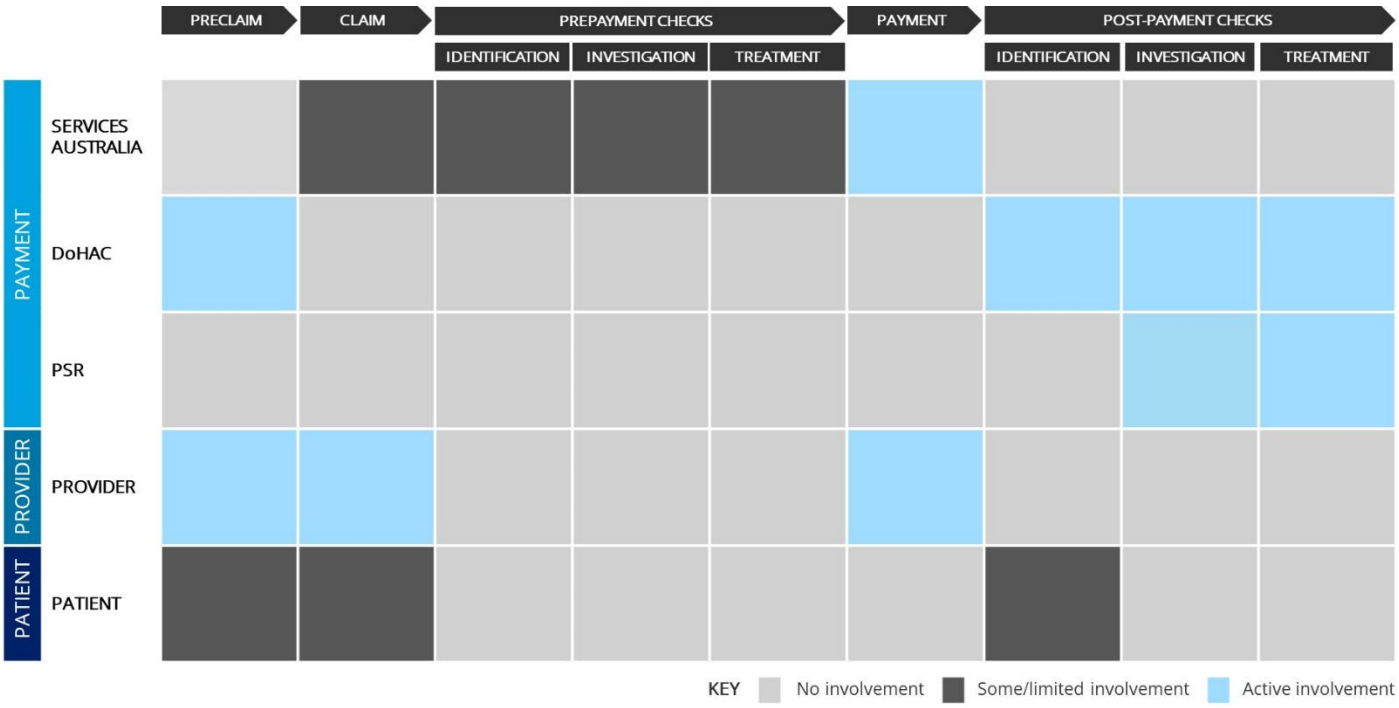
Table 2.4: Role, responsibility and compliance activities of the government in relation to Medicare

Agency	Role	Compliance role	Relevant divisions/teams
DoHAC	Set policy and oversee provider compliance	• Provider compliance (under the delegation of the Chief Executive Medicare)	• Benefits Integrity Division (BID) including analytical, operational, and system areas: • Medicare Benefits and Digital Health Division • Mental Health Division • Primary Care Division
Services Australia	Administer payments	• Public compliance • Third party compliance (where payments are made to third parties who claim the MBS payment on behalf of the customer)	• Fraud Control and Investigations • Medicare Branch

Source: Philip Review (2023)

Figure 2.2 provides a very high-level overview of the key players and their roles in the current state compliance and integrity system from pre-claim through to post-payment. Within the pre-payment and post-payment check phases, a claim may undergo identification, investigation and treatment to ensure services are claimed according to Medicare rules.

Figure 2.2: Current state of the provider compliance and integrity system



Source: Philip Review (2023)

Table 2.5 lays out an overview of the key compliance and integrity services undertaken by Services Australia and DoHAC. It highlights that the workflow starts at Services Australia and then flows through to DoHAC following payment. Table 2.6 outlines the treatments that are applied, highlighting the number of 'enforceable' treatment types which exist that are largely limited to serious cases of non-compliant claims.

Table 2.5: Current compliance activities in relation to the MBS

Stage	DoHAC	Services Australia
Pre-claim	• Education and awareness campaigns • AskMBS email service to provide advice on appropriate claiming • Define the business rules around making claims	• Education and support centred on matters related to claiming/payment administration including: • News for health professionals • Health professional education resources

Stage	DoHAC	Services Australia
		• Communications to health peak bodies • Outreach services through the specialised Medicare Engagement Officers (MEO) to support intensive education and support to healthcare professionals • Telephone lines for Medicare billing, claiming, payments and provider number enquiries • MBS Items Online Checker available in HPOS
Pre-payment	• Limited involvement	• Real-time analysis for public compliance only via the Medicare Common Assessing Engine which performs the assessment for claims originating through the Medicare claiming channels for all claim types • Maintenance and integration of other core systems to match to the Common Assessing Engine, including the Consumer Directory, Provider Directory and Patient History • Cross reference with the Medicare Item Fee File containing the business rules for individual MBS items, and other reference data depending on the claim being assessed
Payment	• None	• Payment is made close to instantaneously with a high degree of importance placed on rapid claims processing
Post-payment (Identification)	• The department receives post-payment data and this is distributed across various functions in the department • Tip offs and targeted 'projects' developed based on market sensing, tip offs and internal risk prioritisation processes are used to inform further investigation processes. Approximately 60 projects are undertaken in a year • Recently, advanced analytics have been introduced as a function within the analytics team of BID to develop some rules-based monitoring for non-compliance in the data • The department also receives external support to operate limited analytics tools • Tip offs and projects are progressed through analytics to relevant treatment pathways based on categorisation	• Profile-based analysis (for public compliance only)
Post-payment (Treatment)	• Targeted awareness campaign • Targeted letter campaign • Alternative Audit Actions (AAA) • Audit • PRP and PSR • Fraud investigation	• Limited opportunities for post-payment compliance checks

Source: Philip Review (2023)

Table 2.6: Description of MBS compliance treatment

Activity	Source	Scope	Description
Education Materials	• Practitioner self-refer/access	• Non-enforceable • Proactive	There are a range of compliance focused educational resources (e.g. guidelines, fact sheets, eLearning programs and so on). However, the usability, accessibility and uptake of this for practitioners appears to be limited. Some observations include eLearning content of this is largely out of date (e.g. directs to the 2013-15 Compliance Program).
Targeted Awareness Raising	• Tip offs • Projects	• Non-enforceable • Reactive • Targeted to cohorts identified • Response to inappropriate practice and incorrect claiming	Targeted letters to providers exhibiting lower levels of possible non-compliance to raise their awareness of Medicare claiming rules. This measure complements existing measures to ensure compliance with Medicare claiming rules.
Targeted campaigns (including Review and Act Now Letters)	• Tip offs • Projects	• Non-enforceable • Reactive • Targeted • Response to inappropriate practice and incorrect claiming	Potential non-compliance is suspected but cannot be confirmed due to: (1) limitations in the availability of data, (2) the non-compliance does not meet criteria for enforceable action, and (3) the potential non-compliance value or quantity does not warrant escalated compliance treatment.
Alternative Audit Approach (AAA)	• Tip offs • Projects	• Non-enforceable • Reactive • Highly targeted • Response to incorrect claiming	MBS/Pharmaceutical Benefits Scheme (PBS) claiming data suggests a breach of legislative requirements has occurred, but the identified potential non-compliance does not meet the Audit case value threshold or is of a nature that is more complex and serious and would warrant an individualised letter and an up-front phone call. AAA have no legislative power.
PRP and PSR Scheme (the PSR can only examine cases referred by the delegates of the Chief Executive Medicare and cannot initiate its own reviews)	• PRP (e.g. tip offs, projects, analytics tools)	• PSR has enforceable powers • Reactive • Highly targeted • Response to inappropriate practice	The PRP function within the department reviews serious cases of inappropriate practice and considers whether the issue should be referred to the PSR. Involves the identification of possible inappropriate practice that is then reviewed by a Professional Medical Advisor in line with the threshold established under s82 of the HIA. The PRP has no enforceable treatment capacity in and of itself. The PSR Scheme is designed for reviewing and investigating the provision of services by a practitioner or behaviour of a corporate entity to determine the engagement in inappropriate practice by investigating: • If MBS funded health services are clinically relevant • Whether benefits are provided in accordance with the regulations of MBS. Note: the PSR is not responsible[4] for pursuing potential criminal activity and if identified, this is referred to the Commonwealth Director of Public Prosecution (CDPP).

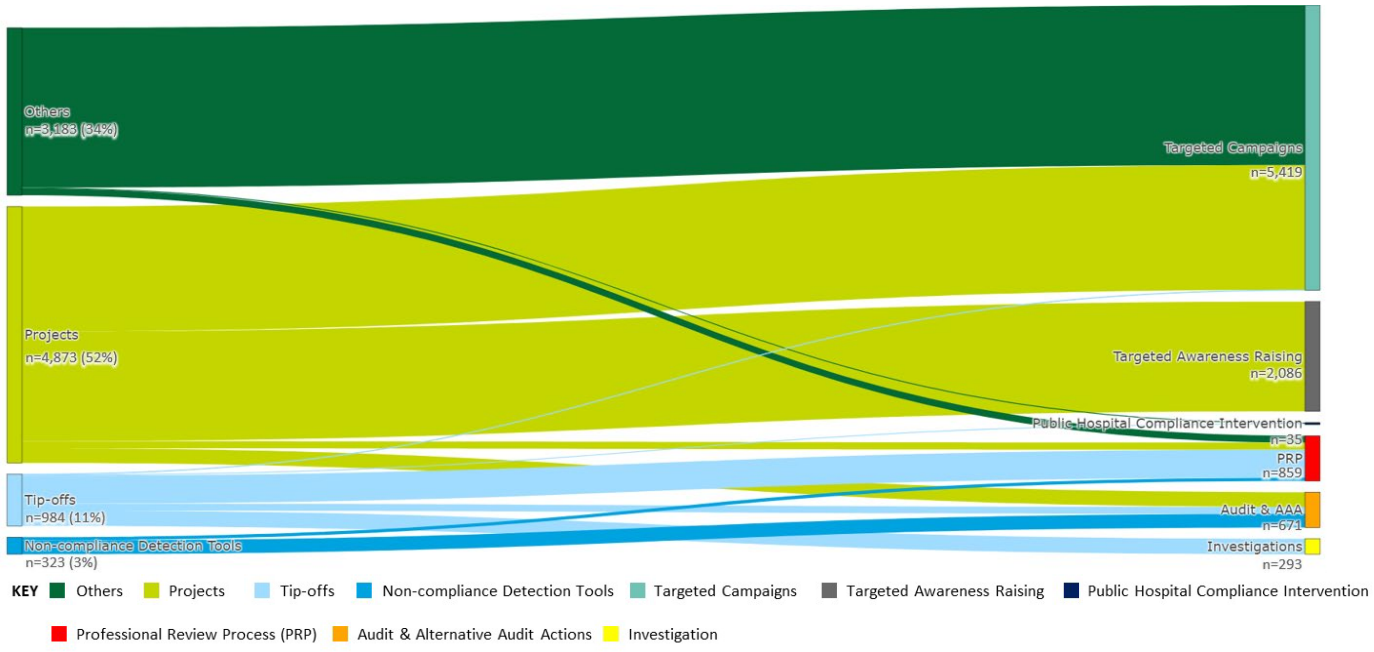
[4] This is commonly misunderstood in public media publications

Activity	Source	Scope	Description
Audits	• Tip offs • Non-compliance detection tools (NCDT) • Projects	• Audit has enforceable powers • Reactive • Highly targeted to claims where there is 'reasonable concern' of incorrect billing	Evidence-based assessments (factual evidence or access to data) of documents supplied by practitioners to check that payments made were compliant. Audits have legislative power and cannot look at clinical relevance.
Fraud investigations	• Tip offs • NCDTs • Projects	• Enforceable powers • Reactive • Highly targeted to cases of non-provision	Fraud Investigation team in DoHAC. Prosecution of fraud requires the CDPP to prove an intent to defraud to the Commonwealth.

Source: Philip Review (2023). Note grey cells indicate activity which are non-enforcement compliance mechanisms and blue cells indicate activity which are enforcement compliance mechanisms

Figure 2.3 maps all treatments back to their initial point of identification. It indicates a strong relationship between projects and non-enforceable treatment types and, equally, a strong relationship between tip offs and non-compliance detection tools with enforceable treatment types. It is important that this reliance on tip offs be complemented by greater use of analytics to ensure continuous monitoring in real time or near real time. Further, it is noted that time-limited scope-limited projects typically include non-enforceable treatments and that these projects lack a strategic and consistent approach to fraud and non-compliance identification and treatment.

Figure 2.3: Case provision by treatment type and source, 2021–22



Source: Philip Review (2023) using DoHAC (2023)* The 'others' category predominantly includes non-MBS compliance data activities and analysis

It is clear that roles and responsibilities across policymakers and those responsible for implementation, along with compliance activities, risk identification, and treatment pathways overlap between Services Australia and the department, without effective clear lines of accountabilities, optimal cooperation, and thus governance.

In my review, I, on a number of occasions, asked members of both organisations as to where accountability and the apex of governance lay, to which the response was overwhelmingly one of confusion.

Key to resolving the deficiencies in controls in the system is having effective governance – end-to-end views of compliance and integrity within the broader health system – and the system need for better integrated planning, policy translations, and infrastructure for appropriate information flows.

Finding 3: Governance and operating models have been established and are documented, in practice they are exhibiting a lack of accountability and overall system governance.

Finding 4: There is a lack of transparency in how Medicare is governed and delivered between government agencies and between government and external parties, including consumers and provider.

2.4 Complexity to deliver and manage Medicare

At the time of preparing this report, there are approximately 6,000 individual MBS items covering all clinical specialties, care settings and patient demographics.

It is clear from the workings of the system that the volume of Medicare items, the variability in clarity and understanding of these items, sub-optimal education and decision supports, and a lack of feedback loops from regulatory decisions to practitioners and patients has rendered the system complex and vulnerable to non-compliance and fraud.

2.4.1 MBS items do not always reflect contemporary models of care

Feedback received through this Review from health professionals described examples where MBS items no longer reflect contemporary service delivery models. Examples put forward included the use of team care arrangement items, chronic disease management items and mental health items.

It is clear that in many instances the MBS could better reflect contemporary models of care (if not necessarily service delivery models). It is also true that the administrative requirements contained in many of these items, designed to confirm or ensure compliance, are significant. In addition, by their very nature, multidisciplinary care items or items rendered by or on behalf of another practitioner are complex.

In other cases, the view that the MBS didn't reflect contemporary models of care resulted from a lack of understanding of the item requirements themselves and the overarching Medicare rules. This was in part due to a lack of appropriate, accessible education.

As the burden of disease changes, with the rise of chronic disease, more and more clinical presentations will involve multiple items and disciplines as a matter of course. This growth in complexity will need to be better accommodated by the MBS and will also necessitate better and different forms of stakeholder engagement and willingness by all parties to understand and engage more fully in the effectiveness of the compliance system.

The recent large-scale review of MBS items has highlighted the need for regular and structured reviews of the composition and application of the MBS in continued consultation with health practitioners. This can assist to ensure the balance between ensuring compliance and achieving value in the provision of Medicare services for patient, provider and taxpayer.

2.4.2 Role of the Medicare Common (Claims) Assessing Engine

The Medicare Common Assessing platform, overseen by Services Australia, acts as the rules engine for Medicare and has been in place since the inception of the Scheme. At its core, this technology platform performs the first pass assessment of submitted claims and checks for high-level validation covering:

- Claim initial validation (e.g. patient and provider eligibility): applies broad checks for the validity of key claim data points such as patient, provider and MBS item details
- Claim line by line validation (e.g. provider geocode access): applies specific checks against items that require additional data points such as Location Specific Practice Numbers for diagnostic imaging items
- Claims interline validation (e.g. Medicare Safety Net): these checks determine if special additional rules, not specific to the item level, apply such as special bulk billing incentive rules or if the item should count toward the Medicare Safety Net
- Any complex validation requirements for a specific MBS item (e.g. item restriction, duplicate services, system or operator overrides): these checks apply the restrictions on services identified in legislation for MBS items. Both the claim items and the patient's claim history are checked at this stage. Restricted item combinations or suspected duplicate claimed services are flagged by the system at this stage and require an override to proceed
- Benefits calculation: claimed items that have successfully passed all the previous checks will then progress to benefit calculation. Any item claimed that has not passed the common assessing checks will not be assigned a benefit

- Finalise the assessment and eligibility of the claim: the outcome of the claim (including rejecting items) is written to patient history.

This rules engine relies on inputs from DoHAC in the form of policy interpretations of individual MBS items that are then built into the system. It has been acknowledged by several stakeholders that the complexity and ambiguity of the wording of some MBS items presents a challenge in applying a definitive rule set to the Medicare Common Assessing platform. This limits an efficient and effective pre-payment eligibility and validation check prior to the payment of an MBS claim.

The lack of specificity in the rules engine limits the ability to identify non-compliant claims in the form of either over servicing, low value care or waste, or clinically inappropriate services delivered to a patient. As such, the up-front validation checks performed by Services Australia to enable payment of an MBS claim cover the core elements, however, there is opportunity to further expand the types and complexity of the checks performed.

Moreover, the technology used to undertake the Medicare Common Assessing has been in place for the last 40 years. This technology has limitations due to its age, including the limitation on the application of 'soft blocks' on MBS items. Soft blocks are types of controls that would prevent inadvertent or accidental non-compliant claiming behaviour. An example of a beneficial soft block would be to restrict access to specialist medical practitioner MBS items. The current technology infrastructure does not readily allow for the application of soft blocks and matching to provider identity details at the point of service provision or claim submission.

Given the age of the technology platform, there are risks to its ability to perform the critical tasks for the future, and, indeed, whether it can be serviceable in the future as old coding skills become harder to find.

2.4.2.1 High complexity of MBS leads to confusion on item application

It was reported that there is often ambiguity in the description of MBS item numbers, and therefore confusion by healthcare provider who are genuinely attempting to ensure compliance in their own practice. Healthcare professionals noted the difficulty in keeping up to date with changes of an already complex MBS that contains around 6,000 items, which is adjusted on both a periodic and ad-hoc basis. The different interpretations of these item numbers allows opportunities for incorrect, non-compliant claiming.

In addition to this, stakeholder feedback suggests that different interpretations and applications of MBS items which are in conflict with one another can be provided to health professionals. Available resources, such as the online website and AskMBS email service are available, however, the responses to health professionals can lack specificity and direct application to clinical situations as they often refer to legal interpretations rather than direct clinical translation. This leads to situations where they refer to the governing legislation rather than a definitive way in which the item should be applied. This has been a source of frustration for some health professionals and their representative peak bodies. Examples of this difficulty with the process were provided through the course of the Review.

2.4.2.2 Limited decision support for MBS claiming embedded in workflows

Additionally, there are points of vulnerability caused by human error, as manual intervention is still required to varying degrees across claiming channels, even those that are digitised. Examples of this include the need for Service Operators at Services Australia to interpret free-text data submitted with claims to interpret their validity, and inadvertent selection errors of items from drop-down menus in the online systems.

When considering the end-to-end claim journey, there are limited consistent decision support technologies available to health professionals at the point of service delivery that draw from the Medicare Common Assessing Engine and clinical documentation recorded by the health professional. In light of this, the whole system is reliant on health professionals and their support staff maintaining a thorough working knowledge of the MBS, its application to their practice, and how individual patient occasions of service align to the rules and requirements.

Models of care across the health system have continued to evolve and develop to continue to optimise the health outcomes of Australians. In some cases, MBS items have been written to directly reflect specific models of care or service models; however, not all patients will fit easily into these models because of clinical variability. This is resulting in health professionals selecting MBS items which 'best fit' the clinical scenario for an individual patient but which may not exactly reflect the requirements and rules of an MBS item. These situations give rise to non-compliant claims, despite being consistent with accepted clinical guidelines and expected quality of care.

- An example provided to the Review described the use of group screening and chronic health disease sessions provided by Aboriginal Community Controlled Health Organisations (ACCHOs) for Aboriginal and Torres Strait Islander patients in order to optimise access to health services, as these patients have significant barriers to keeping individual appointments.
- Relevant MBS items do not support the provision of these group services even though they are culturally appropriate, so non-compliant claims have been submitted to reflect activity provided to patients.

Finding 5: There is a need to improve the clarity, specificity, and application of MBS items and improve the technology at the heart of Services Australia.

2.5 Approach to investigation and treatment of Medicare

There is little to no pre-claim, pre-payment, or even early (e.g. within seven days) post-payment risk identification undertaken of MBS claims up to what would be considered an acceptable or best practice level, namely:

- Risk identification appears to be highly reactive
- Identification of issues emerged primarily from tips offs (from various sources), or through a limited set of projects or campaigns
- Point-in-time risk reviews performed months after the services delivered to patients and claims were made.

Use of data analytics to identify risk themes utilises simple outlier analysis where providers are compared to the billing behaviours of their peers, although more sophisticated analytics is performed as part of targeted project work. This seems to be both an outcome of legislative limitations for the use of data by DoHAC, the capability of DoHAC to complete sophisticated analytics for the purposes of identifying areas of risk, and the lack of technology systems and infrastructure to support this.

It is acknowledged that in April 2019, the Australian Government announced the *Guaranteeing Medicare – improving quality and safety through strong compliance* measure. This measure is aimed at improving Medicare compliance arrangements and debt recovery practices to ensure Medicare services are targeted at servicing the health needs of Australian patients. The measure supports making MBS, PBS, Department of Veterans' Affairs (DVA) and Australian Health Practitioner Regulation Agency (AHPRA) data collected by Services Australia available within DoHAC's technology environment. The work of this initiative has included the development of data dictionaries, with naming conventions, and the data is now regularly transferred to DoHAC. When transferred it includes relevant identifiers and linkages to support better targeting of investigations into fraud, inappropriate practice, and incorrect claiming, and to strengthen data analytics and behavioural-driven approaches to improve compliance.

The methodology for risk identification across the pre-claim to post-payment spectrum is not aligned to contemporary best practice, which recommends continuous, real-time detection. There are also differences in terms of what is completed by DoHAC and Services Australia (noting the issues previously raised about the use of and access to data, and how these impact on risk identification). There are also some simple hygiene factors in terms of data governance, data management, and data standardisation (e.g. data dictionaries and naming conventions) that are ultimately making it challenging to implement effective data analytics algorithms in a proactive or coordinated way.

2.5.1 DoHAC Benefits Integrity Division

Benefits Integrity Division relies on tip offs, received from the public or from other agencies as the starting point for many investigations. Outside of tip offs, BID identifies risk through a 'horizon scanning' process, which monitors emerging risks and threats from external sources. The horizon scanning process acts as a funnel to capture emerging risk typologies, that is potential, identified risks for assessment and validation.

Where risks are deemed to meet the internal materiality threshold and are assessed as actionable with current systems and data, they are captured in a risk register. A number of these risks are then selected for 'projects' periodically, which are supported by an analytics team to develop data analysis for review. The focus of data analysis as part of projects is on outliers (claiming behaviour).

Due to the way risks are captured and assessed, gaps exist in the current process:

- As risks must meet materiality thresholds to be included in the risk register, lower value risks (which may be of large volumes) are not considered for analysis in projects

- Similarly, as risks must be deemed as assessable using current technological capabilities to be included in the risk register, any typologies beyond the current capabilities of the department are not captured or considered for review
- Due to the focused nature of project reviews, more holistic population analysis to identify behaviours across the system are not performed.

A backlog of activities and projects is being worked through by the BID team. This backlog is contributing to considerable delays in the initial identification of non-compliant claiming, its investigation and subsequent treatment. This results in the integrity and compliance activities appearing to be remote from the time of service delivery from the perspective of health professionals and patients.

2.5.2 Services Australia

As outlined in the 2021 Compliance Protocol between the Department of Health (and Aged Care) and Services Australia, Services Australia has prime responsibility for public compliance activities which include:

- Undertaking functions related to health and aged care programs in accordance with relevant legislation and/or guidelines
- Undertaking activities relevant to the degree of risk identified through program management and operational functions
- Liaising with health and aged care peak bodies and other external stakeholders to inform public compliance risks and priorities
- Providing a mechanism for public compliance tip offs to be reported, operationally triaged and case managed
- Investigating and progressing compliance interventions where there are reasonable concerns regarding public access to Commonwealth health and aged care programs
- Informing the Department of Health (and Aged Care) of changes to risk profiles that may affect the health and aged care provider compliance domain
- Providing feedback to the Department of Health (and Aged Care) and internal stakeholders arising from public compliance activities that may affect the policy setting, delivery, or guidelines of health and aged care programs
- Consulting with the Department of Health (and Aged Care) in the development of public compliance education materials to ensure consistency of compliance education messages
- Managing the recovery of all debts raised that result from public compliance activities.

Service Australia's role in risk identification centres on the initial validation of claims via the Medicare Common Assessing platform. It is this platform that performs a series of validations and interacts with a number of databases and systems to perform assessments of claim data from providers and patients, apply restrictions captured in the Item Fee File business rules, and calculate the benefits for individual MBS items and claims.

Complex business rules as well as system and data limitations are preventing the full implementation of new policy and legislative changes including effective up-front controls. The absence of these results in a strong reliance on manual processes, a need for manual data entry, system and business process workarounds which introduce more complexity and inflexibility, post-payment compliance, and long implementation timeframes for policy intents to be realised.

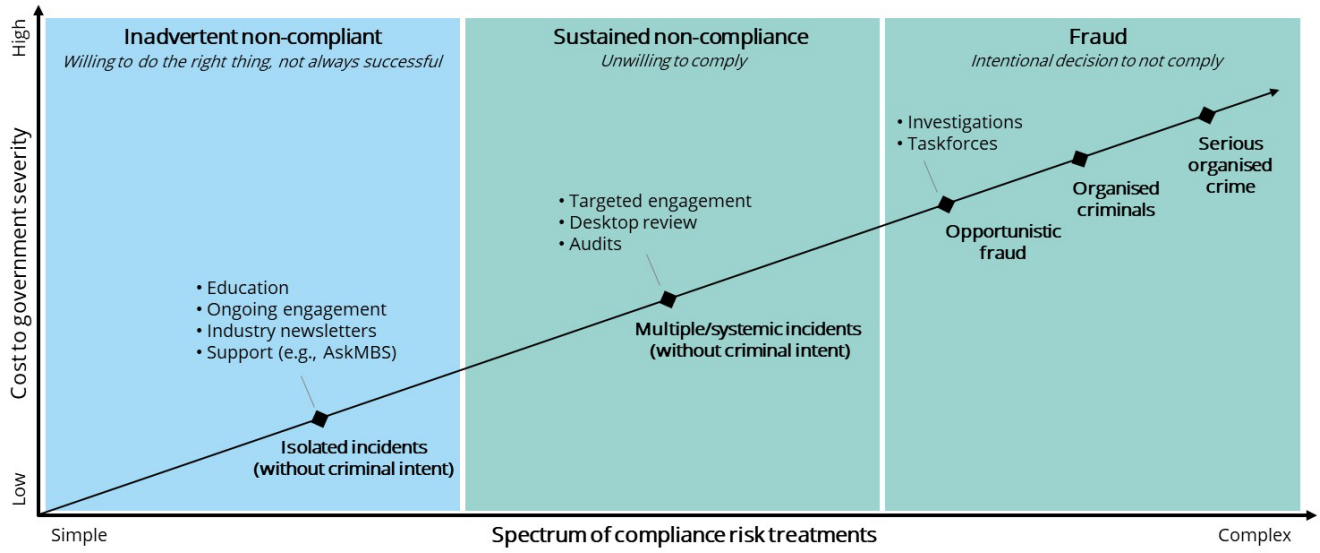
Finding 6: Risk assessment and investigations are overwhelmingly focused on post-payment analysis of claims, with DoHAC responsible for provider analysis while Services Australia perform public compliance activities.

2.6 Risk Treatment

2.6.1 Overview of the treatment pathways

To effectively treat risks, an understanding is required of the motivation driving non-compliant activity. This can range from accidental non-compliance, with no ill intent, to serious organised crime, where intent is for illegal gain. The complexity of the activity and the required response increases as the seriousness of the non-compliance increases as shown in Figure 2.4.

Figure 2.4: Illustration of the types of compliance risk in relation to potential compliance interventions and cost/severity

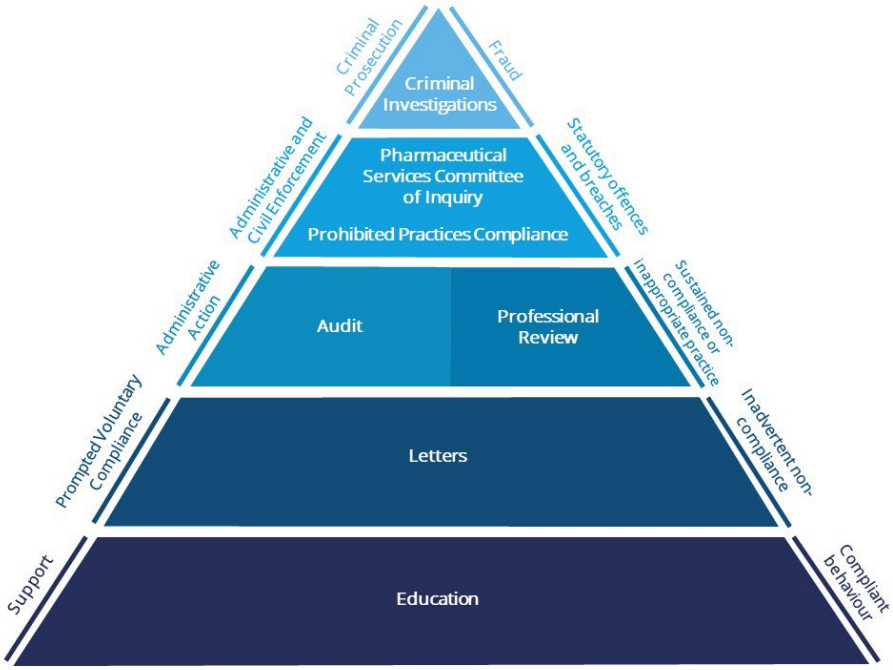


Source: Philip Review (2023)

The department has developed the *Health Provider Compliance Strategy 2021–22* which applies to the MBS, PBS, Child Dental Benefits Schedule (CDBS), and Practice Incentives Program (PIP). The Health Provider Compliance Model is illustrated in Figure 2.5.

- The Health Provider Compliance Strategy (the Strategy) identifies the principles which govern the department's compliance and enforcement function, and the department's compliance and enforcement priorities.
- The Strategy aligns with the department's Corporate Plan 2021–22 and Fraud Control Plan 2021–23.
- Further, the Strategy outlines a comprehensive range of tools and organisational responses to non-compliance and fraud which increase in intensity in relation to: (1) the nature of the alleged behaviour, and (2) any associated criminal or administrative penalties. For example, less confrontational education and awareness activities are applied where behaviour is assessed to be unintentionally non-compliant, whilst criminal investigations are performed in the case of fraud.

Figure 2.5: Health Provider Compliance Strategy 2021–22 Compliance Model



Source: Philip Review (2023) using DoHAC (2023)[5]

[5] Australian Government, *Health provider Compliance Strategy 2021-22*, August 2021

In this Review, I did not identify any fundamental issues with this compliance model per se. However, what I do identify are lower levels of capability maturity in the systems and processes which would enable the compliance model to be more effective, including continuous monitoring, intelligence and data analytics, together with case management tools that enable the department to adopt a proactive, prevention and early-detection focused approach. The implementation of such a model would ideally capture most adverse behaviours as early as possible, minimising the incidence of non-compliance and deterring opportunistic and organised fraud involving the Scheme.

2.6.1.2 Fraud and Organised Crime Taskforces

In addition to the compliance model outlined above, the Australian Government has historically established inter-agency taskforces to address systemic or complex criminal activity within its schemes and programs.[6] Of note, task forces such as these may require special powers and authorisations from government to facilitate some aspects of inter-departmental information sharing. An example of this is the inter-agency Fraud Fusion Taskforce funded in the October 2022 budget to help address organised fraud in the National Disability Insurance Scheme (NDIS).[7] Task forces play a valuable role in coordinating law enforcement assets; however, they are typically deployed in addition to existing benefits integrity activities on an 'exceptions basis' and are not a substitute for proactive risk management.

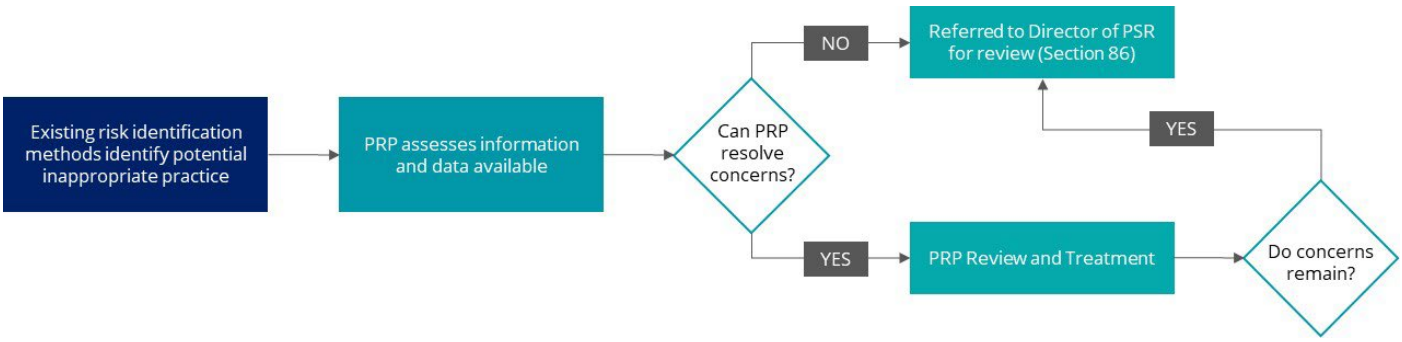
2.6.2 Practitioner Review Program and Professional Service Review

As outlined in previous sections, concerns about inappropriate practice are referred to the PRP. The PRP includes PBS and CDBS along with MBS and aims to identify and intervene when billing and servicing behaviour of practitioners or corporate entities seems to indicate potential inappropriate practice as defined by Part VAA of the HIA.

2.6.3 Overview of the Practitioner Review Program

Cases presented to the PRP are then reviewed to determine the appropriate review, treatment and/or escalation (see Figure 2.6).

Figure 2.6: Pathway of case reviewed under the PRP



Source: Philip Review (2023)

The referral to the PSR can occur at any point within the PRP review and suitability process. This means that it might be that a case is identified early on as needing to be referred to PSR, or that following six-month reviews and/or delegate of the Chief Executive Medicare review, the case is then referred. A detailed description of the PRP process is shown in Figure 2.7.

[6] McKenzie, N. & Ballinger, A. 2022 https://www.smh.com.au/national/the-scumbag-scale-how-organised-crime-has-infiltrated-the-ndis-20220811-p5b95s.html Accessed February 2023

[7] Australian Government, *Budget Paper No. 1,* October 2022

Figure 2.7: Detail of the PRP process

Identification	PRP Review and Suitability Process			Outcomes	
Case Sources	**Initial Screening**	**Initial Review**	**Interview**	**Six-month period of Review**	**Referred to PSR**
• Tip-offs (internal or external) • NCDTs (inc. 80/20 and 30/20 breaches) • 1CAB projects • PREDICT GPs • PREDICT Specialists	• Threshold for inappropriate practice considered in line with s82 of HI Act • Based on assessment of tip-off information and billing data • Assessment completed by a Senior Medical Advisor (SMA) Outcome • Validate if there is a concern, confirm suitable for PRP treatment, assign a priority rating based on level of potential inappropriate practice and risk to Medicare	• Analyst team assess standard set of data for the case and template documents • Assigned to SMA who will assess the case and assign it to professional Advisor (PA) • PA undertakes full analysis of all available data – may request additional data • PA prepares list of concerns and contacts the practitioner to advise them of the concerns and give them an opportunity to undertake an interview with the PA to discuss concerns	• If the practitioner agrees to an interview, they are sent a copy of billing data and a summary of the concerns • The practitioner can then explain their practice and discuss identified concerns • After interview the PA considers the information and decides if the explanation has addressed each of the concerns Outcome • Close the case; or • Offer a six month period of review; or • Refer the case to a delegate of the Chief Executive Medicare for further review without a period of review	• Analyst then reviews data reports and the Advisor then review data, drafts six-month review report and drafts letter advising of the outcome **Delegate Review** • Delegate reviews all available information, writes to the practitioners inviting them to respond to the list of concerns, reviews submission, and if unresolved will refer to the Director of the PSR	• Cases sent to PSR are either required by legislation (80/20 or 30/20 rules) or those that have been deemed by the CEM to still have concerns

Source: Philip Review (2023)

Concerns of non-compliant inappropriate practice are raised with DoHAC primarily via tip offs or data analysis that indicates unexplained or inconsistent[8] variances in a practitioner/corporate entity's initiation or provision of health services. The concern is registered with PRP who review the service provider's Medicare servicing and PBS prescribing behaviours to understand the unexplained variances.

Cases are assessed in the first instance by a Senior Medical Advisor, and then allocated a priority based on potential risk. These cases are then assessed by a team of advisors. During this process, practitioners often have multiple opportunities to provide additional information, data, and commentary to the review team. During interviews, the practitioner can have a support person with them, which might include a practice manager or medical defence representative.

Concerns classified as criminally fraudulent are referred to the investigation area in the Benefits Integrity Division (e.g. sections 89A & 106N of HIA); neither the PSR or PRP investigate or pursue potential criminal activity and consider only those classified as non-compliant inappropriate practice. DoHAC notes that issues relating to corporate entities are usually identified during a review of a practitioner and if concerns are raised and remain following PRP processes they will also then be referred to the Director of the PSR.

Those concerns that are unable to be resolved by a PRP review are referred to the Director of the PSR for further investigation. In addition, all 80/20 and 30/20 rule breaches are not offered interviews and are referred directly to a delegate and subsequently to the Director of the PSR.

If the Director finds a review necessary, they will notify the practitioner/entity and the Chief Executive Medicare of their decision to review. The estimate provided in a submission by DoHAC is that approximately 70% of practitioners change their behaviour after review which means they do not then require referral to the PSR. Referrals to the PSR will have the most severe concerns of potential inappropriate practice after review under the PRP or may have indicated or demonstrated they will not change their behaviour based on the review and potentially their performance after a six-month review.

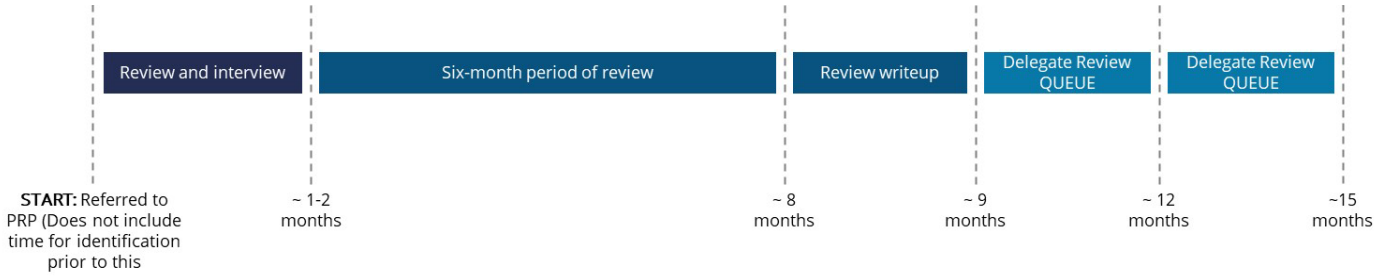
2.6.3.2 Timelines of the Practitioner Review Program

As noted above, there are multiple pathways of the PRP that a provider might go through, and multiple points where they might be referred to the PSR or the case closed out.

[8] Inconsistency from peers in the initiation or provision of health services by a practitioner or entity are investigated by the PRP.

Figure 2.8 provides an estimate of a timeframe for review processes based on consultation with DoHAC. This assumes the full PRP process with progression to PSR, but as previously mentioned the progress through PRP to PSR or case closure can vary.

Figure 2.8: Timeframe of PRP to PSR review processes



Source: Philip Review (2023)

It is important to note that this is the timeline from the point of the case progressing through the PRP. Before the PRP, there are also timeframes for identification and allocation to the PRP area which can vary significantly.

2.6.3.3 Case activity data from the Practitioner Review Program

The following activity data for the PRP has been provided by DoHAC for the Review (see Table 2.7).

Table 2.7: PRP case activity

	PRP interviews	Closed after interview	Closed after 6-month review	Closed after delegate review	Requests to PSR
2019–20	403	48	392	14	126
2020–21	351	17	180	14	72
2021–22	287	16	256	8	108
2022–23 (Till Dec 2022)	130	4	70	4	53

Source: Philip Review (2023) using DoHAC (2023)

The data shows that very few of the billing transactions in the Medicare system are subject to the PRP or PSR processes. Yet, there is a disproportionate amount of 'fear' of the PSR in the system. While regulators should, at one level, be feared, there are questions of process and fairness in the workings of the current system which unnecessarily drive 'fear' – namely, the lack of timeliness and the administrative burden to comply with the system.

2.6.3.4 Comments on the Practitioner Review Program

The PRP appears from review and consultation to be a detailed and medical advisor-led process that allows responses from practitioners and appropriate support and legal representation. It clearly plays an important role in reviewing the information available and connecting with practitioners to understand if compliance issues being raised are related to the unique demographic, geographic, or function of their practice rather than actual non-compliance. It is important to note that the PRP is considered to be an administrative process and no determinations of non-compliance or inappropriate practice are made as part of the process.

There are a few issues identified in relation to non-compliant or 'rorting' behaviours which, while still representing a minority of cases, can have large financial implications.

There is also a careful balance required in review and treatment pathways including the PRP in relation to ensuring there is enough time for practitioners to review findings, provide information, seek advice, and get legal representation if they require or desire. However, when considered in the context of the overarching timeframes of risk identification and treatment, in the current state the current process can mean practitioners are having to respond to issues related to claims made 6 to 18 months ago. In cases where errors are genuinely accidental, this can mean there is significant stress in reviewing a large number of claims and repayments are large. Appropriate controls earlier in the process (including pre-claim and pre-payment) would mean that this would be highly unlikely.

In the current system where there are insufficient early controls, this can have negative impacts on practitioners who may be unintentionally making errors due to the complexity of the system as previously discussed.

2.6.4 The Professional Services Review

The PSR Scheme was introduced under Part VAA of the HIA to protect the integrity of the Commonwealth-funded health benefits programs in Australia. The PSR is designed to review and investigate the provision of services by a practitioner or a corporate entity to determine if their MBS claiming, PBS prescribing and CDBS claiming is classed as inappropriate practice. The PSR was established in July 1994 as an agency within the Health Portfolio to administer the PSR Scheme to safeguard the MBS, PBS and CDBS from inappropriate practice and the associated consequences.

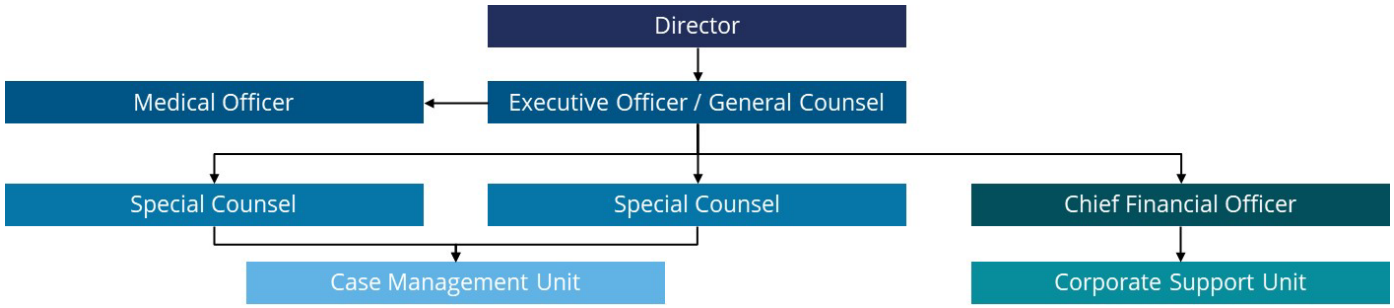
The PSR Scheme defines the scope of inappropriate practice, clarifies the roles and power of the PSR agency and sets out the PSR review process. Through performing its statutory roles, PSR reduces the risks to patients and the community of inappropriate practice and prevents the Australian Government from having to meet the costs of health services because of inappropriate practice. The PSR delivers on these outcomes by:[9]

- Investigating whether the Commonwealth-funded health services are clinically relevant, and
- Investigating whether benefits are provided in accordance with the regulations of the relevant health funding schemes.

2.6.4.1 Roles and structure of the Professional Service Review

The following figure outlines the structure of the PSR. The key decision-makers of review, including the PSR Director, the PSR Panel, and the Determining Authority, are appointed by the Minister of Health after consultations with the Australian Medical Association (AMA) or other relevant professional bodies as stipulated in the HIA.[10]

Figure 2.9: Organisational structure of the PSR



Source: Philip Review (2023) using PSR (2022)[11]

The PSR Director is an independent statutory officeholder appointed by the Minister following approval from the AMA and must be a medical practitioner. They are responsible for the administration and management of the PSR scheme. PSR Panel members are medical and other healthcare practitioners who then comprise a peer review committee as requested for investigative purposes or to provide assistance to the Director.

In recent times, the PSR has started to employ a more diverse panel to cope with the increased scope and complexity of the range of health professionals, specialties, and corporate entities that PSR is being asked to review. The Determining Authority includes a permanent chair who is a medical practitioner, a permanent lay person, and a member representing the profession of the practitioner under review. They are responsible for determining the outcomes for the practitioner given a finding of inappropriate practice. The key decision-makers coordinate and administer matters referred to PSR across the review process. Noting also that the Determining Authority is also responsible for ratifying an agreement under section 92 between a practitioner and the Director of the PSR. These key roles are outlined in Table 2.8.

[9] PSR Corporate Plan 2021–22

[10] Australian Government, *Professional Services Review Our People,* 2022.

[11] Professional Services Review. (2022). Organisational Structure. Australian Government. https://www.psr.gov.au/media/117

Table 2.8: Key roles of the PSR

Role	Number	Description
Director	1	Independent statutory officer and medical practitioner (section 83)
Determining Authority	15	Comprises a permanent chair (medical practitioner), a permanent lay person and a member who represents the profession of the practitioner being reviewed (section 106ZPB)
Panel Members & Deputy Directors	47	Panel members who chair PSR committees (section 85)
Panel Members	107	Medical and other healthcare practitioners who may sit on peer review committees (section 84) or provide assistance to the Director (section 90)

Source: Philip Review (2023) using DoHAC (2023)

The PSR reduces the risks of inappropriate practice through ensuring that the provider's Commonwealth-funded health services are clinically relevant and/or that benefits provided are in accordance with health funding schemes.[12] The PSR adopts a rigorous peer review process and relies on the support of health practitioners, their representative registration bodies, and relevant regulatory authorities to perform its statutory function.

The PSR has a relatively small core team and then renumerates the medical and allied health practitioners who sit on committees for work performed.

2.6.4.2 Key reflections on the Professional Service Review

There is value in having a regulatory body that is perceived to be a real deterrence, and not one that is a 'toothless tiger', however, this needs to be balanced with a process that is timely, fair, transparent and does not have unintended negative consequences. The concern is that if the pendulum swings too far toward an overzealous treatment for inappropriate practice, practitioners are less likely to bill for things that they should bill for in fear of the regulator and becoming involved in its processes.

Based on consultations this seems to negatively impact on First Nations practitioners disproportionately, to such an extent that the National Aboriginal Community Controlled Health Organisation (NACCHO) is currently undertaking a project with the department to improve billing to Medicare.

There has been some media discourse about the intent, nature, and function of the PSR and the lack of understanding by the broader health system and practitioners about the fact that the PSR is only responsible for inappropriate billing practice. Concerns of clinical safety should and are rightly referred to AHPRA, and concerns about fraudulent behaviour are referred to the major non-compliance (fraud) division. There is a clear need to make sure that there is an understanding by practitioners about the intent and function of the PSR, in that it addresses inappropriate billing and inappropriate prescribing, and referral to it is not a reflection of poor or sub-standard clinical practice.

As with the broader reflections throughout this report, there are also some components of the PSR that ultimately no longer fit with the way that healthcare is currently delivered, and how it will be delivered into the future. For example, the positioning of the AMA as a professional body who can veto the appointment of a PSR Director no longer reflects the fact that there are a range of professionals who will be referred to PSR. Either all professions should be engaged and involved in Director appointment decisions, or no professional bodies should be involved.

[12] Professional Services Review. (2022). About the PSR scheme. https://www.psr.gov.au/about-us

There were also comments made during the consultations that ultimately the advice provided by DoHAC, Services Australia, or AskMBS are not able to be relied on as a defence to the claims raised by the PSR against the Provider.

There is also a broader section 92 review that has been recently completed. There are ongoing concerns of practitioners and other key stakeholders which were raised with me that include the perception that section 92 agreements are 'coercive' requiring practitioners to acknowledge 'inappropriate practice'. They are reported to be taken up because the stress, burden, timeframes, and cost to practitioners of proceeding to a committee review are overwhelming.

It is also important to consider the outcomes of the PSR, especially in relation to disqualification from billing MBS services for a period. It is hard to get a good sense of which cases this would be applied to (e.g. it is likely appropriate to disqualify say a GP from using a highly specialised surgical item) but the concern remains about the 'big stick' of the PSR potentially disqualifying practitioners from legitimate items. This then is likely to lead to either underservicing (e.g. turning away patients who need the specific care relevant to the disqualified item), or perversely that the practitioner bills then for 'most appropriate alternative' which is inherently a further inaccurate claim.

There is also the potential for the PSR to feed into the broader recommendations made in this report for continued education and training of providers. Deidentified information about cases and common issues should be fed back to relevant professions, and to date the PSR has done this in a range of ways, including briefings and presentations to Colleges and other peak bodies. Formalisation of this existing work and the broader development of a more rigorous education and training process for MBS will help to contribute to prevention of accidental non-compliance. In my view it would, in fact, be useful for the implementation of the results of this Review to dovetail with the change management efforts that will flow from the recently endorsed report of the Strengthening Medicare Taskforce. Moving the culture of Medicare integrity towards a better balance between continuous quality and safety improvement and the detection of non-compliance and fraud, will promote more buy in to reform and support retention of those parts of the experienced clinical workforce necessary to support a safety culture at a time when many are considering earlier retirement or have retired and the system is recovering from high levels of psychosocial and moral injury due to the ongoing impact of COVID-19.

One final recommendation for the PSR, that would require legislative changes, is the introduction of an 'associate' or other alternative second-in-command role for the Director of the PSR. Currently, there are a range of roles and responsibilities that can only be completed by the Director of the PSR including decision making. In addition, if the Director feels that there is a conflict of interest the only options are either to continue with the process or to take a leave of absence so that an acting Director can be appointed. Having the opportunity for an associate or second Director to be available would help to share the load of the work, ensure that conflicts can be handled more appropriately, and potentially assist with succession planning and training for future Directors.

Finding 7: The current Medicare system lacks timeliness and relies upon post-payment monitoring, delayed identification and investigation of non-compliance.

2.7 Supporting Medicare legislation considerations

The operation of Medicare is primarily governed by the HIA and related regulations. Compliance obligations related to MBS are set out in the HIA and associated amendments (e.g. Health Legislation Amendment (Medicare Compliance and Other Measures) Act 2022). However, Medicare is part of a broader complex legislative landscape that includes numerous other relevant Acts. As I have noted in this Review, it is also important to recognise the proposed changes (including most importantly any potential changes to legislation) are not delivered in a vacuum, and this Review exists in the context of wider health system reform. There are a range of wider policy and practice changes in relation to Medicare (e.g. the Taskforce, discussions about value-based funding mechanisms, and the implementation of findings in relation to item changes) that support the need for coordinated thought and effort in how these changes interrelate as, for example, the appropriate and required compliance activities are informed by the nature of the funding model.

In light of these considerations, there are potential serious unintended consequences to changes to legislation that are not considered holistically in the broader landscape, and instead I suggest that there needs to be a focused body of work that considers all recommendations of recent reviews in consolidation and how these interrelate before legislative changes are progressed. As I raised in my interim letter, the current state of Medicare and some of the challenges that I have raised are the result of previous attempts to apply discrete and band-aid solutions to single issues over time and a lack of system thinking and consideration. This has resulted in a system that, while still a

crucial part of supporting the health and wellbeing of the public, is clunky to apply and administer and no longer aligns to the reality of what care is delivered, by whom, or in what settings.

In line with these considerations, in the following section I outline some of the key areas for consideration that emerged that would require legislative change. I also note that there were a range of legislative concerns raised during consultations that are not directly related to MBS compliance and integrity, but instead are indirectly related to issues including the changing nature of healthcare delivery and the viability of services in the current climate. Where appropriate I have provided a summary of some of these key issues, but note that there were several more detailed suggestions provided by stakeholders that, while important, were not able to be included given the scope of this review. In my view, this points to the wider appetite and need for broader system reform that considers these broader challenges (i.e. who delivers care, to whom, where, how, and is it appropriately funded and funded to support interdisciplinary care).

2.7.1 Power to undertake meaningful compliance and integrity activities

Multiple stakeholders raised concerns about the ability to undertake meaningful compliance and integrity activities in the current system. As one group described it, the enabling Legislation for compliance is 'immensely powerful, but extremely narrow'. There was some good discussion with governmental staff about the appropriate balance between the enforcement powers available and the need for some broader scope. A lot of the activities that we have described as 'non-enforceable' were and are limited because of the legislation. For example, under the current legislation, statutory (and enforceable) audits can't take clinical relevance into account, and this remains the purpose and function of the PSR. However, as I noted in my overview of the PSR, its ability to remain a strong deterrent to inappropriate practice requires having appropriate checks and balances in place before things escalate to this process. It is also important to note that the complexity of Medicare billing and compliance means that there are likely often issues that fit within a grey area of claiming and clinical relevance.

There are also several requirements under the Act to consult with the broad range of professional bodies at multiple different points. While I don't believe that there should be no consultation with professional bodies, I do question the extent to which their inclusion in the legislation specifically (and at multiple points) might be restrictive to the compliance activities, burdensome to the professional bodies, and unintentionally increase the timeframes for activities such as audits. While I am not suggesting that we remove connections with professional bodies, as this is an important part of ensuring that the compliance activities are realistic and appropriate, I do think there could be some consideration to a more coordinated approach to this (as appropriate across the spectrum of different compliance activities) and that this is not something that should necessarily be an explicit part of the related legislation. Especially when there is not a lot of guidance about what this means and ultimately restricts the ability of the DoHAC to use that provision. There were also examples discussed about how the language of the legislation (e.g. the use of a document to substantiate claiming concerns) might not always link to a relevant document that exists, or that is accessible by the investigating officers.

Now, these limitations are not without rationale. These limitations ultimately are in place for a reason and work to ensure that there is an appropriate and fair scope of compliance activities for practitioners, but there is further work to be done on if this has been too restrictive, especially in comparison to the investigative powers under other schemes such as the NDIS.

2.7.2 Broader concerns about the legislation

There were some examples raised in consultations of how the wording of the current legislation can be at times confusing or unclear which might be enabling poor practice. There were also some concerns raised by groups about the way in which lacking penalties in current legislation might be incentivising overservicing that some have raised as problematic. However, it was not possible within the scope of this Review to substantiate the extent and nature of these challenges, only that they were raised by multiple stakeholders. In addition, I report these issues in the interest of completeness, but do not necessarily see them as specifically an issue with compliance activities of the MBS. Instead, it is these sorts of issues that contribute to the overwhelming complexity of the system and that talk to the broader issues about wastage and appropriate care in the system. While I do not see these to be in scope of the review, I do believe that these are issues that are important for government to consider and again point to the importance of a whole-of-system view of drivers of billing behaviours that start to lead towards wastage and leakage of the system, run the risk of tipping into non-compliance, and bring into question for some the integrity of the Scheme as a whole.

For example, there were some concerns about the sections of the Act that relate to things such as the backdating of pathology lab approvals. The concern was that the lack of clarity currently in the Act did not support the requirements of practitioners to ensure that there is appropriate information given for backdating, and what the requirements for backdating actually are.

There were also concerns raised about the impacts of wastage on third parties (e.g. insurers) and there is a further discussion to be had about the role of the government in regulating this. I do believe it is important to remember that Australia's health system ultimately operates as a two-tier system where public healthcare is supported by private insurers. In my view, these sorts of concerns spoke to broader issues about the distribution of costs across the system and the importance of considering these sorts of downstream impacts of legislation. The maintenance of the Australian health system has to include consideration of the funding mechanisms and levers that exist outside of government.

Some other concerns raised included that there are limitations on what information can be provided back to insurers, even when inappropriate billing has been determined. This means that private insurers who do pass on any concerns about inappropriate billing do not receive any commensurate return on providing that information.

Another example raised in consultation that relates to these ideas about viability, funding, and the broader impacts on other stakeholder groups included the perception that there is no monitoring or compliance of some things that do currently exist in the legislation. For example, the co-location of pathology services and the appropriate rents for these co-located services is specified in the HIA. Again, concerns about the price gouging of these services were raised, as there is a perception that currently there would be few co-located services that align to the legislation. Again, it is hard to in such a short timeframe and without appropriate data speak to the 'truth' of these sorts of claims. But I raise them here as a way of demonstrating the importance of having a broader view of what is driving tensions in the sector. Ultimately, issues with viability of healthcare delivery under current funding mechanisms, tensions between stakeholders, and concerns about broader compliance activities (e.g. rent prices by owners of general practice clinics) contribute to the volatility of the discussion and may lead to the sorts of motivations and rationalisations that justify under or overservicing, inappropriate practice, and potentially fraudulent behaviour. At the end of the day, increasing volatility, concerns of fairness, lacking viability of services, and funding all directly end up impacting the consumer most of all.

Finding 8: The current legislative landscape underpinning Medicare both enables the operation and oversight of the Scheme, however, it could also be too restrictive and not allow adequate integrity and compliance enforcement activities.

2.8 Education to support the application of Medicare

It was acknowledged that the targeted education supports provided by DoHAC in the form of letters and engagement has been beneficial for health professionals who may not have had a full appreciation of the application of MBS items. The education supports comprise a number of different strategies, including:

- Webinars
- Website materials (including AskMBS, compliance strategies and fact sheets)
- Face-to-face education at seminars, conferences and events to priority groups
- Implementation of issue specific communication strategies
- Utilisation of relevant representative peak body organisations.

Stakeholders acknowledged that contemporary understanding of the requirements for MBS items by practitioners may be challenging, and the increase in corporate entities managing billing is likely contributing to an understanding gap. Future education and engagement activities would benefit from inclusion of administration staff who may be involved in preparing and supporting MBS claims.

It became evident through this Review that there is a missed opportunity for subtle support and education of providers in the form of decision support at the point of care and service delivery. Presently, there is inconsistent MBS billing decision support embedded in practice management systems which can guide the selection of appropriate MBS items based on their rules and requirements matched to patient details and the clinical inputs from the occasion of service. The ability to provide real-time feedback on the compliant billing of MBS items by practitioners could have a significant impact on reducing instances of inadvertent non-compliant claiming.

Multiple stakeholders shared in feedback to this Review a desire for enhanced fact sheets, including case studies, that are distributed to health professionals when a change to MBS items occurs. This would cover the addition, deletion and replacement of MBS Items and would be written in a way that makes clear how MBS is to be interpreted in clinical practice so as to reduce ambiguity or informal education and advice. These materials would be prepared in collaboration with relevant peak bodies and other representative organisations together with DoHAC and Services Australia.

A large proportion of stakeholders indicated through this Review that DoHAC engage with them as part of the ongoing refinement to MBS numbers, and if practice issues have been identified at a whole of specialty level and ahead of targeted education campaigns they are informed of the details by the department. This enables the department to understand the clinical practice inputs and perspectives in further detail as part of any investigation activities.

It was further put to this Review that there are often differences of interpretation of Medicare items within the department, with AskMBS and other departmental advice differing from PSR outcomes. This underscores even more the need to ensure there is a feedback loop from PSR determinations into the education of all actors in the system. Related, but more specific, consideration should be given to PSR determinations, where the outcome is the finding of misbilling, for relevant private insurers to be informed so they can recoup their payments.

In the event where new Medicare items are created or existing ones materially changed, the department should give consideration to a more planned approach prior to announcement, one which involves consultation with relevant professional groups and the mapping of the new regime to previous claiming practices so that clinicians know how their billing should change.

Finding 9: Current education and engagement activities with health professionals are not always meeting their needs and there is an opportunity to create further tailored and implementable supports that include broader administrative support personnel who support the preparation and submission of MBS claims.

2.9 Valuing non-compliance

A critical question in the discussion of Medicare non-compliance is the level (volume and value) of MBS non-compliance that exists – that is (1) how much of the annual expenditure on the MBS is associated with activities that are not in line with the intentions of the Scheme and (2) to what extent does non-compliance differ across different MBS items and provider groups?

The task of quantifying non-compliance is challenged by:

- The absence of a widely endorsed definition of non-compliance (i.e. the agreed types of non-compliance that should be quantified)
- The many types of non-compliant behaviour that cannot be verified from analysis of data alone (e.g. inappropriate practice or compliance with certain ambiguous item rules, which typically require more information on the clinical circumstance)
- Situations where non-compliant behaviours can be verified from analysis of data alone (i.e. data analysis is deterministic), however, the necessary data assets and capabilities to inform the assessment are often not available (i.e. data analysis is not feasible).

If one puts aside the first challenge and considers only the limitations of the second two challenges, it may be possible to derive a broad estimate of the volume and value of MBS non-compliance. However, there is no 'one size fits all' approach to this analysis. Different non-compliant behaviour types require different validation methods to inform a definitive assessment of whether a claim is non-compliant. This is shown in Table 2.9, which provides a framework for categorising each non-compliant behaviour type by the validation method required:

1. Requires no clinical context and can be assessed with readily available data
2. Requires no clinical context but requires advanced data analytics capabilities
3. Requires clinical context.

Table 2.9: Framework for categorising non-compliant behaviour types by validation required

Data requirement for validation	Description	Examples of non-compliant behaviour types	Feasibility of determining non-compliance
Requires no clinical context and can be assessed with readily available data	Simple rules-based analysis of MBS datasets is required to determine non-compliance	Specialists and consultants claiming multiple professional attendances on the same day for the same patient	High
Requires no clinical context but requires advanced data analytics capabilities	Complex analysis of MBS datasets and/or other data sources is required to determine non-compliance. This may require linked service events (across multiple providers or patients) or matching with other data assets (e.g. home affairs data)	Claiming for an attendance with a deceased patient Claiming anaesthesia item without linked surgical activity	Medium
Requires clinical context	Requires understanding of the clinical context (e.g. through patient medical records or physical presence at time of care) to definitively determine non-compliance	Claiming for pathology or diagnostic tests that are not clinically indicated Abscess drained through regular consultation and no claim made on eligible co-claim procedure item (30219)	Low

Source: Philip Review (2023)

This framework illustrates the key challenge inherent in attempting to quantify the level of MBS non-compliance: some forms of non-compliance can be easily identified through simple analysis of MBS claims data; however, many forms of non-compliance require an assessment of the clinical appropriateness of each claim.

Methods to estimate the value of MBS non-compliance can be classified into the following two broad categories:

- **External approach (assumption-led approaches informed by external benchmarks) -** Seeks to estimate the total level of non-compliance by applying broad assumptions based on the experience of comparable schemes or sourced from literature
- **Internal approach (approaches informed by analysis and audit of MBS claims) -** Draws on a review of MBS claims and clinical activity – through deterministic data analytics and/or assessment of medical records – to verify whether non-compliance occurred. To manage the scale of analysis, this approach would typically assess a sample of claims and scale the findings to estimate the total level of non-compliance.

The second approach is considered more reliable; however, it is resource intensive and has the potential to face substantial ethical and or legislative barriers to full implementation.

In the following sections the methods used to derive previous estimates of MBS non-compliance are summarised and the two alternative 'internal' review methods that should be considered as a way of generating a more reliable estimate are described in full.

2.9.1 Methods underpinning previous estimates of the value of MBS non-compliance

Over the past five years, five studies have attempted to estimate the value of MBS non-compliance (see Appendix A for a detailed overview of each study).

With the exception of Dr Faux's work, the studies all variously apply an external approach, drawing one or more benchmark values on rates of non-compliance from comparable schemes (or associated literature) to total annual Medicare expenditure in the year of the study. The estimates put forward in these external approach studies range between $366 million and $2.2 billion (a rate of approximately 1% to 5%).

The applicability of the key benchmark values used in three previous studies made available to me is difficult to determine, as the source is either not referenced or no longer publicly available. One report references a global meta-analysis by Gee & Button (2016), which found that "6% is considered a reasonable estimate of improper payment rate" in healthcare. However, it is difficult to discern the exact studies used in the analysis from the Australian context as no original sources are included and therefore our ability to review their credibility and applicability to the meta-analysis is limited. Further, the scope of the research published in Gee & Button (2016) included both public and private health insurance schemes.

Dr Faux's methodology – while still in some instances utilising benchmarked assumptions – does represent the only attempt to build up an estimate of non-compliance and fraud utilising an 'internal approach'. Faux uses a combination of data sources, anecdotal evidence and broad assumptions to estimate Medicare fraud and error. Where available, she draws on billing data from her private business – which is notably small and biased, but real billing data nonetheless – to inform assumptions which are then extrapolated out. Dr Faux's current estimate of non-compliance is in the order of $10 billion (a rate of approximately 30%).[13,14]

Notably, Dr Faux's estimate is based on a far broader definition of non-compliance and fraud than that contained in other studies or than that currently employed by the department. Dr Faux's study includes behaviours which are considered by DoHAC as compliant because they cannot be validated via data analysis or are difficult to treat through strict interpretation of the rules. And thus not within the department's purview for intervention. The other studies are less clear in what they define as non-compliant, however they are assumed to align more closely with the DoHAC definitions given these studies were commissioned by the DoHAC.

The definitional matters raised by Dr Faux should not be dismissed. There is a real need to think through whether behaviours and systematic billing practices which, while legally compliant, should be considered as poor-quality healthcare or indeed fraud. Systematic errors could be just that – errors perpetuated as business-as-usual norms – however, they could, under some circumstances, be argued to be fraudulent. Similarly, behaviours such as unnecessarily repeated tests – a significant waste in the system – should not be tolerated as it violates good value for money for taxpayers. At the other end of the spectrum, underbilling was indicated to me as a growing feature of the system, representing poor value for money and potentially missed opportunities to optimise health outcomes for patients and thus the system overall.

All the studies related to non-compliance and fraud suffer from a lack of data from which to build objective and comprehensive analysis.

2.9.2 Alternative approaches to estimating the value of MBS non-compliance

As noted above, the most reliable method for estimating the value of MBS non-compliance would draw on an 'internal' review of MBS claims data and clinical activity to verify whether non-compliance occurred. One example of this is a random sampling audit approach (described in Box 1), which is considered the gold-standard for estimating rates of non-compliance in payment schemes.

[13] Dr Faux was consulted during this review and provided an updated estimated value of Medicare fraud and errors than previously published in the media (approx. $8 billion).

[14] Ferguson A and Gillett C, 2022, ''Medicare is haemorrhaging': The rorts and waste costing taxpayers billions of dollars a year', The Sydney Morning Herald, 17 October, https://www.smh.com.au/politics/federal/medicare-is-haemorrhaging-the-rorts-and-waste-costing-taxpayers-billions-of-dollars-a-year-20221013-p5bpp9.html, accessed 14 February 2023.

Box 1: Ideal-state audit approach to estimating Medicare non-compliance

Most other payment schemes that routinely measure and publish rates of estimated non-compliance (e.g. tax revenue losses, United States Medicaid payment error rates) use random audits that collect data from a representative sample of the population and scale the findings to derive an overall estimated error rate.**15** These audit approaches are considered the most reliable way of estimating levels of non-compliance, as they draw on detailed case-by-case information that is often necessary in determining the appropriateness of a claim.

In an ideal state, a similar approach would be adopted to estimate the level of MBS non-compliance. Blind retrospective examination of individual medical records (coupled with interviews of practitioners and patients involved in the claimed activity) would provide the most reliable assessment of whether a claim is non-compliant. This is especially important for the non-compliant behaviour types that require information on the clinical context to assess whether inappropriate practice occurred. In fact, for these behaviour types (category 3 in Table 2.9), the audit approach is the only way of deriving estimated rates of non-compliance. This blinded approach is an important aspect of the study design as to not affect provider's behaviour at the time of services and billing.

If the sample size had sufficient statistical power and was representative of the claiming population, it could then be scaled to provide a robust estimate of MBS non-compliance in the study year. The chosen sample should be representative of a range of variables, especially those that may be a driver of non-compliance such as: profession type; care settings; industry type; or, geographic area of care delivery.

The feasibility of the approach described in Box 1 is challenged by several practical constraints – it is likely to face resource constraints in the first instance and, has the potential to later face legal or ethical approval barriers. A lighter touch approach that retains the 'internal' focus of reviewing MBS data and records could be considered as an alternative. The trade-off is the completeness of the estimate – by balancing administrative burden, the proposed approach can only generate a lower-bound estimate of the value of MBS non-compliance.

An example of such a lighter touch approach might be to calculate the value of non-compliant behaviour types that require no clinical context and can be verified with readily available data – that is, evaluating non-compliance using data analysis alone is both deterministic and feasible (i.e. category 1 in Table 2.9). The framework for this approach would involve three sequential steps:

1. Develop list of non-compliant use cases across identified risks
2. Map use cases to one of the three non-compliant validation methods required (see Table 2.9)
3. Perform data analysis on use cases in the chosen category in Table 2.10. Use claim volumes and values to estimate the value of non-compliance for this segment of behaviour types.

Table 2.10: Types of non-compliance and respective use case themes

Category	Use case themes	Examples	Analysis feasibility
1. Underclaiming	**Down coding:** services eligible for higher complexity / time-based code but not claimed	• Not claiming a higher value time-based attendance code because allowable reporting time was not factored into the time calculation	Low
	Inefficient code selection: lower value item claimed when a higher value item should have been claimed	• Claiming a time-based attendance item when a higher billing antenatal attendance item could have been claimed	Low
	Eligible co-claiming or unbundling: services eligible for co-claim or unbundling were not claimed or claimed using a bundled item, respectively	• Abscess drained through regular consultation and no claim made on eligible co-claim procedure item (30219)	Low

[15] 2020 Estimated Improper Payment rates for Centres for Medicare and Medicaid Services Programs, https://www.cms.gov/newsroom/fact-sheets/2020-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs, accessed 14 February 2023.

Category	Use case themes	Examples	Analysis feasibility
2. Low value care / overservicing	**Inefficient provision of time-based attendances:** unnecessary (according to relevant clinical guidelines) time-consuming activities leading to time-based upcoding	• Undertaking extensive physical examinations during consult that are not clinically indicated given the assessment of the patient and best practice clinical guidelines	Low
	Overprovision of additional services: additional services (e.g. diagnostics, health assessment) referred to or supplied more than necessary (according to relevant clinical guidelines)	• Referral for blood tests that are not clinically indicated	Low
	Unnecessary repeat / follow-up services: providers scheduling and providing excessive repeat / follow-up services (according to relevant clinical guidelines)	• Scheduling follow-up services that are not clinically indicated	Medium
	Duplicate servicing: provision of care already provided by another practitioner	• Patient presents to multiple GPs seeking non-indicated referral to specialist	Medium
3. Underservicing	**Partial servicing:** providers did not fulfill all expected services as outlined in the item descriptor	• Health assessment item claimed, however not all of the indicated components of the assessment were completed in line with the item's guidance notes	Medium
	Service avoidance: providers not providing all of the care required by the patient and within the provider's capability (according to relevant clinical guidelines)	• A GP under time pressure may advise patient to present to local emergency department for a time-consuming wound repair	Low
4. Incorrect claiming	**Upcoding:** billing for a higher complexity / time-based code than the service provided	• Longer time-based item claimed even though time requirements not met	Low
	Unmet item prerequisites: minimum requirements for a service (e.g. initial attendance, patient demography) not met before claiming	• Health assessment undertaken and claimed more frequently than allowed for the patient • Claiming anaesthesia without linked surgical activity • Antenatal attendance claimed for pre-pregnancy fertility discussion with couple • Non-usual medical practitioner claiming GP Management Plan	High
	Ineligible co-claiming: services ineligible for unbundling but claimed separately	• Co-claiming Computerised Tomography (CT) scans that are not permitted within the same patient episode • Specialists and consultants claiming multiple professional attendances on the same day for the same patient	High - Medium

Category	Use case themes	Examples	Analysis feasibility
5. Non-provision of services	**Non-provision:** claiming of services that were not provided	• Claiming a consult for deceased patients	High - Medium

Source: Philip Review (2023)

This framework could be used by DoHAC on a routine basis to generate a lower-bound estimate of the value of non-compliance that exists in a given year. As more advanced data assets and capabilities become available, the framework could be expanded to include the behaviour types included in category 2 of Table 2.9. Adding the behaviour types that fall in category 3 of Table 2.9 would provide a more complete picture of the true level of MBS non-compliance, however this segment of behaviour types would require some form of the random sample audit described in Box 1.

2.9.2.2 Preliminary estimate of Medicare non-compliance value using Benefits Integrity Division risk assessment records

Even the lighter touch approach described above was not feasible to implement within the constraints of this Review. To generate a lower-bound estimate of the value of MBS non-compliance, I have thus relied on records of suspected cases of non-compliance detected by the DoHAC's BID risk identification and risk analytics teams.

As described in Section 2.5 and Section 2.6, DoHAC's BID risk identification and risk analytics teams have integrity controls in place to detect, treat and recover suspected cases of non-compliance. Notably, these are risks that have largely been brought to the attention of the department and subsequently triaged rather than systematically identified.

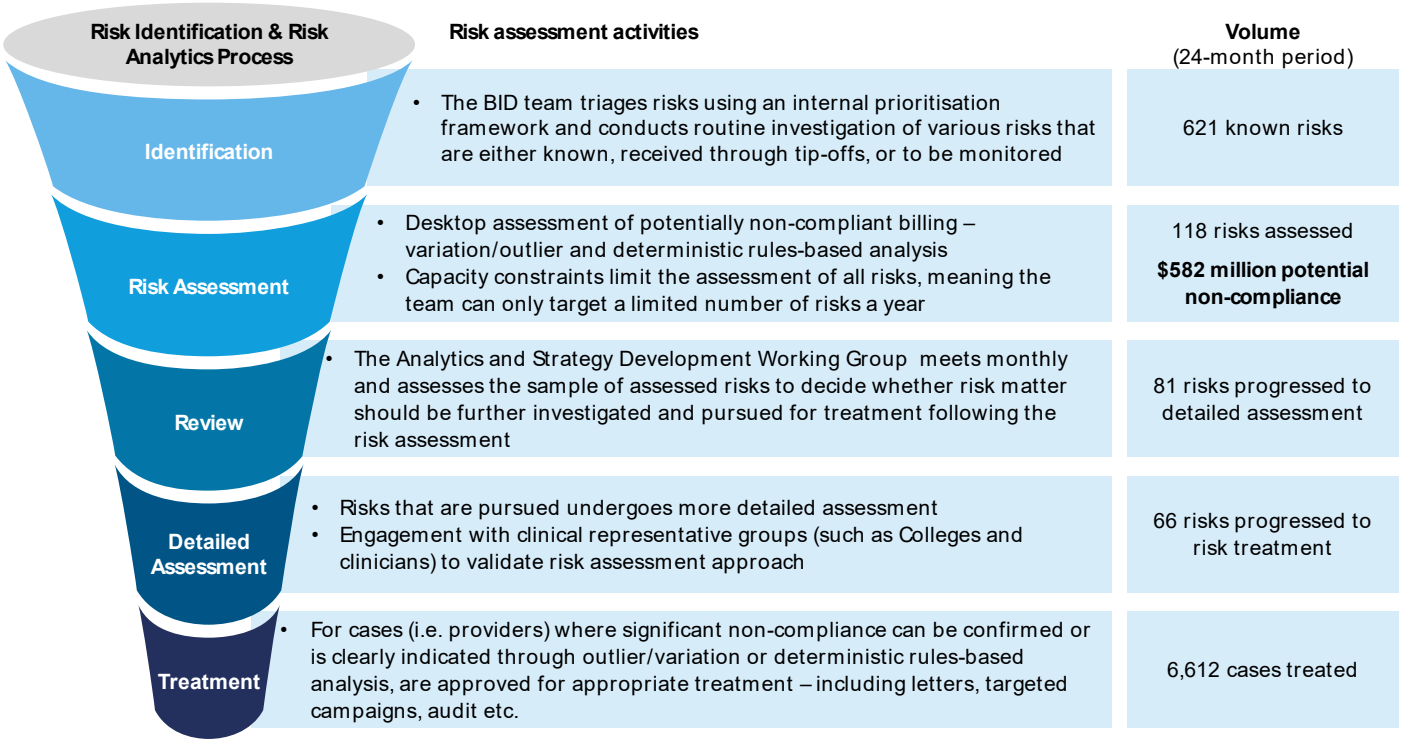
Capacity constraints mean that not all identified risks are considered further. Only a subset of identified risks are deliberately selected to progress to a stage of further analysis – i.e. 'risk assessment' (See Figure 2.10). The criteria for progression include a consideration of the potential scale/impact of identified risks and whether the risks have been recently reviewed.

Within the risk assessment process, a desktop assessment of potentially non-compliant billing is conducted – predominantly through variation/outlier analysis and deterministic rules-based analysis. The output for each risk assessment is a document which provides a conservative valuation of the scale of the identified risk if applied across all MBS transactions of relevance.

The documents are considered by the Analytics and Strategy Development Working Group and a decision is made at this point as to whether the risk should be investigated and progressed further.

The value of non-compliance estimated in the risk assessment documentation therefore represents a unique point of information held by the department – a statistical estimate of the scale of risks calculated ahead of treatment considerations.

Figure 2.10: Risk identification and risk analytics process (July 2020 – June 2022)



Source: Philip Review (2023). Note: the volume of risks and cases shown in the diagram under the Review, Detailed Assessment and Treatment phases is not indicative of all the risks (and their cases) that will progress to these phases (from the 118 risks that were identified and assessed over the period FY20-22). This is because some risks were only assessed toward the end of this 24-month period. For these risks, the window for analysis is not long enough to observe progression through these final three phases

Risk assessment documentation over a two-year sample frame (July 2020 to June 2022) was obtained and analysed. In total the sample included 118 Risk Analytics Section papers (less than 20% of risks identified). Duplicate risk assessments (where the same risk is assessed multiple times within the same year) were cleaned to ensure there was no double counting. The unique risks were then totalled and scaled such that the output is as though all risks occurred within a single year. The output of the analysis therefore represents a constructed estimate of non-compliance within a single year as informed by a sample of risk assessment documents sourced across a two-year sample-frame. This analysis found that the risk identification and risk analytics process had identified approximately **$582 million of potential Medicare non-compliance** at the point of initial risk assessment.

There are **several key limitations** in using this estimate as an indicator of the true level of non-compliance:

1. Only risks that are identified by the department are able to be processed through to risk assessment. Therefore, risks which are missed through lack of systematic monitoring will – by definition – be excluded from this analysis.
2. The risk identification and risk analytics process does not assess every form of potential non-compliance each year (due to capacity constraints) – thus understating the value of non-compliance. Within the sample frame only 19% of identified risks were subject to risk assessment.
3. The list of risks identified only includes projects that have been endorsed by the Case Flow Committee as per the Division's current operating model's governance processes. Projects/cases stemming from the following sources are therefore not included – understating the value of non-compliance:
   a) Non-compliance detection tools
   b) Projects/cases generated through analysis tools
   c) Public hospital compliance projects (noting they are subject to a separate endorsement process)
   d) Cases that are treated as part of the eHealth PIP cancelled payment projects (noting these are also subject to alternative approval arrangements) and cases (including fraud cases) identified through tip offs or data tools, or compliance concerns which cannot be identified in the data.

4. On the other hand, through subsequent review, analysis, and engagement the value of potential non-compliance estimated in the risk assessment stage is generally reduced as non-compliant activity is typically found to only be a subset of the estimate.
5. These assessments generally do not investigate potential underclaiming (not in scope of the risk identification and risk analytics process) which is frequent given the system's complexity and everchanging rules.

2.9.3 Overview of the breadth of estimates

In recent years, five studies have attempted to estimate the quantum of non-compliance and fraud in MBS billing – most recently the work of Dr Faux. With the exception of Dr Faux's analysis, the studies have utilised external estimates of non-compliance and fraud in comparable systems and applied them to the value of MBS. Their estimates range from $366 million to $2.2 billion. Their methods and assumptions are further detailed in Appendix A.

Dr Faux utilised a mix of data from her private business, her personal experience and various sources of literature to build up an estimate of non-compliance in a 'bottom up' manner. Her latest estimate of non-compliance and fraud is in the order of $10 billion. Whilst there are methodological issues and definitional challenges with Dr Faux's estimates, her build-up of an estimate of non-compliance from a sample of MBS billing data and observations of the system is instructive. While it is not directly comparable, it appears approximately $3 billion of Faux's estimate shares the same definition of non-compliance and fraud currently employed by the department.

The methodology I have employed differs from previous studies in that it utilises a far more 'bottom-up' approach to building up the estimate. The analysis which underpins it is targeted to consider relevant Medicare items across all specific providers with a history of billing the item within its sample frame.

Critically, this estimate is missing two things. First, only risks progressed by the department to risk assessment are considered. Owing to capacity constraints less than 20% of identified risks are progressed to this stage. Notably, this progression is determined in a deliberate selection process – prioritising risks that are likely to be more substantive in impact/scale – however, it is inevitable that a large volume of risks in aggregate will be missed. Additional selection criteria mean that the sample used for my analysis also systematically excludes other cases such as those identified through public hospital compliance projects and those treated through the eHealth PIP cancelled payment program.

A second missing aspect of my analysis – and likely more significant – is that its inputs are constrained by the volume of risks which are put onto the risk register in the first place (the 600 risks). These risks are largely ones that have been brought to the attention of the department and does not include non-compliance identified through tip offs, or the fraud and serious non-compliance cases identified through data. That is, they are not inputs that are drawn from a sample of risks which have been identified though broad systematic monitoring.

Together, this implies that my bottom end estimate of $582 million should be scaled up substantially to represent the *true* value of non-compliance. A methodology for doing so was not investigated as part of this analysis.

However, even without quantitatively scaling up the finding, the point estimate serves as a meaningful 'validation' point for the top-down estimates put forward in recent studies. Considered in light of the challenges highlighted elsewhere in this report, it is entirely conceivable that the true value of non-compliance could be multiples higher than the bottom end figure of $582 million.

Together, this analysis highlights three issues:

1. First, even without changing practices around systematic monitoring there are opportunities for the department to identify a larger volume of risks per annum than it currently does. My estimate - based on multiple years of departmental analysis alone - is close to 50% higher than what is identified in a single year. The analysis comprises independent risks which could reasonably be assessed together within a single year – let alone the volume that could be assessed if the capacity constraints, which see only 19% of identified risks progressed to further analysis, were reviewed.

2. Second, the analysis which the department conducts is constrained by its selection process and then again by its sampling - which is largely limited to matters brought to the attention of the department. These gaps imply my bottom-up estimate can and *should* be scaled up. Estimates put forward in previous studies which are multiple times higher are entirely conceivable when considered in light of the challenges highlighted in other parts of this paper.
3. Third, while there are challenges with Dr Faux's methodology, it does present as one of the only attempts to build up a 'bottom-up' measure of non-compliance through a – highly limited – sample of real billing data. In the estimate I put forward in this report, I too have sought to use available data to build a 'bottom-up estimate'. The direction for analysis is to pursue a 'gold standard' measure of non-compliance. This would involve a robust sampling across activity to identify risks and then a more complete analysis of all identified risks.

Finding 10: Calculation of the true quantum of non-compliance is limited by data availability, linkage challenges then muddied by differences in definitions. Previous estimates range from $366 million to $10 billion. Even simple extrapolation of risks currently identified by DoHAC suggests a bottom end figure of $582 million. Reasoning through the data constraints which inform this figure, it is reasonable to consider that estimates put forward in previous 'top down' studies that are two to three times this value are entirely conceivable.

3 The way forward

The findings of this Review have provided the basis of recommended solutions I see that will further strengthen the foundation of Medicare and ensure it remains fit for purpose and meets the needs of the Australian population into the future. In forming these recommended solutions, I would like to acknowledge the improvement and enhancements already being implemented by DoHAC and Services Australia in collaboration with sector representatives and consumers.

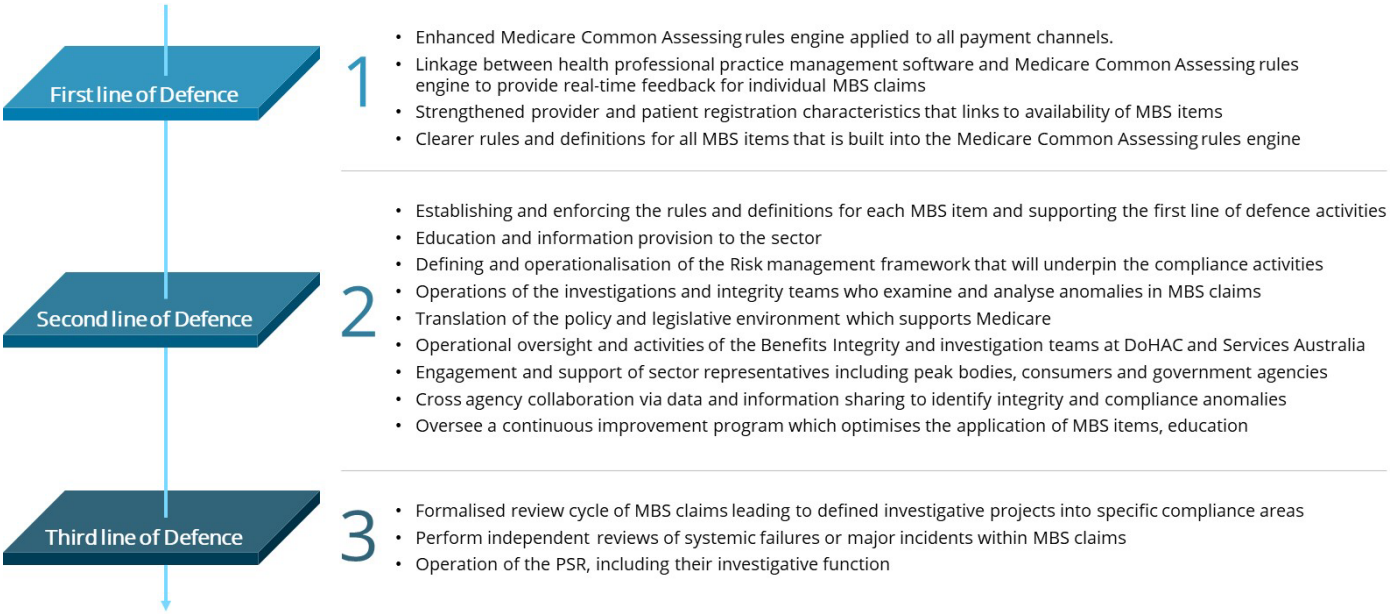
3.1 Establishing and operating Three Lines of Defence

In line with the findings of this Review there is the fundamental need for more structured and proactive integrity and compliance monitoring of Medicare and MBS payments. To achieve this, I propose that a 'Three Lines of Defence' structure and model be implemented.

Each layer of the defence model would deliver defined strategies to optimise the oversight and delivery of Medicare, at both a macro and micro level while building upon and complementing each other. This would put in place a proactive and predictive posture for compliance activities, and importantly enhance the transparency while simultaneously reducing complexity in the system which we heard as a common theme through the feedback from the sector. The approach I have applied is one that looks at the system as a whole, rather than focusing on individual challenges, because, in my view, it is a whole of system coordinated transformation that is required to modernise and future proof Medicare with appropriate levels of control and governance in place.

Figure 3.1 provides an overview of how the three lines of defence will operate and enable continuous and full monitoring of all MBS claim transactions.

Figure 3.1: Overview of three lines of defence model for Medicare



Source: Philip Review (2023)

Inherent within the three lines of defence are five focus areas and categories that I believe should be considered as the basis for a broad transformation of Medicare. These span the enabling legislative environment and instruments, governance of the Scheme, the operating model, the technology and infrastructure, and the analytics and continuous monitoring of transactions. Each of these areas is explored in further detail over subsequent sections.

3.1.1 Summary of recommendations

The recommendations are logically grouped into five areas of focus, and operationally against three broad areas of the Medicare process – claims, payment, and post-payment. Recommendations have been summarised in Table 3.1, with further details included in Section 3.2.

Table 3.1: Summary of recommendations from the Review

	Claims	Payment	Post-payment
Legislation considerations	• Support streamlining, control, and simplification of claims handling through changes in legislation wording and enforcement of existing legislation • Review criteria that disqualify certain patients from being able to claim Medicare benefits	• Enable expanded and appropriate data sharing and linkage for the purposes of integrity and compliance activities (e.g. tighter links with the Hospital Casemix Protocol and Private Hospital Data Bureau datasets)	• Increase effectiveness of enforcement through clarification and specification of legislation • Clarify audit responsibilities and wording to enhance effectiveness of audit measures • Under third line of defence (3LOD), provide alternatives to admission of inappropriate clinical action as a result of PSR
Governance	• End-to-end review of risks and controls coverage over claims and payments • Introduce first line of defence (1LOD) accountability for claims operation and controls	• Line of defence accountability for payment operation and controls	• 1LOD accountability for post-payment integrity detection and investigation • Second line of defence (2LOD) accountability for risk policy, review, and challenge • Introduction of Oversight Committee and supporting functions for risk reporting and monitoring • Remove the veto power of the AMA for the appointment of the PSR Director role
Operating Model	• Reduction of the number of claiming channels to reduce potential for inappropriate claims and duplicate claims. • Mechanisms to provide active notifications to patients, providers, and corporate entities of claims processed through Medicare • Provide proactive guidance to claimants at the point of claim, to assist in selecting correct item numbers and avoid inadvertent non-compliance	• Extend use of 'further assessment' mechanisms for payments that are flagged as non-compliant or requiring investigation	• Uplift of investigations capability • Built-in feedback mechanisms to improve claims and payment controls
Technology and Infrastructure	• Improvements to claims interfaces, uplift of data checks performed during claim submission • Uplift of claims data model, increasing mandatory fields and standardised invoice formats	• Strategic replacement of legacy Medicare Common Assessing Engine (mainframe) • Data quality and governance uplift of patient, provider, claims, and payment data	• Entity resolution and cleansing of Medicare data used for analysis • Replacement of case management system • Uplift of analytical capabilities to include continuous monitoring alerting and triage

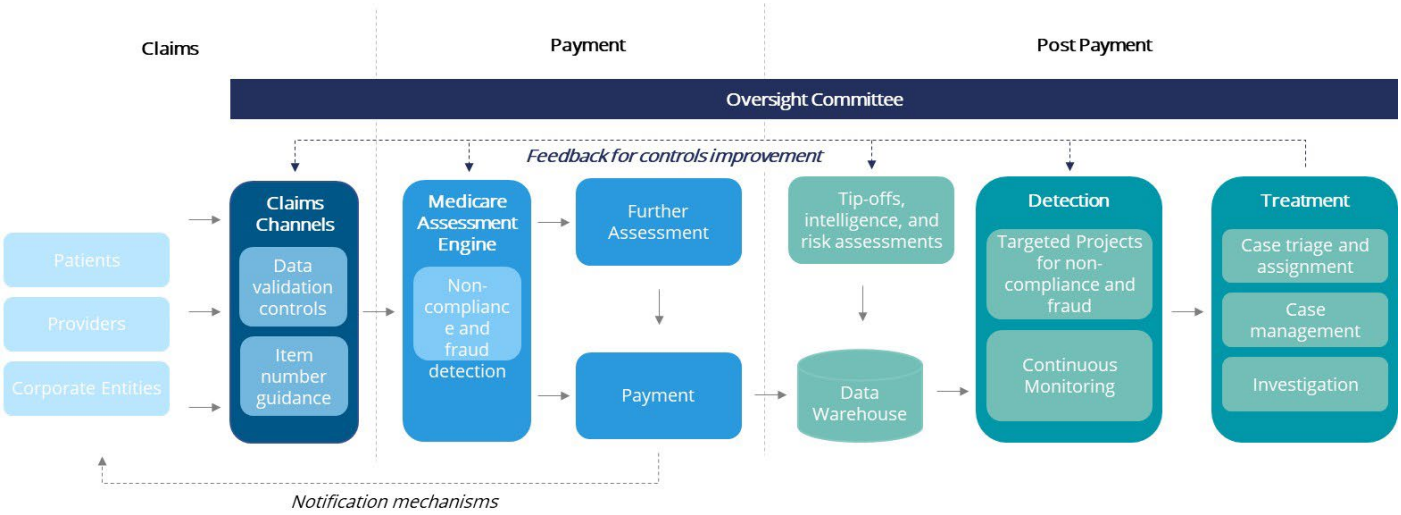
	Claims	Payment	Post-payment
Analytics and Continuous Monitoring	• Uplift of preventative controls for erroneous and fraudulent claims • Uplift of data quality checks for submitted claims • Uplift of controls for provider identifiers used for claims	• Uplift of preventative controls for erroneous and fraudulent payments	• Advanced whole population pattern analysis • Introduction of continuous monitoring detection

Source: Philip Review (2023)

3.1.2 Future state

The recommendations in Section 3.1.1 provide the foundations for a future state Medicare system that is supported by strengthened governance and preventative controls, enhanced capabilities for the detection of non-compliance and fraud, and modernised technology platforms. A high-level overview of this future state with key enhancements based on these recommendations is detailed in Figure 3.2 and in the text below.

Figure 3.2: Future state of the Medicare system



Source: Philip Review (2023)

Within this future state:

- The oversight committee has visibility of risk coverage, controls performance, case statistics for detected instances of non-compliance/fraud, and emerging fraud typologies. This provides a vehicle for transparency between agencies and government, as well as a necessary mechanism for oversight, challenge, and accountability of integrity risk.
- Claiming channels are rationalised and merged where appropriate to reduce the potential for duplication and misclaiming, as well as streamlining the infrastructure to support the claiming channels.
- Participants are provided with guidance about item numbers that are being claimed at the point of claim to minimise inadvertent non-compliance.
- Further data validation controls are implemented within claim channels to prevent submission of claims that do not meet required claim rules.
- The Medicare Common Assessing Engine is migrated from the current legacy mainframe to a modern platform, including upgrades to assessment applications, data model, and data storage.
- Rules within the Medicare Common Assessing Engine are enhanced to detect non-compliance and fraud; flagged claims are passed to specialist teams for further assessment, with all other claims processed for payment.
- Notifications are implemented to inform participants of when their provider/Medicare identifier has been used as part of a claim/payment to promote transparency and a mechanism to report misuse.

- Tip offs, intelligence from law enforcement and other agencies, and integrity risks are mapped against claims and payment data. All such intelligence is used to develop analytical monitoring controls.
- Post-payment detection of non-compliance and fraud includes both targeted projects and continuous monitoring.
- All flagged cases are governed by a modern case management system, which facilitates case triage (based on risk/severity), case assignment, tracking of status, investigation, and detailed reporting. Case outcomes are provided to PRP/PSR as an additional escalation point.
- Feedback from confirmed instances of non-compliance and fraud are fed back into upstream claims and payment systems for continuous improvement of the overall system.

3.2 Detailed recommendations

3.2.1 Governance

Recommendation 1: Strengthen the governance model overseeing Medicare through each line of defence.

Recommendation 1.1: Introduce an expanded governance structure to embed a Medicare Oversight Committee with representation from DoHAC (chair), Services Australia, ADHA, the Digital Transformation Agency and independent experts.

Recommendation 1.2: Establish and embed working groups focused on three key areas of Medicare: 'Policy, Legislation and Program Evaluation', 'Claims and Payments', and 'Technology and Data Management'.

Recommendation 1.3: Consider restructuring the design and composition of MBS numbers with a time-based backbone together with additional specific intervention and procedure codes, bundling of co-claimed surgical items to create single procedure codes, and integration of pre-claim decision support into practice management software.

A formal governance model is required to ensure benefits integrity risks are identified, assessed, and managed in a timely manner. Such a model would facilitate risk-based decision-making and ensure adequate end-to-end oversight of Medicare. Importantly, these activities must be undertaken in a manner that ensures compliance with existing legislation and frameworks, including the *Public Governance, Performance and Accountability Act 2013*, Commonwealth Risk Management Policy, and the Commonwealth Fraud Control Framework.

Table 3.2: Three Lines of Defence Model

Line	Responsibilities
1LOD	• Responsible for the operation of preventative controls in provider-facing business processes and claims/payments systems • Daily operation and tuning of continuous monitoring analytics models (detective controls) • Identification, assessment, and mitigation of emerging threats and risks • Actioning (triage, assignment, and treatment) of continuous monitoring alerts • Provider onboarding (including identity verification and provider due diligence)
2LOD	• Own, develop, and manage the risk management framework • Conduct risk assessments across all business functions and processes, as well as maintaining and updating risk and control registers • Provide reporting on the effectiveness of risk management to senior executives, working groups and steering committees • Responsible for interpretation and providing guidance on the implementation of complex policy and legislation obligations • Provide specialist advice to the Minister and senior departmental executives on key risks, mitigation strategies and action plans • Provide oversight of risk functions to ensure current risk profile aligns with the organisational risk appetite • Provide risk-based training to 1LOD operational staff • Conduct regular post-incident reviews and identifies learnings for enhancement of first line controls
3LOD	• Provide independent assurance on adequacy/effectiveness of risk management program, policies and legislation • Perform independent reviews of systemic failure or major incidents

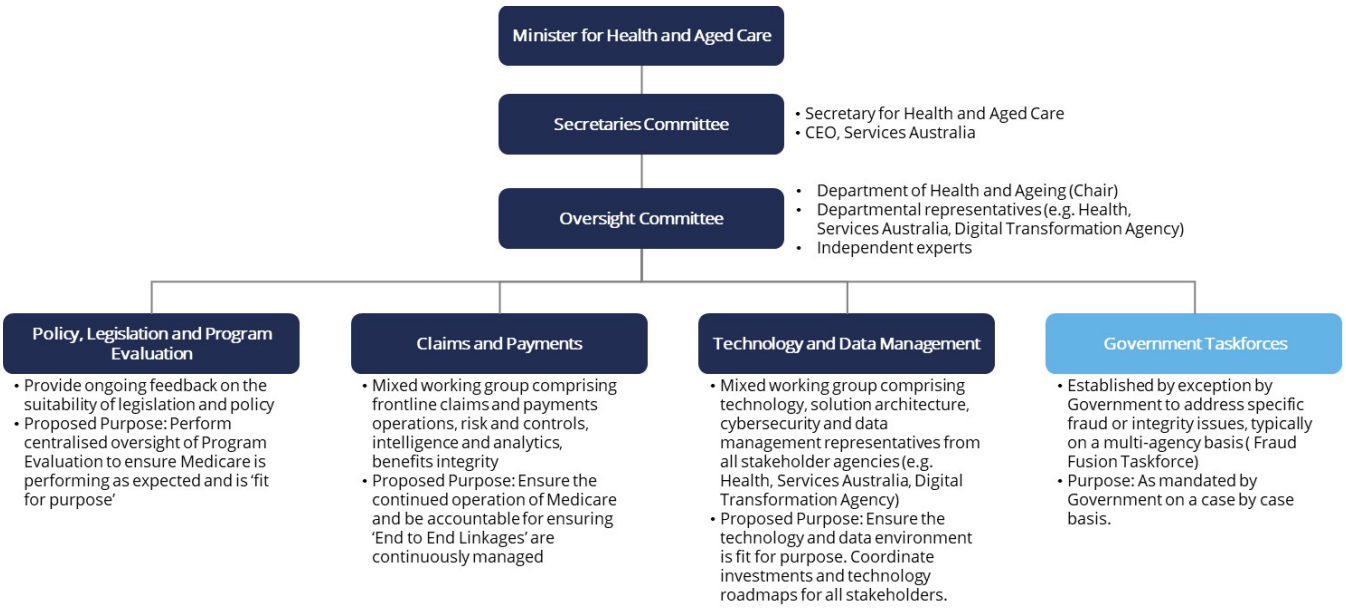
Line	Responsibilities
	• Advise the working group and steering committee on impairments in the risk management process and potential safeguards/controls to fix

Source: Philip Review (2023) using Australian Prudential Regulation Authority (2018)[16]

3.2.1.2 Appropriate Governance and Oversight

To ensure there is appropriate supervision and oversight of the governance framework, establishment of an Oversight Committee (independent board) is recommended. This committee would provide review of and challenge the performance and effectiveness of the governance framework and would receive reporting highlighting key performance and risk indicators (for example, trends in fraud and non-compliant cases detected, value and volume of cases under investigation, or cases identified and awaiting treatment). An illustration of how such a governance structure may work is shown in Figure 3.3.

Figure 3.3: Governance and oversight structure (indicative)



Source: Philip Review (2023)

The Oversight Committee could comprise agency stakeholders, as well as independent experts from industry. Senior executives from relevant departments and agencies would provide a contextual and operational view of Medicare, while experts from industry who have experience in claims and payments systems would provide visibility of best practices in the detection and treatment of fraud and non-compliance from a wider perspective.

Aside from direct operational reporting, the Oversight Committee would also be provided with feedback and reporting from various Working Groups working to improve aspects of the Medicare system (for example, a technology working group providing updates on system and platform upgrades). The committee could also be provided with feedback from, for example, industry advisory bodies providing feedback and guidance on how the system is working from a customer (end user) perspective, with an emphasis on continuous improvement and ensuring the system is fit for purpose. The Oversight Committee would receive regular reporting highlighting performance, feedback and intelligence detailing key risk management outcomes and information.

3.2.1.3 Improve the clarity and specificity of MBS items

There is a distinct need to enhance the clarity of MBS items, with interpretation of these numbers a real challenge for healthcare providers. This includes:

[16] Australian Prudential Regulation Authority (2018) Prudential Practice Guide CPG 220 Risk Management, <https://www.apra.gov.au/sites/default/files/cpg_220_april_2018_version.pdf>, accessed on 2 March 2023.

- **Simplification of language**: Focus on the clinical scenarios and application of the MBS item rather than the current legal language that is present in a number of items
- **Improved specificity**: Specific details of the service – including type, duration, location, and mode, are captured and articulated to ensure providers can be confident with their claiming and translation to individual patient presentations and clinical scenarios
- **Relevancy**: Ensuring MBS item numbers reflect contemporary models of care and remain up to date with the most recent clinical guidelines as they emerge.

Currently, if a healthcare provider bills a combined or comprehensive item, they cannot bill the individual services that make up these items.

Further to this, if more than one item covers a service, the current reliance is on the healthcare provider to understand each item's description and requirements. However, given the sea of MBS item numbers, the constant changes to claim rules, complexity of interpretation and nature that certain item numbers can be co-claimed and others cannot, this leaves an opportunity for claiming errors and non-compliance.

My recommendation is to support enhanced clarity by providing a tiered model which provides structure when co-claiming, helping providers to bill the correct item and preventing errant claiming due to a lack of knowledge.

The proposed model is categorised by common elements of co-claiming; represented through a patient journey, an example is shown below:

Level 1	**Baseline of the time-based item** A patient visits a general practitioner regarding a recent cut/laceration. Example: MBS Item 23 Level B - Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes.
Level 2	**Any additional intervention provided at the occasion of service** The practitioner deems that it is clinically appropriate to repair the wound. The patient receives wound repair using sutures. Example: MBS Item Number 30032 - SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial.
Level 3	**Any additional procedure provided at the occasion of service.** The practitioner deems that it is clinically appropriate to administer a tetanus vaccine. There would be no item number to claim for, as this would be covered through the professional attendance item (23) provided at Level 1.

This structured logic model would enable healthcare providers to actively work through the correct number and type of services that correspond to each individual level/tier, that do not contradict the rulings and parameters of MBS Item Numbers. This model could be beneficial for certain types of patients who often present for multiple, complex issues and/or experience co-morbidities.

Further to this refined structure would be the automatic matching of provider and patient details for each claim item. At the provider registration point the clinical speciality and practice setting will be established. This is a central set of attributes that can then either lock or unlock access to MBS items based on scope of practice that is built into the Item Fee File and applied by the Medicare Common Assessing platform. For example, a GP would be prevented access to complex neurosurgery MBS items for procedures that would be performed in a hospital.

These provider and patient attribute checks would be performed by Services Australia with linkages to their relevant databases and could not be overridden by providers through the claims process.

Combined, these measures would assist avoiding inadvertent claims errors by providers through the timely application of the rules engine to submitted claims.

3.2.1.4 'Bundled' MBS item numbers for common procedures

In some instances, certain MBS item numbers are often associated and co-claimed with others. This offers simplicity by 'pooling' those particular services under the one code, eliminating the need for providers to recall specific elements of a routine service.

An example of this is highlighted through MBS item 16519, which covers "birth by any means including Caesarean section." This item number can draw from four different elements of the service, outlined below:

- Surgical and/or intravenous infusion induction of labour
- Forceps or vacuum extraction
- Evacuation of products of conception by manual removal (not being an independent procedure)
- Episiotomy or repair of tears.

Pooling MBS items under one code that encompasses other aspects of care for those very common and routine procedures can reduce the potential for error by healthcare providers by claiming incorrect codes that are not part of the service, and ultimately reduce the amount of non-compliant claiming.

3.2.2 Continuous monitoring and data analytics

Recommendation 2: Implement enhancements to the end-to-end claiming journey to strengthen the first line of defence position and enable continuous monitoring of all MBS claim transactions.

Continuous monitoring is a term given to the ongoing review and assessment of anomalous activity in a transaction-based data environment, so as to quickly identify and respond to potential issues of non-compliance or fraud. Early identification is critical as this enables compliance officers to employ the application of more constructive and less confrontational compliance interventions before patterns of behaviour become systemic or even criminal.

Payments are made once a claim is submitted by an authorised actor, such as a provider, practice manager, outsourced business processing company or patient. In leading practice, monitoring of payments is only performed once a claim has been validated and assessed as ready for payment. This avoids the need for a more costly reactive response which is onerous on both the Commonwealth and the actor(s) concerned. Whilst some types of benefits integrity risk are most easily detected at the point of payment (such as those involving payments to a common bank account number), in an ideal state invalid claims should not be paid until their status is either resolved or a claim is correctly submitted. We note that deviations to this principle may be appropriate for exceptional circumstances (such as during the response and recovery phase of natural disasters), however such claims and payments should always be quarantined and treated separately.

However continuous monitoring of payments is reactive. Reliance on non-compliance and fraud detection solely at the payments stage forces an organisation to rely on more expensive and onerous debt recovery, litigation, and enforcement mechanisms to recover monies which might otherwise have been avoided if addressed at the 'actor' and 'claim' stages in the system.

Analytics-based continuous monitoring capabilities are not intended to be a replacement for community-based tools such as tip offs and interagency referrals. However, in an ideal state most anomalies would be detected using analytics, with the information provided via a tip off supplementing the data or providing more context not available via other means. We note that in highly complex fraud scenarios it may not be readily possible to detect such intentional activity using analytics with current technologies and data science, and that these cases will be reliant on reactive methods such as tip offs.

3.2.2.1 What are the core components of a continuous monitoring system?

Continuous monitoring systems used to detect non-compliance and fraud are typically integrated with, but adjacent to, core customer relationship management systems, payments infrastructure, and associated environments. Continuous monitoring capabilities use the data retained in core systems and apply intelligence-led models and risk-based processes to that data in order to identify potential instances of non-compliance or fraud (referred to as 'anomalies'), which are then flagged and referred for review and investigation.

There are three main capabilities within a continuous monitoring system which should be considered by Medicare, being:

- **Intelligence:** Comprises the systems and processes which identify behaviours of concern by actors and involves the application of intelligence analysis techniques as well as inter-agency liaison to identify emerging trends and patterns for use in detection analytics.
- **Detection analytics:** Uses insights provided by the intelligence function to design and continuously improve rules, scenarios and models using data science techniques to enable the detection of anomalies in real time or near-real time.
- **Integrated case management system:** Provides a repository of case information, enables automatic case creation of anomalies referred by the detection analytics system, and incorporates advanced tools such as decision engines, risk scoring models, automated workflows, management dashboards and reporting. The investigation case management system is typically integrated with, but separated from, the standard customer relationship management system to provide greater confidentiality, maintain legal privilege and facilitate proper evidence management.

When properly designed and implemented, continuous monitoring systems provide the opportunity to continuously monitor and evaluate large volumes of data with a comparatively small team. The components of a continuous monitoring system must be enabled by an appropriate enterprise data environment. System configurations and access to data should be designed in a manner that ensures compliance with legislation, such as data matching, whilst providing adequate levels of security and audit. In addition, such a continuous monitoring system would require real-time access, via system integrations, with external data sources held by other government agencies as well as public records to inform detection models and risk scoring.

To keep both full-time equivalent requirements and case volumes within manageable limits, tools such as automation, decision engines, risk scoring, and workflows are used by the financial services industry and service delivery agencies to focus human intervention at key points in the process.

Achievement of a future state capability is not possible using technology alone. Successful implementation requires a comprehensive capability comprising appropriate governance, processes, people and data in addition to technology. The role of technology in this construct is as an enabler which provides decision support, allowing departmental officers to appropriately monitor 100% of all actors, claims and payments in the Medicare Scheme in an efficient, effective and publicly accountable manner.

3.2.3 Operating model

Recommendation 3: A refreshed design of key frontline operational processes, and business rules, which consider fraud and non-compliance risks is required and is urgent in order to sufficiently support the early identification and disruption of fraud and serious non-compliance. Enhanced identification of risks should be applied to disrupt fraudulent activity as early as possible.

Recommendation 3.1: More formal and deliberate feedback loops into key controls to mitigate program and integrity risks throughout the life of the MBS must be considered jointly by DoHAC and Services Australia. This involves greater integration across the various functions in DoHAC and Services Australia to build a complete end-to-end picture of compliance and appropriate data sharing.

Recommendation 3.2: A comprehensive system for continuously improving and updating education and awareness for providers regarding the application and use of the MBS must be introduced, including the involvement of key stakeholders.

Recommendation 3.3: Risk identification must be enhanced by both DoHAC and Services Australia, based on continuous monitoring; data from which will enhance detection models based on casework, intelligence and tip offs.

Recommendation 3.4: Implement more proactive identification of policy gaps to further strengthen the MBS compliance capabilities in line with the risk-based approach currently being adopted.

Recommendation 3.5: Consider the optimal operating environment to support a culture of information sharing and risk mitigation awareness across the relevant government agencies and teams, including identification of legislative and privacy-related concerns.

Recommendation 3.6: Consider expanding the use of practical case studies to support existing information and education materials available to health professionals. Closer collaboration in the preparation of education

materials between government agencies and peak bodies, and an expansion of the education efforts to include corporate entities and administrative staff involved in preparing MBS claims.

Recommendation 3.7: Consider ongoing tailoring of the education and reference materials available to providers and patients to support compliant MBS claiming. Ongoing participation in face-to-face seminars and education events for target groups.

Implementation of these future state capabilities requires a 'fit for purpose', risk-based operating model which reflects the challenges and complexities inherent in Medicare such as legislation and the need for information exchange and interoperability between the Commonwealth and State/Territory Governments. Existing Medicare operating models will require the requisite supports and resources to undergo this transformation, as outlined in Table 3.3.

Table 3.3: Supports and resources for an effective operating model

Concept	Description
Design of key frontline operational processes	Implement frontline processes, including provider onboarding and claiming procedures, that consider fraud and non-compliance risks in their design to prevent illegitimate or inappropriate claiming or entry into the Scheme.
Continuous improvement of key controls (preventative, proactive, detective and analytical models) to mitigate program and integrity risks throughout the life of the program	Build feedback loops into the current control environment to ensure controls are operating as intended, and adequately mitigating fraud and non-compliance risks. This process of continuous improvement may include assurance activities such as the pressure testing of controls, analysis of 'near miss' events and lessons learnt through identified cases of fraud.
Continuously improving and updating education and awareness for providers	Ensuring feedback from lessons learned, risk events, near misses, complaints, industry outreach and similar sources are collated, analysed, and appropriately communicated to providers on an ongoing basis. This will help to encourage greater awareness and change non-compliant behaviours whilst making sure providers and patients in the Scheme are aware of their obligations, the agency's stance on fraud and ongoing efforts to identify and respond to instances of fraud and non-compliance acting as a general deterrent to inadvertent and opportunistic exploitation of the Scheme.
Enhancements to detection models based on case work, intelligence and tip offs	Feedback should be applied to analytics and intelligence to continuously refine and improve the department's understanding of fraud and non-compliance and the way it materialises within the Scheme (noting that criminals in particular are constantly evolving their tactics and techniques). This will help ensure detection systems can readily detect undesirable behaviours and trends in a proactive manner (i.e. pre-payment or on provider enrolment into the Scheme), reducing reliance on reactive practices and move towards proactive system-based detection.
Proactive identification of policy gaps to further strengthen Scheme capabilities	Where capabilities have been historically limited by the Commonwealth's access to information and data and/or ability to share information and data between agencies, amendments to policies and memorandums of understanding (MOUs) should be pursued to ensure the right information is available at the right time to effectively prevent, detect and respond to the risk of fraud and non-compliance. This will support the ability to continue to generate a viable Scheme that meets government's expectations and promotes good customer experience.
Support a culture of information sharing and risk mitigation awareness	Improving both intra- and inter-agency collaboration would help to ensure a single line of sight between risk and control owners, supporting continuous improvements to the control environment.

Source: Philip Review (2023)

3.2.4 Future composition and role of the PSR

As with the broader reflections throughout this report, there are also some components of the PSR that ultimately no longer fit with the way that healthcare is currently delivered, and how it will be delivered into the future. For example, the inclusion of only the AMA as a professional body that can veto the appointment of a PSR director no longer reflects the fact that there are a range of professionals who will be referred to PSR and either all professions should be reflected in Director appointment decisions, or none at all. Acknowledging that legislative change would be required to achieve this and that it is not a straightforward decision, I believe it could bring about a measurable enhancement to the perception of the PSR by the sector and any perceived conflicts of interest.

One final recommendation for the PSR, that would require legislative changes is the introduction of an 'associate' or other alternative second in charge role supporting the Director of the PSR. Currently, there are a range of roles and responsibilities that can only be completed by the Director of the PSR including decision making. On top of this, if the Director feels that there is a conflict of interest the only options available to them are either to continue with the process or to take a leave of absence so that an acting Director can be appointed. Having the opportunity for an associate or second Director to be available would help to share the load of the work, ensure that conflicts can be handled more appropriately, and potentially assist with succession planning and training for future Directors. I understand a similar recommendation was made in the section 92 review[17].

3.2.4.1 Proactive education of providers and the sector

Building upon the previous recommendations is the important area of the education of health professionals, consumers, providers and administrative stakeholders who all play a pivotal role in maintaining the integrity of and compliance with the MBS. It is recommended that a tiered approach is considered for ongoing education activities and stakeholder engagement and is informed by the enhanced analytics and monitoring of the MBS.

Tier 1: Readily accessible education materials and advice

Leveraging existing information and communication channels, it is recommended that digital resources are streamlined and tailored to the high priority groups (such as primary and acute care medical practitioners, allied health providers, nursing providers, pathology, radiology and aged care providers). This would include refinement of the 'AskMBS' web and email service, and inclusion of more case study examples of the implementation of individual MBS items.

Given the strong and symbiotic collaboration between DoHAC and Services Australia, it is recommended that these education materials are co-designed with representatives from each agency and relevant peak bodies where appropriate. This would include periodic review cycles for the information and advice made available to the sector.

Where new MBS items are added to the MBS or amendments are made to existing items, to assist the translation of the changes it is recommended that consideration be given to the preparation of an information or fact pack to support the implementation of the changes. Examples of the contents of the fact pack would include clear and concise description of the changes made with a comparison between current and future items, case study examples of how the new MBS item/s will be implemented (relating to the business rules applied to it) highlighting what is different to current practice, and these would be supported by an appropriate lead-in time to implementation. It was suggested to me through the consultations with stakeholders for this Review, that at least 6 months is required for appropriate education and informing of the sector prior to a change to the MBS going live to enable the appropriate change management and education support to providers to be completed.

Tier 2: Face-to-Face engagement with health professionals

It is recommended that the ongoing communication and engagement strategies to reach health professionals via their relevant peak bodies and education seminars in a face-to-face environment continue. Planning engagement at these events to coincide with the outcomes of specific campaigns and compliance drives has the potential to improve compliance with relevant MBS items and practice settings.

Supplementing these activities with issue specific communication strategies can further enhance the impact the campaigns can have on MBS claiming behaviour.

[17] Robin Creyke and Dilip Dhupelia, *Report on review of section 92 of the Health Insurance Act 1973 (Cth*), August 2022

These activities can commence during undergraduate and pre-registration training periods. There is a beneficial element to building the foundational knowledge of the structure and application of the MBS that can be built upon as health professionals specialise through their career and refer to a narrower area of the MBS.

Tier 3: Targeted letters and engagement with peak bodies

It is recommended that the existing targeted letters and engagement with peak bodies to ensure compliance with the MBS continue into the future. Where anomalies in claiming behaviour are identified and intervention is required, the assistance of the relevant peak bodies to propagate the message of concern regarding the claiming as well as to clarify the service delivery model considerations is critical.

3.2.5 Broader health policy response

In addition to mitigating fraud and compliance risk, development of appropriate feedback loops would enhance the ability to effectively share accurate Medicare information across internal and external stakeholder groups to inform and drive broader public good measures. This includes:

- Improved visibility of clinical information, process improvements and workflow gaps across state healthcare settings
- Improved communication across healthcare professionals, working together to provide enhanced continuity of care and health outcomes for patients
- Capitalising on early clinical information systems investment and opportunities to aggregate data and improve healthcare outcomes
- Improved health system planning, management, evaluation, and quality improvement which is informed by data collected across the system
- Feedback from consumers, carers and clinicians is routinely collected and analysed to monitor care experiences and outcomes
- Better user experiences, time efficiency and productivity across the system
- Healthcare demand and capacity across the state can be viewed centrally in real-time
- Healthcare resources are mobilised, and patient flow is directed in response to changing healthcare needs and priorities (i.e. epidemiology disease outbreaks).

By implementing and enhancing information sharing across the stakeholder groups within Medicare, the program will more readily be aware of and respond to public health consideration (with more targeted medical campaigns), better program evaluation and feedback to highlight gaps in the program and provide greater strategic and policy alignment with Federal and State Government counterparts. This will build stronger foundations for public good.

There is a clear need for learning to take place within DoHAC and Services Australia from large investigations, which include:

- Common patterns of identified non-compliant claiming should be proactively applied to other item numbers, professions and claiming channels
- Outcomes of investigations need to inform education material and advice provided to health professionals and patients
- Simplification of MBS items and structures (e.g. how MBS claims are put together) is an important element. Ambiguously written MBS items need to be updated, and clear business rules that are transparent for health professionals to apply in their practice settings have to be applied
- Shifting to a continuous improvement cycle rather than a pure internal audit approach will be a significant step forward
- Input and consultation will continue to be required with the sector to ensure the MBS will remain fit for purpose as models of care change and evolve.

3.2.6 Technology and infrastructure

Recommendation 4: Redesign of the Medicare payments system to a level of capability maturity that is commensurate with the size and complexity of the Scheme today and into the future.

Recommendation 4.1: Implement requirements for greater data checks and compliance within practice management software. This would enable closer integration of practice management software with the claims assessment rules engine to enable real-time claims assessment for providers to avoid unintentional non-compliant claiming.

Recommendation 4.2: Implement technology to enable consistent and complete pre-payment checking and validation of all MBS claims as part of the first line of defence.

Recommendation 4.3: A review regarding replacement of legacy Medicare systems, applications and databases should be conducted within 12 months.

Recommendation 4.4: Urgent consideration should be given to options for the replacement of the ageing Medicare Common Assessment rules engine to a contemporary technology infrastructure.

Recommendation 4.5: New Governance processes should be implemented (and legislative changes may be required) to expand the data exchanged between Services Australia and DoHAC.

Recommendation 4.6: Given the current lack of sufficient controls and analyses, and given the vulnerabilities in the system, DoHAC and Services Australia should conduct an urgent strategic review of current data assets and uplift of current data analysis.

Recommendation 4.7: Consider consolidation of the EDI simplified billing channel into the ECLIPSE billing channel to centralise all hospital inpatient claiming and enable data linkage to acute hospital datasets for compliance analysis.

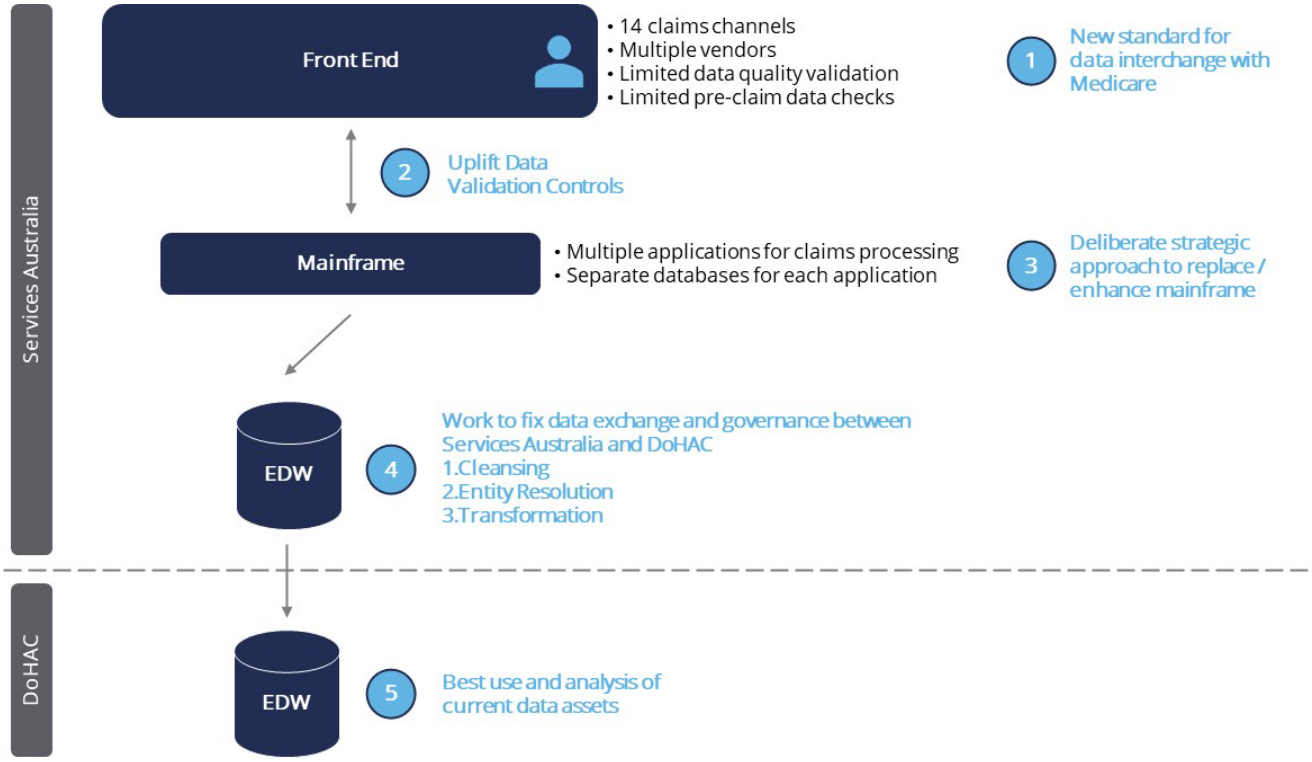
To facilitate the identification of non-compliance and fraudulent claims, and to allow claims processing and payment systems to operate with sufficient levels of quality, efficiency, and control, the quality of data submitted with each claim is critical. As Medicare facilitates claims through multiple channels via multiple vendor solutions, there is an increased risk of incongruous and poor-quality data being entered and successfully processed at the point of claim. The complexity of this data landscape causes difficulties in harmonising data from the different claim channels, which is a contributing factor to unintentional non-compliance while also introducing gaps that may be exploited for fraudulent purposes. Poor quality and incongruous data from multiple channels also limits data analysis that can be performed to detect non-compliance and fraud. The accuracy, quality and reliability of the collected data ultimately determines its value in downstream analytical and detection capabilities, insight generation and the ability to capture, reuse and embed business intelligence and learnings for continuous improvement in compliance and the integrity of Medicare.

The existing technology, data and data flows within the Medicare payments system require redesign to a level of capability maturity commensurate with the size and complexity of the Scheme today and into the future. Achieving this level of capability maturity will confer benefits beyond those related to integrity alone, and be available for reuse in, for example, healthcare modelling, policy development, decision support and clinician/provider education, or public health decisions. This is illustrated in Figure 3.4 and discussed in detail below:

1. Requirements should be introduced for greater data checks within practice management software. For example, the system should not allow submission of incomplete or unvalidated claims, incorrectly formatted data, or duplicate information. Opportunities also exist to implement active decision support for MBS item selection at the point of decision, which would remove some of the complexity involved in interpreting Medicare guidelines when submitting a claim, reducing unintentional non-compliance.
2. The application of extensive data and claim validation would reduce the number of inappropriate claims at the point of claim, before payment and without the need for any compliance effort. For example, validation that an individual is authorised to use a provider number, MBS codes used are compatible with a provider's specialisation, or comparing provider and patient location could be performed prior to allowing online submission of the claim. This would simplify processes for providers and enable practice staff to identify and correct inadvertent data entry errors at the time prior to claiming.

3. A deliberate and strategic overhaul of existing legacy Medicare systems and the myriad of applications and databases that reside on it requires research and consideration. A decision needs to be made about whether this takes the form of system replacement or consolidation and streamlining of the existing systems. Current system complexity and the lack of integration with other systems complicates achievement of a 'single view of provider/claimant' and the timely identification of undesirable or high-risk behaviours in the Scheme. Furthermore, as the Medicare Common Assessing Engine is built on a legacy mainframe platform, there are end-of-life issues related to the lack of skilled programmers who are able to code changes to applications at present, which will continue to escalate in the future. The impact of this is that the department may need to resort to more onerous or unnecessary treatments which may also impact provider experience and confidence in the Scheme.
4. Work to enhance the quality, reliability and insightfulness of data exchanged between Services Australia and DoHAC should be undertaken. Typically, this will include data cleansing, entity resolution and data transformation prior to transfer to DoHAC. Data cleansing and transformation makes the downstream use of any data easier, more accurate and reliable. Entity resolution identifies duplicate provider/claimant records for subsequent removal and/or merging. A single provider or claimant profile enables better analysis and identification of behaviours for both policy and integrity applications. Further, this level of insight on providers allows the application of targeted public education and user support to those areas that really need it. More robust and meaningful data builds confidence in subsequent decisions.
5. A strategic review of current data assets and uplift of current data analysis coverage should be performed as a matter of priority. DoHAC should formally assess current data assets (including data curated from other agencies and external data providers) to identify what additional data is required to enable detection, and what gaps exist in existing data assets. Notwithstanding any identified data gaps, DoHAC should also uplift the scope and coverage of data analysis to, at a minimum, better quantify the volume and value of non-compliant and fraudulent claims within the system. This should include an all-of-population assessment against known risk typologies (behaviours) and would form foundational analysis for a shift to continuous monitoring detection.

Figure 3.4: Future and purpose-built Medicare payments system



Source: Philip Review (2023)

3.2.6.2 Replacement of the Medicare Common Assessing (Rules) Engine

It is acknowledged that the Medicare Common Assessing Engine is maintained on an end-of-life mainframe technology that is not sustainable into the future. It comprises over 200 separate applications to form the engine, and given its age, feedback was provided to me during the Review that maintenance and updates to the platform

require a very specific skillset and knowledge base that is not commonly available. As such there is significant risk for the ongoing viability of this critical piece of infrastructure.

As such, it is recommended that consideration be given to modernising the rules engine as well as the Item Fee File to be contemporary and fit-for-purpose technology infrastructure. This will enable more agile updates and refinements to be made to MBS items and the Scheme as a whole.

Embedded within the future Medicare Common Assessing platform should be the close collaboration between DoHAC and Services Australia to define and agree the critical inputs for the Item Fee File that is uploaded to the Medicare Common Assessing platform. This file, for each MBS item, establishes the common business rules that will be applied to all submitted claims and will form the backbone of the first line of defence integrity and compliance reviews.

3.2.6.3 Integration of practice management software and the claims assessment rules engine

It is recommended that practice management software is integrated with the rules engine to support best practice, compliant billing and claims management.

When an MBS item is captured into the practice management software, it would be cross-referenced with the rules engine. If the item numbers aligned with a service, and adhere to the parameters of the rules engine, there would be no 'red flag', indicating an error. However, if it did result in a claiming error, this would provide, live, real-time feedback for the provider (e.g. a member of staff, practice manager) to then confirm with the practitioner.

These 'soft blocks' would be implemented when there are clear, distinct clinical scenarios that would mean the services could, or could not be claimed.

The benefits of this would also be realised by providers, reducing the number of occasions of a retrospective audit, along with the time and resources necessary to respond to an audit.

3.2.6.4 Consolidation of MBS claiming channels

Significant duplication exists amongst claiming channels, which provides the opportunity to consolidate these to provide an enhanced, and less convoluted claiming experience. For example, at present, hospitals and private health insurers can utilise either the EDI or ECLIPSE claiming channels, and both enable the involvement of private health insurers. The opportunity exists to consolidate EDI, which is used for inpatient claims and represents 0.2% of total claim volumes, into the ECLIPSE Simplified Billing channel, which is also used for Inpatient medical claims and processes approximately 6% of total claim volumes.

Combining the two hospital inpatient billing channels will enable:

- Streamlined and centralised MBS data sets to enable linking with the acute hospital datasets for the purposes of claims verification (e.g. visibility of admission and discharge dates, application of Diagnosis Related Groups and their link to MBS procedure items)
- Building and maintenance of common technology infrastructure that links to the relevant hospital technologies to optimise data, and avoidance of duplicated effort, costs and technology capability currently in place across the two channels.
- Enhanced provider and health insurer experience with the need to interact with a single claiming channel.

Into the future there could be opportunities to further consolidate and rationalise the claiming channels as enhancements and replacement of the supporting technology infrastructure is realised. This could enable the consolidation of the digital channels into MBS Online as the existing dominant claiming channel. This has the potential to reduce confusion or ambiguity in the application and operation of Medicare, though, it would need to be balanced with the transformation and change management needed for the transition to the centralised channel.

Consideration can be given to rationalisation of the manual claiming channels, however, it is noted that these handle only a small proportion of the overall claims volume (approximately 0.3%) and are vital for people who have limited access to the tools and infrastructure of the digital channels. While there are seven channels operating today, each one represents a preferred method of engagement for patients, and removal of a channel should be weighed against the risks of worsening equity of access to Australia's health system.

3.2.7 Legislation considerations

Recommendation 5: Consider ongoing review of Medicare's enabling legislation and regulations to achieve the envisioned future state. Approaches employed by other regulators to ensure a consistent and contemporary approach should also be considered – including mechanisms such as statutory penalties to deter inappropriate behaviour and encourage earlier resolution of compliance cases, expansion of powers to ensure all types of serious non-compliance can be effectively dealt with and a reduction in regulation and legislation that hinders the effectiveness of compliance activities.

Recommendation 6: Remove the veto power of the AMA in the selection process of the Director of the PSR given the breadth of health professions whose registrants could be subject to a review by PSR. Additionally, the appointment of a second in charge or Associate Director could manage conflicts of interest and workloads.

To respond to findings noted in Chapter 2 of this report and the recommendations outlined in this section, legislative amendments are likely to be needed to enable achievement of the outcomes. I recommend that consideration be given to a whole of system review of relevant legislative instruments and environment, and how these interrelate to inform potential changes, such as:

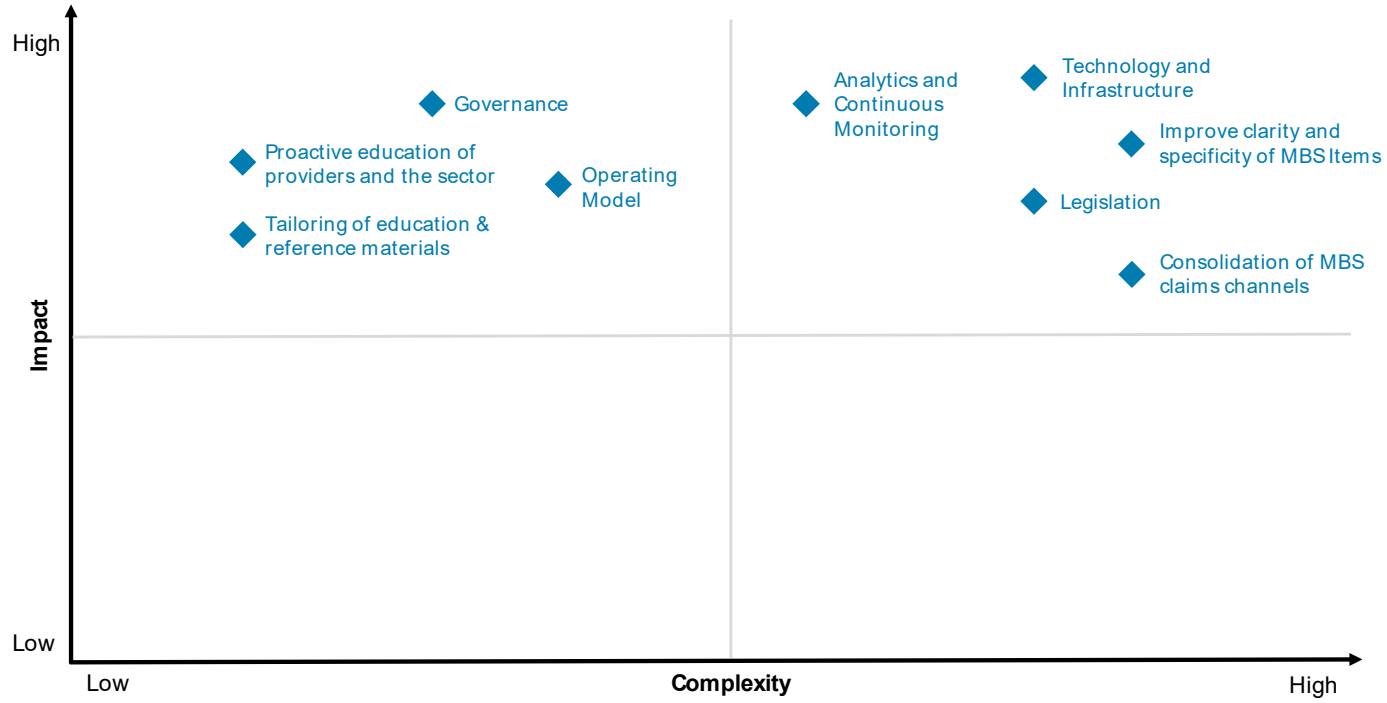
- Amendments to privacy legislation to enable appropriate data and information sharing between government agencies to maintain Scheme integrity. Amendments to the PSR supporting legislation to enable the appointment of authorised officers as appropriate to perform PSR functions with a removal of the veto power of the AMA in the selection process of the Director of the PSR.
- Review and where appropriate amend existing legislation to allow for the regular and ongoing exchange of information to prevent/detect/investigate/remediate and continuously enhance Scheme integrity and where appropriate introduce suitable criminal offences and/or administrative provisions for non-compliance and fraud. This may require changes to legislation such as data matching legislation, Privacy Act 1988, HIA, the PSR Act, and other legislation as determined by the department's legal advisors.
- Review of the thresholds outlined in various regulatory instruments that determine the trigger points for audits of individual health professional's practice and MBS item claiming practices. This is with a view to more timely, targeted and effective review of practice.

4 Implementation considerations

Acknowledging the effort DoHAC, Services Australia and peak bodies are directing to the continuous improvement activities as well as the day-to-day management of the Medicare system, the intention of the recommendations outlined in Section 3 of this report are to build upon this work and further strengthen the integrity of Medicare through optimised and broader compliance activities.

To assist the prioritisation and sequencing of the response to the recommendations, a high-level depiction of how the various activities and recommendations should be acted upon are shown in Figure 4.1. It provides an assessment of the relative impact and complexity to implement the various recommendations, followed by Figure 4.2 which translates this into a sequencing based on dependencies.

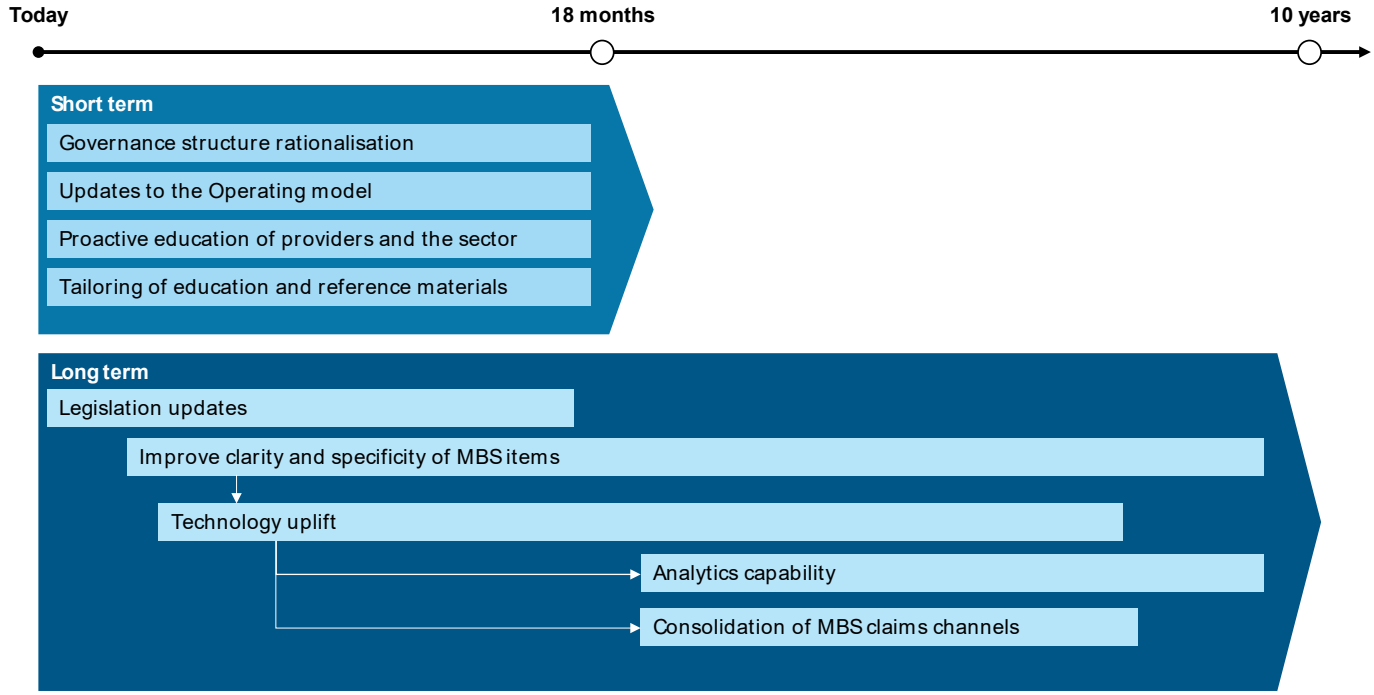
Figure 4.1: Prioritisation of recommendations



Source: Philip Review (2023)

Sequencing of the recommendations highlights dependencies that exist between establishing the governance and operating model to support Medicare that will enable the enaction of legislative changes and realisation of the full potential and benefits of the fit-for-purpose technology environment. Figure 4.2 outlines the dependencies and therefore sequencing of initiatives that will form part of the broad recommendation categories.

Figure 4.2: High-level view of the sequencing and dependencies



Source: Philip Review (2023)

This is a transformation journey that will require the input and collaboration of all stakeholders from across the healthcare sector. It is essential that we have a long-term plan and view to address the findings and enable the recommendations to set Medicare on the correct future path. Medicare is a complex system that supports the Australian population and transforming it to be fit for purpose into the future is not realistically achieved in the short term. As such, a 10-year journey is planned for with ongoing continuous improvement initiatives and activities to be completed.

Appendix A Previous estimations of non-compliance in Medicare

Table A.1: Estimates of the cost of health provider non-compliance

Source	Extract from source	Commentary on source used to derive input	Approach to estimating non-compliance in Medicare in Australia	Calculation to estimate non-compliance in Medicare in Australia	Value of non-compliance ($ million)
Estimates from the Australian National Audit Office (2021) Report					
Health Provider Compliance Division Strategy and Operating Model Summary Boston Consulting Group (2016)	"Global examples suggest that a compliance division such as the Health Provider Compliance Division should be able to recover 1-4% of total healthcare spend."	No source was referenced for the 1-4% figure. A broader desktop review could not locate this figure.	Top-down approach	1-4% * total Medicare expenditure in 2018–19*	366 – 1,464
Analytics in Health Provider Compliance at Department of Health McKinsey (2016)	"6% is considered a reasonable estimate of improper payment rate."	This report references a research study undertaken by Gee & Button (2016), which takes account of loss measurement data from 1997 to 2013 and reports on a total of 107 exercises. Fourteen different types of healthcare expenditure in 33 organisations from seven countries are included in their analysis. The source does not describe the methodology adopted in full.	Top-down approach	6% * total Medicare expenditure in 2018–19*	2,196
PBID Audit Review Boston Consulting Group (2018)	"Industry heuristics and research…show total non-compliance likely to be between 3% and 5% of total payments made."	The reference for the 3% and 5% was not located in the source.	Top-down approach	3-5% * total Medicare expenditure in 2018–19*	1,098 – 1,830

Source	Extract from source	Commentary on source used to derive input	Approach to estimating non-compliance in Medicare in Australia	Calculation to estimate non-compliance in Medicare in Australia	Value of non-compliance ($ million)
Medicare compliance: what providers need to know Department of Health (2019)	"It is estimated that two to five percent of claiming may be non-compliant."	This source was not accessible/available for review.	Top-down approach	2-5% * total Medicare expenditure in 2018–19*	732 – 1,830
Estimate from Dr. Margaret Faux's Thesis					
Value of Common Medicare Fraud and Errors Dr Faux (2023)	"Grand total of $10.0 billion"	A build-up of a series of assumption drawn from various sources, her experience and her own analysis of her company's data was used in the updated estimate of Medicare fraud and error.	Mixed methods	Various	10,000

Source: As indicated in the table *Calculations are based on $36.6 billion expenditure in 2018–19 on the three health funding schemes (MBS, PBS and CDBS) and an incentive program (PIP)

Appendix B List of consultations

Table B.1: Consultations throughout this review

Organisation/Division/Group
Australian Medical Association
Dr Margaret Faux
Professional Services Review
Royal Australian College of General Practitioners
Services Australia
Private Healthcare Australia
Medical Indemnity Sector • Avant • BH Specialty • MDA National • MIGA • MIPS

Department of Health and Aged Care
• Benefits Integrity Division senior executives
  • Audit Section
  • Health Provider Fraud Section
  • Professional Review Section
  • Provider Early Intervention Section
  • Policy and Legislation Section
  • Public Hospital Compliance Section
  • Risk Analytics Section
  • Risk Identification Section
  • Risk Treatment Section
• Medicare Benefits and Digital Health Division executive
• Chief Nursing and Midwifery Officer
• Brendan Murphy (Secretary)
• Penny Shakespeare (Deputy Secretary, Health Resourcing)

National Aboriginal Community Controlled Health Organisation
Australian Pathology
Australian Diagnostic Imaging Association
Consumers Health Forum of Australia
Individual and independent consumer
Royal Australasian College of Surgeons
Australian Digital Health Agency
Royal Australasian College of Physicians
Pharmacy Guild of Australia

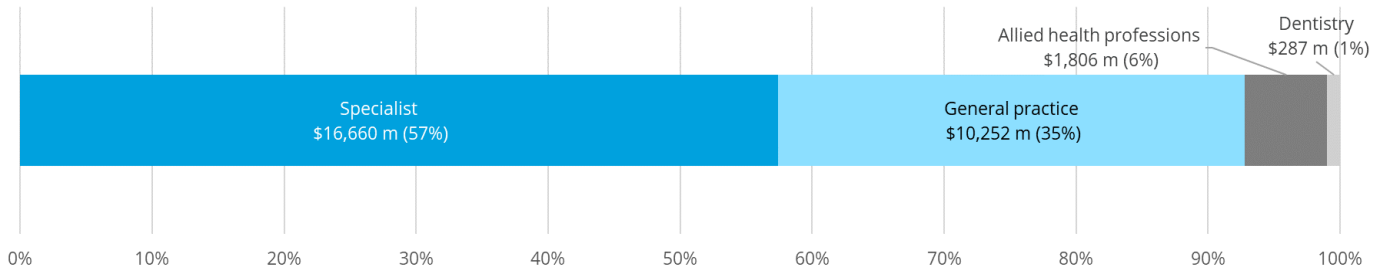
Source: Philip Review (2023)

Appendix C Medicare claiming and payment pathways

C.1. Overview of MBS including who can claim

Medicare is Australia's universal health insurance scheme that ensures Australians (and some international visitors) have access to appropriate healthcare at low or no cost. The MBS is the listing of the Medicare services that are subsidised by the Australian Government through the Scheme and includes around 6,000 items. In 2021–22, there were 511.5 million Medicare instances of service, for a total of $29.1 billion in benefits paid (see Figure C.1) across 14 claiming channels (see Section C.2).

Figure C.1: MBS benefits paid by profession, 2020–21*



Source: Philip Review (2023) using DoHAC Medicare data

* These figures include Dental Practitioners claiming CDBS. Both MBS and CDBS are paid through the same systems and channels. Also, Specialist expenditure includes diagnostic imaging and pathology reimbursements

There has recently been increasing media attention on Medicare[18],[19], including calls from industry and peak bodies for reform to improve the viability and usability of the Scheme. This has been primarily focused around: (1) discussions about the appropriateness of the MBS and how it does, or does not, reflect current models of care, and (2) reports of significant inefficiencies in the system driven through fraud, error and waste.

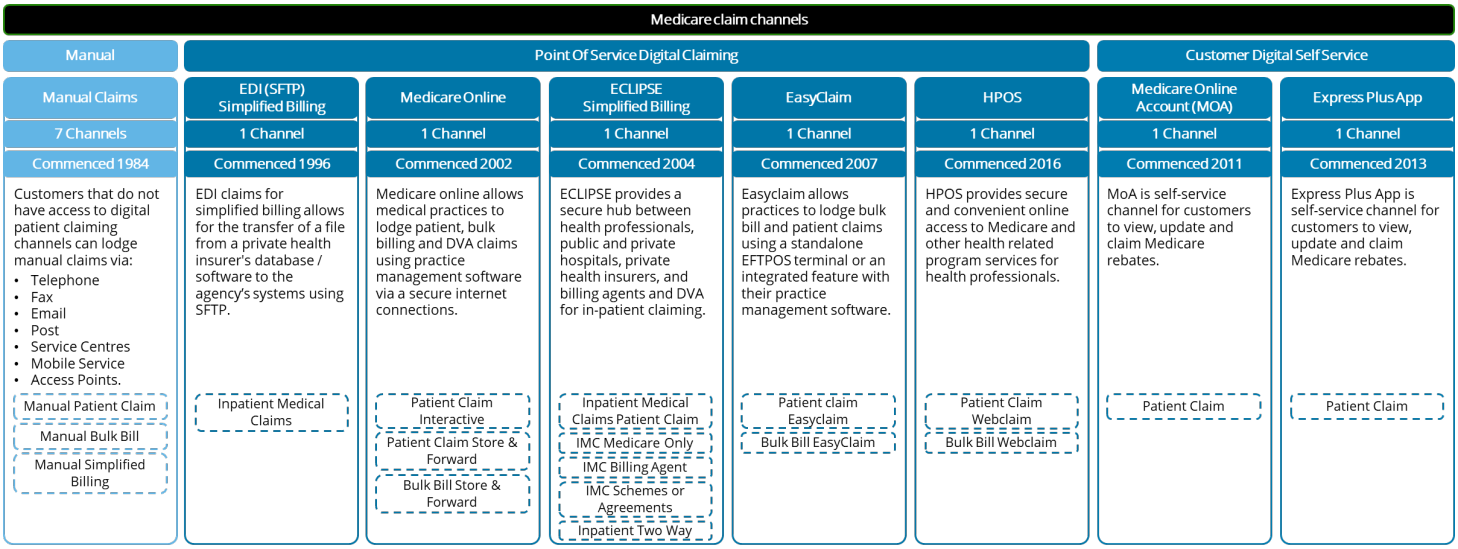
C.2. Claiming channels

The number and model of claiming channels has evolved since inception of Medicare in 1984 and there are now 14 that seek to accommodate a broader range of health professionals providing MBS reimbursed services and supports. These include seven manual claiming channels, five point of service digital claiming channels, and two customer digital self-service channels (Figure C.2). The transition to 99.7% of MBS claims and billings flowing through digitised claiming channels has enabled more efficient and timely payment of MBS claims.

[18] ABC News, Adele Ferguson, *Expert estimates $8 billion a year lost to Medicare fraud and waste*, 17 Oct 2022

[19] The Sydney Morning Herald, Adele Ferguson and Chris Gillett, *Mediare watchdog investigates just 0.07% of medicos each year*, 24 Oct 2022

Figure C.2: Overview of Medicare claiming channels



Source: Philip Review (2023) with information sourced from Services Australia (2023)

A wide range of health professionals can submit MBS claims via these various claiming channels (see Table C.1). Embedded in this list are the diagnostic providers (both radiology and pathology) and both public and private hospital facilities who also play an important role as providers and care settings within the system.

Table C.1: Health professionals who can claim MBS benefits

Category	Professions	
Medical Practitioners	• Medical Registrars • Medical Trainees • General Practitioners	• Medical Specialist • Consultant Physician • Other Medical Practitioners
Nurse Practitioners and Midwives	• Nurse Practitioner	• Midwife
Allied Health professionals	• Aboriginal Health Workers • Audiologists • Chiropractors • Diabetes Educators • Dieticians • Exercise Physiologists • Mental Health Nurses • Occupational Therapists	• Orthoptists • Osteopaths • Physiotherapists • Podiatrists • Psychologists • Social Workers • Speech Pathologists
Dental Practitioner*	• Dental Practitioner • Dental Specialist • Dental Prosthetists (short-term, interim or provisional period only)	• Dental Hygienist, dental therapist or oral health therapist
Optometrist	• Optometrist	

Source: Philip Review (2023)* Only certain Dental Practitioners can claim Medicare benefits and many of these professions claim under the CDBS

The claiming channels and actors operating within them to deliver the payment process are outlined below which demonstrates the important roles each stakeholder plays to combine to the fulsome end-to-end claiming process, including:

- **Patients/consumers:** Attend the service and provide their Medicare identification, and in some channels, confirm service provision by way of secondary verification for eligibility for MBS reimbursement.
- **Individual health professional provider:** Deliver services and supports to patients in line with appropriate clinical care and needs. Selection of MBS items to the interaction and attribution of this to the occasion of service. Practitioners should, but are not always able to easily, review the MBS claims attributed to their provider number.

- **Patient management software technologies:** Some practices and health professionals utilise technology solutions to provide decision supports to determine the most appropriate MBS item numbers, and these systems integrate with the clinical desktop software solutions.
- **Practice Manager:** Access online webforms to translate the allocated MBS item via integration point with the practice management software. The practice should have in place a process by which submitted MBS claims/bills and their application to patients and providers is accurate.
- **Services Australia:** Responsible for the system and processing, inclusive of the up-front claim verification. Following submission of the claim from the practice, initial claim verification activities are completed, including confirming patient Medicare eligibility, provider eligibility and verification, based on the rules engine as part of the supporting technology infrastructure. Following completion of the claim verification activities, Services Australia assesses, processes and pays claims to the provider or patient according to the claiming channel employed.
- **DoHAC:** It is DoHAC's responsibility for the general business rules, including their role to establish the business rules and claiming restrictions applying to items that underpin the up-front claim verification performed by Services Australia, together with post-payment compliance activities. It is important to note, that together, whilst DoHAC and Services Australia share a role in compliance, they have their own responsibilities for different elements and aspects of claiming.

Appendix D Professional Services Review overview

D.1. Process of the PSR

The legislated review process followed by PSR comprises up to three stages:

- Stage 1: PSR Director reviews the information
- Stage 2: PSR Committee decides if inappropriate practice occurred
- Stage 3: Determining Authority makes the decision

Stage 1: PSR Director reviews the information

The PSR process commences with the request by a delegate of the Chief Executive Medicare that asks the PSR Director to review a practitioner's provision of services during a specific period (through the PRP). Upon receiving a request, the Director considers materials provided by the delegate, and continues to obtain and evaluate a sample of billing statistics of the practitioner if inappropriate practice appears to occur. The Director may then meet with the practitioner to discuss the matters. In cases where the Director could reasonably conclude the occurrence of inappropriate practice, they prepare a report to explain the identified compliance concerns and the rationale behind and invite the practitioner to submit a response to assist the informed decision making. It is noted that approximately 90% of practitioners have representation at this stage, however this data was not made accessible for this Review.

The Director has seven days to alert a practitioner that a review is to take place and that includes information about the concerns. The recently completed section 92 independent review[20] noted that this was usually through the practitioner's legal or other representative (usually provided by the Medical Indemnity insurer) and the Director of the PSR reports that they 'strongly advise' practitioners to be represented at this stage.

Upon examining the relevant materials provided, the Director decides on the outcome:

- Dismissing the matter if there are insufficient grounds to reasonably conclude that the practitioner engaged in inappropriate practice
- Negotiating a section 92 agreement with the practitioner in cases where the practitioner acknowledges their inappropriate practice (the agreement needs to be ratified by the Determining Authority before it takes effect); or
- Referring to a PSR committee if a section 92 agreement is not achievable.

The Director is also required to refer the practitioner under review to appropriate bodies (e.g. medical boards, AHPRA, etc.) if concerns over patient safety and/or concerns relating to non-compliance with professional standards arise. Additionally, the Director is required to refer cases with evidence of criminal behaviours, including suspected fraud, to the Commonwealth Director of Public Prosecution for further investigation.

Notably, as imposed by relevant legislation, the Director's stage of a review has a maximum statutory timeframe of 12 months.[21]

Stage 2: PSR committee decides if inappropriate practice occurred

A PSR committee is an independent decision-making body established by the Director, consisting of at least 3 members drawn from the PSR Panel:

- A Deputy Director who serves as the chair of the committee
- At least two members of the practitioner's profession
- Additional one to two members to provide a wider range of clinical expertise as needed.

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[20] Robin Creyke and Dilip Dhupelia, *Report on review of section 92 of the Health Insurance Act 1973 (Cth)*, August 2022

[21] Professional Services Review (2022) Professional Services Review Annual report 2021–22, <https://www.psr.gov.au/publications-and-resources/publications/annual-reports/annual-report-2021-22>, accessed 2 March 2023.

The Director would provide the practitioner with documents that detail the membership of the committee, the MBS, PBS and/or CDBS items of concern being referred to the committee, and a report explaining the reasons for the identified inappropriate practice. Practitioners under review are allowed to challenge the appointment of committee members on the grounds of bias.

The investigation begins with the committee asking the practitioner to provide billing statistics regarding the items to be examined. The committee will then hold a hearing if review of the current evidence reveals the possibility of inappropriate practice. The hearing is designed to obtain information from the practitioner regarding their practice and the specific services they have provided.

After the hearing, upon considering the relevant materials provided, the committee prepares a draft report that outlines the preliminary findings about inappropriate practice, if there is any, along with the reason for those findings, and invites the practitioner to submit a response to address those findings and suggest changes to the report.

Finally, the committee prepares a final report for the practitioner, the Director, and the Chief Executive Medicare with an outcome such as:

- Insufficient grounds to conclude inappropriate practice and thus no further action needs to be taken; or
- Inappropriate practice is identified and thus the final report will be referred to the Determining Authority to decide sanctions following the findings.

It is expected that 80% of PSR committees can finalise their investigations within 18 months of commencing investigation.[22] This timeframe was extended to 24 months in light of COVID-19.[23]

Stage 3: Determining Authority makes the decision

The Determining Authority has two main functions in the PSR process. Firstly, it is responsible for ratifying the agreements entered into between the Director and practitioners under review. Upon considering relevant materials provided by the Director, the Determining Authority ratifies the agreement if it is considered as fair and reasonable. In cases where the agreement is not ratified, the Determining Authority provides reasons for refusal, whereby the Director and the practitioner negotiate a new agreement for ratification.

Secondly, the Determining Authority decides sanctions to impose following a committee's findings of inappropriate practice. The Determining Authority cannot revisit a committee's findings. Its focus is limited to making a determination that includes at least one of the sanctions set out in section 106U of the HIA:

- A reprimand
- Counselling
- Disqualification from billing certain MBS and CDBS items, providing Medicare services to a class of persons, or providing some or all Medicare items from a certain location for up to 3 years
- Full disqualification from billing all MBS items for up to 3 years
- Repayment of some or all of the Medicare benefits for MBS or CDBS billed and found to have been provided inappropriately during the review period
- Full disqualification from the PBS for up to 3 years.

Upon considering a committee's final report and extra information provided by the Director, the Determining Authority invites the practitioner to make a submission about the sanctions it should impose. The practitioner will then be provided with a draft determination and an invitation to make a further submission focusing on the details of the decision and the reasons for any suggested changes to make.

The final determination will take effect 35 days after a copy is received by the practitioner, unless court proceedings are instituted by the practitioner.

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[22] Professional Services Review (2019) Professional Services Review Annual report 2018–19, < https://www.psr.gov.au/publications-and-resources/publications/annual-reports/annual-report-2018-19>, accessed 2 March 2023.

[23] Professional Services Review (2022) Professional Services Review Annual report 2021–22, <https://www.psr.gov.au/publications-and-resources/publications/annual-reports/annual-report-2021-22>, accessed 2 March 2023.

D.2. PSR activity data

Table D.1 provides an overview of the high-level PSR data.

Table D.1: PSR case statistics

	Action	2021–2022	2020–2021	2019–2020	2018–2019	2017–2018
PSR Director	Requests received from the Chief Executive Medicare	108	73	126	101	109
	Requests by Chief Executive Medicare to review a practitioner with a previous effective determination or negotiated agreement for a second or subsequent time	9	4	4	3	10
	No further action (under sections 88A, 91 or 106KE of the HIA)	6	6	5	2	1
	Requests withdrawn or lapsed	0	0	0	0	0
PSR Committees	Referrals from the PSR Director to new PSR committees (under section 93 of the HIA)	15	12	16[a]	19	19
	Committees in progress (at 30 June)	32	39	34	31	23
	Committee reports finalised	19	10	11	12	12
	Reports finding inappropriate practice	18	10	11	12	12
	Reports finding no inappropriate practice	1	0	0	0	0
	Committee matters indefinitely suspended	0	0	0	0	3
	Practitioners referred to AHPRA/Boards (under sections 106XA or 106XB of the HIA)	22	22	20	15[b]	14
	Referrals to Chief Executive Medicare/regulatory authority for suspected fraud	3	1	3	2	1
Determining Authority	Negotiated agreements (under section 92 of HIA) ratified and effective	57	90	78	90	49
	Final determinations made	13	10	15	9	14
	Final determinations effective	13	9	12	8	17
	Cases on hand at 30 June	**154**	**123**	**155**	**125**	**125**

Source: Philip Review (2023) using Professional Services Review Annual Report 2018–2019; 2019–2020; 2020–2021; 2021–2022. [a] Excluding a matter remitted back to the Director by the Federal Court. [b] 15 referrals were in respect of 11 practitioners. [c] As PSR receives referrals from Chief Executive Medicare throughout the year, case data cannot be reconciled within a 12-month period

Table D.2 Illustrates the breakdown of PSR outcomes since the 2017–18 financial year. The majority of PSR outcomes have been section 92 agreements. From 2017–18 to 2021–22, 465 cases were finalised following the PSR process, where 364 cases were finalised with section 92 agreements after review, 81 cases were referred to a PSR committee under section 93, and 20 cases were section 91 outcomes (i.e. no further action needed after review).

Table D.2: Breakdown of PSR outcomes since the 2017–18 financial year

Year	Referrals to PSR from DoHAC	Cases dismissed by the PSR Director (s91)	Negotiated agreements ratified and effective (s92)	Referrals to new PSR committees (s93)	Referrals to medical boards/AHPRA by committees	Referrals by committees to Chief Executive Medicare/regulatory authority for suspected fraud
2017–18	109	1	49	19	14	1
2018–19	101	2	90	19	15	2
2019–20	127	5	78	16	20	3
2020–21	73	6	90	12	22	1
2021–22	108	6	57	15	22	3
Total	518	20	364	81	93	10

Source: Philip Review (2023)