

Medicare Compliance Audits

Department of Human Services

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Canberra ACT
23 April 2014

Dear Mr President
Dear Madam Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Human Services titled *Medicare Compliance Audits*. The audit was conducted in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit to the Parliament.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's website—<http://www.anao.gov.au>.

Yours sincerely



Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

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For further information contact:

**The Publications Manager
Australian National Audit Office
GPO Box 707
Canberra ACT 2601**

Phone: (02) 6203 7505

Fax: (02) 6203 7519

Email: publications@anao.gov.au

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Audit Team

Emilia Schiavo
Christine Preston
Donna Burton

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Abbreviations

ANAO	Australian National Audit Office
CDDD	Core Design Discussion Document
CDDS	Chronic Disease Dental Scheme
CRAR	Compliance Risk Assessment Report
CWG	Compliance Working Group
CWMS	Compliance Workload Management System
DoH	Department of Health
GCT	General Compliance Team
Human Services	The Department of Human Services
IMCA initiative	Increased Medicare Compliance Audits initiative
KPI	Key Performance Indicator
MBS	Medicare Benefits Schedule
Operations Report	Compliance Operations Findings Report
QA	Quality Assurance
RTO	Risk Topic Overview
RTR	Risk Topic Register
SFNC	Strategic Fraud and Non-Compliance
URU	User Reference Utility

Glossary

Compliance Program	The Compliance Program outlines Human Services' compliance priorities, approach and model for managing the diverse mix of programs it delivers on behalf of the Australian Government.
Health professional	Any medical or health practitioner who provides a professional service for which a Medicare benefit amount is paid. Professional services for which Medicare benefits may be paid include services provided by doctors, specialists, optometrists and in specific circumstances dentists and other allied health practitioners.
IMCA initiative	The Increased Medicare Compliance Audits initiative was announced in the 2008–09 Federal Budget and was introduced to further protect the integrity of Medicare by: conducting an additional 2000 audits each year on health professionals to ensure appropriate claiming of MBS items; and increasing Human Services' audit powers, including in certain circumstances to issue a 'notice to produce', which enables the department to compel health professionals to produce documents to substantiate services provided under Medicare.
Medical Adviser	An employee of Human Services who is a medical practitioner.
Medicare	<p>Medicare is Australia's universal healthcare system, designed to provide Australians and other eligible persons with access to free or subsidised health and hospital care, with options to also choose private health services.</p> <p>Health professionals must meet legislative requirements, including registration with the Australian Health Practitioner Regulation Agency and the Department of Human Services, before they can provide Medicare rebatable services to the public.</p>

'notice to
produce'
documents

A formal notice that can be issued to health professionals under subsection 129AAD of the *Health Insurance Act 1973* requiring a health professional to produce documents that substantiate services provided under Medicare where there is a reasonable concern that a benefit has been paid that exceeds the amount that should have been paid.

80/20 rule

A deeming provision known as the 80/20 rule was introduced in the *Health Insurance (Professional Services Review) Regulations 1999* to address the consistent high volumes of services rendered by health professionals. The regulations specify that a general practitioner or other medical practitioner is deemed to have practised inappropriately if he or she has rendered 80 or more professional attendances on each of 20 or more days in a 12 month period.

Summary and Recommendations

Summary

Introduction

1. Medicare is Australia's universal healthcare system designed to provide Australians and other eligible persons¹ with access to free or subsidised health and hospital care.
2. Medicare is the fourth largest expenditure item in the Federal Budget. In 2012–13 payments totalled \$18.6 billion, accounting for approximately five per cent of total government expenses. Expenditure under Medicare is expected to continue to grow, with payments estimated to reach \$23.7 billion by 2016–17. Future Medicare spending is expected to be influenced by higher demand for increasingly expensive health services, driven by growth in Australia's total population, an ageing population profile and new health technologies.
3. The Department of Human Services (Human Services) is responsible for administering Medicare, in accordance with policies developed by the Department of Health (DoH).² The department's policy role includes defining the type of health services, and their corresponding payments, that can be claimed by health professionals under Medicare. The eligible health services claimable are listed on the Medicare Benefits Schedule (MBS), which includes over 6000 items.³

Medicare Compliance

4. In 2012–13, 344 million Medicare services were provided for the \$18.6 billion in payments processed by Human Services. The integrity of these payments relies in large part on health professionals correctly determining and

1 Persons eligible for Medicare benefits include people who reside in Australia and either: hold Australian citizenship; hold a permanent visa; hold New Zealand citizenship; or have applied for a permanent visa. Additionally, the Australian Government has signed Reciprocal Health Care Agreements with some countries and, subject to the agreements, residents of these countries are entitled to restricted access to health cover while visiting Australia, available from the Department of Human Services website, <<http://www.medicareaustralia.gov.au/provider/medicare/>> [accessed 4 September 2013].

2 The former Department of Health and Ageing was renamed the Department of Health (DoH) under the Administrative Arrangements Order, 18 September 2013. Throughout the report the department will be referred to as DoH.

3 For the Medicare Benefits Schedule see <<http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>> [accessed 4 September 2013].

claiming (billing) against the MBS item/s that correspond with the services provided.⁴ Given the large volume of transactions involved, Human Services, as part of its broader Compliance Program⁵, adopts a number of strategies to treat risks to Medicare and maintain the integrity of Medicare payments, including a risk based approach to checking health professionals' compliance with Medicare requirements. Specifically, Human Services' compliance activities range from preventive/education activities—including distributing 'targeted feedback letters' to defined groups of health professionals⁶—to review activities such as investigations into suspected fraud or criminal behavior and practitioner reviews (conducted under the Practitioner Review Program)⁷, as well as a rolling program of compliance 'audits'.⁸

5. Compliance audits are used to verify the details of services provided by health professionals, where Human Services has identified a risk that Medicare payments and benefits may have been claimed incorrectly.⁹ Generally, Medicare compliance audits are identified and completed as part of an individual compliance 'project'¹⁰, which targets those health professionals whose claiming and billing patterns or practices are considered high risk for a particular service/s. Unlike 'targeted feedback letters', compliance audits involve a series of defined steps conducted by a dedicated compliance officer¹¹ and an audit can often involve the assessment of multiple claims made by one

4 Medicare Australia, Submission for the Senate Community Affairs Committee: *Inquiry into Compliance Audits on Medicare Benefits* [Internet], June 2009, available from <http://www.aph.gov.au/~media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/medicare_benefits_compliance_audits/submissions/sub16_pdf.ashx> p. 3 [accessed 27 August 2013].

5 Department of Human Services, *Compliance Program 2013–15*, August 2013, available from <<http://www.humanservices.gov.au/corporate/publications-and-resources/compliance-program>> [accessed 27 August 2013].

6 Targeted feedback letters are developed using a template enabling Human Services to distribute these letters across a large population of health professionals where a risk appears to be widespread. The letters provide the opportunity for health professionals to voluntarily acknowledge incorrect claiming.

7 Human Services administers the Practitioner Review Program to examine practitioners whose provision of services under the MBS (and/or Pharmaceutical Benefits Scheme) suggests they may be engaged in 'inappropriate practice', such as providing services that are not clinically necessary.

8 While the department refers to this compliance activity as an audit, these audits do not represent conventional external or internal audit activity undertaken against auditing standards.

9 Department of Human Services, *Compliance Program 2013–15*, op. cit.

10 A project will typically involve a number of compliance audits and can take up to 12 months to complete from the time a project is approved through to the completion of the project's audits and any related internal reporting.

11 Refer Chapter 1, Figure 1.1 for an outline of the compliance audit process.

health professional.¹² The main stages in the department's compliance audit process are:

- identifying a compliance risk, by monitoring MBS claim trends, following-up tip-offs and assessing input from stakeholders (such as DoH and peak health bodies);
 - collecting evidence to verify whether services claimed have met the MBS requirements; and
 - determining compliance. For audits where non-compliance is identified, the total debt for incorrect claiming is calculated and pursued for recovery.
6. In administering the Medicare compliance program, Human Services regularly engages with DoH and stakeholders such as the Australian Medical Association and Royal Australian College of General Practitioners to consult and exchange views on program issues, compliance risks and associated mitigation strategies.

Increased Medicare compliance audits and expanded audit powers

7. The 2008–09 Federal Budget's Increased Medicare Compliance Audits initiative (IMCA initiative)¹³ enhanced Human Services' capacity to deliver Medicare compliance audits by: providing funding to increase the number of completed audits targeting health professionals each year from 500 to 2500 (an increase of 8000 over four years); and expanding the department's audit powers under the *Health Insurance Act 1973*¹⁴, effective from April 2011.¹⁵ The legislative changes enabled Human Services to:

- issue a written notice ('notice to produce') requiring a health professional to produce documents, if there is a reasonable concern that a Medicare benefit has been overpaid;

12 For example, for a sample of the ten Cryotherapy 2011–12 audits reviewed by the ANAO, health professionals were audited for between 26 and 108 separate claims with an average of 44 services for each.

13 Australian Government, *Budget Measures, Budget Paper No. 2 2008–09*, 'Responsible Economic Management—Medicare Benefits Schedule—increase compliance audits', p. 404.

14 Changes to the legislation were considered in the Senate Community Affairs Legislation Committee's *Inquiry into Compliance Audits on Medicare Benefits* [Internet], June 2009, available from <http://www.aph.gov.au/~media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/medicare_benefits_compliance_audits/submissions/sub16_pdf.ashx> [accessed 27 August 2013].

15 The *Health Insurance Amendment (Compliance) Act 2011* gave effect to the new audit powers accessible to the department and became law on 9 April 2011.

- impose administrative penalties where a health professional is unable to substantiate a Medicare claim¹⁶; and
- introduce a formal process for health professionals to voluntarily acknowledge incorrectly claimed benefits.

8. In the context of Human Services' enhanced audit powers and increased compliance audit program, the IMCA initiative was expected to deliver the following financial outcome:

This measure will provide savings of \$147.2 million over four years and will cost \$76.9 million to administer, leading to net savings of \$70.3 million over four years.¹⁷

9. The initiative was delivered in an environment of ongoing change within the Human Services portfolio related to service delivery reforms from 1 July 2011.¹⁸ To support implementation of the IMCA initiative, Human Services developed procedures to guide the use of its new legislative powers, and prior to a full transition to the new procedures, the department trialled the initiative during 2012.¹⁹

Audit objective, criteria and scope

10. The objective of the audit was to assess the effectiveness of the Department of Human Services' management of Medicare compliance audits.

11. To form an opinion against the audit objective, the ANAO examined the design and operation of departmental processes against the following high-level criteria:

- Human Services effectively identifies, selects and prioritises potential cases of non-compliance for compliance audits.

16 See Appendix 2 for a summary of the penalty system.

17 Australian Government, 'Responsible Economic Management—Medicare Benefits Schedule—increase compliance audits', op. cit.

18 While Medicare Australia was initially responsible for administering the budget measure, on 1 July 2011, Centrelink and Medicare Australia were integrated into the Department of Human Services. Human Services advised that service delivery reforms resulted in the department undertaking a review of governance, risk management and control arrangements to address, among other things, the different corporate cultures of the previously separate agencies. In parallel, major organisational restructuring, in-sourcing and integration of the department's ICT platforms were also being managed.

19 Human Services used the Cryotherapy 2011–12 project to trial changes introduced by the IMCA initiative, noting that the scope of the trial did not include the 'notice to produce' component.

- Compliance audits are conducted in accordance with legislative and operational requirements.
- Non-compliance actions are managed and the information is used to inform future compliance activities.

12. The ANAO interviewed Human Services staff involved in the conduct of Medicare compliance audits and key stakeholders, and reviewed key guidance materials and documents, including departmental reports that capture Medicare compliance performance information. The ANAO also reviewed a sample of Medicare compliance audits.

Overall conclusion

13. Medicare is a long-standing publicly funded program which aims to make affordable health care accessible for Australians and other eligible persons. The integrity and sustainability of the Medicare program, which features a high volume of transactions, is supported by Human Services' ongoing monitoring of claims by health professionals against the Medicare Benefits Schedule (MBS) and a program of compliance activities, including audits of billing by health professionals. The 2008–09 Budget measure—Increased Medicare Compliance Audits initiative (IMCA initiative)—provided Human Services with enhanced legislative powers and substantial additional funding to support an expanded program of Medicare compliance audits.²⁰

14. Overall, the effectiveness of Human Services' management of Medicare compliance audits has been mixed. Human Services has delivered a program of compliance audits and related compliance activities, which has helped reinforce health professionals' awareness of their compliance obligations. However, the department's administration of Medicare compliance audits and its implementation of the Budget measure, the IMCA initiative, demonstrated a range of shortcomings that detracted from the department's performance in delivering these elements of its broader Compliance Program.

15. Human Services largely determines its program of Medicare compliance audits in response to compliance risks identified through a mix of environmental scans (such as monitoring MBS claiming patterns), tip-offs and stakeholder input. The ANAO's review of a targeted sample of Medicare

20 See paragraphs 7 and 8.

compliance audits indicated that for the most part, key compliance audit processes were followed, and audit outcomes, such as the number of health professionals assessed as non-compliant and the total amount of debts raised, are appropriately documented. The department has also captured operational lessons learned and identified recommendations for action that have the potential to contribute to the conduct and improvement of future compliance activities.

16. However, there remain a number of areas where Human Services can improve its administration of Medicare compliance audits, to the benefit of the broader Compliance Program. While the department has processes in place to identify risks to the Medicare program²¹, historically it has not routinely undertaken preliminary analysis of emerging risks in a timely way. Consequently, a large number of identified risks have not been substantively analysed to determine whether their treatment should be given priority and factored into Human Services' compliance planning. The department has very recently taken some steps to consider such a process. The ANAO's review of a sample of Medicare compliance audits also identified inconsistent approaches within Human Services to calculating debts²², with variability in the standards of proof accepted by different compliance officers in calculating debts. There would be merit in Human Services finalising and implementing a debt calculation policy, to address inconsistencies and strengthen the department's overall management of non-compliance.

17. Since 2008–09, the department has administered an expanded program of Medicare compliance audits funded through the IMCA initiative. The initiative, which was a measure funded by the Budget, provided \$76.9 million to Human Services to conduct an additional 8000 Medicare compliance audits over four years and return an estimated \$147.2 million in savings, thus anticipating net savings of \$70.3 million. However, between 2008–09 and 2012–13, Human Services only raised a total of \$49.2 million in debts and recovered \$18.9 million from Medicare compliance audits.²³ The available

21 Including through tip-offs, stakeholder consultations and monitoring MBS claiming patterns.

22 Debts can be owed to the department following the department identifying non-compliant billing (or claiming) by the audited health professional.

23 The debt raised and recovered figures were provided by Human Services to the ANAO on 28 January 2014.

Footnote continued on the next page...

Human Services' data shows that there was a \$128.3 million shortfall in the savings achieved by the department, in the form of monies actually recovered²⁴, against the target set by the budget initiative—some 87 per cent less than the \$147.2 million in expected savings.²⁵ From the performance information available, the ANAO's analysis indicates that since the introduction of the budget measure, the compliance audits performed by the department, including those performed under the department's enhanced legislative powers, were delivered at a net cost to government.

18. The responsible Minister (the then Minister for Human Services) and the policy Minister (the then Minister for Health and Ageing) had been asked by the Expenditure Review Committee (ERC) of Cabinet in 2008 to report back to government on achievements against the IMCA Budget measure in 2011–12. In this context, Human Services did not develop or implement its proposal to monitor and report on savings to support this reporting requirement²⁶; an opportunity missed, given ministerial expectations of a significant return on the government's investment.

19. As mentioned above, the IMCA initiative funded Human Services to deliver a substantially increased audit program. The department only met its key performance indicator—2500 completed Medicare audit and review cases per year²⁷—once in 2011–12, when it reported completing 2549 Medicare audits and reviews.²⁸ While the annual target had been agreed by Ministers in the

The department's financial and case management systems do not provide for the production of disaggregated data that can be used to demonstrate the amount of debts raised and recovered as a result of compliance audits conducted on health professionals since commencement of the initiative in January 2009. The department advised that the data provided may include compliance activities other than Medicare compliance audits as well as activities that were not performed as a result of the IMCA initiative.

- 24 The department advised that compliance work related to the Chronic Disease Dental Scheme (CDDS) has been a factor that has contributed to the shortfall in the monies recovered. The scope of the ANAO's audit did not include the CDDS, which was closed in 2012.
- 25 In the past, the ANAO has highlighted issues regarding the cost-effectiveness of services delivered by Human Services when compared to the budgeted cost and reporting savings attributable to compliance action within the portfolio. See ANAO Audit Report No.47 2011–12 *Small Business Superannuation Clearing House*, paragraph 21, p. 18; and ANAO Audit Report No.19 2009–10 *Child Support Reforms: Stage One of the Child Support Scheme Reforms and Improving Compliance*, Recommendation No.6, p. 27.
- 26 Human Services' public reports on savings are limited to the number and value of debts raised across all Medicare compliance activities.
- 27 The department's revised target comprised the existing annual output of 500 Medicare audits and reviews plus an additional 2000 annual Medicare audits on health professionals; a total of 10 000 Medicare compliance audits over the four years of the IMCA initiative.
- 28 The department reported delivering 2365 Medicare audits and reviews in 2009–10, 2179 in 2010–11 and 2073 in 2012–13.

2008–09 Budget context, during 2012–13 Human Services altered the mix of compliance activities it counted towards the target, by including 500 less onerous ‘targeted feedback letters’, as well as compliance activities directed towards members of the public rather than health professionals. The department subsequently reported completing a total of 2819 Medicare compliance cases in 2012–13, against the revised activity mix. If the additional compliance activities were excluded, the number of Medicare compliance audits and reviews completed in 2012–13 (against the Ministerially agreed target) was 2073. While acknowledging the department’s advice that targeted feedback letters were a valid compliance treatment intended to encourage voluntary compliance, their inclusion resulted in inaccurate performance reporting for the budget measure, as well as inaccurate and inflated internal reporting of its compliance coverage rate. There would have been merit in Human Services informing their Minister of the proposal to change the compliance activities to be conducted and reported against publicly.

20. The audit highlights the need for agencies to meet government expectations and effectively monitor and report on the delivery of intended outcomes, including the realisation of expected savings. The department’s failure to implement its proposed monitoring and reporting arrangements for the IMCA initiative restricted its capacity to demonstrate whether it had delivered the expected return on the Government’s significant investment in an expanded program of Medicare compliance audits. The ANAO has made two recommendations to strengthen Human Services’ management of its Compliance Program for Medicare. The recommendations focus on strengthening the department’s assessment of Medicare compliance risks and its capacity to effectively target resources by better capturing and reporting on the benefits realised from Medicare compliance audits, in the context of the broader Compliance Program.

Key findings by chapter

Identifying the need for Medicare compliance audits (Chapter 2)

21. The careful selection of compliance activities can contribute to the effective treatment and mitigation of risks and forms part of a structured approach to risk management. Human Services’ approach to identifying compliance risks to Medicare relies on a mix of environmental scans (such as monitoring MBS claiming patterns), tip-offs and stakeholder input. The department delivers a program of targeted Medicare compliance audits as part

of its response to program risks and within the resourcing levels directed to its overall Compliance Program.

22. Until recently, the department did not have a routine process to perform a preliminary analysis of risks as they were identified, limiting the department's ability to determine whether these risks required further compliance activity. This approach has meant that a large number of identified risks have not been substantively analysed and as a consequence have not actively informed the development of Human Services' planned compliance activities.

23. In the course of this audit, Human Services introduced a number of enhancements to its risk prioritisation process, including a risk working group which is intended to strengthen governance arrangements and establish a more explicit framework for selecting and prioritising risks to be addressed through compliance activity. While the risk working group and other initiatives are still in their infancy, they have potential to assist the department to establish a more effective framework for managing Medicare risks by analysing emerging and known risks (that are yet to be assessed), in a more timely manner, and targeting significant compliance risks as a priority.

24. The alignment of risks with appropriate and proportionate treatments can contribute to the cost-effective management of non-compliance. While Human Services has a suite of compliance activities available to treat risks, unwritten 'common knowledge' has to date largely guided staff in selecting treatment options for particular risks. The department has indicated that it plans to develop formal guidance to support staff in the treatment selection phase. Human Services' guidance should have regard to any evidence gathered on the relative effectiveness of the different treatment types (including consideration of their comparative cost of administration) in influencing health professionals' compliance with the MBS requirements. Further, the effective recording and dissemination of this guidance would promote consistency and strengthen Human Services' overall management of risks to the incorrect billing of Medicare by health professionals.

25. In 2012, the department designed and trialled a scoring system to assist in prioritising compliance audit activity—an initiative with potential to achieve efficiencies and better target limited resources. However, after several trials which showed that further refinements were warranted to be confident of its reliability, Human Services is yet to finalise its 'priority scoring system'.

Conducting Medicare compliance audits (Chapter 3)

26. MBS billing arrangements can be complex and may vary significantly by MBS item. As a consequence, Medicare compliance audits can vary in their complexity, and there can be challenges in accurately calculating debts to be recovered from health professionals. The ANAO's review of a targeted sample²⁹ of Medicare compliance audits indicated that for the most part, key compliance audit processes were followed. However, in the sample of Cryotherapy compliance audits reviewed, different approaches were identified to calculating debts for claimants whose billing was assessed as non-compliant. In some audit cases compliance officers made decisions with supporting evidence from health professionals, while others made decisions without documented evidence. In this context, there is a risk that some debts in the wider population of Medicare compliance activities are also calculated inconsistently and, therefore, inaccurately, highlighting room for improvement in the operational guidance and debt calculation tools provided to staff.

27. Human Services has been aware of inconsistent approaches to debt calculation for Medicare compliance since 2012 and an interim staffing instruction is in place while outstanding technical and legal matters are resolved. There would be merit in Human Services finalising and implementing a debt calculation policy to address inconsistencies. A more consistent approach would improve the accuracy of debt calculations and strengthen the department's overall management of non-compliance, providing assurance to stakeholders that the operational approach to calculating debts is equitable.

28. One of the cornerstones of a reliable program information system is the quality of data used to track performance against key outcomes. Data quality depends in part on the adequacy of system controls and review activity. In a subset of Medicare compliance audit data reviewed by the ANAO (Medicare audits completed between March 2013 and 30 June 2013), various data anomalies were identified which resulted in the inaccurate reporting of the MBS non-compliance rate; a measure which is provided internally to management and to key stakeholders such as DoH. Of the 359 completed

29 The sample comprised a targeted and random sample of ten cases from the IMCA Cryotherapy 2011–12 project (which included a targeted sample of two audits which involved a penalty as part of the audit outcome); a random sample of ten cases from the IMCA Telehealth June 2012 Validation project; and a random sample of five cases from a pre-IMCA project, Interventional Radiology—Phase 1.

Medicare audits, 33 (nine per cent) contained data inaccuracies that resulted in compliant claims being incorrectly recorded and reported as non-compliant. To improve the accuracy of its Compliance Program reporting, there would be benefit in Human Services strengthening its system based controls to improve data quality.

29. Legislation governs the use of clinical and other sensitive information collected for Medicare compliance purposes. While Human Services has developed guidance to support the management of sensitive information during Medicare compliance audits, the compliance officers interviewed indicated different understandings and adopted differing practices regarding the storage of sensitive information, including documents of a clinical nature. There is scope, in the context of an evolving framework under the *Privacy Act 1988*³⁰, for Human Services to review existing policies and, as necessary, tailor its guidance to promote greater consistency in its management of sensitive information for Medicare compliance activities.

Measuring and reporting on Medicare compliance outcomes (Chapter 4)

30. Effective monitoring of performance enables an agency to advise and report to government and stakeholders on delivery against anticipated benefits. To monitor the implementation of the IMCA initiative and assess progress against the Budget measure's success, the ERC requested (in the context of the 2008–09 budget process) that the responsible Minister, the then Minister for Human Services and the then Minister for Health and Ageing agree on performance information for monitoring the measure's success and report back on expected outcomes in the context of the 2011–12 Budget. However, the department was unable to capture and report definitive results to the Australian Government on the outcomes achieved from IMCA. In particular, Human Services was unable to demonstrate the level of savings achieved through its management of the IMCA initiative as the department did not implement a savings methodology to monitor and a report on savings realised. Further, there was no follow-up by Human Services to the ERC's request that Ministers report back to government in 2011–12.

30 On 12 March 2014, the Information Privacy Principles were replaced by the Australian Privacy Principles. See the Office of the Australian Information Commissioner's website <<http://www.oaic.gov.au/privacy/privacy-act/australian-privacy-principles>> [accessed 26 March 2014].

31. It is expected that departments will implement suitable monitoring and reporting arrangements to gauge the effectiveness of the implementation of new policy measures. Such arrangements operate most effectively when embedded within agencies' business-as-usual processes. In the absence of specific monitoring and reporting arrangements for the IMCA initiative, the department undertook some analysis during the course of the audit and provided the ANAO with data for the value of debts raised and recovered as a consequence of Medicare compliance audits performed on health professionals.³¹ Between 2008–09 and 2012–13, Human Services raised a total of \$49.2 million in debts from Medicare compliance activities and recovered \$18.9 million.³² The available Human Services data shows that overall there was a shortfall of \$128.3 million in savings (monies recovered) against the Budget initiative's savings target—some 87 per cent less than the \$147.2 million in expected savings. Even if all the debts raised (\$49.2 million) were recovered, the result would be a shortfall of \$98 million or 66 per cent less than the expected IMCA savings.

32. The data indicates that the audits completed since the introduction of the measure, including those performed under the department's enhanced legislative powers, were delivered at a net cost to government and do not represent a positive financial return on its investment. While acknowledging the department's Compliance Program has a range of objectives in addition to achieving savings—including reinforcing health professionals' awareness of their compliance obligations—the department's experience in managing the IMCA initiative shows that Human Services should improve reporting on outcomes by better capturing the benefits realised from administering Medicare compliance audits so that departmental resources are properly targeted.

33. Under the IMCA initiative, Human Services committed to completing an additional 2000 Medicare audits each year on health professionals, in addition to the 500 Medicare compliance audits it normally completed each year; a revised target of 2500 completed Medicare audits per annum. The

31 See footnote 23.

32 The department advised that in any given year there may be a difference between the total value of debts raised and recovered, due to the operation of repayment plans which may see debts repaid over time, including over different financial years. Further, during this period the department was managing debt recoveries for the CDDS, including the government decision to waive \$12 million in debts in 2012–13 (refer Chapter 4, Table 4.3).

department has met this target only once, in 2011–12, where it reported completing 2549 Medicare audits and reviews.³³ In 2012–13, Human Services expanded the types of activities included in its reporting against the target, by including both ‘targeted feedback letters’ and compliance activities directed towards members of the public. However, both these activities were outside the scope of the IMCA initiative’s key performance measure agreed to by government—to increase Medicare compliance audits of health professionals. In this context, the department reported a total of 2819 completed Medicare compliance cases in 2012–13; however, if the recently added compliance activities are excluded, the department completed only 2073 Medicare compliance audits and reviews in 2012–13, falling short of the 2500 target. While ‘targeted feedback letters’ and compliance activities directed towards members of the public are valid compliance activities, their inclusion in a measure that increased the number of compliance audits to be conducted on health professionals has resulted in inaccurate reporting by Human Services against the IMCA initiative’s key performance indicator as well as inflating its reported compliance coverage rate.

34. More broadly, the department reports on the results of compliance activities performed to protect the integrity of Medicare through a number of internal and external avenues. The department’s operational reporting can help identify improvements to its internal processes and can potentially inform its future compliance activities. However, there are limitations to the reliability and validity of some of the information captured and tracked in these reports (such as the financial data externally reported to government, as well as internal performance measures such as the MBS non-compliance rate and the compliance coverage rate). These limitations, combined with the other monitoring and reporting issues raised in this audit, restrict the department’s capacity to demonstrate the overall effectiveness of its Medicare compliance activities.

33 The department delivered 2365 audits and reviews in 2009–10, while 2179 were completed in 2010–11 and 2073 in 2012–13.

Agency response

35. Human Services' letter in response to the proposed audit report is reproduced at Appendix 1. Human Services' response to the proposed audit report is set out below:

The Department of Human Services welcomes this report, and considers that implementation of its recommendations will build on work already undertaken and will enhance the department's approach to management of Medicare compliance audits.

The Department of Human Services agrees with the ANAO's recommendations. The department is pleased to note the ANAO's acknowledgement of improvements already undertaken by the department, particularly relating to risk prioritisation.

While risk management, the completion of audit work and achievement of savings is key to the department's compliance activities, the department is also pleased that the ANAO has noted the additional objectives of the Compliance Program, including education and reinforcing health professionals' awareness of compliance obligations. Prevention and positive behaviour change are a very important part of the department's Compliance Program.

Recommendations

Recommendation No. 1

Paragraph 2.16

To more effectively identify and prioritise risks for Medicare compliance activities, including compliance audits, the ANAO recommends that Human Services further develop its risk management framework so that:

- incoming risks (and previously-identified risks that are yet to be analysed) are assessed in a timely manner; and
- decisions to prioritise compliance activity focus on targeting the significant compliance risks to the Medicare program.

Human Services' response: *Agreed.*

Recommendation No. 2

Paragraph 4.26

To more effectively target resources, the ANAO recommends that Human Services develop a methodology to monitor outcomes and report on the effectiveness of Medicare compliance audits, including anticipated benefits, in the context of the broader Compliance Program.

Human Services' response: *Agreed.*

Audit Findings

1. Introduction

This chapter provides an overview of Medicare and background information on a component of the Department of Human Services' Compliance Program—Medicare compliance audits. It also sets out the audit objective and approach.

Medicare

1.1 Medicare is Australia's universal healthcare system designed to provide Australians and other eligible persons³⁴ with access to free or low cost health and hospital care, including treatment by health professionals such as doctors or specialists, with subsidies tailored to particular services. In 2012–13 Medicare payments totalled \$18.6 billion (for the 344 million Medicare claims processed), accounting for approximately five per cent of total government expenses. Expenditure under Medicare is expected to continue to grow, with payments estimated to reach \$23.7 billion by 2016–17.³⁵

1.2 The Department of Human Services (Human Services) is responsible for administering Medicare in accordance with policies developed by the Department of Health (formerly the Department of Health and Ageing).³⁶ The Department of Health's (DoH) policy role includes defining the type of health services and their corresponding payments that can be claimed by health professionals under Medicare. The eligible medical services for which claims can be made are listed on the Medicare Benefits Schedule (MBS), which includes over 6000 items.³⁷

1.3 The integrity of Medicare relies in large measure on health professionals correctly determining and claiming (or billing) against the MBS

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- 34 See Department of Human Services website <<http://www.medicareaustralia.gov.au/provider/medicare/>> [accessed 4 September 2013]. Persons eligible for Medicare benefits include people who reside in Australia and either: hold Australian citizenship; hold a permanent visa; hold New Zealand citizenship; or have applied for a permanent visa. Additionally, the Australian Government has signed Reciprocal Health Care Agreements with some countries and, subject to the agreements, residents of these countries are entitled to restricted access to health cover while visiting Australia.
- 35 Australian Government, *Budget Paper No. 1: Budget Strategy and Outlook 2013–14*, 'Statement 6: Expenses and Net Capital Investment', p. 6-12.
- 36 The Department of Health and Ageing was renamed the Department of Health (DoH) under the Administrative Arrangements Order, 18 September 2013. Throughout the report, the department will be referred to as DoH.
- 37 For the Medicare Benefits Schedule see <<http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>> [accessed 4 September 2013].

item/s that correspond with the services they have provided. After providing eligible services, health professionals generate claims for Medicare payments either:

- by directly claiming MBS rebates through Human Services—known as ‘bulk billing’; or
- through issuing a receipt to allow patients to claim reimbursement from Human Services.

1.4 In both scenarios the health professional indicates the service that has been provided, and consequently the benefit that is payable.³⁸

Medicare compliance responsibilities

1.5 Human Services manages its responsibilities for the administrative integrity of Medicare payments through a risk-based compliance approach. Human Services’ roles and responsibilities for compliance activities, including for Medicare are outlined in a 2012–15 Bilateral Agreement³⁹ between DoH and Human Services. The departments have agreed to:

- develop and coordinate compliance activities;
- produce a National Compliance Program (Compliance Program) on an annual basis, and allocate appropriate resources and deliver activities identified in the Compliance Program;
- identify any significant new or increasing program risks and proposed controls; and
- communicate to DoH any significant new or increasing risks to the management of its programs.

1.6 Human Services also engages with DoH on an ongoing basis through formal and informal means, including through committees established to address program integrity and compliance issues and approve actions to resolve MBS and other health program issues. Additionally, Human Services

38 Medicare Australia, Submission for the Senate Community Affairs Committee: *Inquiry into Compliance Audits on Medicare Benefits* [Internet], June 2009, available from <http://www.apf.gov.au/~media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/medicare_benefits_compliance_audits/submissions/sub16_pdf.ashx> p. 3 [accessed 27 August 2013].

39 The Bilateral Agreement came into effect on 1 November 2012. Human Services advised that since the change of government in September 2013, it has been involved in bilateral management negotiations with DoH that may result in variations to current roles and responsibilities.

has a formal stakeholder engagement framework involving key groups such as the Australian Medical Association and Royal Australian College of General Practitioners. Table 1.1 provides a brief description of the key committees and working groups that the department participates in to engage with stakeholders on compliance activities.

Table 1.1: Key compliance committees and working groups

Committee or Group	Purpose
Stakeholder Consultative Group	The peak stakeholder consultation forum. Provides an opportunity for key stakeholder groups to engage at a strategic level with Human Services on its business priorities and programs. As such, it allows for a two-way exchange of views on issues of mutual interest.
Strategic Fraud and Non-Compliance Steering Committee	Tasked to: <ul style="list-style-type: none"> Review and recommend the overall strategic approach to address fraud and non-compliance for social, health, welfare and child support payments across Human Services and the Department of Veterans' Affairs. Endorse an annual Compliance Plan and Performance Report. Consult with partner departments and central agencies on future governance arrangements to best respond to Cabinet requirements.
Compliance Sub-Committee	Provides a forum for discussion between Human Services and DoH on program integrity and compliance issues, and provides governance and direction on those issues within the Human Services portfolio.
Compliance Working Group	Provides a channel for health, medical and pharmaceutical peak bodies to engage with Human Services on identifying compliance risks and developing practical and appropriate mitigation strategies relating to MBS benefits and subsidies under the Pharmaceutical Benefits Scheme, and health related incentives.

Source: Human Services documentation.

Medicare compliance activities

1.7 The *Compliance Program 2013–15*⁴⁰ outlines Human Services' compliance priorities, approach and model for the diverse mix of programs it delivers on behalf of the Australian Government. The model recognises that most people

40 Department of Human Services, *Compliance Program 2013–15*, August 2013, available from <<http://www.humanservices.gov.au/corporate/publications-and-resources/compliance-program>> [accessed 27 August 2013].

do (or aim to) comply with program and payment requirements and comprises four types of compliance activities to treat risks to Medicare; one of these activities is compliance audits.

1.8 To assist in identifying Medicare compliance risks, the department relies on a mix of environmental scans (such as monitoring MBS claiming patterns), tip-offs and stakeholder input. The four different types of audit and investigation activities the department can select to treat a Medicare compliance risk are:

- education/preventive strategies—primarily undertaken to remind health professionals of their obligations when claiming under Medicare or other health programs and increase voluntary compliance. General education activities conducted include the development of articles for inclusion in Human Services' Forum or Bulletin Board publications⁴¹, while preventive strategies include the distribution of targeted feedback or targeted education letters⁴² to health professionals where there appears to be a widespread risk;
- practitioner reviews—conducted under the Practitioner Review Program. Practitioner reviews are performed on practitioners whose provision of services under the MBS and/or the Pharmaceutical Benefits Scheme suggest they may be engaged in inappropriate practice (which is defined in connection with rendering or initiating services that would be unacceptable to the general body of members of that profession). For instance, the department conducts practitioner reviews as part of its strategy to confirm whether health professionals have breached the 80/20 rule⁴³;
- criminal (fraud) investigations—used to investigate suspected fraud or criminal behaviour by health professionals who seek to

41 Department of Human Services, *Health Professional News*, available from <<http://hpnews.medicareaustralia.gov.au/>> [accessed 5 November 2012].

42 Refer to Chapter 2, Table 2.1, which describes the major difference between targeted feedback and targeted education letters.

43 To address the consistent high volumes of rendered services, a deeming provision known as the 80/20 rule was introduced in the *Health Insurance (Professional Services Review) Regulations 1999*. The regulations specify that a general practitioner or other medical practitioner is deemed to have practised inappropriately if he or she has rendered 80 or more professional attendances on each of 20 or more days in a 12 month period. The *Health Insurance (Professional Services Review) Regulations 1999* are available from <<http://www.comlaw.gov.au/Details/F2006C00473>> [accessed 5 November 2013].

opportunistically, intentionally, recklessly or negligently defraud health related programs and schemes; and

- compliance audits—used to verify the details of services provided by health professionals where Human Services identifies a risk that payments and benefits claimed under, for example, the MBS may have been made incorrectly.

1.9 Generally, Medicare compliance audits are identified and completed as part of a defined ‘project’. Projects are one of the department’s three compliance input streams⁴⁴ and are supported by a corresponding compliance strategy. Projects generally target multiple health professionals that are considered high risk with regard to claiming and billing patterns or practices for a particular service/s. The department runs multiple projects simultaneously and in 2012–13, the department commenced Medicare compliance audits under 13 different projects across the Medicare program. Compliance audits are conducted as either desk or face-to-face audits.⁴⁵ Where an incorrect payment is confirmed Human Services is required to recover the money from the health professional and provide advice and information to educate, support and encourage future voluntary compliance by the affected service provider.

Increased Medicare compliance audits and expanded audit powers

1.10 The 2008–09 Federal Budget’s Increased Medicare Compliance Audits initiative (IMCA initiative) expanded Human Services’ capacity to deliver Medicare compliance audits, on the basis that:

The Government will further protect the integrity of Medicare by increasing its compliance audit program to ensure appropriate claiming of items on the Medicare Benefits Schedule by health care providers [and] will amend relevant health legislation to increase the audit powers available to Medicare Australia to gain access to medical records supporting Medicare billing where

44 The other two compliance input streams are: ‘business approach’—a range of compliance activities undertaken to address breaches of regulations such as the 80/20 rule as well as other health programs such as the Practice Incentives Program; and ‘tip-offs’—which generally result in the development of an individual compliance case and a decision made on a case-by-case basis.

45 Desk audits involve compliance officers making enquiries over the telephone or via correspondence, while face-to-face audits involve the officer attending the health professionals’ place of business.

appropriate and, under certain circumstances, to apply sanctions where providers are found to be claiming inappropriately.⁴⁶

1.11 The Budget initiative was estimated to save \$147.2 million over four years and to cost \$76.9 million to administer, leading to net savings of \$70.3 million over four years. Human Services committed to conduct an additional 2000 audits each year targeting health professionals at risk of incorrectly claiming MBS payments and benefits, increasing the total number of audits to be conducted from 500 to 2500. Further, changes to the *Health Insurance Act 1973*, which were subsequently enacted in April 2011, would extend the department's audit powers and enable the department to:

- issue a written notice ('notice to produce') requiring a health professional to produce documents to substantiate one or more MBS items included in a Medicare compliance audit⁴⁷;
- impose administrative penalties where a health professional is unable to substantiate a Medicare claim⁴⁸;
- introduce a formal process for health professionals to voluntarily acknowledge incorrectly claimed benefits; and
- provide the opportunity for health professionals to seek a formal review of a decision to recover benefits paid to them.⁴⁹

1.12 To support the implementation of the IMCA initiative, Human Services developed compliance audit procedures to guide the use of its new legislative powers. Prior to a full transition, the department trialled the IMCA initiative during 2012 using all 42 audits completed under the Cryotherapy 2011–12

46 Australian Government, *Budget Measures, Budget Paper No. 2 2008–09*, 'Responsible Economic Management—Medicare Benefits Schedule—increase compliance audits', p. 404.

47 Issuing a 'notice to produce' is at the discretion of the department and is only to be used if and when a health professional chooses not to produce documents to substantiate the audited MBS item/s and where all legislated criteria are met. There are three legislated criteria, see s. 129AAD Notice to produce documents of the *Health Insurance Amendment (Compliance) Act 2011*, available from <<http://www.comlaw.gov.au/Details/C2011A00010>> [accessed 5 November 2013].

48 Refer Appendix 2 for a summary of the penalty system.

49 The legislative amendments were considered in the Senate Community Affairs Legislation Committee's *Inquiry into Compliance Audits on Medicare Benefits*, [Internet], June 2009, available from <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/medicare_benefits_compliance_audits/index> [accessed 27 August 2013].

The *Health Insurance Amendment (Compliance) Act 2011* gave effect to these changes and became law on 9 April 2011.

project.⁵⁰ The trial included the majority of the new legal components—the application of penalties, the review of decision component, voluntary acknowledgements and the development of a specific health professional guideline—but did not include the ‘notice to produce’ component. The department implemented the ‘notice to produce’ component in August 2013, applying changes to business processes, systems and staff guidance materials to support the use of the enhanced power should the circumstance arise. As at October 2013, the department advised that the ‘notice to produce’ component had not been invoked during the conduct of any Medicare compliance audits.

The compliance audit process

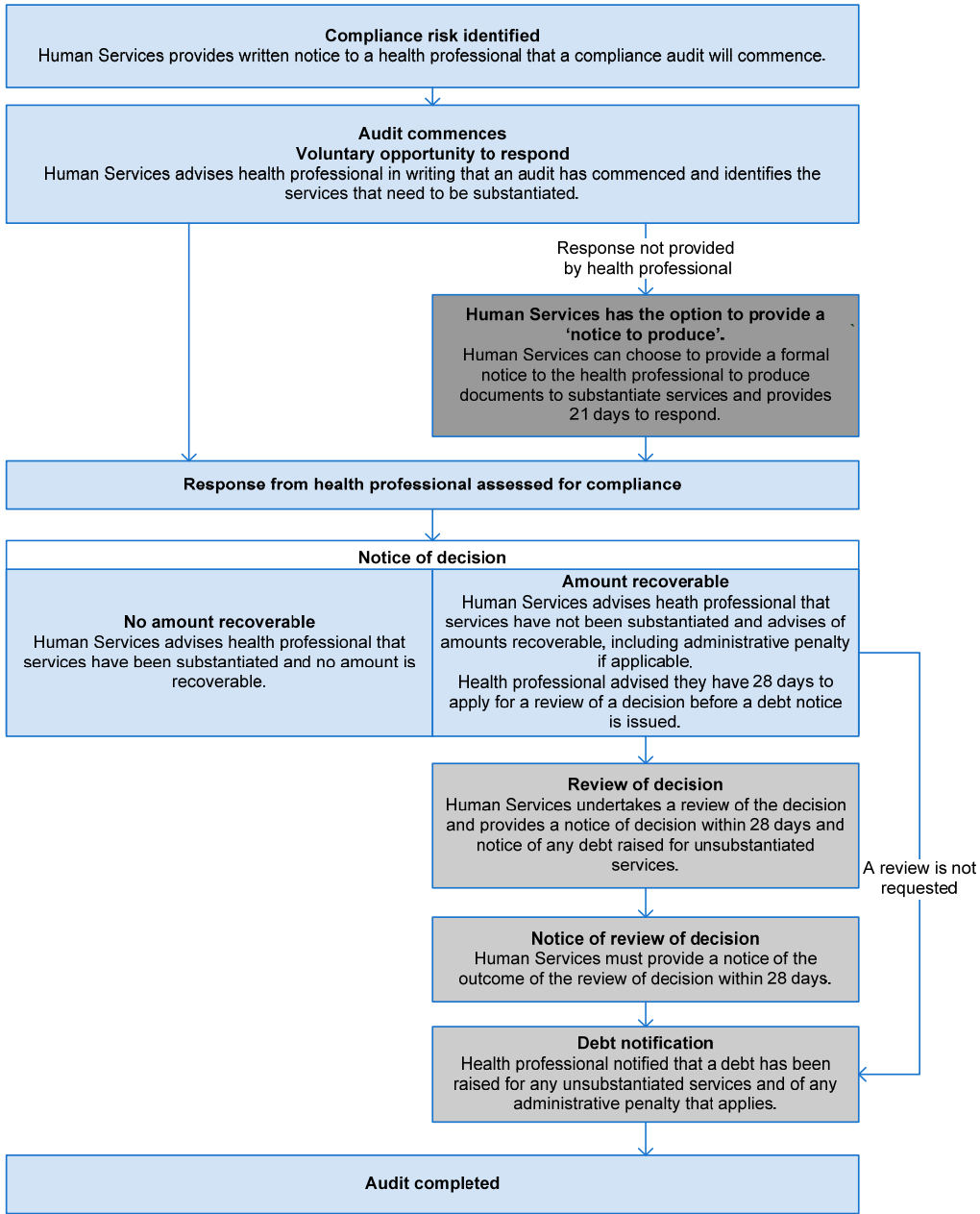
1.13 The main stages in the Human Services compliance audit process are:

- identifying a compliance risk, by monitoring MBS claim trends and assessing input from stakeholders (such as DoH and peak health bodies) and tip-offs;
- collecting evidence to verify whether services claimed have met the MBS requirements; and
- determining compliance. For audits where non-compliance is identified, the total debt for incorrect claiming is calculated and pursued for recovery.

1.14 Figure 1.1 provides an outline of the compliance audit process which incorporates the 2011 legislative reforms across the various compliance audit stages.

50 The Cryotherapy audit objectives included to trial the implementation of elements of the IMCA initiative.

Figure 1.1: Medicare compliance audit flow chart



Source: ANAO adaptation of the department's Medicare compliance audit flowchart.

1.15 In 2012–13 Human Services raised 590 debts and initiated action to recover \$3.5 million. Table 1.2 shows that between 2008–09 and 2012–13, the department initiated action to recover \$49.2 million in debts that were largely a

result of Medicare compliance audits completed since the IMCA initiative was introduced, and recovered \$18.9 million.

Table 1.2: Debts and recoveries from Medicare compliance activities

FY	Number of debts raised	Savings ^A	
		Value of debts raised (\$m)	Recoveries ^B (\$m)
2008–09	635	4.0	^C Not available
2009–10	472	7.8	6.8
2010–11	306	25.7	5.0
2011–12	402	8.2	4.7
2012–13	590	3.5	2.4
Totals	2405	49.2	18.9

Source: Human Services data, provided to the ANAO 28 January 2014.

Notes: ^A The department advised that the number and value of debts raised, and the recoveries figures provided excludes Medicare compliance cases conducted on members of the public but may include criminal or fraud investigation cases. Further, the department advised that the recoveries data may also contain monies recovered from cases that were completed prior to the introduction of the IMCA initiative.

^B The department advised that the department is able to enter into a plan for repayment of debts, particularly those of large value and as a result there is no direct correlation between debts raised and recovered in the same financial year.

^C As a consequence of the manual reconciliations between two separate systems that Human Services needed to perform to provide data to the ANAO, the department advised that the recoveries information for 2008–09 is not available.

Audit objective, criteria and scope

1.16 The objective of the audit was to assess the effectiveness of the Department of Human Services' management of Medicare compliance audits.

1.17 To form an opinion against the audit objective, the ANAO examined the design and operation of departmental processes against the following high-level criteria:

- Human Services effectively identifies, selects and prioritises potential cases of non-compliance for compliance audits.
- Compliance audits are conducted in accordance with legislative and operational requirements.
- Non-compliance actions are managed and the information is used to inform future compliance activities.

1.18 The ANAO interviewed departmental staff involved in the conduct of Medicare compliance audits, key stakeholders, and reviewed key guidance materials and documents, including departmental reports that capture Medicare compliance performance information. The ANAO also reviewed a sample of Medicare compliance audits: a targeted and random sample of ten cases from the IMCA Cryotherapy 2011–12 project⁵¹; a random sample of ten cases from the IMCA Telehealth June 2012 Validation project; and a random sample of five cases from a pre-IMCA project, Interventional Radiology—Phase 1.

1.19 The scope of the audit did not include: an assessment of DoH's roles and responsibilities in relation to Medicare compliance audits; compliance audits the department conducts for other programs, such as the Pharmaceutical Benefits Scheme; other compliance activities such as criminal investigations and/or practitioner reviews to address potential fraud or inappropriate practice; an examination of debt management processes; re-conducting individual compliance audits to determine if the decisions were 'correct'; decision reviews; or compliance audits for MBS item claims relating to the Chronic Disease Dental Scheme (CDDS).⁵²

1.20 The audit was conducted in accordance with ANAO audit standards at an approximate cost to the ANAO of \$468 010.

ANAO audit coverage of Medicare

1.21 This audit is part of the ANAO's wider coverage of Human Services' management of risks to Medicare and complements the ANAO's *Integrity of Medicare Customer Data* audit (scheduled to table in the Parliament in the second quarter of 2014). This audit assesses Human Services' management of risks related to health professionals' MBS claiming at the post-payment stage, while the *Integrity of Medicare Customer Data* audit builds on previous ANAO assessments of Medicare data⁵³ that examine the department's management of risks at Medicare's entry point, when customers are enrolled.

51 The sample for the Cryotherapy project included a targeted sample of two audits which involved a penalty as part of the audit outcome.

52 The CDDS was closed to new patients from 8 September 2012 and Medicare billing ceased for services provided after 30 November 2012.

53 Part of the *Integrity of Medicare Customer Data* audit is to examine Human Services' implementation of the six recommendations from the previous ANAO audit, Audit Report No.24, 2004–05 *Integrity of Medicare Enrolment Data*.

Table 1.3: Report structure

Chapter 2 Identifying the Need for Medicare Compliance Audits	Examines Human Services' arrangements to identify, assess and rate risks so as to inform the department's approach to developing compliance strategies, which include conducting Medicare compliance audits to treat identified risks.
Chapter 3 Conducting Medicare Compliance Audits	Examines Human Services' operating environment for compliance activities, and the department's arrangements for evidence collection and verification of Medicare services, determining audit outcomes and finalising audits.
Chapter 4 Measuring and Reporting on Medicare Compliance Outcomes	Examines Human Services' arrangements to measure and report on compliance outcomes, including for savings achieved against the Increased Medicare Compliance Audits initiative. The chapter also reviews the department's broader reporting for Medicare compliance audits.

2. Identifying the Need for Medicare Compliance Audits

This chapter examines Human Services' arrangements to identify, assess and rate risks so as to inform the department's approach to developing compliance strategies, which include conducting Medicare compliance audits to treat identified risks.

Introduction

2.1 A structured approach to risk management enables an entity to identify and assess risks and to prioritise, plan and implement responses to mitigate any significant risks. The effective monitoring of current and emerging risks is also essential to appropriately managing risks, allowing entities to determine which risks require a compliance response. A risk register can be a useful way to capture important risk information, such as the likelihood, priorities and potential impacts of identified risks, supporting compliance planning that effectively targets a compliance response to those risks that have been assessed as significant.

2.2 Human Services' approach to identifying risks to Medicare is informed by a number of environmental scanning and intelligence gathering activities. Following from these activities, specific risk treatment options, such as Medicare compliance audits, are identified through the development of compliance strategies.⁵⁴ To determine whether the department's arrangements effectively support the identification, selection and prioritisation of potential cases of non-compliance for Medicare compliance audits, the ANAO reviewed Human Services' approach to:

- identifying, analysing and rating risks;
- developing compliance strategies, including selecting a compliance audit as the treatment type, and identifying the health professionals to be audited; and
- allocating Medicare compliance audits to compliance operations staff.

⁵⁴ Medicare compliance audits can also be selected as a treatment type outside a defined compliance strategy, primarily in response to a tip-off received by Human Services (refer paragraph 2.23 and footnote 63).

Identifying, analysing and rating risks

2.3 Identifying, analysing and rating Medicare risks is part of a ‘hybrid risk, intelligence and problem solving (Sparrow⁵⁵)’ approach that Human Services employs for compliance actions covering Medicare and other health-related programs. The end-to-end compliance cycle implemented as a consequence of this approach consists of five stages—identification, analysis, strategy, treatment and evaluation; and incorporates three layers of intelligence—strategic, project, and tactical.

Identifying risks

2.4 Human Services employs a risk-based approach to select health professionals for involvement in compliance activities such as Medicare compliance audits. A number of environmental scanning and intelligence gathering activities inform the approach and are intended to assist in detecting: new and emerging risks; and any changes to known risks. Such activities include:

- monitoring claim trends for the MBS (including MBS growth workshops) to identify areas of unexplained growth or unusual patterns of claiming;
- examining tip-offs and referrals received from members of the public via the Fraud Hotline and by Human Services staff members through the ‘Report a Risk’ mailbox⁵⁶;
- input from internal and external stakeholders (including DoH) through standing consultative committees, meetings and risk workshops; and
- capturing feedback and knowledge gained from previous compliance strategies and activities.

55 Professor Malcom K Sparrow is a professor at Harvard University’s John F Kennedy School of Government, and specialises in issues of enforcement strategy, regulatory policy, risk control and intelligence analysis. In March 2013, Professor Sparrow presented expert advice to Human Services regarding the environment in which the department’s compliance function operates. Key elements of this advice are highlighted in Chapter 4.

56 Tip-offs can be received through the Report a Risk mailbox internally from Human Services staff as well as from outside the department. In 2012–13, 183 risks were reported through this mailbox, compared to 145 in 2011–12.

Capturing and recording risks on the risk topic register

2.5 The department captures all known risks for the MBS and other health programs such as the Pharmaceutical Benefits Scheme in a Risk Topic Register (RTR). The department groups risks by topic or areas of focus; for instance, specialty health professional groups such as optometrists, or specific MBS item numbers, such as those for after hours consultations. As at 16 October 2013, a total of 210 risk (and research) topics were listed across the different health programs Human Services administers. Approximately 40 per cent of these topics were risks that related to health professionals' billing/claiming of the MBS.

2.6 A risk register can be a useful way to document actual or anticipated risks, including information about the likelihood, priority and potential impacts of risks. In October 2013, Human Services added new categories in its RTR that reflect key components expected for a good practice register, including the: level of risk; likelihood and consequence of the risk; and level of risk after any mitigation. The additional categories provide the department with the opportunity to capture and record essential risk information, and if well maintained, the register will increase the department's overall visibility of risk levels (both pre- and post- compliance activity) and in particular of priority risks warranting further attention.

2.7 The RTR contains a large number and variety of risk entries, highlighting the breadth of potential risks related to health programs, particularly the MBS. A review of the RTR illustrates that while Human Services may simultaneously run multiple compliance projects⁵⁷, the department's capacity to conduct risk analysis and respond to risks is limited. There are a large number of identified MBS risks in the RTR that have not been substantively analysed⁵⁸—at one end of the spectrum the register records risks that the department has extensively analysed and implemented one or more compliance strategies for (such as Cryotherapy), while at the other end of the spectrum the register records risks in respect of which the department has undertaken little or no assessment work (such as for Teleradiology). The

57 A project will typically involve a number of audits and generally target multiple health professionals that are considered high risk with regard to claiming and billing patterns or practices for a particular service/s.

58 As at 16 October 2013, the ANAO identified that 58 per cent of the identified MBS risks related to health professionals had a formal risk rating assigned or recorded. Of the risks with a formal rating assigned, approximately 40 per cent were also assigned a work priority rating.

department advised that historically it automatically assigned an initial informal rating of Low or Unknown to risks for which the department did not have the capacity to perform a preliminary analysis. By adopting this approach, departmental management did not have full visibility that all of the significant risks were being identified and consideration given to implement a compliance response for these risks.

2.8 While the RTR has been strengthened since October 2013, Human Services attributes the previous informal arrangements for ‘initial’ risk analysis as a contributing factor for the majority of the risks that have had little or no risk analysis work performed. While some of the risks subject to this approach may have posed a considerable risk to the integrity of the Medicare program, the ratings they were assigned largely excluded them from inclusion in the rolling Compliance Workplan (the workplan) and consequently, from being considered and prioritised for compliance action. Other unexamined risks may have warranted the ‘low’ rating, but in the absence of a preliminary analysis, the rationale for the informal ratings assigned to risks is not clear.

2.9 Human Services lists risk topics that are selected for compliance work in its rolling workplan so that detailed risk analysis can occur—often resulting in the development of a compliance strategy (refer Figure 2.1). However, in 2011–12 and 2012–13 the department applied a largely qualitative approach (including considering stakeholder views) to prioritise risks for inclusion in its workplans⁵⁹, and overall, the department’s approach to prioritise risks for inclusion in the workplans was not supported by a framework that could usefully drive a systematic and transparent process.

2.10 The department’s management of risks under these arrangements was limited in a number of areas, namely the department’s capacity to: perform risk analysis for all identified risks in a timely manner so that all significant risks (from the full list of identified risks) could be considered for compliance action; and demonstrate that decisions to prioritise risks for treatment are transparent, soundly-based and suitably documented.

59 Human Services advised that the 2011–12 workplan formed the basis of the 2012–13 workplan (which the department advised was then updated according to new data, reassessed risks and changes to stakeholder concerns).

Analysing and rating risks

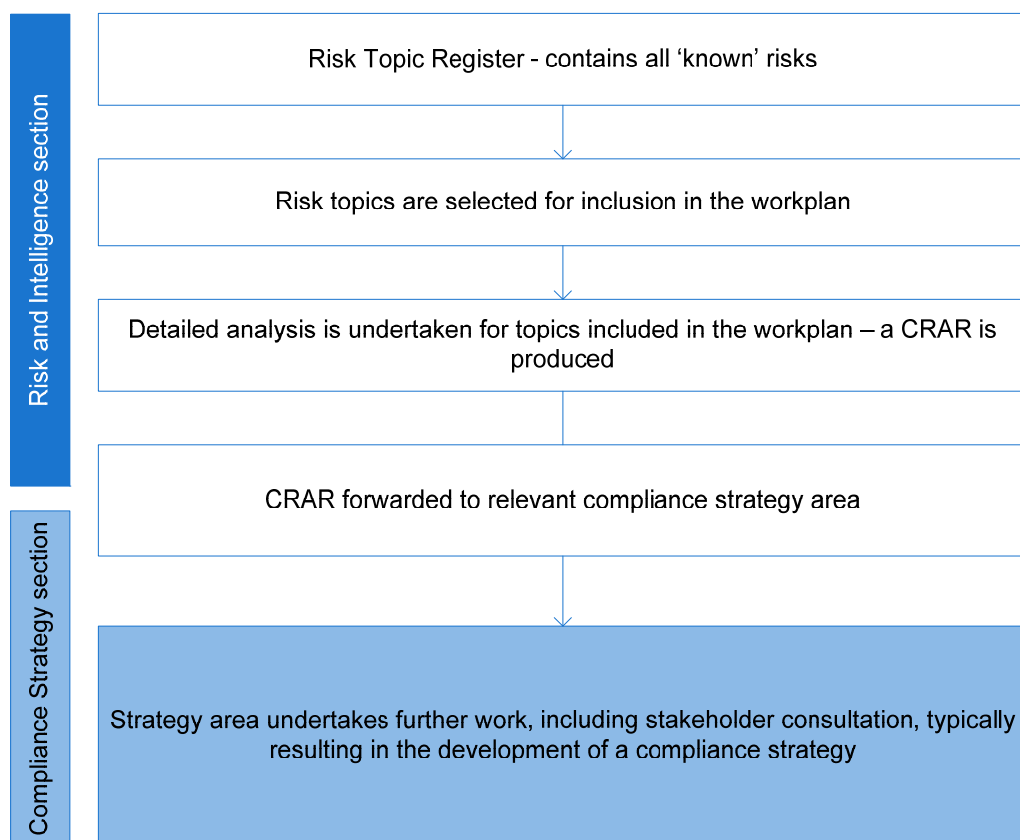
2.11 Critically analysing risks is a way of gaining an understanding of their cause, source, likelihood, possible severity and impact. Risk analysis informs decisions about which risks need treatment and their relative priorities.

2.12 As previously outlined, Human Services uses the RTR as the basis for selecting topics to be included in its workplan. Inclusion in the workplan triggers a process of detailed risk analysis through the completion of a Compliance Risk Assessment Report (CRAR).⁶⁰ The department's risk analysis involves identifying the possible extent of behaviour that may indicate non-compliance, the potential impact of the risk, and determining the topic's overall risk rating—High, Medium or Low.

2.13 During the risk analysis phase, the relevant compliance strategy area⁶¹ is also consulted and following the completion of a CRAR, a compliance strategy for a particular risk topic is generally developed (refer Figure 2.1). Typically, the data assessment undertaken as part of this phase also informs the strategy area of the initial parameters for identifying those health professionals that would be considered at risk of potential non-compliance with the relevant MBS requirement.

60 The CRAR was introduced in 2012 and replaced three separate reports that were previously required to be completed during the risk analysis phase.

61 There are three compliance strategy areas: GP and Specialists; Allied Health and Health Support; and Business and Public. The Allied Health and Health Support strategy area would therefore be consulted and later receive a CRAR for topics related to MBS claiming by allied health professionals such as chiropractors.

Figure 2.1: Selecting risk topics for assessment

Source: ANAO analysis.

2.14 The process to complete a CRAR was introduced in 2012, after the department undertook analysis work for the risks related to the Interventional Radiology (IR—Phase 1) and Cryotherapy 2011–12 projects reviewed as part of this audit. It should be noted that the compliance strategy for the Telehealth June 2012 Validation project (Telehealth), another project reviewed as part of this audit, was not supported by formal risk analysis. Human Services developed the Telehealth strategy following a DoH request to investigate compliance in this area because of an MBS policy change to Telehealth associated payments. The ANAO's review shows that while there may be circumstances where data assessment is not performed, such as for the Telehealth project, which was initiated upon request by the responsible policy department (DoH), the department's strategies for the IR—Phase 1 and Cryotherapy 2011–12 projects were informed by past data analysis of the risk topic.

2.15 In the course of this audit, the department introduced a number of enhancements to the risk prioritisation process, including a risk working group which is to consider risks (these may include ‘older’ risks that have never previously been formally examined) and determine whether they should be prioritised for inclusion in the workplan. Related processes are also being proposed or developed to leverage off this newly formed working group, including the development of a Divisional list of Risk Priorities. Nevertheless, the risk working group and other initiatives are still in their infancy. Pursuing these developments will assist the department to establish a more effective framework for managing MBS risks and can be expected to support Human Services to: analyse incoming risks in a timely manner; target significant risks for priority compliance action; and demonstrate that decisions are transparent and soundly-based.

Recommendation No.1

2.16 To more effectively identify and prioritise risks for Medicare compliance activities, including compliance audits, the ANAO recommends that Human Services further develop its risk management framework so that:

- incoming risks (and previously-identified risks that are yet to be analysed) are assessed in a timely manner; and
- decisions to prioritise compliance activity focus on targeting the significant compliance risks to the Medicare program.

Human Services’ response:

2.17 *Agreed. Since the commencement of this audit, the department has made significant changes to risk identification and risk prioritisation. These changes include:*

- *All new risks undergo preliminary assessment and are then scheduled for detailed assessment.*
- *Older or previously unknown risks have either been assessed or are assigned for analysis.*
- *All risk assessments are discussed at the Risk Working Group, with priorities approved at General Manager level.*

Developing compliance strategies

2.18 After a risk is analysed, the CRAR is forwarded to the relevant compliance strategy area to implement a suitable compliance response. Typically the strategy area undertakes work to develop and design a compliance strategy for the analysed risk. Compliance strategies may include specific treatment options, such as Medicare compliance audits, to verify details of a particular MBS service/s billed by a targeted group of health professionals. The department develops compliance strategies by:

- drawing upon the intelligence and indicators of potential non-compliant claiming identified through the data analysis and risk analysis phases; and
- consulting with internal and external stakeholders, including through the Compliance Working Group. In some cases a Core Design Discussion Document (CDDD) is developed to seek formal feedback from stakeholders on the compliance activities recommended.

2.19 While CDDDs were not developed for the Telehealth and Cryotherapy 2011–12 projects examined as part of this audit, Human Services consulted with internal stakeholders to assist in finalising the projects' respective compliance strategies.

2.20 On occasion, Human Services also seeks legal advice to assist in developing the compliance approach. The department advised that the legal advice sought for the Telehealth project, along with comments received from the department's Medical Advisers, was used to inform approaches made to patients as part of the audit project.

Key elements of a compliance strategy

2.21 A Human Services compliance strategy generally includes six key components: Compliance Issue; Risk/s; Objectives; Background of the risk/s; Stakeholder Engagement; and Compliance Strategies. The Compliance Strategies phase applies PESTLe analysis⁶², which is the approach used across

⁶² The department's Risk and Intelligence section describes PESTLe as the framework by which risks are assessed and treated. The components of PESTLe are: policy—growth in volume of services and providers; economic—changing ways of delivering health services; social—community expectations and demand; technological—the effect of eBusiness and other technologies; and legal—interpretation and application.

the department to understand environmental factors influencing non-compliance. A compliance strategy also outlines the:

- treatment type/s chosen to treat the risk/s;
- parameters to identify and select health professionals for the individual compliance activities; and
- any other activities that will be undertaken by the department to address the risk.

Selecting the treatment type

2.22 Responses to identified risks should be proportionate to the risk they address. Selecting the appropriate treatment type is important to achieve the desired compliance outcomes, including verifying claims and recovering monies where incorrect claims are confirmed, and providing (as needed), education to encourage future voluntary compliance. In a constrained resourcing environment, the relative cost-effectiveness of treatment types in particular circumstances should also be a consideration.

2.23 As outlined in Chapter 1, Human Services can choose from a variety of available treatment activities, which include compliance audits. Compliance strategies and the associated project may include more than one treatment type to address a risk.⁶³ The IR—Phase 1 compliance strategy for example, includes three separate treatments: desk audits; targeted feedback letters; and education.

2.24 While staff can select from a range of treatment types, Human Services has not developed documented criteria, including possible circumstances or indicators, that could be used to inform a decision to pursue one particular treatment type over another. Such criteria are potentially a useful aid to helping staff determine the most appropriate, proportionate and cost-effective treatment for different risks. Human Services advised that ‘common knowledge’ among staff guides choice of treatment, and there is a general understanding that compliance audits are selected when potential incorrect claiming is identified and where evidence can be requested to confirm

⁶³ Medicare compliance audits can also be selected as a treatment type outside a defined compliance project, primarily in response to a tip-off received by Human Services. Compliance officers undertake ‘entity analysis’ to assess the relevant MBS claiming data of an individual health professional or organisation/corporation related to the identified concern and then recommend whether or not treatment, such as a compliance audit, should be pursued.

compliance or non-compliance against legislative requirements. In the course of the audit, the department documented for the ANAO, in summary form, the rationale for the selection of each particular treatment type (refer to Table 2.1).

Table 2.1: Rationale for selecting treatment types

Treatment type	General reasons
General audits	
Desk	Simple and small number of legislative requirements that can be audited—i.e. not clinical. Small number of ‘concerns’ per health professional to be audited.
Face-to-face	More complex legislative requirements that can be audited—i.e. not clinical. Indication that health professionals will require education in addition to the audit. Health professional has multiple concerns to be handled in the one audit.
Targeted feedback	
Targeted feedback letter	Risk appears to be widespread and across a large population of health professionals and data relevant to claiming practices can be extracted.
Targeted education letter	Risk appears to be widespread across a large population of health professionals but no data relevant to claiming practices can be extracted.
Education	
Education—articles or products (eLearning, quick reference guides)	Risk appears to be widespread across a large population of health professionals. Non-compliance is limited to one or two specific issues.
Reviews and investigations	
Practitioner Review Program	Risk relates only to clinical aspects—e.g. was the appropriate service performed. Health professional has multiple concerns in the area of inappropriate practice.
Criminal investigation	Evidence of intentional incorrect claiming. Claiming for services that have not been provided and data error an unlikely explanation for the data pattern.

Source: ANAO representation of the department’s advice.

2.25 While local knowledge and experience can be invaluable, the explicit alignment of risk against the selection of treatment type provides a sound basis for selecting a cost-effective and proportionate response to risk, and the consistent application of available treatments to similar circumstances. The

department acknowledged the benefit of providing formal guidance for the treatment selection step and advised that it plans to develop written guidance to support staff in this phase. In developing its treatment selection guidance Human Services should be mindful of any evidence gathered on the effectiveness of the different treatment types (including consideration of their comparative cost of administration) on health professionals' compliance. The effective dissemination of such guidance would promote consistency and strengthen the department's overall management of risks to the incorrect billing of Medicare by health professionals.

Identifying health professionals for compliance activities

2.26 In addition to outlining the selected treatment type, Human Services' compliance strategies include consideration of particular claiming patterns, to identify the health professionals to be selected for treatment, including those to be audited. The claiming parameters developed for each project are unique. For instance, for two of the case review projects examined in this audit, the parameters were as follows:

- IR—Phase 1—included three tiers of claiming parameters with corresponding risk categories and the development of different treatment types (refer Table 2.2).
- Cryotherapy 2011–12—included one claiming pattern criterion for the selection of health professionals.

Table 2.2: MBS claiming pattern parameters: IR—Phase 1

Claiming pattern	Risk category	Treatment type
20% or more of total MBS item A services; and 10 or more MBS item A services where there is no association of relevant pathology items.	High risk	Desk audit
<20% of total MBS item A services; and between 10 and 5 MBS item A services where there is no association of relevant pathology items.	Medium risk	Targeted feedback letter
<20% of total MBS item A services; and <5 MBS item A services where there is no association of relevant pathology items.	Low risk	Education

Source: ANAO analysis of the department's compliance strategy for IR—Phase 1.

2.27 Following the development of claiming parameters, the department determines the health professionals to be audited by extracting and analysing the relevant MBS services claimed against the chosen parameters and within a specified timeframe.⁶⁴ For IR—Phase 1, the department selected 334 health professionals for desk audits, and 196 health professionals for targeted feedback letters. For Cryotherapy 2011–12, 49 health professionals were selected for desk audits. The number of services for the relevant MBS items audited for each health professional was:

- subject to a pre-defined and tiered criteria for IR—Phase 1: all services if the range was 10 to 20 MBS item A services; and 20 randomly selected services for a range of 21 to 500 MBS item A services; and
- unlimited for Cryotherapy 2011–12.

2.28 Percentage based claiming parameters are not always applied when selecting health professionals for compliance activities. For instance, for the Telehealth project, health professionals were selected randomly.⁶⁵

2.29 Human Services' approach, which tailors each strategy's parameters to the specific risk profile and health professional population, provides flexibility to adapt activities across the MBS, which includes over 6000 items. However, the ANAO's examination of risk and strategy documentation identified only broad linkages between the data analysis findings and the claiming parameters used to identify health professionals as part of the Cryotherapy 2011–12 project. The department advised that a higher risk threshold was chosen for Cryotherapy so that 'a more manageable number' of audit cases could be identified for action.

2.30 The ANAO notes that there may be circumstances which limit clear linkages between the data analysis findings and the claiming parameters to select health professionals. However, the department would benefit from considering options to promote greater transparency, where appropriate, in compliance strategy documentation so that the rationale used to select the

64 For both the IR—Phase 1 and Cryotherapy 2011–12 projects, Human Services extracted MBS data over a 12 month period. The department used the Cryotherapy 2011–12 project to trial elements of the Increased Medicare Compliance Audits initiative as the data extract timeframe included MBS services rendered after 9 April 2011.

65 Human Services advised that as the Telehealth project was conducted in response to a request from DoH, informal risk analysis was performed which identified that a random sample of 92 claims would represent a statistically acceptable sample.

population of health professionals for compliance audit activity is appropriately supported and justified.

Allocating Medicare compliance audits

2.31 Once the individual health professional is selected for a particular treatment, such as a desk audit, the audit is usually allocated to a General Compliance Team (GCT).⁶⁶ The Workload Management area is responsible for allocating compliance cases to the relevant GCT.

2.32 The process for allocating Medicare compliance audits involves a forecasting tool and is to take into account the geographic location of the health professional to be audited and the capacity of a GCT, including skills and team availability. The department advised that workload capacity forms part of regular business discussions, including between the compliance strategy areas and GCTs, and a tool is also being developed to assist managers to estimate capacity.

Priority scoring for compliance audit workflow

2.33 With the introduction of the Compliance Workload Management System (CWMS), which has the ability to automate the flow of compliance activities, the department is developing a 'priority scoring' approach for the allocation of priority audits. The system is designed to provide a criteria-based method to allocate a score to an individual compliance audit at the entity analysis phase. The score allocated affects the work priority assigned to an audit⁶⁷, noting that formal authorisation of a case still needs to occur. Broadly, the approach is based on assigning a score out of 100, with 100 representing an audit of the highest priority. All cases begin with a default score of 50.⁶⁸

2.34 The department has conducted several trials of the priority scoring system, with an initial two-part trial undertaken in 2012. Part B of the trial

66 Human Services recently restructured its compliance operations area to create a more flexible and multi-skilled compliance workforce. A key element of the new structure was the development of GCTs, which combined two previously specialised compliance teams—desk/analysis and field (refer paragraph 3.10 for further discussion on the restructure and GCTs).

67 The department also advised that 'cases that are part of a project/strategy will have a higher score as they do not need entity analysis and should progress straight through to treatment, whilst those requiring analysis [such as tip-offs] will be more highly scrutinised and prioritised according to the priority matrix'.

68 A priority score of 100 or 90 is automatically given to cases such as those where Ministerial requirements have been identified, have direct harm/safety implications to an individual, and or where fraud has been identified.

involved seven compliance officers applying the draft scoring criteria to 10 separate audits. The trial results showed variability in the scores:

- For seven of the 10 audits, only two⁶⁹ officers gave the same score, while for the remaining three audits, different scores were given by each officer.
- For half of the audits in the trial, a difference in the scoring range was greater than or equal to 40 points.

2.35 The trial results indicate that discrepancies in scores will occur due to compliance officers' individual interpretations of information and understanding of how the scoring system is to be applied.

2.36 Notwithstanding several trials of the priority scoring system, Human Services has not finalised the scoring methodology, on the grounds that a larger number of cases need to be trialled and further refinements are warranted to be confident of its reliability. As at 10 October 2013, priority scores had been applied to 671 compliance cases. The department advised that results from a recent survey distributed to operations areas will potentially contribute to further changes to the methodology and that once implemented, consideration would be given to further evaluation.

2.37 Given the trial results and changes that continue to be made in response to more recent operational feedback, it is important for the department to: closely monitor score outcomes following the latest adjustments; and once the methodology has been finalised, promote the consistent application of the scoring methodology by providing appropriate training and guidance across the GCTs.

Conclusion

2.38 Human Services undertakes a number of environmental scanning activities to detect new and emerging risks and captures known risks on its Risk Topic Register (RTR). The department uses the RTR as the basis for selecting risk topics for detailed analysis; the first step in developing a strategy to deliver compliance activities, such as Medicare compliance audits. However, until recently, the department's arrangements for the management of identified risks limited the department's capacity to perform a preliminary

69 For one of these audit cases, three compliance officers allocated the same priority score.

analysis on incoming risks in a timely manner so that all significant risks (from the full list of identified risks) could be effectively targeted for compliance action. Consequently, there remain a large number of previously identified risks that have not been substantively analysed, and the compliance risks they may pose (including their possible cost to Medicare) remain unknown. Notwithstanding that the consequences of some risks, once examined, may be well understood and managed without a formal compliance response, it is essential that the department's risk management framework provides a platform to analyse risks in a timely manner so that the department can consider from the full list of identified risks, those that do, or do not, require compliance treatment.

2.39 The department has recently introduced a number of enhancements to the risk prioritisation process, including a risk working group. The working group is expected to strengthen governance arrangements and establish a more explicit framework for selecting and prioritising risks to be addressed through compliance activity. The risk working group and related initiatives can be expected to assist the department in developing a more effective framework for managing risks and enabling Human Services to: analyse risks in a timely manner; and demonstrate that decisions to prioritise particular Medicare Benefits Schedule (MBS) risks for compliance activity are transparent and soundly-based. The department should monitor the implementation of its recent risk management initiatives so that the department can make suitable adjustments, as needed, to support achievement of the desired outcomes.

2.40 Compliance strategies are a key element of the department's arrangements to address MBS risks and involve the selection of appropriate compliance activities, such as a Medicare compliance audit, to treat an identified risk. The effective alignment of a risk with a proportionate and appropriate treatment type can contribute to the cost-effective management of non-compliance. During the course of the audit, Human Services agreed to develop formal guidance for staff on selecting risk treatments, including criteria to assist staff in their selections. Establishing and disseminating documented criteria would promote consistency in the selection of treatment types and strengthen the department's management of risks to the incorrect billing of Medicare by health professionals.

2.41 Human Services audits that are identified as part of a compliance strategy or through the tip-off entity analysis process are currently allocated to General Compliance Teams (GCTs) with the assistance of a forecasting tool

and regular business discussions. The department's recent initiatives to strengthen audit allocation processes—such as developing a priority scoring system—provide the department with the opportunity to achieve further efficiencies and better target limited resources to priority compliance activities. However, Human Services is yet to finalise its priority scoring system. After several trials beginning in 2012, the department has continued to make changes to the scoring methodology in response to operational feedback. To facilitate the effective and consistent implementation of the methodology, Human Services will need to focus on appropriately training staff and monitoring its application.

3. Conducting Medicare Compliance Audits

This chapter examines Human Services' operating environment for compliance activities, and the department's arrangements for evidence collection and verification of Medicare services, determining audit outcomes and finalising audits.

Introduction

3.1 Medicare compliance audits are a major component of the compliance activities undertaken by Human Services to provide assurance that Medicare payments are claimed appropriately. The purpose of compliance audits is to establish, by assessing and verifying evidence provided, whether Medicare benefits have been correctly claimed. Debts and penalties are required to be raised for cases assessed as non-compliant.

3.2 Medicare compliance audits are conducted through a series of interactions between a departmental compliance officer and the audited health professional via telephone, face-to-face interviews and/or written correspondence. Consistent and accurate audit processes and decisions, including adherence to key legislative and business procedures, are critical to the equity, integrity and intended effect of Medicare compliance audits, and a 'no surprises' approach to auditing. The ANAO reviewed the department's arrangements for conducting Medicare compliance audits, including the department's:

- operating environment for compliance activities;
- evidence collection and verification of MBS services;
- processes to determine an audit outcome (compliant or non-compliant), including managing identified non-compliance; and
- approach to finalising audits.

3.3 Further, to assist in establishing whether Human Services' compliance audits are conducted in accordance with key requirements, the ANAO performed a targeted case review of a sample of completed Medicare compliance audits. The ANAO's review included: a targeted and random

sample of ten cases from the IMCA Cryotherapy 2011–12 project⁷⁰; a random sample of ten cases from the IMCA Telehealth June 2012 Validation project; and a random sample of five cases from the pre-IMCA Interventional Radiology—Phase 1 (IR—Phase 1) project. An assessment of the accuracy of the audit decision was not made as part of the review.

Operating environment for Medicare compliance audit activities

Overview of the audit process

3.4 Once initiated, the key steps in the audit process generally involve the compliance officer identifying, via a letter to the health professional, that: an audit has commenced; the Medicare items that will be audited; and the evidence that is to be provided to substantiate that the service/s provided meet the criteria for the benefit claimed. Once the audit commences, the compliance officer assesses any evidence submitted by the health professional to determine compliance or non-compliance. Health professionals are to be notified in writing of the outcome of the audit, their review rights, as well as any debt that may be raised as a result of the audit outcome.⁷¹

Increased Medicare Compliance Audits initiative requirements

3.5 A number of supplementary elements to the formal audit process have been introduced as a consequence of the amendments to the *Health Insurance Act 1973* in April 2011. Legislative changes now provide Human Services with increased powers when undertaking compliance audits, enabling the department to:

- issue a written notice ('notice to produce') requiring a health professional to produce documents to substantiate services if there is 'reasonable concern' that a Medicare benefit has been paid that exceeds the amount that should have been paid;
- impose an administrative penalty where debts that total over \$2500 have been determined; and

70 The sample for the Cryotherapy 2011–12 project included a targeted sample of two audits which involved a penalty as part of the audit outcome.

71 The ANAO's targeted case review of Medicare compliance audits indicated that for the most part, key compliance audit processes were followed.

- provide health professionals with the opportunity to voluntarily acknowledge incorrect claiming and to seek a formal review of a decision to recover funds where non-compliance is identified.

Handling clinical information

3.6 In response to a 'notice to produce', a health professional may provide documents such as an extract or copy of clinical details of the patient which can include sensitive personal and health-related information. In light of the privacy considerations and other sensitivities surrounding the doctor-patient relationship, safeguards were incorporated into the amended legislation. Human Services is required to provide:

- at least 21 days for health professionals to provide documents in response to a 'notice to produce'; and
- the option for documents containing clinical details relating to individuals to be provided to a Human Services employee who is a medical practitioner (Medical Adviser).⁷²

Trial implementation of Increased Medicare Compliance Audits

3.7 Recognising the significant changes contained in the legislation, Human Services trialled parts of the IMCA initiative prior to a full transition to the new procedures. The department chose all 42 audits from the Cryotherapy 2011–12 project for the trial, as they included MBS items that were subject to the new legislation (services rendered on or after 9 April 2011). The new processes included in the trial were: the application of penalties; the review of decision components; voluntary acknowledgements; and the development of a specific health professional guideline.⁷³

3.8 Implementing a trial to assist in the transition to new processes reflects a sound approach. However, at the time of the trial the department had not yet implemented business processes to support the use of the 'notice to produce' and as such, the trial did not include this new element. The 'notice to produce' element was subsequently approved for use⁷⁴ and the department has advised

72 See subsections 129AAD(6) and 128AAD(8) of the *Health Insurance Act 1973*.

73 Human Services, Guideline: *Substantiating proof of malignancy where required for MBS items* [Internet], available from <<http://www.medicareaustralia.gov.au/provider/business/audits/files/8677-cryotherapy.pdf>> [accessed 30 August 2013].

74 The department implemented the business processes to support the use of the 'notice to produce' on 7 August 2013 and advised that as at October 2013, it had yet to exercise the new power.

that a process for monitoring the introduction of the new power has been agreed and will include a Post Implementation Review once a number of notices have been issued.

Compliance Teams

3.9 Well-organised and trained compliance staff can contribute to the success of a compliance program, including the consistent and accurate application of program requirements. A quality assurance framework can further contribute to the integrity and effectiveness of a compliance program, by testing business processes and their application by staff.

3.10 In December 2012, Human Services restructured its compliance operations area to establish General Compliance Teams (GCT) which combined two previously specialised compliance teams—desk/analysis and field.⁷⁵ The aim of the new structure was to create a more flexible and multi-skilled compliance workforce able to complete the end-to-end compliance treatment process. Achieving an end-to-end capability will be expected to provide operational efficiencies to the department's compliance function. Currently, there are three GCTs; they are regionally based with staff spread across seven of the states and territories, with 139.1 full time equivalent staff (as at 30 September 2013).

3.11 Following the implementation of the new GCT structure, Human Services identified that, while it was operating satisfactorily, there was still a need to:

- further improve processes and align work practices across teams and states in the interests of consistency; and
- address a range of skill gaps considered to be a risk to the overall success of the GCTs.

3.12 While a formal project management approach was proposed to drive the proposed business improvements, the department advised that it is instead proceeding to make enhancements to GCT operations as opportunities arise and where capacity exists, as part of ongoing business. The issue of staff capability is expected to be addressed largely through on-the-job training.

⁷⁵ In addition, a Serious Non-Compliance Unit was created to deal with serious fraudulent matters, and as such is out of scope for this audit.

Guidance and support

3.13 Human Services provides a range of guidance material and tools to support its compliance officers. Of particular importance is the User Reference Utility (URU) an internet based tool providing a single repository for processes, templates and additional resources for staff undertaking compliance activities. In addition to the URU, compliance audits conducted as part of projects are supported by additional guidance materials such as compliance strategies and activity treatment guides which provide background to the audit, and the approach for conducting audits. The department also has a dedicated information technology system—the Compliance Workload Management System (CWMS)—to manage the information collected at all stages of the audit process. Compliance officers are required to record in CWMS all contact made with health professionals, decisions reached and the outcomes of audits.⁷⁶

3.14 The URU also sets the standards by which the department's quality assurance (QA) area assesses the quality of compliance activities. Human Services has recently undertaken QA assessments of URU and CWMS usage and found that while staff have adapted well to using the systems, neither system is being fully utilised. The department advised that a combination of general education activities, Post Implementation Reviews and enhancements to the URU have all been identified as actions considered necessary to improve staff usage and application of URU business rules.

Quality assurance

3.15 In October 2012, Human Services' health compliance division introduced a revised approach to quality assurance, supported by a new quality assurance framework. The new framework was developed to provide more comprehensive coverage of all elements of the compliance business and to use a variety of business approaches including spot checks, full case reviews and peer reviews.

3.16 The objective of the new framework is to establish 'business as usual' practices for monitoring quality, while also providing options to respond to identified areas of need for quality assurance. The results from the quality assurance measures are reported biannually, with two reports completed in

76 Further, evidence collected for a compliance audit is to be scanned and stored electronically and linked directly to the audit case in CWMS.

2012–13 (refer paragraphs 4.46–4.47 for further discussion on quality assurance reporting).

Collecting evidence and verifying Medicare services

3.17 Once a Medicare compliance audit is allocated to a compliance officer, the officer generally commences verification of the service/s identified as part of the audit.⁷⁷ To verify each case, compliance officers are required to gather evidence in order to establish compliance or non-compliance. Methods used for collecting evidence can include:

- viewing facilities and equipment used to provide services;
- conducting telephone or face to face interviews; and
- requesting that health professionals provide documents including claim documents, reports, referrals and clinical notes.

Communicating to health professionals

3.18 To facilitate the collection of information and the effective conduct of the audit process, it is important that Human Services clearly and consistently communicates to health professionals their obligations as part of an audit. Human Services has developed communication templates and/other information to do so.

3.19 For instance, the department has developed templates for the different letters sent at various stages of a Medicare compliance audit, supported by project specific guidance to assist compliance officers complete the templates. Human Services also develops, in consultation with stakeholders, guidelines to assist health professionals understand the type of documents that can be used to substantiate services in an audit, and usefully provides a schedule outlining the MBS items claimed that are relevant to the specific Medicare compliance audit. Sent with the initial audit advice letter, the schedule is particularly important as compliance audits can often involve the assessment of multiple claims made by the one health professional⁷⁸ and require the audited health

⁷⁷ There are however a number of factors which can still lead to audit activity not proceeding at this late stage. For example, in the Telehealth project, one case was closed early as the health professional was on maternity leave.

⁷⁸ For the sample of ten Cryotherapy 2011–12 audits reviewed by the ANAO, health professionals were being audited for between 26 and 108 separate claims with an average of 44 services for each audit.

professional to provide evidence to substantiate each individual claim (refer Figure 3.1 for an example of a schedule).

Figure 3.1: Example of a schedule of services for the Cryotherapy 2011–12 project

Schedule of services: Cryotherapy / Serial Curettage services (MBS items 30196 to 30205)
Dr [Name of Health Professional subject to audit]
Provider stem: [XX]
Phone no. (XX) XXXX XXXX
Date range: 01 November 2010 to 31 October 2011

Item descriptors - Medicare Benefits Schedule 1 November 2010 - for further information please see Explanatory Notes T8.11

MBS Item 30196 - MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.)

MBS Item 30197 - MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 OR MORE LESIONS) (Anaes.)

MBS Item 30202 - MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies

MBS Item 30203 - MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS)

MBS Item 30205 - MALIGNANT NEOPLASM OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE THE MALIGNANT NEOPLASM EXTENDS INTO CARTILAGE (Anaes.)

Patient Surname	Patient First Name	Patient DOB	Medicare Card Number	Date of service	Item Number Claimed	Item Benefit Claimed	Proof of malignancy? YES/NO	Type of proof returned (Histology or specialist opinion)	Practitioner comments

Source: ANAO edited version of a Human Services compliance audit document.

Note: A new line is completed for each claim. All identifying data has been removed from this example.

3.20 The ANAO’s review of a sample of audits identified a number of shortcomings in the department’s communication to health professionals. While audit advice letters sent to health professionals involved in the Cryotherapy 2011–12 and Telehealth compliance audits provided general directions to the guidelines available on the department’s website, they did not advise which guidelines were directly relevant to the auditees. Considering that as at March 2014 there were 19 guidelines listed on Human Services’ website, informing busy health professionals of the relevant guideline/s in the audit advice letter would improve the communications process by providing ready access to important information. During the course of the audit, the

department advised that its communication to stakeholders has been amended accordingly for an upcoming compliance project.

3.21 Further, the Telehealth 'initial audit advice letter' did not clearly or meaningfully identify the reason for the audit. This was due to the Activity Treatment Guide for the Telehealth project not including sufficient information to support the completion of this letter template. Human Services has advised that all Activity Treatment Guides will now be amended to provide greater clarity on the reason for the audit.

Sending and storing sensitive information

3.22 As part of evidence gathering for an audit, Human Services compliance officers can be required to send and store sensitive information. Respecting the integrity and privacy of the doctor-patient relationship is recognised as essential to good medical practice and there are various legislative obligations governing the use of information collected for the Medicare program, including: specific requirements in the *Health Insurance Act 1973* and the *National Health Act 1953*⁷⁹; and general requirements set out in the Information Privacy Principles (IPP) under the *Privacy Act 1988*.⁸⁰

3.23 Human Services has developed guidance documents to support compliance officers managing sensitive information in the course of a compliance audit and has advised that privacy training is an element of the orientation course provided to new compliance officers. However, the training does not provide, for the benefit of staff, explanations of the specific processes compliance officers are to use to collect and store sensitive compliance audit information. Compliance officers interviewed by the ANAO exhibited different understandings of the requirements relating to the storage of sensitive documents for Medicare compliance audits. A key discrepancy in officers'

79 Section 130 of the *Health Insurance Act 1973* and s. 135A of the *National Health Act 1953* prohibit officers disclosing information about a person except in the performance of their duties. Human Services is also required to comply with the *Privacy Guidelines for Medicare Benefits and Pharmaceutical Benefits Programs* issued by the Privacy Commissioner. The guidelines introduce standards additional to the IPPs to regulate the way agencies link and store claims information obtained under programs such as Medicare.

80 The *Privacy Amendment (Enhancing Privacy Protection) Act 2012* was passed by the Australian Parliament on 29 November 2012 and includes a set of new, harmonised, privacy principles that will regulate the handling of personal information by both Australian government agencies and businesses. These new principles are called the Australian Privacy Principles, which replaced the IPPs on 12 March 2014.

See the Office of the Australian Information Commissioner's website <<http://www.oaic.gov.au/privacy/privacy-act/australian-privacy-principles>> [accessed 26 March 2014].

understanding was whether clinical notes were to be stored electronically and/or whether clinical details were required to be censored.

3.24 In October 2013, in the course of the audit, Human Services issued instructions to all GCT staff that: clinical records received as part of a compliance audit should be stored electronically in Human Services' document management system (TRIM); and information stored electronically is accessible only on a 'need to know basis' and is therefore considered by Human Services as 'secure' as information stored in hardcopy. Additionally, the department advised that it is considering the implications of forthcoming amendments to privacy legislation and its impact on the department's compliance work. As part of this process and in view of the instructions recently issued, there is scope for the department to review existing policies and tailor current guidance to staff to promote greater certainty and consistency in its management of sensitive information collected for Medicare compliance operations.

Determining the audit outcome and managing non-compliance

Assessing evidence

3.25 Compliance officers are required to assess evidence provided by health professionals to determine whether or not claim requirements have been met for each item in an audit schedule, and to establish whether or not the claim is substantiated. The types of evidence needed to substantiate claims can vary across projects. Accordingly, Human Services provides more specific guidance and advice for audits conducted under individual projects. For instance, staff guidance for the Cryotherapy 2011–12 project provided explanations of the types of evidence needed to substantiate claims, including:

- types of documents that could show proof of malignancy;
- medical terms and abbreviations that do and do not indicate malignancy; and
- types of information that would demonstrate a specialist medical practitioner's confirmation of malignancy.

3.26 Compliance officers are also able to consult with in-house Medical Advisers to assist with understanding the context of clinical terms used by a health professional.

Addressing non-compliance

3.27 If one or more items claimed are found to be unsubstantiated, the overall finding of an audit is that there has been non-compliant claiming (or billing) by the audited health professional. The department's guidance outlines that a debt is to be raised in cases where a health professional's claim is found to be non-compliant.⁸¹ Compliance officers calculate and inform health professionals of debts resulting from non-compliance, including any administrative penalties that may be applied as a result of the debt.

Identifying and calculating debts

3.28 In the Cryotherapy 2011–12 audits reviewed by the ANAO, some health professionals identified an alternative Medicare item that they considered they should have claimed, in lieu of the item they had incorrectly claimed. The department's operational practice for some Cryotherapy 2011–12 project audits involved crediting the value of the alternative item against the value of the incorrect item. This approach either resulted in a reduction in the recoverable amount for that MBS item, or a recoverable amount that was negative. Table 3.1 shows two examples of how different alternative item numbers were provided to replace the same original item claimed and the different recoverable amount outcomes.

Table 3.1: Examples of how different alternative item numbers can affect a recoverable amount

Example Patients	Item Number Claimed	Item Benefit Claimed	Alternative Item Number	Value of Alternative Benefit	Recoverable Amount
Patient X	Item A	\$39.55	Item B	\$32.35	\$7.20
Patient Y	Item A	\$39.55	Item C	\$51.95	-\$12.40

Source: ANAO analysis of decision making schedules used for Cryotherapy 2011–12 audits.

Note: Patients and item numbers have been de-identified.

3.29 In relation to the treatment of alternative items, the ANAO's review of a sample of 10 Cryotherapy 2011–12 audits found inconsistencies in

⁸¹ Human Services guidance identifies that the department has a legal obligation under s. 47 of the *Financial Management and Accountability Act 1997* to pursue the recovery of debts to the Commonwealth.

compliance officers' calculation of debts. Where alternative MBS item numbers were provided, there were:

- three cases where no evidence was provided to support the alternative items. In each of these cases, all of the alternative items were accepted and used to offset the debt calculation; and
- two cases where health professionals did provide documents to substantiate the alternative items. The documents were assessed against claim requirements of the alternative items provided; however, not all of the alternative MBS items were accepted.

3.30 The results of the ANAO's review indicate shortcomings in the department's guidance for debt calculation and more broadly, the department's debt calculation policy for compliance audits.

3.31 Concerns have previously been raised within Human Services regarding the accuracy of the calculation of debt amounts. The department is aware of inconsistent approaches in debt calculation involving alternative MBS items and as far back as May 2012, the department identified inconsistencies in debt calculations involving complex MBS rules.

3.32 While MBS billing arrangements can be complex, calculating debts is a regular feature of Human Services' administration where health professionals are found to have incorrectly claimed or billed MBS items. It is therefore reasonable to expect well established policies and procedures to be in place. However, only an interim staffing instruction was in place as at August 2013 as Human Services was in the process of seeking legal advice to address longstanding yet still unresolved issues related to compliance debt calculations. Early finalisation and implementation of its debt calculation policy, supported by up-to-date guidance to staff would promote consistency in debt calculations and ensure equity in the department's treatment of non-compliant health professionals.

Calculating Penalties

3.33 Since the introduction of the recent *Health Insurance Act 1973* amendments, Human Services has the power to apply an administrative penalty to health professionals who have been unable to substantiate their claims. The legislation provides for the circumstances in which a health professional may incur a penalty and the size of the penalty applied (refer to Appendix 2 for a summary of the penalty system).

3.34 To support compliance officers with the calculation of penalties, Human Services has developed a penalty calculator. The ANAO reviewed the two cases that had resulted in administrative penalties as part of the Cryotherapy 2011–12 case review and found that in one of the cases, a small arithmetical error was made when summing the total value of the penalty. Departmental staff interviewed by the ANAO commented that it is largely at the discretion of the compliance officer and the team leader to decide the extent of quality checks to be undertaken during the audit process. The department informed the ANAO that work is underway to identify key points during the compliance process for team leaders to undertake quality checks.⁸²

Finalising audits

3.35 Health professionals are informed in writing of the outcome of an audit. If compliance issues have not been identified in an audit, auditees are notified in writing that no concerns were identified and that the matter has been finalised.

3.36 Under the IMCA process, where non-compliance is identified, a three-step process is used to communicate non-compliance to the health professional. This process allows health professionals two opportunities to identify any concerns with the decision prior to the final debt being determined; and includes the opportunity for a health professional to request a formal review of a decision to recover funds where non-compliance is identified.

3.37 Human Services reports internally on the status of compliance review cases. Between 1 February 2012 and 30 June 2013, Human Services reported completing 22 administrative reviews and one IMCA initiative review.⁸³ Of the 22 administrative reviews, 55 per cent were confirmed, 41 per cent were varied (primarily as additional information was supplied) and 5 per cent were revoked.⁸⁴ As at October 2013, the result of the sole IMCA initiative review completed was a reduction in the debt amount by \$165 (a 0.03 per cent decrease from the original recovery amount). The department noted this change was due to an arithmetic error on the original audit recovery schedule.

82 The complexity of rules underpinning the MBS presents an ongoing challenge to the quality and consistency of decision making during the audit process.

83 The department's reports refer to reviews of audits that have not been conducted under IMCA legislation as 'administrative reviews'.

84 Please note percentages add to 101 due to rounding.

Recording audit decisions

3.38 Human Services has a dedicated information technology system, CWMS, to manage the information collected at all stages of the audit process.

3.39 The ANAO's case review identified aspects of sound record-keeping practices including: written correspondence between Human Services and health professionals, which was stored electronically as part of the audit record; and the retention, as part of the audit record, of a description of the key steps followed during the audit. However, in the sample of audit cases reviewed, the ANAO did not find examples of a report being produced which identified how the information collected justified the decisions reached; a requirement identified in the URU. If these reports were well maintained they would provide a single record of audit decisions that is readily available.

3.40 Audit decisions entered in CWMS are used to inform Human Services' reporting of compliance activity results. The ANAO's review of CWMS data used to report on the non-compliance case rate (for Medicare compliance audits completed between March 2013 and 30 June 2013)⁸⁵ identified potential data anomalies in 78 (22 per cent) of 359 Medicare compliance audits within the data subset. The department advised that of the 78 potential data anomalies identified by the ANAO, 45 entries were incorrect and of those, 33 (nine per cent of the 359 completed MBS audits) resulted in compliant claims being incorrectly recorded as non-compliant. These data anomalies inflated the non-compliance case rate, which is an internal performance indicator⁸⁶ tracked and reported monthly by Human Services to key stakeholders such as the Department of Health. Human Services has advised that the errors identified will be discussed with staff and further training will be offered if required.

3.41 Issues relating to the quality of data in CWMS have also been identified by Human Services as a result of QA activities and Post Implementation Reviews. The department advised that it has taken some initial steps to

85 The time period March 2013 to 30 June 2013 was chosen for analysis because of an operational directive given by Human Services in February 2013 that limited the circumstances in which a particular data category could be selected to record an audit decision outcome. Further, in line with the scope of the audit, the dataset analysed only included general compliance audit cases relating to MBS claims (excluding other Medicare activities such as targeted letters and activities related to the Chronic Disease Dental Scheme, potential fraud and inappropriate practice).

86 The internal performance indicator for the non-compliance case rate is 'no less than 41 per cent'. See Chapter 4, paragraphs 4.30–4.34 for a discussion on the non-compliance case rate.

identify key quality controls to improve data quality. Given the implications of incorrect data entry for the accuracy of Medicare compliance program reporting, and the department's ability to assess the effectiveness of the compliance program, the department should continue to focus on the remediation of data quality issues.

Conclusion

3.42 Human Services undertakes compliance audits to provide assurance that Medicare payments are claimed appropriately. Since April 2011, Human Services has developed and implemented new internal policies, procedures and, staff training as well as guidance materials for health professionals to support the introduction of the IMCA initiative and the exercise of its new legislative powers. During December 2012, the department implemented a restructure of its compliance operational areas which combined two previously specialised teams into General Compliance Teams (GCTs), and started a process to cross-skill staff across the compliance team for end-to-end capability.

3.43 Appropriate handling of sensitive information by departmental staff is particularly important in the context of the department's ability, under IMCA, to request health professionals to produce documents (which may contain patient clinical details) to substantiate a Medicare Benefits Schedule (MBS) claim. Human Services has developed guidance to support the management of sensitive information during Medicare compliance audits and has advised that privacy training is provided to new compliance staff. However, compliance officers interviewed during the audit indicated different understandings of the requirements for storage of sensitive information, including documents of a clinical nature. In the context of an evolving framework under the *Privacy Act 1988*, there is an opportunity for the department to review existing policies and as necessary, tailor its guidance to further promote consistency in its management of sensitive information for Medicare compliance activities.

3.44 Where health professionals have been identified as non-compliant with the MBS requirements, Human Services must calculate the total debt for incorrect claiming. The ANAO's review of a sample of Cryotherapy audits identified different approaches to calculating debts. Human Services has also identified wider inconsistencies in the approach taken by staff to calculate debts. Calculating debts is a regular feature of Human Services' compliance audit process and it is therefore reasonable to expect well-established policies

and procedures to be in place. However, only an interim staffing instruction was in place as at August 2013 as the department was in the process of seeking legal advice to address unresolved issues relating to debt calculations. Early completion of its debt calculation policy, supported by up-to-date procedures to staff would promote consistency in debt calculations and ensure equity in the department's treatment of non-compliant health professionals.

3.45 Medicare compliance audit results are recorded in Human Services' Compliance Workload Management System (CWMS), with information from this system used for internal and external compliance reporting. Recording anomalies were identified in a data sample of Medicare compliance audits reviewed by the ANAO. Of the 359 Medicare audits completed between March 2013 and June 2013, 33 (nine per cent) were incorrectly recorded as non-compliant instead of compliant. There would be value in the department strengthening its system based controls to improve data quality and the accuracy of its Medicare compliance reporting.

4. Measuring and Reporting on Medicare Compliance Outcomes

This chapter examines Human Services' arrangements to measure and report on compliance outcomes, including for savings achieved against the Increased Medicare Compliance Audits initiative. The chapter also reviews the department's broader reporting for Medicare compliance audits.

Introduction

4.1 Human Services employs a range of compliance actions to improve the integrity of Medicare billing.⁸⁷ The 2008–09 Federal Budget's Increased Medicare Compliance Audits initiative (IMCA initiative) enhanced Human Service's capacity to deliver one of its compliance activities, Medicare compliance audits. The IMCA initiative provided funding to increase the number of completed audits targeting health professionals each year from 500 to 2500; and expanded the department's audit powers under the *Health Insurance Act 1973*. In the context of Human Services' enhanced compliance audit program, the IMCA initiative was expected to return an estimated \$147.2 million in savings.

4.2 Establishing effective arrangements to capture and monitor achievements provides a sound basis for assessing and reporting on the performance of a government program or initiative. This chapter examines Human Services' implementation and management of the IMCA initiative, with a focus on the department's performance against the budget measure's expected outcomes. The department's broader arrangements to measure and report on the outcomes of Medicare compliance audits are also reviewed.

4.3 The ANAO examined Human Services':

- performance against the agreed IMCA initiative targets (savings achieved and the number of compliance audits performed); and
- performance measures and reporting (for both internal and external purposes) for Medicare compliance audits and activities.

87 Refer to Chapter 1, paragraph 1.8 for further details on these Medicare compliance activities.

Performance against the IMCA targets

IMCA targets

4.4 The IMCA initiative was introduced in the 2008–09 Budget to deliver the following outcome:

This measure will provide savings of \$147.2 million over four years and will cost \$76.9 million to administer, leading to net savings of \$70.3 million over four years.⁸⁸

4.5 The IMCA initiative incorporated two performance targets: an increased number of Medicare compliance audits conducted in relation to health professionals (an additional 2000 per annum, or 8000 over four years)⁸⁹; and net savings of \$70.3 million to the MBS over four years (2008–09 to 2011–12).

Allocation of funding to administer IMCA

4.6 The Budget measure provided Human Services⁹⁰ with \$76.9 million to administer IMCA and achieve the expected targets. Table 4.1 provides a breakdown by financial year of the funding provided to Human Services and expected savings (both gross and net) for the MBS.

88 As discussed in Chapter 1, the initiative was introduced in the 2008–09 budget. See Australian Government, 'Responsible Economic Management—Medicare Benefits Schedule—increase compliance audits', op. cit.

89 Australian Government, *Portfolio Budget Statements 2008–09*, 'Outcome 3—Access to Medical Services', Health and Ageing Portfolio, p. 83.

90 The budget measure was originally administered by Medicare Australia, which was subsequently integrated into the Department of Human Services on 1 July 2011. All subsequent references in this chapter are to Human Services.

Table 4.1: Human Services funding and expected net savings for the MBS from the IMCA initiative

	2008–09 (\$m)	2009–10 (\$m)	2010–11 (\$m)	2011–12 (\$m)	Total (\$m)
Human Services funding	20.4	18.7	18.8	19.0	76.9
Expected gross savings to the MBS	-21.2	-42.2	-41.5	-42.4	-147.2
Expected net savings to the MBS ⁹¹	-0.8	-23.5	-22.7	-23.3	-70.3

Source: Australian Government, *Budget Measures, Budget Paper No. 2 2008–09*, 'Responsible Economic Management—Medicare Benefits Schedule—increase compliance audits', p. 404.

Note: The funding figure for 2008–09 includes \$6.2 million in capital related expenditure.

4.7 Human Services advised the ANAO in January 2014 that the specific components for the \$76.9 million in additional funding included:

- around 70% of the ongoing staffing funding used for staff undertaking the increased number of audits...
- approximately \$1 million non-salary costs for the maintenance of the case management system and postage
- funds allocated to project management, information technology, legal advice, debt management and communication
- funds allocated for corporate overheads such as superannuation, long service leave, Comcare and 3% admin[istration] per employee
- capital expenditure to procure a new case management system (\$4.2 million) and enhance the electronic communication channel used by health professionals (\$2 million).

Reporting on the IMCA savings target

4.8 The IMCA initiative formed part of the 2008–09 Health Portfolio Budget Submission, prepared by the then Department of Health and Ageing. Co-ordination comments in support of the new policy proposal were provided

91 The Budget submission did not contain detailed modelling relating to the basis for the estimated savings.

by Human Services, which noted the importance of closely monitoring the measure to ensure that the savings ratio was achieved. As part of the Budget process, the Government tasked responsible Ministers⁹² to:

- agree on performance information to be used by Human Services to monitor the success of the measure; and
- report back to the Expenditure Review Committee (ERC) of Cabinet in 2011–12 on the success of the measure; a prudent approach given the size of the Government’s investment and the level of savings anticipated.

4.9 Further, the new policy proposal indicated that the effect of the new measure would be monitored on an ongoing basis and reported on every three months.

4.10 In 2009–10, the Government noted Human Services’ proposal for a methodology to monitor savings for the IMCA initiative. Human Services proposed to analyse and compare changes to health professionals’ MBS claiming patterns prior to and following a Medicare compliance audit. The methodology proposal also suggested indicators of effectiveness, including: changes in the claiming rates of MBS items/areas of the MBS being targeted; the number of health professionals audited; and the value of penalties applied.

4.11 In the event, the department did not develop or implement its proposal to monitor savings, nor did it establish any systems or processes that would enable it to capture and report specifically against the IMCA savings target. Further, there was no follow-up by Human Services to the ERC’s request that Ministers report back to government in 2011–12.

Capacity of established systems to report on savings

4.12 Developing suitable monitoring and reporting arrangements to demonstrate the outcomes achieved by savings measures is sound practice, and such arrangements operate most effectively when embedded within agencies’ business-as-usual processes. Human Services advised the ANAO that in the absence of a mechanism to report specifically against the IMCA savings target, its established systems only allow for the following, more general, reporting:

92 The relevant Ministers were the then Minister for Health and Ageing and the Minister for Human Services. The then Minister for Finance and Deregulation was also asked to agree the performance information element of the initiative.

- cost figures based on the total costs for the Health Compliance Division as a whole and staff conducting compliance activities, but not limited to MBS; and
- savings figures limited to the value of total debts raised through all MBS compliance activities, not just Medicare compliance audits on health professionals. The debts raised figures that are captured and publicly reported therefore include MBS compliance cases conducted on members of the public, as well as criminal and fraud investigations.

4.13 Table 4.2 summarises Human Services' information on the overall cost of administering Medicare compliance and the value of debts raised as a result of all Medicare compliance activities from 2008–09, drawing on publicly available reporting and departmental documents.

Table 4.2: Debts raised and the cost of administering Medicare compliance as reported by Human Services

FY	Cost (\$m)	Savings	
		Number of debts raised	Value of debts raised (\$m)
2008–09 ^A	Not reported	719	4.5
2009–10	Not reported	497	8
2010–11	Not reported	331	^C 25.9
2011–12	41.1	428	8.6
2012–13	40.8	639	3.8
Total	^B >81.9	2614	50.8

Source: Medicare Australia and Human Services Annual Reports 2008–09 to 2012–13 and internal Human Services documents.

Note: ^A Human Services implemented the increased program of Medicare compliance audits from January 2009.

^B Human Services does not publicly report on the cost of administering Medicare compliance.

^C Human Services advised that in 2010–11, 32 Chronic Disease Dental Scheme audits were closed with \$19.9 million in debts identified.

4.14 In summary, the information made available by Human Services does not directly report on the department's performance against the financial return expected from the \$76.9 million in additional funding, which was provided to the department to administer the IMCA initiative. Further, while the value of debts raised is reported publicly there is no reporting on the quantum of monies actually recovered as a result of the department's Medicare Compliance Program. As a consequence, it is not possible to use 'monies

recovered' as an indicator of the level of savings achieved by the Compliance Program, as not all debts raised are actually recovered.⁹³

4.15 In response to the ANAO's inquiries regarding the department's performance against the IMCA initiative's expected savings, Human Services undertook some analysis⁹⁴ and provided the ANAO with the value of debts raised and recovered that were largely a result of Medicare compliance audits completed since the initiative was introduced⁹⁵ (refer Table 4.3).

Table 4.3: Debts and recoveries from Medicare compliance activities conducted from 2008–09 to 2012–13

FY	Number of debts raised	Savings ^A	
		Value of debts raised (\$m)	Recoveries ^B (\$m)
2008–09	635	4.0	^C Not available
2009–10	472	7.8	6.8
2010–11	306	25.7	5.0
2011–12	402	8.2	4.7
2012–13	590	3.5	2.4
Totals	2405	49.2	^D 18.9

Source: Human Services data, provided to the ANAO 28 January 2014.

Notes: ^A The department advised that the number and value of debts raised, and the recoveries figures provided excludes Medicare compliance cases conducted on members of the public but may still include criminal or fraud investigation cases and so differ from the figures presented in Table 4.2. Further, the department advised that the recoveries data may also contain monies recovered from cases that were completed prior to the introduction of the IMCA initiative.

^B The department advised it is able to enter into a plan for repayment of debts, particularly those of large value and as a result there is no direct correlation between debts raised and recovered in the same financial year.

^C The department advised that the recoveries information for 2008–09 is not available.

^D The department advised that while a higher number of debts were raised in 2012–13, larger value cases, such as those related to the Chronic Disease Dental Scheme (CDDS), had been withheld for action (including the approval by the then Special Minister of State or his delegate to waiver debts totaling \$12 million for 39 dental practitioners) over a significant period of time, therefore affecting the results for 2012–13. As at January 2014, the department advised that there are 550 CDDS cases yet to be completed, with significant debt value attached.

93 A limitation in using 'debts raised' as an indicator for 'savings', is that 'savings' from identified debts are only realised once the debts have been recovered and returned to government.

94 The analysis performed by the department included manual reconciliation of data between two separate systems.

95 As noted in Table 4.2 Note^A the increase in audit activity commenced in January 2009. Further, as outlined in Table 4.3 Note^A, the data provided by the department does not fully align with the parameters of the IMCA initiative as it is not limited to Medicare compliance audits conducted on health professionals, nor the population of 2000 additional audits per annum.

4.16 As shown in Table 4.3, the department raised a total of \$49.2 million in debts between 2008–09 and 2012–13 and recovered \$18.9 million over the same period, from all Medicare compliance audits conducted, compared to the expected savings of \$147.2 million from the IMCA initiative alone. This represents a significant shortfall of \$128.3 million, or 87 per cent less than the \$147.2 million in savings expected through IMCA. Even if all the debts raised (\$49.2 million) were in fact recovered, the result would be a shortfall of \$98 million or 66 per cent less than the expected savings.

4.17 Overall, the available Human Services data shows a significant shortfall in the savings achieved by the department when compared to the results expected from the IMCA initiative. From the limited performance information available, the ANAO's analysis indicates that since the introduction of the measure, the compliance audits performed by the department, including those conducted under the department's enhanced legislative powers, were delivered at a net cost to government. While acknowledging the range of objectives in the department's Compliance Program that are in addition to achieving savings—such as reinforcing health professionals' awareness of their compliance obligations—the development of monitoring arrangements, as originally planned, would have enabled Human Services to track and assess the effectiveness of the Australian Government's \$76.9 million investment in the IMCA initiative.

IMCA performance target—completed audits and reviews

4.18 As discussed, the 2008–09 Budget measure provided additional resources of \$76.9 million for Human Services to deliver a five-fold increase in the number of Medicare compliance audits of health professionals; extending audit coverage from 0.7 per cent to 4 per cent of health professionals claiming Medicare.⁹⁶ From January 2009, the department committed to complete 2500 compliance audits annually, an increase of 2000 audits.⁹⁷ The key performance indicator (KPI) and target adopted by Human Services—2500 completed Medicare audit and review cases per annum—were first included in the

96 N Roxon, (Minister for Health and Ageing) and J Ludwig, (Minister for Human Services), 'Ensuring The Integrity of Medicare: Increased MBS Compliance Audits', media release, 13 May 2008.

97 The department's revised target comprised the existing annual output of 500 Medicare audits and reviews plus an additional 2000 annual Medicare audits on health professionals.

department's 2012–13 Portfolio Budget Statements, four years after the initiative was introduced⁹⁸ (refer Table 4.4).

Table 4.4: Portfolio Budget Statements information related to Medicare compliance audits

Program 1.1 Objective	Deliverables	Key performance indicator	Target
Individuals, families and communities are supported to achieve greater self-sufficiency	Providing access to health payments and services on behalf of government. The department provides access through service centres (including one-stop-shop co-located offices) located across Australia; online services; call centres; and systems that support the delivery of services by providers and business	Achievement of payment integrity standards— Medicare: Completed audit and review cases ⁹⁹	2500

Source: *Portfolio Budget Statements 2013–14: Department of Human Services*, pp. 28–33.

4.19 While the 2500 target was only recently introduced to the Portfolio Budget Statements, the department has reported annually on the number of completed Medicare audit and review cases since the initiative was introduced in 2008–09.

Compliance activities included in the IMCA performance target

4.20 Funding under the budget measure was provided specifically to increase the number of annual Medicare compliance audits targeting health professionals from 500 to 2500. However, since 2011–12 the department has changed the mix of compliance activities included in its reporting against the 2500 target. In 2011–12 Human Services included Medicare compliance activities directed towards members of the public (Medicare public cases), and

98 Human Services advised that as a result of the scale of services and programs the department delivers and manages not all of the department's performance indicators are selected for inclusion in the Portfolio Budget Statements.

99 Human Services conducts Medicare compliance reviews under the Practitioner Review Program.

during 2012–13¹⁰⁰, the department added ‘targeted feedback letters’—a less time and resource intensive activity than compliance audits.¹⁰¹

4.21 The new policy proposal’s scope did not extend to ‘targeted feedback letters’ or any other type of Medicare compliance activity that was not a compliance audit. In this context and notwithstanding that ‘targeted feedback letters’ are one of a suite of useful treatment activities Human Services can perform, the department did not inform their Minister of the proposal to expand the types of compliance activities it could conduct under the Budget measure. Instead, the decision¹⁰² was made internally by the Compliance Sub-Committee¹⁰³ in February 2013.

Performance against the completed audits and reviews target

4.22 ANAO analysis shows that between 2009–10 and 2012–13 Human Services achieved the 2500 target¹⁰⁴ once—in 2011–12, when 2549 Medicare audit and review cases were completed (refer Table 4.5).¹⁰⁵

100 Human Services included Medicare public cases in its 2011–12 internal reporting against the target and in 2012–13 also included Medicare public cases in its public reporting.

101 ‘Targeted feedback letters’ are developed using a template enabling Human Services to distribute these letters across a large population of health professionals where a risk appears to be widespread and in circumstances where no specific non-compliance has been identified, yet may be suspected. The primary purpose of the department’s ‘targeted feedback letters’ to health professionals is to promote voluntary acknowledgement of incorrect claiming.

102 The Minutes from the Compliance Sub-Committee meeting, 27 February 2013, stated that ‘Members agreed to the recommendation of the paper that 20% of MBS audits could consist of targeted feedback letters’. As a result of the committee’s decision, from 2012–13 onwards, targeted feedback letters could contribute up to 20 per cent (500 of the 2500 audits and reviews) of the 2500 completed Medicare audit and review cases.

103 As outlined in Chapter 1, Table 1.1, the Compliance Sub-Committee provides a forum for discussion between Human Services and DoH on program integrity and compliance issues, and provides governance and direction on those issues within the Human Services portfolio. It should be noted that the committee tasked the responsible area in Human Services to look ‘into the original NPP requirements of compliance coverage to ascertain the scope of the original coverage requirements, in order to determine that Human Services is not inadvertently claiming coverage of items that were in fact out of scope’.

104 As discussed above, the mix of activities included in the target by Human Services changed over time.

105 Human Services advised that throughout 2009–10 the department was developing its capability to identify sufficient case work to meet the newly established target, including to address more complex compliance issues.

Table 4.5: Human Services' reporting of completed Medicare compliance activities 2009–10 to 2012–13

	2009–10		2010–11		2011–12		2012–13	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Medicare audits and reviews	2365	100	^A 2179	100	2549	93	2073	73
Medicare public cases ^B	Not reported		Not reported		189	7	246	9
Targeted feedback letters	Not included		Not included		Not included		^C 500	18
Total Medicare audit, review and compliance cases	2365		2179		2738		2819	
Achievement against target 2500 completed audit and review cases	Not met 2365 completed		Not Met 2179 completed		Met 2549 completed		Not met 2073 completed	

Source: ANAO analysis of Medicare Australia and Human Services annual reports 2009–10 to 2012–13 and Human Services Compliance Summary Reports June 2012 and June 2013.

Notes: ^A The *Department of Human Services Annual Report 2010–11* states that: 'The decrease in the number of completed MBS compliance audits and review cases between 2009–10 and 2010–11 was due primarily to the movement of resources to undertake audits on the Chronic Disease Dental Scheme...'

^B Prior to 2011–12, Human Services was unable to report Medicare public cases separately.

^C For 2012–13, the targeted feedback letters included towards the final KPI result were the first 500 completed in the financial year.

4.23 As Table 4.5 shows, the department's change to the mix of compliance activities reported as part of the target has resulted in inaccurate reporting against the IMCA performance indicator of 2500 completed Medicare audits and reviews. Despite the department reporting in 2012–13 that it met the target and completed a total of 2819 Medicare compliance audits and reviews, the ANAO's analysis shows that the department only performed a total of 2073 Medicare compliance audits and reviews. Further, since the department added Medicare public cases and 'targeted feedback letters' to its mix for performance reporting, the number of Medicare compliance audits and reviews performed by Human Services—as a proportion of total Medicare compliance activities—has decreased by 20 per cent, from 2549 or 93 per cent in 2011–12 to 2073 or 73 per cent in 2012–13 (also refer Table 4.5).

4.24 In summary, there have been shortcomings in the implementation of the IMCA initiative and limited transparency regarding its performance as the department was unable to fulfil its reporting obligations to government and provide definitive results for the outcomes achieved from IMCA. As discussed, Human Services did not implement the proposed methodology to assess and report on savings, notwithstanding a government expectation that it would do so, and the mix of compliance activities funded under the IMCA initiative was expanded to include less onerous activities, without advice to the responsible Minister.

4.25 Effective monitoring of performance enables an agency to report to government and stakeholders on the achievement of anticipated benefits, including any projected savings. Human Services' management of the IMCA initiative shows that the department should improve reporting of outcomes by developing suitable monitoring and reporting arrangements to demonstrate the benefits realised from administering Medicare compliance audits so that departmental resources are properly targeted.

Recommendation No.2

4.26 To more effectively target resources, the ANAO recommends that Human Services develop a methodology to monitor outcomes and report on the effectiveness of Medicare compliance audits, including anticipated benefits, in the context of the broader Compliance Program.

Human Services' response:

4.27 *Agreed. Since the audit has been finalised, the department has formulated a formal savings framework which will enable the estimation of savings for Medicare Benefits Schedule audits by referencing robust and defensible methodologies.*

4.28 Human Services advised that to help maintain the integrity of MBS payments, the department undertakes a range of compliance activities that focus on prevention and early intervention that can, if effective, inform and change claiming behaviours of targeted groups of health professionals. These prevention activities can deliver a range of compliance outcomes, including in

the form of potential ‘savings’ from incorrect claims that have been avoided or acknowledged voluntarily by health professionals.¹⁰⁶

Measuring and reporting on Medicare compliance activities

Internal performance indicators

4.29 In addition to the publicly reported KPI discussed above, Human Services has a number of internal performance indicators and corresponding targets that cover stakeholder feedback on compliance officers’ professionalism and the non-compliance rate (refer Table 4.6 for the targets to be achieved and results for 2012–13). The department internally tracks and reports results against both targets in its monthly Compliance Summary Reports.¹⁰⁷

Table 4.6: Internal performance indicators

Indicator	Target	Results 2012–13
Professionalism Survey results	≥ 83% of respondents strongly agree/agree to the survey questions	82%
MBS non-compliance case rate	No less than 41% of cases are assessed as non-compliant	44%

Source: Human Services Compliance Summary Reports.

MBS non-compliance case rate

4.30 As shown in Table 4.6, the department met the MBS non-compliance case rate target in 2012–13. However, recent expert feedback to Human Services indicated that the audit non-compliance rate is an ‘ambiguous measure’ and cannot be ‘meaningfully interpreted unless the real underlying non-compliance rate is also measured’.¹⁰⁸ High rates of non-compliance against the current performance indicator could therefore indicate effective targeting of compliance activities, or conversely, extensive non-compliance. Human

¹⁰⁶ However, as with Medicare compliance audits, the department cannot capture these potential ‘savings’ as the capacity of its established systems do not enable it to consistently track ‘savings’ across the full suite of MBS compliance activities.

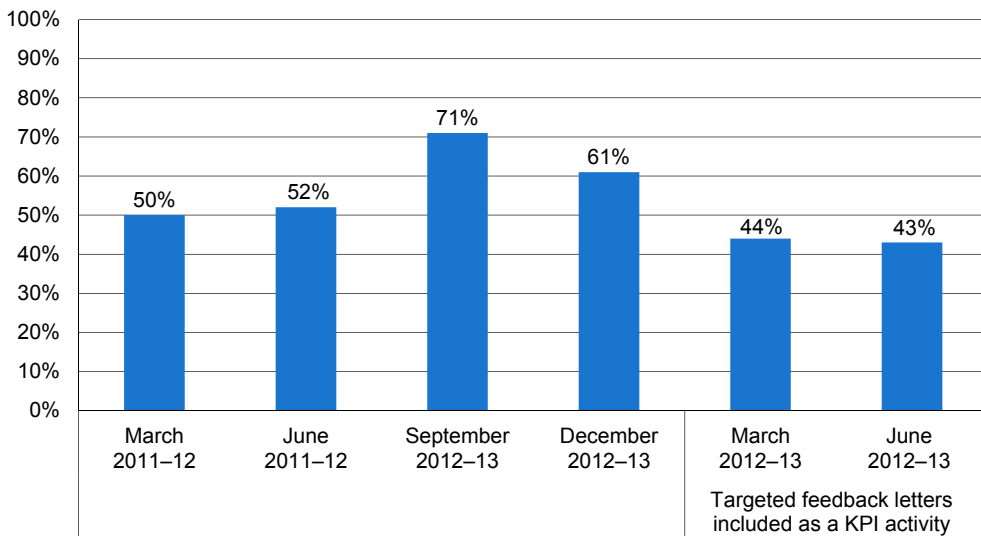
¹⁰⁷ Results for the Professionalism Survey are reported quarterly in the Compliance Summary Reports, while the MBS non-compliance case rate is reported monthly. Human Services also publishes the Professionalism Survey results in its annual reports.

¹⁰⁸ In March 2013, Harvard University’s Professor Sparrow presented expert advice to Human Services regarding the environment in which the department’s compliance function operates.

Services advised that the non-compliance rate was ‘developed on the basis of historical data’ and has not been reviewed since it was established in 2011.

4.31 Recently, there has been a significant decrease in the reported MBS non-compliance rate. Figure 4.1 shows a 28 per cent decrease in the non-compliance rate from the first quarter (September 2012) to the last quarter (June 2013) of 2012–13. Further, the figure highlights the lower levels of non-compliance in the 2012–13 March and June quarters, compared to the corresponding 2011–12 quarters where targeted feedback letters were not included as a KPI activity.

Figure 4.1: Reported MBS non-compliance rates



Source: ANAO analysis of Human Services' Compliance Summary Reports.

Note: Non-compliance percentages do not include MBS public or Chronic Disease Dental Scheme cases.

4.32 The inclusion of ‘targeted feedback letters’ towards the 2500 target from March to June 2013 contributed to this result. The department distributes ‘targeted feedback letters’ to health professionals to promote voluntary acknowledgement of incorrect claiming. These letters are used in circumstances where no specific non-compliance has been proven, but is suspected. Of the 500 targeted feedback letters included in the 2012–13 KPI results, four (or one per cent) contributed to a change in the non-compliance

rate—as the respective health professionals voluntarily acknowledged¹⁰⁹ incorrect claiming in response to the targeted feedback letter.

4.33 Currently, Human Services does not have a reliable underlying measurement for MBS non-compliance and as a consequence cannot assess the effectiveness of MBS compliance activities, including Medicare compliance audits. Recently, the department has taken steps to refine its approach in response to expert advice that random or representative sampling is required to measure the ‘real’ underlying non-compliance rate. Human Services’ compliance planning for 2013–14 indicates that random sample based auditing techniques are to be introduced and performed.

4.34 The introduction of random sample based auditing will assist Human Services to establish, over time, a suite of reliable MBS non-compliance rates so that the department can better assess the effectiveness of compliance actions.

Coverage of compliance activities

4.35 While the department does not set a performance indicator or corresponding target for compliance coverage, Human Services internally tracks the extent of compliance coverage across its full suite of compliance activities through its monthly Compliance Summary Reports.

4.36 In 2012–13 the department adjusted the methodology used to calculate the compliance coverage rate to include not only Medicare compliance audits, but all other health-related compliance activities conducted, including those performed on members of the public. As a consequence, there was a sharp increase in the coverage rate reported for 2012–13. The 2012–13 compliance coverage rate was 6.5 per cent, compared to the 2.6 per cent reported for 2011–12.¹¹⁰ The attendance of health professionals at general education sessions accounted for 58 per cent (5690 of 7560 compliance activities) of the total number of compliance activities conducted during 2012–13.¹¹¹

109 Health professionals can voluntarily acknowledge incorrect claiming by submitting a Voluntary Acknowledgement Form. The Voluntary Acknowledgement Form is available from the Department of Human Services’ website, see <<http://www.medicareaustralia.gov.au/provider/business/audits/files/4703-0811-voluntary-acknowledgement-of-incorrect-payment.pdf>> [accessed 13 February 2014].

110 In 2012–13 a total of 7560 compliance activities were completed, representing 6.5 per cent compliance coverage of the 115 500 active MBS and non-MBS billers, while in 2011–12 a total of 2738 Medicare compliance activities were completed, representing 2.6 per cent compliance coverage of the 107 000 active MBS billers.

111 Health professionals’ details are not recorded at education sessions and there may therefore be overlap in the number of health professionals being counted across the relevant categories.

4.37 Further, while Human Services calculates the total coverage rate as a percentage of active MBS and non-MBS billers, the base population for calculating coverage does not encompass members of the public—which is not consistent with the inclusion of Medicare public cases in the total number of compliance activities completed. The department could usefully revisit the methodology to calculate the coverage rate to appropriately take into account particular outliers, such as compliance conducted on members of the public, so as to produce a more accurate compliance coverage rate.

Internal reporting

4.38 The department's internal Compliance Summary Report, completed monthly, is the key overarching report that covers all of the department's health program compliance activities. While this is an internal report, it is also used to provide compliance information to Human Services' main external stakeholder, DoH. Human Services also produces a suite of more detailed reports at the project level, as well as reports that capture the history and results of compliance strategies, and impacts of particular compliance activities (Appendix 3 provides a summary of these internal reports, including their key elements, purpose, distribution to internal stakeholders and frequency of reporting).

4.39 To examine the quality of Human Services' project reporting, the ANAO reviewed in detail the suite of reports Human Services completed for the Cryotherapy 2011–12 project.¹¹²

Reporting for the Cryotherapy 2011–12 project

4.40 Human Services trialled the implementation of various elements of the IMCA initiative, such as the penalty provisions and legislated review function, through the Cryotherapy 2011–12 project. Monitoring and reporting on the success of the trial was an important means to identify and address issues related to the department's approach, particularly to embed effective IMCA initiative processes for future business as usual activities.

4.41 The Cryotherapy 2011–12 project was approved in December 2011, and compliance audits were scheduled for February to July 2012. The first project

¹¹² The ANAO focussed on the Cryotherapy 2011–12 project reports because: Human Services used the Cryotherapy 2011–12 project to trial parts of the new legislative powers it acquired through the IMCA initiative; and of the three projects reviewed by the ANAO, Human Services' full suite of project reporting was complete for the Cryotherapy 2011–12 project at the time of the audit fieldwork.

report, the Compliance Operations Findings Report (Operations Report) was completed on 15 October 2012 and identified that 49 health professionals had been selected for audits. However, seven of these health professionals were not assessed—five health professionals advised that they did not have access to the patients’ records, while the other two were recently subject to other compliance activities. In total, 42 audits were undertaken, and the results of these audits are outlined in Table 4.7.

Table 4.7: Audit results for the Cryotherapy 2011–12 project

Audits performed	Compliant		Non-compliant		Total debts raised	Total penalties raised
	No.	%	No.	%		
42	2	5	40	95	\$80 596	\$2577

Source: Human Services Compliance Operations Findings Report—Cryotherapy 2011–12 project.

4.42 The Operations Report also highlighted that a majority of the health professionals assessed as non-compliant voluntarily acknowledged incorrect payments (32 of 40, or 80 per cent). These voluntary acknowledgements accounted for 75 per cent (\$60 085) of the total debts raised. The administrative penalties raised were for five of the audited health professionals.

4.43 The Operations Report identified that while there were no major issues with the IMCA initiative transition, a number of lessons learned were outlined and a total of eight recommendations made. As at October 2013, six of the eight recommendations were yet to be finalised, noting that full implementation of three recommendations is conditional on pending legal advice, while implementation of another is contingent on results from a re-run of the Cryotherapy compliance strategy in 2013.

4.44 External stakeholders are a central part of Human Services’ compliance arrangements and keeping relevant stakeholders abreast of key strategy outcomes can contribute to achieving compliance outcomes. Human Services used the Compliance Working Group (CWG) as the key forum to inform and update external stakeholders during the introduction of the Cryotherapy 2011–12 project, including seeking feedback on the development of the Health Professional Guidelines for Cryotherapy. However, formal communication through the CWG on the completion of the Cryotherapy 2011–12 audits to key external stakeholders such as DoH, the Australian Medical Association and the Royal Australian College of General Practitioners, did not occur until seven months after the Strategy Outcome Summary was finalised.

Impact Evaluations

4.45 Human Services undertakes Impact Evaluations for compliance activities on an ad-hoc basis (see Appendix 3 for further information), with nine completed as at October 2013. Typically, an Impact Evaluation involves analysis of health professionals' billing data six months after compliance activities are undertaken to assess the impact of the treatment activities. Recently, Human Services used two of these Impact Evaluations¹¹³ as evidence to support the proposal to the Compliance Sub-Committee that as a treatment type, targeted feedback letters can affect health professionals' billing behaviours and should be included as part of the 2500 completed cases and reviews target.

Quality Assurance

4.46 Human Services also undertakes Quality Assurance (QA) of its health-related compliance activities. Since Human Services introduced a revised QA framework in October 2012, the results of QA activities are reported biannually. As a consequence, the department no longer tracks or reports against the previous QA performance indicator (the indicator was that ≥85 per cent of cases met the QA review criteria). The department advised that the performance indicator was no longer applicable, as reporting under the new framework shifted from a largely quantitative approach to a mix of qualitative and quantitative.

4.47 The QA reports for 2012–13 reflected the move away from quantitative reporting. As the primary audience for these reports is Human Services' Senior Executive, it is important that information reported clearly demonstrates the outcomes of QA activities and provides management with sufficient visibility of risks and key issues.

External reporting

4.48 Human Services currently provides information on Medicare compliance activities externally via two reports—the Compliance Summary Report, and the department's annual report. The Compliance Summary Report is provided to DoH as the responsible policy department, while the annual report contains high level information for Medicare compliance activities

113 The two Impact Evaluations used were of the Bulk Billing Incentives and Optometrical Services strategies.

performed within a financial year such as the value of debts raised as a result of incorrect billing identified by the department.¹¹⁴ As previously discussed however, data such as the amount of debt actually recovered per annum is not included in the annual report, notwithstanding its value as an indicator of the effectiveness of the Medicare Compliance Program. To provide a sound basis for external reporting, it would be beneficial for the department to embed arrangements to track and report on savings, including attribution of the impacts (such as debts raised and recovered and changes effected to potentially incorrect billing) from particular compliance actions, within business-as-usual processes.¹¹⁵

Conclusion

4.49 Human Services employs a range of compliance activities to improve the integrity of Medicare billing. From 2008–09 the department received a significant boost in funding for its Medicare Compliance Program through a Budget measure. Under the Increased Medicare Compliance Audits initiative (IMCA initiative) the department was expected to deliver and report to the Australian Government on: an increased number of Medicare compliance audits conducted on health professionals (from 500 to 2500 per annum, an increase of 8000 over four years); and \$147.2 million in savings, leading to expected net savings of \$70.3 million to Medicare over four years. Notwithstanding the Australian Government’s request that the department implement additional compliance audits and performance monitoring arrangements to assess and report back on its performance in delivering the IMCA initiative, Human Services:

114 The annual report includes the department’s performance against the Portfolio Budget Statements target of 2500 completed Medicare audits and reviews, the number and amount of debt raised, reviews conducted, and the different types of compliance activities undertaken.

See Department of Human Services, *Annual Report 2012–13*, available from <<http://www.humanservices.gov.au/spw/corporate/publications-and-resources/annual-report/resources/1213/resources/dhs-annual-report-2012-13-web.pdf>> [accessed November 2013], p. 14 and pp. 208–212.

115 In the past, Human Services also prepared a report for government—the Strategic Fraud and Non-Compliance Annual Performance Report (SFNC performance report). In late 2013, the department advised the ANAO that the SFNC performance report was an initiative of the previous government, and consequently, the department completed the last SFNC performance report in 2011–12. However, the then Department of Finance and Deregulation raised concerns regarding the limited financial information that was included by Human Services, particularly for actual expenditure and practical savings realised for all fraud and non-compliance programs as well as individual compliance measures.

- did not develop and implement the proposed methodology to report on savings achieved;
- expanded the mix of compliance activities funded under the IMCA initiative to include less onerous activities, without reference back to the responsible Minister; and
- only met the 2500 target once, in 2011–12.

4.50 In the absence of specific monitoring arrangements, the department was not able to respond to the ANAO's inquiries on its performance in respect to the Budget measure and had to undertake analysis to provide the ANAO with relevant data. Human Services cannot separate out the number, and value of debts raised and actually recovered that relate specifically to the IMCA initiative, in order to establish its performance against the initiative's savings target.

4.51 On the basis of limited data extracted from established reporting systems, the department advised that it raised a total of \$49.2 million in debts and recovered \$18.9 million between 2008–09 and 2012–13, largely as a result of Medicare compliance audits conducted on health professionals. The quantum of debts recovered represents a shortfall of \$128.3 million, or 87 per cent less than the \$147.2 million in savings expected through IMCA. Even if all debts raised were recovered, there would remain a shortfall of \$98 million or 66 per cent less than the expected savings. The ANAO's analysis indicates the program of additional compliance audits funded under the budget measure was delivered at a net cost to the Australian Government and did not represent a positive financial return on its investment, while acknowledging that there may have been other benefits such as reinforcing health professionals' awareness of their compliance obligations.

4.52 Further, while the two additional compliance activities that were added to the mix of compliance activities funded under IMCA are valid compliance actions, their inclusion has resulted in inaccurate reporting by Human Services against the IMCA initiative's annual target of completing 2500 compliance audits, as well as amplifying its reported compliance coverage rate.

4.53 The IMCA initiative has been implemented in a manner inconsistent with the original new policy proposal considered and agreed by Ministers. Given the road travelled to date, Human Services should improve reporting on outcomes by better capturing the benefits realised from administering Medicare compliance audits, including any savings, so that departmental

resources are properly targeted. Arrangements that facilitate the effective monitoring of performance, allow an agency to inform key stakeholders, including government, on delivery against the benefits intended, and operate most effectively when embedded within agencies' business-as-usual processes.

4.54 Further, the department reports more broadly on the results of compliance activities performed to protect the integrity of Medicare through a number of different reports—its annual report, monthly Compliance Summary Report, as well as project specific reports such as the Compliance Operations Findings Report. The department's operational reporting can help identify improvements to its operational processes and can potentially inform its future compliance activities. However, there are limitations to the reliability and validity of some of the information captured in these reports; in particular the financial data externally reported to government, as well as internal performance measures (the MBS non-compliance rate and the compliance coverage rate). These limitations, coupled with the other monitoring and reporting issues raised, restricts the department's ability to show the overall effectiveness of its Medicare compliance activities.



Ian McPhee
Auditor-General

Canberra ACT
23 April 2014

Appendices

Appendix 1: Agency Response



Australian Government
Department of Human Services

Kathryn Campbell CSC
Secretary

Ref: EC14/84

Dr Tom Ioannou *8/4*
Group Executive Director
Performance Audit Services Group
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601

Tom
Dear Dr Ioannou

Thank you for the opportunity to comment formally on the proposed 'section 19' report arising from the Australian National Audit Office's (ANAO) performance audit of *Medicare Compliance Audits*, dated 6 March 2014.

The Department of Human Services (the department) agrees with the ANAO's recommendations.

Attachment A to this letter details the department's overall response to the proposed report and to each of the ANAO's recommendations.

If you would like to discuss the department's response, please do not hesitate to contact Mr Darren Box, General Manager Debt, Appeals and Health Compliance, on (02) 6143 7331.

Yours sincerely

Kathryn Campbell

30 March 2014

Appendix 2: Administrative Penalty Scheme for Increased Medicare Compliance Audits

Description	Penalty rate if <\$30 000 debts in last 24 months	Penalty rate if >\$30 000 debts in last 24 months (50% increase in base penalty) ^B
Base penalty ^A	20%	30%
Health professional advises Human Services of an incorrect amount prior to being contacted by the department—100% reduction in base penalty	0%	0%
Health professional advises Human Services of an incorrect amount before a notice to produce documents is issued, but after being contacted by the department—50% reduction in base penalty	10%	15%
Health professional advises Human Services of an incorrect amount after a notice to produce documents has been issued but before the due date in the notice—25% reduction in base penalty	15%	22.5%
Health professional does not comply with a notice to produce documents by the due date in the notice—25% increase in base penalty	25%	37.5%

Source: ANAO representation of Human Services advice.

Note: ^A If the applicable recoverable amounts on the notice of debt are \$2500 or less then no administrative penalty is applied, regardless of other circumstances.

^B If notices of debt under s129AC and notices of administrative penalty under s129AEA totalling more than \$30 000 have been served on the provider in the previous 24 months then the 50 per cent increase to the base penalty rate is applied.

Appendix 3: Internal Reports Covering Medicare Compliance Audits

Report	Purpose of the report		Provided to internal stakeholders	Frequency of reporting
Overarching report				
Compliance Summary Report	Tracks and monitors key performance targets, such as the 2500 completed audit cases and reviews and the non-compliance rate.		Yes (and DoH)	Monthly
Project specific reports				
Compliance Operations Findings Report	Presents key audit findings and results, and includes: lessons learned which may assist in the development of future compliance strategies; and recommendations, which can include further interventions, such as education or policy/legislative changes.		Yes	Once all compliance activities planned for a project are completed
Compliance Project Closure Report	The report is authorised by the National Manager and marks the closure of a compliance project. Key information detailed in the report includes: the reasons for the strategy's closure; a summary of achievement against the strategy's deliverables; and the results of any QA or evaluation activities,			
Strategy Outcome Summary Report	High level report which summarises the risk and related treatment strategy as well as high level results from the strategy's compliance activities, including an outline of what stakeholder communications have occurred and whether outcomes are to be referred to update a Risk Topic Overview.		No	Once all projects related to a strategy are completed
Overviews/evaluations of activities conducted				
Risk Topic Overview (RTO)	A short overview of activities undertaken to treat one or more risks as part of a broader risk topic. Human Services advised an RTO is to be updated to capture all related key intelligence.		No	Previously ad-hoc. Commitment for 2013–14 is for a RTO to be developed for all major projects completed

Report	Purpose of the report	Provided to internal stakeholders	Frequency of reporting
Impact Evaluation	Provides an assessment of treatment activities' impact on health professionals' claiming/billing behaviour for a particular risk topic.	Yes	Ad-hoc
Quality Assurance			
Quality Assurance Report	Highlight key observations from QA activities, and includes limited quantitative reporting.	Yes	Bi-annually

Source: ANAO analysis of Human Services reports.

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