# 10 PAYMENTS TO PHYSICIANS

## BACKGROUND

**10.1** The Canada Health Act establishes conditions and criteria for insured health services which provinces are required to provide. In Nova Scotia, the Health Services and Insurance Act governs the provision of insured services. The Act and its related Regulations prescribe the insured physician services residents are entitled to receive and the payment plans associated with delivering these services.

**10.2** Insured services under the Medical Services Insurance (MSI) plan are generally defined as services rendered by physicians which are medically required or which are deemed to be medically required. Certain dental-surgical procedures medically required and rendered in a hospital are also insured. Medically required services are those provided for the purpose of maintaining health, preventing disease or diagnosing or treating injury, illness, or disability. All residents of the Province, with the exception of members of the RCMP or Canadian Armed Forces and inmates in Federal penitentiaries, are entitled to receive insured services. For the year ended March 31, 2002, Provincial payments for medical services and related expenditures totaled $401 million (see Exhibit 10.2).

**10.3** In addition to the basic insured services provided under the MSI plan, the Province also provides limited coverage for vision care to all Nova Scotians, a special dental program for certain client groups, and a children's dental plan.

**10.4** The Health Services and Insurance Act confers to the Minister of Health the authority to "*negotiate, in good faith, compensation for insured professional services.*" As a result, the Nova Scotia Department Health (DOH) negotiated an agreement with the Medical Society of Nova Scotia covering the time period from April 1, 2001 to March 31, 2004. In addition to specifying medical practitioner compensation levels, the agreement also covers areas such as human resources, alternate funding arrangements, and dispute resolution processes. Compensation for insured dental services is addressed in the Insured Dental Services Tariff Agreement covering the same time period.

**10.5** DOH has agreements with Atlantic Blue Cross Care (ABCC) and Quikcard Solutions Inc. (QSI) to process and pay physician and dental claims respectively on behalf of the Department. In 2001-02, DOH paid ABCC $7.1 million and QSI $0.3 million for administrative services. In that year, 7,176,859 physician services and 282,877 dental services were processed.

**10.6** In 2002, the Department of Health disbanded its Insured Programs Division and assigned responsibility for areas previously under Insured Programs to various other divisions within the Department (see Exhibit 10.1 for a summary of responsibilities related to medical payments).

**10.7** The majority of physicians in the Province are paid under the traditional fee-for-service arrangement. Certain groups of physicians have opted to be paid on an alternative funding basis (fixed-fee contract), and therefore do not submit regular fee-for-service claims, but instead are required to submit shadow billings for monitoring activity levels. In 2001-02, payments under alternative funding arrangements totaled $90 million. Payments under alternative funding arrangements were previously audited and reported on by this Office in 2000 and therefore are not included in the scope of this audit.

**10.8** Fee-for-service payments made directly to physicians or physician groups under the following programs are included in the scope of this audit: regular MSI fee-for-service; radiology and pathology; optometric; children's dental; special dental; prosthetic; and dental surgical (see Exhibit 10.2). For the year ended March 31, 2002, these payments totaled $266 million.

**10.9** In the past, payments to physicians have been audited periodically by our Office. The last such audit was completed in 1994. More recently, a computer environment control review of Maritime Medical Care Inc. (now Atlantic Blue Cross Care) was conducted and reported on in 1998 and an audit of alternative funding initiatives was conducted in 2000.

## RESULTS IN BRIEF

**10.10** The following are the principal observations from this audit.

- A sample of medical and dental fee-for-service claims was tested for compliance with the Health Services Insurance Act and Regulations and the Agreement with the Medical Society of Nova Scotia. All claims tested complied with the provisions of the Act and Agreement.

- Pre-assessment controls and the audit and monitoring of payments to physicians for bulk-billed radiology and pathology claims are deficient. Inadequate pre- and post-assessment controls increase the risk that inappropriate radiology and pathology claims will be paid.

- A 1997 decision by the Department of Health to pay physician services claims for patients with expired health cards was not supported by appropriate analysis to identify and assess the potential risks. We have recommended that DOH conduct a detailed analysis of the risks and benefits associated with the payment of claims for patients with expired health cards and that appropriate controls and procedures be implemented.

- The Department of Health has assigned responsibility for the audit of physician fee-for-service claims to Atlantic Blue Cross Care under the current administration contract. ABCC has a comprehensive audit process in place to ensure the accuracy of physician fee-for-service claims other than for radiology and pathology claims. There is a need to ensure that audits are also

performed by external auditors or the Province's Corporate Internal Audit Group on a regular basis.

- The current administrative contract with ABCC does not include provisions which clearly define roles and responsibilities, reporting and information requirements, and mechanisms for the assessment of ABCC performance. DOH should ensure that all new contracts with service providers include such provisions.

- We audited certain aspects of the administration of the Children's Dental Program by Quikcard Solutions Inc. and made recommendations to improve accountability.

- Prior to our audit, DOH had not completed an analysis of whether expected savings from the move to Quikcard Solutions Inc. for processing dental claims had been realized. We have recommended that DOH ensure appropriate follow up is completed to determine whether expected cost savings have been achieved by new projects.

- Our 1998 Report recommended that DOH obtain legal counsel with respect to its rights of ownership over the software used by ABCC to process physician medical payments. The recommendation has not been implemented. This is an important issue that should be examined as part of the Department's assessment of alternatives for the administration of physician medical payments.

## AUDIT SCOPE

**10.11** The objectives of this assignment were to:

- obtain current documentation of the controls and accountability for the physician, children's dental, optometric, and radiology and pathology payment systems; including those at the Department of Health and those in place at the contracted administrators;

- gain an understanding of the contract with the administrators and audit the administrator's allocation of administrative expenses to MSI;

- review the results of internal audit activity for 2002 (at Department of Health, Atlantic Blue Cross Care, and Quikcard Solutions Inc.), and any audit plans for the upcoming year (2003), and form an opinion on the adequacy of internal audit activity;

- test a sample of physicians, children's dental, dental surgical, optometric, and radiology and pathology claims for compliance with the applicable Regulations under the Health Services and Insurance Act and any applicable terms of the Agreement between the Province and the Medical Society; and

- follow up on the implementation of recommendations from our 1998 Computer Environment Control Review and our 2000 audit of Physician Alternative Funding Initiatives.

**10.12** The audit criteria were taken from recognized sources including the CICA Criteria of Control Board's *Guidance on Control*, Canadian Council on Health Services Accreditation's *Standards for Acute Care Organizations: Contracted Services*, Office of the Auditor General of Canada's *Financial Management Capability Model* and *Modernizing Accountability Practices in the Public Sector* and the Health Services and Insurance Act.

**10.13** Our audit approach included interviews with DOH, ABCC and QSI management, review of Corporate Internal Audit files and other relevant documents, and detailed testing of medical payments conducted at ABCC and QSI for the fiscal year ended March 31, 2002.

## PRINCIPAL FINDINGS

### Accountability Framework

**10.14** DOH has contracted the administration of physician and dental payments to Atlantic Blue Cross Care and Quikcard Solutions Inc. The Department's current contract with Maritime Medical Care Inc. (MMC) was signed in 1992 and has been extended several times, with the most recent extension expiring March 31, 2004. Under this contract, MMC is to provide physician and dental claims processing, payment of claims on behalf of DOH, and audit verification work on processed claims. In January 1999, MMC entered into a joint venture agreement with ABCC and merged all operational areas. Legislation formalizing the merger was subsequently passed in 2002 and proclaimed on January 1, 2003.

**10.15** Based on the original contract, DOH reimburses ABCC for administrative costs associated with processing and payment of medical payments and related audit work. For 2001-02, ABCC administrative costs totaled $7.1 million. An annual audit of ABCC administrative costs is conducted by the Corporate Internal Audit Group for government.

**10.16** In June 2001, processing and payment of dental claims was contracted to Quikcard Solutions Inc. DOH pays Quikcard a fixed amount annually based on the contract. For 2001-02, DOH payments to QSI under contract were $0.3 million.

**10.17** Both ABCC and QSI provide monthly expenditure reports to DOH detailing total physician and dental claims paid for that period. DOH prepares journal entries to reflect the payments made on its behalf to physicians and dentists. ABCC also provides monthly reports on administrative costs year-to-date and forecast to year end which DOH verifies.

**10.18** ABCC has a Monitoring and Statistics division that conducts audit verification and analysis on previously paid claims (see paragraph 10.27 for further discussion

of this). QSI is required to provide DOH with an annual external audit opinion indicating whether QSI has complied with the terms of its agreement with the Department.

## Edit and Assessment of Submitted Claims

**10.19** Service providers' pre-assessment controls - The majority of claims for payment of insured physician services are received by ABCC electronically from the submitting physician. Physicians submit one or more claims per patient for each separate patient encounter. Individual claims include the identification of the patient and a listing of the medical services provided along with the amount being requested for payment. For 2001-02, 7,176,859 physician services were provided (source: *Medical Services Insurance (MSI) Tables* for 12 months ending March 31, 2002).

**10.20** Prior to being approved for payment, claims are subjected to numerous electronic edit checks designed to detect inappropriate claims. Edit checks search for duplicates, date of service prior to the 90 day submission limit, assignment of the proper medical service units to the procedure code, and compliance with the information requirements in the Act. Claims rejected by the electronic edit checks are sent to a manual adjudication system for processing. Claims can be submitted at any time. Payments of approved claims are made bi-weekly.

**10.21** Dental claims for payment of insured services are received by QSI in paper form. Once received, QSI staff enter the information into an electronic dental payment system. The manually entered claims are subjected to a variety of electronic edit checks prior to approval for payment. QSI also has a manual approval process for unusual and special circumstance claims.

**10.22** Testing results - Our audit included testing a random sample of 100 medical (including optometric) and dental fee-for-service payments for compliance with the Health Services and Insurance Act and Regulations as well as the Province's Agreement with the Medical Society. Testing of the sample of medical payments was conducted at ABCC, while dental payment testing was completed at Quikcard Solutions Inc. We conducted analytical procedures (electronically) on all 2001-02 fee-for-service payments, excluding radiology and pathology claims, to detect certain types of non-compliance such as gender specific procedures being performed on the wrong gender. As a result of our sample and analytical testing, we determined that payments are accurate, timely and in accordance with contract requirements.

## Expired Health Cards

**10.23** In 1997, based on direction provided by DOH, ABCC stopped refusing MSI claims made by physicians for patients with expired health cards. Nova Scotians are required to renew health cards in order to receive insured medical services, however this requirement is currently not enforced. Based on our discussions with DOH management, dental claims processed by Quikcard for individuals with expired health cards are rejected. Insured hospital services, other than

emergency services, also require a current health card prior to service provision. Accompanying the decision to stop refusing expired health card claims was the commitment of a Ministerial review in six months. Based on our discussions, the review was never conducted.

**10.24** Current DOH management indicated that an analysis was not performed in 1997 to identify and assess the financial and other related risks associated with the decision to pay physician claims for patients with expired health cards. Department management indicated that an underlying assumption supporting the change was that the majority of these services would have been provided to otherwise eligible residents of the Province who simply neglected to renew their health cards. Management also indicated that the Department is currently in the process of studying this issue.

**10.25** ABCC provided our Office with documentation indicating that from May 7, 1997 to March 31, 2002, $1.66 million in MSI claims had been paid to physicians for services provided to patients with expired health cards. However, we did not determine the portion of these expired card claims that pertained to ineligible individuals. The most common cause of ineligibility would be moving out of Province. Since there are reciprocal agreements with other provinces, there is risk that an individual could continue to have Nova Scotia pay for services after moving.

**10.26** In addition to the risk of paying claims for ineligible individuals, not enforcing renewal of health cards results in inaccurate personal information for use in ABCC's audit procedures to verify and monitor processed claims.

**Recommendation 10.1**

We recommend that DOH conduct a detailed analysis of the risks and benefits associated with the payment of claims for patients with expired health cards and that appropriate controls and procedures be implemented.

## Audit and Monitoring of Paid Claims

**10.27** ABCC Monitoring and Statistics audit work - ABCC has a Monitoring and Statistics division responsible for conducting audits of payments to providers, including physicians and dentists. Staff prepare an audit plan whenever significant changes are made to how physicians are paid since this may impact the type of audit work needed to verify payments. Various types of audit tools are used to verify claims submitted by physicians such as service verification letters sent to patients, physician profiles, on-site billing audits, and internal billing audits. The audit work completed for dental claims is less extensive since the funding for dental claims represents less than 3% of total fee-for-service funding.

**10.28** ABCC produces an annual report summarizing the results of audit activity each year. This report is provided to DOH for information. The 2001-02 report noted that:

- 76,380 service verification letters were sent out with an 81% response rate. There were 156 denials that the patient had received the service resulting in recoveries of $13,772.
- As a result of audits identified through the provider risk analysis, 152 on-site billing audits were conducted. 78 providers were identified as having billed inappropriately, resulting in recoveries of $196,357.
- Also using risk analysis, 546 internal billing audits were conducted. Inappropriate billing was identified in 385 audits resulting in recoveries of $197,171, representing 0.09% of total billings.

**10.29** It is important to point out that ABCC uses risk analysis to identify types of services or specific physicians for billing audits. The percentage of errors found in these audits is much higher than errors found through the service verification letters which are routinely sent, on a sample basis, to patients of all physicians. Since billing audits are conducted on perceived high risk areas, a higher error rate is to be expected and does not imply that this error rate exists throughout the entire population of physician claims.

**10.30** If audits reveal instances of inappropriate billing, the funds are recovered from the physician. ABCC employs a medical consultant to ensure the adequacy of supporting documentation for the claims under review. Once a physician has been audited, he/she is automatically put on the list for follow up in two years. At that time, ABCC Monitoring and Statistics staff will determine whether another audit is necessary.

**10.31** Lack of appeals process - The Corporate Internal Audit Group for government reviewed ABCC's internal audit activity and noted a concern with the lack of appeals process for physicians who do not agree with the decision of ABCC's Monitoring and Statistics division. When an audit has been completed and ABCC determines that a recovery is warranted, the physician may appeal this decision. Since there is currently no appeals process, the file is held pending an appeal. At the time of our audit, nine files were being appealed. Some of these appeals are several years old. The Health Services and Insurance Act had a section which dealt with the appointment of a commission to hear appeals. This section was repealed in 1992 and no process has been established to replace it. The Department is aware of this situation and is working with all parties affected to develop an appeals process.

**Recommendation 10.2**

We recommend that DOH establish an audit appeals process.

## Radiology and Pathology Claims

**10.32** Provincial payments of bulk-billed radiology and pathology claims totaled $31 million for the year ended March 31, 2002. The payment process in place for these claims varies from the normal fee-for-service payment procedures. Radiologists and pathologists are not required to submit claims electronically to ABCC for processing. Instead, paper reports are submitted by individual physicians or physician billing groups via the mail and manually entered into the system by ABCC staff. While physicians submitting fee-for-service claims electronically are required to provide detailed patient information on every claim (i.e., patient name, age, sex, health card number), radiology and pathology bulk billings specify the bi-weekly or monthly totals only for each type of procedure performed.

**10.33** As discussed in paragraph 10.20 above, there are a number of electronic edit checks for regular fee-for-service claims to help ensure validity and accuracy. The manual nature of the payment process for bulk-billed radiology and pathology claims and the lack of patient-specific information prevent ABCC from conducting these edit checks. At the time of writing this Report, DOH had not performed a risk analysis to determine whether the risk of submitting ineligible radiology and pathology claims for payment is less than for other MSI fee-for-service claims. In the absence of such an analysis, it is difficult to justify the reduced level of pre-assessment controls which currently exist.

**10.34** Audit and monitoring activities equivalent to those conducted on other MSI fee-for-service claims are not performed on radiology and pathology claims. ABCC management informed us that the lack of patient-specific information on bulk-billing reports limits the ability to confirm the occurrence and accuracy of these claims through existing audit procedures. For example, since patient names and addresses are not included on billing reports, ABCC cannot verify that services were provided. ABCC is able to perform some analysis of total procedures by radiology or pathology service type at each institution. If an analysis identified a significant variance, ABCC staff informed us they would attempt to determine the cause.

**10.35** Our Office performed detailed testing on a sample of bulk-billed radiology and pathology shadow billings submitted to ABCC by physicians at the IWK Health Centre as part of an audit we conducted at that hospital (see Chapter 8 of this Report). Bulk-billed shadow billings are submitted in the same manner as bulk-billed fee-for-service claims but are simply not paid because the IWK radiologists and pathologists have an alternative funding arrangement with the Province. Shadow billing information is important because it is used in the health statistics system to accumulate accurate totals of services provided for monitoring service types and volumes. Results of our testing indicated that one of the 33 patient shadow billing claims included an error. A procedure which was cancelled was mistakenly submitted.

**10.36** In addition to the detection and recovery of inappropriate claims by physicians, the audit and monitoring of medical payments helps deter inappropriate billings. The 2001-02 ABCC *Monitoring and Statistics Annual Report* suggests that program savings of 3 to 5% may be achieved by having an established audit and monitoring process which helps discourage inappropriate claims. Based on this estimate, the potential cost to the program of not having an audit process in place for bulk-billed radiology and pathology claims could be between $0.9 and $1.5 million for the year ended March 31, 2002.

**10.37** Management at DOH indicated that they are aware that very little audit work is currently being conducted on radiology and pathology claims by ABCC. No analysis and assessment of the risks associated with not auditing these claims has been prepared by the Department.

**Recommendation 10.3**

We recommend that DOH perform a risk analysis on bulk-billed radiology and pathology claims and establish appropriate audit procedures in conjunction with ABCC.

## Monitoring and Accountability of Contracted Administrators

**10.38** Compliance with ABCC agreement - ABCC is complying with most of the key requirements of the agreement with the Province with the following exceptions. Forecasts and variance explanations for ABCC's administrative expenses are required on a quarterly basis but have only been provided when requested. DOH staff were preparing forecasts and variance analysis for administrative expenses and discussing them with ABCC if required. Department staff were not aware that ABCC was required to provide this information as part of the agreement. DOH management informed us that they have requested quarterly forecasts be provided to the Department in the future.

**10.39** ABCC is also required, under the original contract with MMC, to provide audited financial statements to DOH. At the time of our audit, the Department had not been receiving these statements. DOH staff have informed us that they have requested and received audited statements for 2002 and have informed ABCC that the Department will be enforcing the contractual requirement for annual audited statements. It is important to note that the audited financial statements do not show detail related to physician payments. The only related disclosure is a single line-item showing the administration fee received from the Province.

**10.40** Department of Finance internal audit work - During the time period covered by our audit, staff at the Corporate Internal Audit Group for government conducted three separate audits of ABCC's operations relating to administration of medical payments to physicians. The audits included a review of pre-assessment controls, audit and monitoring of claims, and an audit of the actual administrative expenses paid to ABCC for 2002. Audit reports have been provided to DOH on two of these

audits. The reports concluded that there were adequate controls over pre- and post-assessment of claims at ABCC. The audit of administrative expenses had not been finalized at the time of writing this Report.

**10.41** Historically, there has been a lack of independent, external audit activity on medical payments to physicians. The external audit of MMC financial statements includes administrative revenues only. Although payments to physicians are audited by ABCC's Monitoring and Statistics division, accountability could be improved by establishing an independent audit process. There has been some improvement in this area recently with the increased frequency of the Department of Finance's Corporate Internal Audit work on physician payments.

**Recommendation 10.4**

We recommend that DOH ensure external auditors or the Department of Finance's Corporate Internal Audit Group are engaged annually to audit medical payments to physicians paid by ABCC.

**10.42** Future plans for administration of physician claims - As noted in paragraph 10.14, the current contract between the Province and ABCC is quite old (dating back to Maritime Medical Care in 1992) and has been extended several times. The current extension expires March 31, 2004.

**10.43** DOH has identified deficiencies in the contract with ABCC and is taking action to ensure these areas are addressed when the Department negotiates a new contract for the administration of the MSI program. DOH contracted a consultant to look at the existing contract with ABCC and make recommendations for change. In the Request For Proposal at the time of hiring the consultant, DOH noted the following areas of concern with the existing agreement:

- *"program and management objectives and deliverables not clear*
- *to the extent that objectives exist, they are often too rigid to allow for the effective use of the information and data provided for effective decision making, and to align with and support emerging health system priorities such as the creation of an electronic health record, primary health care reform, and population initiatives*
- *day to day management of the program is extremely time and resource intensive*
- *mechanisms to identify and measure service delivery performance are not adequate."*

**10.44** The consultant has been meeting with staff at ABCC as well as DOH to determine improvements required to the existing system. Ultimately, the consultant will present an analysis of options and a recommended approach for acquisition of services to process medical payments. At the time of our audit, the final consultant's report had not been received by the Department.

**10.45** Administration of dental claims - In 1999, DOH entered into an agreement with Quikcard Solutions Inc. to lease QSI's software for the adjudication of dental

claims. ABCC used this software to process and pay dental claims from 1999 to 2001. QSI sent an unsolicited proposal to DOH indicating interest in taking over claims adjudication for the Province. DOH entered into a contract with Quikcard to process dental claims and in June 2001, QSI took over from ABCC. Under the agreement between the Province and QSI, QSI receives fixed semi-monthly payments based on a pre-established claims volume. Contract payments remain the same unless this volume varies by more than 20%.

**10.46** QSI must provide the Province with an external audit opinion each year indicating that it has complied with all the requirements of the agreement including adequate controls over claims processing, controls to detect duplicate claims and other requirements. The auditors are engaged by QSI. For the period June 1, 2001 to March 31, 2002, QSI had an unqualified audit opinion indicating that they had complied with the requirements of the agreement with the Province in all significant respects.

**10.47** Our audit included a review of controls at QSI. During this review we noted a lack of segregation of duties. We understand that this lack of segregation of duties was also identified by the external auditors and verbally reported to Quikcard but no action was taken to remedy the situation. We have been informed by Quikcard management that they are addressing this problem by reassigning certain tasks to other staff.

**Recommendation 10.5**

We recommend that DOH amend the contract with Quikcard Solutions Inc. to require the external auditors of Quikcard to prepare a management letter detailing any internal control weaknesses as well as a short-form audit opinion.

**10.48** Quikcard appears to be complying with the reporting requirements under the agreement with the Province. Monthly reports on claims processed as well as quarterly reports showing total claims paid are being provided. QSI is also required to provide an internal audit review of 30 claims each quarter. Although these reviews were being provided, the individual performing the reviews had access to process claims and was therefore not an independent party.

**Recommendation 10.6**

We recommend that DOH ensure quarterly internal audits of claims processed are performed by an individual who does not have claims processing responsibilities.

**10.49** Cost effectiveness of move to Quikcard - During our audit, we reviewed supporting documentation surrounding DOH's decision to move processing of dental claims to QSI. The cost analysis prepared by DOH prior to this move

suggested annual savings of approximately $270,000. Prior to our audit, DOH had not performed an assessment of whether anticipated cost savings had been realized. In response to our request, DOH reviewed the move to Quikcard and informed us that the cost savings of $270,000 were achieved. We did not audit the original cost savings projection or the analysis prepared indicating the cost savings were achieved and, therefore, express no opinion on them.

**Recommendation 10.7**

We recommend that DOH ensure appropriate follow up is completed to determine whether expected cost savings have been achieved by new projects.

## Follow up from Previous Audits

**10.50** During the current audit we followed up on significant findings from our 1998 and 2000 audits. Five of the 14 findings have been implemented and four are in progress. The remaining five findings have not been addressed. Exhibit 10.3 details the most significant findings reported and the action taken by both DOH and ABCC in response.

**10.51** One of the more significant findings which has not been addressed relates to the ownership of the MSI software. Paragraph 10.47 of our 1998 Report recommended that DOH have legal counsel examine the ABCC contract and provide an opinion on the ownership of the software used to process and administer medical payments to physicians. DOH management informed us that a consultant engaged by the Department determined that the Province has sole ownership of the software. In light of DOH's plans to evaluate possibilities for the administration of medical payments, ownership rights to the processing software could be an important factor in the consideration of alternatives and should be confirmed.

**Recommendation 10.8**

We recommend that DOH fully address all findings from our 1998 and 2000 Reports. In particular, we recommend that the Department obtain a legal opinion regarding ownership rights to the MSI software.

## CONCLUDING REMARKS

**10.52** ABCC and QSI have agreements with the Province to process physician and dental fee-for-service claims, respectively. Generally, the claims payments process appears to be well-established, with audit verification work performed by ABCC staff for both physician and dental claims. Because the detailed audit work is

performed by staff of ABCC, we have recommended that the Department of Health also ensure annual audits by external auditors or the Province's Corporate Internal Audit Group.

**10.53** The establishment of systems and controls to ensure that only eligible claims are being paid is essential to the effective management of payments to physicians. Overall controls are adequate but we identified weaknesses in the areas of payment and verification of bulk-billed radiology and pathology claims, and the acceptance of expired health cards. To limit the Department's exposure to the payment of inappropriate claims in these areas, a risk analysis should be completed and systems and controls implemented as required.

## Medical Payments to Physicians
## Summary of Responsibilities and Reports Submitted

Exhibit 10.1

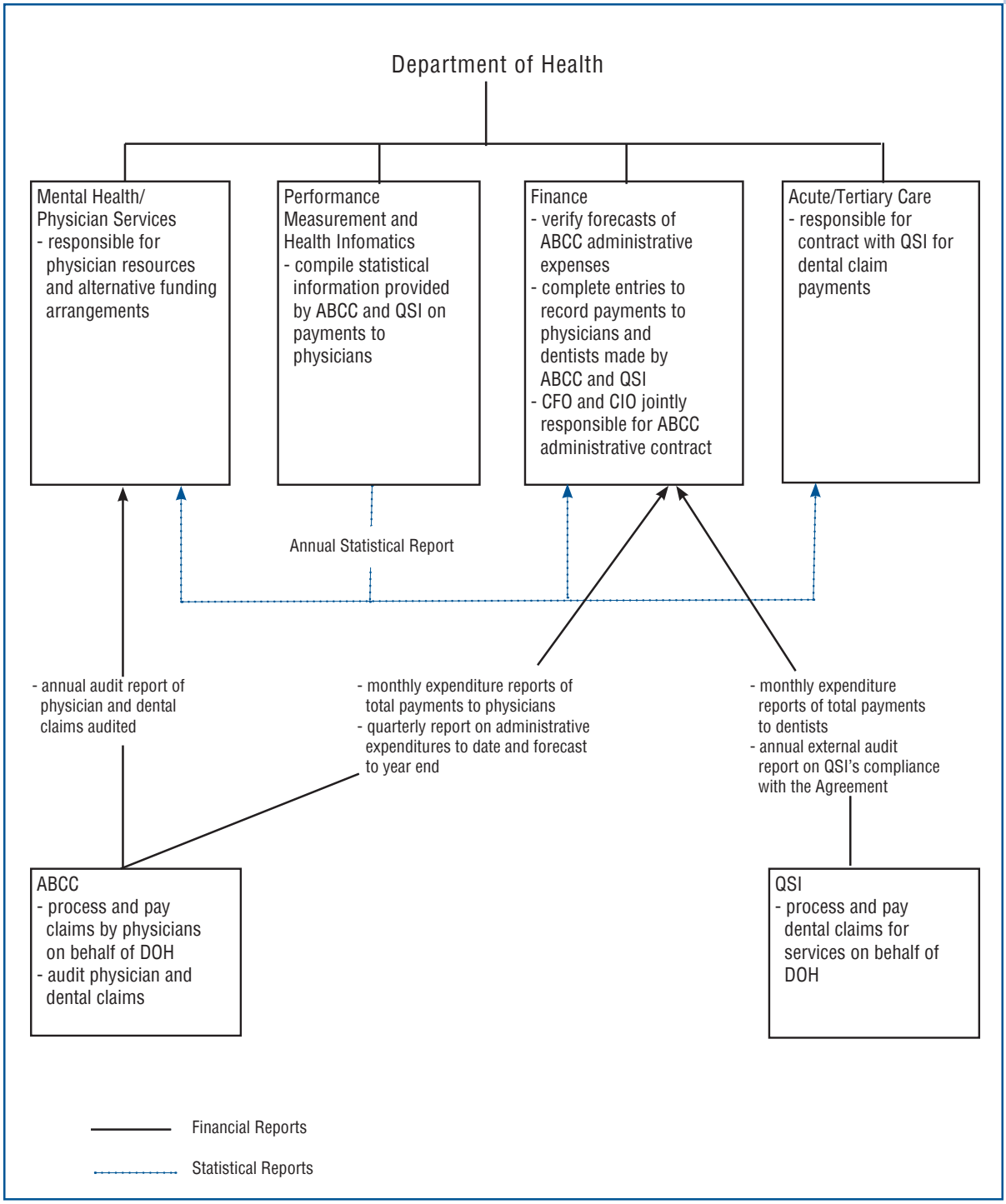

Exhibit 10.2

## Expenditures on Medical Payments ($ millions)

| Payment Method | 2001-02 | 2000-01 |
|---|---|---|
| Fee-for-Service | $222.4 | $220.4 |
| Alternative Funding | 89.8 | 85.3 |
| Tariff Agreement | 4.0 | 2.1 |
| Radiology and Pathology | 31.0 | 30.1 |
| CMPA | 4.5 | 5.2 |
| Re-Entry Physicians | 1.1 | 1.5 |
| Locum | 0.5 | 0.3 |
| Rural Stabilization Fund | 9.1 | 9.2 |
| HST | 7.5 | 7.4 |
| GP Recruitment and Retention | 0.1 | 0.1 |
| Other Insured Programs | 31.4 | 25.8 |
| Total | $401.4 | $387.4 |

*Source - SAP March 31, 2002 and 2001*

## Other Insured Programs ($ millions)

| Initiative | 2001-02 | 2000-01 |
|---|---|---|
| Optometric Payments | $2.3 | $2.1 |
| Children's Dental Program | 7.4 | 7.3 |
| Special Dental Plans | 0.2 | 0.2 |
| Special Drug Programs | 17.6 | 13.8 |
| Prosthetic Services Payments | 1.5 | 1.2 |
| Dental Surgical | 0.9 | 1.0 |
| Special Programs | 1.5 | 0.2 |
| Total | $31.4 | $25.8 |

*Source - SAP March 31, 2002 and 2001*

## Follow-Up of Issues Identified in Prior Reports of the Auditor General

Exhibit 10.3

| Paragraph | Recommendation from 1998 Report | Status |
|---|---|---|
| 10.10 | The computer control environment at MMC (now ABCC) should be subject to periodic independent assessments. | Implemented - Periodic audits are performed by government's Corporate Internal Audit Group. |
| 10.10 | A disaster recovery and contingency plan for MMC should be completed and tested as soon as possible. | Not Implemented - The lack of a disaster recovery plan was noted during our 1994 audit as well. Department staff informed us that this has been identified as a project and will be scoped during 2003-04. |
| 10.10 | The Department had not conducted a formal post-implementation review of the new MSI system to determine the extent to which benefits have been realized and how these results compare to original plans. | Not Implemented - There has been no post-implementation review. |
| 10.16 | Program staff copy revised programs back into production. This process should be performed by someone without programming responsibilities. | Implemented – Program staff no longer copy revised programs into production. |
| 10.32 | Root authority access to the MSI system provides unlimited capability to add, delete and modify data files and directories. A process for regular independent reviews of the activities of individuals with this access should be established. | Not Implemented - There is still no regular (i.e., monthly) report which is reviewed by management of the organization to ensure there are no unauthorized changes. The Corporate Internal Audit Group is looking at root authority access as part of a 2003 audit but this is not a regular process. |
| 10.47 | The wording of the 1992 agreement between the Province and MMC suggests that both parties have joint ownership of the MSI program software. DOH staff informed OAG that they believe the Province has sole ownership. The Department should have legal counsel clarify ownership. | Not Implemented - DOH has not obtained a legal opinion on this issue. A consultant engaged by the Department indicated ABCC did not have any ownership rights to the software. The contract with ABCC is more than 10 years old and DOH is currently looking at options for physician payment services. If the Department decided to move to a new service provider, ownership of this software could be an issue. |

| Paragraph | Recommendation from 2000 Report | Status |
|---|---|---|
| 9.10 | New Alternate Funding Initiatives (AFI) should be supported by documented analysis with specific outcomes and comparisons of estimated AFI cost to fee-for-service. | Implemented - To date, existing AFI have been renewed, parties involved have agreed to work collaboratively to develop a framework for mutually agreed upon specific deliverables. DOH informed us that new AFIs involve greater analysis and comparisons to estimated fee-for-service costs. |
| 9.10, 9.22, 9.23 | Controls and monitoring for AFIs should be increased to reduce risk of inaccurate data input and duplicate payments. | In progress - Data entry is not verified by supervisory staff on a regular basis. ABCC has reports that show payments under both alternative funding arrangements and fee-for-service. These reports help ABCC identify duplicate payments and recover the appropriate amount from the physician. |
| 9.10 | Monitoring of the completeness of shadow billing information was performed on an ad hoc basis and controls were not adequate. | Implemented - DOH now receives quarterly reports on shadow billing which show AFI payments and shadow billing amounts. If shadow billing amounts are lower than expected by DOH, DOH staff follow up with physicians to determine reasons. The Department and other parties are looking at alternatives to shadow billing. |
| 9.10, 9.47 | AFI contract evaluations by DOH should be done more frequently and include evaluations of service delivery methods, stakeholder satisfaction and clinical outcomes as called for in AFI contracts. | In progress - Contract evaluations are not being done more frequently. DOH is looking at developing measurable deliverables for AFI contracts. DOH management informed us a database is currently being developed which includes an inventory of all contracts, individual physicians and due dates for deliverables. Management indicated the Department plans to implement follow-up procedures to ensure deliverables are met. |
| 9.10 | AFI contracts include provisions allowing payments to be reduced after 90 days if the actual service level is less than contract payments. The Department should ensure this provision is being enforced. | In progress - DOH staff indicated the Department is beginning to develop a document which outlines the process to be used in evaluating service levels in these instances. We were informed this process should be in place by March 2004. |

| Paragraph | Recommendation from 2000 Report | Status |
|---|---|---|
| 9.10, 9.16 | Base funding for AFI contracts is calculated using the highest of the past 3 fee-for-service years. The implication is that on average, AFI contracts will cost the Province more than historical fee-for-service. | Not Implemented - DOH indicated it is difficult to quantify whether an AFI arrangement is costing more than fee-for-service since other issues such as market value review and change in the scope of the practice to assist with recruitment or retention of physicians are also considered when determining AFI contract payments. |
| 9.18 | Acute care facilities can provide financial incentives to attract medical specialists without informing DOH. This funding is not fully considered when new AFIs are negotiated. | Implemented - It is now a legislated requirement that DOH sign all physician services contracts. Guaranteed compensation under AFI contracts must remain at the negotiated rate. |
| 9.28 | Roles and responsibilities of the Department versus ABCC with respect to AFI contract monitoring should be clarified. | In progress - Roles and responsibilities have been clarified. DOH management informed us the Department is working on implementing better contract monitoring and developing a process to evaluate service delivery. |