Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

ONTARIO HEALTH INSURANCE PLAN

(Section 3.08, 2006 Annual Report of the Auditor General of Ontario)

2nd Session, 38th Parliament
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Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Michael A. Brown, MPP
Speaker of the Legislative Assembly

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Norman Sterling, MPP
Chair

Queen's Park
May 2007

STANDING COMMITTEE ON PUBLIC ACCOUNTS

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2nd Session, 38th Parliament

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PREAMBLE

The Standing Committee on Public Accounts held hearings on the Auditor General's 2006 audit of the Ministry of Health and Long-Term Care's Ontario Health Insurance Plan (OHIP), section 3.08 of his *2006 Annual Report*, on February 12, 2007. The Committee has endorsed the Auditor's findings and recommendations.

This report constitutes the Committee's findings and recommendations. Background information on sections of the original audit report is followed by an overview of the hearings' main findings and, as appropriate, new recommendations. *Hansard*, the verbatim record of the hearings, should be consulted for the complete proceedings.

Acknowledgements

The Committee extends its appreciation to officials from the Ministry of Health and Long-Term Care for their attendance at the hearings. The Committee also acknowledges the assistance provided during the hearings and report writing deliberations by the Office of the Auditor General, the Clerk of the Committee, and staff of the Legislative Library's Research and Information Services.

1. AUDIT OBJECTIVE AND MAIN FINDINGS

The audit's objective was to assess whether the Ministry had adequate systems and procedures in place to ensure that OHIP fee-for-service claims and payments to health-care providers were legitimate and accurate. Audit activities included examining documentation, analyzing information, interviewing Ministry staff, and visiting six OHIP district offices. The audit fieldwork was substantially completed by May 2006.[1]

The Auditor concluded that while claims were being accurately processed, the Ministry should strengthen its systems and procedures in a number of areas to help ensure that all OHIP fee-for-service claims and payments to health-care providers were legitimate. Among his findings were the observations that

- photo health cards with more security features have been issued to replace older red and white cards since 1995. The conversion was originally planned to be completed in 2000 but has been delayed. The current conversion rate would see the process take at least another 14 years;
- there were approximately 300,000 more health cards in circulation than population in the province, the majority of which were held by individuals with addresses in Toronto or in regions close to the American border;
- limited resources were devoted to monitoring health-card usage even though audit staff's computer data-extraction analysis of medical claims records indicated areas where expenditure patterns warranted review or investigation;

- the Fraud Programs Branch did not have a mandate to conduct fraud audits and did not have access to records that would allow it to conduct fraud monitoring activities;
- the authenticity of citizenship documents for about 70% of existing card holders had yet to be verified;
- data files received from the College of Physicians and Surgeons of Ontario (CPSO) used to update physician-licensing information were not complete; and
- the activities of the Medical Review Committee, which was mandated to review cases in which physicians may have filed inappropriate claims, had been suspended since September 2004. Based on past recovery rates, it was estimated that as much as $17 million in potential recoveries may have been lost during this period.[2]

2. COMMITTEE REQUEST FOR MINISTRY RESPONSE

The Committee requests that the Ministry of Health and Long-Term Care provide the Committee Clerk with a written response within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly.

2.1 Committee Recommendations

1. The Ministry of Health and Long-Term Care report to the Committee on options to reduce the time needed for the conversion, including related time-frames by which red and white health cards can be converted to photo health cards.

One option that the Committee would like to have considered is an extension of the renewal time-frame for photo health cards. Any savings from this extension should be allocated to expediting the replacement of red and white health cards.

2. The Ministry of Health and Long-Term Care provide the Committee with an update on the activities of the Fraud Programs Branch since the expansion of its mandate.

3. The Ministry of Health and Long-Term Care provide the Committee with the current number of backlogged eligibility assessment cases and a reassessment of its ability to achieve, by the end of 2007, a sizeable reduction in that number.

4. The Ministry of Health and Long-Term Care report to the Committee on the status of its negotiations with Citizenship and Immigration Canada and the Canadian passport office.

5. The Ministry of Health and Long-Term Care report on the number of cases reported as unmatched with Citizenship and Immigration Canada and Ontario Registrar General records.

6. The Ministry of Health and Long-Term Care provide the Committee with an update on the recommendations regarding the health card application and registration process put forward by the contracted security expert and Ministry staff.

7. The Ministry of Health and Long-Term Care report on the number of cases and related total dollar amounts under review at the time the Medical Review Committee was suspended and confirm that these cases will not be reopened with the new review process.

8. The Ministry of Health and Long-Term Care report on actions planned to enhance the process for reviewing rejected claims based on the recommendations of the Access Control Review Project.

3. Overview

The Ontario Health Insurance Plan (OHIP) is a significant vehicle for the delivery of health services. It allows the Ministry of Health and Long-Term Care to determine eligibility for coverage, and remunerate physicians and other health-care professionals for services rendered. Insured services include diagnostic, preventive and rehabilitation services provided by generalists and specialists, and services provided by community laboratories. OHIP rates are also paid for emergency treatment provided to Ontario residents in other provinces or countries. Over $7.4 billion was paid in 2004/05 for approximately 180 million claims. Ontario fee-for-service providers received $5.5 billion (74%), while the remaining $1.9 billion covered a variety of non-fee-for-service payments such as those to community laboratories.

In order to access services, Ontarians require a valid health card. To be eligible for a card, an applicant must be a Canadian citizen or landed immigrant, have a home in Ontario and reside here for at least 153 days in any 12-month period. Cards are either red and white or a photo card. Approximately 12.9 million valid cards were in circulation as of January 2006, 7.2 million of them photo cards.[3]

AUDIT OBSERVATIONS AND RECOMMENDATIONS

4. Health Cards

4.1 Conversion of Red and White Cards to Photo Health Cards

The Ministry moved from a family-based to an individual-based registration system in 1990 by issuing approximately 10 million red and white health cards.[4] Cards were given to those who provided a health number and matching surname.

Photo cards were introduced in 1995. The Ministry planned to re-register all residents and authenticate eligibility over five years. However, the conversion had yet to be completed at the time of the audit. As of January 2006, there were over 5.7 million red and white cards in circulation. A conversion rate of approximately 400,000 cards per year had been achieved over the past few years. (The conversion rate at the time of the audit was about half of what it had been in 1998.) The Auditor estimated it would take at least 14 years to complete eligibility verification and phase out the old cards.

The Ministry of Transportation (MTO) began a similar conversion to replace the two-part driver's licence with a photo card in 1995. That project was completed in 2000, after issuing over seven million new licences. The Auditor recognized that this process was facilitated by licences having expiry dates but felt it demonstrated that province-wide conversions were possible.

The accuracy of records underlying the red and white cards is questionable. The lack of an expiration date means address information is often out of date. Ministry statistics indicated that about 25% of mailings to red and white card holders were returned as undeliverable. Assuming this rate was applicable for all red and white card holders, the address information was out of date for an estimated 1,425,000 individuals.[5]

4.2 Number of Health Cards in Circulation

Statistics Canada reported that Ontario's population was 12.59 million as of December 2005. Audit staff's data analysis found that at the time of the audit there were approximately 12.895 million cards in circulation, a difference of over 300,000. The Auditor realized that many of the cards could belong to former residents or the deceased but expressed concern that some could be in the hands of ineligible individuals. A review of address data found that 263,000 (86%) of the extra cards were in circulation in the Toronto area. There also appeared to be over 10,000 extra cards in certain regions that border the United States.[6]

The Auditor recommended that the Ministry expedite the conversion of the red and white OHIP cards to photo cards in order to properly verify the eligibility of the holders of the older cards.[7]

Committee Hearings

The registered persons database contains information for all eligible individuals in Ontario registered for an OHIP card. It is critical to the functioning of a number of key programs.

A data integrity project was initiated in August 2004 to reduce the number of health cards on the registered persons database. The Ministry indicated that in June 2006, it cancelled eligibility for over 192,000 red and white cards with no claims for the previous seven years and where the client did not respond to requests to attend an OHIP office to convert to a photo card. An additional 95,000 cards were cancelled in 2006/07. As of December 31, 2006, 287,000 had been

cancelled. The Ministry planned to determine the status of the remaining extra cards and cancel those that were ineligible by the end of February 2007.

(The Ministry is encouraging Ontarians to keep their address current. That request appears on the Ministry's web site and in all of the notices it sends out. According to Ministry staff, Bill 171, the *Health System Improvements Act*, introduced in December 2006, would require that individuals report address changes.

If the card of someone who is actually eligible for health services is cancelled, that individual will have to report to one of the Ministry's 27 district offices and prove their eligibility. Once that is accomplished, coverage will be backdated and the person will be reimbursed for any relevant expenses.[8])

A technology change in June 2006 further automated the process of mailing notices to clients, allowing the Ministry to contact and process a greater number of clients in a short time frame. The number of weekly notices sent was increased from a few hundred to 10,000. As of January 1, 2007, there were 7.45 million photo cards and 5.11 million red and white cards in the province.

(Committee members were told that 4% (17,000) of those contacted through the data integrity project have reported to a district office. The return rate on invitations to re-register was approximately 60%.[9] Re-registration is taking place across the province but is focussed on district offices, a number of which are near or in border communities. Invitations are being sent out from offices in batches based on postal codes. Wait times for the trusted registration (in-person) process average about 20 minutes with actual transaction times of approximately six to eight minutes.[10])

Other data integrity controls and processes are in place to cancel red and white cards on an ongoing basis. For example, automated system feeds with the Ontario Registrar General automatically cancel the cards of those reported to be deceased. Information on in-province deaths is also received from family members and entered in the medical claims payment system by a physician on pronouncing a death. In the case of the latter, the card is cancelled three days after the pronouncement is received. The Ministry also has an information exchange with its provincial counterparts to enable the cancellation of cards for those who have permanently left the province and register for a health card in another jurisdiction. It is not advised about deaths out of province or country.[11]

Ministry staff told the Committee that faster conversion of the red and white cards was a desirable goal. However, they felt consideration had to be given to such factors as the costs associated with increasing staff to manage client interviews, space to house the increased business volume, and the costs associated with producing the photo card. These issues had to be weighed against the opportunities the associated funding would provide to support health services.[12]

More conversions occurred in 1998 because people were being re-registered for photo cards where the Ministry was rostering patients to primary care physicians. This resulted in pockets of the province being completely re-registered and others

with almost no re-registration; there were areas where the primary care initiative was more popular. It also created pressures five years later when cards had to be renewed. Conversions have been evened out in the time since and the Ministry no longer requires patients to register for a photo card when rostering with a family physician for primary care.[13]

Options for Consideration

Options for changing the business process related to the existing photo cards were being reviewed, with the objective of absorbing some of the costs involved in the conversion. This would enable the Ministry to complete the re-registration of all remaining red and white cards within a shorter time frame.[14] (Ministry staff estimated it would cost between $110 million and $130 million to convert within three to five years.[15])

Reference was also made to the government's integration of registration processes. The Ministry has been working with Service Ontario and, since 1995, the MTO. There are validation, documentation, privacy, and database linkage issues to be dealt with, but the driver's licence and the health card use the same technology for picture-taking and signatures. The two ministries also have the same contract for card production.[16]

Extending the expiry date of photo cards has been considered to enable more time to be devoted to conversions. There are consequences and costs associated with this option. The Ministry is attempting to keep its cycles consistent with those of the driver's licence because of its partnership respecting card production. The longer the renewal period, the more likely an address is to change. Medical practitioners rely on a person's address to verify their clinical records. (Health cards are swiped in offices through a validation system operated by the Ministry.)[17]

The Ministry does not have a service delivery network that could handle a significant increase in the number of individuals registering for a photo card. The system is almost at capacity in processing 2.2 million people a year. (The MTO driver's licence conversion had a private issuers network across the province.[18]) Committee members were told it would take more than 12 years to convert at the current rate. Ministry staff did allow though, that they could probably increase the number of conversions by 100,000 this year. They were also looking at offsets in their budget that would allow more to be done in 2008.[19]

Over the next two years consideration will be given to moving some renewal work away from the counter and to a mail-in process (e.g., for people over 80) or on to the Internet. Ministry staff expressed the hope that by 2009 these and other options might enable counter staff to do more conversions.[20]

Supplementary Information

On March 9, 2007, the Minister of Transportation announced the introduction of a new driver's licence card. The new card will have "technologies and security features to protect holders from identity theft and make it more difficult to tamper

with or counterfeit." Card production will be outsourced to Giesecke and Devrient Systems Canada.[21]

Less than 1% (1,673) of the over 192,000 red and white card holders whose eligibility was cancelled in June 2006 have had their eligibility restored by reporting to a district office and completing the trusted registration process for a photo card. Approximately 60% of these have had their eligibility restored after the three-month waiting period. In most of these cases, the three-month wait was invoked because the individuals had moved out of the province for a period of time, making them ineligible for coverage upon their return.[22]

4.3 Health-Card Monitoring

The audit found little monitoring of individual health-card usage. One of the main reasons is the difficulty in balancing an individual's right to privacy and the Ministry's responsibility for the stewardship of public funds.

A consulting firm was contracted in 2004 to conduct a study of potential health card fraud. It recommended the development of a fraud measurement framework to be used as a benchmark and guide for future work. Consumer fraud was estimated to be between $11 million and $22 million annually.

Investigations into suspected abuse are typically triggered by calls to the Ministry's Fraud Line or staff's suspicions when processing applications. Specific medical procedures are also reviewed to identify ineligible claims.

A Fraud Programs Branch (FPB), staffed with OPP detective inspectors and fraud examiners, was established in 1998. At the time of the audit, it did not have a mandate to conduct fraud audits and did not have access to records that would allow it to conduct OHIP monitoring activities. Suspected fraud cases were referred to the OPP. Branch activities were limited to assisting program-area personnel to assess fraud risk, and to identify and mitigate potential frauds.

Some special projects had identified ineligible card holders and were described by the Auditor. For example, card holders are generally not permitted to have postal box addresses. With few exceptions, they are required to have a permanent civil address in Ontario. A project completed in 2003 investigated 1,562 cards with postal addresses serviced by two mailbox outlet companies. Letters were sent to card holders. Many were returned as undeliverable or the card holders were found to be ineligible. The Ministry cancelled 1,157 cards, but the project was discontinued due to budgetary restraints. Data-extraction audit tests run by audit staff identified almost 32,000 people still using a postal box as their address.

Other than the projects described by the Auditor, the Ministry had done little to monitor health-card usage to detect anomalies. Consequently, audit staff performed a number of analyses on medical claims records for the period January 2001 through December 2005.[23]

Anomalies in Health Card Usage

Claims from providers from various locations often occur due to an individual's movement within the province. Their appearance over a short period of time could indicate that a card has been compromised. An analysis by audit staff found that there were 11,700 card holders who each had claims from all three regions in the province over a nine-month period in 2005.

Six individuals were identified as having received extensive psychotherapy counselling services from one provider. Total payments to the provider were $800,000 from 2001 to 2005.

The analysis discovered 4,000 patients being treated by a group of clinics and affiliated physicians, who had been submitting claims related to a specific treatment totalling $31 million since 2001. Procedure frequency was much higher than that recommended by the CPSO. Audit staff estimated the payments for excess treatments to be approximately $9.7 million since 2001. The majority of the paid claims related to laboratory tests. Claims were submitted through physicians from their own practices. Physicians are allowed to submit claims for laboratory testing, but only if the tests are conducted in their office. Physicians' practices were often significant distances from where patients resided and the clinics operated. The Ministry advised that, due to a complaint, the clinics had been under investigation since May 2003. However, the data analysis indicated that payments to the clinics continued to increase for the time periods reviewed.[24]

Review of Potential Cases of Ineligibility

Tips from the public on OHIP card use by those who are potentially ineligible are tracked in a Registration Information Tracking System. District office staff use the System when suspicious about an applicant's eligibility. When criminal intent is suspected, the matter is referred to the OPP. The Auditor noted that the Ministry did not have documented standards or procedures for evaluating such cases. Audit staff reviewed a sample of case files and noted inconsistent practices in evaluating them as well as in the decisions made.

As of October 2005, there was a backlog of over 7,000 outstanding cases awaiting review. Over 90% were more than six months old. The average time to resolve a case was 10 months. Approximately 40% of these card holders were eventually found to be ineligible and their cards were suspended. Based on this rate, there may be an estimated 2,800 ineligible individuals whose health cards are still active.[25]

The Auditor recommended reviewing the mandate of the FPB, with a view to expanding the range of its activities to include OHIP-usage monitoring and fraud investigations. He also recommended considering the expansion of the Ministry's monitoring activities to identify potentially suspicious individual health card usage, to resolve the outstanding backlog, and to follow up on potentially ineligible cases in a consistent, rigorous and timely manner.[26]

Committee Hearings

Fraud Programs Branch

The mandate of the FPB is being expanded to ensure a more comprehensive approach to fraud detection, prevention and loss reduction. It will be the centralized coordinator of all fraud-related activities. All suspected cases of fraud will be referred to the FPB for review and evaluation before being sent to the OPP Health Fraud Investigation Unit, a team of 22 officers. The FPB will analyze the Ministry's claims payment systems in order to detect possible fraudulent activity. It will also analyze patterns of activity that could indicate an area of concern.[27]

The FPB's staff complement of 10 will be increased to 12 or 13 this year. Staff have also been given specific approvals for access to OHIP databases.[28] A new process for referring cases to the OPP has been established and was introduced in early February 2007. A number of referred cases will be repatriated from the OPP and reassessed according to the new criteria.[29]

The number of actual cases of fraud that have been prosecuted was said to be relatively small. The Ministry suggests that this is not a large problem, but it will have a better sense of the actual situation with the FPB's new mandate.[30] The Committee was also told that health card fraud was difficult to prosecute. Ministry staff felt the FPB's new mandate would see better-prepared cases moving forward in a more timely fashion, leading to better convictions.[31]

Supplementary Information

The FPB has developed screening criteria to be used for cases of suspected consumer or provider fraud. The included factors are meant to serve as a case review guideline.

1. Does the information gathered provide a basis to suspect that there has been a misrepresentation in such a form as to be a statement of fact, concealment of fact or an omission of fact?
2. Is the suspected misrepresentation material to a provider receiving payment to which he/she is not entitled or a consumer receiving benefits to which he/she is not entitled?
3. Does the public interest favour referring the matter to the OPP Health Fraud Investigation Unit? In making this assessment, [the] FPB will consider all relevant circumstances, including, but not limited to the following:

(a) Does the conduct result in risk to the public?

(b) Does the conduct impact on the integrity of Ministry data in a manner that may adversely affect a registered person(s)?

(c) Could the conduct in question undermine public confidence in the MOHLTC ability to protect health care resources?

(d) Could the conduct in question result in actual or potential financial loss to the Ministry?

(e) Are there intra-, inter-ministerial and/or external implications to consider?

(f) Is the incident isolated or widespread?[32]

Consulting Firm and Fraudulent Registration

Ministry staff were asked if the recommendations of the consulting firm hired in 2004 had been acted upon.[33]

Supplementary Information

According to information provided by the Deputy Minister following the hearings, the consultant had concluded that there were two major means to sustain and improve consumer fraud control.

1. Sustain the highly effective systems of fraud prevention, detection and control currently in place.

....

2. Develop a working Fraud Measurement Framework to be used as a bench mark to measure higher risk areas, to measure the effectiveness of preventative and detective methods applied and to guide future work to mitigate consumer fraud in OHIP.

The consultant's work primarily consisted of a "methodology to identify areas of risk for fraud" and then estimate the cost of fraudulent activity in those areas. Much of the methodology was a review of clients' claims "to discern anomalies or patterns that may suggest fraudulent activity."

With its new mandate, the FPB will employ a similar methodology to analyze the claims payment systems to "proactively detect possible fraudulent activity." Efforts will also be focussed on "early detection, quick intervention and measuring interventions for effectiveness." The FPB will identify areas of risk "that pose the greatest concern and develop strategies to prevent fraud in these areas." Best practices will be developed from post-project assessments.[34]

Postal Box Project
The 32,000 cardholders using their postal box address were being loaded into the data integrity project. Those cards will be cancelled or require re-registration. Members were advised that the Client Registration System was rebuilt in 2002 so that a postal box address could not be included in the resident address.[35]

Anomalies in Health Card Usage
The Auditor identified a high occurrence of claims in a short period of time in different parts of the province. Those patterns will be examined by the FPB. There are reasons why people receive services in different parts of the province. College and university students are away from home at school. Anyone who travels for business sometimes makes claims around the province. People seeing specialists may have to incur claims in different areas of the province.[36]

The clinics treating 4,000 patients referred to by the Auditor were methadone clinics. In the fall of 2006, the clinic corporation was convicted of fraud. A repayment of some of the billings was made to the Ministry of Finance.

The Ministry continues to assess the laboratory billing concern. A committee is working with the Ontario Medical Association (OMA), and the Provider Services and Laboratories branches to introduce changes to the laboratory and physician schedules of benefits that will improve the ability of physicians to bill appropriately for those services.[37]

Supplementary Information
The clinic corporation referred to above was Comquest. The group of physicians was the Ontario Addiction Treatment Centre. In October 2006, Comquest was charged with being a party to an offence for contravening the *Health Insurance Act*. It was convicted and fined $25,000. A voluntary payment of $250,000 was made to the Ministry of Finance.

The case of the six individuals receiving counselling from one provider is the subject of an ongoing Ministry review. The Committee was told that appropriate steps are being taken.[38]

Review of Potential Cases of Ineligibility
As of January 1, 2007, the Ministry had closed 1,900 of the 7,000 backlogged eligibility assessment cases noted by the Auditor. Eligibility was ended or ongoing eligibility was granted. Resources continue to be dedicated to completing assessments and longer-term business improvements are being reviewed.

Some of the files the Auditor considered to be backlogged are in process. Given the nature of client eligibility assessment, the Ministry will always have approximately 1,300 files in process. At the time of the hearings, the backlog was estimated to be 3,800. The Ministry hopes to have the backlog substantially reduced by the end of 2007.[39]

Ministry staff advised that they will never attain a zero backlog. The figure of 1,300 was thought to be a reasonable number to have in process at any given time. Resources are dedicated to clearing the backlog; these are considered low-risk cases but have to be dealt with.[40]

The process of assessing eligibility can take months, depending on how responsive the person is to a request for additional documentation and questions about their absences from Ontario. Cases are sometimes closed because of the length of time they have been dormant. There is always a danger that someone could be left without a card. In those instances, they can re-register when they require health services.[41]

Supplementary Information

Following the hearings, the Committee was advised that 36% of the 1,900 closed files were found to be ineligible for coverage as of February 14, 2007. Because this was a point-in-time measurement, it was subject to change. A person's status could change if they contacted the Ministry with further information to support their eligibility. The Ministry's decision could also be appealed to the General Manager's Review Committee or the Health Services Appeal and Review Board. On average, about 32% of the people reviewed through the eligibility assessment process were found to be ineligible for OHIP.[42]

Committee Recommendations

The Committee is well aware that the original intent was to have the conversion of red and white health cards to photo health cards completed over five years, after the introduction of photo cards in 1995. It also acknowledges the challenges faced by the Ministry of Health and Long-Term Care in meeting that intent. However, the Committee remains concerned that the Auditor's *2006 Annual Report* estimated that it would take approximately 14 years to complete the re-registration process and phase out the old cards.

The Committee therefore strongly recommends that:

> **1. The Ministry of Health and Long-Term Care report to the Committee on options to reduce the time needed for the conversion, including related time-frames by which red and white health cards can be converted to photo health cards.**
>
> **One option that the Committee would like to have considered is an extension of the renewal time-frame for photo health cards. Any savings from this extension should be allocated to expediting the replacement of red and white health cards.**

The Committee also recommends that:

2. The Ministry of Health and Long-Term Care provide the Committee with an update on the activities of the Fraud Programs Branch since the expansion of its mandate.

3. The Ministry of Health and Long-Term Care provide the Committee with the current number of backlogged eligibility assessment cases and a reassessment of its ability to achieve, by the end of 2007, a sizeable reduction in that number.

The Committee requests that the Ministry provide the Committee Clerk with written responses to these recommendations within 120 days of the tabling of this report in the Legislature.

4.4 Authentication of Citizenship Documents

New registrations, renewals, replacements, and changes of personal information are processed at 27 OHIP district offices. Applicants must provide proof of citizenship, residency and personal identity. Since 1995, the Ministry had electronically authenticated some citizenship documents with Citizenship and Immigration Canada (CIC), and electronically validated Ontario birth certificates with the Registrar General. Audit staff found that only 54% of active photo cards and 30% of all cards in circulation had been authenticated in this manner.

The Ministry entered various pieces of information into the Client Registration System and matched them with data from CIC or the Registrar General. Unmatched cases must be followed up. The Ministry also accepted Canadian citizenship cards and passports as proof of citizenship, but it did not verify these documents with the issuing government departments.

Audit staff found that resources dedicated to the authentication process were insufficient to process the number of new unmatched cases identified each month. The backlog had doubled since May 2004. As of March 2006, it amounted to over 154,000 unmatched cases with CIC and 101,000 cases with the Registrar General. At the time of the audit, more than 76% of these cases were more than a year old.[43]

The Auditor recommended timely follow-ups on outstanding cases in which the authentication of citizenship documents resulted in unmatched differences. He also recommended that consideration be given to expanding the scope of the electronic authentication program to other commonly used citizenship documents, such as the Canadian passport and citizenship card.[44]

Committee Hearings

The Ministry is reviewing options to further automate the authentication of citizenship documents. For example, it is negotiating with CIC to enable the

Ministry to authenticate the Canadian citizenship card. System changes will allow for this if an additional data exchange agreement can be completed.

The Ministry has also held initial discussions with the Canadian passport office. Both parties have committed to begin work to enable the Ministry to electronically authenticate Canadian passports. Both have included this work in their 2007/08 business plans. As a first step, the passport office will share information on lost and stolen passports.

At the time of the hearings, the Ministry authenticated citizenship documents for 64% of all photo card holders. If Canadian passports and citizenship cards are added, the Ministry would then have 84% of documents being authenticated. Ministry staff thought they would probably never get to 100% because many people do not have the necessary documents.[45]

Committee Recommendations

The Committee recommends that:

4. The Ministry of Health and Long-Term Care report to the Committee on the status of its negotiations with Citizenship and Immigration Canada and the Canadian passport office.

5. The Ministry of Health and Long-Term Care report on the number of cases reported as unmatched with Citizenship and Immigration Canada and Ontario Registrar General records.

The Committee requests that the Ministry provide the Committee Clerk with written responses to these recommendations within 120 days of the tabling of this report in the Legislature.

4.5 Application Processing

During visits to district offices, audit staff found that procedures to ensure that all transactions were valid, complete and accurately processed could be improved. There were no reconciliation procedures to match the number of registrations and renewal or replacement applications accepted with the actual transactions processed and cards issued. There was no supervisory review of applicant information being entered into the Client Registration System against information provided on application forms or supporting documents. Once individuals are entered into the system, they are automatically eligible to receive a card. Because copies of the supporting citizenship documents are not kept for future reference, reconciliations and supervisory checks would reduce the risk of unauthorized transactions being processed, improper documents being accepted for processing or erroneous information being entered into the registration system.[46]

The Auditor recommended reconciling health-card applications received to processed transactions, and performing random supervisory checks matching system data to application and supporting documents.[47]

Committee Hearings

The Ministry will be contracting with a security expert to review its health card application and registration process. The review will make recommendations on mitigating the risks for fraudulent activity by referring to industry best practices and internal control measures implemented by other government agencies. The Ministry will consider the advice and recommendations in the reports from these reviews and take appropriate action.[48] Ministry staff expressed the hope that the work would be completed within three months so that a report would be received by June 2007. Some internal business review activity had already been started. An undertaking dealing with accessibility was expected to be complete by March or April 2007.[49]

Committee Recommendation

The Committee recommends that:

> **6. The Ministry of Health and Long-Term Care provide the Committee with an update on the recommendations regarding the health card application and registration process put forward by the contracted security expert and Ministry staff.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

4.6 Special Registration

Registration for the Homeless

A homeless person often does not have the required documents to obtain a health card. Agencies dealing with the homeless assist them in applying for cards. Ministry policy requires these bodies to have agreements setting out Ministry and agency roles and responsibilities.

During their visits to district offices, audit staff found that controls to ensure transactions were legitimate could be improved. Actual agreements differed from the standard Ministry agreement, and signatures of appropriate agency staff were not required or the requirement was not enforced.

Any person referred by an agency is registered regardless of whether they can provide citizenship-status documents. The Ministry relies on the agencies to work with the individual to obtain and submit the appropriate documents. District offices said that agencies rarely report back on these individuals. Accordingly, the Ministry had little, if any, assurance that the proper documents had been obtained.

In many cases, agency staff had no personal knowledge of their clients. About 9,700 homeless individuals had been registered without the required citizenship documents since July 1995. The Ministry usually issued cards with a one-year expiry date to such individuals. A data analysis indicated that approximately 690 had had their health cards renewed without the proper documents.[50]

Exemption from Photo or Signature Requirements
Some applicants are exempted from photo or signature requirements for medical reasons, meaning their physician must provide a signed exemption form. A review of forms collected by district offices found that a physician's identity or authenticity was not verified with the CPSO's database in order to validate these exemptions.[51]

The Auditor recommended ensuring that all agencies assisting homeless individuals to obtain health cards have valid agreements with the Ministry and obtain proof of applicants' eligibility for publicly funded health-care services. He also recommended verifying the authenticity of providers who sign photo/signature exemption forms.[52]

4.7 Protection of Personal Health Records

Personal health information is maintained in the Client Registry System and the Medical Claims History Database. The audit reviewed security over the two systems and concluded that it should be improved in several areas. System access and user-group profiles were not adequately monitored, the latter being the authority assigned to individuals in a group to access, modify or delete data. The audit report makes specific reference to issues related to the Client Registration System, the Claims History Database and the Claims Correction System.[53]

The Auditor recommended ensuring that proper approvals are obtained before establishing or changing user-group access profiles and enforcing the requirement for periodic reviews for unwarranted system access at district offices. He also called for strengthening the effectiveness of the existing security review process and monitoring tools, implementing more rigorous security features to control access to the Claims Correction System, and restricting security administration duties to qualified staff.[54]

Committee Hearings

The Ministry initiated the Access Control Review Project in July 2006 to review its access control policies and procedures, and to make recommendations for improving the security requirements that govern staff access to corporate systems. The Project was expected to develop recommendations by March 2007. The recommendations will deal with improvements and any emerging requirements to align with the Auditor's recommendations and security requirements under the *Personal Health Information Protection Act.*

Highly sensitive OHIP data is stored in databases on the mainframe computer system in a secured data centre. The mainframe has specialized and tightly controlled access control mechanisms, with access granted only to staff who need access to the particular data or applications. The mainframe is not directly accessible to the Internet in order to prevent unauthorized access.

Information is sent to the Ministry on secure networks, like the Smart Systems for Health network, which provides encryption services to make the data stream

unintelligible. Data streams are a series of codes, such as health number, billing codes, and dates that are meaningless to most people.

Threat-risk assessments, privacy impact assessments, security tests, constant monitoring, and audits have been undertaken on a continual basis to provide assurance that the information is being protected.[55]

5. Health-Care Providers

5.1 Provider Monitoring and Control

Providers are responsible for ensuring their submitted claims comply with the *Health Insurance Act* and the Schedule of Benefits, a regulation under the *Health Insurance Act*. The Monitoring and Control Unit reviews claims. It also educates providers on the claims-submission process and practices, and pursues the recovery of overpayments resulting from submission errors.

The two claims-monitoring processes are pre-payment screening and post-payment review. Submitted claims are screened for compliance with predefined medical rules programmed into the Medical Claims Payment System. These rules are not sufficiently comprehensive to detect all inappropriate claims. The post-payment review involves analyses on paid claims to determine if they were submitted properly and in accordance with the Schedule of Benefits. Potential criminal cases are referred to the OPP for investigation.[56]

Suspension of the Medical Review Committee
Post-payment reviews can result in a variety of possible actions, including educating the practitioner, direct recovery for claims containing errors, referral of suspected fraud cases to the OPP and, up until its September 2004 suspension, referral of questionable claims to the Medical Review Committee (the Committee). The Committee had a structure and review process similar to those committees in other provinces. Its reviews could result in a number of possible outcomes. From 1999/00 to 2002/03, an average of 90 cases a year were referred to the Committee and approximately $4.9 million was recovered annually.

Long-standing complaints about the review process led to the Minister's June 2004 appointment of retired Supreme Court of Canada Justice Peter Cory to study the matter. Three months later, the Minister suspended the Committee and created the Transitional Physician Audit Panel. The Panel would act as a temporary appeal body for results on audits conducted before the suspension or for decisions relating to the recovery of paid claims made after the suspension.

Cory released his final report in April 2005. His 118 recommendations included the establishment of a new medical audit process and a new physician audit board, independent of the Ministry and professional regulatory bodies. The basis for any audit was to be clear, the methodology transparent and the process fair. The Ministry committed itself to an implementation plan for the report by the summer

of 2005. At the time of the audit, a plan had been submitted to Cabinet but legislative changes had yet to be introduced.

When the Committee process was suspended, 110 cases were under review. It was the Auditor's understanding that none would be reopened when the new process is in place. Based on 1999/00 to 2002/03 recovery rates, a potential $13 million to March 2006 may have been lost due to the Committee's suspension.[57]

The Auditor recommended the implementation of an effective review process as soon as possible.[58]

Committee Hearings

The changes required for a revised medical review process were included in Bill 171, the *Health System Improvements Act*, introduced by the Minister on December 12, 2006. If the legislation is enacted, the new system will have four phases: education; payment review; review by a new physician audit board; and an appeal process.[59] Education activities are already under way. They include one-on-one education on accurate claims submissions and the continuation of ongoing Ministry and OMA education about correct OHIP billing procedures.[60]

The old system was said to have been judged unfair to physicians. The proposed system complies with much of what Justice Cory recommended, short of new review or quasi-judicial procedures. More direct contact will be made with physicians to explain procedures and work out differences. Efforts will be made to ensure that the Ministry comments on claims it has concerns about within a reasonable amount of time. Should there be disagreement, matters would go to the review board.[61]

When asked if resources were best spent on tackling fraudulent card use or errors in service provider billings, Ministry staff replied that both had to be dealt with. However, in light of the Auditor's report and the new medical review process proposed by Bill 171, they thought that their short-term focus would be on fraud. Bearing in mind reports such as those from the Auditor and the results of risk analyses, priorities for immediate action could change year to year.[62]

Committee Recommendation

The Committee recommends that:

> **7. The Ministry of Health and Long-Term Care report on the number of cases and related total dollar amounts under review at the time the Medical Review Committee was suspended and confirm that these cases will not be reopened with the new review process.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

5.2 Provider Registration

There are approximately 28,000 health-care providers in Ontario. All must register with the Ministry and obtain an OHIP billing number in order to submit claims. They must also have an Ontario practice address and hold a current valid licence with their professional governing body. District offices receive and process registration forms and the accompanying supporting documents. The audit found that provider files were often incomplete.[63]

5.3 Provider Information Updates

Provider records are maintained in the Provider Registry System. Periodic updates are received from governing bodies. The CPSO, for example, sends weekly electronic updates which include new physicians and those whose licences have expired or been terminated. This data was found to include only licence expirations due to suspension. Audit staff requested and obtained a listing of all active physicians as of February 2006 from the CPSO. In a comparison with Ministry records, they identified 725 non-licensed physicians as still active in the Ministry's database. The Ministry was provided with the relevant details and said it would follow up on them.

Notices were sent to the Ministry updating the status of other practitioners. Audit staff requested and obtained listings of active dentists and optometrists from their respective colleges as of February 2006. They concluded that these records, too, were not being properly updated.

The Auditor recommended that the Ministry work more closely with all professional governing bodies to ensure that provider records are updated in a timely manner.[64]

Committee Hearings

Of the 725 non-licensed physicians identified by the Auditor, only 40 submitted claims for services after their licence ended. The total amount paid was approximately $81,000. All of the circumstances have been assessed as administrative errors, not fraud.

Claims were submitted and paid to three physicians who, according to CPSO records, were deceased. The total value of these claims was $514. In two of the cases, the claims were within days of the death and were assessed to be errors made on recording the date of service to the patient. The remaining case was also determined to be an error made in a claims submission.

In the case of the physician who violated the terms and conditions of his licence and was paid for services to 300 patients, the CPSO told him in January 2003 that his licence was being revoked retroactively to May 1, 2002. In the interim, the physician had provided services to patients in June 2002 and billed OHIP approximately $8,000. At the time of the payment, the physician had a valid CPSO licence and was able to bill OHIP.

The Ministry completed discussions with the CPSO to provide an enhanced data feed which started in early September 2006. Information is received on a weekly basis and updated in the corporate provider database within three working days. The data feed will include all categories of physicians who are inactive. (Categories such as death and retirement had not been included prior to the enhanced feed.) The licensing information for physicians identified by the Auditor was updated in July 2006.

The Ministry is working with regulatory colleges to create a data baseline containing a listing of licensed practitioners in order to facilitate future electronic data feeds. (Other practitioners who can bill are a limited group: optometrists, some podiatrists and designated physiotherapy clinics. Billing information is also maintained for categories such as nurse practitioners who can make referrals for services.) In the interim, practitioner information is kept current through regular communication with the colleges.[65]

5.4 Protection of Provider Records

The audit reviewed the Provider Registry System's security administration procedures and concluded that there were several areas where security should be improved (e.g., missing approval documents for system access and creation of user group profiles without proper approval).

The Auditor recommended developing proper documentation for all user-group profiles and the maintenance of all system-access approvals to ensure that all access rights are maintained on a need-to-know basis. He also recommended enforcing a regular review of access privileges to the Provider Registry System so that only necessary privileges are maintained.[66]

In its initial response, the Ministry reported that a project was introduced in July 2006 to review its access control policies and procedures and make recommendations for improving the security requirements that govern staff access to corporate systems. A database that captures all authorization information for access to the Corporate Provider Database was implemented in June 2006. It produces quarterly reports for review which allows updates to be made appropriately, including confirming ongoing eligibility of authorized profiles.[67]

Ministry's Implementation Status – January 2007

The new database's first report for the period ending November 30, 2006 has been produced and reviewed. Reports will continue on a quarterly basis.[68]

6. Medical Claims Processing

All claims submitted by providers are reviewed for provider and patient eligibility and assessed against predefined medical rules to ensure that payment is made only for authorized services. While claims processing is, for the most part, done accurately, the Auditor had specific concerns described below.

6.1 Medical Rule Updates

A change to the Schedule of Benefits requires system changes by the effective date to ensure claims are properly processed and payments are accurate. The audit found that medical rules were not always updated accurately or in a timely manner. Required changes from the latest release of medical rules were completed for 22 of 68 by the October 2005 effective date. The remainder were not fully implemented until March 2006. More than 20 medical rules with errors were awaiting correction at the time of the audit.

The Auditor recommended that the Ministry implement all new medical rules and corrections in a timely manner.[69]

In its initial response to the Auditor's report and his recommendation under the heading 'Medical Claims Processing,' the Ministry referred to the most recently negotiated Physician Services Agreement as being very complex. It had challenged the aging architecture of the claims payment system. A review would be undertaken in 2007/08 to consider solutions that would allow for more effective processing of payment streams. Attention would be paid in negotiating future agreements to ensure that there was sufficient technical capacity to support implementation of the negotiated elements of the agreement.[70]

6.2 Rejected Medical Claims

Over 9.5 million claims were initially rejected in 2005/06. Claims rejected under the automated medical-rule review are forwarded to district offices to be reviewed. Rejected claims may then be overridden and paid if staff deem them to be medically necessary or legitimate, or returned to the provider for correction and resubmission. The Auditor's office had raised concerns about the process for overriding rejected claims since 1993. Audit staff found that there were inadequate guidelines, standards or procedures to assist district office staff in making decisions when assessing rejected claims. District offices did not maintain sufficient documentation supporting their override decisions. A number of these decisions were reviewed with Ministry staff, who confirmed that 10% were made in error. There was no ongoing management review of overridden transactions to ensure that decisions were consistent, appropriate and accurate.[71]

The Auditor recommended developing guidelines and procedures to assist district staff in making consistent and appropriate decisions on overriding rejected medical claims, and reviewing a sample of overridden transactions on an ongoing basis to ensure consistency and compliance with developed guidelines.[72]

Ministry's Implementation Status – January 2007

The Access Control Review Project will consider the Auditor's recommendation. It is expected to present its recommendation report in March 2007.[73]

Committee Hearings

Ministry staff were asked if there have been changes to clarify the circumstances under which an override provision would go into effect. Overrides are sometimes performed because the required systems changes have not been made. Changes are made in a priority order and as they get made, the need for overrides is decreased. The Access Control Review Project is looking at these processes, the conditions under which some kind of override will continue and the type of oversight required.[74]

Committee Recommendation

The Committee recommends that:

> **8. The Ministry of Health and Long-Term Care report on actions planned to enhance the process for reviewing rejected claims based on the recommendations of the Access Control Review Project.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

6.3 Paper Claims Processing

About 750,000 claims are submitted on paper forms and entered into the system manually every year. Audit staff found deficiencies in ensuring that these types of claims were authorized (e.g., poor controls over access to the data-entry system, and no tracking, review or reconciliation).

The Auditor recommended establishing procedures to reconcile the number and dollar amounts of paper claims, and strengthening the security controls over the data entry system for paper claims to ensure that system access is appropriately restricted.[75]

Ministry's Implementation Status – January 2007

The Access Control Review Project will consider the Auditor's recommendation. It expected to present its recommendation report in March 2007.[76]

NOTES

[1] Ontario, Office of the Auditor General, *2006 Annual Report* (Toronto: The Office, 2006), pp. 180-181.
[2] Ibid., pp. 181-183.
[3] Ibid., pp. 179-180.
[4] The red and white cards were introduced after the elimination of health premiums. See Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Official Report of Debates (Hansard)*, 2nd Sess., 38th Parl. (12 February 2007): P-214.
[5] Office of the Auditor General, *2006 Annual Report*, pp. 183-184.
[6] Ibid., p. 184.
[7] Ibid., p. 185.
[8] Standing Committee on Public Accounts, *Official Report of Debates*, p. P-212.
[9] Ibid., p. P-229.
[10] Ibid., pp. P-211 and P-222 - P-223. The Ministry also has 180 outreach sites which serve smaller communities at scheduled times. See Ibid., p. P-211.
[11] Ibid., pp. P-208 and P-213.
[12] Ibid., p. P-208.
[13] Ibid., pp. P-210 and P-211.
[14] Ibid., pp. P-208 and P-213.
[15] Ibid., pp. P219 – P220.
[16] Ibid., p. P-216.
[17] Ibid., pp. P-212 – P-215.
[18] Ibid., p. P-212.
[19] Ibid., pp. P-211 and P-217.
[20] Ibid., pp. P-216 and P-217.
[21] Ontario, Ministry of Transportation, "McGuinty Government to Introduce New Driver's Licence Card," *Canada Newswire*, 9 March 2007.
[22] Letter from Deputy Minister, Ontario Ministry of Health and Long-Term Care to Chair, Standing Committee on Public Accounts, 15 March 2007, p. 4.
[23] Office of the Auditor General, *2006 Annual Report*, pp. 185-187.
[24] Ibid., p. 187.
[25] Ibid., pp. 187-188.
[26] Ibid., p. 188.
[27] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P-209 and P-222.
[28] Ibid., p. P-221.
[29] Ibid., p. P-220.
[30] Ibid., p. P-215.
[31] Ibid., p. P-222.
[32] Letter from Deputy Minister to Chair, Standing Committee on Public Accounts, pp. 1-2.
[33] Standing Committee on Public Accounts, *Official Report of Debates*, p. P-221.
[34] Letter from Deputy Minister to Chair, Standing Committee on Public Accounts, pp. 2-3.
[35] Standing Committee on Public Accounts, *Official Report of Debates*, p. P-220.
[36] Ibid., p. P-220.
[37] Ibid., pp. P-218 and P-224.
[38] Letter from Deputy Minister to Chair, Standing Committee on Public Accounts, p. 3.
[39] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P-209 and P-221.
[40] Ibid., p. P-224.
[41] Ibid., p. P-224.
[42] Letter from Deputy Minister to Chair, Standing Committee on Public Accounts, p. 3.
[43] Office of the Auditor General, *2006 Annual Report*, pp. 188-190.
[44] Ibid., p. 191.
[45] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P-209 and P-219.
[46] Office of the Auditor General, *2006 Annual Report*, p. 190.
[47] Ibid., p. 191.
[48] Standing Committee on Public Accounts, *Official Report of Debates*, p. P-209.

[49] Ibid., p. P-222.
[50] Office of the Auditor General, *2006 Annual Report*, pp. 190-191.
[51] Ibid., p. 191.
[52] Ibid.
[53] Ibid., pp. 191-192.
[54] Ibid., p. 192.
[55] Standing Committee on Public Accounts, *Official Report of Debates*, p. P-209.
[56] Office of the Auditor General, *2006 Annual Report*, pp. 192-194.
[57] Ibid., pp. 193-194.
[58] Ibid., p. 194.
[59] Schedule G of Bill 171 provides for the creation of the Physician Payment Review Board, the Joint Committee on the Schedule of Benefits and the Physician Services Payment Committee.
[60] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P-209 – P-210 and P-218.
[61] Ibid., pp. P-225 – P-226.
[62] Ibid., p. P-227.
[63] Office of the Auditor General, *2006 Annual Report*, pp. 194-195.
[64] Ibid., pp. 195-196.
[65] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P-210 and P-226.
[66] Office of the Auditor General, *2006 Annual Report*, p. 196.
[67] Ibid., p. 198.
[68] Ontario, Ministry of Health and Long-Term Care, "2006 OAGO Annual Report Response, Section 3.06 – Ontario Health Insurance Plan," 12 February 2007, p. 10.
[69] Office of the Auditor General, *2006 Annual Report*, pp. 196-197.
[70] Ibid., p. 199.
[71] Ibid., p. 197.
[72] Ibid.
[73] Ministry of Health and Long-Term Care, "2006 OAGO Annual Report Response," pp. 10-11.
[74] Standing Committee on Public Accounts, *Official Report of Debates*, p. P-222.
[75] Office of the Auditor General, *2006 Annual Report*, p. 197.
[76] Ministry of Health and Long-Term Care, "2006 OAGO Annual Report Response," pp. 10-11.