

Drug Programs Activity

Background

The Drug Programs Branch (Branch) within the Ministry of Health and Long-Term Care (Ministry) administers Ontario's drug programs. Legislative authority for payments made through these programs is established under the *Ontario Drug Benefit Act*, the *Drug Interchangeability and Dispensing Fee Act*, and the *Health Insurance Act*.

The Branch administers the following drug programs:

- Ontario Drug Benefit Program: provides prescription drugs to Ontario seniors, social-assistance recipients (Ontario Works or Ontario Disability Support Program), persons receiving professional services under the Home Care program, and residents of special-care and long-term-care homes.
- Trillium Drug Program: provides assistance to people who do not meet the eligibility requirements of the Ontario Drug Benefit Program and who have prescription-drug costs that are high relative to their income.
- Special Drugs Program: provides funding to cover the costs of certain drugs provided to hospital out-patients for the treatment of specific health conditions as set out in regulations under the *Health Insurance Act*.

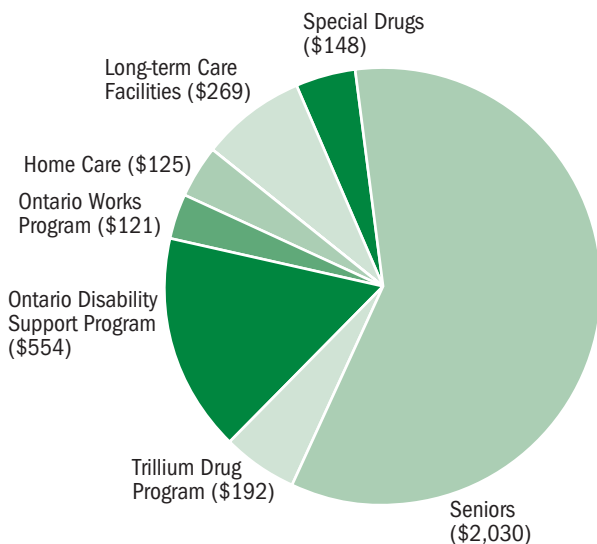
The Branch is also responsible for monitoring the development, operation, and maintenance of the Health Network System (Network), a computer system that links the Branch to approximately 3,050 pharmacies and 100 other dispensers; provides on-line information to pharmacists; and makes possible the submission, adjudication, and payment of drug claims. The Network, which annually processes 90 million prescriptions for approximately 3.2 million eligible recipients, is operated on behalf of the province by a private-sector service provider. The Branch also processes, monitors, and audits claims from drug-benefit providers and acts in an advisory capacity for matters related to drug-benefit claims and payments.

In the 2006/07 fiscal year, Ontario's drug programs had total expenditures of \$3.7 billion, compared to \$3.4 billion in 2005/06. (Figure 1 shows a breakdown of these expenditures.) Of the \$3.7 billion, \$742 million was paid by the Ministry of Community and Social Services for drug benefits for social assistance recipients.

According to the Ministry, the growth of expenditures from \$1.98 billion in 2000/01 (see Figure 2) is owing to many factors, including the increased use of newer and more expensive drugs, the aging of the population, new diseases, new areas of pharmacology, and the shift to outpatient care arising from the restructuring of the health system.

Figure 1: Drug Programs Activity Expenditures, 2005/06 (\$ million)

Source of data: Ministry of Health and Long-Term Care (2006/07 figures not available at the time of our audit)



Note: The expenditure for Homes for Special Care was \$3 million.

The Branch employs approximately 102 staff, and it incurred operating expenditures of \$42 million in the 2006/07 fiscal year, up from \$30 million in the 2000/01 fiscal year, the time of our last audit.

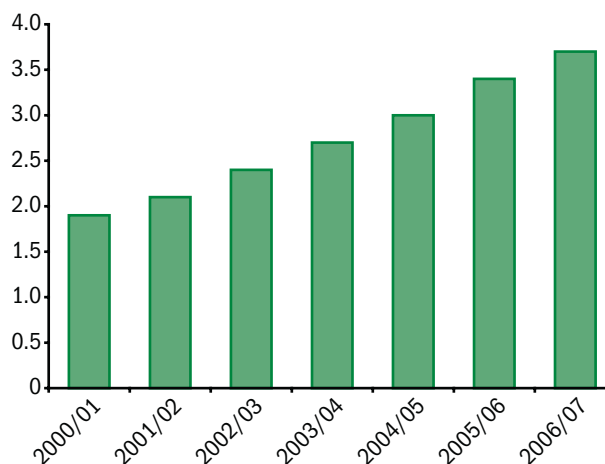
LEGISLATIVE CHANGES

In 2005, the Ministry established the Drug System Secretariat, which was to conduct an objective, system-wide review of Ontario's entire drug system. This review, completed in January 2006, determined that significant improvements were needed to manage the drug-system framework aggressively through changes in policy, legislation, and regulation. The key framework areas included the pricing of and reimbursements for drug products, access to drug products, more appropriate use of partnerships, innovation, and the strengthening of the governance and operations of the Ontario drug system.

As a result, both the *Ontario Drug Benefit Act* and the *Ontario Interchangeability and Dispensing Fee Act* were amended, effective October 1, 2006. The

Figure 2: Expenditures on Drugs, Drug Programs Activity, 2000/01–2006/07 (\$ billion)

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



Ministry anticipates that these amendments should result in savings through volume discounts for all drugs purchased for the Drug Programs Activity, and in improved access for patients to drugs through new conditional listings and timely reviews of innovative drugs.

The legislative amendments also created the position of Executive Officer of the Ontario Public Drugs Program, who exercises the functions and powers that were formerly held by the Minister of Health and Long-Term Care or the Lieutenant Governor in Council. This person's responsibilities now include designating drug products as interchangeable and publishing updates to the Ontario Drug Benefit Formulary (Formulary), which lists all government-approved drug products and prices. The Ministry expects this will allow for significantly quicker updating of the Formulary than under the previous system.

In 2004, the Standing Committee on Public Accounts recommended that the Ministry "periodically collect and analyze data on the prices paid for comparable drug products in other provincial jurisdictions." The latest review was conducted in early 2007, when the Ministry completed a comparison of the Formulary prices of the top 50 drug products in Ontario by total government

expenditures with those in three other provinces (British Columbia, Saskatchewan, and Quebec). This comparison revealed that the prices paid by Ontario were generally in line with these three other provinces.

CHANGES IN THE DRUG PROGRAMS BRANCH

In June 2007, after our fieldwork, the activities of the Drug Programs were reassigned to the newly created Ontario Public Drug Programs Office and to a new branch called the Individual Eligibility Review Branch. Although the activities were reassigned, the Ministry continues to be responsible for the areas detailed in this report.

Audit Objective and Scope

Our audit focused on the claims payment and verification process of the Drug Programs Activity. Our objective was to assess whether the Ministry had adequate policies and procedures to:

- approve, process, and pay claims for drugs dispensed to eligible recipients and to inspect dispensing agencies to ensure compliance with legislation;
- ensure that resources devoted to the claims process and inspection process are managed with due regard for economy, efficiency, and effectiveness; and
- measure and report on its performance in managing drug claims.

Given that the Ministry had recently reviewed the Formulary, we did not examine the processes pertaining to the review and approval of drugs and drug pricing for inclusion in the Formulary.

In conducting our audit, we reviewed and analyzed relevant ministry policies and procedures, reviewed ministry files, and conducted interviews

with ministry staff in Toronto and Kingston. We reviewed files and conducted interviews at a third-party vendor that administered both the Senior Reduced Co-payment Program (part of the Ontario Drug Benefit Program) and the Trillium Drug Program. We met with staff of the Ontario College of Pharmacists to gain an understanding of its role relative to the Drug Programs Activity and to obtain relevant statistical information. We also attended a ministry inspection audit at a dispensing agency.

Before starting our audit, we decided what audit criteria would be used to address our audit objective. These were reviewed and agreed to by senior ministry management.

Our audit was performed in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants, and accordingly it included such tests and other procedures as we considered necessary in the circumstances. To minimize any duplication of effort, we also relied on certain related work done by the Internal Audit Services of both the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services.

Summary

We were generally satisfied that the externally managed Health Network System (Network) processed drug claims in accordance with the legislative requirements and ministry policy. In addition, the Ministry has acted on our previous audit recommendation to tender the contract for the Network; this will result in significant savings to the Drug Program. To control costs further, however, the Ministry must be more vigilant in ensuring that the risks related to ineligible claimants and unusual drug-claim patterns are being appropriately addressed. Specifically:

- The Drug Program was required to closely monitor eligibility granted by pharmacists to persons identified as ineligible for drug coverage by the Health Network System by entering override codes in the system. However, we found little evidence that this monitoring was performed even as part of the routine inspection audits that required the inspectors to check support for the use of such codes. Our audit found instances where the Ministry paid for drugs dispensed to persons identified by the system as ineligible for drug coverage through pharmacy overrides. In one case, a pharmacy made more than 300 claims in a five-month period through system overrides for one person who was ineligible for drug coverage during that time. While the Ministry was unable to provide support for all the overrides, it was able to obtain temporary eligibility cards from dispensing pharmacies that supported the majority of the payments. Because it does not consistently monitor these overrides, the Ministry is unable to detect and minimize the chance that ineligible individuals will receive drug coverage.
- Pharmacists can be paid for drug prices in excess of the Formulary prices if they enter an override code in the system when they acquire drugs at costs greater than the Formulary prices. Our review of a sample of price override claims paid in February 2007 found that more than 30% of the unit drug prices exceeded their Formulary prices by more than 100%. In one case, the price claimed exceeded the Formulary price by 12,500%. This resulted in the Ministry paying almost \$2,400 for a claim that, according to the Formulary price, should have cost less than \$20. In some cases, the Ministry conducted follow-up investigations and found that the higher drug prices claimed were the result of input errors at pharmacies and, therefore, the excess amounts were recoverable.
- Our audits in 1996 and 2001 revealed a lack of ministry inspection resources, a lack of planning for efficient utilization of inspectors, and insufficient inspection coverage. The Standing Committee on Public Accounts recommended that the Ministry review its inspection resources and report to the Committee after the anticipated completion of the review by late 2004, including a plan to respond to the review. Our current audit revealed that the above concerns were not addressed and the review recommended by the Committee was not completed. Since our last audit, the growth in claims activity, combined with a reduction in the number of field inspection staff, has significantly reduced the inspection coverage of dispensing agencies. Currently, inspectors can only examine each dispensing agency about once every 30 years.
- Given its limited inspection resources, the Ministry needs to use them more effectively by targeting high-risk dispensing agencies across the province. We found that unusual claims statistics, which highlight areas for investigation, had not been effectively used for inspection selection. For instance, our review of data for the 2005/06 fiscal year where 20 dispensing agencies filled prescriptions for an average drug supply of less than three days, showed that only one of them had been inspected in more than six years. Such statistics could highlight dispensing agencies that might be inappropriately dividing the quantity of a prescribed drug into smaller amounts in order to dispense it more often and charge more dispensing fees. In conjunction with the Ministry, we selected a dispensing agency that had a high number of claims per drug recipient and attended the related field inspection. This single inspection found

\$270,000 in overpayments, with more than \$240,000 of that due to claims for invalid dispensing fees.

- The Ministry did not pursue the recovery of annual outstanding unpaid deductibles under the Trillium Drug Program. In 2005/06, some 19,300 Trillium households received \$23 million in drug coverage but had more than \$6 million in outstanding unpaid deductibles at year-end. The Ministry could not provide information on the number of these households that had had outstanding unpaid deductibles in previous years.

In our *2001 Annual Report*, we expressed concern about the Ministry's extending a contract with the same vendor since 1993 for maintenance and development of the Health Network System without using a competitive selection process. Its most recent contract—for five years, at a total cost of \$63 million—was to expire in November 2005. The Ministry requested and subsequently received Management Board approval to extend the contract with the same vendor for another 24 months. During the 24-month period, an external consultant was engaged to assess contract requirements. On the basis of the results of that review, the Ministry decided to deliver directly some of the services that had been part of the previous contract. It then completed a competitive selection process, resulting in a new contract with a different vendor for a term of six years at a significantly reduced cost of about \$28 million.

We sent this report to the Ministry and invited it to provide responses. We reproduce its overall response below and its responses to individual recommendations following the applicable recommendation.

OVERALL MINISTRY RESPONSE

The Ministry is dedicated to the fair and responsible delivery of public drug programs to ensure

that recipients of Ontario drug benefits, who are among Ontario's most vulnerable citizens, have access to the medications and treatments they need. The Ministry generally accepts the recommendations of the Auditor General and will take action to address them.

Detailed Audit Observations

ELIGIBILITY FOR DRUG COVERAGE

The Ontario Drug Benefit Program (Program) covers most of the cost of over 3,100 drug products listed in the Ontario Drug Benefit Formulary (Formulary). The majority of these drug products are prescription drugs; there are also nutritional and diabetic-testing products. The Formulary includes the price the Ministry will pay for each drug, which the drug manufacturers have agreed to. A person is eligible for drug coverage if he or she is an Ontario resident, has valid Ontario Health Insurance, and falls into one of the eligible drug coverage categories. To receive drug coverage, eligible recipients may be asked to pay some portion of the cost of their prescription drug product, in the form of co-payments and deductibles, for each benefit year. A benefit year runs from August 1 to July 31 of the following year. The eligible categories of drug coverage and the related deductibles and co-payments are shown in Figure 3.

Eligibility for Senior Reduced Co-payment

When a person turns 65, he or she is automatically eligible for drug coverage as a "high-income" senior. There were 1.1 million high-income seniors, who received \$1.4 billion in drug coverage in 2005/06. In order to qualify for the reduced co-payment program, a "low-income" senior must

Figure 3: Categories of Eligibility, Deductibles, and Co-payments, by Drug Program as of 2006/07

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

Eligibility Category	Deductible(s) (\$)	Co-payments (\$)
Person Aged 65 or Older		
single senior, income greater than \$16,018	100	6.11 ¹ /2.83 ²
senior couple, income greater than \$24,175	100 each	6.11 ¹ /2.83 ²
single senior, income less than \$16,018	—	2.00
senior couple, income less than \$24,175	—	2.00
Other		
resident of long-term-care home	—	2.00
resident of a Home for Special Care	—	2.00
recipient of professional services under the Home Care Program	—	2.00
recipient of benefits from Ontario Works or Ontario Disability Support Program	—	2.00

1. retail pharmacy

2. hospital pharmacy

submit an application with appropriate supporting income documentation, such as a Notice of Assessment from the Canada Revenue Agency (CRA). In 2005/06, there were 341,000 low-income seniors, who received \$627 million in drug coverage. Once a person has been assessed as eligible for the reduced co-payment, no further annual applications need be made; seniors are required only to notify the Ministry if their income increases during their enrolment. The Ministry entered into an agreement with the CRA in April 2005 enabling the Ministry to obtain confirmation of seniors' annual income levels through an electronic link. However, at the time of our audit, this link had not been put in place for the reduced co-payment process—although we noted that it was in place for the Trillium Drug Program income-verification process.

Data Pertaining to Eligible Social-assistance Recipients

In the 2006/07 fiscal year, the Ministry reported that 585,000 social-assistance recipients received \$742 million in drug coverage. Every day, the Program receives data from the Ministry of Community and Social Services (MCSS) documenting the eligible recipients of Ontario Works and Ontario Disability Support Program assistance. Data pertaining to new and terminated social-assistance recipients is provided through an automatic interface that is uploaded into the Health Network System (Network). In addition, a monthly comparison of the Network data to the MCSS database is made and any data mismatches are followed up on by MCSS.

MCSS issues a system-generated or manual drug card to social-assistance recipients for drug coverage every month. Pharmacists are allowed to grant temporary eligibility to individuals who present a valid drug-benefits card even if the system does not recognize them. The pharmacist does this by entering an override code in the system. In 2006/07, 155,000 eligibility overrides were granted, for which 518,000 individual drug claims were submitted and paid. We selected a sample of recipients who received drug coverage for a significant number of claims through eligibility overrides granted by pharmacists. We verified this sample directly with MCSS to determine whether these recipients were actually eligible for social assistance in the 2006/07 fiscal year. On the basis of MCSS data, we found that some of these recipients with pharmacists' overrides received drug coverage when they were apparently ineligible. In one case, a pharmacy used system overrides to make more than 300 claims in a five-month period for one person who was ineligible for drug coverage during that time. (See Inspection and Verification later in this report.)

A March 2007 report issued by MCSS internal audit services identified similar concerns regarding pharmacists' overrides. However, MCSS staff did not have the authority to conduct physical inspections at the pharmacies. The authority lay with the

Inspection Unit of the Branch. Although all of these drug costs related to social assistance are borne by MCSS, the onus for inspection remained on the Drug Programs Inspection staff. The Inspection Unit Policy and Procedures Manual specifically requires inspection staff to monitor the use of these eligibility overrides closely. We found little evidence that inspection audits had reviewed any of these overrides we found. Once we had pointed out the above cases, Program staff conducted a follow-up investigation and found that most of the eligibility overrides we reviewed were supported by manually issued eligibility cards. As noted earlier, there was little verification by Program inspectors of these eligibility overrides. We were concerned that even when inspection staff were required to verify eligibility overrides as a standard test for routine audits, there was no evidence that the test was performed in over 80% of the routine audit files we reviewed.

Because of the lack of ministry monitoring of system overrides on a routine basis, it is not able to detect and minimize the risk that ineligible individuals will receive drug coverage.

Eligibility for Residents of Long-term-care Homes

In the 2006/07 fiscal year, 99,800 program recipients in long-term-care homes received \$295 million in drug coverage. The Program does not obtain information on residents of long-term-care homes from sources such as the homes or the Ministry's Long-Term Care Program to verify eligibility for drug coverage. In addition, Program Inspection staff indicated that they did not have the authority to audit the records of long-term-care homes. Instead, they rely on individual pharmacies to claim for drugs provided to long-term-care residents by entering the identification number of an active long-term-care home.

The lack of independent verification may lead to drug claims being made for ineligible recipients. In fact, our review of the Ontario College of

Pharmacists' disciplinary notices showed a number of instances where dispensing pharmacists were under review for continuing to claim for drugs dispensed to recipients who had either died or were no longer residing at a long-term-care home.

RECOMMENDATION 1

To ensure that only eligible recipients receive or continue to receive drug coverage, the Ministry of Health and Long-Term Care (Ministry) should ensure that:

- income levels of seniors receiving reduced co-payments are supported by proper documentation or through electronic means, such as the Canada Revenue Agency income link;
- eligibility override codes used by pharmacists are applied and supported appropriately;
- the use of override codes is monitored and abnormally high override rates are investigated; and
- continuing eligibility of long-term-care residents is confirmed independently by obtaining information from the long-term-care homes or the Ministry's Long-Term Care Program.

MINISTRY RESPONSE

In 2005, the Ministry began a phased implementation of automated income-verification linking to the Canada Revenue Agency (CRA) database. The Trillium Drug Program was implemented as the first priority because it poses a higher risk than the other programs, having higher deductibles. Further systems development is still required. Once the implementation is completed, the Ministry will implement a process for the Seniors' Co-payment Program. Seniors applying for the lower co-payment program have always been required to provide hard-copy proof of income, such as a Notice of Assessment from the CRA.

The Ministry will continue to pursue appropriate use of eligibility override codes and will review and document their use in a consistent manner as part of routine audits.

The Ministry will identify options to verify claims from long-term-care clients.

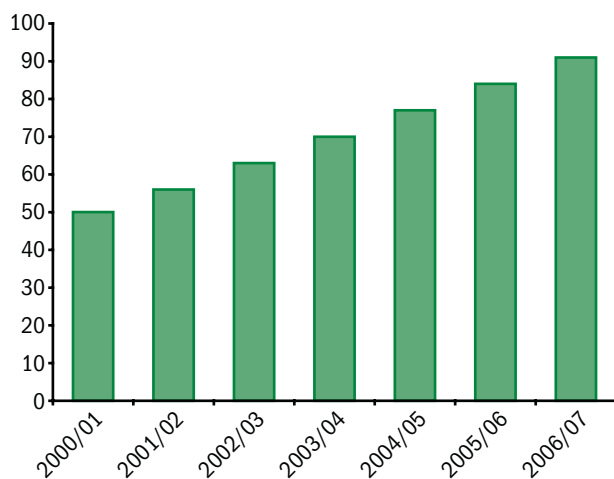
PROCESSING OF PAYMENT CLAIMS

The Health Network System (Network) is an on-line, real-time claims system that links all Ontario dispensing agencies directly to the Ministry for claims adjudication and processing. The Network processes claims seven days a week 24 hours a day. The Network also emails information on drug benefit changes, program changes, and payment information to dispensing agencies.

As illustrated in Figure 4, in the 2006/07 fiscal year, the Network processed over 90 million claims transactions—an increase of over 80% from the 2000/01 fiscal year. About 99% of these were on-line claims from dispensing agencies. The remaining claims included paper claims and prescription receipts submitted for reimbursement.

Figure 4: Total Number of Claims (million), 2000/01–2006/07

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



Electronic Processing of Payment Claims

The Network automatically performs a series of adjudication processes, including assessment of eligibility, validation of claim submission data, calculation of a recipient's co-payments and deductible amounts, computation of the Program's share of costs, and provision of information or warning messages to dispensing agencies.

From our testing, we found that the Network generally processed claims in accordance with the legislative requirements and ministry policy, with the following exceptions:

- The *Ontario Drug Benefit Act* states that Ontario Works recipients are limited at any one time to a drug supply sufficient for a 35-day course of treatment. Our audit found that the Program management made a business decision to process Ontario Works recipients' claims with drug supply limits of up to 100 days if the person is also eligible under another program, such as Trillium. Although there is likely no additional cost to taxpayers, the business decision did not comply with the legislated maximum limit of 35 days for Ontario Works recipients.
- In July 2003, owing to a regulatory change, the Network was modified to increase the dispensing fee allowed for hospital pharmacies. This modification inadvertently increased the amount of the drug recipients' co-payment, which should have remained unchanged. The Program only identified and corrected this error in October 2006, three years after the incorrect change was made. We estimate that this error, over a three-year period, resulted in about \$400,000 in overpayments by drug recipients.
- A legislative regulation specifies the amount of the dispensing fee the Program pays to hospital pharmacies. Before October 2006, this was about half the amount paid to retail pharmacies. In some cases, individuals choose

to pay for their own prescriptions and then submit receipts to the Program for reimbursement. We found that, in such cases, if the prescription was filled at a hospital pharmacy, the Network erroneously paid the individual dispensing fee at the retail rate rather than the lower rate established by the legislation. We noted that the regulations were changed in October 2006 so that hospitals and retail pharmacies receive the same maximum dispensing fee. However, if the dispensing fees were to diverge again, the Network would continue to apply the dispensing fee in effect for retail pharmacies to reimbursements for prescriptions filled at hospital pharmacies.

In addition to the above concerns, we contacted the Ontario College of Pharmacists to obtain a 2006 listing of pharmacies that had closed. Over half of the pharmacies we reviewed that were listed by the College as being closed were still recorded in the Network as being open.

RECOMMENDATION 2

To help ensure that all claims are processed accurately and completely in accordance with legislative and policy requirements, the Ministry of Health and Long-Term Care should:

- periodically perform Health System Network (Network) assessments or tests to identify areas of non-compliance, with particular emphasis on ensuring that the network has been updated for program changes; and
- regularly obtain information from the Ontario College of Pharmacists on pharmacy closings to update the Network database.

MINISTRY RESPONSE

The Ministry is reviewing the adjudication rules on the Health Network System (Network) and will specifically review the rules that deal with adjudication of claims by Ontario Works clients.

New Acquirer Host Network agreements implemented in June and July 2007 require that the Ministry be notified of changes to a pharmacy connecting through such a network. The Ministry will enforce the agreements to ensure it promptly receives information on pharmacy changes.

The Ministry verifies a pharmacy's licence from the Ontario College of Pharmacists (OCP) when the pharmacy registers for an Ontario Drug Benefits Program billing account. The OCP previously provided the Ministry with updates of changes for accredited pharmacies. This practice was discontinued because the Ministry was the only user of the report. The Ministry will investigate the possibility of reinstating the regular OCP updates.

Cost-to-operator Payments

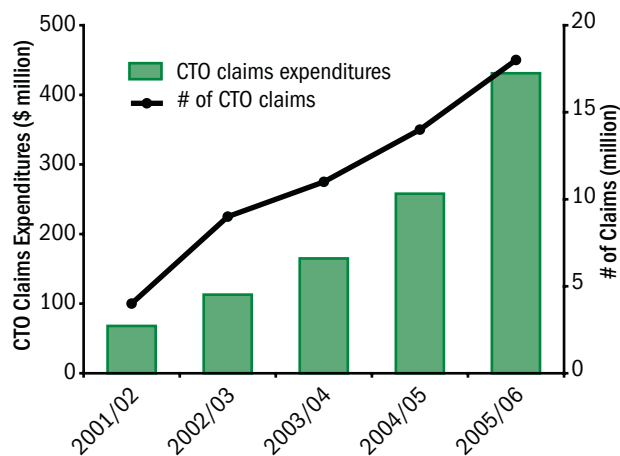
Although drugs are to be provided at Formulary prices, the *Ontario Drug Benefit Act* allows claims to be submitted and paid at the acquisition cost of a drug plus a mark-up of 10% (8% effective April 2007), if the drug exceeds the Formulary price. These claims are referred to as “cost-to-operator” claims (an “operator” being a dispensing agency) and are processed on-line through the Network when the pharmacists input a price override code in the system.

Ministry statistics show a significant increase over the past five years in cost-to-operator claims and expenditures—instances where drug prices paid by dispensing agencies exceeded the published Formulary prices—as seen in Figure 5. In the 2005/06 fiscal year, total cost-to-operator expenditures were \$431 million, compared to \$67.8 million in the 2001/02 fiscal year—an increase of over 500%.

We reviewed a sample of cost-to-operator claims paid out during February 2007 and found that over

Figure 5: Total Cost-to-operator (CTO) Claims and Expenditures, 2001/02–2005/06

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



30% of the unit drug prices in this sample exceeded the related Formulary drug prices by more than 100%. When we brought these observations to the Ministry's attention, program management indicated that most of these cost-to-operator claims were owing to drug manufacturers charging market prices that exceeded the Formulary prices, including one claim that was over 12,500% higher than the Formulary price. This resulted in the Ministry's paying almost \$2,400 for a claim that, according to the Formulary price, should have cost less than \$20. In some of these cases, the Ministry conducted follow-up investigations and found that the higher drug prices claimed were because of pharmacy inputting errors. Program management stated that they would pursue the pharmacies to recover the overpayments.

The Ministry indicated that, when drug manufacturers do not comply with the Formulary prices, it can take any of the following actions: de-list the drug product from the Formulary; refuse to review any other drug submissions from the manufacturer; and claim overpayment refunds from the manufacturer. However, discussions with ministry staff indicated that the Ministry has not taken any of the above actions. While it was not within the scope of

our audit to review the setting of prices for drugs in the Formulary, we were advised that the Drug System Secretariat is reviewing this issue relating to cost-to-operator payments.

Effective October 1, 2006, legislative changes were made to limit the use of cost-to-operator intervention codes for processing claim payments. To provide for a reasonable transition period, the Ministry decided to continue to pay all cost-to-operator claims up to March 1, 2007. We were informed after our audit that, in June 2007, the Ministry implemented a process where the cost-to-operator intervention code would not be accepted for the processing of cost-to-operator claims for generic drugs. We understand that the Ministry was considering this same process for its review of brand-name drugs.

RECOMMENDATION 3

To ensure that it pays drug prices charged in excess of Formulary prices only when appropriate, the Ministry of Health and Long-Term Care should:

- regularly review and monitor pharmacy claims for manufacturer costs exceeding Formulary prices for accuracy and for evidence of manufacturer invoice support; and
- take appropriate action to recover overpayments when claims are found to be invalid or incorrect and when drug manufacturers are in non-compliance with Formulary prices.

MINISTRY RESPONSE

The Ministry had identified the issue of non-compliance with Formulary prices, and, as part of initiatives relating to the *Transparent Drug System for Patients Act, 2006*, regulations were amended to restrict cost-to-operator claims. The Ministry has implemented processes to disallow the use of cost-to-operator intervention codes for interchangeable (generic) products

and is in the process of blocking use of the code for single-source (brand) products with price agreements and where there are no equivalent interchangeable products. As part of routine inspections, these claims are reviewed and subjected to recovery. The Ministry recently reviewed Formulary products to ensure that the information was accurate and up-to-date, and discontinued products were removed.

Manual Processing of Paper Claims and Reimbursement Receipts

In certain cases, pharmacists must submit paper claims for processing. These include instances where, for example, a claim was submitted for a drug that was dispensed more than seven days previously, the claim is equal to or greater than \$10,000, or the drug took more than 99 minutes to mix.

As part of our review of controls over manually processed claims, we selected a sample of recently completed manual claims for our assessment. Our review found that more than 10% of the manually processed claims contained inputting errors. Such errors included incorrect dispensing fees, dispensing fees entered in the wrong field, incorrect claim amounts for drugs, and failure to include payments from private insurance companies. Because manually processed claims usually cover large amounts of money, incorrect processing can result in significant costs to the Program. For example, among the errors described above, we noted that:

- A \$1,500 payment was incorrectly entered as \$15,000, resulting in a Program overpayment of \$13,500.
- A private insurance payment was not included in the calculation of the final claim amount, resulting in a Program overpayment of \$5,000.

Because there was no quality-assurance review process for any of these cases, Program staff were unaware of these overpayments until we brought

them to their attention. Program staff told us that they would try to recover the overpayments.

RECOMMENDATION 4

To ensure that all manual claims are valid and are accurately processed in compliance with legislative and policy requirements, the Ministry of Health and Long-Term Care should conduct regular quality-assurance reviews of such claims.

MINISTRY RESPONSE

The Ministry has implemented a quality-assurance process that has reduced errors in manually processed paper claims. The Ministry will conduct periodic reviews to ensure continued data integrity. The quality-assurance process will be adjusted accordingly.

In the identified overpayments case, claims were corrected and overpayments recovered.

INDIVIDUAL CLINICAL REVIEWS

The Individual Clinical Review (ICR) process exists to enable physicians to make funding requests on behalf of their Program-eligible patients for drugs generally not listed in the Formulary. Each request submitted is individually assessed by the ICR Unit, which comprises about 40 full-time staff. This review process was originally introduced as a special authorization process to provide access to drugs in exceptional circumstances where Formulary drugs were ineffective or not tolerated, or where no alternative was available on the Formulary. The types of products requested included, for example, cancer drugs, hematologic drugs, and oral hypoglycemic drugs.

Ministry statistics show a significant increase in the number of ICR requests since our last audit, from 84,000 in the 2001/02 fiscal year to about

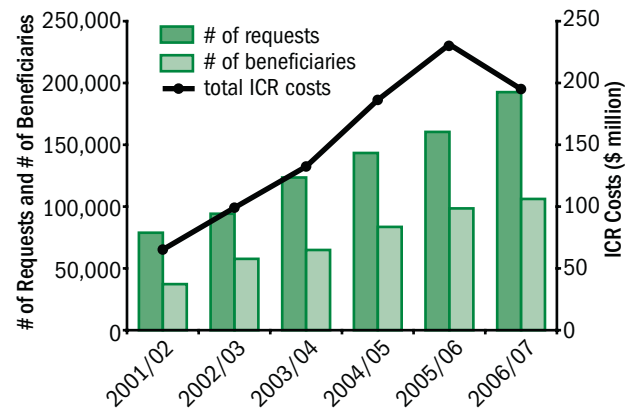
190,000 in 2006/07, as illustrated in Figure 6. A corresponding growth in ICR claim payments also occurred over this period, from \$65 million in 2001/02 to \$195 million in 2006/07. The significant growth in the number of ICR requests over the past six years demonstrates that this process, which was intended to handle exceptional circumstances, has now become a routine and labour-intensive review process for non-Formulary drug funding.

Aware of this significant growth, the Ministry took action in 2006 and, through legislative changes, introduced a new “Conditional Listing” category in the Formulary to allow patients access to new drugs or to existing drugs for use under specific conditions. During the period of our audit, the Ministry, through partnership agreements with drug manufacturers, approved nine categories of high-request drugs, representing 33 drug products, for inclusion in the Formulary, many of them under the conditional listing category. For a sample of these drugs, we compared their Formulary prices to their market prices before their inclusion in the Formulary. We found that the Formulary prices for these drugs once they were included were either the same or lower than the amounts previously paid for them.

The Ministry estimated that the inclusion of these drugs in the Formulary would result in an annual decrease of about 40,000 ICR requests. However, the exact figure could not be determined because, while the current information system can track high-volume-request drugs, it did not track the requests for specific drugs according to the medical condition for which they were being prescribed. Because the Formulary allows particular drugs to be prescribed for certain medical conditions and not for others, the Ministry would need to track ICR requests by diagnosis to determine more precisely how many such requests could be eliminated by including specific high-request drugs in the Formulary. Given that each ICR request is assessed individually, a further decrease in requests could result in significant savings for the Ministry and less paperwork for the prescribing physicians.

Figure 6: Total Number of ICR Requests, ICR Beneficiaries, and Total ICR Costs, 2001/02–2006/07

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



RECOMMENDATION 5

To more effectively identify high-request drugs for inclusion in the Formulary, the Ministry of Health and Long-Term Care should consider tracking Individual Clinical Review drug approvals by diagnosis type and the related numbers of requests.

MINISTRY RESPONSE

The Ministry uses volume and cost data to identify high-request drugs—considered through the Individual Clinical Review process—for inclusion in the Formulary. This information is tracked. Diagnostic information is less relevant to the analysis.

TRILLIUM DRUG PROGRAM

The Trillium Drug Program (Trillium) was introduced in 1995 to provide financial assistance to individuals and families who were not eligible for coverage under the Ontario Drug Benefits Program but who had incurred high drug costs relative to their incomes. Trillium’s benefit period operates from August 1 to July 31 of the following year.

Recipients must pay an annual deductible payable in quarterly instalments. The deductible amount is based on the number of people in the household and the household's net income, and is generally about 4% of the total household net income. Once the quarterly deductible is met, households pay only \$2 per prescription. If the deductible is unpaid in one quarter, it is added to the next quarter's deductible. In 2006/07, Trillium's total costs were \$234 million, compared to \$77 million in 2000/01, the time of our last audit.

Commencing in 2006, the Ministry received income information electronically from the Canada Revenue Agency to determine the individual deductible amounts. Individuals have the option of consenting to this electronic transfer of income information. Those who do not consent must still provide annual proof-of-income documentation.

Our review of the Trillium Drug Program found the following:

- More than 20% of the Trillium applications we reviewed lacked the required proof-of-income documentation, and there was no evidence of ministry or third-party-vendor follow-up to obtain the proper documentation.
- In our *2001 Annual Report*, we noted that the Ministry did not pursue the recovery of annual outstanding unpaid quarterly deductibles. There was no follow-up on outstanding unpaid deductibles, and they were not carried forward to the first quarter of the next benefit year. During this current audit, we found that the Ministry still did not pursue the recovery of these annual outstanding unpaid quarterly deductibles. In addition, the Ministry could not tell us how many of the 19,300 Trillium households with \$6.1 million in outstanding unpaid deductibles had outstanding unpaid deductibles in prior years. These households received \$22.9 million in drug coverage in 2005/06.
- The Ministry had not conducted any analysis or follow-up on the potential collectibility

of the unpaid amounts from any of the prior years.

Our review of the outstanding Trillium unpaid deductibles since our last audit, in 2000/01, shows that outstanding unpaid deductibles have increased by over 700% and drug coverage for households with outstanding deductibles has increased by almost 520%, as illustrated in Figure 7.

In response to our 2000/01 audit findings, the Ministry indicated that it would examine options for reducing or eliminating underpayments of the deductible and options for recovery. However, there is still no ministry policy to require follow-up and recovery of unpaid Trillium outstanding deductibles at year-end.

Figure 7: Expenditures for Claims by Households with Unpaid Deductibles, 2000/01–2005/06

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

	Households with Outstanding Deductibles (000)	Outstanding Deductibles (\$ million)	Drug Coverage Received by these Households (\$ million)
2000/01	5.0	.75	3.7
2001/02	7.8	1.45	7.5
2002/03	8.9	1.75	9.0
2003/04	9.4	1.96	10.4
2004/05	14.1	4.00	15.2
2005/06	19.3	6.10	22.9
Total Increase	286%	713%	519%

RECOMMENDATION 6

To ensure that the Trillium Drug Program is administered in accordance with legislative requirements, the Ministry of Health and Long-Term Care should:

- ensure that households provide appropriate documentation verifying income; and

- develop and implement appropriate policies and procedures to pursue unpaid deductibles owed to the Ministry.

MINISTRY RESPONSE

In the processing of Trillium applications, Canada Revenue Agency (CRA) income data are used wherever available. For consenting individuals, the CRA provides data electronically, with a 96.5% success rate. Approximately 85% of Trillium members provide consent.

The Ministry is considering legislative, policy, and operational options relating to recovery of unpaid deductibles. The Ministry does not currently have the legislative authority to carry over unpaid deductibles to the next year (Trillium eligibility terminates on July 31 each year).

SPECIAL DRUGS PROGRAM

The Special Drugs Program covers the full cost of certain drugs used in the outpatient treatment of 12 diseases or conditions listed under the Regulations to the *Ontario Health Insurance Act*, including HIV, end-stage renal disease, growth failure, and schizophrenia. Eligible recipients do not pay any deductible or co-payments for drugs obtained under this program. To be eligible, the person must be an Ontario resident with valid Ontario Health Insurance, have one of the diseases or conditions covered by the program, meet the established clinical criteria, and be approved by a designated facility, usually a hospital, for a specific drug product.

Program expenditures were \$154 million in the 2006/07 fiscal year, an increase of more than 40% over the \$107 million spent in the 2000/01 fiscal year, the time of our last audit. The increase over this period was mainly due to the lifting in 2002 of a freeze imposed nine years earlier on adding new drugs to the Special Drugs Program.

Processing and Monitoring of Special Drugs Claims

Hospitals generally submit monthly claims to the Ministry for cost reimbursement for special drugs used to treat eligible recipients. The hospital drug prices paid to manufacturers are either the current market drug prices or contract drug prices negotiated between the drug manufacturers and the Ministry.

We selected a sample of hospital claims to verify whether the prices paid were equal to or less than the maximum contract prices negotiated by the Ministry. In half of the sample, drug manufacturers' invoices had been submitted. For these claims, we were generally satisfied that drug prices paid were in accordance with contract prices.

For the other half of the sample, however, drug manufacturers' invoices were not provided; instead, internally generated hospital reports were submitted. Our review of these claims and the internally generated hospital reports showed the following:

- Claims from two of the six large hospitals did not provide sufficient details—such as the drug quantities purchased or the per-unit price paid—to enable us to make a comparison to the related contract prices. There was also no evidence that the Ministry obtained the necessary details to verify the prices paid against the maximum contract prices in effect. These claims represented about one-third of the claims we reviewed.
- For the remaining two-thirds of the claims, most did not have contracts with negotiated drug prices, so the details provided in the internally generated hospital reports could not be verified. For the non-contract drugs, we noted that one drug increased in price by 25% within a three-month period; as well, one hospital paid 40% more for one drug than another hospital had paid three months earlier. In one case where there were contract prices, we found that the per-unit prices paid

exceeded the contract prices by 15%. Since the Special Drugs Program did not perform any analysis on the hospital claims submitted, the reasonableness of the higher prices could not be assessed.

There was no evidence that the Ministry requested further details to support any of the drug prices claimed or to verify the accuracy and validity of the information submitted by the hospitals.

In addition, we noted that hospitals were reimbursed on two different bases. Some of the hospital claims were reimbursed on the basis of their purchases of the special drugs. Others were reimbursed on the basis of the actual use of the special drugs by their outpatients. Because most drugs have expiry dates, one would expect that reimbursements based on actual drug use would encourage better inventory control and management of drug stock. At the time of our audit, however, the Ministry had not assessed which claims-reimbursement method would result in better drug-inventory management practices and therefore less cost to the Ministry.

RECOMMENDATION 7

To ensure that the cost of special drugs used is minimized, the Ministry of Health and Long-Term Care should:

- develop and implement appropriate and consistent policies and procedures relating to the Special Drugs Program that address the supporting claim information required, including details about drug quantities and unit prices paid, and the acceptable reimbursement method;
- consider securing more contracts with drug companies for better special-drug prices; and
- consider conducting periodic reviews of hospital supporting records to verify the accuracy and validity of the amounts claimed.

MINISTRY RESPONSE

The Ministry is taking action to develop consistent policies and procedures for the Special Drugs Program. A process has been initiated with hospitals to standardize invoicing practices. Contracts, similar to agreements with manufacturers to establish price commitments for Formulary-listed products, may be a suitable model for the Special Drugs Program to control the prices of the products the program funds.

INSPECTIONS AND VERIFICATIONS

The Inspection Unit's key objectives are to co-ordinate and support province-wide, post-payment verification of the accounts of pharmacists, dispensing physicians, and other providers supplying services to persons eligible for drug benefits and to ensure that claims submitted to and paid by the Program comply with the legislation and the Ministry's inspection policies and procedures manual. Any overpayments identified through inspection audits are to be recovered. During the 2005/06 fiscal year, the Inspection Unit completed approximately 110 field-inspection audits and identified over \$1 million in recoverable overpayments.

Our audits in 1996 and 2001 raised significant concerns regarding the lack of ministry inspection resources, the lack of planning for efficient use of limited resources, and insufficient inspection coverage.

Our current audit found that our previous concerns over inspections had still not been addressed, as noted in the sections below.

Inspection Resources and Coverage

In our *2001 Annual Report*, we expressed concerns about the Ministry's limited inspection resources;

the Ministry responded that it would conduct a review of the resources for inspecting pharmacies. The Standing Committee on Public Accounts also recommended that the Ministry review its inspection resources and report to the Committee after the anticipated completion of the review by late 2004, including a plan to respond to the review. Our current audit revealed that the review recommended by the Committee was not completed even though the number of claims increased by about 80% between the 2000/01 and 2006/07 fiscal years, from 50 million to about 90 million. The number of full-time inspection field staff had decreased over the same period from five to three.

Our review showed that the Ministry conducted about 100 inspections during the 2006/07 fiscal year, covering about 3% of the total number of dispensing agencies in Ontario. If the Ministry continues at this rate, each dispensing agency will be audited approximately once every 30 years—a much longer period than when we did our last audit, when it was estimated that every dispensing agency would be inspected once every 10 years. This is a significant concern because the *Ontario Drug Benefit Act* requires only that pharmacists retain certain documents for two years. Given the low audit coverage rate, pharmacy records maintained for only the minimum required time would not likely be available for inspection.

In addition to the limited inspection coverage, the Ministry has not prepared an overall inspection audit plan for the numbers and types of inspection audits to be conducted. An overall plan would facilitate the effective allocation of inspection audits among the inspection staff.

Inspection Selection

To use the available inspection resources in the most efficient and effective manner, the Ministry should select for audit those dispensing agencies that will best meet its stated objective of ensuring

that overpayments are identified and recovered. This would require that the Ministry's inspection selection process be effective in targeting high-risk dispensing agencies in order to identify abuses, recover overpayments, and provide deterrence. At the time of our audit, although the Network had the capability to extract data according to specified risk factors, the Ministry was not using this capability in a systematic way across the province. Instead, it relied significantly on complaints and referrals.

Our audit identified a number of high-risk areas that warrant more regular inspection efforts. For example, as mentioned earlier, if a person who is not in the Network presents a valid drug-benefit card to a pharmacist, the pharmacist may override the system to grant that person temporary eligibility for drug coverage. To assess the Inspection Unit's efforts to review these Network overrides, we looked at a sample of dispensing agencies with a high number of overrides, ranging from 500 to over 10,000, during the 2005/06 fiscal year. We found that about half of these agencies had not been inspected since our last audit in 2000/01. The other half had been inspected, and we found that the Ministry had identified overpayments in all cases. However, we noted that there was no evidence that these overpayments were related to reviews assessing the validity and appropriateness of granting eligibility, which might potentially identify additional overpayments.

Another high-risk area involved agencies inappropriately reducing prescribed quantities of drugs in order to charge more dispensing fees. Accordingly, we reviewed the data for 20 dispensing agencies that in 2005/06 dispensed an average supply of less than three days' worth of drugs to recipients. Our review showed that only one of these agencies had been inspected in more than six years. As part of our current audit, for observation purposes, we requested to attend at a field-inspection site. Together with the Ministry, we selected for inspection purposes a dispensing agency with a high

number of claims per drug recipient. Upon completion of the inspection, about \$270,000 was identifiable as recoverable, with more than \$240,000 of this amount due to claims for invalid dispensing fees.

Review of Completed Inspection Files

Inspectors conduct three different types of inspections: routine inspections, where they examine a cross-section of various claims; in-depth inspections, where they examine a targeted selection of claims, prompted by specific allegations or unusual claims-payment statistics; and specific inspections, where the scope is limited to a particular type of claim. To support the inspection work and related recoveries, the inspectors are responsible for accurate and complete documentation of the work conducted.

We reviewed a sample of completed inspection files over a three-year period from the 2004/05 to 2006/07 fiscal years and found the following:

- For the routine inspection files we reviewed, none contained evidence of testing in all of the claim types, as required by the Inspection Unit's policy and procedures manual. For example, testing for eligibility overrides through review of drug-benefit cards was not conducted in over 80% of the reviewed files, even though the manual requires that the inspection unit closely monitor the use of these overrides. In addition, for half of the files sampled, there was no evidence of testing for the validity of dispensing more expensive brand-name drugs instead of the lower-cost generic equivalents.
- There were no standard inspection audit programs by inspection type. This may have contributed to the fact that all the files we reviewed were missing documentation or contained inconsistent documentation for review. For instance, some files contained a summary

of the inspection procedures conducted and the results of the inspection work, while other files did not contain any information on the inspection procedures followed or any summaries of the inspection tests completed. Lack of documentation makes it difficult to assess the completeness and appropriateness of the inspection work conducted.

- According to the Inspection Unit's policy and procedures manual, inspectors must use their judgment to evaluate whether further investigation or corrective procedures are required, and to determine the degree of follow-up monitoring. However, the Ministry had not developed any guidelines or criteria to help inspectors identify situations for follow-up monitoring. For instance, our review of the inspection files and discussions with inspectors indicated that follow-up inspection work was not regularly conducted.
- Workload standards did not exist for the time taken to complete the inspection of a dispensing agency according to its type and size. None of the inspection files we reviewed recorded the time taken to conduct and complete the inspections. Through discussions with each inspector responsible for the files, we found that the inspection time varied from a low of less than one day to a high of 26 days, with the average being 9.5 days. In addition, the Ministry did not formally monitor inspectors' workload performance to identify areas for improvement. Our review of the 2006/07 inspection data found that the workloads varied from 10 inspections conducted by one inspector, who found \$75,000 in overpayments, to 59 inspections by another inspector, who found \$680,000 in overpayments.
- Our review of inspection files indicated that lack of inspection-audit training partly accounted for deficiencies in the completeness of the inspection work conducted and

the quality of the documentation support. We noted that inspection staff received training mainly by attending conferences on fraud and courses on privacy legislation. Individual inspectors sometimes also sought permission to attend pharmacological seminars and other sessions of interest to them. However, while all the inspectors were pharmacists, they received no formal training in how to conduct an audit using techniques such as risk assessment, development of inspection programs, selection criteria, file completion, and follow-up requirements.

In the case of the recovery of overpayments from dispensing agencies, ministry policy allows for repayment to be made in instalments and for interest to be charged on such instalment payments. However, we found that the Ministry never charged interest penalties on any instalment payments. In addition, under the *Ontario Drug Benefit Act*, the Ministry can take court action to penalize dispensing agencies for identified offences. This route was seldom taken to deter repeat offenders. Our file reviews found cases where the inspectors had discovered agency overpayments in the same areas as in a previous inspection of the same agency.

RECOMMENDATION 8

To promote thorough and effective inspections that encourage ongoing compliance, the Ministry of Health and Long-Term Care should:

- conduct a review of the inspection staffing resources and develop an overall audit plan to ensure that sufficient inspection resources are in place to provide adequate inspection coverage across the province;
- on a regular and systematic basis, select dispensing agencies for inspection using appropriate risk factors;
- provide inspectors with ongoing formal audit training in how to conduct an audit,

including risk assessment, development of inspection programs, file completion and documentation, and follow-up requirements; and

- deter repeat offenders by enforcing existing legislative penalties.

MINISTRY RESPONSE

The Ministry values the work of its inspectors. Work is currently under way to augment pharmacy-inspection resources. As part of this work, the Ministry will address the qualifications and ongoing training requirements of its pharmacist-inspection staff. Various quality-assurance measures are in place to review inspectors' work. The team meets regularly to discuss program changes and identify audit functions to support changes. The Ministry continues to support ongoing training for the inspectors. In almost all cases, pharmacists agree with audit findings and recovery amounts. The Team Leader reviews the findings of each inspection. Significant issues are reviewed with management.

Annual inspection and performance plans are set by management. Targeted inspections may be performed on the basis of program priorities that may not be identified in the annual plans. Variation exists in inspection time depending on pharmacy size and inspection complexity. A standard format to document audit scope, methodology, and findings will be created.

Once a claim is determined by the Ministry to be inappropriate, the reimbursed amount for that claim is recovered. This is an effective deterrent. Potential fraudulent activities are referred to the Ontario Provincial Police and tracked by the Ministry. Professional practice issues are referred to the Ontario College of Pharmacists.

COMPETITIVE SELECTION OF VENDORS

Health Network System

Management Board directives require that the procurement of services be obtained competitively in an open, fair, and transparent process. This is intended to minimize the risks of over-dependence on a single supplier and to obtain services at the best cost to the taxpayer.

In our *2001 Annual Report*, we expressed concern that the Ministry had extended a contract with the same vendor since 1993 for the development and maintenance of the Health Network System (Network) without using a competitive selection process. The most recent contract—for five years, at a total cost of \$63 million, or an average of about \$12.6 million a year—was to expire in November 2005. The Ministry indicated that it would commission an evaluation of the Network in 2003 to assess the services provided and the options available for future operations. However, we noted that the evaluation was not performed in 2003. As a result, the Ministry requested and subsequently received Management Board approval to extend the contract with the same vendor for another 24 months, from November 2005 to November 2007, at a cost of about \$26 million. During the 24-month period, the Ministry engaged an external consultant to assess contract requirements. On the basis of that review, the Ministry decided to deliver directly certain of the services that had been part of the previous contract.

At the time of our audit, we noted that the Ministry had recently completed a competitive selection process to acquire services to support the Network. A new contract for a term of six years was signed with a new vendor. The contract commenced in November 2006—with the first year being a transition year with the previous vendor—and is set to end in November 2012 for a contract price of about \$28 million. The Ministry has the option to extend the contract for two additional

two-year terms. Through this competitive selection process, the Ministry will generate significant cost savings.

Trillium Drug Program and Seniors Reduced Co-payment Program

Since 1996, the Ministry has outsourced the administration of the Seniors Reduced Co-payment Program. In the 2004/05 fiscal year, the Ministry prepared an assessment of its options with respect to the administration of the Trillium Drug Program and, on the basis of this assessment, decided to outsource Trillium as well. The Ministry conducted a competitive selection process to acquire the services of a vendor to administer both the Seniors Reduced Co-payment Program and Trillium. In June 2006, the Ministry entered into a three-year contract with the successful vendor for administering the two programs. This contract allows for an option to renew the contract for two separate one-year extensions, with an overall maximum contract price of approximately \$12 million over the five years. We were satisfied with the Ministry's competitive process used in the selection of the vendor.

CONTRACT MANAGEMENT

The contract entered into in 1996 for the third-party administration of the Seniors Reduced Co-payment Program included performance standards against which the Ministry would measure the vendor's actual activities, such as receipt processing and application processing. The contract also specified charge rates for these activities and allowed for onsite inspection audits of the vendor's premises to verify accuracy. Under the new contract for the Seniors Reduced Co-payment Program and the Trillium Drug Program, the Ministry continues to have the right to monitor contract management to ensure that proper levels of service are provided and that the Ministry does not overpay.

On the basis of work we conducted at both the Ministry and the third-party vendor's premises, we found the following:

- Prior to our audit, the Ministry had never conducted onsite inspection audits of the vendor's processes to verify the validity and accuracy of the monthly invoiced amounts. Accordingly, we visited the vendor's premises to review the vendor's supporting materials for a sample of invoices. We identified instances where the backup records did not agree with the monthly invoiced amounts. For example, we noted discrepancies for each of the four days we reviewed. On one day, the Ministry was overcharged about \$1,130. Although this overpayment is not large, collectively, a review of all days could result in a significant difference.
- The Ministry did not independently reconcile its data against the third-party reported data for areas such as new and renewal applications processed or receipts processed.

The Ministry informed us that, at the time of our audit, it was assessing and developing a periodic review process for onsite inspection audits and was in the process of reviewing and defining the information required to generate ministry reports for reconciliation purposes. During the audit, the Ministry initiated onsite reviews.

RECOMMENDATION 9

To ensure that the third-party processor of the Trillium Drug Program and the Seniors Reduced Co-payment Program complies with the terms of its contract, the Ministry of Health and Long-Term Care should:

- regularly conduct ongoing audits of the third-party processor's records and supporting documents to confirm the accuracy and validity of the amounts invoiced; and

- develop and implement the necessary ministry information reports to facilitate reconciliation of the amounts invoiced.

MINISTRY RESPONSE

In 2006, the Ministry outsourced Trillium to a vendor to administer in conjunction with the Seniors Co-payment Program. Once the transition was completed, the Ministry initiated, in November 2006, a project to design and implement ongoing regular inspection and verification of the vendor's processing of claims and invoices. Interim reports on this work were shared with the Auditor General. In February and March 2007, inspection began, and reporting tools to document inspection results and outcomes with the vendor were implemented in July 2007.

Ministry report requirements are being defined to facilitate reconciliation of invoices.

PERFORMANCE MANAGEMENT

The Ministry annually prepares a Report Card that provides statistical information on all aspects of the Drug Programs Activity. We noted that the Ministry has done a good job of putting in place various performance standards for work conducted by third-party vendors that measure and report on:

- the timeliness in processing of claims, such as downtime-tolerance standard, response-time standard per transaction, and pay-cycle completion standard;
- help-desk effectiveness in providing various kinds of support to dispensing agencies, such as maximum time in responding to telephone inquiries, average length of calls, and the average maximum percentage allowed daily for abandoned calls;

- eligibility assessment for the Trillium Drug Program and the Seniors Reduced Co-payment Program, such as standards for processing receipts for reimbursements, maximum time for application processing, and acceptable percentage of processing errors.

In contrast, we noted that the Ministry did not have performance standards for work conducted internally to monitor the quality of services and post-payment verification, such as inspection workload standards mentioned earlier. While a Ministry correspondence standard exists to address complaints and inquiries, we found that the time taken to respond to complaints and inquiries exceeded the standard ministry-required response time by an average of 11 days. In addition, we noted that complaints and inquiries received about pharmacy practices were not logged so that the type of complaint or the action taken by the Ministry could be tracked. Such a tracking system would enable the Ministry to analyze the information to determine if there are any common patterns or concerns that may require more focused attention in a particular area or may require legislative or policy changes.

RECOMMENDATION 10

To better monitor and assess the performance of the Ministry of Health and Long-Term Care in meeting its objectives, the Ministry should:

- regularly measure and report actual results against the performance standards, with variances, if any, being resolved on a timely basis;
- comply with its correspondence standards in handling complaints and take corrective action when response times exceed ministry standards; and
- track and analyze the types of complaints and inquiries received about pharmacy practices in order to identify areas for corrective action or improvement.

MINISTRY RESPONSE

The Ministry is defining performance standards for processing Individual Clinical Review requests. Guidelines have been in place regarding processing rush and semi-rush requests.

A joint tracking system for the Individual Eligibility Review Branch and the Ontario Public Drug Programs is in place to assist in ensuring compliance with correspondence standards and issues-management standards.

A more formal process for tracking incoming complaints related to pharmacy practices will be implemented.