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Fee-for-Service Physicians

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Honourable Ross Wiseman, MHA

Public Accounts Committee

Chair: Jim Bennett, MHA

Vice-Chair: Kevin Parsons, MHA

Members:

Keith Russell, MHA
Eli Cross, MHA
George Murphy, MHA
Tom Osborne, MHA
Calvin Peach, MHA

Clerk of the Committee: Elizabeth Murphy

Appearing:

Office of the Auditor General
Terry Paddon, Auditor General
Sandra Russell, Deputy Auditor General
Lindy Stanley, Audit Manager
Jayme Martin, Audit Senior

Department of Health and Community Services
Bruce Cooper, Deputy Minister
Michelle Jewer, Assistant Deputy Minister
Tony Maher, Executive Director, Audit and Claims Integrity
Barry Stanley, Manager, Medical Audit and Compliance
Larry Alteen, Director of Physician Services

The Committee met at 2:00 p.m. in the House of Assembly Chamber.

CHAIR (Bennett): Good afternoon.

We are back on right now.

This is a hearing of the Public Accounts Committee of the Province of Newfoundland and Labrador. This afternoon we are inquiring into the Report of the Auditor General on Fee-For-Service Physicians; in particular, part 3.2 of the Auditor General's report.

The Auditor General's staff have already been sworn. When somebody has been previously sworn, then we do not need to have them sworn again. So, each individual will identify themselves by name. When we come to questioning, the staff at the Broadcast Centre and also at Hansard have asked that people be sure the red light is on before they begin to answer. They cannot actually see the proceedings and it makes it easier for them if they have that minor pause in response. It is like a three-second delay or five-second delay. It is not quite like Open Line, but is kind of like that in a way.

My name is Jim Bennett; I am the Chair. The members will introduce themselves, and then I will go to the Auditor General and also the witnesses who are appearing so we have your name available for the transcript prepared by Hansard. Also, it is useful for the broadcast staff to know who is answering the question, because that way the person can put the right name on the right person.

So, I am going to start at my left.

MR. OSBORNE: Tom Osborne, Member of the House of Assembly.

MR. K. PARSONS: Kevin Parsons, Member for Cape St. Francis.

MR. PEACH: Calvin Peach, Member for Bellevue district.

MR. CROSS: Eli Cross, Bonavista North.

MR. MURPHY: George Murphy, MHA for St. John's East.

MR. PADDON: Terry Paddon, Auditor General.

MS MARTIN: Jayme Martin, Audit Senior, Office of the Auditor General.

MR. COOPER: Bruce Cooper, Deputy Minister, Health and Community Services.

MS JEWER: Michelle Jewer, ADM, Corporate Services, Department of Health and Community Services.

MS RUSSELL: Sandra Russell, Deputy Auditor General.

MS L. STANLEY: Lindy Stanley, Audit Manager, Office of the Auditor General.

DR. ALTEEN: Larry Alteen, Director of Physician Services, Department of Health and Community Services.

MR. MAHER: Tony Maher, Executive Director, Audit and Claims Integrity, Department of Health and Community Services.

MR. B. STANLEY: Barry Stanley, Manager of Medical Audit and Compliance.

CHAIR: Thank you.

Ms Murphy is our clerk and she will swear any witnesses who have not yet been sworn. She already has a list of the people who have previously been sworn before this session of the House of Assembly. So, do not feel left out if you are not asked to be sworn; you already did that at a prior appearance before us.

Swearing of Witnesses

Bruce Cooper
Michelle Jewer
Tony Maher
Larry Alteen
Lindy Stanley
Barry Stanley

CHAIR: That noise may be a BlackBerry or something near a microphone, or a notepad. Members are doing it all the time; that is why I know what it is. It makes the Speaker crazy, especially when we do not know whose it is.

The format that we follow is that members ask questions generally in about ten-minute increments, ten minutes or maybe a little more than that, and the witness who is best able to provide the answer, assuming that there is an available answer, is the witness that responds. It is not one particular witness, because one person may know information that the others do not know.

We have a significant number of you, so presumably between all of you whatever questions are asked, you will have the answers. If you do not, we can pursue them at a later date or maybe there are no answers, but we will deal with that as we go along. The Auditor General provides clarification sometimes on different aspects of the report when it is necessary. The whole matter is recorded and prepared for Hansard, and I do not think we are liable, although we may well be – I know we are at least recorded.

If nobody has any questions, I will start with Mr. Osborne.

MR. OSBORNE: Thank you, Mr. Chair.

In the Auditor General's report over the six-and-a-half year period there were only eighty-seven audits started. I do commend the department because, as of December 13, they have started twenty-three audits. So I have noted some improvement there. Of the twenty-three audits that have been started since the Auditor General's report of 2013, have any of those been completed?

MR. COOPER: Actually, just to provide a further update, the response that we gave the Public Accounts Committee did indicate that were twenty-three that had started. Since then, there have been thirty-eight that we have initiated: twenty-five GP audits, and thirteen specialists. In addition, we have done approximately sixty physician file reviews.

In terms of the number that we have completed since that time – I am sorry; I do not have the information on how many we have actually completed of the number that we started since the AG's review. I would expect it would be a small number because of the process involved in completing the audits since January.

MR. OSBORNE: Okay.

The department has also indicated that the methodology used for the selection of audits is under review. Are you able to give us an update as to where that is at the moment?

MR. COOPER: We are looking for opportunities to improve the methods, to make sure that the five doorways into audit that we currently use, that we select a better informed target for when we should be using the selected fee code review, when we should be using the claims management system data, and other methods.

So, we are in the process – we have completed an operational plan, which has us engaging in a jurisdictional analysis of methods, and we have done some of the jurisdictional analysis. We have not landed yet with respect to the identification of new methods, but it is certainly something that is contained within our significant operational plan that we have put together to respond to the Auditor General's findings.

MR. OSBORNE: Okay.

You indicate under the methodology that you are going to be using for the audits, that you anticipate an increase in the average of fee-for-service physicians that will be audited. Do you have specific targets in place for that?

MR. COOPER: We do not yet know what the right target is. One of the questions we are looking at is – because you recognize that high average income is not only an indicator of the risk of misbilling, the average income of a physician is determined by a number of dynamics, such as how long they work per day, the amount of billing they do and so on.

We are both looking at the data that we have and also trying to dial in on what the right target would be. Right now, as the AG pointed out, we had 11 per cent of physicians who were above average and we are looking for guidance on this. What should that target be? What are the other indicators besides average income that we can use to help us determine the appropriate audit plan?

MR. OSBORNE: Okay.

Can you give us an update on the work you are doing to prevent the double billing between MCP and workers' comp?

MR. COOPER: Yes. Since the Auditor General's review we have had discussions with Workplace Health, Safety and Compensation Commission. Both of us have an interest in addressing this issue. They have the same interest we do in ensuring that there is appropriate use of resources.

We have identified some options that may have us – we are exploring the possibility of actually using the MCP system to help run some of their claims. That would remove the risk of having two claims entered because it would come through the single MCP system.

The idea has been floated. We have work ongoing to see what the implications of that would be and when we can implement. Our hope is that we will be in a position to implement in the new fiscal year, April of 2015, but there are still some aspects of this within workers' comp and our own department that we need to sort through before we can commit to that. We have had very good discussions, and planning is underway.

MR. OSBORNE: Okay.

Will the department be looking at doing any retro-audits to capture any double billing that may have occurred in the past?

MR. COOPER: That is not something that we have entertained.

MR. OSBORNE: Okay.

Do you anticipate that it would be a worthwhile venture? Would it not pay for the work involved in going after any double billings that may have occurred?

MR. COOPER: Certainly on the face of it, it seems like a reasonable approach. It is certainly something we would be interested in taking away. I am just going to confer with my ADM to see if in fact there has been more discussions that I am not aware of in relation to that.

We were just discussing the fact that in terms of the number of transactions, there is upwards of 85,000 transactions a year through worker's comp as opposed to 5 million through the MCP system. So, in terms of the risk, I guess that is just a preliminary sense that perhaps the risk could be on a quantum basis low. That said, I think it is a conversation that is worth having, and not something that we have a plan to do but certainly something we can talk about.

MR. OSBORNE: Okay.

The operational plan that the department has put in for the various divisions, you had indicated in the response back to the Committee that copies of that will be made available when the plan is finalized. Do you have a date on the finalization of that plan?

MR. COOPER: Yes, we have a final plan and we actually have copies with us. If you wish, we can table them.

MR. OSBORNE: Yes, if you could.

CHAIR: If we could take a brief moment, because members might want to have a look at the operational plan. That may shape some of their questions, rather than having us go to the end of the day looking at the operational plan and then saying we should have asked such and such a question. Maybe we should just take a slight recess and have a look at the operational plan, because that would seem to be key to the operation of any organization.

If we could go off for about ten minutes, and no more than ten minutes.

Recess

CHAIR: We are ready to resume.

Mr. Osborne will go for another few minutes and then we will go to Mr. Parsons.

MR. OSBORNE: Thank you.

I have one question on the document just tabled. The review of current legislation is currently in progress. Can you give any update to the Committee on where that is and what changes you anticipate in legislation, the Medical Care

Insurance Act and the Hospital Insurance Agreement Act?

MR. COOPER: We are very much at the early stages. This came about, in part, due to a comment in the AG's report wondering whether we had sufficient authority in the legislation inside the division to be able to recover money by just allocating sort of a percent reduction in future billings. Currently, we have legislative powers – the minister has the power, under a ministerial order to do this, but it was a question I asked after reading the report and I have asked staff to work together to take a look at it if there is anything we should be suggesting to government with respect to changes to legislation in that regard.

It is very much in its early days, it is inside the department, and we are taking a look at whether we need to make any tweaks to better do our job.

MR. OSBORNE: Okay.

We talked about the fact that over six-and-a-half years there were only eighty-seven audits. Since the Auditor General's report now, we were over thirty this year. Do you see any benefit in going back over previous years to conduct audits of previous years as opposed to just on a go-forward basis increasing the number?

MR. COOPER: I am not certain how to answer that question. In our policy, we have a two-year window that we audit. So, we would always be working from the year we are in. From a pragmatic perspective, we have five staff in this area. Some of the reason we were challenged in that period of time that you referenced where we had lower numbers than we would want. Part of the dynamic that was at play during that time was very much a turnover of staff.

As you saw in our response, there are Medical Auditor 1 and Medical Auditor 2 positions – two of each. In the case of the Medical Auditor 1 positions, we had a turnover of five people since 2010, a short period of time, and I think seven people in the other position from 2007. That is part of what our productivity challenge was.

With a full complement of well-trained staff going forward, I think we will focus on the go-forward billing. I would not view the numbers that we achieved during that time of the audit as a sentinel event or an issue that requires us going back and taking remedial action. I think we are always committed to continually getting better and improving our performance. I would view it as more of a go-forward process than retrospectively.

MR. OSBORNE: Okay.

Maybe I can ask the Auditor General a similar question. Obviously this has raised concern with the Auditor General and part of the Auditor General's report: the overbilling. Is there value in going back to previous years to determine whether or not there was overbilling? Would the recovery of any potential overbillings be worth the effort to go back?

MR. PADDON: I would answer it this way I guess, and I hear what the deputy says, that they have a two-year window that they would look at. Essentially, as soon as they open up an audit file this year, you are automatically going back a couple of years anyway, so there is an element of retroactivity in it.

I would suggest or suspect that if in those audit files, you start to see some systemic issues or some issues that have enough prevalence to suggest that maybe you should go back and look further back, because there might be issues that are further back than two years – yes, perhaps the evidence that you find in these audits might put you in that direction.

In the absence of that, I am not quite sure that given limited resources, whether – so essentially what you would end up having to do is to take your four or five people and direct them back three and four years ago versus focusing on the current and the go forward. Unless you found compelling evidence in the thirty to forty files that you are currently doing that suggests that there might be something systemic, I am not sure that there would be all that much value in directing the resources back there.

CHAIR: Maybe we should go to Mr. Parsons.

MR. K. PARSONS: Thank you very much for coming here today, on this beautiful July day that we are having here.

MR. OSBORNE: Just for a bit of humour, you should skip to the next person. He told me I asked all his questions.

MR. K. PARSONS: I know. He asked all my questions.

I will just go back to the one that Tom did ask. You talked about the turnover in the department, and obviously that is a huge problem in any department when you have huge turnovers like you guys are having there. What is the procedure in place now – is there something that should be brought in so there is not so much turnover in that department? It seems like it could be the whole issue that we are having here today with reporting of stuff and as a new person comes in, obviously they have to get their feet wet and they have to get into the different files and everything else, and it does take a lot of time to do that.

With a department so small - you guys only have five employees there - to have a turnover of seven, I think you said, in a couple of years, what is being done to make sure that we do not have the turnovers like we are having there?

MR. COOPER: Yes, you are right. The turnover, not only does it mean we lose efficiency because we are managing a vacancy for a period of time, it also means there is a training period that people must go through. For the first year of an auditor's practice, there is a learning curve, and naturally productivity at the beginning of the second year is much better than productivity in the middle of the first year.

Yes, it is something that we are concerned about. It is also a positive thing. The public service is a great place to work. This is a wonderful training ground. If I look at the list of people who have come in through these positions, they have exercised their desire for a career ladder and have moved on. The very question you have asked is why you see in our operational plan the desire to develop a human resource plan. We are going to be working with the Human Resource Secretariat to examine what we can do to improve our recruitment and retention in that area.

At this point, we know that this is a great stepping stone to other jobs in government. I have questions, as deputy, about what we could be doing to retain people better. What are the factors that are causing people to choose to rapidly cycle through? Some of them are inevitable, they are retirements; but others are really people advancing their careers, as you would expect.

We are developing a plan with HRS to identify what might be at play and to come up with some options to try to bring greater stability to that team.

MR. K. PARSONS: The Medical Consultant's Committee that you have in place there, obviously they were not meeting on a regular basis whatsoever. What are you implementing now so at least that committee is meeting on a regular basis?

MR. COOPER: We have a regular calendar that we have established. We are pre-booking meetings over the year. That is a very minor administrative point, but it is a quality improvement.

More to the point, we are also going to be looking at the functioning of the committee. The Auditor General quite correctly pointed out that there were some files being viewed by the medical consultant committee that were two years old perhaps by the time they got to the committee. We are looking at how we can make the best use of this important group's time, maybe boil down what is coming to the committee so that we provide them with support to actually be able to get through more files in the run of their time.

So, that is part of the plan we are implementing now, is to look at how we can maximize the time. When we do have the meetings, to maximum the time we have so that we can get more cases seen quicker.

MR. K. PARSONS: Okay.

Is there going to be a regular – will it be a two-month, three-month period? Will the committee have a time frame that will say, okay, we are going to meet the first Monday of every month or –

MR. COOPER: Correct. Yes, we have quarterly meetings.

MR. K. PARSONS: Okay.

To implement performance, the measurements that you do there, what are you doing to – I just read there that time. What are the procedures you are going to put in place for that?

MR. COOPER: Well, the first thing is that we want to measure our progress against our own plan. Part of what we are going to do inside this plan is actually figure out, what are the top ten performance indicators that we should be using as a program to measure ourselves against? There have been some that were used in the Auditor General's report in terms of the percentage of audits that we are conducting on fee-for-service physicians who earn above an average. Once we determine what the target should be, we will then measure ourselves against that target.

As we work through the identification of ways that we can improve our audit procedures, part of that work will also be saying: If we are making these improvements, how are we going to know that they are continuing in perpetuity? How are we going to report internally on our progress? So we will be developing performance indicators relative to the various objectives inside our plan.

MR. K. PARSONS: Okay.

I am going back to the member previous to me, a question that he had, and it was about the double-dipping and double billing that is there. You said you would not go back past the two years, but if there was something that came up that you saw, there were procedures or something you could see, would you go back further than that?

MR. COOPER: Yes, absolutely, and I appreciate the opportunity to clarify.

The two-year window is what we use as par for the course inside the audit process; but, if we are doing an audit and find there is a disproportionate occurrence of a particular billing practice, we of course not only have the discretion but we have the obligation, and will have the obligation, to go back further to see if in fact this is a systemic problem that would allow us to capture more years than the two that we use as the entry level.

We are refining our policies. Right now there is discretion around the two-year period, but part of the improvement of our written policies that you will see will be clarification of this very obligation. Our mandate is to make sure we are maximizing recoveries. So we would not be ignoring data.

MR. K. PARSONS: When it comes to workers' comp, are there any examples you can give me where this could happen, the double billing, where you could see it? You would think that if you are dealing with workers' comp they would have the same files and whatnot and see where charges were going out that we would say in the Department of Health, where would this occur to?

MR. COOPER: For that question I am going to have to defer to Tony Maher, to answer the question regarding what the risks would be.

MR. MAHER: The question is?

MR. K. PARSONS: I am just wondering where you would see it. Have you seen this double billing in dealing with workers' comp? That is what we are talking about basically. Where would we see it? What is the situation that would happen here?

MR. MAHER: We have not had an information sharing agreement with workers' for quite some time. We did have an information sharing agreement back in the early 1990s, I believe, was the last time we did this. There was some degree of double billing. It was not alarming, but there was some.

The program was discontinued by workers' comp. It was seen to be too administratively burdensome. We are now trying, of course, to get that program back in place; slightly modified of course because we are anticipating that we will be processing workers' claims.

There will be some efficiency there. Will there be any double billing? Absolutely, I think there will be. I cannot say it is out of hand, it is

rampant; I would not say that at all. I would say there is very little, but when we get two systems combined we will get that down to a manageable level, hopefully none.

MR. K. PARSONS: Okay.

I just have one final question to ask. I want to ask it to the Auditor General. I looked at this report myself and I looked at the responses that were given to you, and then today with this coming towards us. What is your feel on the responses that you have received from the department? This one in particular to me just seems like there is due diligence done. You brought up the report, and there is a lot of information that came back afterwards.

MR. PADDON: For me, Mr. Parsons, I think it is the provision of the operational plan. When I scanned through it the issues that seemed to be covered in the operational plan appear on first blush to be sort of trying to address the issues that were raised in our report. From that perspective, I would see that as a positive direction.

The fact that close to forty audits have been commenced since December is a fairly significant increase. I would view that positively as well. It remains to be seen over the course of time where this – because as the deputy points out, it is still early days. They are still in the process of implementing the plan. There are a lot of balls in the air, so we will see how it goes. On first blush, yes, it is positive.

MR. K. PARSONS: I have to compliment the department too because whenever you would like to see a plan, you will see dates that are put there where you think it is going to be finalized, and that is very, very good.

That is basically all the questions I have.

CHAIR: Mr. Murphy.

MR. MURPHY: Thank you very much, Mr. Chair.

Thanks for being here today to answer some of the questions. It is a lot of material. I would like to thank you too for the operational plan that you have in place. It is nice to get a piece of information, albeit I would have liked to have another day or two to have a look at it to have more questions.

I do have some questions as regards taking a quick look at this. You mentioned earlier about changes to legislation that are needed in goal 4. If you want to carry out some of these pieces that you are undertaking in the operational plan, it is obvious to me that you would need the Hospital Insurance Agreement Act and the Medical Care Insurance Act. You would want to get those legislative changes made sooner rather than later.

What is it particularly in these acts that you would want to see changed? In my mind I am thinking too that you would need these changes in order to affect your operational plan to put it into effect. Is there anything there that would hold it up otherwise?

MR. COOPER: I would not say that the changes in our operational plan are contingent on legislative change.

MR. MURPHY: No?

MR. COOPER: At this point, we are just looking to how we might modernize and improve the legislative framework, the lessons learned from the report, to ensure that we have the tools. This is very much for us kind of inside this discussion of how can the act support our audit process. We are very much at the infancy in those discussions.

Really, what we are trying to convey in this goal and this action is that, as officials, it is our obligation, as we are looking at all of the elements of our work or all of the elements of the policy framework, our organizational structure, our systems and processes that support us in doing the best we can do. Part of that does have to be the legislation.

It is premature for me – I do know the one issue that was sort of tweaked was the question of whether we need to do anything to actually give the department more authority quicker to be able to actually recover from physicians in a manner that is allocating the recovery against future billings. That was really the comment that caused us to say let us take a look at the

legislation and see. It is always a good thing to do. This legislation is old. So I cannot really give you the full details on everything at this point, but we are still in the process of reviewing.

MR. MURPHY: Okay.

You talk about in your goals for measurement, in goals one and two, about how to measure where you have been. You are going to be putting in reviews to the assistant deputy minister every quarter. Are they going to be available publicly as well? Will the general public be able to have access to those to see what is happening there, or legislators, for that matter?

MR. COOPER: Well, inside every department the executive are responsible for monitoring the performance of their divisions. I would view this as just regular operational reporting within the department. This is accountability between manager and supervisor, for lack of a better term. So, we have not looked at the question of whether we would be making that publicly available. Certainly, the progress towards achieving our goals naturally we would always be open to answer questions on that, but actually sharing the document is not something we have contemplated.

MR. MURPHY: It was just a matter of curiosity.

MR. COOPER: Yes.

MR. MURPHY: I want to come down to goal number six, when it comes to recruitment and retention. I think I heard earlier you are working with seven people. Is that enough, in your mind?

MR. COOPER: Actually, the division has five staff. I had the same question about whether, in fact, we were adequately staffed. So, following the AG review, we refreshed our jurisdictional scan. I am comforted to see that when you look at the allocation of staff as a ratio to the number of fee-for-service physicians in provinces, when we look across the country, we are actually on par with the rest of the country. I felt some comfort that, in fact, we do have enough staff. In fact when we look at our performance, the performance in terms of recoveries is quite good in terms of the amount that the dedicated group of five staff return. As a percentage of the budget, their recovery rate is actually quite good compared to other provinces in Canada. The area where we need to improve is time limits.

MR. MURPHY: Okay.

I wonder about the whole question as well around staff retention – I guess probably for an obvious reason, that it is pretty much standing in front of everybody. You mentioned earlier about 5 million transactions versus 85,000 transactions for the Workplace Health, Safety and Compensation Commission. We know that we are dealing with an older population and an older workforce, so your caseloads may be increasing in the future. I am just wondering: With the number of staff that you have now and the possibility of these numbers increasing, for example, for billings for the Workplace Health, Safety and Compensation Commission, are you going to have enough staff on hand in order to handle that workload in the future?

Is it time to hire more staff, for example, maybe one, maybe two people more to handle that case workload? Is that something you would be looking at?

MR. COOPER: Certainly we are always looking at the question of are we optimally set up in terms of our human resources. I firmly believe that before we would land in a place where we say we need more resources, we need to first of all make sure that we are working as efficiently as we can with what we have. I think we know that there are areas for improvement.

Before I could even formulate a view on whether we need more staff, I need to make sure that we have optimized our efficiency in our processes, we are maximizing the use of the various committees we have, we have our targets in place and our benchmarks in place in terms of the audit process; and, in our human resource plan, we have looked at what support needs might staff have, what are some new technologies that might be available to support us and support staff in doing their work.

There is an awful lot of work to be done to make sure we are squeezing the most efficiency and value and quality out of the resources we have before I could ever consider needing more resources.

MR. MURPHY: Okay, but you are looking at it obviously?

MR. COOPER: Down the road, after we try making the best use of existing resources, if that did not work to improve our performance then at that point I would probably be looking at that.

MR. MURPHY: Okay.

Have you done exit surveys, for example, on the people who have left the department, who have gone on, to see the reason why they left? You said that some people have gone on to different departments.

MR. COOPER: I do not believe that we have done formal exit interviews with the people who have left. Again, there were a number who left for retirement and there are other people who left because they were promoted; but no, we have not done exit interviews. I would expect that it would be part of a fulsome HR plan, that we should do that, and it is something we are trying to get better at as an employer.

MR. MURPHY: It might give you flavour too of what everybody is thinking about the workplace and everything. I would probably make that suggestion to you, if somebody else has not already.

MR. COOPER: Yes.

MR. MURPHY: I want to come to some general questions that I had around the report then – and again, thank you for the operational plan. I guess if we have any more questions on it, we could write to you and ask some questions based around that, probably in the future – just for information purposes, I guess.

I want to come back to some of the questions in general, what the Auditor General was saying. When the Auditor General suggested the Audit Services Division does not use available reports to the fullest extent, is this a function of insufficient staffing or is there some other factor at work when he said that?

MR. COOPER: My response to that would be that we do employ the various statistical reports that are available and they were always employed, and I think that was acknowledged that we do use them; however, we did not have time tables in place. I mean, there could be more structure brought is the way that I interpreted that, and we should be codifying the circumstances under which we use various reports and looking at can we actually make better use of some of the reports that we already do review.

We have implemented a system now where statistical reports are referenced and used at monthly staff meetings. We are getting the team together; we are actually using the data in the report on a regular basis. I would like to think that that is part of the performance change that we are seeing in some of our numbers. Again, I do not want to be too bullish about that because the impact of one or two complicated audits can slow us down a bit.

We did implement a process where the provider practice profile reports that were generated from the system are now reviewed by the manager and the Auditor IIs on a quarterly basis as well. So that is a change that we have made to make better use.

The other reports from the MCP statistical system are updated every two weeks now and are reviewed as well at that monthly staff meeting. We are actually bringing staff together to use the data we have. We are also going to be looking in our operational plan at, should we be targeting a certain percentage of audit selection from these various reports?

I think we have made already incremental improvement in how these are used, structures around regular staff meetings, around use of them. We have a bit more work to do to make sure we have targeted where it makes sense, and that we have good written policy to support the practice that it started.

MR. MURPHY: Okay. So you do not feel it is a staffing issue right now?

MR. COOPER: I do not believe so.

MR. MURPHY: Because on the outside I think that – it is painting a picture for me, and I am thinking to myself, and call me crazy, but it sounds like if you only have five people there, that you have a heavy workload. It sounds like you are looking for efficiencies where I think that yes, it is great to be looking for efficiencies, but at the same time you do not need to be increasing workload on people who may be already stressed now, and you have people leaving at the same time.

I do not know, I could be wrong. That is one of the reasons for the exit survey, maybe they are under stress. It sounds to me there is a bit of stress on the system there. If you need extra help here from the extra employee, do not be afraid to ask for it, right – because like I said, I think we are going to be dealing with more of these cases in the future and your workload is going to get bigger anyway. So it is probably a secondary issue that is going to have to be dealt with.

CHAIR: Mr. Murphy, we should go on to Mr. Peach now.

MR. MURPHY: Sure, okay.

MR. PEACH: I just have one question, really for clarification more so than anything else.

I am looking at the findings on the table of the annual report with regard to the Medical Consultants' Committee. I was looking at it from 2008-2014 and the consistency of the meetings there. In 2008 there were four meetings, and then it goes down to one. In 2010 and 2011, one; then back up to three, and then down to one again in 2013.

Are they based on the number of audits that are done? How do these meetings be determined? The consistency of the meetings, is it because you cannot get the groups together all the time?

MS JEWER: I think for the most part it was scheduling, trying to get everyone together to meet at that certain time. You will notice that the number of audits to review in 2010 were two, and in 2011 were three. So there were a low number of audits there. I would say they were – and I will turn to Tony just to make sure, but there were probably more complex cases at that time that were taking up a lot of the auditors and the division's time to deal with.

Going forward, we are trying to set up quarterly meetings in advance so that everyone knows it is a standing meeting, and then we will address audits at that time.

MR. PEACH: Going forward, 2014, as of today, are there any meetings – well, this one here was in January, the report, but were there any meetings since then?

MS JEWER: We have one scheduled for mid-September, coming September. We have not had one since the AG review.

MR. PEACH: Would that be sufficient in trying to determine the auditor's reports on this?

It says there, "The Medical Consultants' Committee is not meeting on a regular basis. This results in delays in issuing assessments and also delays in recoveries which increases the risk of not collecting the full amount of the assessments."

MS JEWER: Right. Our plan is that we will have a meeting in mid-September, and from then we will have them every quarter.

MR. PEACH: From there on?

MS JEWER: There will be four in a year.

MR. PEACH: From there on?

MS JEWER: Yes.

MR. PEACH: Okay, thanks.

That is all I have, Mr. Chair.

CHAIR: Next, we will go to Mr. Osborne.

MR. OSBORNE: Thank you.

Bruce, I earlier commended the department – I still commend the department – for going from twenty-three to thirty-eight audits. If you look at the twenty-three audits that were done over a six-and-a-half year period, that is less than

fourteen a year. Now we have gone to thirty-eight in eight months, audits that were started. What changed to allow the department to move from less than fourteen per year to thirty-eight in eight months?

MR. COOPER: We have had this discussion and I have asked the same question. We certainly have implemented some improved management practice with the regular meetings. There is some good team work happening where people are gathering around the statistical reports. To be honest, the Auditor General's reports, any kind of public accountability report is a useful thing to help sharpen the saw, to help make us all focus more fully, and I think that is a factor.

Certainly, we took to heart the AG's findings and want to do better. That is what I am seeing among – it is a very dedicated group of staff in this area. We are already high performers in terms of our outcomes, but we want to be higher performers in terms of our outputs as well, in terms of the numbers. So that is the commitment that is there, and I think that is fundamentally it. That is all we have is people who are committed, and that is pretty good.

MR. OSBORNE: Okay.

In the event of a pattern of, and looking at a go-forward basis, especially, but leaning on past practices and past experiences, if there is a pattern of overbilling – without being politically incorrect in what I am saying – found, what actions are taken? What measures are taken with the physician where you find that pattern?

MR. COOPER: There are actually a number of choices, a number of tools in the toolkit that we can use to deal with that. Naturally, if there is a pattern of overbilling than that is obviously a trigger for a comprehensive audit and out of the comprehensive audit would be through either the support of the Medical Consultants' Committee, the outcome of mediation, ADR, or the outcome of an audit review committee would be a decision to recover.

In cases where you have an obvious systemic problem where a physician, in spite of intervention, their billing practice is not improving, they actually, for those codes and that sort of area of professional practice, they get brought inside the PCIP which is, they sort of get brought into the parking lot in a sense and all of their claims for this particular service are kicked out of the MCP system. They do not get paid, and they come to the staff in this division and they get assessed.

That is a pretty significant, not only power, but also a significant tool that can be used by staff to intervene and to – and it is only when the behaviour corrects itself and we start to see better billing practice, that they get released from the PCIP and actually would go back into having those particular services paid for without that same level of PCIP scrutiny. So those are some of the tools that are available to us to deal with that.

I do not know, Michelle, if there is anything I have missed.

MS JEWER: There is also the CMS system, which is a Claims Monitoring System as well, similar to the PCIP. We use that a lot if you have a new physician. A new physician comes on and probably does not really understand the fee code process and might be billing something incorrectly, so a physician will go into CMS – and also certain fee codes might get kicked out and they have to provide documentation before those claims are paid. Those are some tools that we use to kind of help with the process.

MR. OSBORNE: Okay. I know PCIP can be very onerous, not only on the physician but on the department as well. Over the past two or three or five years, how many physicians have been brought into the PCIP program?

MR. COOPER: I do not have that information with me.

Tony, do we have that information?

WITNESS: (Inaudible).

MR. COOPER: We do not have that statistical information with us, but we would be happy to get it and supply it.

MR. OSBORNE: Has it happened over the past couple of years?

MR. COOPER: Oh, physicians in PCIP? Absolutely; every year.

MR. OSBORNE: Okay.

Again, trying to use my words carefully –

MR. COOPER: Sure.

MR. OSBORNE: If a lawyer were determined to be taking inappropriate actions, the Law Society would deal with them and they would possibly be disbarred from practice. Other than going into PCIP, what measures are in place – have we taken action against physicians who are chronically overbilling and their billing practices have not improved?

MR. COOPER: Yes, obviously there is a judgement call. When something moves from being misbilling and something that can be corrected with the proper intervention versus something that would be tipping into fraudulent behaviour, naturally we have an obligation to ensure and part of the professional judgment that gets made would be: Is this misbilling, something we can correct; or is this actually something bigger, something that is fraudulent?

There are times when there are referrals made in that regard to the appropriate authorities, as well including the regulatory body, and to the police. There have been some very public cases where that has occurred and that we have been involved in laying the complaints. I do not have the statistics in terms of how many, I do not know the prevalence, but certainly it is there as another tool.

MR. OSBORNE: Other than Dr. Buckingham, which was a very public case, have there been other cases over the past four or five years where somebody's licence to practice has been removed?

MR. COOPER: We do not have that information with us.

MR. OSBORNE: Okay. That was more for information purposes.

MR. COOPER: Yes.

MR. OSBORNE: When error rates are detected, the Auditor General had found that the division does not consistently pursue audits when higher rates are detected. Can you talk about the measures that have been taken as a result of that finding?

MR. COOPER: Sure.

I think the example that was provided by the Auditor General related to five cases where there were error rates over 80 per cent and the department did not engage in audits. Part of the explanation of that is that you have circumstances where you may have a high error rate but a really low number of billings so that if you have ten billings and you have five of them that are a problem, that is a 50 per cent error rate; and then you have to look at the materiality and from a percentage perspective, it may be high, but from the point of view of the dollar value of what we would recover and the opportunity to use other methods, particularly if it is a low dollar value, to correct the behaviour.

In these instances, as we took a look at them, the majority of these instances were brand new physicians who were getting used to the system and they made errors at the outset and they were caught, and they were correct in going forward.

We do not have a policy that says we do not go after misbillings, but there is judgement and there is a materiality threshold that gets used to judge when it is appropriate use of our resources to go after something. If it going to be a small return, even though it may be a high percentage, there may be times we would – and in these instances, those were times where we technically met a high percentage but from a volume perspective it was low. The important thing is preventing it happening in the future, and we do have an educational approach.

MR. OSBORNE: So even though you will not pursue an audit, if the percentage is high but the dollar value is low there is still some intervention?

MR. COOPER: Yes, absolutely. We use the Claims Monitoring System as an educational intervention to help prevent the behaviour from occurring again.

MR. OSBORNE: Okay.

One of the other findings is that recoveries of overpayments were not always pursued. Can you talk about what the department is doing since the Auditor General's report to improve upon that?

MR. COOPER: This was the finding based on an example where there was audit conducted of a physician who did identify a recovery inside the two-year window, and then between the time that we completed the audit and the findings letter went out there were other billings that occurred in that space. So there was one instance where this occurred, and again, because we use a two-year window, there was a judgement made to recover the amount that we audited – and educational going forward.

I think it is appropriate we have management discretion. Judgements get made all the time using the best knowledge and sort of the skills and competencies that exist in that area, but I have asked for us to look at our policy to try to give more guidance to management; to say that if we have knowledge of money that is there, we should be recovering it, even if it falls outside the two-year window. So that is part of the work that I have asked to be done inside the operational plan: to confirm that, in fact, we do not leave money on the table.

MR. OSBORNE: Okay.

I just want to go back for a second; we were talking about PCIP and so on. I know that there is a huge challenge in attracting physicians sometimes to Newfoundland and Labrador, and in particular in rural areas. So there is a bit of a balance, but fee-for-service physicians are paid out of the public purse. In the event of a chronic overbilling, weighing that putting a physician in a rural area versus a physician that may be taking advantage of the fee-for-service billing system, does the department have any plans themselves to take action or to try to mitigate those concerns? Again, understanding the delicate balance of trying to put a physician in a certain area.

MR. COOPER: The question is in circumstances where we know a fee-for-service physician may have some, for lack of a better term, chronic misbilling, would we allow that person to continue to practice as a response to capacity issues in rural Newfoundland? Is that more or less the question?

MR. OSBORNE: Yes.

MR. COOPER: We do not have, as a department, the kind of control over the continuation of fee-for-service physicians. If you look in the primary care area, family physicians, once we issue a provider number, a fee-for-service physician can set up – and it is largely based upon market conditions.

Inside the health authorities, we work with the health authorities on their allocation of the services that are required in the fee-for-service budget, but we do not technically get into kind of a certification process that would have us take someone's billing number away unless there was really – I guess I cannot even answer the question if we have ever taken a billing number away, except in circumstances where there has been criminal conduct.

Does anybody have any experience with that?

WITNESS: (Inaudible).

MR. COOPER: It is a little tough to answer the question because it is not something we have encountered – not something I have encountered.

MR. OSBORNE: Okay.

MR. COOPER: I would be speculating if I went too far with that.

MR. OSBORNE: I am being told by the Chair that I am allowed to ask one more question before they move on.

That does raise some concerns I guess, knowing that if the government does not have the ability to take away a billing number for a physician that government is aware – and I am not suggesting that there is somebody at the moment, but in the event that there is a physician that government are aware there is a chronic abuse of the fee-for-service billing that government cannot take action and remove a billing number for that particular physician.

MR. COOPER: I do not want to leave you with the impression that we cannot remove a billing number. What I am saying is in my experience I have not encountered a circumstance where we have removed. I am sure that we have criteria we need to use for the allocation of billing numbers, but I would need to get some further advice regarding how to answer that sort of question.

MR. OSBORNE: Okay.

CHAIR: Mr. Cross.

MR. CROSS: I am last to speak; I guess most of the questions are covered.

There are a couple of things, probably general information, that I would want to ask. The previous member went and covered most of the sections there with regard to the recoveries of overpayments. One question I would have had that I am not exactly sure if it was covered in his pursuit of that: My thought is that you have now started just about forty audits in the last year, where in the previous six years there were only eighty-seven. So in this case, with more audits taking place, there are going to be generally a chance to find more chances of overpayments of whatever. In the past, these overpayments were not always pursued. As a result of that, missing some of the opportunities, then, isn't it going to be a greater opportunity now that you are going to miss if we do not pursue; or what is there to tighten up this idea of when you pursue the overpayments?

MR. COOPER: Certainly part of the work, as I suggested earlier, that we are doing is to ensure greater clarity around the discretion we have around recoveries, to maximize recoveries. We are also looking inside our operational plan at how we can improve our efficiency. Because if we improve the processes we are using and we have good quality benchmarks, we have good quality performance data, then that will all serve to improve the recovery rate that we achieve. Not only the number of audits we do, but, I would like to think, the return.

MR. CROSS: The pursuing itself is the intention there.

MR. COOPER: Yes.

MR. CROSS: Especially if it fits into the new operational plan.

The alternate dispute process has not been mentioned much yet. It says, as one of issues, it is intended to complete within ninety days, but it takes an awful lot longer than ninety days. So, why is there that length of time if the intent is to have it done within three months? Some of them when I look through them – I do not know if I read this correct; it says as of November 2013, some of these audit files were into a process in excess of 400 days, two or three of them –

MR. COOPER: Correct.

MR. CROSS: – when the plan was that the ninety-day process might be there.

MR. COOPER: I appreciate the question, actually, because you give me an opportunity to clarify part of the response we provided to the Committee, and if I could please clarify the record in regard to the letter that we presented to you. In that letter we indicated a thirty day – there was a typo in that letter. The fact is the ninety days, as you correctly said, is the standard that we have set. So, just to be clear, there was an error in our letter and apologies for that.

So, the ninety days is the standard. Why are we over ninety days? Once you get into the Alternate Dispute Resolution process, the successful process leaves with a mutual agreement about recovery amount; physicians will often engage counsel to support them in that process, and then there is an exchange of records and it becomes a formal process. So, some of the delay has been as a function of the provider dynamics that are at play there.

So, part of what we are doing in our plan – we have a ninety-day policy and once we agree to ADR, it seems reasonable to assume we should be able to conclude in ninety days. We are looking at means we could use to tighten that up and really to compel all parties, ourselves included, to achieve the outcome in ninety days. We are going to get our policy right, but one of the options we are exploring is should we actually have the audit review committee there at the end of the ninety days as, if you cannot settle it in ninety days, it automatically gets

trigged to go to the audit review process, which would be a third-party decision, almost akin to an arbitrator making a decision.

MR. CROSS: Okay.

MR. COOPER: So, there are complex dynamics that cause some of the delays, and we are going to work to tighten it up.

MR. CROSS: One of the concluding parts of that was that it would go before this Audit Review Board, but the trouble with that was for a period of three years, that board did not even meet.

MR. COOPER: Right.

MR. CROSS: Would that have lengthened some of these out to make this time that I read, or am I just missing –

MR. COOPER: No, it is a good question. The fact of the matter is that thankfully in that time there was no request for an Audit Review Board. At the time that we did not have a full roster, we were having some recruitment problems. We also had, at the time, legislation where basically once a member of the committee expired, they were done. We have since changed the legislation to deal with that continuity issue so that people will continue to be appointed until they are even past their expiration date – until they are 'dis-appointed', I guess. We have done some things to try to tighten it up, and we do now, through recruitment, have a full roster of people for that Audit Review Board. We have fifteen names that we can draw upon – is that right?

WITNESS: There are nine members.

MR. COOPER: Nine members, right.

I hope I have answered your question.

MR. CROSS: Yes, at least I got the feel for where it is.

I have one other question. Back on page 82 of the report, finding three says, "There are no safeguards in place to prevent double billing of services…" – and we had gone through that; but is it only in a fee-for-service situation where such double billing can occur or could it occur with a salaried physician whereby someone is paid through the Workplace Health, Safety and Compensation Commission as well as through a salaried doctor? Is that a possibility or is there a mechanism in place to prevent that?

MR. COOPER: This is about fee-for-service physicians and I am wondering whether there is any Alternate Payment Plans because in an Alternate Payment Plan there is an element of salary and an element of fee-for-service. I am just going to turn to Dr. Alteen to see if there would be any circumstances where an APP physician might actually be billing.

MR. CROSS: That was the next part of my question.

DR. ALTEEN: Under the salaried system the physicians are able to bill workers' compensation claims separately and recover those claims themselves, and it is permitted in the agreement with the Newfoundland and Labrador Medical Association. For APP physicians, the same thing would apply.

I do not think that is clearly articulated anywhere, but it is a valued point that, going into the next negotiations, it should be something that we should clarify for people because they are getting fixed remuneration for their work. Presently, the salaried physicians are able to bill workers' compensation and keep those claims themselves.

MR. CROSS: I sort of heard that was the case –

DR. ALTEEN: Yes, that was agreed to (inaudible) –

MR. CROSS: – that could have happened but I did not know how that would be termed towards someone on a fee-for-service who, if they did claim it, or would get paid for it, then it would be a double billing.

That concludes the points I had that I wanted to pursue more so than what some of the other members had, and I really enjoyed it, the questions, as they are coming here today because it is a big learning opportunity. So, I thank you for your information.

CHAIR: Mr. Murphy.

MR. MURPHY: Thank you, Mr. Chair.

I guess we will continue on. Again, coming back to the Auditor General's report, some questions that I have – and I have to recognize that some of the other members of the Committee have asked in some regard some of these questions. I just wanted to get clarification on some of them.

The Medical Consultants' Committee was not meeting on a regular basis before the Auditor General looked at the department. Was this a scheduling issue, lack of work for the Committee – you note in your answer to the Auditor General that the department will ensure that the Committee meets on a regular basis. I am just curious about the timing of the meetings before the Auditor General looked and, afterwards, what was the change here. Why weren't they meeting beforehand? What is going to be your measure to make sure these meetings are going to happen from now on?

MR. COOPER: I will start with the last question first, and I am going to ask Michelle Jewer to pick up the first part of your question.

In terms of what we are going to do to make sure going forward that we have continuity and good, efficient meetings, we have set up quarterly meetings now; we have a calendar, an expectation of regular quarterly meetings. We are again going to be looking at ways that we can streamline the work of the Committee to make sure that we are maximizing their time.

These are highly expert people that we call in to help us puzzle through the legitimacy, the medical necessity of various billings. We want to make sure that we are bringing them the relevant questions, the relevant documentation only, and look for opportunities to be more efficient in that regard. We will also engage the Committee in looking at ways that we can streamline their work to make it a more efficient process for everybody involved.

That is our go-forward plan. In terms of the challenges that we encountered that led to a lower volume of meetings, I will ask Michelle Jewer to answer that.

MS JEWER: As I had mentioned before, on this Committee we need medical expertise. During that period of time, we had some challenges in trying to get that medical expertise to sit and meet with us. As well we had some complex audits during that period of time. Those were ones that we were continually working on. As will you see, there were a low number of audits in those years anyway.

Also, coupled with the turnover issue that we had talked about earlier, obviously the Medical Auditor II and I's would be instrumental in preparing information for the MCC meetings. With vacancies happening in those positions, we did not have the staff to be able to prepare for those Committee meetings at the time.

MR. MURPHY: Would you say that that is a workload issue on the part of not being able to have the medical expertise available for those meetings?

MS JEWER: A workload issue on the physician's part?

MR. MURPHY: Yes, on the part of those physicians not being able to meet at the time (inaudible) –

MS JEWER: I think there were a number of things ongoing at the time. I do not know the exact details, but in getting those scheduled meetings it was a challenge. The main issue, though, was ourselves with the turnover in staff, and complex audits as well.

MR. MURPHY: Again, your recruitment and retention issue also had an effect on that?

MS JEWER: Correct.

MR. MURPHY: The department notes in its response to the Auditor General that they would adhere to the ninety-day time limit to the Alternate Dispute Resolution process, when that process is invoked. So how are you going to do that?

MR. COOPER: We are going to obviously be working with the physicians closely to advise them that we will be living to our policy. Again, we will be looking for options for how we can expedite, including the consideration of an

automatic trigger for the audit review process. So, that is our intention.

The parts of the process that we can control, we will work faster with; and the parts that depend upon providers, medical practitioners to respond, we will just be very clear that if the response does not happen in – now, there may be exceptions; we have to be reasonable. Our standard will be more prevalent in our response times and in our statistics.

MR. MURPHY: Okay, so you are going to be looking at implementing that as part of your operational plan? That will be in there?

MR. COOPER: Correct.

MR. MURPHY: All right.

The department's response to the question regarding the lack of an Audit Review Board, the department notes that the board has not been required or used since 1998 – that is a long time – but then says the department has one and it can be used in the future, if required. So I am curious as to why it was not used before now, but now all of a sudden this is a tool that is available and always has been – why was it not utilized beforehand?

MR. COOPER: It is really an artifact of the implementation of the Alternate Dispute Resolution and our emphasis on that area. Physicians are choosing to work in that kind of a mediation style to try to come to a resolution, as opposed to going, for lack of a better term, more the arbitration route, more an adjudicative panel.

MR. MURPHY: So it is a mediation choice?

MR. COOPER: Exactly. They are choosing door number one, which is for the Alternate Dispute Resolution mediation and a mutual resolution, as opposed to passing the decision making over to a third party.

MR. MURPHY: Okay.

The Auditor General also noted the collecting of the monies owed in a timely manner – he made note of that. In response, the department said that it is now implementing operational plans through the divisions in the department.

I just wanted to get some more details on exactly how you are going to be collecting, number one. Number two, when you said earlier about the monies collected that there was a choice made when the amount was small, it would be at their discretion; who makes that choice as regard to whether they are going to collect when monies are owed and who does not collect even though there is still money owed?

In my mind if somebody owes $5, they owe $5. CRA wants a balance collected if we owe anything over a $1. I think they actually changed it to $2; but either way, if there is an amount outstanding, who makes the choice that they do not bother to collect?

MR. COOPER: In terms of discretion regarding collection – this finding was based upon a case that I described earlier wherein we had applied our policy that an audit period is two years, and the recovery period implied in that is two years. The money that was not collected fell outside of the two-year audit window and the discretion currently rests with management whether to collect or not, and it is again interpreting policy that says our window shall normally be two years.

Part of the work that we are doing, I want to tighten that up. I do not want to fetter discretion, but I want to make sure discretion is guided more fully by our outcome, which is collections.

MR. MURPHY: In that particular case that you referred to that was outside of that two-year window, how much was that?

MR. COOPER: It was $17,000.

MR. MURPHY: It is kind of a substantial amount, I would think. Have you talked about increasing your window from two years to three years?

MR. COOPER: It used to be a five-year window back years ago and there was a pragmatic issue there, of course, in terms of capacity. That is a large frame to audit within. That said, as I have responded in relation to other questions, we are looking at our process. I am not going to say that we are not looking at expanding the window, but certainly I would

like to think that that will be expanded when we have evidence that there is value in doing so.

For example, as we spoke about earlier, if there is a circumstance where an audit of a two-year window captures as such a systemic issue that it makes us curious about three to five years, then naturally my intention is to see our policy address that and to make sure that there is clarity that we shall go and look in those circumstances.

The window may not always have to be wider than two years, but we should have criteria that say when we do need to widen it, and in the interest of clarity for staff and for the program.

MR. MURPHY: Presently there are no rules, for example, to go back and find any long-standing amounts. For example, in year three – that was just outside the window that you have described – it was $17,000. We do not know if it was $17,000 in year four, et cetera, on down the line.

MR. COOPER: The current policy does allow discretion to go further than two years, but I guess we are looking at how we can make it clearer.

MR. MURPHY: What was the reason why they decided not to go after that $17,000?

MR. COOPER: Because the behaviour immediately corrected itself. From the day that the letter was received – so what we are talking about here, you have a two-year audit window and then the audit completes, and then the audit findings and the recovery plan is presented to the physician. The window where there was still some incorrect billing was between the completion of the audit and the notification of the physician. It was a relatively small window, still $17,000.

Then when they did a run on the physician's billing practice from the day that the letter was sent, the behaviour corrected itself. Again, it is a judgment. The educational role that we play, we have a role not only to recover – so when something has happened, to solve it through recovery, but we also have a prevention role or an education role. There was a judgement made that the behaviour had corrected itself and resources are moved on to other work.

MR. MURPHY: Who would have made the decision not to pursue the $17,000?

MR. COOPER: It is a program management decision. It is within the appropriate mandate of a manager applying their discretion inside the program.

MR. MURPHY: So they have parameters for that that they have already set?

MR. COOPER: That is correct.

CHAIR: Mr. Murphy, we should go to Mr. Parsons now.

MR. MURPHY: All right.

MR. K. PARSONS: I just have one question I would like to ask, and it is the role of the Newfoundland and Labrador Medical Association. Obviously, there are new doctors coming into the field and coming to a province where maybe there is a different billing system than what are in other provinces.

What role does the department have with the Newfoundland and Labrador Medical Association on informing new physicians – and I would imagine some of this, especially the double billing part, is done in error, but it is done in an error where they were not sure what procedures were in place and how the billing should be done. So I am just wondering the role the Newfoundland and Labrador Medical Association plays with the department in making sure that doctors and physicians know what procedures are in place.

MR. COOPER: The NLMA play a significant role in terms of working closely with the department to not only convey to us ways that they think we could make our system more user-friendly, to make the experience of the physician who has to work with the billing system work better – and we value their perspectives in that regard. Also, they disseminate through their communication network physician bulletins which provide education information to physicians about the generalities of billing and very specific details. If there is a new billing code that gets put in place, they play a role in getting that out there for us.

So there is a very close working relationship with the NLMA with respect to that. They play a role in advancing names to us. Certainly, they put forward names for the Medical Consultants' Committee and our audit review group.

Larry, I do not know if you have anything else that we could add in terms of the partnership we have with the NLMA, anything I have missed?

DR. ALTEEN: I think the other point to make is that physicians who move into a fee-for-service work environment go through a training session with MCP so they understand – now, you cannot cover every scenario, but at least they know who to call when they get involved in that.

They have the opportunities to learn some of those things, and as Michelle has alluded to before, the whole Claims Monitoring System is a process. You get educated first when you do the claims monitoring, hopefully hoping to stop behaviour – and it is not always because people are doing this on purpose; sometimes they just forget the rules. I take an example of: if a family physician did a regular full checkup on somebody, there are rules around what you have to do. Sometimes, because it is not documented - and that is our tool that we use – it is not because they necessarily did not do it, but they did not document it, and if it is not documented it will not be paid. That is the rule we have.

So, those are some of those things you have to look at. It is not always someone doing that fraudulently or on purpose; sometimes it is just to understand the rules properly. There are a bunch of systems that we work with and we work with the NLMA. If we identify that there are areas that either side is not working through properly, then we try to clarify that for certainly new people coming into the system.

MR. K. PARSONS: Okay. What I was wondering basically was the training part of it, if there were people, and that is great.

I just want to thank you. That is all I have.

CHAIR: Mr. Murphy, would you have more questions?

MR. MURPHY: I am just going down through my list.

CHAIR: Does any other government member have questions?

MR. PEACH: This is not a question, but I just want to make a comment on the mandate that they passed out earlier and the different goals that you had set. It is good to see that you also have timelines set in those goals. That is really good and helpful for us too. Especially, for the auditor's report, there are a lot of things here that you have addressed.

I want to compliment you on the great job that you have done on that.

Thank you very much.

CHAIR: Mr. Cross?

I will take this opportunity to ask a few questions. We will come back to Mr. Murphy later if he wants.

I realize one of the questions that we did not ask early on is, and it might seem like a strange question, what do you do? What does your division do? We have been asking the questions about the nuts and bolts. It is like we took the insides of a Swiss watch or whatever, but no one knows what it looks like from the outside. In a nutshell, before I ask you a few more questions, exactly what do you do?

MR. COOPER: You are asking for a description of the mandate of the audit group?

CHAIR: We have these five people that you refer to auditing these physicians and these claims and workers' comp and whatever, and it sounds like a lot of money. Somebody may be watching and saying: I wonder; what do they do?

MR. COOPER: I am going to pass that to Michelle to give a description of what the division does, how it all fits together, like a Swiss watch.

MS JEWER: I will try; I might need to defer to Tony to get to the real details of it.

We have been talking about recoveries and maximizing recoveries. The mandate of the division is about ensuring that only legitimate and accurate claims from physicians are paid – fee-for-service physicians. We have about 750 fee-for-service physicians.

I think there are over 4,000 fee codes in the system. We get around 5 million claims a year. What the Medical Auditors would do is they look at reports that come from the system and they find trends, they look at billing patterns. There might be some information coming from a complaint where they say this physician might be billing something that they should not be. There are a number of different ways that we would look at saying we need to do something about this and look at an audit.

I guess to get into the whole process of what we do if we identify an audit and it goes through preliminary or comprehensive, I do not know if you want to go that detail. Basically what we are doing is we are ensuring that what the fee-for-service physicians are billing to MCP is legitimate and should be paid.

CHAIR: How much do we pay fee-for-service physicians annually now?

MS JEWER: That was one stat I forgot to say in my full stats. In 2013-2014 the budget for fee-for-service physicians was about $320 million.

CHAIR: Obviously, you cannot audit them all, so you do like spot audits or whatever comes up that looks unusual.

MS JEWER: Yes, we are looking at reports, looking at trends, looking at billing patterns. As I said, there is the complaint way in to an audit.

What else is there, Tony? What other way would they –

WITNESS: You are doing pretty good.

MS JEWER: Obviously, we talked about CMS before. It is put in place for new physicians – for all physicians, it is in place, but it is a good tool for new physicians, especially around education. What that does, it takes random samples of claims from physicians. Basically, we will look at the claim. We will say: Is it right? Should it be paid? Is it accurate? If it is, it goes on. If not, then we ask for more information from the physician. The physician would send in a record; we would look at it. If it is good, it goes on. If there is an issue with it, then we ask for more claims to come in, and that is how we start to look to see if there is a pattern.

The more poor claims, for lack of a better word, that come through, the more we ask for and the more we look at. That is a really great tool for us when we are identifying issues.

CHAIR: The five individuals, what are their job descriptions? Are they accountants? Are they managers? What are they?

MS JEWER: We have two Medical Auditor I's, two Medical Auditor II's, and admin support – right Tony?

CHAIR: What kind of training would they require?

MS JEWER: I will pass that on to Tony.

MR. MAHER: The Medical Auditor I's would need training, on the job basically, in MCP claiming procedures. They would need to be able to look at a doctor's record – they would have to know how to read it; that is a big challenge. They would have to know what the requirements are in our payment schedule preamble; that is another big challenge. They would have to be able to know what the record should have been paid at if it is billed incorrectly.

The division also has two Medical Auditor II's. These people are accountant-types, maybe Bachelor of Commerce, maybe they are on a program, CMA, CA, CGA, and let us call them 'data minors' – how about that? We have a huge data warehouse. With 5 million claims, how do we know if they are billed correctly? How do we know who is billing incorrectly? It is really difficult.

So they look at such things as provider practice profiles – very complicated reports. They compare people. They compare one doctor to another. They compare doctors to their speciality groups. They compare doctors to their

regions in the Province. It is very comprehensive. If there are any aberrancies, the reports point those out. It is up to the manager and his staff to decide which ones to pursue.

There are other ad-hoc reports, like who is the highest earner in the Province in such-and-such a speciality. That is something that could be looked up, and it could be decided from there whether or not an audit has to be done. Is that –

CHAIR: The Medical Auditor I, what sort of background or educational training would that person have or require?

MR. MAHER: They would have medical terminology. They would probably have just the standard office procedure course. They are not accountants; they are more medically inclined. The two we have there now, and previous ones as well, have come up through the MCP system, claims processing and assessment systems, and they are very familiar with how the claims processing system and payment systems work. You are not going to get somebody out of a school, out of CNA, who is trained to do this particular job. It is on-the-job training, it is a steep learning curve, and it could take, I believe, we say six months to a year to train somebody.

CHAIR: Have you been able to consider how you might be able to better retain people? Earlier you said you have positions that – if people are, I think I may have heard, cycling through in a career ladder, from the perspective, I think, of the people of the Province, we really would not want people moving on once we had invested that kind of money in training them when they might move on someplace else if they could be kept. A third of a billion dollars is what is exposed to audit with people you have to pick up and fill the positions again – that is a fair bit of financial exposure for people who are very specialized.

MR. COOPER: Yes, we certainly are looking at retention, recruitment, and training needs. We are going to look at, in our operational plan, the development of a human resource strategy for this section to ensure that we understand how we can better retain people and to look at the factors that are contributing to fairly significant flow-through of staff.

CHAIR: Is there any way to recruit from, or to utilize people from, other areas of government, from the health authorities or whatever, who might be able to be trained more quickly or maybe retain longer; or do you have to start with somebody who is going to be pretty new?

MR. COOPER: I think that is a good question for our ongoing plan development.

CHAIR: Do you face competition from the private sector with your staff? This seems very specialized. In other areas, accounting professionals, it seems like I am starting to get the feeling that we recruit them and train them and get them moving through the system and when they can be really productive for the people, someone else wants to hire them in industry.

MR. COOPER: Private sector competition is not a big dynamic at play here. I think it is more this, in some ways, being an entry-level position in the public service and it is a stepping stone. Beyond those who have retired, the people who I have seen who have moved on have moved on to higher, more responsible positions; because being such a complex area and the learning you do there is quite useful for other roles in the public service.

CHAIR: One of the reasons, I think, for delay or maybe a lower volume of cases earlier was that there was reference to some complex cases. What is a complex case? To me they all sound complex, but that is because I do not know anything about the area anyway. What would a complex case be to you?

MR. COOPER: So a complex case may be one where there is a significant misbilling identified, high recovery amounts, litigious, the engagement of legal counsel. I think that would qualify as complex.

MS JEWER: (Inaudible).

MR. COOPER: Right. Sorry, Michelle just clarified for me that it is also the number of fee codes involved, the scope and magnitude of fee codes that would be involved in (inaudible) –

CHAIR: Earlier there was some questioning about if there was an amount from an earlier

time and you decided not to pursue it. Is that because there would be a possibility of there being like a mutual mistake, the person really did not know what they were doing? Well, they did not understand the procedures properly so it may have been a genuine mistake from a long time ago. Now they have a reasonable case, say, reasonable legal case that they thought they were doing the right thing because of whatever reason.

MR. COOPER: No, the example that I gave was of a circumstance where we applied our policy of a two-year audit window being the recovery and discretion was used, particularly given the fact that the behaviour corrected itself going forward.

CHAIR: Okay.

I would like to go to the Auditor General and his accounting staff to see if they have questions or observations and I promised to go back to Mr. Murphy, and I would really like to conclude before 4:00 p.m. Who would like to go first?

Four is not the magic number, but it is summer hours and nobody wants to insist that we stay longer than that. I am sure we can do it.

MR. PADDON: I do know how to take a cue.

I have no comments.

CHAIR: I did not really mean to be that abrupt.

MR. PADDON: Nor do my staff.

CHAIR: Mr. Murphy may have some questions.

MR. MURPHY: I was just going to say you might be able to take a cue, and 4:00 p.m., I know how to use a barbeque. I think we all get the hint.

I just want to commend the staff on the fine work that you are trying to do. My personal feeling is when I read all the material and I have been going over it now for some time that there is a logistical issue there. When you said over $300 million of the taxpayers' money is being looked after here, I think you are short staffed and I think that you need all the help that you can get here.

I get the feeling sometimes that you feel like you are marginalized a little bit and I do not think that you give yourself the degree of importance that you deserve. I think it is a very important piece of work that you are doing here and I think that there need to be more resources poured into it.

If the Auditor General has found that there are problems as regards some monies that were paid out, I think that there are monies here to be recovered and kept on the taxpayers' behalf, and that is what we have to be the guardians for. Again, I think one particular amount that you talked about, the $17,000, may seem small, but that is just one doctor and we do not know if it was a mistake or whatever, if it was part of a learning curve; but, either way, the other 1,154 doctors that were in the system last year should learn from it. So there is a learning curve there for everybody.

I would impress that you are doing a good job with what you have. The Auditor General has found some things there and now you have an operational plan in place. I just wonder at the same time if there is going to be some difficulty pulling off the operational plan because I do not know if you have enough staff to do all the work that you have intended to in the operational plan. I still have some valid concerns here, I think, with regard to that. Again, I will leave it at that.

Thank you very much for the work that you are doing, and we will see you at the barbeque.

CHAIR: Mr. Cooper, did you or your staff have any observations or questions? We have been asking the questions, but it seems only fair to give you an opportunity if you have any. You certainly do not have to have any.

MR. COOPER: No. Thank you very much, though, for the opportunity.

CHAIR: Thank you for coming.

We need a motion to adopt the minutes from the May 21 meeting.

MR. K. PARSONS: So moved.

CHAIR: So moved.

Do we have a seconder?

MR. CROSS: Seconded.

CHAIR: Seconded by Mr. Cross.

On motion, minutes adopted as circulated.

CHAIR: In that case, we need a motion to adjourn.

MR. K. PARSONS: So moved.

CHAIR: So moved.

Thank you very much.

On motion, the Committee adjourned