Shared Debt Recovery Submission

What types of employment or contractual arrangements should the Minister be aware of when determining which classes of persons (or organisations) will be included in or excluded from the Scheme?

The Minister should be aware that corporate medical practices, which may include sessional room contracts and cost sharing contracts can give rise to significant complexity when deciding if a shared debt would exist. Corporate medical practices operate under a variety of models, from the relatively simple model that provides management and services, to a model that entails complete divesting of a doctor's existing practice, with the doctor then becoming an employee of the practice.

Independent Contractors

The most common arrangement in the corporate medical practice environment is one where the medical practitioners or allied health providers or private practicing specialists operate as individual contractors. Depending on the contractual arrangement with the corporate entity these practitioners may be sharing the costs of the practice facility, practice administration and practice support staff both clinical (e.g. nurses) and administrative (receptionists), through an arrangement where a percentage of their billing revenue is paid to the corporate entity as a management fee. Under this type of arrangement, most Corporates will process a practitioners' billings as part of the service arrangement. Revenue from billings, including bulk billed MBS items, under these arrangements would typically be paid to the practitioner's nominated account with the practitioner than paying an agreed percentage to the corporate entity as per the contractual agreement. In some practices, although this is less common, all revenue from billings may be paid to the practice account from which the deduction of management/service fees are made, and the net receivable remitted to the relevant medical practitioner. Or, the practitioners may be renting the rooms in which they provide their services from the corporate entity, i.e. paying a specified amount for the space, and paying either a specified amount for administrative support, or again a percentage of their billings.

Under arrangements where the corporate entity undertakes the billing on behalf of the medical practitioner, practitioners may find themselves in a vulnerable position from a compliance perspective because they do not have immediate oversight of their billings. As medical practitioners are primarily held accountable for their billings, they should regularly obtain or be provided a report of their billings and have any billing errors corrected. Ideally, it would be best for this to occur daily, but in practice may not occur as often as it should. Billing reports are often lengthy and at times in a format that is hard to interpret, making it easy for any errors to be missed. This is particularly the case when practitioners are at the end of a busy work day and were not directly involved in the billing of the patient at the time of consultation. At the end of a busy day it is often hard to remember which of the 40-50 patients seen had a long vs a standard consultation, some other type of consultation or a particular service provided.

Given the complexities of the Medicare Benefits Schedule (MBS), medical practitioners often welcome delegating or using the services of an agent or entity with a perceived greater expertise than them to manage the billing. Again, this can leave practitioners vulnerable because they may not possess the technical competency to interpret the legal intricacies of what is a constantly changing billing environment and thus not feel equipped to query or challenge the correctness of billing practices undertaken on their behalf. This is especially true for those practitioners who are new to Australia's health system and have limited understanding of the intricacies of the MBS.

Medical practitioners who are new to Australia's health system and to a private practice environment are particularly vulnerable to exploitive contracts and may also find themselves subject to compliance

concerns as they may not feel empowered to challenge the appropriateness of any billing agreement or contractual arrangement.

Most Corporates will insist that medical practitioners maintain their own professional indemnity insurance. This is also a natural corollary of the independent contractor nature of most arrangements and serves to place a convenient barrier between the medical practitioner and the Corporate, whereby the latter takes no responsibility for acts on the medical practitioner's part and further, under most contracts that the AMA is aware of, the medical practitioners provide a specific indemnity to the Corporate in the event of any such loss occurring.

Any contractual arrangement that takes control of a practitioner's billing, includes a fixed period of service, any incentive tied to type or volume of services, includes required billing targets, or KPIs which require a defined clinical activity target and for which there are associated penalties for non-compliance, could be considered coercive and thus appropriate for consideration of a shared debt arrangement. Where there is evidence of a coercive arrangement this should be a factor in considering the apportioning of a higher and significant percentage of debt under the shared debt recovery scheme.

<u>Common methods of engagement</u>

The method of engagement varies considerably across practices. The most common methods are:

1. A "serviced entity" arrangement whereby the practice supplies an office, administrative support and consumables in return for payment of a facility fee.
2. As a contractor where the practice engages a solo GP (or his/her practice company) to undertake work caring for patients. Often this is as a locum.
3. As an "associate" where the doctors agree to share all expenses.

Where a health care provider rents rooms but is not required contractually to share a percentage of their billings with the corporate entity, nor do they share in services of reception/administrative staff the AMA would expect that the Shared Debt Recovery Scheme would not apply.

Where a provider has given another entity the authority to manage their billings, they would need to be included in the Shared Debt Recovery Scheme. Providers who this may apply to could include, general practitioners, allied health providers, nurse practitioners and midwives.

Specialists (excluding general practitioners) in public hospitals

Note: Please note that when referring to "specialists", we are referring to medical practitioners with a speciality qualification other than general practitioner.

The forms of specialist engagement differ in public hospitals across state / territory jurisdictions and are governed by either or both registered industrial agreement and/or common law contract. Pertinent to the Minister's considerations is whether the specialist has, through formal agreement:

a) rights of private practice (alongside their public hospital duties), and
b) have authorised their public hospital to have agent status in respect of the billing management for those private patients.

Secondary considerations would be whether the specialists is legally characterised as a contractor or employee and how the specialist is engaged to perform work. All the following engagement styles could be managed via employment or contractor agreements:

- Full time,
- Part time,

- Sessional (at least one 3.5 hour period of engagement – weekly, fortnightly or monthly),
- Fee for service, or
- Casual

Under what circumstances could control or influence by a secondary debtor lead to the making of a 'false or misleading' statement?

A secondary debtor could control or influence the making of a 'false or misleading' statement in the following circumstances:

- where they decide what item/s to bill for services provided by the practitioner
- where contracted arrangements give them control of patient billing, including claims against Medicare
- where there are no provisions in place to support or enhance billing assurance under Medicare
- where the billing culture encourages over-servicing or up-coding
- where they dictate billing practices
- where the practitioner is incentivised to meet service provision or billing targets
- where the practitioner is penalised under contractual arrangements for failing to meet a service provision or billing target
- where practitioners have no oversight of the billings made on their behalf
- where the practice culture discourages practitioners from questioning or challenging the practices of the entity

It should be remembered that the medical practitioners may not be the only staff members subject to influence/coercion. Staff responsible for processing billing may also find themselves pressured to code services a particular way that could constitute the making of a false or misleading statement.

What forms of evidence could the Chief Executive Medicare or their delegate consider to determine whether a secondary debtor obtained a financial benefit from the making of a 'false or misleading' statement?

Forms of evidence that the CME (or delegate) could consider would include:

- Service Contracts/Agreements
- Bank statements for the account/s where Medicare/PIP payments are paid, or entity service fees are paid
- MBS claims history for the medical practitioner or allied health provider
- PIP statements if they form part of the shared remuneration arrangement
- Remuneration statements – where entity or billing agent transfers practitioner's proportion to them
- Statutory declarations from staff of the possible secondary debtor as to the billing culture of entity
- Evidence of compliance with Good Accounting Practice as contractually – i.e. Audit trail claims made on behalf of the primary debtor
- Reconciliation records between the clinical information provided by the primary debtor (practitioner) to secondary debtor (hospital/billing agent) for the purpose of billing items of service
- Correspondence from the secondary debtor (i.e. hospital) in which the offer of private practice arrangement is made.
- Statement from a secondary debtor (i.e. hospital) describing the basis upon which a private practice arrangement offer was made.

- A written term where the secondary debtor expressly advises the primary debtor to seek independent legal advice in advance of signing an agreement.
- Any available forensic audit of practice or organisation/entity revenue.

Is a proportion of 65%/35% (primary debtor owing/secondary debtor owing) an appropriate prescribed percentage?

The AMA supports the percentage of any recoverable debt owed by the primary and secondary debtors to be that by which they have contractually benefitted from Medicare benefits. While a 65%/35% split is the most common, GP registrars for example may only be paid on 50%/50% basis and in some locations (remote or areas with extreme or extended workforce shortage) the split could be 70%/30%. Where this cannot be reasonably determined from the documentation provided to the CEM, the AMA supports the proposed 65%/35% as a default percentage of any recoverable debt owed by the primary and secondary debtors respectively. The AMA acknowledges that it may be appropriate to amend the percentage recoverable by either the primary or secondary debtor and welcomes the CEM's ability to do so, if the circumstances in a specific matter warrant it. For example, coercive behaviour from a corporate entity, where practitioners do not have ready and reasonable oversight to billings administered on their behalf, or for repeat offenders.

If you answered "no", what would be an appropriate prescribed percentage and why?

Not applicable as per above.

Under what circumstances might the Chief Executive Medicare or their delegate decide to vary the percentage of the debt that is recoverable from the secondary debtor?

Where a contract/agreement clearly specifies another split that represents the proportion of billings overall, or where indicated for the specific MBS items that form part of the compliance action, the medical practitioner/allied health provider pays to the entity.

Where evidence can be produced to demonstrate that the culture of the practice/corporate entity was such that providers were coerced into making false or misleading claims or were prevented from having oversight of the billings made on their behalf, or were prevented from taking any corrective action.

Conversely if a practice/corporate entity could demonstrate they had billing assurance processes in place, counselled contractors if they had concerns about MBS compliance, and/or reported a contractor for billing they believed to be false or misleading this should be considered when determining what liability, the secondary debtor may have. Consideration should also be given to the period of time between counselling and reporting to ensure that secondary debtors are not absolved of liability where they allowed suspect billing to continue for an extended period while still collecting their share of the contractor's billings.

Where there is evidence of recidivist behaviour by a secondary debtor especially if at multiple centres and if over multiple occasions the responsibility may need to be increased up to 100% as a reflection of an apparent deliberate systematic policy underlying the entity's operations.

In all circumstances, the AMA suggests that a graded responsibility for the primary or secondary debtor could be considered as follows:

- First offence – determination may be flexible

- Subsequent or multiple offences – may be reasonable to increase their liability

Do you have any concerns or questions about the Scheme that were not addressed in this consultation?

The limited period (14 days) proposed under 19ACA(8) for response to the CEO upon advice that a determination is to be made is of concern to the AMA. Our concerns are related to the extra pressure that this may put a practitioner under, in what is already a stressful situation. We know from Beyond Blue survey's that medical practitioners already suffer higher levels of psychological distress than the general community. The 14 days provide very little time for busy or part-time medical practitioners to consult with their Medical Defence Organisation or representative body for advice, or to prepare a sound and reasoned response to the CEO as to why a determination should not be made and what the appropriate percentage split should be, or to produce any additional evidence to support this position. In the interests of fairness and given that any case made during this period could potentially avoid additional costs to all involved should the matter be progressed, reviewed and appealed, the AMA would suggest that increasing the 14 days to 28 days would be more reasonable.