

# Ontario Health Insurance Plan

## Background

A key objective of the Ministry of Health and Long-Term Care (Ministry) is to provide all Ontario residents with a high-quality health-care system that is readily accessible, publicly funded, and accountable. One of the most significant vehicles for delivering these health-care services is the Ontario Health Insurance Plan (OHIP). Under this plan, the Ministry determines the eligibility of Ontario residents for coverage and remunerates physicians and other health-care professionals for health-care services rendered to eligible patients.

The insured services covered under OHIP include diagnostic, preventive, and rehabilitation services provided by both generalists and specialists, as well as services provided by community laboratories. Through OHIP, the Ministry also pays the established OHIP rates for emergency medical and hospital treatment provided to Ontario residents in other provinces or countries. In the 2004/05 fiscal year, OHIP paid approximately 180 million medical claims for insured services. These payments totalled over \$7.4 billion. Of this amount, \$5.5 billion (74%) was made to fee-for-service providers in Ontario, including some 23,000 physicians and 2,400 other practitioners, such as dentists, optometrists, and

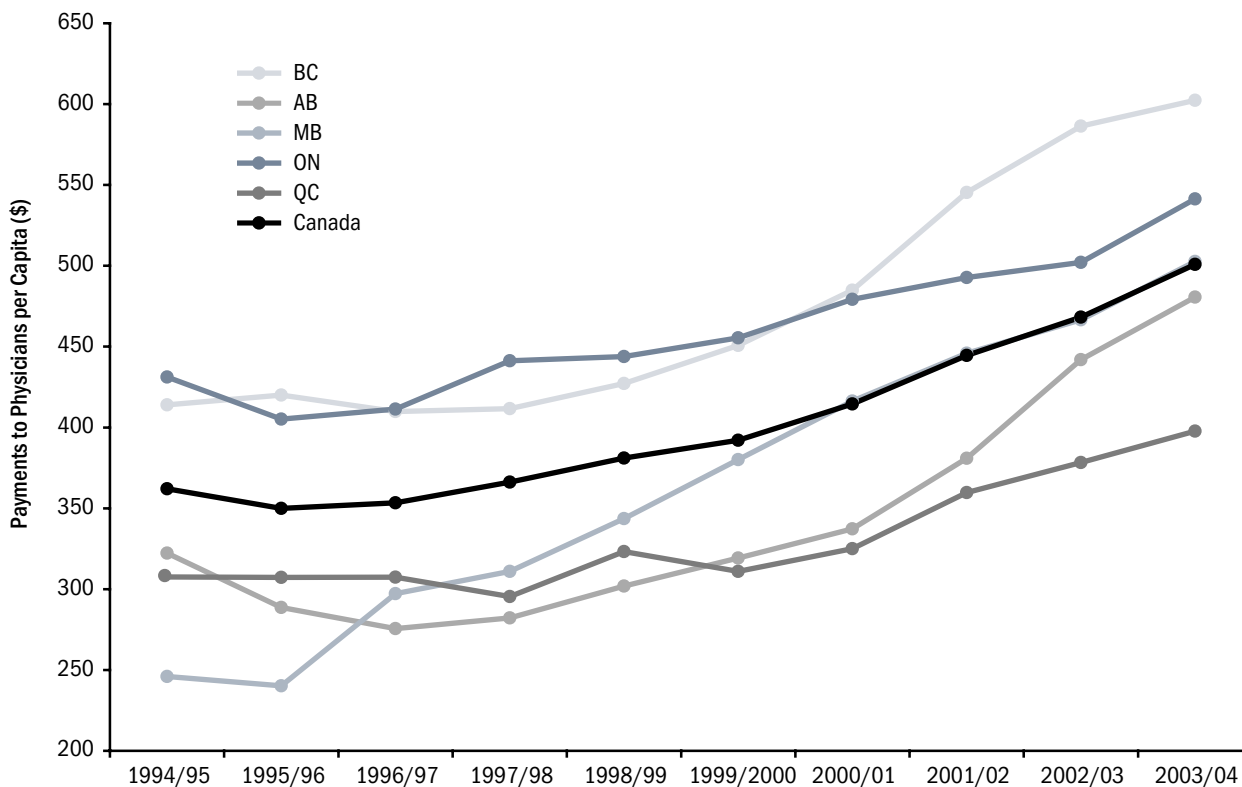
podiatrists. The remaining \$1.9 billion covered a variety of non-fee-for-service payments, including those to community laboratories, alternative payment arrangements for physicians, hospital on-call coverage, and out-of-province and out-of-country claims.

As illustrated in Figure 1, according to information provided by the Canadian Institute for Health Information (CIHI), in the 2003/04 fiscal year, Ontario paid \$540 per capita to physicians for health-care services, with only British Columbia spending more on a per capita basis. CIHI is a national, non-profit, independent organization focusing on promoting collaboration among major health-care stakeholders. It provides Canadians with essential statistics and analysis about their health and their health-care system.

Ontario residents must have a valid health card to access provincial health-care services at no personal cost. To be eligible for an OHIP card, applicants must be Canadian citizens or have landed immigrant status, have their home in Ontario, and reside in Ontario for at least 153 days in any 12-month period. The OHIP card can be either a traditional red-and-white card or a photo health card. The latter was introduced in 1995. As of January 2006, there were approximately 12.9 million valid

**Figure 1: Larger Provinces' per Capita Health Services Payments to Physicians, 1994/95–2003/04**

Source of data: Canadian Institute for Health Information



OHIP cards in circulation—5.7 million red-and-white cards and 7.2 million photo cards.

The legitimacy of the expenditure of more than \$6.8 billion per year under OHIP relies upon two major factors:

- that OHIP cards used to obtain health-care services are restricted to Ontario residents legally entitled to them; and
- that the medical profession works with integrity in billing the government appropriately for its services.

The Ministry relies on three main information systems to support OHIP:

- The Client Registration System is used to register eligible Ontario residents in the insurance plan. It maintains personal and eligibility information on about 12.6 million Ontario residents.

- The Provider Registry System is used to register health-care providers. It maintains information on all health-care providers who can deliver health-care services and bill OHIP for these services, either on a fee-for-service or other basis.
- The Medical Claims Payment System processes claims submissions. It verifies provider and card-holder eligibility, ensures that claims are for insured services, and issues payments to providers.

## Audit Objective and Scope

The objective of our audit was to assess whether the Ministry had adequate systems and procedures in place to ensure that OHIP fee-for-service claims and

payments to health-care providers were legitimate and accurate. The audit did not address expenditures other than fee-for-service expenditures.

We identified audit criteria to address our audit objective. These were reviewed and accepted by senior ministry management. Our audit included examining documentation, analyzing information, interviewing ministry staff, and visiting six district offices. In addition to our interviews and fieldwork, we employed a number of computer-assisted audit techniques (CAATs) to analyze card-holder data, medical claims data, and providers' records.

Our audit was substantially completed in May 2006 and was conducted in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances. We also reviewed relevant recent reports and activities of the Ministry's Internal Audit Services Branch, which had identified a number of issues that were helpful in conducting our audit work.

## Summary

While we noted some processing weaknesses, we found that controls and procedures were generally adequate to ensure that claims are paid accurately. However, we do not believe that controls are adequate to effectively mitigate the risk that people who are not entitled to Ontario Health Insurance Plan (OHIP) services could receive medical care free of charge.

With respect to the medical profession, the OHIP program embodies a trust relationship between the government and health-care providers. While the Ministry of Health and Long-Term Care (Ministry) has a number of mechanisms to detect inappropri-

ate OHIP claims, the system relies fundamentally on the integrity of health-care professionals to bill appropriately for their services. The relationship between providers and their patients is essentially a private one, and the government pays for health services provided to patients based solely on claim submissions from providers. Accordingly, there is an opportunity for unscrupulous providers to commit fraud or otherwise abuse the system, and the task of designing and instituting sufficient controls and monitoring mechanisms to prevent and detect inappropriate OHIP billings is an ongoing challenge.

While there is little doubt that the vast majority of card holders and health-care professionals act honestly and with integrity, we concluded that the Ministry should strengthen its systems and procedures in a number of areas to help ensure that all OHIP fee-for-service claims and payments to health-care providers are legitimate and accurate. In particular:

- Since 1995, the Ministry has been issuing photo health cards to replace the older red-and-white cards. The new cards have more security features than the older cards, and card holders are subject to significantly more rigorous eligibility verification procedures. However, while the Ministry originally planned to complete the conversion of all of the older, red-and-white cards to the new photo card by 2000, the conversion has been delayed for a number of reasons. At the current conversion rate, it will take at least another 14 years to phase out the old cards and verify the eligibility of all card holders.
- We continue to have concerns, originally reported on in our *1992 Annual Report*, that there are still approximately 300,000 extra health cards (that is, 300,000 more health cards than individuals in Ontario's population) in circulation in the province. Our analysis of these cards indicates that the majority are being held by individuals with addresses

either in Toronto or in regions close to the United States border.

- The Ministry devotes very limited resources to monitoring health-card usage. Our computer data-extraction analysis of medical claims records indicated that there were several areas where expenditure patterns warranted review or investigation. For example, we identified 11,700 card holders who had medical claims submitted from numerous different regions across the province within a short period of time, possibly indicating that health-card numbers were being used inappropriately. We also identified six individuals for whom a particular provider billed and was paid \$800,000 from 2001 through 2005. Our analysis also highlighted a group of clinics and their affiliated physicians that have been billing for medical tests on some 4,100 patients at much higher frequencies than recommended by the College of Physicians and Surgeons of Ontario. We estimate the potential overbilling from these providers to be some \$9.7 million since 2001. There were also indicators that some of these physicians might not have actually treated the patients involved. The Ministry advised us that, based on a complaint received, these clinics had been under investigation since 2003.
- The Ministry established a Fraud Program Branch in 1998 to promote health-fraud awareness. Although the Branch is staffed with Ontario Provincial Police detective inspectors and fraud examiners, it has never had a mandate to conduct fraud audits, nor has it had access to health records that would allow it to conduct fraud monitoring activities, and no suspected fraud cases have ever been referred to this Branch.
- The review process for health-card use by potentially ineligible individuals needs to be improved. As of October 2005, there was a backlog of over 7,000 outstanding cases involving potential ineligibility to be investigated, and the Ministry had no documented standards or procedures on how such cases were to be evaluated or the timeliness thereof. We also noted that the recovery rate on cases where ineligible individuals have had medical services paid for was quite low. For example, since 1998, the Ministry has referred some 1,150 of its most serious cases, amounting to a potential claims recovery of \$700,000, to the Ontario Provincial Police, but the courts have only been able to recover on five of the 1,150 cases, with a total recovery of \$37,000.
- Our data analysis indicated that, to date, the Ministry has not yet verified the authenticity of the citizenship documents for about 70% of all existing health-card holders. As well, procedures for registering applicants for health cards can be improved. While applicants can use a number of documents to prove their Canadian citizenship status, the Ministry authenticates only a few of them. Also, of the types of documents the Ministry does authenticate, there was a significant backlog of 256,000 cases requiring verification with either Citizenship and Immigration Canada or the Ontario Registrar General.
- The data files received from the College of Physicians and Surgeons of Ontario used to update physician-licensing information were not complete, as they did not include data on physicians who had died, retired, resigned, moved out of the province, or had their licences cancelled for other reasons. Our analysis identified 725 physicians who were no longer licensed by the College of Physicians and Surgeons of Ontario but could still submit medical claims, and, in fact, 40 of them had billed and received full payment from the Ministry subsequent to their licences expiring. For example, we found that one physician,

suspended for violating the terms and conditions of his licence, had subsequently submitted claims and was paid for treating almost 300 patients.

- Since September 2004, the activities of the Medical Review Committee, which was mandated to review cases in which physicians may have filed inappropriate claims, have been suspended. While the Ministry has committed to replace this committee and develop a new audit process based on recommendations made in April 2005 by The Hon. Mr. Peter Cory, a retired justice of the Supreme Court of Canada, these changes have yet to be implemented. At the time of the suspension, there were 110 outstanding cases under review; all these reviews have since been cancelled. The Ministry has also not initiated any new audit reviews since September 2004. Based on past recovery rates, we estimate that as much as \$17 million in potential recoveries from physicians may have been lost during this suspension period.
- Medical rules were not always kept up to date in the Ministry's system, which can lead to errors and omissions in verifying claims. The Ministry did not have sufficient guidelines or management review procedures to ensure that overrides on rejected claims, allowing them to be paid, were made consistently and accurately.
- Improvements in information technology security were also needed to protect the confidentiality of card holders' personal health records and providers' records in the Ministry's computer databases.

## Detailed Audit Observations

### HEALTH CARDS

#### Conversion of Red-and-white Cards to Photo Health Cards

In 1990, the Ministry of Health and Long-Term Care (Ministry) moved from a family-based registration system to an individual-based system, and issued approximately 10 million red-and-white health cards to individuals. During this conversion process, the Ministry relied on the then-existing Ontario Health Insurance Plan (OHIP) records to determine who was eligible to receive a card. Applicants who provided a health number and matching surname received a health card without having to provide any additional documentation, such as proof of identity or residency.

In 1995, the Ministry introduced photo health cards and planned to re-register all Ontario residents and authenticate their eligibility over a five-year period (that is, by 2000). However, for several reasons, including resource limitations and a number of card design changes, this conversion project has yet to be completed. In our *1998 Annual Report*, we recommended that the Ministry complete the verification process for persons who registered prior to 1995; however, as of January 2006, there were still over 5.7 million red-and-white health cards in circulation for which the Ministry has yet to verify card-holder eligibility. At the time of our audit, the Ministry was converting only about half the number of cards annually that it converted in 1998. At the conversion rate of approximately 400,000 cards per year achieved over the last few years, it will take at least another 14 years to complete the eligibility verification process and phase out the red-and-white cards.

Figure 2 shows the number of conversions completed by year since the photo card was introduced.

**Figure 2: Conversion Rates of Red-and-white Cards, 1995–2005 (000)**

Source of data: Ministry of Health and Long-Term Care



By way of comparison, the Ontario Ministry of Transportation also commenced in 1995 a similar conversion project to replace the province's previous two-part driver's licence with a photo card. This conversion project was completed in 2000, with over 7 million new driver's licences having been issued to Ontario's licensed drivers. While we recognize that this conversion process was facilitated by the fact that driver's licences, unlike red-and-white health cards, have always had expiry dates, we believe that the success of the process for driver's licences does demonstrate that such province-wide conversions are feasible.

Ontario was the last jurisdiction in Canada to move to an individual registration system for health cards. Figure 3 compares features of each Canadian jurisdiction's health card. As it illustrates, Ontario's red-and-white health card has the least amount of printed information of any Canadian jurisdiction's card. It does not include any personal information other than the name of the card holder: there is no date of birth or address to assist in authenticating the card holder's identity. Also, unlike most other jurisdictions' cards, Ontario's card does not expire.

The accuracy of the card-holder records underlying the red-and-white cards is also questionable. Because these cards never expire and many card

holders do not inform the Ministry when they move, card-holder address information is often out of date, and the Ministry has no reliable means of locating such individuals. Ministry statistics indicated that about 25% of mailings to red-and-white-card holders are returned as undeliverable. Assuming this rate is applicable for all red-and-white-card holders, the address information is out of date for an estimated 1,425,000 card holders. This increases the risk that valid OHIP cards may be held by people who no longer reside in Ontario.

### Number of Health Cards in Circulation

We reported our concerns with the reliability of OHIP data in our *1992 Annual Report* when we noted that, at that time, there were approximately 300,000 more cards in circulation than the estimated population of Ontario. The Ministry acknowledged at that time that, given the limited controls in place at the time of converting from a family-based to an individual-based registration system, it was almost impossible to detect cases of fraud.

As of December 2005, the Statistics Canada estimate of the population of Ontario stood at 12,590,000. According to our data analysis, at this time, there were approximately 12,895,000 health cards in circulation, indicating that there were still approximately 305,000 extra health cards in circulation. While we recognize that many of these cards may belong to individuals who have died or no longer reside in Ontario, some of these cards may be in the hands of ineligible individuals.

To analyze this issue further, we reviewed the health-card-address data and found that 263,000 or 86% of these extra cards were in circulation in the Toronto area. Given the Toronto population, this amounts to one extra health card in circulation for every 10 Toronto area residents. We also noted that there appeared to be over 10,000 extra health cards in certain Ontario regions that border the United States. These regions included Algoma District, Essex County, Thunder Bay, and Rainy River.

## RECOMMENDATION 1

To ensure that publicly funded health services are provided only to eligible individuals, the Ministry of Health and Long-Term Care should expedite the conversion of the pre-1995 red-and-white Ontario Health Insurance Plan (OHIP) cards to the current OHIP photo cards in order to properly verify the eligibility of these health-card holders.

### Health-card Monitoring

The monitoring of health-card usage can be of great assistance to the Ministry in identifying possible ineligible access to publicly funded health-care services. Moreover, as the health-care profession moves towards greater sharing of electronic records, the risk increases that a patient could be misdiagnosed or mistreated if his or her health records have been compromised by those of another individual using the same health-card number. Accordingly, moni-

toring can also help ensure the safe treatment of patients.

Although the Ministry conducts certain monitoring activities, particularly to detect ineligible practitioner billings, little monitoring takes place on individual health-card usage. We were informed that one of the main reasons for the Ministry's lack of activity in this area is the difficulty in striking an appropriate balance between individuals' right to privacy over their health records and the Ministry's responsibility for the stewardship of public funds.

In 2004, the Ministry contracted with an external consulting firm to conduct a study on potential fraudulent registration and use of health cards. The study recommended that the Ministry "develop a Fraud Measurement Framework to be used as a benchmark to measure higher risk areas, to measure the effectiveness of preventive and detective methods applied and to guide future work to mitigate consumer fraud in OHIP." The consulting firm also estimated the amount of consumer fraud in Ontario's health-care system as being between \$11 million and \$22 million annually.

**Figure 3: Provincial Comparison of Health-card Features**

Prepared by the Office of the Auditor General of Ontario

	Name	Birth Date	Address	Expiry Date	Renewal Cycle (years)	Photo	Magnetic Stripe on Back	Special Security Features
BC	✓	✓					✓	
AB	✓	✓						
SK	✓	month/ year		✓	3		✓	
MB	✓	month/ year	✓					
ON photo	✓	✓	✓	✓	5	✓	✓	rainbow printing, holographic overlay, micro printing
red-and-white	✓						✓	
QC	✓	✓		✓	4	✓	✓	hologram
NB	✓	✓		✓	3		✓	
NS	✓			✓	4		✓	
PE	✓	✓		✓	5		✓	
NL	✓			✓	5			

In the absence of a proactive monitoring program, investigations into suspected health-card abuse are typically triggered by calls from the general public to the Ministry's Fraud Line, or staff suspicions aroused when processing card applications. The Ministry also focuses on reviewing specific medical procedures rendered, in an effort to identify ineligible claims such as the removal of a patient's gall bladder a second time, or a hysterectomy on a man.

The Ministry established a Fraud Program Branch in 1998 to raise public awareness of health fraud. Although the Branch is staffed with Ontario Provincial Police (OPP) detective inspectors and fraud examiners, at the time of our audit, it had never had a mandate to conduct fraud audits, nor did it have access to health records that would allow it to conduct monitoring activities directed at OHIP. Rather, all suspected fraud cases were referred directly to the OPP by the program areas without any involvement of this Branch. Upon request, branch staff would assist program-area personnel to assess fraud risk and to identify and mitigate potential frauds in their particular program area. However, given that the Branch is staffed by police detectives and fraud experts, this limited role may not be the best use of such specialized resources.

Over the years some special projects have been conducted to identify ineligible card holders, the results of which illustrate the importance of ongoing monitoring of card use. For example, in the Child Survey Project conducted in the 1998/99 fiscal year, the Ministry identified 6,800 children who had had no health claims for an extensive period of time—which could be indicative of ineligible card holders living outside Ontario. We were concerned, however, by the lack of follow-up conducted on these cases. Only 30 of these 6,800 files were investigated to confirm OHIP eligibility. Even though this sample of 30 led to the cancellation of the health coverage of a total of 13 of the children

together with 24 of their relatives, the Ministry did not investigate the remaining 6,770 files.

Another area that has been the subject of a special review is card-holder addresses. By regulation, OHIP card holders are generally not permitted to have postal box addresses. With few exceptions, card holders are required to have a permanent civil address in Ontario to be eligible for insured health care. The Ministry completed a Postal Office Box Project in 2003 by investigating 1,562 health cards with postal box addresses serviced by two mailbox outlet companies. Verification letters were sent to these card holders; in many cases these letters were returned as undeliverable or the card holders were found to be ineligible. While the Ministry did cancel 1,157 of these health cards, the project was discontinued due to budgetary restraints. Our data-extraction audit tests identified almost 32,000 individuals who used a postal box as their address at the time of our audit.

Under another recent monitoring activity, the Ministry sent out approximately 394,300 notices to clients for whom no claims had been filed since April 1998, requesting that they re-verify their eligibility. The Ministry received approximately 10,800 responses, and approximately 189,300 notices were returned as undeliverable, indicating that the Ministry did not have the most current addresses for these individuals. The Ministry terminated 194,100 of these cards. While the remaining 194,200 cases had not yet been followed up on at the time of our audit, the Ministry subsequently advised us that it has sent a further 100,000 final notices to these card holders and plans to complete action by the end of the 2006/07 fiscal year.

Other than the above projects, the Ministry has done little work in monitoring health-card usage to detect anomalies. For this reason, we performed a number of data analyses on medical claims records for the five-year period from January 2001 through December 2005 and found some cases, detailed below, that we brought to the Ministry's attention.



### Anomalies in Health-card Usage

Insofar as some individuals may be very mobile within the province—due to the nature of their work, their family situation, or because certain health treatments or specialists are not available in their local community—claims for a single individual from providers from various geographical locations often occur. However, the occurrence of such claims within a short period of time could be an indication that the health card has been duplicated, has been used by more than one individual, or has otherwise been compromised. Our analysis indicated that there were 11,700 card holders each having health claims originating from all three regions of the province within a nine-month period in 2005.

Analysis of health-card usage helps not only to identify possible misuse by ineligible card holders but may also signal fraudulent claims submitted by medical practitioners. In this regard, our analysis also identified a group of six individuals who received extensive psychotherapy counselling services by the same provider, with total payments to the provider of \$800,000 from 2001 through 2005. Figure 4 illustrates the dramatic growth in the number of medical services and payment amounts for these individuals over this period. The Ministry has commenced a review of this case.

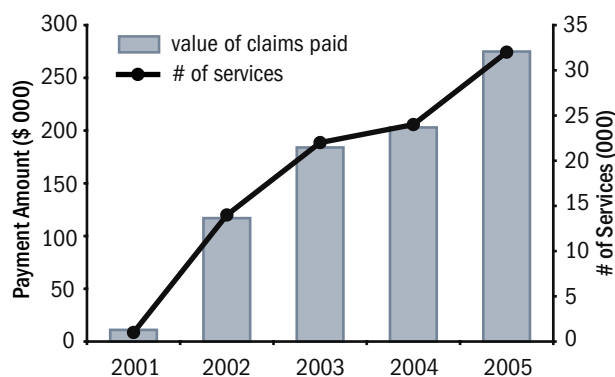
We further noted in our analysis 4,000 patients being treated by a particular group of clinics and

a number of affiliated physicians, who had been submitting extensive medical claims relating to a specific treatment, with total payments of some \$31 million since 2001. The frequency of the procedures conducted by these physicians for individual patients was dramatically higher than what the College of Physician and Surgeons of Ontario recommended as a best practice. We estimated the payments for those treatments in excess of what the College recommended to be approximately \$9.7 million since 2001.

The particulars of this case also raised concerns about the possibility of claims being paid for patients who were not seen by the physician submitting the claims. This practice is contrary to OHIP rules. Specifically, the majority of the paid claims related to thousands of laboratory tests, typically done twice per week on each patient. The claims were submitted through a number of physicians affiliated with the clinic, from their own practice locations. Physicians are allowed to directly submit claims for laboratory testing, but only if the tests are conducted in their own offices. The practice locations of these physicians were often significant distances from where the patients resided and the clinics where they were being treated. We are therefore concerned that these billings may not have been in accordance with OHIP regulations. The Ministry advised us that, due to a complaint received, these clinics have been under active investigation since May 2003. However, our data analysis indicated that payments to these clinics have continued to increase for the time periods that we reviewed, as illustrated in Figure 5.

**Figure 4: Psychotherapy Counselling Services to Six Patients Billed by a Single Provider**

Source of data: Ministry of Health and Long-Term Care

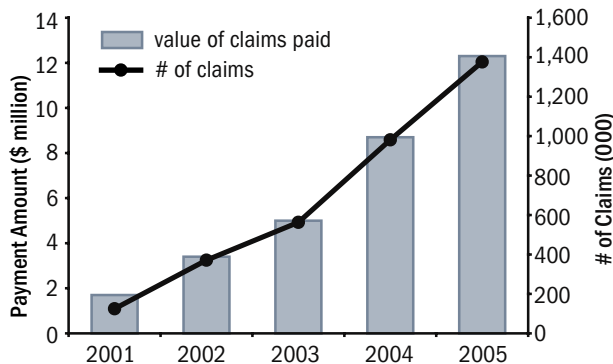


### Review of Potential Cases of Ineligibility

When the Ministry receives a tip from the public on use of an OHIP card by an individual who is potentially ineligible for health-care services through its telephone Fraud Line or other means, the case is tracked in a Registration Information Tracking System. This system is also used when district office

**Figure 5: Claims from Clinics for Frequent Procedures Relating to a Specific Treatment**

Source of data: Ministry of Health and Long-Term Care



staff are suspicious about a health-card applicant's eligibility. Investigation of these cases may lead to the termination of the card holder's eligibility where warranted. For significant cases in which criminal intent is suspected, the matter is referred to the OPP for further investigation. We noted that the Ministry did not have documented standards or procedures for evaluating such cases. We reviewed a sample of case files and noted inconsistent practices in evaluating them as well as in the decisions made.

As of October 2005, the Ministry had a backlog of over 7,000 outstanding cases awaiting review. Over 90% of these cases were more than six months old, with the oldest case dating back to January 1998. Ministry data indicated that the average time to resolve a case is 10 months and that approximately 40% of the card holders are eventually found to be ineligible and their health cards are suspended. Accordingly, based on this ineligibility rate, there may be an estimated 2,800 ineligible individuals of the 7,000 backlogged cases whose health cards are still active.

Timely resolution of backlogged cases and suspension of ineligible cards is important because the Ministry has no restitution process and, once claims have been paid, recovery is very difficult, even when a claim is subsequently found to be ineligible. For example, since 1998, the Ministry has

referred about 1,150 cases, for claims amounting to approximately \$700,000, to the OPP for criminal investigation. Out of these 1,150 cases, the OPP eventually laid approximately 100 charges, which, to date, have resulted in one voluntary and four court-ordered repayments, for a total recovery of \$37,000, or approximately 5% of the \$700,000.

## RECOMMENDATION 2

To identify potential ineligible use of publicly funded health services, the Ministry of Health and Long-Term Care should:

- review the mandate of its Fraud Program Branch, with a view to expanding the range of its activities to include OHIP-usage monitoring and fraud investigations;
- consider expanding its monitoring activities to identify potentially suspicious individual health-card usage; and
- resolve the outstanding backlog and follow up on potentially ineligible cases in a consistent, rigorous, and timely manner.

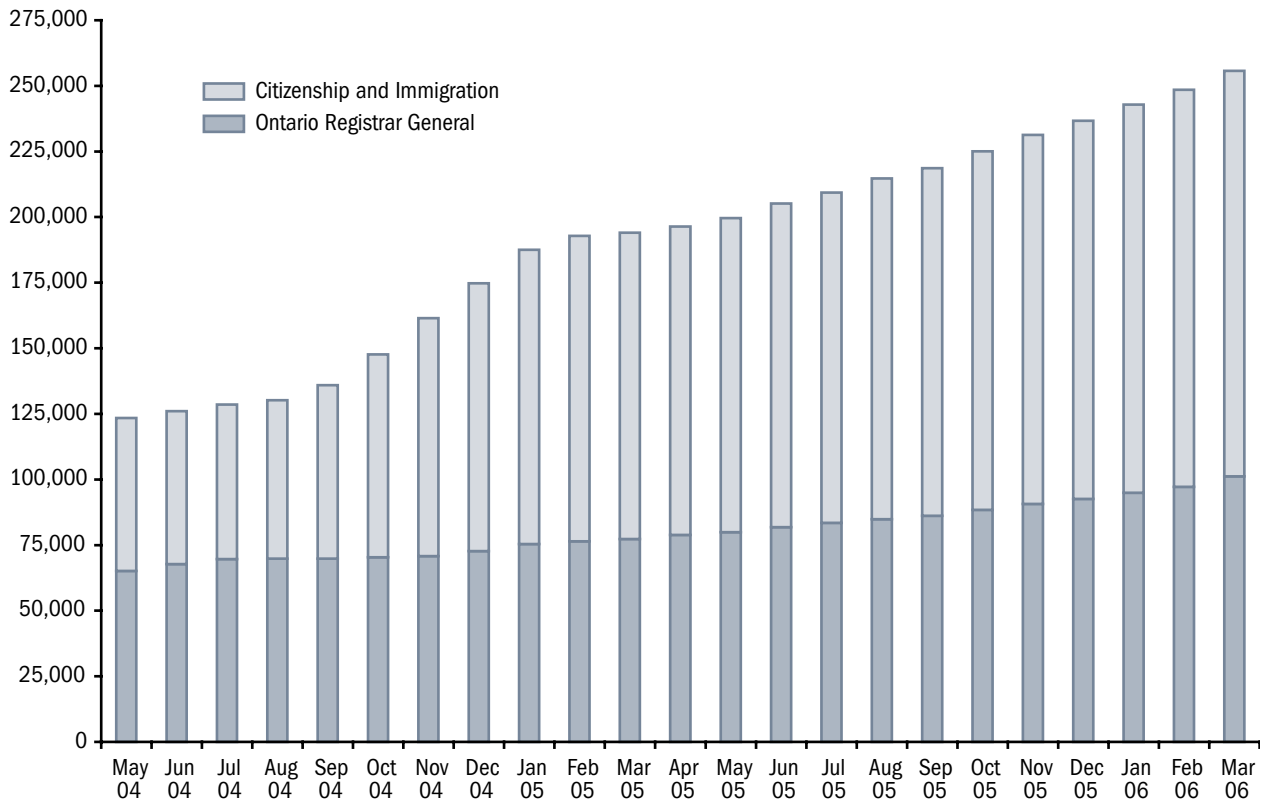
## Authentication of Citizenship Documents

An OHIP card is an acceptable piece of identification for many purposes. For example, it is often used in obtaining a Canadian passport, an Ontario driver's licence, or a mortgage or line of credit from a financial institution. Accordingly, proper authentication of an applicant's identity and citizenship status before a health card is issued or its underlying information is revised is essential not only to ensure that public health care is provided only to eligible individuals, but also to reduce fraud in other areas.

All new health-card registrations, renewals, replacements, and changes of personal information are processed at one of 27 OHIP district offices located throughout the province. To complete any of

**Figure 6: Document Authentication Backlog, May 2004–March 2006**

Source of data: Ministry of Health and Long-Term Care



these transactions, applicants must provide proof of citizenship status, residency, and personal identity.

Since the photo health card was introduced in 1995, the Ministry has been electronically authenticating some citizenship documents, such as landing records, permanent resident cards, and working permits with Citizenship and Immigration Canada (Citizenship and Immigration). In addition, the Ministry has been electronically validating Ontario birth certificates with the Ontario Registrar General. However, at the time of our audit, only 54% of the active photo health cards and only 30% of all cards in circulation had been authenticated in this manner.

Under the authentication process, the Ministry enters the applicant's name, date of birth, and document number of the proof of citizenship into the Client Registration System and matches this information with data from Citizenship and

Immigration or the Registrar General. Unmatched cases must be followed up to determine the reason for the discrepancy. The Ministry also accepts as proof of citizenship Canadian citizenship cards and Canadian passports, which are presented by about 20% of applicants, but, unlike its practice with other documents, it does not verify these two types of documents with the issuing government departments to ensure their validity.

While we support the authentication process, we found that available resources dedicated to it were insufficient to process the number of new unmatched cases identified each month; accordingly, there is a large and increasing unmatched backlog. As illustrated in Figure 6, this backlog has doubled since May 2004. As of March 2006, it amounted to over 154,000 unmatched cases with Citizenship and Immigration and 101,000 cases with the Registrar General—for a total of

approximately 255,000 cases. The Ministry notified us that, among these backlogged items with the Registrar General, it has identified over 45,000 duplicates or cases in which no further action will be required due to such events as the death of the applicant or termination of his or her health card for other reasons.

At the time of our audit, more than 76% of these backlogged cases were more than one year old. Timely resolution of unmatched cases is important because the applicants already have their health cards and therefore have full access to Ontario health services.

### Application Processing

During our visits to the OHIP district offices, we also found that procedures to ensure that all transactions were valid, complete, and accurately processed could be improved. Specifically, the Ministry had no reconciliation procedures to match the number of registrations, renewal or replacement applications accepted in the district offices with the actual transactions processed and health cards issued. We also noted no supervisory review, even on a spot-check basis, of applicant information being entered into the Client Registration System against the information provided on the application forms or on the supporting documents. This is especially important because, once an individual is entered into the system, he or she is automatically eligible to receive an OHIP card. Because copies of the supporting citizenship documents are not maintained for future reference, such reconciliations and supervisory checks would act as a compensating control by reducing the risk of unauthorized transactions being processed, improper documents being accepted for processing, or erroneous information being entered into the registration system.

### Special Registration

The OHIP district offices also provide special registration support for homeless individuals, newborns, patients in long-term facilities, or individuals with accessibility issues that prevent personal attendance at OHIP offices.

#### Registration for the Homeless

Although a homeless person without a permanent resident address must still meet OHIP eligibility requirements in order to obtain a health card, such individuals often do not have the required citizenship, residency, or identity documents. Agencies dealing with the homeless, such as shelters, work with the Ministry to assist these individuals in applying for their health cards. Ministry policy requires all such agencies to have agreements in place with the Ministry setting out their respective roles and responsibilities.

During our district office visits, we reviewed procedures for registering homeless people and noted that controls to ensure that all such transactions were legitimate could be improved. For example, we found that five of the six district offices we visited registered homeless people referred by agencies that did not have the required agreement with the Ministry. We also found that, although the Ministry had developed a standard agreement, actual agreements often differed from this standard. As well, signatures of appropriate individuals at the agencies were not required, or the requirement was not enforced, when the applications of clients referred from these agencies were processed.

The Ministry registers any person referred by these agencies regardless of whether he or she can provide citizenship-status documents, and relies on the agencies to subsequently work with the individual to obtain and submit the appropriate documents. However, the district offices informed us that the agencies rarely reported to the Ministry if individuals had difficulties obtaining these

documents or, in fact, had problems with their citizenship status, and the district offices did not follow up with the agencies on these outstanding cases.

We also noted that, in many cases, agency personnel have no personal knowledge of the clients they assist. For this reason, special registrations may enable ineligible individuals to gain access to Ontario's health system. The Ministry indicated that about 9,700 homeless individuals had been registered without the required citizenship documents since July 1995 and that, as a control measure, the Ministry usually issues health cards with a one-year expiry date to such individuals. Our data analysis indicated that approximately 690 of these individuals had had their health cards renewed without the proper documents having been obtained.

### Exemption from Photo or Signature Requirements

The Ministry also exempts some applicants from photo or signature requirements for medical reasons. In such cases, the applicant's physician must provide a signed exemption form. When we reviewed the exemption forms collected by the district offices, we found that the Ministry did not verify the physician's identity or authenticity with the College of Physicians and Surgeons of Ontario's database in order to validate these exemptions.

## RECOMMENDATION 3

To better ensure that health cards are issued only to eligible individuals, the Ministry of Health and Long-Term Care should:

- follow up, in a timely manner, on outstanding cases in which the authentication of citizenship documents resulted in unmatched differences;
- consider expanding the scope of the electronic authentication program to other commonly used citizenship documents, such as

the Canadian passport and the Canadian citizenship card;

- reconcile health-card applications received to processed transactions, and randomly perform supervisory checks matching system data to application and supporting documents;
- ensure that all agencies assisting homeless individuals to obtain health cards have valid agreements with the Ministry and obtain proof of applicants' eligibility for publicly funded health-care services; and
- verify the authenticity of providers who sign photo/signature exemption forms.

### Protection of Personal Health Records

The *Personal Health Information Protection Act* defines personal health information as any information related to an individual's physical health record. This includes the individual's health number, information regarding eligibility, and any payments for health services rendered. All of this personal information is maintained in the Ministry's Client Registry System and in the Medical Claims History Database. We reviewed security within the Ministry over these two systems, focusing on security administration procedures and the protection of electronic files, and concluded that security should be improved in several areas.

System access and user-group profiles (the authority assigned to individuals in a user group enabling them to access, modify, or delete data) were not adequately monitored, thereby increasing the risk that unauthorized individuals within the Ministry could gain access to personal health records. Specifically:

- We found that the Ministry did not have any approval documents to support the set-up or changes made to any of the user-group profiles for the Client Registration System.

Accordingly, we were unable to ascertain if these profiles were appropriate.

- System access was not being restricted to a need-to-know basis. We noted that some users had excessive access rights to the system and that users no longer requiring access were not removed promptly.
- Regular reviews of user access to ensure that this access was warranted were not completed for a number of district offices.
- Access rights to a special user group that could generate reports or perform ad hoc queries to the Client Registration System and the Claims History Database were not regularly reviewed.
- The security tools used to track users' access rights and change requests for user access were inadequate and inconsistent, resulting in erroneous access rights being granted or maintained.
- Security features restricting access to the Claims Correction System were very weak. For example, there were no password controls.

Security administrators typically have more system rights than general users. Due to resource constraints, the Ministry delegated certain security administration duties to an inexperienced temporary staff member who inadvertently assigned inappropriate security administrator privileges to another staff member.

#### RECOMMENDATION 4

To better protect confidential personal health records from unauthorized access and data tampering, the Ministry should:

- ensure that proper approvals are obtained before establishing or changing user-group access profiles;
- enforce the requirement for periodic reviews for unwarranted system access at the district offices;

- strengthen the effectiveness of the existing security review process and monitoring tools;
- implement more rigorous security features to control access to the Claims Correction System; and
- restrict security administration duties to qualified staff.

## HEALTH-CARE PROVIDERS

### Provider Monitoring and Control

Health-care providers are responsible for ensuring that their submitted medical claims comply with the *Health Insurance Act* and the Schedule of Benefits. The latter, a regulation under the *Health Insurance Act*, is an extensive listing setting out all of the health-service procedures that providers can render and be paid for and the billing codes relating to those health services. The Ministry has also established a Monitoring and Control Unit to review provider claims to ensure that they are appropriate. This unit educates providers on the claims-submission process and practices and pursues recovery of any overpayments resulting from claims-submission errors.

There are two types of medical claims-monitoring processes: pre-payment screening and post-payment review. All medical claims submitted by providers are screened for compliance with predefined medical rules that are programmed into the Medical Claims Payment System. For example, there are medical rules disallowing payment for certain fee codes used more than once for the same patient on the same day, or restricting payments for certain medical treatments when they are performed at the same time. However, due to the complexity of health-care services, medical rules cannot be sufficiently comprehensive to detect all inappropriate claims.

During the post-payment review, the Ministry conducts analysis on paid claims to determine if the providers submitted their claims properly and in

**Figure 7: Medical Review Audit Process by Jurisdiction**

Prepared by the Office of the Auditor General of Ontario

	Trigger to Initiate Reviews				Composition of Medical Review Committee				
	Complaints	Treatment Disputed in Verification Letters	Statistical Analysis/ Profile Review	Other <sup>1</sup>	Medical Assn.	College	Govt.	Public (e.g., CA, lawyer)	Total
BC	✓	✓	✓		1	1	1	1	4
AB	✓	✓	✓	✓	5	0	0	0	5
SK	✓	✓	✓		2	2	2	0	6
MB	✓		✓	✓	3	1	3	0	7
ON	pre-09/04	✓	✓	✓	0	18	0	6	24
	post-09/04	✓	✓	✓	Medical Review Committee and audit process suspended				
QC	✓		✓	✓	5	0	1	1	7
NB	✓	✓	✓		5	0	0	0	5
NS	✓	✓	✓		6	0	0	1	7
PE <sup>2</sup>	n/a	n/a	n/a	n/a	5	0	2	0	7
NL	✓	✓	✓	✓	5	0	4	1	10

1. For example, an anomaly is noticed when a specific kind of treatment is being analyzed or reviewed.

2. Due to the small number of doctors in PEI (about 140), audits are performed at least once per year on each provider.

accordance with the Schedule of Benefits. Potential criminal cases are referred to the OPP for investigation. However, the Ministry has not referred any inappropriate claims identified by this analysis to the Medical Review Committee (Committee) since September 2004, when this committee was suspended, as discussed below.

### Suspension of the Medical Review Committee

A post-payment review can result in a variety of possible actions. These include attempts to educate the practitioner, direct recovery for claims containing errors, referral of suspected fraud cases to the OPP, and, before the Committee was suspended in September 2004, referral of questionable claims to the Committee for its review.

The Committee had a structure and review process similar to other Canadian jurisdictions, as illustrated in Figure 7. A number of outcomes were possible once the Committee had completed its review, including directing the physician to repay

the Ministry for those services it deemed not to have been rendered, deliberately or inadvertently misrepresented, not medically necessary, or not performed according to accepted professional standards. From the 1999/2000 fiscal year through the 2002/03 fiscal year, the Ministry referred an average of 90 cases per year to the Committee and was able to recover approximately \$4.9 million annually.

Prompted by complaints from physicians over several years that the Ontario medical review process was too rigid, onerous, and unfair, in June 2004 the Minister of Health and Long-Term Care appointed The Hon. Mr. Peter Cory, a retired justice of the Supreme Court of Canada, to conduct a study of the review process. Figure 8 provides a timeline summarizing The Hon. Mr. Cory's review and subsequent developments.

In conducting his study, The Hon. Mr. Cory received written submissions from the Ministry, the Ontario Medical Association, the College of Physicians and Surgeons of Ontario, and other medical associations and professionals. In September 2004,

while awaiting The Hon. Mr. Cory's recommendations, the Ministry suspended the activities of the Committee and created a new panel called the Transitional Physician Audit Panel to act as a temporary appeal body for results on audits conducted before the Committee's suspension or for decisions relating to the direct recovery of claims paid that were made after the Committee's suspension.

When The Hon. Mr. Cory released his final report in April 2005, he made 118 recommendations to the Ministry, including the establishment of a new medical audit process and a new Physician Audit Board. The Board would be independent of the Ministry and of the professional medical governing bodies. He also recommended that the basis for any provider audit must be clear, the auditing method must be transparent, and the process must be fair. The primary goal of the new process should not be to penalize providers or recover funds, but rather to educate physicians in order to facilitate compliance with billing requirements. In May 2005, the Ministry committed to provide an implementation plan for the Cory Report by summer 2005. However, at the time of our audit, while the implementation plan had been submitted to Cabinet, legislative changes had not yet been introduced.

We noted that, when the Committee audit process was suspended, it had 110 outstanding cases under review. We understand that none of these cases will be reopened when the new audit process is

put in place. We reviewed these cases and noted that the Ministry has calculated potential recoveries for 42 of them, totalling \$3.8 million. In addition, based on the recovery rates from the 1999/2000 through 2002/03 fiscal years, we estimate that a potential \$13 million in claims recoveries to March 2006 may have been lost due to the suspension of the audit process.

## RECOMMENDATION 5

To help reduce the risk of inappropriate billing from health-care providers and to identify and recover overpayments from such cases, the Ministry of Health and Long-Term Care should implement an effective audit process as soon as possible.

### Provider Registration

In Ontario, there are approximately 28,000 health-care providers. These include family physicians, dentists, optometrists, nurse practitioners, and midwives. In order to submit claims for insured health services, all providers must register with the Ministry and obtain an OHIP billing number. Each provider must have an Ontario practice address and hold a current valid licence with his or her professional governing body. These governing bodies

### Figure 8: The Hon. Mr. Cory's Review Timeline

Source of data: Ministry of Health and Long-Term Care

June 2004	<ul style="list-style-type: none"> <li>Ministry appoints The Hon. Peter Cory to review the medical audit process</li> </ul>
June to November 2004	<ul style="list-style-type: none"> <li>The Hon. Mr. Cory accepts written and oral submissions from interested parties</li> </ul>
September 2004	<ul style="list-style-type: none"> <li>Medical Review Committee suspended</li> <li>Transitional Physician Audit Panel created to act as temporary appeal body</li> </ul>
April 2005	<ul style="list-style-type: none"> <li>The Hon. Mr. Cory submits his final report</li> <li>Ministry releases report on same day</li> </ul>
May 2005	<ul style="list-style-type: none"> <li>Ministry announces at Ontario Medical Association meeting it will provide an implementation plan to address the Cory Report recommendations by summer 2005</li> </ul>
April 2006	<ul style="list-style-type: none"> <li>implementation of the Cory Report recommendations and revised medical audit process still pending</li> </ul>



include the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, the College of Optometrists of Ontario, the College of Nurses of Ontario, and the College of Midwives of Ontario.

Ministry district offices receive and process provider registration forms and the accompanying supporting documents, such as a copy of the licence issued by the associated governing body. While all registration forms and updates of provider's information should be maintained in the district offices for future reference, we found that the provider files kept at the district offices were often incomplete. During our visits, we sampled provider registration files. In 10% of these cases, we were unable to locate the registration documents, and, where documents were available, key supporting documentation was missing in 70% of them.

### Provider Information Updates

The Ministry maintains records for each provider electronically in its Provider Registry System and receives periodic updates from the respective governing bodies. These updates include changes in licence status, address, and specialty. Licence status is particularly important in determining whether the provider has the right to submit claims for services provided.

With respect to family physicians, the Ministry receives electronic files weekly from the College of Physicians and Surgeons of Ontario and updates the physicians' records accordingly. This weekly file submission includes new physicians as well as those whose licences have expired or been terminated. However, we found that this data feed was not complete because it only included licence expirations due to suspension, and not expirations due to the physician's death, retirement, resignation of membership, or moving away from the province. Hence, the physicians' licence status was not always being updated properly in the Ministry's database.

Because the information received from the College of Physicians and Surgeons of Ontario was incomplete, we requested and obtained from the College a complete listing of all active physicians as of February 2006 and compared it with ministry records. We identified 725 non-licensed physicians who were still active in the Ministry's database and, accordingly, could still submit medical claims and be paid.

Figure 9 outlines the reasons for which these licences had expired.

We reviewed the claims submissions from these physicians and found that 40 of them had claimed for health services provided after their licences had expired. All received full payment for these claims. For example:

- Three physicians claimed for treating more than 800 patients over 16 months after their licences had expired and had received payments of about \$58,000.
- Medical claims were submitted and paid to three physicians who, according to College records, were deceased.
- A physician suspended for violating the terms and conditions of his licence had subsequently submitted claims for almost 300 patients.
- One physician continued to perform a number of surgical procedures after licence expiration.

**Figure 9: Non-licensed Physicians Active in Ministry Database, February 2006**

Source of data: College of Physicians and Surgeons of Ontario and Ministry of Health and Long-Term Care

Reason for Licence Expiry	# of Physicians
deceased	77
non-payment of membership fee	25
resigned membership	451
retirement	147
violation of terms and conditions of licence	25
<b>Total</b>	<b>725</b>

We provided the Ministry with the details of these instances and were advised that the Ministry would follow up on them.

For other practitioners, such as dentists or optometrists, the Ministry receives letters or written notices updating the status of licences on a case-by-case basis as changes occur. We requested and obtained from the respective colleges a complete listing of all active dentists and optometrists as of February 2006 and concluded that these practitioner records were also not being properly updated. Fifteen dentists and two optometrists with expired licences were still on the ministry system and, accordingly, could continue to submit medical claims, but we noted no evidence that they had done so. Some of these licences had expired a number of years ago.

### RECOMMENDATION 6

To ensure that medical claims are paid only to licensed providers and that the public is protected, the Ministry of Health and Long-Term Care should work more closely with all professional governing bodies to ensure that all provider records are updated in a timely manner.

### Protection of Provider Records

Provider records, such as name, practice address, medical specialty, and licence status or restriction, are maintained in the Provider Registry System. All medical claims submitted are verified against these provider records to ensure that the provider's status is active and that the provider is permitted to provide the specific health services. We reviewed the security administration procedures for the Provider Registry System and concluded that there were several areas where security should be improved:

- Special privileged system access, which enabled updates of provider records, was main-

tained for staff who did not require such access to fulfill their job duties.

- Dormant user accounts were not being removed from the system promptly.
- Approval documents for system access were missing in over 25% of the cases we examined.
- User-group profiles, which enabled users to have privileged system access, were created and assigned to users without proper approval.

### RECOMMENDATION 7

To better protect confidential provider records from unauthorized access and data tampering, the Ministry of Health and Long-Term Care should:

- develop proper documentation for all user-group profiles and maintain all system-access approvals to ensure that all access rights are maintained on a need-to-know basis; and
- enforce regular review of access privileges to the Provider Registry System so that only necessary privileges are maintained.

### MEDICAL CLAIMS PROCESSING

As discussed earlier, all medical claims submitted by the providers are reviewed for eligibility of both the provider and the patient, and assessed against predefined medical rules to ensure that payment is made only for authorized health services. While claims processing is, for the most part, done accurately, we have some concerns about the updating of medical rules, the overriding of claims rejected by the system, and the processing of paper claims.

#### Medical Rule Updates

When there is a change to the Schedule of Benefits, that sets out the rules for provider claims, system changes must be implemented by the effective date in order to ensure that claims are properly processed

and that payments are made accurately. However, we found that the Ministry did not always update medical rules accurately or in a timely manner.

We analyzed the implementation of the latest release of medical rules and found that the required changes were completed for only 22 of the 68 rules by the October 2005 effective date. In fact, the rules were not fully implemented until March 2006. We also noted more than 20 medical rules with errors awaiting correction at the time of our audit. For instance, one of the rules that restricted the number of antenatal preventive health assessments within a defined time frame was implemented incorrectly in April 2002; corrections were not made until August 2005. Although we acknowledge that some of the claims paid for these assessments may well be appropriate, we estimated that this delay may have led to potential overpayments of up to \$1 million.

### Rejected Medical Claims

The Ministry reported that over 9.5 million claims (6% of total claims processed) were initially rejected by the system in the 2005/06 fiscal year. When medical claims are rejected under the automated medical-rule review, they are forwarded to district offices where staff further review these rejections for reasonableness. The rejected claims may then be overridden and paid if staff deem them to be medically necessary or legitimate, or returned to the provider for correction and resubmission.

Since 1993, our Office has raised concerns about the Ministry's process for overriding rejected claims, and we continue to have concerns in this area. We found that there were inadequate guidelines, standards, or procedures to assist district staff in making consistent and appropriate decisions when assessing rejected claims. We also found that the district offices did not maintain sufficient documentation supporting their override decisions. We reviewed a number of override decisions with ministry staff, who confirmed that 10% of these decisions were made in error. We also noted that there

was no periodic, ongoing management review of overridden transactions, even on a spot-check basis, to ensure that decisions made by staff were consistent, appropriate, and accurate.

### Paper Claims Processing

Although almost all medical claims are submitted via electronic data transfer, diskette, or tape, about 750,000 claims are submitted on paper forms and entered manually every year. During our visits to the district offices, we reviewed the process to handle these claims, and found deficiencies in ensuring that all paper claims entered are authorized:

- There was no tracking, review, or reconciliation of the number of paper claims received, processed, or paid.
- There were poor controls over access to the data-entry system for paper claims, in that no system account or password was required. This would make it much easier for fraudulent or non-existent claims to be entered.

### RECOMMENDATION 8

To help ensure that all valid medical claims are processed accurately, the Ministry of Health and Long-Term Care should:

- implement all new medical rules and corrections in a timely manner;
- develop guidelines and procedures to assist district staff in making consistent and appropriate decisions on overriding rejected medical claims, and review a sample of overridden transactions on an ongoing basis to ensure consistency and compliance with the guidelines developed;
- establish procedures to reconcile the number and dollar amounts of paper claims; and
- strengthen the security controls over the data entry system for paper claims to ensure that system access is appropriately restricted.

## MINISTRY OF HEALTH AND LONG-TERM CARE RESPONSE

The Ministry of Health and Long-Term Care (Ministry) appreciates the audit observations and recommendations issued by the Auditor General. Maintaining strong controls and the integrity of the OHIP registration and claims processing systems is very important to the Ministry, and we are pleased that the Auditor General notes in his report that controls and procedures are generally adequate to ensure claims are paid accurately.

### Recommendation 1

The Ministry agrees that the conversion of red-and-white cards is important. The Ministry will review options and a business case for accelerating the conversion.

### Recommendation 2

The Ministry agrees with the Auditor's recommendation concerning the Fraud Programs Branch. The Ministry is in the process of expanding the role of the branch to increase its monitoring activities. These will include active risk identification within the program and ministry information systems to identify potential cases prior to referring them to the Ontario Provincial Police Health Investigation Team for follow-up (schedule implementation begins 2006/07).

Also, the Ministry implemented system changes in June 2006 to more effectively monitor client eligibility. With these system improvements, the Ministry is now sending out 10,000 notices to clients each week to re-verify eligibility and expediting the review of the outstanding cases where there have been no claims since April 1998.

The Ministry agrees with the Auditor's recommendation concerning the backlog of eligibility case assessment and is revising its business processes to enable it to more effectively use its

resources to resolve and close the outstanding cases.

### Recommendation 3

The Ministry agrees that it is important to follow up on outstanding cases of citizenship document authentication. The Ministry will complete a review of the options, including automation, that would enable these business improvements in 2006/07.

The Ministry agrees with the Auditor General's recommendation to expand the scope of the electronic authentication program to include other commonly used citizenship documents. The Ministry has begun discussions with Citizenship and Immigration Canada and is initiating discussions with the Canadian Passport Office.

The Ministry is also following up on the Auditor General's recommendation regarding reconciling health-card applications received to processed transactions. The Ministry will review the requirements that would allow for the validation of the billing number for physicians who sign the photo and signature exemption forms.

### Recommendations 4 and 7

The Ministry initiated a project in July 2006 to review its access control policies and procedures and make recommendations for improving the security requirements that govern staff access to ministry corporate systems.

A database that captures all authorization information for access to the Corporate Provider Database was implemented in June 2006. This system produces quarterly reports for review (first report due November 2006), which allows updates to be made appropriately, including confirming ongoing eligibility of authorized profiles.

**Recommendations 5 and 6**

The Ministry is already proceeding to implement a revised physician audit process in response to the recommendations brought forward in the Cory Report. Policy approval has been secured and we are in the final steps for implementation.

The Ministry has also completed discussions with the College of Physicians and Surgeons of Ontario to provide an enhanced data feed, which commenced in early September 2006.

**Recommendation 8**

The most recently negotiated Physician Services Agreement is very complex and has challenged the aging architecture of the claims payment system. A review will be undertaken in 2007/08 to consider solutions that will allow for more effective processing of payment streams. Attention will be paid in negotiating future agreements to ensure that there is sufficient technical capacity to support implementation of the negotiated elements of the agreement.