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Monday 12 February 2007

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Lundi 12 février 2007

Standing committee on public accounts

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Auditor General:
Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Monday 12 February 2007

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Lundi 12 février 2007

The committee met at 0940 in committee room 1, following a closed session.

SUBCOMMITTEE REPORT

The Chair (Mr. Norman W. Sterling): Good morning, Deputy Minister of Health. Thank you for coming. Before you begin, we have just one very short item of business to take care of: Mr. Milloy wants to move a motion to adopt the report of the subcommittee on our committee business. Mr. Milloy.

Mr. John Milloy (Kitchener Centre): I'd like to move the subcommittee report. Based on our meeting on Tuesday, December 12, I'd like to move the following:

(1) That the selections for consideration by the committee from the 2006 Annual Report of the Auditor General be as follows:

Section 3.06: Hospitals—Management and use of diagnostic imaging equipment

Section 3.08: Ontario health insurance plan

Section 3.03: Community colleges—Acquisition of goods and services

Section 3.07: Hydro One Inc.—Acquisition of goods and services

Section 3.10: Ontario Realty Corp.—Real estate and accommodation services

(2) That the official opposition be allowed to provide a second selection to the committee at a later time.

(3) That the committee request authorization from the House to sit up to three days during the winter adjournment to consider the 2006 Annual Report of the Auditor General.

(4) That the committee begin each section with a closed-session briefing by the Auditor General and the research officer.

(5) That the deputy minister and other appropriate staff of each ministry be asked to attend the committee following the closed session briefing to provide a response to the auditor's report and to answer any questions.

(6) That the clerk of the committee, in consultation with the Chair, be authorized, prior to the adoption of the report of the subcommittee, to commence making any preliminary arrangements to facilitate the committee's proceedings.

The Chair: Any discussion? If not, is everyone in favour? Agreed. The motion passes.

2006 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.08, Ontario health insurance plan.

The Chair: Thank you very much for your patience, Mr. Sapsford.

Today the committee is going to review section 3.08 of the auditor's report, which was brought down in early December 2006. This particular section deals with the Ontario health insurance plan, and we are pleased today to have the Deputy Minister of Health, Ron Sapsford, with us.

Mr. Sapsford, you have some opening remarks, and I would ask you to proceed.

Mr. Ron Sapsford: Thank you, Mr. Chair. I'm very pleased to be here this morning. On behalf of the Ministry of Health and Long-Term Care, I want to thank the public accounts committee for providing me and my staff with this opportunity to address the 2006 Annual Report of the Auditor General relating to the Ontario health insurance plan.

I'm joined this morning, on my left, by Dawn Ogram, who is the assistant deputy minister of corporate and direct services, and, in a few moments, for questions of the committee, by Suzanne McGurn, who is the director of the provider services branch of the ministry, and Pauline Ryan, who is the director of registration and claims.

Let me state at the outset that the ministry fully supports and appreciates the work of the Auditor General in completing this audit. Overall, the ministry supports the recommendations of his report and recognizes their significance for the health care system and indeed for all Ontarians. Let me also state that I take seriously the ministry's accountability for the broader health system and want to assure the committee that we continually review our programs, services and processes to ensure that a cost-efficient and effective program is provided to Ontarians. I am extremely proud of the ministry's accomplishments to date since the auditor's review and since his report was made public last fall.

Today I will report to you specifically on our progress in five key areas identified by the auditor, and at the same time I intend to clarify some areas that may be interpreted in more than one fashion.

My focus today will be on the following:

(1) Conversion of red and white health cards to the newer photo cards.

(2) The new mandate of the fraud programs branch.

(3) Document authentication and registration processing.

(4) Protecting the privacy of personal information.

(5) Provider monitoring and control.

Let me start by discussing what the ministry is doing and has done about converting the older red and white health cards to the newer photo cards.

The auditor indicated that the Ministry of Health and Long-Term Care should expedite the conversion of the pre-1995 red and white OHIP cards to the current OHIP photo cards in order to properly verify the eligibility of these health card holders, and the ministry certainly agrees that the conversion of red and white cards is important. I am keenly aware of the ministry's responsibility to ensure that the integrity of the data on the registered persons database is maintained. The registered persons database is the ministry database that contains the pertinent information for all eligible individuals in Ontario who have been registered for an OHIP card. It is critical to the functioning of a number of key programs that deliver health services, drug benefits and other programs. To that end, the ministry has worked to continue to reduce the number of red and white cards, using existing space and resource capacity.

In August 2004, the ministry initiated a data integrity project in order to reduce the number of health cards on the database for clients who appeared to no longer live in the province. In June 2006, the ministry cancelled eligibility for over 192,000 red and white cards where there were no claims against that card for the previous seven years and where the client did not respond to numerous requests to attend an OHIP office to convert to a photo health card. An additional 95,000 cards were cancelled in the current fiscal year, past June, for a total of 287,000 cards cancelled as of December 31, 2006.

To support this initiative, the ministry implemented a technology change in June 2006 to further automate the process of mailing notices to clients. This system change has allowed the ministry to contact and process a far greater number of clients in a short time frame. Specifically, the ministry was able to increase the number of notices sent to clients from a few hundred to 10,000 every week. This is an ongoing monitoring process for red and white cards, and the ministry continues to send notices to clients and will continue to cancel cards for ineligible cardholders. On average, the ministry converts 400,000 red and white cards to photo cards each year. As of January 1, 2007, there were 7.45 million photo cards and 5.11 million red and white cards in the province.

I agree with the auditor that converting red and white cards to the more secure photo cards faster is a desirable goal. However, we need to consider a number of factors in increasing the conversion rate, such as the costs associated with increasing staff to manage the interviews with clients; space or facilities to house this increased business volume; and the actual costs associated with producing the photo card. The ministry must weigh these increased costs against the opportunities that the associated funding would provide to support health services in the province.

0950

We are currently reviewing the options for changing the business process related to the existing photo cards, with the objective of absorbing some of the costs involved in the conversion of the red and white cards to photo cards. This would enable the ministry to complete the re-registration of all 5.1 million remaining red and white cards within a shorter time frame.

I should point out that the ministry also has other data integrity controls and processes in place that cancel red and white cards on an ongoing basis. For example, we have automated system feeds with the Ontario Registrar General that automatically cancel the cards of deceased persons when this data is sent to the ministry. As well, the ministry has an information exchange with other provincial Ministries of Health to enable the cancelling of cards for clients who have permanently moved out of the province and register for a health card in another province.

Related to the conversion of red and white cards is the matter of the extra cards in circulation. The auditor's report found that the ministry's database contains 300,000 more health card holders than the estimate by Statistics Canada of Ontario's population. This anomaly had already been noted by the ministry, which led to the 1994 data integrity project that I mentioned earlier. In fact, prior to the start of the auditor's review, the ministry had already begun the process of reviewing red and white cards that had had no claims for seven years and mailing notices to these cardholders. By the time the auditor's report was released, the ministry had already cancelled most of the additional health cards noted in the report, and it will have determined the status of the remaining cards and cancelled those that are ineligible by the end of this month.

The auditor was particularly concerned about the number of cardholders in border communities as compared with Statistics Canada's population figures for those communities. The ministry is aware that there is always some risk that some clients who register for a health card in a border community may not make Ontario their permanent and principal home. As a matter of standard practice, the ministry requires all clients to present documents to confirm their Canadian citizenship, their identity and the fact that their permanent and principal home is in Ontario when they register for a photo health card. And we continue to actively convert red and white cards to photo health cards within our existing capacity to do so.

I'll talk now about the fraud programming.

The auditor's report identified the need to enhance the ministry's activities in the area of health card monitoring in order to reduce the potential for fraud. It is difficult to estimate how much fraud costs the health system. Fraud is a hidden crime and, until detected, any attempts to quantify the losses are guesses at best.

As the steward of the health system, the ministry is keenly aware of the importance of protecting the integrity of the system and safeguarding taxpayers' funds against fraud. I am pleased to inform you that the ministry is expanding the mandate of the fraud programs branch in order to ensure a more comprehensive approach to fraud detection, prevention and loss reduction.

The fraud programs branch will be the centralized area within the ministry that will coordinate all fraud-related activities. All suspected cases of fraud against ministry resources will be referred to the branch for review and evaluation before being sent onward to the Ontario Provincial Police health fraud investigation unit. In addition, the branch will analyze the ministry's claims payment systems in order to proactively detect any possible fraudulent activity. The branch will also have the capability to analyze patterns of activity that may point to an area of concern. This is a significant step forward in the ministry's efforts to protect the public purse and the integrity of the health system as a whole.

In addition to the foregoing activities, as of January 1, 2007, the ministry closed 1,900 of the 7,000 backlogged OHIP eligibility assessment cases that were noted by the auditor in his report.

The ministry continues to dedicate resources to complete these assessments and is reviewing longer-term business improvements, including automation. It is important to note that some of the files that the auditor considered to be part of the backlog are in fact files in process. Given the nature of client eligibility assessment, the ministry will always have approximately 1,300 of these files in process in any given year. The current backlog of cases is now estimated to be 3,800.

Document authentication and registration is the next area of the auditor's report, and the ministry agrees with the Auditor General's recommendations around the authentication of documentation, in particular citizenship documents presented by clients.

I'm pleased to report that the ministry is reviewing options to further automate the authentication of citizenship documents to ensure that ineligible individuals do not receive health cards. For example, the ministry is currently negotiating with Citizenship and Immigration Canada to enable the ministry to authenticate using the Canadian citizenship card. If an additional data exchange agreement can be completed with CIC, system changes would allow the ministry to authenticate using this card.

The ministry has also held initial discussions with the Canadian passport office and both parties have committed to begin work to enable the ministry to electronically authenticate using Canadian passports. Both parties have included this work in their 2007-08 fiscal business plans and the Ministry of Health and Long-Term Care has assigned resources to this important task.

As a first step, the passport office will be sharing information with the ministry on lost and stolen passports. This will go a long way to help us identify potential cases of fraudulent applications for health cards.

Currently, the ministry authenticates the citizenship documents for 64% of all photo card holders. With the additional ability to authenticate Canadian citizenship cards and Canadian passports, the ministry will be able to authenticate the citizenship documents for 84% of all photo card holders.

Furthermore, 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.

Privacy and protection of personal health information is the next section. Again, the ministry agrees that it is important to protect confidential personal health records from unauthorized access and data tampering. To that end, the ministry initiated a 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 ministry corporate systems. By March of this year the project will have developed recommendations for improvements and for any emerging requirements to align with the auditor's recommendations and the security requirements under the legislative framework of the Personal Health Information Protection Act.

As I indicated earlier, the ministry is also contracting with a security expert to review its health card application and registration process. It will include a review of related ministry systems. The ministry will consider the advice and recommendations in the reports from these reviews and take appropriate action.

Let me emphasize that highly sensitive OHIP data, such as that relating to registration and medical claims, is stored in databases on the mainframe computer system in a highly 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 to fulfill the requirements of their jobs. The mainframe is not directly accessible to the Internet in order to prevent unauthorized access.

Information in transit to the ministry is sent on secure networks, like the Smart Systems for Health network, which provides encryption services to make the data stream unintelligible. The data streams themselves are a series of codes, such as health number, billing codes, dates, and so forth, that are utterly meaningless to most people.

Threat-risk assessments, privacy impact assessments, security tests, constant monitoring and audits have been undertaken to continually provide the assurance that the ministry is protecting this information on behalf of the public.

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Finally, let me turn to the ministry's activities in the area of monitoring and controlling health care provider activities. I'm pleased to say that good progress has been made in responding to the recommendation to implement an effective audit process as soon as possible. The ministry has proceeded with the next steps to support implementing a revised physician audit process. Changes

required for the revised audit process were included with the Health System Improvements Act, introduced by the government on December 12, 2006. If this legislation is enacted, the new medical audit system would have four phases: education, payment review, review by a new board and an appeal process. The process would emphasize educating and assisting physicians about correct billing and providing additional opportunities for them to respond to ministry concerns about their billings.

Education activities are already under way—for example, one-on-one education on accurate claims submissions for physicians, and continuation of ongoing ministry and Ontario Medical Association education about correct OHIP billing procedures through OHIP bulletins to physicians, interpretive bulletins published in the Ontario Medical Review, seminars, and other physician education programs.

In terms of ensuring that payments for services rendered are only made to licensed providers, I would like to put in context the findings noted by the auditor with regard to physicians whose licences were identified as not valid, yet still able to bill OHIP. Of the 725 non-licensed physicians identified by the auditor, only 40 had submitted any claims for services dated after their licence ended. The total amount paid to these physicians was approximately $81,000. All of the circumstances have been assessed as administrative errors and not fraud.

In terms of payments to deceased physicians, claims were submitted and paid to three physicians who, according to college 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 claims submission.

Finally, with regard to the case of the physician who violated the terms and conditions of his licence and was paid for services to 300 patients, the College of Physicians and Surgeons of Ontario notified the physician 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. When the payment to this physician was made, the physician had a valid CPSO licence and was active to bill OHIP.

The ministry does recognize and appreciate the auditor's findings with regard to ensuring that only eligible physicians are able to bill OHIP, and as noted in our response to the report, the ministry completed discussions with the College of Physicians and Surgeons of Ontario to provide an enhanced data feed, which started in early September 2006. The data feed from the college will now include all categories of physicians who are inactive. Further, the ministry updated the licensing information for physicians identified by the auditor in July 2006.

With regard to practitioners who bill OHIP, the ministry is currently working with the practitioner regulatory colleges to create a data baseline containing a full listing of licensed practitioners in order to facilitate electronic data feeds from these colleges in the future. In the interim, the ministry continues to keep current the practitioner information through regular communication with the colleges.

I hope that the foregoing has demonstrated some of the many significant ways in which the ministry's activities align with the recommendations of the Auditor General's report, and I hope I have done justice to how the ministry is currently managing these areas and how it intends to work even harder in the future. The ministry is committed to ensuring that Ontario's health care system will continue to provide the best possible care for all Ontarians and that it is managed as cost-effectively and efficiently as possible.

The ministry is grateful for the Auditor General's report. It makes an important contribution to providing the necessary analysis and feedback which are important to maintaining the high standards to which we all aspire.

Continuous improvement is the key to achieving excellence in all our endeavours, and constant re-examination is the means to that improvement. The Auditor General's report is indeed an invaluable report card that tells us how and in what areas we can improve Ontario's health care system.

The Chair: Thank you very much, Mr. Sapsford. We appreciate your attendance here. We have some questions from Ms. Martel to begin with.

Ms. Shelley Martel (Nickel Belt): Thank you, Deputy, for being here. Thank you to the staff who are here, as well, for the information that was sent to us in terms of the updates from January 29.

I wanted to start with the conversion process. The auditor encouraged expediting, but I'm curious about even the ministry's current conversion. You've said that you convert about 400,000 red and white cards to photo cards each year; the auditor pointed out that that is about half of the conversions that were going on in 1998. I'm wondering why there has been a decline in the number of conversions. Is that a function of fewer staff?

Mr. Sapsford: Mr. Chair, with your permission, I'll call one of my staff forward for the details.

The Chair: Sure. Could you introduce them as they come to the table, please?

Ms. Pauline Ryan: I'm Pauline Ryan. I'm the director of the registration and claims branch.

Thank you for the question. In 1998, the reason why we were doing a lot more conversions at that point in time was because the ministry had linked the photo health card conversion to the primary care rollout. So where we were opening and rostering patients to primary care physicians in particular areas of the province that were starting up—this was at the very beginning of the primary care piece—we were re-registering people for photo health cards as they rostered with their family physician. What we found in doing that was that we ended up with pockets of the province that had all re-registered for a photo health card and other areas where we had done almost no re-registration for a photo health

card, and we determined that it was because, once you get into the process of getting a photo health card, there's a renewal cycle that is included. For example, we did heavy re-registration in the Hamilton area, and five years later we got a very big push of people coming back into the office to renew their photo health card. That puts a strain on our service delivery network. So what we've done is we've evened out the conversion of the cards across the province so that we don't get that kind of push in one area. Now the conversion is happening evenly across the province. We have completed some areas of the province where there are smaller populations. That's the reasoning behind the change from 1998.

Ms. Martel: I can understand that you had people rostering because of the change to primary care, but there were supposed to have been any number of new family health teams up and running since 1998 as well, where people would have to have been rostered. So why aren't we seeing the same kind of numbers in terms of those rosterings? Is it because they're falling farther behind in terms of opening or because you're trying to manage both the re-registration and a new rostering at the same time?

Ms. Ryan: It's to do with the managing of it across the province so that we're not ending up with service delivery failures. When we started out with primary care, there were specific places in the province where primary care was more popular—and I'm going back to 1998, which you were referring to—like Chatham and Carp in eastern Ontario, where we went in and we did a specific re-registration, but what it ended up doing was creating pressures for us five years later when they were all trying to renew. So what we did was we stopped the requirement to get a photo health card being associated with rostering with a family physician for primary care. That was no longer a requirement.

Ms. Martel: I can see that, but wouldn't that make your life easier in terms of actually getting the conversion?

Ms. Ryan: If the rollout of primary care was done evenly across the province, it would; but because primary care grew at different rates in different places in the province, it made it more unmanageable.

Ms. Martel: There was a suggestion by the Chair earlier that maybe we should think about not doing the renewals and focus on the conversion; maybe you want to comment on that and what change that would make at the ministry if that's actually what you did. Are you considering that as an option in order to get the conversion going?

1010

Ms. Ryan: Yes, that is something that the ministry is looking at currently. Right now, our renewal rate is very big in our offices. We're looking at business re-engineering that would allow for mail-in renewals or renewals over the Internet, those types of things, that would clear the counter space and allow us to bring people in to actually re-register for a photo health card and go through the in-person service. That would then allow us to catch up in terms of getting rid of more of the red and white cards.

Ms. Martel: In terms of the actual conversion. What's the cost of doing the conversion?

Ms. Ryan: It depends on how quickly we do the conversion. Right now, we're doing about 400,000 a year, and that's under our current capacity. That's going to take us a number of years to complete. Within our current capacity, we can probably increase that by 100,000 this year, and we're looking at ways in which to do that. We're also looking at some offsets that we can find within our budget that would allow us to do even more in 2008.

Ms. Martel: Can I get an estimate, though, of the actual cost? The reason I'm asking that is that one of the options you're looking at had to do with the renewal cycle absorbing some of the costs involved in the conversion. I wasn't clear what that meant. I have a red and white one. I've never been asked to do the photo card, so I don't even know if there's a fee attached to that and if you're trying to change the fee. How is it that you're going to, with a renewal change, deal with some of the cost of the conversion?

Ms. Ryan: There is no fee associated with getting a photo health card. I'd be happy to arrange an appointment for you wherever you'd like to go.

Ms. Martel: You have to do Sudbury. We have never been asked.

Ms. Ryan: We've got a beautiful office in Sudbury. You can attend that and we'd be happy to re-register you, no problem.

If we were to try and do it immediately, like in a three- to five-year range, the cost is somewhere between $110 million and $130 million, which sounds like a great deal of money. The reason for that is—and I don't know how many people have been through the photo health card process—that it's a trusted registration process; it's an in-person process. You actually have to attend at one of our offices. We have 27 offices across the province and we have 180 outreach sites in which our staff visit smaller communities and towns you're probably familiar with. In that process, you actually have to show the documentation that I think the deputy referred to: proof of citizenship, proof of identity, proof of residency in Ontario. You get your photo captured and your signature captured for the card, so it's an interaction with an actual clerk at a counter.

In order to keep our wait times down, which now average around 20 minutes in our offices—some of our metro locations in the GTA are much longer than that. We have very big volumes in our Scarborough and Mississauga offices, so the wait times are a little longer there, but it's about 20 minutes on average. The transaction times are usually about six to eight minutes, depending on whether people have English as a first language and whether there are other issues that they have when they come forward to us.

That trusted registration process is really key to ensuring that only eligible individuals are getting the cards.

That's a process that the ministry feels strongly they want to continue, so if you have to convert another five million people to the photo health cards, you have to bring those people in in a gradual process and put them through that.

Ms. Martel: In your implementation status of January 29, it says, "The ministry is reviewing options for changing the renewal cycle for the existing photo cards with the objective of absorbing some of the costs involved in the conversion." So going from five to something longer, is that what you're trying to meet?

Mr. Sapsford: We're looking at all possible ways of addressing the volume question. As Ms. Ryan has just said, we have a sizable number of people we have to bring in. Perhaps that could be balanced by lengthening the life of the card so that the re-registrations could be reduced for a period of time so we could focus on conversion. There is consequence to that, however. We're trying now to keep our cycles consistent with the driver's licence, for instance, because we're working in partnership with the Ministry of Transportation on card production and so forth. We've looked at options of taking the address off the card so that we can simplify the reissuing of photo cards as people move. So we're looking at all these options to see if we can't find a better way of streamlining the process to divert or reallocate those resources to re-registering the red and white cards. We're looking at all those options now and trying to come to the best conclusion.

Ms. Martel: When you talk about MTO, the auditor noted they had a major conversion of drivers' licences to photo ID. Was there significant new funding added? Is that what happened that makes it different from the position you're in?

Ms. Ryan: When they did that, they already had an expiry date. You'll notice the red and white cards don't have an expiry date on them. The driver's licence cards had an expiry date that required everybody to actually come in and do that conversion.

Ms. Martel: But they would still have had a huge volume of people also coming in, which is—

Ms. Ryan: They also have a larger network in terms of their—

Ms. Martel: More staff.

Ms. Ryan: More staff; they have their private issuers network across the province.

Ms. Martel: Okay. The auditor also talked about 25% of the mailings to red and white cardholders returned as undeliverable. Then the auditor applied that on a bigger scale and suggested about 1.4 million cardholders' information in terms of address would be out of date. I know you've increased your project to get more stuff out the door and there was a technology change, but I wasn't quite clear if what you were doing in June was also dealing with the auditor pointing out that you could have the wrong address for that many people. Is that being caught?

Ms. Ryan: There are probably two ways to answer that. One is that the ministry is really putting an emphasis on asking people to keep their address current with the Ministry of Health. It's on our website, it's on every envelope we send out to people when they receive a card or they get a notice from us reminding them that they need to advise us of any address changes so that we can improve our currency on addresses on the database. In the recent health services improvement bill that's before the House there is actually a requirement in there for people to report their address change to the ministry so that we can keep that current.

Ms. Martel: Am I okay for a few more minutes?

The Chair: Sure.

Ms. Martel: I wanted to go to the numbers that you gave us with respect to checking the information and having a cancellation of the extra cards. You gave us information that suggested that as of June 2006, some 194,000 extra cards had been eliminated—"cancelled," I think, is the better word—and then you gave us an idea of when the rest would be dealt with. The question that I have is, are they cancelled on the basis that you know that someone has either moved out of province, you know that they have died, or is it that, if you don't get any response back, you just cancel at that point? The dilemma you're dealing with is that someone has moved and is going to go back and register somewhere else. Out of what you're getting back, can you make those determinations between who is really eligible and not eligible and who has just moved or hasn't used their health card in some time and has moved and is going to come back into the system?

Ms. Ryan: That project started in 2004, and it was indeed looking at cards where there had been no claims in seven years. You have individuals where there's no activity on the card in seven years, so you're talking about people who are either really healthy or they're not there. Our job, then, is to find out if you are still at the address you've given us, which we have on the system for you. We actually send out two notices to individuals and it's done over a period of time, so this is an ongoing project.

We capture all of the health numbers that have no activity for seven years off the claims system. They go into a special area, we start pulling them off 10,000 at a time per week, and we send out notices. We give them a time frame to get back to us. We send them a second notice. We give them time after the second notice to notify us. Since we've been doing this project, 17,000 people have notified us that they are indeed in the province and have come in and gotten a photo health card, but that's a 4% response rate.

If we don't hear from them, we cancel the card. If they do turn up seeking health services after that, all they need to do is come into a ministry office and show that they are eligible for OHIP and we will backdate their coverage and reimburse them for any health services they may have had.

1020

Ms. Martel: You counted some of those in terms of the 300,000 that the auditor said was over and above the population, so what I was trying to sort out is, is that

really an accurate reflection? You've got, on one hand, the auditor noting 300,000 more cards in circulation than population, and you've got a project going on where you actually mailed out to 394,000 and got so much information back in terms of what is listed for us. How do we know what problem has been fixed? Do you understand what I'm getting at?

Mr. Sapsford: The gap in the population estimate to the registered cards—I mean, we know how many registered cards there are. The Statistics Canada estimate can either be above or below. It's based on a census from 2001, I believe, so we use it as an indicator of relative growth in the population. The new census data, I believe, is out this year, so we'll have another opportunity to compare the total number of cards against a more accurate census.

I guess what I would say is that we generally capture growth in the population, either through immigration or birth, through the new photo card process. We're still only focused on the red and white cards, which have been in circulation for a long period of time, and presumably 99% are legitimate citizens of Ontario such as yourself with a red and white card. We look at the red and white cards as a declining base, and increases in population or new residents coming into Ontario are captured in the new photo health card registration system.

I agree with you. It's difficult to tell, and we're simply using the population census as a benchmark against which we're comparing total cards.

Ms. Martel: So more work would have to be done to actually make a determination of eligibility versus ineligibility.

Mr. Sapsford: Yes, and that eligibility test is where we're focused, to ensure that the eligibility tests are more effective, streamlined, automated, and so the work we're doing with the passport office and Citizenship Canada around authentication is, from our point of view, the more important process. The actual total number of cards is controlled through that new registration, and then the conversion of red and white into that system.

Ms. Martel: Okay. I'll stop there, Chair.

The Chair: Mr. Hardeman.

Mr. Ernie Hardeman (Oxford): Thank you very much for the presentation. Just quickly, in your opening you thanked us for the opportunity to be here. I was wondering, is that an accurate description of your attendance here? Or am I to take that with a grain of salt?

Mr. Sapsford: I always view these requests to attend as opportunities to provide the committee with information.

Mr. Hardeman: I would say that I appreciate that, because there does seem to be a lot of good information to present here that would make it look like you are doing a lot of the things that need to be done to address the auditor's concerns. So I appreciate that.

I wanted to first of all go to the red and white card conversions, somewhat on the same line as Ms. Martel was talking about. First of all, it would seem to me that if we have a problem with more cards than we have people, and we have two systems—one that clearly identifies that the person holding the card is the person eligible for the service, and we have the other half of the cards that are not identifiable at all—we would spend less time worrying about the renewal date on the green and white cards and more time getting more of those green and white cards in the system. As you were looking at speeding up the process, it would seem to me almost automatic that we would look at—why don't we just say that everybody whose card is due this year gets an extra five years, without question, and get all the red and white cards out of the system?

Mr. Sapsford: In fact, those are the kinds of options that we've been looking at. Deferring for five years has some downsides to it in terms of going 10 years instead of five, but we've looked at maybe not 10 but six or seven years and taking that excess and putting it to the red cards. So these are the very options that we've been looking at.

The longer you leave the card, of course, the more likely addresses are not current. We found the other day in discussion that practitioners rely on the address in terms of verification for their own clinical records, so to defer the renewal portion of it comes at some cost as well to accuracy in the health system. But, Mr. Hardeman, these are the very options that we're currently looking at to see if we can't speed the conversion.

Mr. Hardeman: The other thing, on the total numbers—and again, Ms. Martel kind of asked that question too. If the numbers of cards that are in existence are primarily based on fraudulent cards issued, that they were issued to names of people who didn't exist and so forth, when you notified them as to the problem—they haven't used their card in seven years, and we're going to make the assumption they are never going to use it because that person doesn't exist; it's a card with no patient—wouldn't it mean that every one of those should not respond? The people who do respond are not part of that 300,000. Is that right?

Mr. Sapsford: No. The actual 300,000 was the cancelled. That includes the red and whites.

Ms. Ryan: That only works if you assume that all 300,000 are fraudulent cards. What we're finding when we are doing this project and sending out notices is that people don't advise us that they died out of province or out of country. That's what we're finding. The system works so that if a person dies in Ontario, we get notified one of three ways. Either the family notifies us and sends the health card back to us directly, the Ontario Registrar General gives us a feed of the deaths in the province and we make sure that those health cards are cancelled, or, thirdly, for physicians who pronounce a person dead in Ontario, that's a code that comes in on the medical claims payment system, and then three days after that pronouncement of death is received, that card is cancelled. So we have a way to know when people have died within the province.

We also have a method of knowing when people leave the province to live in another province. We have feeds

with all of the other provinces and we keep track of who is moving from province to province so that we know who is covering those individuals for health care. They do get three months of health care from Ontario if they move to another province, and vice versa, but after that they become part of the other province's system, so they are paying premiums in some provinces and they are not in others. But we have that system, so we know when you've moved out and we can actually end your coverage, end your card, when you've moved out of the province. Either you tell us that you have or we capture it because of an information feed that we get.

The pieces that we don't have are when people move out of the country and don't tell us or they die out of country or out of province and we're not notified. With a lot of the cards that we're finding, that's the circumstance.

Mr. Hardeman: Thank you. I guess my concern is, I think this is a great exercise we're on here and, as the auditor pointed out, it's necessary to have an accurate database so there are no more cards than there are people. But from my perspective, that doesn't improve the quality of the system at all if all we're doing is removing cards that are ineligible. I'm more concerned about those cards that are going to people who aren't eligible for the service. Have you got any idea of whether that is prevalent, or is there any way of finding that, those people who have cards who are not eligible to have cards?

Mr. Sapsford: I'll let Ms. Ryan answer the details of that. You're talking now about the actual authentication, not so much the red and white piece. As we've said, we're trying to improve the authentication process so that people are who they say they are, that they have appropriate information to confirm their Canadian citizenship, and, thirdly, that they are permanent residents of Ontario. We require pieces of documentation to ensure that. This, as Ms. Ryan said, is a person-to-person engagement between the person wanting to gain access to a health card and the OHIP office. So we try as best we can to ensure that the person is correctly identified, that they do have citizenship and that they are resident. Those are the three major requirements for authentication in the province. I guess your question is: Can someone slip through that? Can someone show false documents? Can someone, although they may be Canadian, not be resident in the province and use false information? I suppose in any system there's the opportunity to do that. Our belief is that that's in a minority of cases, if it occurs.

The other point I would raise is that we currently have this review going on to ensure that we're using the best procedures possible to ensure that we are minimizing that kind of false identity or false information in the registration process.

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Mr. Hardeman: I guess my concern is that it doesn't matter how many cards we have out there that have no people; that will not negatively impact the system. It doesn't make the auditor very happy, because he says we've got all these cards we've got no people for, but not one of those people—if it's a card for my canine, the canine is not going to utilize it. So it shouldn't be in the system, but it doesn't bother the system. What bothers the system is when my relatives come and visit—I have some people who live on the other side of the border who might very well like our health care system—and if they have a card and come and use it, that hurts our system. That's why I'm anxious to see the card process move forward faster. We may be doing a job of catching those people: When they're told their card has to be renewed, they can't get it renewed, because they can't come up with the proper documentation. But we still have five point some million cards out there that can still get away with that without any risk at all. We have a card, we go to the doctor, we get the service and we go home. Is there a need to look at that or is that, in your estimation, not a problem area?

Mr. Sapsford: Well, that moves into the question of fraud. I think the biggest single change we've made as a result of the report is expanding the role of our fraud programs group. Before this change, fraud was really handled on a case-by-case basis with referral to the Ontario Provincial Police, who would investigate and then proceed on their own. The ministry really didn't carry those cases. So with the auditor's report and some of the observations, we're actually changing the process that we use, having members of the ministry in the fraud programs branch actually begin to look at the database more intently to look for patterns of practice, to look for unusual occurrences in the billing system itself, both from the perspective of provider fraud as well as uninsured use of a card. We're hopeful that we can begin to do that kind of trend analysis to try to identify problems and then move quite aggressively, then, to address the problem. That's a major change in the business process that the ministry has used up to now, and it's too early to tell whether that will yield any results, but at least we're making the efforts to try to detect patterns of fraudulent use.

Mr. Hardeman: I'm a step ahead of Ms. Martel: I have a new card. Is there any process in place that requires or that would have a physician ask for further identification, other than the health card, to provide health services? Again, if I have a red and white card with just a name, it could belong to anyone. Is there any way I have to identify who I am besides the health card?

Ms. Ryan: Physicians do have the ability to know that the card you're submitting is a valid card. So you're submitting it saying that you are Ernie and you're here to access health services. The doctor then uses that number to bill OHIP for the service. There's a validation system that the ministry operates that allows him to swipe the card in his office and know that your card is a valid card.

You're asking about how do I know—the red and white cards, when they were sent out in 1990, were based on the elimination of premiums that was done the year before. So the cards were issued, and the ministry at the time felt that they were issued fairly securely because everyone had a family OHIP number that they were

attached to at that time for premium purposes and they were now sending out cards to people based on that OHIP number. So when the cards were issued in 1990, it wasn't as if we felt that they were going all over the place. There was a method as to how they were issued at the time. A lot of time has passed since then, and generally speaking, we still have those validation processes that are available for physicians that are going to show the validity of the card.

I didn't talk about this before, but I do want to point out that in terms of fraud and people here from other provinces or other countries accessing the system using somebody else's card, we do have a fraud line that takes calls from the public, from emergency rooms. We get calls from doctors indicating that they think somebody is fraudulently using the system. We investigate all those cases. We do follow up on a lot of that. We have done, in the past, some pattern work, but that's really going to improve once we move to this new mandate for the fraud programs branch, where they can have a much more comprehensive look at the databases and see where the patterns are in that and identify risk.

Mr. Hardeman: Say my brother visits from the states, and I have a red and white card, and he gets ill here—he's not eligible for free health care—and he takes my card and goes to the doctor. There is nothing in the system that would catch that going through, that that was an inappropriate billing?

Ms. Ryan: Unless the doctor raises it himself—and that's what we do get. We get a lot of calls from Windsor emergency rooms telling us that they've got people there. We call that third party use of the card: Somebody is using somebody else's card. They suspect that, and then we do the investigation. If we find that it starts to look like it is a fraud piece, it will then get passed over to the fraud programs branch and then to the OPP, who will investigate for criminal purposes.

Mr. Hardeman: I guess it all leads to the final question on that issue, and that was mentioned in the report on page 6. In order to deal with this, we have to do cost-benefit analysis. We only have so much capacity to get to the new card; we can only do so much in space and in resources. So we really need to do a cost-benefit analysis of what we're doing based on where we want to go and how important it is to get there. If we don't have any idea of how much of the health care system is being used fraudulently because of not yet having the cards changed, how do we know how much resources should be spent to get them changed quicker?

Mr. Sapsford: Well, it's partly based on the frequency with which we have cases reported, as has just been said. If we have a huge increase in the number of suspected frauds reported from hospitals or physicians, then the follow-up by the OPP—many of them have explanations; the number of actual cases of fraud that have been prosecuted is relatively small. All of the indicators that we have at the end of it would suggest that, at least at this point, it's not a huge problem, although, I grant you, we don't know for certain. But all of the indicators we do have would suggest that it isn't a large problem. As we have this new fraud group looking at patterns and trying to identify them, we may get a better sense of that.

The cost-benefit, the fraud end of the benefit of moving faster, is a difficult thing to asses; I agree with you. The problem with re-registration on a massive scale when we're in a circular renewal is that we have to pay very close attention to how we stage the implementation. We can't have a system where in year one, because of the way we've implemented registration, we have one million people who need to be re-registered, then the next year six million, then the next year two million, and then up and down. Part of the real business process problem we're trying to solve is: How do we move the five million over into photo registry and still have a reasonable way of managing the ongoing application? That's really where we're trying to look at options to move as quickly as we can.

Mr. Hardeman: If I could just quickly—this is a typographical error, I'm sure, but in the presentation on page 5, "95,000 cards were cancelled in the current fiscal year for a total of 287,000 cards cancelled since"—

Mr. Sapsford: "As of."

Mr. Hardeman: Prior to?

Mr. Sapsford: As of that date, yes.

Mr. Hardeman: "As of," not "since."

Mr. Sapsford: Correct.

Mr. Hardeman: That would be a lot of cancellations in a month and a half.

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The Chair: There's a few minutes left on your party's—I think Mr. Yakabuski had a short question.

Mr. John Yakabuski (Renfrew–Nipissing–Pembroke): Yes, I do. You were talking about the conversion of the red and white cards. I hold one of those, so I'm not in any rush to convert it, I can tell you. But a lot of people in my riding also have red and white cards and they're not in any rush to convert them, and I'll tell you why. People in my riding might have to drive as far as 80 miles to get a new OHIP card. This issue has been around for some time and we hear, "Well, it's the Ministry of Transportation," "No, it's the Ministry of Health," and everybody is passing the buck. But I do wonder how many people in Toronto, Ottawa or London would tolerate having to drive up to 80 miles to get a new OHIP card. That's what people actually have to do in parts of my riding; for example, in Whitney. The issue of being able to issue cards at licence bureaus has been out there. It would be hard to believe that the technology isn't there. I'm told by the licence bureau operators that the technology is there.

As a rural member, I would like to know what the reason or the problem is so that we as rural residents can get some semblance of similar service, because everybody who is an adult has to have an OHIP card. You only have to have a driver's licence if you choose to drive, which is, I guess, most of us. But at the same time, if you're an adult, you have to have an OHIP card. I've got seniors, for example, having to drive 80 miles to get a

new OHIP card. Why are they in no hurry to see this red and white card go? It's because they know they're going to be faced with driving 80 miles to get a new card.

Who is at fault? Which ministry is it? And are we going to do something to bring some real, genuine service to rural people on this issue?

Mr. Sapsford: Well, the Ministry of Health is responsible for issuing health insurance cards, so this would be the ministry that's responsible. We have a number of permanent counters where, as I've said, people do come for the registration or re-registration process. We also have an extensive outreach program where ministry staff actually go out to communities. It certainly doesn't hit every rural community in the province, but we're very mindful that people can't travel in all cases. So we have a van, I believe. We have people who fly out specifically to rural communities at scheduled times to actually do that registration process.

In future, we're looking at other options with respect to Service Ontario where the government is trying to integrate to the extent we can some of these registering processes.

But in the case of health insurance, as I've said, it's important that we have the appropriate documentation and validation of residency and so forth, whereas with the driver's licence, as an example of comparison, the same kind of detail is not required for the issue of a driver's licence. So to some extent the process of registration is directly dependent upon the use of the card or use of the government service and, because we want to assure ourselves that we don't have fraud and inappropriate use of cards, we need to keep that particular part of the process patent.

But we are looking at alternatives in terms of how we provide the service, and if you need more detail on which communities and how that is organized, I'll be happy to answer.

Mr. Yakabuski: Could that not be integrated in a licence-issuing centre? I'd like to believe that here in the province of Ontario we're concerned about fraudulent driver's licences as well. I know, having assisted people who are having problems getting a driver's licence because of change of residency from another country or another province, there are some significant issues that are at play and significant pieces of information and identification that are required to get a driver's licence. While we may talk about the difference, I don't think the difference is unbridgeable, so why is it not possible that the Ministry of Health—I think it would be cheaper to allow these people to issue health cards than having mobile fly-ins, or whatever you want to call it, to rural communities to allow them to get an OHIP card. And of course, if they're only coming on a once-in-a-while basis, if somebody can't make that particular day, they're not going to be able to make that appointment. We lead busy lives. There's no technological reason, I don't believe, and if we can get by some of those fraud issues, could we not integrate that in with the driver's licence issuing?

Ms. Ryan: That is something that we've been working on with the Ministry of Transportation over a number of years, and Service Ontario, which is the new arm providing government services. There are some privacy issues and linking databases and things that we need to get past, but, as you said, the technology for picture-taking and signatures for a driver's licence and a health card is the same technology. We have the same contract for the card production. It is integrated. We work very closely and have done since 1995 with the Ministry of Transportation in that process.

You talk about your particular area, and you were talking about the re-registration piece. I've been asked a few times, "Why can't you just get rid of all of those red and white cards?" It's for that very reason that you're talking about: There are places in the province that we know are more rural, where the demographic is an older demographic, where we have to think carefully about how we're going to complete that re-registration. Once we've got all of your residents re-registered in your area, we then have to think about how those cards are going to be renewed.

One of the things we are looking at right now is to introduce a mail-in process for people over the age of 80, so that people over the age of 80 don't actually have to come into an office to renew their card. We currently have a process in place that anyone who has any kind of medical problem and can't attend an office can get a photo-exempt card. Their physician just fills out the form and we will send them a renewal card automatically. We do have some of these pieces in place. For children under the age of 16 there is no office visit required. It's a mail-in process for anyone under the age of 16 who was born in Ontario. If you've already been through our process once when you were a newborn, you don't have to go through anything again until you're 16 and we have to capture your photo.

We are doing some very serious thinking about how to reach out to some of the more rural communities because we can, from our database, see in the province where the red and white cards are and what the demographic is in those areas. We are doing some careful thinking about how we would re-register those areas.

The Chair: Thank you very much. I think we should move on to the Liberal caucus. Just for a point of clarification, if somebody doesn't know where Whitney is, it's just west of Barry's Bay. Dr. Kular?

Mr. Kuldip Kular (Bramalea–Gore–Malton–Springdale): Thank you, Chair. I do have the photo card. As you remember, we were on a legislative committee to Scotland. That's when I lost my red and white card and I ended up with a photo card.

The Chair: I don't think "lost" is the right word.

Mr. Kular: As the deputy has said, there are about 5.1 million people who still have red and white cards. As I understand, the red and white card was started in 1990 by the Liberal government at that time. It was mass-mailed to people. In 1995, the NDP government introduced the photo ID card. The question I have is, was there adequate

funding to change from red and white cards to photo ID cards at that time?

Mr. Sapsford: I think different governments started different processes and we've come to a stop in some cases because technology changes. The red and white card was improved by the photo card and I think then a subsequent government decided to look at whether we should go to smart cards, where the actual stripe on the card would include more health information, so as people went from provider to provider they were carrying health information.

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Each time we've re-looked at it, there's been a new aspect of technology, and some governments have decided to move ahead and others have decided not to move ahead with these various technologies. As a result of that, we're currently in the position of having red and whites and photo cards and doing the best we can to convert from one to another.

It's taking a long time—in 1995 the conversion started—but that's partly because subsequent governments have taken a new look to re-evaluate whether this is the technology that we wanted to stay with. As it stands today in 2007, we're still working with the assumption that we're going to use the photo card as the basic registration vehicle and not more advanced smart card technology.

Mr. Kular: If we have 5.1 million people with red and white cards, what would happen if we called them all in over a period of one year and said, "Look, this is going to be attached to it"?

Ms. Ryan: It has been suggested to us—I think I mentioned it—that we bring everyone who has a red and white card in. We don't have a service delivery network that could sustain that. Our service delivery network right now sees 2.2 million visitors every year, so we handle 2.2 million clients at the counter. That's almost at capacity, so were we to bring in five million people on top of that in one year, we would have the problems that Mr. Yakabuski indicated in rural areas where people would have to travel. We would have something probably akin to what's happening in the passport office these days in terms of hundreds and hundreds of people wanting to get their cards converted or thinking they needed to get their cards converted immediately or they would risk not having access to health services, and they would swamp our offices.

What we really need to do, and this is what we've been doing, is look carefully at our capacity: How many offices do we have? How many counters do we have? How many staff do we have? How many people can we go through in a day? What's our capacity like in order to up the number of conversions from red and white to photo health cards? What we're looking at for this year is an increase of sending out an additional 100,000 notices on top of what we've been doing within our existing capacity—we think our existing capacity could probably handle that—to increase the number of cards that are being converted from the red and white to the photo health card.

Mr. Kular: How long is it going to take if we're going with the present system? You said about 400,000 people would be converted from red cards to the photo cards. How long will it take for us to complete this, for 5.1 million people to change their cards?

Ms. Ryan: It would take more than 12 years to complete, if we stayed at our current state, but that's why we're looking at other options, increasing it for next year. In 2008 we're looking at another increase, and the increased costs will be offset by the program, to invite more people in. During the next two years we really have to look very carefully at opportunities to move some of that renewal work—this is the discussion we were having earlier—off of the front counter and put it into a mail-in process or onto the Internet so that you could renew your card on the Internet; do that kind of work over the next two years so that by 2009 we're in a better state in terms of we've got other options that are open and our counters are more available to do the actual conversion from red and white to photo health card.

Mr. Kular: Thank you.

Mrs. Liz Sandals (Guelph–Wellington): I'm interested in the area of what happens around actual fraud. I take it that you are changing the role of the fraud branch. It sounds to me like what you're proposing is that it will be more actively engaged in identifying fraud and looking at potential fraud. But the auditor's report mentions a specific case already that had to do with, I believe, a group of methadone clinics that were billing. One of those happens to be in my community, so it's actually become rather a local issue for me.

I guess my questions are—because I take it that this has perhaps been to court and fines levied and all that sort of thing, some partial payback. What happens now? Because there was a group of clinics that seem to have been identified as behaving in a manner that was unacceptable, at least from an OHIP billing point of view, so now what? It isn't just, "Did we find the fraud?" which is a good thing, but having found the fraud, what's the follow-up?

Mr. Sapsford: I'll ask Suzanne McGurn, who's in professional services, to answer. This is the group that would deal with the whole question of physician billings and provider relationships.

Ms. Suzanne McGurn: I apologize for my voice.

Mrs. Sandals: It's okay; I'm having the same thing. Mine's better, but I know your problem.

Ms. McGurn: What I'd first like to do is draw a distinction between the previous MRC process and the new physician audit processes that are looking at regulatory approaches to resolving what might be inappropriate billing. That is separate and distinct from circumstances where fraud may be suspected. In circumstances were fraud is suspected, Ms. Ryan has already spoken to the circumstance of how that will be handled in the future. In the past it was a similar process, but without the intermediary strengthened fraud programs branch. So in those

circumstances, a referral would be made to a police area. The police would go through their investigation and, where required, seek the support of the program area to gather information. So with regard to the specific circumstance that you have spoken about, in October the corporation was charged with being a party to an offence, and they did make a repayment under that offence to the Ministry of Finance.

With regard to circumstances where the billing concerns may be inappropriate in nature, as was mentioned, a new physician payment audit process was introduced in the proposed legislation in December. Through that process, physicians would be going through a process of being educated, a process of discussion with the ministry to correct their billing, make those changes, and if that continues to be unresolved, go to the new physician audit board that would be established under the legislation.

Specifically with regard to the lab code billing concern that was identified, the ministry has been continuing to monitor the billing and, in fact, we have a joint committee that is working with OMA, provider services branches and lab program branches to bring forward changes to the lab and physician schedule of benefits that will make clarifications on a go-forward basis to improve the ability of physicians to bill appropriately for those services.

Mrs. Sandals: I find it interesting in some ways that you didn't mention the college, because I guess one of my concerns would be, where there seems to be inappropriate behaviour, this isn't about physician education and somebody inadvertently billing something not quite the way the codes expect, but where there's inappropriate behaviour to the point where somebody's actually been charged. I'm surprised that that doesn't trigger some sort of interaction with the college. I guess the question in part is, would the college then accept a complaint or communication from the ministry saying, "Hey, we have identified some inappropriate behaviour; the courts have confirmed this"? How does that communication work in terms of communicating with the college with respect to discipline on the professional behaviour?

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Mr. Sapsford: I think one of the few times when we do that formal communication is where there are issues of patient safety, certainly. So if there is something we discover during the billing process that would indicate there's some concern about patient safety, the college is independent of the ministry, so they administer their own legislation and it would be the professional misconduct requirements under the independent health professions legislation that the college would look at. Certainly, they will respond to complaints, either from patients or from—

Mrs. Sandals: And in this particular case, I happen to know that individuals in the community attempted to bring forward a third party complaint and were told that you couldn't do that.

Mr. Sapsford: Third party.

Mrs. Sandals: Yes. I mean, given that the actual patients here are, by definition, people who are not inclined to go and complain about their provider of methadone, we seem to be in an interesting circle of, how does one follow up.

Mr. Sapsford: Particularly where fraud charges have been laid and convictions issued, the college would respond clearly to that kind of evidence put before them. I think the difficulty they have is, is there proof of misconduct, and without some kind of completed proceeding in another administrative jurisdiction, it's very difficult for them to do that independently of a patient's complaint, where they're generally looking at complaints about care and treatment, as opposed to behaviour around billings and things like that. But it is an area of continuing discussion between the ministry and the college. Certainly, as our skills improve at identifying behaviours that are beyond acceptable, we'll continue that discussion.

Mrs. Sandals: It seems to me that that's something that would be—and I realize that it's really outside the auditor, who has been looking at, obviously, is money being appropriately spent? Where does the interconnection between the money and the practice cross, which is a little bit outside of the auditor's area of interest, but an interesting public policy question.

The Chair: Mr. Patten?

Mr. Richard Patten (Ottawa Centre): I have a new card and I'm pleased that you allow us to at least smile when we take our picture, because any of you who have applied for a new passport might have experienced that you're not allowed to smile anymore and therefore it's a less pleasing picture.

I have a couple of questions that kind of interrelate. I don't know whose language this is, whether it's a carry-over or what: We refer to our citizens, the people of Ontario, as clients. We're not really a business; we provide a public health service. So I'm just curious as to why that label is used, number one.

Secondly, in contact with some private businesses who are in the security field, I had some estimates that were rather different and made the auditor's estimates look rather conservative—small-c, of course, Mr. Yakabuski. I see here that you are engaging a security expert to help review the application and registration process etc., and what that person would do: Is that a company, is that an individual, is it somebody from the police or is it somebody from the private sector? What would that function help with?

Then my longer question is, we hear rumours all the time, of course, that you're working with transportation on a new system, because you're saying that the basic database and security dimensions are similar. I'd be interested in whether—and I gather that decision has not been made yet, but there's some exploration of it. But I hear that there's some discussion that this is going to a big American firm because our Canadian companies aren't apparently big enough—although some are.

Anyway, I'll leave that first one. Back to that security expert review: What does that really entail and where are you on that one?

Ms. Ryan: We've actually put out a request for services to consulting firms to come in and do a risk assessment on our front counter business and our registration process. The auditor has pointed out some vulnerabilities in our system, some of which we were aware of, some we weren't aware of. We want to confirm those and see if there is anything else we should be aware of and should be mitigating in terms of the way our system is designed.

I'll give you some examples. Our system won't allow you to register the same person twice. A duplicate message will come up on the system warning the clerk that this person is already registered on the system or this health number is already registered on the system or this birth certificate number is already on the system. So there are things within our computer system that mitigate the fraud piece. So we're looking to see where we should be improving things.

One of the things that the auditor pointed out that we're working on is the authentication of the documents. Right now, we only authenticate with the Ontario Registrar General and with Canadian immigration. While that covers about 64% of the people who come in for a photo health card, if we added Canadian passports and the Canadian citizenship card, we then have 84% of the documents being authenticated. We will probably never get to 100% because there are lots of people in the province who don't have regular documentation, so we are relying on secondary documentation from some folks. For example, the homeless are ones where we have a whole different set of rules.

Mr. Patten: So you haven't hired this person yet.

The other one is whether you are engaging any other estimates or analysis of especially the fraudulent cards in use. Some of the information I have is that the biggest fraudulent use is really in the border towns on the other side of the border, where it's quite a business, I've been told, and that someone who may just live in Malone and has a little cabin or a cottage or whatever does have a registry through the municipality and this kind of thing. They go to a doctor, they have a card, and they say—the one question that was asked before is, "What do they ask you?" They always say, "Well, are you at the same address?" So I say, "What's the address you have down for me?" Of course, it is my actual address, but I could say, "Yes, that is my actual address," which may have continued to be a fraudulent address in the past or one that I have access to but as a cottager, not as a resident, or these kinds of things.

My point in asking this is in expediting your service, when you say it's going to take 14 years and now that period has dropped, it seems to me there is a lot of potential in it, because the closer you get to 90% or 85%, the more assurance you have of having a grip on the problem and to an extent some of the lost—well, it's not lost revenue, it's charges that are illegitimate, being used by the ministry.

I'm not sure if it's Alberta, but I think it is Alberta, where they have one card for your health card and your motor vehicle card. What's the pattern when you look at other jurisdictions? I remember years ago when we looked at the ultimate smart card where you had everything on it and it covered you for every possible service and identification, and it can be cross-referenced very easily. There were few ways that there could be abuse with it.

Mr. Sapsford: As far as other jurisdictions, I'm not aware, as I sit here, of exactly what goes on, but maybe Pauline—

Ms. Ryan: I'm not aware of one card covering multiple things in Alberta with respect to the health card. I know that they did have some problems with their health cards a few years ago and they did get an auditor's report that indicated people had six and seven Alberta health cards. Those health cards are issued in a completely different process than Ontario uses and it doesn't have—the stringent process that we use is not used out there, but I think they are making a lot of changes to the way they issue those cards now.

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Mr. Patten: Your security expert—is that for companies or just consulting firms? The reason why I ask that is there's a very large Ontario company that seems to be ignored by Ontario but is doing a hell of a lot of work in other jurisdictions, other provinces, the United States and Europe. Their perception of the problem is quite different, so I don't know why they're not consulted or talked to.

Ms. Ryan: When we put out these requests for services, we do it off the vendor of record for the Ontario government. That's the Ministry of Government Services approved list of consulting firms. I don't know whether they're on one of those lists or not, but that's the process.

Mr. Patten: I don't either. So they have to apply to be on that list, rather than just sort of being on it?

Ms. Ryan: Yes.

Mr. Patten: Okay.

The Chair: Thank you very much, Mr. Patten. Ms. Martel?

Ms. Martel: I want to return to some issues that I didn't cover under the broader heading of "conversion." Just so I'm clear, about $100 million to $130 million to do the full conversion would be the ministry's estimate?

Ms. Ryan: That's in three to five years. It's the time frame that's important.

Ms. Martel: That was going to be my next question: what the time period is. To crank it up would be particularly expensive. If you carry on, what is the amount of money that's attached to the current, or even adding 100,000 a year?

Ms. Ryan: Do you mean in terms of what our allocation is?

Ms. Martel: If you're doing the current conversion, which is about 400,000, and if within the staff you have

now you can get that up another 100,000, what's the price tag attached to that on an annual basis?

Ms. Ryan: Usually, we use the rule of about $20 a card. That includes the whole transaction with the clerk. That's roughly the estimate that the ministry uses.

Ms. Martel: Okay, great.

The auditor talked about the fact that there are some cardholders who are using their postal box address and that there had been a project under the former government, it looked like—it was 2003—and that had been cancelled—I'm not sure by who. In their work, about 32,000 individuals were using a postal box address. Is the ministry focusing on those folks? I mean, (a) by regulation, they shouldn't be, and (b) that may be where you're going to hit some of your problems around border communities, I would think. Is there a particular focus on that, it having now been identified by the auditor?

Ms. Ryan: Yes. The post office box ones are now being loaded into the data integrity project, which is the one that sends out the notices. They've been put into that process, so those cards will either be ended or people will have to come in and re-register. We rebuilt the client registration system, which is the computer system that we use to register people, in 2002. When we did that, we built the front end so that a postal box address like Mail Boxes Etc. couldn't be put into the resident address. There are still some around, and some of those will be captured under that. But there are still some there.

Now, there are legitimate post office box addresses for people, but usually that's accompanied by a residential address that says—I had one that said, "Lot 1, concession 3."

Ms. Martel: A rural mailbox.

Ms. Ryan: That's right; yes. We capture both of those now, but some of the ones you're talking about are the previous form, the red and whites. They're now put into that new process.

Ms. Martel: So they will all be picked up.

My second question had to do with the auditor identifying a high occurrence of claims in a short period of time in different parts of the province. I'm not sure how he pulled that out, but I'm wondering if the ministry is now pulling that out to look specifically at that possibility, which may indicate fraudulent use of cards?

Ms. Ryan: And it may. Those kinds of patterns are something that the fraud programs branch will be looking at in terms of their new mandate.

There are explanations for people having services in different parts of the province. One is, college and university students typically are getting services far away from home because they're at school far away from home. Anyone who does any business where they travel a lot is sometimes incurring claims around the province. If you're a truck driver who drives from Windsor to Cornwall, you may be picking up claims here and there. People who are seeing specialists in different areas of the province may be incurring claims in different places; their family physician may be in one spot and their specialist in another. There are some reasons.

I think when we looked at some of the data, we could see why people were using the resources that they were using. But that's not to say that there wouldn't be some potential for fraud out there. That's something that the fraud program branch would be focused on.

Ms. Martel: I wanted to ask some questions about the fraud program branch because it wasn't clear to me, and maybe I just missed it, what the major differences are going to be. It looked like you had a unit that didn't have a whole lot of capacity to investigate fraud if they couldn't access health information and that wasn't part of their mandate. The auditor identified a couple of things in that regard in terms of concerns that the ministry didn't seem to have documented standards or procedures to determine which cases to refer to the OPP. I would be interested to know, if you've got some changes happening there, what those new standards or procedures are. Is the branch going to have some kind of access to health records now that will allow them to see patterns? After they see patterns, is that the point of referral, then, to the OPP if they've got some suspicious, I guess is the best word, pattern? If you can give me some clarification about what the changes are, because I wasn't clear how big they were.

Ms. Dawn Ogram: I'll take that question. Our fraud program branch will be looking through the databases and determining patterns, as Pauline has indicated. What we will be doing is creating—we have new criteria. I'd be happy to provide those if the committee would like to see those.

Ms. Martel: Yes, please.

Ms. Ogram: I can certainly provide those criteria; the process for referring cases to the OPP has been established. We've been working on this since July-August of the past year. Our process was recently rolled out, in the beginning of February, to allow the programs to liaise with the fraud program branch, who are individuals with investigative experience. They'll be able to look at the cases according to the criteria and according to their understanding of the way fraud may have been perpetrated in other jurisdictions, to allow us the opportunity to refer only those cases that appear to have good evidence to the OPP.

You're probably aware that we have a team that the ministry contracts with of 21 OPP officers who are working in a dedicated fashion on health care fraud within the province of Ontario. There have been a number of cases referred to these individuals that will be repatriated and reassessed according to the criteria and then determined to be cases that we will take forward and investigate.

I think the positive aspect that I will flag for the committee is that we now have an opportunity to centre all of the activities around fraud in one area within the ministry, which provides us with a much greater opportunity to see patterns across programs. So where there may be patterns within programs, there may also be opportunities for us to look at issues that affect provider services, assistive devices, card fraud in itself, and other areas such

as that. I think this will provide us with what the ministry requires to do a really good job in this area.

Ms. Martel: Let me back up. The 21 officers are in the existing fraud branch?

Ms. Ogram: No, the 22 officers are OPP contract and there are a staff of 10—increasing to 12 or 13 this year—within the fraud program branch itself.

Ms. Martel: So the 22 are on contract doing—

Ms. Ogram: They are OPP officers within the OPP divisions and they are looking at cases that are referred by the ministry to the OPP.

Ms. Martel: So they're specifically taking the ministry cases and working solely on those?

Ms. Ogram: Yes, they are.

Ms. Martel: Okay, got that. It would be helpful if you could provide us with the criteria, because I know that was an issue that the auditor raised.

Ms. Ogram: We'll do that.

Ms. Martel: I wanted to ask about the backlog of cases. In the background that you gave us, it said that as of January 1, 2007, the ministry had closed 1,900 of the 7,000. I'm assuming there were no problems and that's the reason they are being closed. That would be correct?

Ms. Ryan: When you say "no problems"—we've resolved them. We've either ended eligibility for someone or we've granted them eligibility ongoing.

Ms. Martel: I thought in this case the backlog was referring to cases where there was a question about fraud, not just eligibility.

Ms. Ryan: No. These are eligibility assessment cases. They may lead to fraud, but the initial cut is, "Are you really eligible for OHIP?"

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Ms. Martel: Okay. And where it says, "The current backlog of cases is now estimated to be 3,800 files," do we assume that means that there isn't any work at all being done on those right now?

Ms. Ryan: No. Those are currently being worked on and we have dedicated resources on that backlog. We hope to have substantially reduced that way down by the end of this calendar year.

Ms. Martel: And how long, on average, would it take to deal with one of those, then?

Ms. Ryan: It really depends. I'll give you an example of what happens. If somebody phones in to our fraud line and says, "A neighbour who comes and seasonally stays next door to me during the summer in a cottage has got himself an OHIP card and is accessing health services in July and August every year, and then he lives in Lake Placid for the rest of the year," if we get a tip like that—and that is a tip for us; that's all that is—we then have to substantiate it. That's when the work begins in trying to contact that individual and find out whether he actually does reside and make his permanent and principal place of residence in Ontario or in New York. We go through a whole process with them that can take months, depending on how responsive the person is to our request for additional documentation and questions that we need answered about absences from Ontario and things like that. That's why those cases sometimes take a while.

Sometimes we have to just shut the cases down because they've been dormant for years. So we have to put them in another category which says that someone reported that you were living in Nevada in 1998, and so we've closed coverage on your card based on some other substantiating information we had about you, and that card is still cancelled as of 1998. If you show up today and you move back to Ontario, you have to then show us that you have indeed moved back to Ontario, that you make Ontario your new home. Then you are covered for Ontario health coverage once you've passed the waiting period.

Ms. Martel: The three-month residence waiting period.

I wanted to ask a more general question around fraud measures. The auditor noted that the ministry in 2004 had hired an external consulting firm. That firm made recommendations to the ministry around a fraud measurement framework to be used as a benchmark to measure high-risk areas etc. Is this in effect in the ministry? And in what way is it in effect, then? I don't know what the recommendations were. Were they followed up? Were they put into place?

Ms. Ogram: I don't have specific information on that report. I can certainly provide that to the committee after the meeting if that would be helpful.

Ms. Martel: That would be great. It would be interesting to see where it went after it was provided to the ministry.

Mr. Sapsford: I don't know specifically, Chair, of this particular report. I think the biggest shift here is a result of the auditor's work. It used to be that in the ministry this area of fraud was quite compartmentalized. So OHIP people would, based on tips or based on complaints, do the assessment—is it an eligibility issue or is it a fraud issue?—and then make an independent decision. But it was based on selected input.

The difference now is that we want to take a systematic approach to the issue of fraud, as the auditor has suggested. It used to be that the fraud programs branch did educational work—training, public education, public information—and now their role has shifted to being really a systematic examiner of the databases. We've had to give them specific approvals for access to the OHIP databases, which they never had before. So there's been a significant change in our internal process as to how we're handling these issues, and that characterizes, at least for me, the biggest change in the internal process around the issue of fraud.

Ms. Martel: Okay, so folks have some access where they didn't have it before, which is one of the concerns the auditor noted.

Mr. Sapsford: He's also said that we need to be careful about who does have access.

Ms. Martel: That was going to be my next question, because he referenced "need to know." How does the ministry come to sort out need to know? Or is that

essentially the question that you've asked the external consultant, to look at some of those broader questions about who really should have access and why, at what period of time and how?

Mr. Sapsford: I think all those questions are fair questions: Who needs to know? Under what circumstances? But it's also having a system of ensuring that only those people are going into the appropriate areas of the information system. So in a sense, it's partly building our own audit trail on who actually does have access. I think to some extent that was the auditor's concern, not only that we do have the rules but we have evidence that the rules are being followed appropriately, and that's the purpose of our review in that area.

Ms. Martel: So the consultant who is now out for—the request for service is part of responding to the auditor's concerns about who has access and how they get access and verifying that access etc. Okay. You're just at the very start of that. You haven't made a selection; it's just out right now to various firms? Okay. Do you have some timelines around that?

Ms. Ryan: What we're hoping is that the work would be completed within three months so we would have some kind of report by June.

Ms. Martel: That you could then work with in terms of recommendations.

Mr. Sapsford: Yes.

Ms. Martel: Okay.

Mr. Sapsford: Some of this is going on in different processes, so the one around accessibility to information should finish a bit earlier than that, probably in March or April of this year. We're not relying entirely on external consultants. There has been a certain amount of internal business review, and as we come to those conclusions, we'll be implementing them.

Ms. Martel: So the piece around accessibility was done by ministry staff themselves?

Mr. Sapsford: It started there, yes.

Ms. Martel: I just want to follow up a little bit more on the recovery rate. I don't know if you can answer this or if it's really more for the OPP. It didn't look like the recovery rate around real fraud was very significant. Is it a question that people are essentially out of the country, they're gone? Is that usually what the problem is around recovery? Is that an unfair question? I don't know if someone can answer that.

Ms. Ryan: This is the card fraud that you're talking about? Okay. The card fraud is difficult to prosecute and it is sometimes that people are out of the country; they've left Ontario or they've been living out of Ontario for a number of years and we can't get at them. Again, it comes down to building the best case possible in a timely manner and getting that through the OPP and to the crowns, who then prosecute the cases. The crowns are looking for cases that are significant and winnable. Those kinds of things are taken into account.

Again, with the change to the mandate of the fraud programs branch, what we should be seeing is better-prepared cases moving forward in a more timely manner that will then show some better convictions and that sort of thing. The recovery rate just depends on where the people are when the case happens.

Just for your information, people actually voluntarily pay us back if they actually admit that they weren't eligible for OHIP during a certain period of time. We tell them what they cost the system and they will actually issue us a cheque. That has happened. I can't give you the numbers of how much money that is. It's not huge, but it just gives you an indication that there is out in the public an acknowledgement that you need to be eligible in order to access a publicly funded system.

Ms. Martel: If I can go to the last set of recommendations that the auditor was talking about around medical claims processing: One of the points he raised was that the ministry needed to have some better guidelines and procedures for the staff out in the field who are making decisions on overriding rejected medical claims. I'm not sure if this is part of the work the consultant is doing or if this is part of the work the ministry is doing. Have there been some changes now so it's clearer to staff about the circumstances under which an override provision would go into effect?

Ms. Ryan: Yes, there are two things there. One is that sometimes we have to perform overrides because we haven't made systems changes that we need to make. The systems changes are done in a priority order. We're going through that list and there are always ongoing changes that need to be made, and as those get made, the need for overrides is decreased. So the ministry is working diligently at that.

The second piece is that there is a project, and it's the internal one, that is looking at those processes and where we do indeed have to continue to do some kind of an override, what kind of oversight we need there so that it's not just a clerk doing the override; there's some management view of that. That project is the one that is to end by the end of March to report back.

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Ms. Martel: Okay. I think that's it for me, Chair. Thank you.

The Chair: Mr. Hardeman?

Mr. Hardeman: I'm going back just quickly to the red and white cards. How do you make the decision on who is going to become renewable, recognizing that none of those cards have any expiry date or any significant identifiable trait? How do you decide who is going to be renewed?

Ms. Ryan: Who is going to be re-registered?

Mr. Hardeman: Who is going to be asked to update their card?

Ms. Ryan: As I said, we've sort of smoothed out the re-registration across the province, so instead of focusing on a particular city or town, we're actually doing it across the province, but we're focused in on our permanent sites, our 27 offices that we have around the province. We are basically inviting people in in waves, based on their postal code, from where the office is located outwards. So, for example, we've pretty much re-registered

all of Kenora, because we have an office in Kenora, and we've been able to pull as many people as we can in from that area. Thunder Bay is another example, where we've almost completed all of Thunder Bay. The metro areas like Toronto and Hamilton—Hamilton is pretty much done, but in Toronto we are still focused on our offices that have capacity in Toronto and can do the re-registrations here. Anyone who lives very close to our 777 Bay Street office has probably already received a notice to come in and re-register, as that's the pattern that we're using. So we're trying to do it within existing capacity and within our existing network.

Mr. Hardeman: From the auditor's report it would indicate to me that there are identifiable areas within the province where the problem may be greater than the average across the province. Wouldn't it make more sense to identify where the need to renew the cards would be the greatest, as opposed to where we've always had the offices that need work to do?

Ms. Ryan: Actually, a lot of the offices are located near or in border communities. We have offices in Windsor, Sarnia, Sault Ste. Marie, St. Catharines; we do outreach to Niagara Falls, that area, and Welland and Port Colborne; we do a lot of work in Thunder Bay and Kenora, up in that area. So we actually have offices in a lot of the border communities, and those offices are doing the re-registration. They are actively doing it.

Mr. Hardeman: So I can assure the people of Ontario that the rate of change of the cards in those problematic areas that the auditor pointed out is going at a greater rate than in the rest of the province?

Ms. Ryan: I wouldn't say that it's going at a greater rate. We're focusing on offices where we have existing capacity. Those offices happen to be border community offices, so they are taking care of that risk. If we wanted to, I suppose what we could look at would be creating more capacity in the border community offices to do more re-registration in those areas. That, though, will then come back and haunt us in five years when everyone tries to renew their card. So again, we're trying to do it in a phased kind of approach.

Mr. Hardeman: I guess I would just point out that in any other case—or in most cases; I shouldn't say in any other case—where we have a problem in society, we centre our solution on the most problematic areas. So if we're looking at an overall upgrading of the system, wouldn't we be looking at that upgrading and starting from the neediest areas to do it in and working out from there, as opposed to blanketing the whole province at the same speed?

Mr. Sapsford: I don't disagree with what you're saying, but just remember the context here. The auditor's comment was that there was a disproportionate number of red and whites in those communities, principally because the photo card was applied based on registration for primary health care teams, which went on in different parts of the province. So to a degree we've got a mal-distribution in the cards because of previous actions of the ministry, not specifically that that's a direct indicator of fraud in those communities. I just want to make sure the context is correctly understood here. Yes, the volume of conversions that we have yet to do is focused in certain parts of the province and we're trying as best we can to address that, but not to the extent where we re-register all of Windsor in one year, because of the skew that that would provide in our whole re-registering as time goes on.

So these are the issues that we're trying to look at, as I've said, in adjusting our business practice, and certainly those are the communities where we know we have the larger problem, because, as has been said, Kenora and some of these other communities are entirely re-registered now. So we have to begin to divert our resources to other areas.

The Chair: With the committee's indulgence, can I just ask a supplementary on that? Within those areas, to target the high-risk red and white cards, you have the ability to identify red and white cards that are used excessively, that are used in multiple locations. Would it not make sense to require those cards to be renewed first, even if you don't increase the number of renewals?

Mr. Sapsford: That's actually not a bad idea. Certainly as we now start looking more closely at the patterns of use, we can identify people who have high use with red and whites in certain communities and, as you've said, they could be given priority for the re-registration process. We've not done that in the past, but I think with the changes we've indicated, that's what we're looking at in the future, to begin to identify those areas of utilization and perhaps make those the priorities.

The Chair: You have the technical capability to do that?

Mr. Sapsford: Yes.

The Chair: Mr. Hardeman?

Mr. Hardeman: In your presentation, Deputy, you pointed out some of the areas that were pointed out in the auditor's report that needed investigation. You did a good job of pointing out the number—what was it, 40?—of physicians who were not licensed and who sent in claims, and there were 725 unlicensed billings and so forth. The dollars it referred to, those in your report, don't seem to be a great number, and it could very well be the timing of when their licence was stopped and when they actually still had some billing to do.

But I was more concerned about the ones that weren't mentioned in your report and what happened with those, like the $10 million that went to clinics in 2001 that the auditor referred to, and there's another one where the auditor referred to six individuals for whom a particular provider billed and was paid $800,000 between 2001 and 2005. Is there a reason why those are not mentioned in your report, as to what we found out about those? There is no explanation for those.

Mr. Sapsford: It may be that we are still looking at those. I'd ask Suzanne McGurn—she has the detailed information—to speak to that.

Ms. McGurn: I'll separate it into two parts. The first is the 725 individuals who were identified as missing

from being updated because of categories that we didn't get information from, and that was people who had resigned, were deceased, retired or with non-payment of dues. Of those 725 individuals, only 40 had submitted claims, and the total dollar figure, as was referenced, was about $81,000. The other ones that you point out I believe—I will look—were in reference to other circumstances not related to updating of data in the provider registry. So I will just have to validate where those questions are. They are unrelated to this piece of information.

I do believe the clinic reference may be in reference to some of the cases that were in transition between the old MRC process and the new physician audit, but I will validate those specific circumstances.

Mr. Hardeman: I'm still concerned, and I understood those that were just explained. They are in your report as you reported here this morning. I appreciate that. I'm just concerned about the reference in the auditor's report that says a group of clinics have potentially overbilled the Ministry of Health and Long-Term Care for almost $10 million for medical tests since 2001. When you read that, what has been done about that one?

1140

Mr. Sapsford: This was the particular case that I believe Ms. Sandals raised, where actually the clinic company was in fact charged. There has been repayment of at least some of the billings that were made, and the company, I believe, has been convicted of fraud directly, so that was the resolution of that case. The $10 million was an estimate based on, I guess, assumptions that were made if it was all fraudulent, and that was the number that was included. So that case, from my perspective, has been resolved in the courts.

Mr. Hardeman: Okay. Is that also true for the group of clinics and their affiliated physicians who did tests for 4,100 patients at a much higher—

Mr. Sapsford: Yes.

Mr. Hardeman: That's under the same explanation of where that's—

Mr. Sapsford: Yes, that's the same.

Mr. Hardeman: Thank you. The other one is, in your report you mentioned about the backlog not being as high as reported in the auditor's report because there's a certain number that are ongoing cases that are under review. How do we decide what is a backlog and what is under review? Isn't everything that's not resolved a backlog?

Mr. Sapsford: That's a good question. How long should one wait before one says it's a backlog versus ongoing review? I think the explanation was that, depending on the individual circumstances, it sometimes takes some months to resolve the issue. I suppose it's always open for the ministry at some point in time—pick a number: six months, seven months—simply to say the card in invalid and retract the card. The danger of that, of course, is that you leave citizens without a card. Now, there's appropriate recourse. As people need health services, they can be encouraged then, at that point, to re-register. But it's a question of judgment as to when you say, "Enough is enough. The card is invalidated."

I think the indication we gave is that somewhere around 1,300 or 1,700 cases at a time is not an unreasonable number to have in process, as it were. So we had closed 1,900; we were down to 3,800. Of the 3,800, we're trying to get down into the 1,500 to 1,800 range as being a reasonable pool of cases to be assessing at any period of time. It's simply based on the volume of the questions that come forward about authentication of cards.

Interjection.

Mr. Hardeman: Yes, go ahead.

Ms. Martel: Sorry, can I just have a follow-up, because I'm looking at your status back to us. I just want to be clear on the numbers. The auditor said 7,000 cases were backlogged for eligibility, and you've said 1,900 of that 7,000 have been closed, which is great, which would leave 5,100. You say that on an ongoing basis about 1,300 of these files are in process, and then your final line is, the current backlog is now 3,800. I'm just trying to add all this up. It seems to me that there is probably a distinction between the 1,300 that you've identified as being in process and then another 3,800 backlogged.

When I first read it, which is why I asked the previous question, I assumed nothing was being done on those 3,800. On the 1,300 that you say are in process, something is being done, which would actually bring you up to the 7,000 that the auditor identified. Can you just give us some clarification about those numbers?

Ms. Ryan: Maybe we haven't characterized it properly here, but what the ministry is trying to get at is that a zero backlog is not something that we think we can ever get to. So we had to pick a point, and we picked 1,300 cases. We thought that was a reasonable amount of cases to have in progress at any given time. The 3,800 that we've got is indeed a backlog, and we need to get rid of that backlog, but at any given time after that we expect to have about 1,300 in progress.

Ms. Martel: You said earlier that it's hard to know when you can deal with that, because some cases take longer than others. Are there specific new resources that are being applied to clear the 3,800 minus 1,300?

Ms. Ryan: Yes. There are dedicated resources on that to clear them. They are really low-risk cases, but the auditor pointed it out and we do need to deal with it.

Ms. Martel: Thank you. Thanks, Ernie.

Mr. Hardeman: I was almost to my answer before Ms. Martel started.

Ms. Martel: I'm sorry.

Mr. Hardeman: No, I say this: I'm more confused now than when I started. We have 1,300 in process that are being reviewed at the present time. The ministry says those are not a backlog. Then we have 3,800 that the ministry considers a backlog, but the auditor says there are 7,000 cases. Where are the rest of them?

Mr. Sapsford: We've dealt with those.

Mr. Hardeman: Where?

Mr. Sapsford: A decision was made on the first 1,900. They were either authenticated or they were refused. They're done, of the 7,000.

The Chair: How many were authenticated or were refused, of the 1,900?

Ms. Ryan: I don't have the information in front of me.

The Chair: Could you provide that to us, please?

Ms. Ryan: With eligibility assessment cases, we usually end eligibility in about 32% of the cases, on average, but the cases that you're looking at are older cases and low-risk cases and I'm not sure whether that percentage would be right or not. But I can get back to you on that.

Mr. Hardeman: Well, thank you very much. I think I've got it clear now.

The next one is the issue of the authenticity of the application of citizenship. Presently it's at 64%, I think you said, or in the 60s, and with the agreement with the passport office we would bring it up to 84%. What makes that so difficult? A passport is a passport, and every time I cross the border or get on a plane and I show them the passport, authenticity is there. Why is it that it takes more to do that authenticity for the health card?

Ms. Ryan: What we're actually doing is authenticating the number, so when you come up to one of our offices and we say, "We need to see proof of citizenship," and you're carrying your Canadian passport, we take that number off that passport, your name and your date of birth, and we match it against their database in Ottawa. That's what we're doing, to make sure there's a match there. So what we're doing is we're authenticating the fact, and they can come back and say, "Yes, there is a passport that has been issued to Ernie Hardeman, date of birth this, and here's the passport number." It authenticates that what we've seen in the office is an actual passport; it's listed on their database. That's the process we want to put in place for passports. That's the same process that we have in place right now for Ontario birth certificates and for any immigration documents that are issued by CIC. We're matching numbers, names and dates of birth with the issuing source.

Mr. Hardeman: And we can only do that for 64% of the applications?

Ms. Ryan: What we're looking at, when people come into our office, is, what are you showing us to prove your citizenship? Right now, 64% of people coming into our offices are showing us either an Ontario birth certificate or an immigration document. Another 20% are showing us either a Canadian citizenship card or a Canadian passport, but at the moment we're not actually authenticating that information with the issuing source, so that's what we'd be doing once we enter into these agreements and we get a data feed between us and Passport Canada and us and the citizenship cards.

Mr. Hardeman: So is the end target of this to do as they're doing with cross-border use of a passport right now, to make sure that everyone would have one of those identifying documents to get the health card, or is that already required?

Ms. Ryan: Well, we're thinking that because so many people are now applying for a Canadian passport, we're going to see more people showing up and using their Canadian passport as proof of citizenship than we've seen in the past.

Mr. Hardeman: Thank you. Oh, nope—one more.

The Chair: You've got one more minute, sir.

Mr. Hardeman: Okay. I'll take it the next time. Go ahead.

The Chair: Okay. Mr. Milloy?

Interjection.

The Chair: You go ahead and finish it off.

Mr. Hardeman: I just wanted to ask a question about the medical review committee that was suspended, and Bill 171 is going to replace it. In this process, of course, there has been a lot of, shall we say, need for the committee that hasn't been met. Even if we accept that the committee, according to the Cory report, was well beyond what we as a society thought it should be, obviously some type of process needs to be put in place to audit the medical system. What are we doing about that, and if and when something gets in place to do that, how are we going to deal with that which has happened between the time of the suspension and the time of a new process being put in place? Will everything be fair game in that time or is it going to become retroactive?

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Mr. Sapsford: That's a good question. We're moving forward, the Legislature being willing, to implement the new process. What we've been doing in the interim, of course, is with respect to the educational piece. A lot of this is about interpretation of the rules. It's not about physicians committing fraud every day of the week. It's about interpretation, it's about errors in administration of the system and so forth, so we want to reduce errors to the degree that we possibly can. I think the criticism, through the Cory report, was that the process that the ministry used to in fact manage that was judged to be unfair to physicians. There's much we're doing now that's in compliance with Cory, short of the new review procedures or the quasi-judicial procedures. That really speaks to the education, the communication with physicians, where we identify problems in the billing. There's more direct contact back to explain the problems the ministry has and to try to get changes in the way physicians' offices are actually billing or interpreting the fee code. That's really where we're focused: more clarifying bulletins, more frank discussion with the OMA about how we view the interpretation around billing practice. That's really where the branch will be focused until the new legislative or regulated regime is put into place.

Mr. Hardeman: And your vision at the end of it is to stay with that and not go to an auditing process where you physically get to check the individual establishments for compliance?

Mr. Sapsford: The regulatory framework around review and so forth is quite independent of what I would call audit. We have our own internal processes around audit of the accounts and the billing practice—we've

talked, again, today about fraud—which are, in my view, one component of making sure that the system has integrity. In terms of the details around audit, though, I'll turn to one of my colleagues.

Ms. McGurn: As the deputy has mentioned, it's a continuum of activity, from education and information through gathering enough information to be able to give effective feedback to someone, either through them providing us with samples of their records so we can say, "Does this justify the type of claims you're making?" or through a process, as proposed in the new legislation, where, hopefully, those differences will be able to be worked out between the ministry and the physician or group of physicians, as it may be. Only where there's a point of disagreement would that matter need to be presented at the level of an independent review board.

In keeping with Justice Cory's recommendation as far as timelines, what they're certainly looking at is that efforts should be focused at the front end: making sure physicians have the right information and that, where possible, physicians are not paid for claims that are not appropriate—so prepayment rules, those types of things, to make sure that we're only dealing with those circumstances where an agreement could not be found—and again, wanting to ensure that that process is timely, so that if you have been paid for claims, the ministry would be back to you within a reasonable amount of time to give comment on those claims if they had concerns and bring them forward to a review board, should that be the outcome of the discussion.

Mr. Milloy: I just have a point of clarification, following up on one of the points Mr. Hardeman raised about the 725 doctors. You noted, Deputy, in your presentation that a lot of that has been cleared up. I understand how with 13 million people there are all sorts of problems, but there are only several thousand doctors in the province. I just wonder, what was the old system? How did we end up with 725 doctors; that even if they weren't claiming, they had the right to claim—and you talk now about this new agreement. I just wanted some clarification of what the history of all this is.

Mr. Sapsford: It's simply communication: the time it took for the college to take people off the active list, to compile the list, and for that to come to the ministry. I'm not sure if it was done on paper or not, but it was really the speed at which the information was transmitted between the college and OHIP. We're now working on having those updates done electronically so that there's an electronic feed from the college to the ministry, so that the amount of time that elapses between the licence of the physician being revoked or lapsed and that notice coming to OHIP would be less. In most of the cases, I think, of the 725—there were only 40 where there were actual billings. Most physicians retire. They let their licence lapse and they don't keep on billing, and that's what we saw in the majority. That was for deaths or retirements, for leaving the province; it was for all causes. So the majority of those changes take place without incident. It was only in the smaller number of cases where the auditor pointed out some unusual occurrence; I'll put it that way—so making them electronic, speeding up the time that goes by between the college's decision and the indication in OHIP.

Ms. McGurn: Where the college is making a decision for licensing, that was an effective process and the information was provided in a timely fashion. Not all of the categories existed in the data feed, such as death and retirement, and perhaps it was that those were ones where it wasn't anticipated that physicians would keep billing in the past. So now the data feed has been corrected to ensure that all categories of a licence, where it might not be active, will now be fed to the ministry as well. As in circumstances such as Ms. Ryan has talked about, the ministry does get information in other ways as well. The families of physicians who retire or who have become deceased may let their district office that they have contact with know that information, so it would in fact have been updated in some other circumstances as well. I think you'll note that of the 725, over 120 were not active anyway because of the information having been received in other fashions. However, we now have a complete data feed from CPSO. It is received in our offices on a weekly basis and that information is updated in the corporate provider database within three working days.

Mr. Milloy: Can I just ask, and you may not have an exact figure, how many physicians—and then I guess that's extended to other health care professionals—in Ontario can bill OHIP, roughly? There are not that many, are there?

Ms. McGurn: I'm the one who should actually be able to answer that. There are approximately 21,000 physicians who have the ability to bill OHIP. I don't know the practitioner numbers off the top of my head. However, they are a limited group: optometrists, a limited number of podiatrists and designated physiotherapy clinics in the province. It is a small group. The billing information is also maintained, though, for other categories such as nurse practitioners etc., where they do have an ability to make referrals for services, for example, so that information is maintained as well.

Mr. Milloy: And, based on the presentation, you are working with those other areas to make sure that if they retire or are deceased, their names come forward.

Ms. McGurn: Correct. The largest group would be the optometrists.

Mr. Milloy: Okay. Thank you.

The Chair: Mr. Arthurs.

Mr. Wayne Arthurs (Pickering–Ajax–Uxbridge): First, let me say how much I've enjoyed this morning as my first visit as a member of public accounts. It's refreshing, both from the standpoint of the presentation—that is always fresh anyway—but also the questions that have been asked to date compared to my experience in estimates over a period of time. It tends to be a little more partisan in that environment, so this has been both informative and refreshing, but I'm sure there will be points in time when there will be some partisanship expressed.

My question is relatively short. I note that the questions that have been asked have drilled down intently on some areas, which has been interesting to listen to and hear in addition to the information provided. More generally, the information provided on the provider monitoring and control: I was listening to all the questions being asked around the photo cards, the red and white cards, the numbers that are out there, how soon they are going to be converted, and also the presentation in here on this issue of monitoring control. The responses to the Auditor General's queries and comments were quite explicit, referencing X number of doctors and specific amounts. Would that be the kind of information you had readily at hand for all practical purposes, or did one have to do a lot of research in response to the Auditor General's queries in that regard? You reference $500 in one instance and $88,000, I think, in another. Is that something you had to do a lot of research on or is that kind of information reasonably readily available to you by virtue of the systems that are currently in place?

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The second part of my question would be, given the resource capacity that the ministry has, would you find those resources best expended on the issue of billings by service providers where you see unusual occurrences, unusual growth in billings, or to use those resources for the purposes of tackling the fraudulent card use, the old red and white card? Where would you apply the resources if you had to make a determination as to what the priorities would be? Is the information that was requested by the Auditor General on this particular round something that is fairly readily available to you or did you have to do a lot of digging, in essence, to acquire these kinds of data?

Ms. McGurn: With regard to the first part of your question about how difficult it is to gather the information, I think in the circumstance of the 725 providers, we were actually provided with a provider list. It was relatively easy for us to be able to extract that information and run an analysis of what claims were submitted on those billing numbers. So that information was readily available once the information was brought to our attention.

Again, as Ms. Ryan said when she spoke earlier, where you focus your energy is often where you'll see large sums as well. So it might not naturally have come to our attention—three physicians who are deceased—with such a small billing. However, we won't have that concern in future because those will be picked up within three days of the information being here. But as far as being able to get the information and produce it back, that's readily available information to us.

Mr. Arthurs: If one had to apply the resource base available, had to make some different allocation of that resource, where would you apply it given those two kinds of choices?

Mr. Sapsford: That's a really hard question, of course.

Mr. Arthurs: I'm obviously not suggesting—

Mr. Sapsford: No. I guess at a high level—the ministry has to do both. In terms of relative resource, we would look at a variety of indicators: just off the top of my head, our success, though, in recovering, so recovered dollars, if that's a measure of effectiveness or success. I guess our experience would be that we stand a much better chance of recovering dollars from physicians for errors in payment than we have had in terms of fraud recovery. That's partly because they're very different processes. It's very difficult to detect fraud, so it's not the only measure that one would take into place.

I think, based on the auditor's report and because we have a new legislative framework that's being proposed, if the Legislature passes it, then we'll be focused on implementing that new regulatory framework for the provider side of it. So I would suspect, in the short term, more of our effort will be spent on the fraud side, with its new branch and new mandate, looking at new survey techniques, trying to find new patterns to really get below the surface and see whether that is a bigger problem than currently we believe it is.

In the short term, in terms of focus, I would argue we would be looking more at the fraud. When the new regulatory framework is in place, that would give us a different impression of the kinds of problems we have with providers. But I would argue that it's a balancing, year over year, depending upon the systems we have in place and the problems that are outlined through auditors' reports or other means.

Mr. Arthurs: Would that be as well reflective not only of the capacity to recover but reflective of the level of exposure to public dollars by virtue of—

Mr. Sapsford: Correct, so the risk analysis is a very important part of that, that we've talked about earlier. Ms. Ryan mentioned that some of the outstanding cases are low risk. What does "low risk" mean and who are these people likely to be? Do we have other evidence? Is there likely to be fraud in this set of circumstances or with this group of citizens or red and white cards or whatever the case? So the risk analysis is a very important part of helping the ministry decide which, of all of these issues, comes to the top and requires more immediate action.

The Chair: Mrs. Sandals.

Mrs. Sandals: Just a couple of comments and then a question. In respect to the last discussion where you're looking at fraud recovery or incorrect billing recovery from physicians versus inappropriate use of cards by individuals, it seems like the one you can obviously measure in terms of recovery of incorrect payments. The other one, I'm not quite sure how you measure, because what you're really doing is diverting incorrect access to service, and you would somehow have to measure that in a different way, because you can't recover the service anyway. And it isn't necessarily the physician's fault; you've still got to pay the physician, because in some ways they were—it isn't like they're a party to the fraud. So it's almost like you'd need different measurements for those two categories of things.

I was just going to comment that I think the idea of trying to identify high-risk or potential auditees in the pattern from your data that may identify areas where you want to look further is useful. Again, though, we have to be really careful what the indicator is. I was thinking of this business of the three-region billing. I think that probably in the last few years the majority of members of my family would have fallen into that category, none of which was fraudulent. It just happens to do with the geography that the family tends to run around to, and the fact that the tertiary treatment centres aren't in anybody's hometown. So finding indicators is good, but we need to be maybe a little bit more sophisticated sometimes about the indicators.

The question I wanted to ask is, as we get better and better about requesting documents and verifying documents in order to make sure that people have a health card and they're really entitled to service, one of the things that we certainly see in the constituency office is people who are the most marginalized in society or the people who are most likely to not have access to the correct document and for whom it's sometimes problematic to help them track it down. So even getting the foundation document, the birth certificate, may be a challenge because they really don't know all the information about how their birth was registered, for one reason or another. So that can be quite a lengthy process, just to get them reattached to the foundation documents.

Do you have a standard set of procedures that each of your OHIP offices would use in terms of dealing with those cases where people have quite possibly an urgent need to access health care but no way to urgently actually get a properly verified health card?

Ms. Ryan: Yes, I'll answer that. There are people who are able-bodied and can come into our offices and register and have documents. There are other groups out there that don't have the documents, aren't able to come in, and we have set up separate processes for those people. So we have special processes for the homeless; special processes for psychiatric patients, in and out; we have special processes for newborns. We have special processes for a number of different areas. What we're trying to get at is we know that there are people out there who sometimes are living sort of on the fringes of society and they don't have the kind of documentation that you would normally be looking for. We have to take that into consideration. If you have somebody like that in your office or your constituency, we do have a 1-800 MPP line that you can call, and we take care of any sort of problems where people need immediate medical attention.

Mrs. Sandals: Yes, and we're fortunate enough in my constituency that there actually is a permanent OHIP office at 1 Stone Road, at the Ministry of Agriculture, through Service Ontario. So for us that's fairly easy; we just hook them up. What I was wondering was that you do have consistent processes that all the offices would be using so that there are defined processes, as opposed to the whim of—

Ms. Ryan: There are defined processes specifically with the homeless. There's a specific process that we use where an agency—and we have agencies on record with us—can provide a letter to us attesting that this person is homeless and in their care. The agency will actually be assisting the person to get their documents. In the meantime, we will give them one year's coverage while they try to get their documents.

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Quite frankly, every so often we come across people who we cannot get documents for, and they are people who are homeless, people who are on the fringes of society, who seek medical attention. We continue to work with constituency offices and with other health care professionals to try to get people's documentation straightened out. In the meantime, we extend their coverage on a year-to-year basis.

Mrs. Sandals: Okay, thank you. Because somewhere in the accountability loop, we need to have the exceptional circumstances covered as well.

Ms. Ryan: Certainly, yes.

The Chair: I'd just like to ask a couple of questions in clarification that some of the members have asked. When you were posed the question of how you decide which red and white cards are being replaced, you talked about the office capacity and the ring around the office and that kind of thing. I assume that after that, it's randomly done, is it, or is it done alphabetically?

Ms. Ryan: It's actually done by postal code. Our system is set up—

The Chair: It's random, then?

Ms. Ryan: Yes, by postal code, so we're just moving out in postal codes. That's how it's done.

The Chair: Okay. The second question is, of the 194,000 rejections, or taken-away cards, do you have any number on how many of those have come back in terms of, you know, people have moved and they are entitled to OHIP coverage? Do you have numbers on how far down the 194,000 number comes over a period of time?

Ms. Ryan: The information that I have on the continuing data integrity project that we started in 2004 is that we've had in total 17,000 people actually walk into the office. So of the notices that we send out, 17,000 people have actually walked into the office and said, "Yes, I'm here. I haven't had claims in seven years, but I am a resident of Ontario."

If you move out of the province and then you move back into the province, I don't have numbers on that, but that sort of restarts you again. You would have to then come in and apply for a photo health card at that time. Even though you may have had a red and white card six years ago, we would have cancelled it through that project. You would have to come in and register for a photo health card. Again, we would use the same number because we're still following you. You would be out of the province and ineligible for a period of time and then eligible again once you've shown us your documentation.

The Chair: You've gone from 200 to 10,000 a week in terms of the notices going out. You can't give us a

percentage of how many we would expect of the 10,000 revocations—or not 10,000; of the 194,000 revocations—you would expect to get back in the next year?

Ms. Ryan: How many—sorry?

The Chair: Of the 194,000 revocations that you have done because you didn't get an answer back from the mail, do you have any idea what the true number of actual revocations will be?

Ms. Ryan: All right. I'm hoping I've got your question right. In the project that we're doing on data integrity, where they haven't had claims in seven years—and I talked about the 17,000 coming back in—that's a 4% return rate, so we see 4% of the people who get those notices actually coming into the office. On top of that particular project, we send out the invitations for people to actually come in and re-register for a photo health card, and we do those in the rings out. The return rate on those is about 60%.

Mr. Sapsford: We're dealing with two different things here.

The Chair: Yes, I know. But I don't know how real the 194,000 number—

Mr. Sapsford: The 194,000 were the actual cards that were cancelled.

The Chair: Right. But I want to know how many are going to walk in the door because they said, "Well, I just moved around the—"

Mr. Sapsford: Of the mail-out, about 4% come back and identify and say, "I'm here. Give me a new card." Then we cancel the cards. I guess the question is, after we've cancelled the cards, who else is out there whose card we've inappropriately cancelled and then they show up for health services. Is that where you're—

The Chair: That's right, yes.

Mr. Sapsford: That's a harder thing for us to do.

Ms. Ryan: Yes. I don't have a number on it, but I know what you're talking about. You're talking about the people who have moved, we've gotten returned mail, we've cancelled their card, and then all of a sudden they'll come in for medical services and their card will be no good and they'll be told that they need to go to an OHIP office and sort out their eligibility. Then what we do is register them for a photo health card.

The Chair: I'm interested in the number.

Ms. Ryan: Yes, in the number.

Mr. Sapsford: What proportion.

Ms. Ryan: I'd have to get back to you on that.

Mr. Sapsford: Could we look at that a little more closely?

The Chair: Yes, sure.

The last question I have is this. Essentially the Ministry of Health is operating what I would call an insurance scheme. Is it necessary that this insurance scheme finds itself in the Ministry of Health, or would it be better found in the Ministry of Revenue or another area? In my view, your focus should be somewhere else other than running an insurance scheme.

Mr. Sapsford: It's in fact a question that the ministry is looking at. I think we need to draw a distinction between the policy framework around the insurance program versus the payment side of what would be an insurance system. So what we're currently doing—and there is a group that's organized to do that—is looking at the various business functions of the OHIP system. So registration is one piece, making sure that the registration side of both providers and citizens is accurate. There's the payment function, which has to do with bill-paying of submitted claims from physicians and other practitioners. Then the third part is the policy framework, what does the insurance plan pay for, what does it not pay for, and under what circumstances.

So we're doing an assessment right now of the various functions and looking at whether there are other ways that we could in fact provide that business function, either in partnership with other ministries—you've heard us talking about the cards with respect to transportation, Service Ontario as an integrated business function of the government, and can we look at different parts of our business being integrated there—or in fact right outside the Ministry of Health, where we use third parties for some aspects, for instance, of the drug benefit program.

So, yes, Mr. Chair, we're looking at those aspects of it. Whether OHIP could simply move out of the ministry lock, stock and barrel, I don't think so, because the ministry would guard very jealously the parts of the business that talk about the size and shape of the insurance: What do we pay for, what do we not? That's very much linked to the interests and role, quite frankly, of the ministry. But other parts of it, I think, are open for discussion.

The Chair: Ernie, you just had—

Mr. Hardeman: Yes, I just have one question. We talk about cancelling cards and eligibility or non-eligibility. Is it possible for someone who is eligible but, through neglect, does not renew their card when they were supposed to, at some point in time, to be denied health care in Ontario; and, secondly, that they would not even be able to get it back after they verified that they really never had been ineligible?

Mr. Sapsford: No. No one would be denied health care on the basis of the administrative process, unless of course you're not eligible. So if you're judged to be ineligible, then the costs would be your responsibility. But for all eligible people, whether they have a valid card or not, the process that's in place always weighs in favour of the person getting service. In fact, in some cases, where eligibility has been judged retroactively, OHIP has reimbursed on that basis.

Mr. Hardeman: I think it's important. We had someone in our office just last week whose health card had reached an expiry—I think it was an expirable one—and she couldn't get an appointment to get it renewed. She was quite concerned that she would not have health care. So I think it's important for people to realize that it

isn't based on if you didn't get it renewed in time that your health care would not be available.

Mr. Sapsford: That's correct. That's not the case.

The Chair: I think we're finished with questioning.

I'd like to thank the deputy, the assistant deputies and everyone else who has been here with us today. We have appreciated your candour and your answers. We look forward to your written responses to those questions that couldn't be answered here today.

The committee will break for about five minutes. There is lunch next door. You can grab a sandwich, bring it back in, and then we'll have an in camera discussion about writing the report, to give directions to Ms. Campbell, who will be assisting us in doing that.

Thank you very much.

The committee recessed at 1220 and continued in closed session at 1228.

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