Medical Care & Dental Health Plans

Independent Auditor's Report

March 2025

OFFICE OF THE AUDITOR GENERAL
NEWFOUNDLAND AND LABRADOR

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Audit Overview

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NEWFOUNDLAND AND LABRADOR

Objective

To determine whether the Department of Health and Community Services' claims system has controls in place to ensure physician and dentist claims are processed accurately, and whether the department is providing effective oversight of the Medical Care Plan (MCP) and Dental Health Plan.

Audit Period

April 1, 2021 to March 31, 2024

Why this Audit is Important

The Newfoundland and Labrador Medical Care and Provincial Dental Health Plans are publicly administered comprehensive medical and dental insurance plans provided to the province's residents. The Department of Health and Community Services' Audit and Claims Integrity Division is accountable for ensuring public health care funds are distributed appropriately to health care providers for services delivered to the plans' beneficiaries. As such, the division must have well designed and effective systems and controls to process health and dental claims. It must also exercise diligence in its administration of audit processes, including the collection of recoveries, thereby providing public assurance that health care funds are used appropriately.

Conclusions

The findings in this audit indicate that the Department of Health and Community Services is unable to ensure that public health care funds are distributed appropriately to health care providers for services provided to beneficiaries of the Medical Care and Dental Health Plans. Many of the same findings relating to audit and recoveries were noted in our last MCP report from 2014 - over 10 years ago.

MCP has been slow to develop strong control processes, including the prevention of double payments with WorkplaceNL. Controls around manual adult dental reimbursement are still not entirely sufficient to prevent potential fraud, similar to the occurrence between 2015 and 2019. IT system controls are not entirely reliable either; a third of the claims processing rules we looked at either served no purpose or did not work properly. Finally, the age and complexity of MCP's systems contribute to inefficiencies. Systems are old, built on outdated technology, with known issues, and would benefit from significant upgrades. There are no plans to replace them any time in the near future.

We found that the design of the claims audit processes is generally adequate. However, audits took a long time, with the reason for delays being difficult to understand. Moreover, not many audits are being completed by the audit division; at times only one or two a year. Once they are completed, there is very little success in recovering money. There are tools available that could improve the process that are seldom used, reducing overall effectiveness. With low productivity and insignificant recoveries, we question the effectiveness of the current audit function as an oversight measure for the MCP program.

Summary of Recommendations

We recommend that the Department of Health and Community Services:

1. Ensure the various information technology issues identified throughout this audit are addressed, such as the state of their aging systems, general control deficiencies, and the lack of data entry controls.
2. Work with WorkplaceNL to implement a process that would prevent and detect double billing of services.
3. Mitigate the risk of fraud by ensuring that any adult dental program payments made through the manual reimbursement process are approved by management prior to being issued.
4. Ensure their internal audit processes operate in the spirit and intent of their legislation, regulations, and policy.
5. Strengthen oversight processes, including the use of key performance indicators, to ensure that public funds are distributed appropriately to providers for Medical Care and Dental Health Plan services.
6. Implement adequate and timely overpayment collection processes, including the use of recovery tools such as payment interceptions and ministerial orders.

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What We Found

Claims Systems

IT General Controls

- MCP had a strong management control framework and a high level of operating effectiveness of IT general controls around access, segregation of duties, change management, and backup configurations for its claims processing system – meaning the controls around the environment were appropriate.
- We identified certain areas of weakness with respect to the effectiveness of IT general controls. Failure to complete comprehensive annual disaster recovery and business continuity plan testing was the most significant of these issues.

Application Controls

Age of IT Systems

- MCP's systems were dated.
- Updates to the MCP claims processing system were cumbersome given its age.
- There was no formalized plan to replace claims entry, processing, or monitoring systems with more modern applications.

Claims Entry Systems

- The Audit and Claims Integrity Division had limited awareness of data entry controls to ensure the accuracy or completeness of claims.

Claims Processing System

- The process of creating provider profiles for claims processing had a design flaw. The online provider profile registration form was outdated and missing a required sub-specialty field.
- The initial setup of providers in the claims processing system did not operate effectively.
- The process for linking profiles to fee codes during initial setup was properly designed.
- Fee codes added to physician profiles at a later time were not always supported.
- The claims processing system failed to prevent payment to ineligible fee codes in certain circumstances. The system was designed with capability to attach a stop date to a fee code; however there were cases of the system failing to recognize a stop date and claims being paid inappropriately.
- There were gaps in the design of the controls intended to ensure the appropriateness of processed claims.
- Edit and Provider & Fee Rules were not always appropriately designed, and therefore would not operate effectively.
- In one case, we found a rule intended to restrict billing for certain fee codes to particular physicians did not refer to the correct fee codes. This resulted in the inappropriate payment of 528 claims between April 2023 and March 2024, for a total of $11,966. We noted the rule had been in place since 1993, and had not been updated since 1994; meaning similar payments were likely made throughout the preceding 30 year period.
- Edit and Provider & Fee Rule documentation was often inaccurate.
- Patient History Rules were often not designed appropriately, and therefore would not operate effectively.
- Documentation for Patient History Rules was sometimes inaccurate or incomplete.

Claims Monitoring System

- There were issues with the system that monitors the appropriateness of claims billed under MCP, including inadequate details and instruction to physicians when documentation was requested, and administrative burden created by the volume of requests for documentation.
- The Claims Monitoring System was not used to monitor dental claims.

Other Systems and Controls

- The division lacked a process to prevent or detect possible double billings between MCP and the WorkplaceNL workers compensation program. The development of a process had not been completed 10 years after being recommended in our 2014 report.
- We found a deficiency in the design of controls for payments made through the adult dental manual reimbursement process. New controls implemented subsequent to adult dental fraud noted in 2015 to 2019 did not fully mitigate the risks inherent in the manual process used.

Oversight

Monitoring

- The department failed to make significant progress on oversight issues identified in the 2014 Auditor General's report.

Audit Processes

- The division generally had adequate audit processes.
- The division's policies were not updated regularly.
- The division did not have an operational plan to assist it in focusing activities toward achieving identified objectives. It also did not have goals, targets, or key performance indicators for physician or dental audits.
- There were no formal monitoring or quality control processes relating to the administration of MCP audits.
- There was no formal audit selection process, and the division did not use all the tools at its disposal to identify audits.
- In the absence of defined procedures to identify audits, an inadequate number of audits were selected. Audits were initiated on less than 2.6 per cent of fee-for-service providers in 2024, and well under one per cent in 2023 and 2022. Our 2014 report had a similar finding.

Audits

- Audits took a long time to complete. Only 43 per cent of preliminary audits were completed within the 3.5 month benchmark considered reasonable, and only 11 per cent of comprehensive audit assessments finished within the 8.5 month benchmark considered reasonable.
- The eight preliminary audits that exceeded reasonable timeframes took over 1.6 years to complete on average, and three took over three years.
- The 16 comprehensive audits that exceeded reasonable timelines took 4.2 years on average to complete, with the longest requiring almost six years.
- Three comprehensive audits were abandoned during the audit period, with no samples collected and no assessment made on an amount owing.
- Audit results were often not communicated to the Newfoundland and Labrador Medical Association within legislated timelines.
- Our 2014 report also noted that audits took a long time to complete.
- Audits were sometimes delayed by the failure of the Medical Consultants' Committee to meet regularly, which was also noted in our 2014 report.
- During our audit period audits waited for approximately half a year on average before presentation to Medical Consultants' Committee, with the longest being delayed by almost three years.

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Audit Review and Recovery

Alternative Dispute Resolution

- Our 2014 Auditor General's report found the alternative dispute resolution process, which is intended to be completed within 90 days, was taking considerably longer. This is still an issue 10 years later.
- The alternative dispute resolution processes completed during our audit period took an average of 767 days (over 2.1 years); the longest taking 1,383 days (over 3.5 years).
- The 27 files in active alternative dispute resolution at the end of our audit period were, on average, approximately 4.4 years old. The oldest had been ongoing for seven years.
- The division routinely agreed to extensions to the alternative dispute resolution process beyond 90 days, which may not have been permissible under legislation.

Audit Review Board

- The Audit Review Board did not serve a functional purpose during our audit period - there has not been a review board hearing since 1997.

Physician Claims Intervention Program

- The Audit and Claims Integrity Division made very little use of the Physician Claims Intervention Program. Only four physicians were referred to the program throughout our audit period, for an average of 1.3 referrals per year.

Audit Recoveries

- The division collected very little of the balances owing from providers. Across our three-year audit period only $146,598 was collected, representing approximately seven per cent of the balance owing on March 31, 2024.
- No recoveries at all were made in 2023.
- Collections were not completed in a timely manner. For example, the funds recovered across our audit period had been outstanding for an average of approximately five years before being collected.
- Similarly, the balances that remained outstanding were old; more than 3.5 years old on average, with the oldest outstanding for over seven years. These findings were similar to those of our 2014 report.
- The division did not use available tools to collect balances owing from providers. The division did not recommend the use of ministerial orders throughout our audit period.

After reading this report, you may want to ask the following questions of government:

Given its responsibility for oversight of the Audit and Claims Integrity Division, how will the Department of Health and Community Services:

1. Manage the IT systems, the identified control weaknesses, and process inefficiencies?
2. Ensure that enough audits are undertaken to provide confidence that public health care funds are distributed appropriately and potential fraud is detected?
3. Address issues with the collection of overpayments to physicians and dentists, to ensure that funds are consistently recovered on a timely basis?

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Background

The Newfoundland and Labrador Medical Care Plan (MCP) is a publicly administered comprehensive medical insurance plan which was introduced on April 1, 1969. It covers the costs of various services for provincial residents who have met eligibility criteria to register as beneficiaries. MCP operates in accordance with the Medical Care and Hospital Insurance Act, and related legislation and regulations, covering insured medical services provided by physicians. The Act was assented in June 2016.

The Provincial Dental Health Plan consists of three programs governed by memorandum of agreements between the Department of Health and Community Services and the Newfoundland and Labrador Dental Association:

- Surgical Dental Program: covers insured services as defined by the Medical Care and Hospital Insurance Act and Regulations;
- Children's Dental Health Program: provides universal access for eligible dental services for children ages 12 and under, as well as for children 13 to 17 years old whose families are in receipt of Income Support benefits; and
- Adult Dental Program: provides basic services as listed in the Adult Dental Program Schedule. This program is limited to those enrolled under the Foundation Plan of the Newfoundland and Labrador Prescription Drug Program.

Provincial residents must register to become and remain a beneficiary of MCP. Applicants must meet eligibility criteria laid out in the regulations in order to be accepted to the plan, and there are established criteria to ensure regulations are applied consistently and fairly. There are further requirements for the Dental Health Plan, and proof of eligibility is required to receive service. For all insured physician services and services covered under the dental health plan, a valid MCP number is required.

Provincial physicians can receive payments from government through three methods:

- Fee-for-service payment – paid through MCP, based on services provided. Fee-for-service claims and payments are within the scope of this report.
- Alternate payment plans – compensation in a format other than salary or fee-for-service, in return for medical services. Alternate payments plans are not within the scope of this report.
- Salary payments – paid to physicians through Newfoundland and Labrador Health Services, rather than through MCP. Salary payments are not within the scope of this report.

Dentists receive payments from government for fee-for-service claims submitted through all three dental programs.

Within the Department of Health and Community Services, the Audit and Claims Integrity Division is responsible for the overall operation of the Medical Care Plan and Dental Health Plan. The division deals directly with the service delivery and auditing of both plans, ensuring that public health care funds are distributed appropriately to health care providers (physicians and dentists) for services provided to beneficiaries of the MCP and the Dental Health Plan. The division has three sections:

- Public Services: registers beneficiaries and issues MCP cards and is located in St John's and Grand-Falls Windsor.
- Claims Operations: processes and assesses medical and dental claims and is located in Grand-Falls Windsor.
- Medical Audit and Compliance: audits both dental and physician claims and is located in St. John's.

In the administration of provider claims, MCP manages three systems:

1. TeleClaim - a claims entry system;
2. A claims processing system; and
3. Claims Monitoring System.

Approximately $389 million of fee-for-service claims were processed for MCP for 2023-24. Of this amount, $378 million was paid to physicians and $11 million paid to dentists. In the year ended March 31, 2024, 1,466 physicians and 238 dentists received fee-for-service payments from the province.

Our audit period covered April 1, 2021, to March 31, 2024, and included two lines of inquiry. The objective of the audit was to determine whether the Department of Health and Community Services' claims system has controls in place to ensure physician and dentist claims are processed accurately, and whether the department was providing effective oversight of the Medical Care Plan and Dental Health Plan. Four criteria were established to assess these lines of inquiry.

For reference, in January 2014, the Auditor General published a report on the fee-for-service physicians audit process, with a similar scope to objective two of this current report.

Summary of Key Findings

Claims Systems

IT General Controls

- MCP had a strong management control framework and a high level of operating effectiveness of IT general controls around access, segregation of duties, change management, and backup configurations for its claims processing system – meaning the controls around the environment were appropriate.
- We identified certain areas of weakness with respect to the effectiveness of IT general controls.
- Failure to complete comprehensive annual disaster recovery and business continuity plan testing was MCP's most significant IT general control issue - a high risk finding.
- There were instances of MCP staff accounts remaining active, despite personnel being terminated.

Application Controls

Age of IT Systems

- MCP's systems were dated.
- Updates to the MCP claims processing system were cumbersome given its age.
- There was no formalized plan to replace claims entry, processing, or monitoring systems with more modern applications.

Claims Entry Systems

- The Audit and Claims Integrity Division had limited awareness of data entry controls to ensure the accuracy or completeness of claims.

Claims Processing System

- The process of creating provider profiles for claims had a design flaw. The online provider profile registration form was outdated and missing a required sub-specialty field; 12 of 44 registrations reviewed during our testing used the outdated version of the form.
- The initial setup of providers in the claims processing system did not operate effectively; 25 of the 44 provider profiles examined (57 per cent) had missing forms or differences between the forms and system data.
- The process for linking profiles to fee codes during initial setup was properly designed.
- Fee codes added to physician profiles at a later time were not always supported; there was missing documentation for 24 of the 122 fee code additions (20 per cent) we examined. While many of these fee codes were added well before our audit period, they remained active and MCP was unable to provide evidence that they were appropriate.
- The claims processing system failed to prevent payment to ineligible fee codes in certain circumstances. The system was designed with capability to attach a stop date to a fee code; however there were cases of the system failing to recognize a stop date and claims being paid inappropriately.
- There were gaps in the design of the controls intended to ensure the appropriateness of processed claims.
- Edit and Provider & Fee Rules were not always appropriately designed, and therefore would not operate effectively; three of the 35 (nine per cent) we sampled were designed incorrectly.
- In one case, we found a rule intended to restrict billing for certain fee codes to particular physicians did not refer to the correct fee codes. This resulted in the payment of 528 claims between April 2023 and March 2024, for a total of $11,966. We noted the rule had been in place since 1993, and had not been updated since 1994; meaning similar payments were likely made throughout the preceding 30 year period.
- Edit and Provider & Fee Rule documentation was often inaccurate. In eight of 35 samples tested (23 per cent), there were inconsistencies between the rule code and the rule documentation.
- Patient History Rules were often not designed appropriately, and therefore would not operate effectively. Of 38 rules we tested, 11 (29 per cent) did not capture all intended fee codes, potentially allowing inappropriate evaluation of a claim.
- Documentation for Patient History Rules was sometimes inaccurate or incomplete. Issues were noted in documentation for seven of 38 rules tested (18 per cent).

Claims Monitoring System

- There were issues with the system that monitors the appropriateness of claims billed under MCP, including inadequate details and instruction to physicians when documentation was requested, and administrative burden created by the volume of requests for documentation.
- The Claims Monitoring System was not used to monitor dental claims.

Other Systems and Controls

- The division lacked a process to prevent or detect possible double billings between MCP and the WorkplaceNL workers compensation program. The development of a process had not been completed 10 years after being recommended in our 2014 report.
- We found a deficiency in the design of controls for payments made through the adult dental manual reimbursement process.
- New controls implemented subsequent to adult dental fraud noted in 2015 to 2019 did not fully mitigate the risks inherent in the manual process used. Under the process management approved only the initial setup of the beneficiary as a vendor, with no separate approval of payments.

Oversight

Monitoring

- Communication between the Assistant Deputy Minister of the Department of Health and Community Services and the Director of Audit and Claims Integrity at MCP was informal.
- The department failed to make significant progress on oversight issues identified in the 2014 Auditor General's report.

Audit Processes

- The division generally had adequate audit processes.
- The division's policies were not updated regularly.
- The division did not have an operational plan to assist it in focusing activities toward achieving identified objectives. It also did not have goals, targets, or key performance indicators for physician or dental audits.
- There were no formal monitoring or quality control processes relating to the administration of MCP audits.
- There was no formal audit selection process, and the division did not use all the tools at its disposal to identify audits. There was no methodology or guidance relating to how audit selection methods should be used.
- In the absence of defined procedures to identify audits, an inadequate number of audits were selected. Audits were initiated on less than 2.6 per cent of fee-for-service providers in 2024, and well under one per cent in 2023 and 2022. Our 2014 report had a similar finding.

Audits

- Audits took a long time to complete. Only 43 per cent of preliminary audits were completed within the 3.5 month benchmark considered reasonable, and only 11 per cent of comprehensive audit assessments finished within the 8.5 month benchmark considered reasonable.
- The eight preliminary audits that exceeded reasonable timeframes took over 1.6 years to complete on average, and three took over three years.
- The 16 comprehensive audits that exceeded reasonable timelines took 4.2 years on average to complete, with the longest requiring almost six years.
- Three comprehensive audits were abandoned during the audit period, with no samples collected and no assessment made on an amount owing.
- Audit results were often not communicated within legislated timelines. The Newfoundland and Labrador Medical Association was not notified within the required 30 days of the physician in six of the 13 (46 per cent) comprehensive audits where notification was required.
- Our 2014 report also noted that audits took a long time to complete.
- Audits were sometimes delayed by the failure of the Medical Consultants' Committee to meet regularly, which was also noted in our 2014 report.
- The Medical Consultants' Committee did not have a formal Terms of Reference which would state the number of meetings required.
- During our audit period MCP audits waited for approximately half a year on average before presentation to the committee, with the longest being delayed by almost three years. The committee is expected to meet when one or more audits have reached the stage where they are ready for review, and historically has met one to four times a year.

Audit Review and Recovery

Alternative Dispute Resolution

- Our 2014 Auditor General's report found the alternative dispute resolution process, which is intended to be completed within 90 days, was taking considerably longer. This is still an issue 10 years later.
- The alternative dispute resolution processes completed during our audit period took an average of 767 days (over 2.1 years); the longest taking 1,383 days (over 3.5 years).
- The 27 files in active alternative dispute resolution at the end of our audit period were, on average, approximately 4.4 years old. The oldest had been ongoing for seven years.
- The division routinely agreed to extensions to the alternative dispute resolution process beyond 90 days, which may not have been permissible under legislation.

Audit Review Board

- The Audit Review Board did not serve a functional purpose during our audit period - there has not been a review board hearing since 1997.
- The duration of the alternative dispute resolution process may have contributed to the Audit Review Board not being used.

Physician Claims Intervention Program

- The Audit and Claims Integrity Division made very little use of the Physician Claims Intervention Program. The division did not use specific, predefined criteria to determine where the program was appropriate, relying instead on the professional judgment of an analyst. Only four physicians were referred to the program throughout our audit period, for an average of 1.3 referrals per year.

Audit Recoveries

- The division collected very little of the balances owing from providers. Across our three-year audit period only $146,598 was collected, representing approximately seven per cent of the balance owing on March 31, 2024.
- No recoveries at all were made in 2023.
- Collections were not completed in a timely manner. For example, the funds recovered across our audit period had been outstanding for an average of approximately five years before being collected.
- Balances that remained outstanding were old; more than 3.5 years old on average, with the oldest outstanding for over seven years. These findings were similar to those of our 2014 report.
- The division did not use available tools to collect balances owing from providers. The division did not recommend the use of Ministerial Orders throughout our audit period.

Findings - Claims System

Objective 1

To determine whether the Department of Health and Community Services' claims system has controls in place to ensure physician and dentist claims are processed accurately.

Criteria 1 — The department's claims system has appropriately designed system controls, including general information technology controls.

Criteria 2 — The department's claims system's controls are operating effectively.

What We Expected

We expected MCP to have strong information technology (IT) general controls and effective processes to manage access, segregation of duties, change management, and systems and data backup configuration. We also expected modern claims entry, processing, and monitoring systems, that were appropriately designed with well documented controls. We expected these controls to operate effectively to ensure the accuracy of claims, to prevent the payment of improper claims, and to monitor the ongoing appropriateness of claims submitted by providers over time. Finally, we expected robust controls for any processes that operate outside of the normal fee-for-service claims systems, to prevent inappropriate payments, and to detect such payments if they occur.

What We Learned

IT General Controls

IT general controls relate to an environment that supports IT applications. The appropriateness and effectiveness of these controls impacts all of an organization's IT applications. We engaged the services of a professional firm to evaluate the effectiveness of the IT general controls of the MCP claims processing system.

We found MCP had a strong management control framework and a high level of operating effectiveness of IT general controls around access, segregation of duties, change management, and backup configurations for its claims processing system – meaning, the controls around the environment were appropriate. However, **we identified certain areas of weakness with respect to the effectiveness of controls.**

We found a failure to complete comprehensive annual disaster recovery and business continuity plan testing was MCP's most significant IT general control issue - a high risk finding. A business continuity plan defines steps and guidance in the case of an IT interruption, such as a catastrophic event, cyberattack, or other unforeseeable circumstances. A disaster recovery plan contains procedures for restoring systems and data and minimizing loss of information and downtime. Disaster recovery testing and business continuity planning are particularly important for MCP given the age of its system, as discussed in the sections that follow.

We found there were instances of MCP staff accounts remaining active, despite personnel being terminated. While these accounts remained active, users were disabled in Active Directory, restricting their access to the network.

We found a comprehensive user access review of MCP's claims processing system had not been performed. User access review functions as a control to verify that only legitimate users have access to applications or infrastructure. It is recommended that reviews should be performed at least annually.

We found documentation of error resolutions within the MCP claims processing system was not always maintained. This could lead to an increased likelihood of errors remaining unresolved and data not being processed correctly.

Application Controls

Application controls are manual or automated controls that apply to the processing of transactions by a specific IT application. They can be preventative or detective and are designed to ensure the integrity of records. We found some deficiencies existed across these systems.

Age of IT Systems

We found MCP's systems were dated. With respect to TeleClaim, MCP's claims entry system, version 6.3 was in use as of March 31, 2024. We found that version 6 of the system was at least 17 years old at the end of our audit period with the update to release 6.3 occurring over seven years ago.

We found updates to the MCP claims processing system were cumbersome given its age. The system was first implemented between 1990 and 1992 and was written in a program language that has been in use for over 55 years. Updates to this technology are time consuming, with the addition of a single fee code taking six to eight weeks. Such delays could impact the ability of providers to bill for services, and incentivize the use of alternative, inappropriate fee codes.

MCP monitors the integrity of claims billed by physicians through its Claims Monitoring System. We found this program was fully implemented approximately 16 years ago in 2008.

We found there was no formalized plan to replace TeleClaim, the MCP claims processing system, or the Claims Monitoring System with more modern applications.

Claims Entry Systems

Fee-for-service claims can be entered by providers using three types of systems:

- TeleClaim - developed and managed by MCP with support from the Office of the Chief Information Officer;
- Electronic Medical Records - jointly governed by the Department of Health and Community Services, the Newfoundland and Labrador Medical Association, and Newfoundland and Labrador Health Services, but not managed by MCP; or
- Various other third-party systems - developed and operated independently without management, guidance or direction from MCP. On its website the Department of Health and Community Services lists three "known" third party systems, with the explicit indication that none are endorsed.

We found the Audit and Claims Integrity Division had limited awareness of data entry controls to ensure the accuracy or completeness of claims. Specifically:

- The division indicated that there were limited data entry controls in the TeleClaim system, while explicitly noting it was the responsibility of the provider to ensure claims information was accurate.
- For Electronic Medical Records, which operated outside of its direction, the division indicated that Newfoundland and Labrador Health Services was responsible for controls.
- The controls for third-party systems, which were developed without guidance or direction from the division, were at the discretion of the vendor.

Claims Processing System

Provider Profiles

We found the process of creating provider profiles for claims processing had a design flaw. To initiate setup, the provider completed a registration form with the necessary information. **We found the online registration form was outdated and missing a required sub-specialty field. We also found 12 of 44 registrations reviewed during our testing used the outdated version of the form.** Given that sub-specialty was not provided on the outdated form, there may have been increased risk of providers not being granted access to appropriate fee codes. As of December 2024, this online form had still not been updated to include the sub-specialty field.

We also found the initial setup of providers in the claims processing system did not operate effectively. We tested the accuracy of profiles against registration forms completed by providers. **We found 25 of the 44 provider profiles examined (57 per cent) had missing forms or differences between the forms and system data.** When differences existed there was no documentation of how discrepancies were resolved.

We found the process for linking profiles to fee codes during the initial setup was properly designed. However, we found fee codes added to physician profiles at a later time were not always supported. In certain situations, a physician may have needed access to a fee code that was not attached to their profile. When this happened, there was an informal process for staff to receive support from the appropriate authority. We examined 44 physician profiles, of which 24 had fee codes added to their profile beyond those normally associated with their specialty. Collectively, these 24 providers had 122 additional fee codes. **We found there was missing documentation for 24 of these 122 fee code additions (20 per cent). While many of these fee codes were added well before our audit period, they remained active and MCP was unable to provide evidence that they were appropriate.**

We also found the claims processing system failed to prevent payment to ineligible fee codes in certain circumstances. The system was designed with capability to attach a stop date to a fee code; however, we found it did not operate effectively. There were cases of the system failing to recognize a stop date and claims being paid inappropriately. As a result, the division no longer uses stop dates, opting to remove fee codes instead. This decision increased the risk of fee codes not being removed as intended and inappropriate payments being made.

Claims Processing Rules

We found gaps in the design of the controls intended to ensure the appropriateness of processed claims. The automated fee-for-service claims process evaluates provider claims through processing rules. These rules check data submitted by providers to ensure completeness and accuracy and include Edit Rules, Provider & Fee Rules, and Patient History Rules.

Edit and Provider & Fee Rules

We found Edit and Provider & Fee Rules were not always designed appropriately, and therefore would not operate effectively. Edit and Provider & Fee Rules control the quality of data in the claims processing system, with Edit Rules detecting errors, omissions, or invalid data, and Provider & Fee Rules reviewing for further issues with provider information or fee codes. We tested a sample of 35 rules, representing 19 per cent of the Edit and Provider & Fee Rules in the system. **We found three of the 35 (nine per cent) were designed incorrectly.**

In one case, we found a rule intended to restrict billing for certain fee codes to particular physicians did not refer to the correct fee codes. This resulted in the payment of 528 claims between April 2023 and March 2024, for a total of $11,966. Further, we noted the rule had been in place since 1993, and had not been updated since 1994; meaning similar payments were likely made throughout the preceding 30 year period. In response to the finding, MCP management provided documentation indicating that the rule had not been in use since 1994. This was inconsistent with a version of the same document that had previously been provided. It was also noted that rule's expiry date field was blank in the claims processing system.

In another instance we found a rule that checked for appropriate preapproval of claims unintentionally omitted approximately 100 fee codes; this could have resulted in claims being paid inappropriately. We also found seven of the 35 Edit and Provider & Fee Rules tested (20 per cent) could never be triggered, adding unnecessary complexity to the system.

Finally, we found Edit and Provider & Fee Rule documentation was often inaccurate. In eight of 35 samples tested (23 per cent), there were inconsistencies between the rule code and the rule documentation. In all eight, the rules achieved desired results, but documentation of intended functionality was inaccurate. Accurate documentation is particularly important given the complexity of managing the system's 704 rules, coded in a programming language that is 55 years old.

Patient History Rules

We found Patient History Rules were often inappropriately designed, and therefore would not operate effectively. These rules are intended to ensure claims are not paid for services more often than permitted within a specified time period under MCP's Medical Payment Schedule, or where ineligible based on a patient's history. We tested the conditions related to a sample of 38 rules, representing seven per cent of the total Patient History Rules. **We found, for 11 of 38 rules (29 per cent), not all intended fee codes were captured, potentially allowing inappropriate evaluation of a claim.** In one case, there was a rule intended to prohibit physicians from certain types of billing. As designed, 185 intended billing codes were not covered by this rule, which could have resulted in claims being paid inappropriately. We also found two cases of rules which could never be triggered, unnecessarily adding to the complexity of the system.

Finally, we found documentation for Patient History Rules was sometimes inaccurate or incomplete. Issues were noted in documentation for seven of 38 rules tested (18 per cent). In four cases, the documentation of the fee schedule was inaccurate or incomplete. The remaining three were designed to enable the provider to bypass the rule under certain circumstances, but the bypass was not covered in the rule's documentation.

Claims Monitoring System

We found issues with the system that monitors the appropriateness of claims billed under MCP. The Claims Monitoring System was designed to ensure physicians are aware of requirements to substantiate billings. It identifies claims for verification and is used as an indicator for potential audits. Payments to physicians may be withheld through the Claims Monitoring System while verification is ongoing. **Issues were noted with the system providing inadequate details and instruction to physicians when documentation was requested, as well as with the administrative burden created by the volume of requests for documentation.** During our audit period, the Claims Monitoring System generated approximately 39,000 requests for information from physicians, equaling approximately nine requests per physician per year. **We found the system was not used to monitor dental claims.**

Other Claims Systems and Controls

WorkplaceNL Workers Compensation Payments

We found the division lacked a process to prevent or detect possible double billings between MCP and the WorkplaceNL workers compensation program. In our 2014 report, the Auditor General recommended the division "work with the WHSCC to implement a mechanism that would prevent and detect the double billing of services." **We found that a process had not been implemented, and was still under development 10 years after the 2014 report.**

The division investigated five possible cases of MCP and WorkplaceNL double billings in 2024 (which happened after the start of this audit). One of those investigations progressed to a comprehensive audit, due to potential double payments. Prior to investigating these five instances, no other potential double billings had been reviewed since the 2014 report release.

Adult Dental Manual Reimbursement Process

We found a deficiency in the design of controls for payments made through the adult dental manual reimbursement process. In contrast to the Medical Care and Dental Health Plans in general, in a small number of specific cases costs are reimbursed to beneficiaries directly through a manual process, rather than to fee-for-service providers through the normal automated process. Between 2015 and 2019, a divisional employee defrauded the Dental Health Plan of more than $500,000 by opening numerous bank accounts and fabricating claims.

While new controls were implemented subsequent to the fraud event, they did not fully mitigate the risks inherent in a manual process. We found that, while management approved the initial setup of the beneficiary as a vendor, there was no separate approval of payments. In two of the 36 samples we tested, new vendor setup was not required, and there was no management approval prior to payment being made.

Why It Matters

Deficiencies in IT general controls increase risks across systems. In the absence of disaster recovery testing and business continuity planning, MCP may be unprepared to recover from a catastrophic event such as a cyberattack. Moreover, weaknesses in user access review and the deactivation of former employees' access increase the risk of sensitive systems or information being accessed inappropriately.

Ineffective controls in claims entry, processing, and monitoring systems create the risk of inappropriate use of healthcare funding, or conversely, of physicians and dentists not being paid for the services they provide.

Outdated and poorly documented systems compound these risks, calling the vulnerability of systems into question, making improvements more cumbersome and time consuming, and increasing the likelihood that overly complex systems will not operate as intended. Furthermore, outdated systems with inadequate controls to prevent inaccurate claims could also impact service providers, creating inefficiencies and unnecessary administrative burden.

Findings - Oversight

Objective 2	**To determine whether the Department of Health and Community Services is providing effective oversight of the Medical Care Plan and Dental Health Plan.**
Criteria 1	The department monitors the operations of the Medical Care Plan and the Dental Health Plan.
Criteria 2	The department audits the claims related to the Medical Care Plan and Dental Health Plan.

What We Expected

We expected the Department of Health and Community Services to effectively manage and monitor the operations of the Medical Care Plan and the Dental Health Plan. We expected policies and procedures to be kept current, documenting when and how tools and processes should be used.

We expected the Audit and Claims Integrity Division to employ the tools at its disposal to identify appropriate audits, ensuring that a sufficient number were undertaken to provide value. We further expected the use of key performance indicators to measure and track the progress of audits, guaranteeing their timely completion.

Finally, we expected the diligent and timely collection of funds owing from audits. We expected that the full range of tools and processes available would be leveraged to ensure the efficient completion of audits and the collection of balances owing.

What We Learned

Monitoring

We found communication between the Assistant Deputy Minister at the Department of Health and Community Services and the Director of Audit and Claims Integrity at MCP was informal. Within the department, the Audit and Claims Integrity Division is responsible for the overall operation of the Medical and Dental Care Plans. We inquired about meetings and communication between them and were informed communication occurred on an almost daily basis, but no meeting minutes were kept.

We also found the department failed to make significant progress on oversight issues identified in the 2014 Auditor General's report. The 2014 report identified the absence of an operational plan and a lack of performance measures specific to the fee-for-service audit function. There are still concerns in these areas ten years after the publication of the 2014 report, as discussed in the following sections.

Audit Processes

Policies, Procedures, and Processes

We found the division generally had adequate audit processes. The processes were defined within the Physician's and Dental Information Manuals. **However we found the division's policies were not updated regularly.** The manuals were last updated in 2011 and 2013 By comparison, the new Medical Care and Hospital Insurance Act, which governs the MCP program, was assented to in 2016, and updated in 2018, 2020, and 2022.

We found the division did not have an operational plan to assist it in focusing activities toward achieving identified objectives. We also found the division did not have goals, targets, or key performance indicators for physician or dental audits. In the absence of such benchmarks, concerns were noted with the number of audits completed, how long they took, and with the collection of balances owing. For example, only three comprehensive audits were started between April 1, 2021 and March 31, 2023. Similarly, no dental audits were completed throughout our three-year audit period.

We found there were no formal monitoring or quality control processes relating to the administration of MCP audits. Without formal quality control, the division lacked assurance that audits were conducted according to policies and procedures.

Audit Selection

We found there was no formal audit selection process. The division advised that an audit can be selected based on one or more of the following indicators:

- Physician practice profiles – reports that compare service patterns of physicians (not used for dental audit identification due to the small volume of claims);
- Targeted fee codes – audits initiated when there appears to be widespread incorrect billing;
- Beneficiary utilization audits – investigation resulting from a beneficiary, a provincial resident receiving insured medical services, who is flagged due to high levels of utilization (not used for dental audit identification as few beneficiaries meet the criteria for MCP insurable dental services);
- Beneficiary verification audits – discrepancies may be investigated from requests for confirmation of services from beneficiaries;
- Claims Monitoring System – audits may be undertaken if errors are noted in claims randomly selected by the automated claims monitoring system; and
- Complaints/voluntary information – complaints received regarding billings of a particular provider.

We found the division did not use all the tools at its disposal to identify audits. Of the 32 audits completed between April 1, 2021, and March 31, 2024, our review noted that:

- 14 of the 32 (44 per cent) used physician practice profiles;
- 18 of the 32 (56 per cent) used targeted fee codes;
- None used beneficiary utilization audits;
- None used beneficiary verification audits;
- Nine of the 32 (28 per cent) used the Claims Monitoring System; and
- Two of the 32 (six per cent) used complaints or voluntary information.

Moreover, **we found there was no methodology or guidance relating to how these selection methods should be used.** Division officials indicated that professional judgement by individual analysts was used to select audits.

In the absence of defined procedures to identify audits, we found an inadequate number of audits was selected. Based on the current divisional structure, up to six people may be assigned to select and conduct audits. A total of 47 audits began over our three-year audit period. Of these, 44 started in fiscal 2024, 35 of which began subsequent to the initiation of our audit. **We found audits were initiated on less than 2.6 per cent of fee-for-service providers in 2024, and well under one per cent in 2023 and 2022.**

We also noted our 2014 report had a similar finding, highlighting an inadequate number of audits. This continues to be an issue 10 years later, as illustrated in Table 1. Across these 10 years there was an average of 5.1 million fee-for-service claims totalling $332.3 million annually.

Table 1: Audits Started in Relation to Providers

Fiscal Year	Audits Started	Number of Providers	Percentage of Providers Audited
2014-15	38	1,593	2.39%
2015-16	34	1,597	2.13%
2016-17	43	1,613	2.67%
2017-18	41	1,647	2.49%
2018-19	5	1,696	0.29%
2019-20	9	1,718	0.52%
2020-21	9	1,641	0.54%
2021-22	1	1,693	0.06%
2022-23	2	1,647	0.12%
2023-24 Before Audit [1]	9	1,704	0.53%
2023-24 During Audit	35		2.05%

Source: Prepared by the Office of the Auditor General based on information provided by MCP, unaudited.
1. Audit Examination started December 1, 2023.

Audits

The division conducts two types of audits: preliminary and comprehensive. For preliminary audits, a small random sample of claims is selected for review; where the review has no or insignificant findings, the audit is closed. A comprehensive audit may result from a preliminary audit, or from other audit indicators. Comprehensive audits normally review two years of activity, with a sample size based on a statistical formula.

Division officials indicated that a timeframe of approximately 3.5 months was reasonable for completion of a preliminary audit, and 8.5 months for a comprehensive audit assessment. **We found 43 per cent of preliminary audits were completed within 3.5 months, and 11 per cent of comprehensive audit assessments finished within 8.5 months. In short, we found audits took a long time to complete.**

Table 2: Duration of Audits

Type of Audit	Completion Target	Audits Completed	# Completed on Target	% Completed on Target
Preliminary Audits	3.5 months	14	6	43%
Comprehensive Audits	8.5 months	18	2	11%

Source: Prepared by the Office of the Auditor General based on information provided by MCP and applicable to our audit period

We found the eight preliminary audits that exceeded reasonable timeframes took over 1.6 years to complete on average, and three took over three years. The 16 comprehensive audits that exceeded reasonable timelines took 4.2 years on average to complete, with the longest requiring almost six years.

We found three comprehensive audits were abandoned during the audit period, with no samples collected and no assessment made on an amount owing. One of these audits was open for four years, and was abandoned when the division was notified that the physician was no longer a member of the College of Physicians and Surgeons of Newfoundland and Labrador. For the other two, staff failed to request samples within three years of audit initiation, and the audits were subsequently terminated due to their age.

We also found audit results were often not communicated within legislated timelines. The Medical Care and Hospital Insurance Act states that the Medical/Dental Association shall be notified of audit findings within 30 days of the provider being notified. **We found the Newfoundland and Labrador Medical Association was not notified within 30 days of the physician in six of 13 (46 per cent) comprehensive audits where notification was required.**

Our 2014 report also noted that audits took a long time to complete.

Medical Consultants' and Dental Monitoring Committees

We found audits were sometimes delayed by the failure of the Medical Consultants' Committee to meet regularly, which was also noted in our 2014 report. The Medical Consultants' Committee is responsible for reviewing claims referred by MCP as part of the comprehensive audit process and making recommendations where guidance is required. It was established pursuant to legislation.

Table 3: Medical Consultants' Meetings by Fiscal Year

	2022	2023	2024
# of Sessions (in days)	0	6	2
# of Agendas Covered	0	2	2
# of Audits Reviewed	0	10	4

Source: Prepared by the Office of the Auditor General based on information provided by MCP.

We found the Medical Consultants' Committee did not have a formal Terms of Reference which would state the number of meetings required. We found only four meeting agendas of the committee were documented over our three-year audit period, with certain agendas requiring multiple sessions. The first meeting during our audit period was the first to occur in 21 months. In another instance, 13 months elapsed between meetings during our audit period. **We found MCP audits waited for approximately half a year on average before presentation to the Medical Consultants' Committee, with the longest being delayed by almost three years. The committee is expected to meet when one or more audits have reached the stage where they are ready for review, and historically has met one to four times a year.**

We found the Dental Monitoring Committee met quarterly, as required under its Terms of Reference. The Dental Monitoring Committee has the mandate to assess and make recommendations regarding cases of dentist inappropriate billing. No dental comprehensive audits were undertaken throughout our three-year audit period.

Audit Review and Recoveries

Alternative Dispute Resolution

In our 2014 Auditor General's report, we found the alternative dispute resolution process, which is intended to be completed within 90 days, was taking considerably longer. We found this is still an issue ten years later.

Where requested by a provider, alternative dispute resolution can be used following a comprehensive audit assessment, for resolving issues between the provider and the division. There is no direct cost associated with the process because staff from government departments represent the Crown. The process has a maximum 90-day time limit. After 90 days, if a mutual agreement has not been reached, audit conclusions and recovery amounts stand, and the file proceeds to recovery or a hearing before the Audit Review Board. Alternative dispute resolution was requested for 13 of the 19 comprehensive audit recoveries (68 per cent) completed during our audit period. Alternative dispute resolution processes that were completed between April 1, 2021, and March 31, 2024 resulted in a total reduction of approximately $20,000 (11 per cent) to balances owing.

We found the alternative dispute resolution processes completed during our audit period took an average of 767 days (over 2.1 years); the longest taking 1,383 days (over 3.5 years), significantly exceeding the 90-day time limit. We found the 27 files in active alternative dispute resolution at the end of our audit period were, on average, approximately 4.4 years old. The oldest had been ongoing for seven years. These ongoing processes had resulted in a total reduction of approximately $92,000 (four per cent) to balances owing to that date. We found 26 of these files still had not reached conclusion as of December 2024.

In the management of these active files, **we found the division routinely agreed to extensions to the alternative dispute resolution process beyond 90 days, which may not have been permissible under legislation.** Extensions were authorized under section 26.7 of the Medical Care and Hospital Insurance Act. However, section 26 of the Act specifically covers requests for "a review by a review board of the findings of an audit," with no mention of alternative dispute resolution.

Audit Review Board

We found the Audit Review Board did not serve a functional purpose during our audit period - there has not been a review board hearing since 1997. The Audit Review Board is defined in the Medical Care and Hospital Insurance Act. Providers have the option to make a written representation of their position and request a hearing before the board. We found an initial request for an Audit Review Board to be used if necessary was noted in 32 of the audit files reviewed but none occurred throughout our audit period.

We found the duration of the alternative dispute resolution process may have contributed to the Audit Review Board not being used. As previously noted, active alternative dispute resolution processes were, on average, 4.4 years old at the end of our audit period. Given the provider would not be expected to remit payment prior to the resolution of this process, there may have been limited incentive for the provider to conclude alternative dispute resolution and proceed to an Audit Review Board.

Physician Claims Intervention Program

We found the Audit and Claims Integrity Division made very little use of the Physician Claims Intervention Program. This program is designed to prevent incorrect claims payments. Providers with questionable billing patterns or practices are identified and their claims for selected services are rejected, until submitted documentation is reviewed and approved by the division. Under normal circumstances, when the program is not used, inappropriate payments could be made, and not recovered unless identified and pursued by the division.

We found the division did not use specific, predefined criteria to determine where the Physician Claims Intervention Program was appropriate, relying instead on the professional judgment of an analyst. In the absence of specific, predefined criteria, **we found the division referred only four physicians to the program throughout our audit period, for an average of 1.3 referrals per year.** This average represents less than one tenth of one percent of the 1,466 active fee-for-service physicians in the fiscal year 2024. No dentists were referred to this program during the audit period.

In our 2014 report, we noted that, while referrals to the program were the decision of the manager of the division, they were guided by the following defined criteria:

- where physicians were undergoing a comprehensive audit,
- where audit recovery was made, or
- where documentation requirements were inconsistent with the MCP Payment Schedule.

During our audit period, from April 1, 2021, to March 31, 2024, 19 comprehensive audit recoveries were completed and 34 audit recoveries were outstanding. As mentioned, only four cases were referred to the Physician Claims Intervention Program during this time.

Audit Recoveries

We found the division collected very little of the balances owing from providers. Across our three-year audit period only $146,598 was collected, representing approximately seven per cent of the balance owing on March 31, 2024. We found no recoveries at all were made in 2023.

Table 4: Audit Recoveries and Accounts Receivable by Fiscal Year

	2022	2023	2024
Audit recoveries	$42,111	$0	$104,487
Recoveries as a % of Total Fee-for-Service Payments	0.0126%	0%	0.027%
Accounts Receivable balance net of allowances	$2,046,291	$2,046,291	$2,215,584
% of balance recovered	2%	0%	5%

Source: Prepared by the Office of the Auditor General based on information provided by MCP, unaudited

We also found collections were not completed in a timely manner. For example, the funds recovered across our audit period had been outstanding for an average of approximately five years before being collected. The oldest was outstanding for almost eight years before being collected and 13 of 16 (81 per cent) payments collected had been outstanding for approximately three years or more.

Similarly, we found the balances that remained outstanding were old. There were 34 audits on the accounts receivable listing at the end of our audit period, totalling approximately $2.2 million. **These audits were more than 3.5 years old on average, with the oldest outstanding for over seven years. We found these findings were similar to those of our 2014 report,** which concluded that assessed amounts were not collected on a timely basis.

Table 5: Age of Balances Owing to MCP
As at March 31, 2024

Assessment Date	Amount to be Recovered	Time Outstanding
March 2017	$430,905	7 years
June 2017	$101,666	6 years, 9 months
July 2017	$48,130	6 years, 8 months
August 2017	$243,528	6 years, 7 months
Oct 2017	$20,664	6 years, 5 months
Dec 2017	$260,862	6 years 3 months
Feb 2018	$54,833	6 years, 1 month
Sept 2018	$259,624	5 years, 6 months
June 2019	$25,434	4 years, 9 months
Oct 2019	$184,636	4 years, 5 months
Nov 2019	$16,270	4 years, 4 months
Dec 2019	$99,632	4 years, 3 months
Jan 2021	$92,457	3 years, 2 months
Oct 2023	$94,454	5 months
Nov 2023	$180,444	4 months
Jan 2024	$60,121	2 months
Feb 2024	$6,832	1 month
March 2024	$35,091	0 months

Source: Prepared by the Office of the Auditor General based on information provided by MCP.

We found the division did not use available tools to collect balances owing from providers. In the case of delinquent collections, the division may recommend that the Minister of the Department of Health and Community Services issue a ministerial order, which could include:

- Deducting from future amounts payable;
- Imposing a penalty of up to ten per cent of the balance owing;
- Ordering the provider to pay part or all of the cost of the audit or the audit review board hearing; and
- Barring the provider from MCP billing.

We found the division did not recommend the use of ministerial orders throughout our audit period.

Why It Matters

The Department of Health and Community Services is ultimately responsible for the delivery of the Medical Care Plan and Dental Health Plan through its oversight of the Audit and Claims Integrity Division. When the department and the division fail to develop or maintain consistent processes, there is a risk of work not being completed to a reliable standard.

In the absence of direction around how audits should be identified, there may be overreliance on employees' personal judgment, and a risk that audits will not consistently be undertaken when necessary. Without standards and key performance indicators, the number and timeliness of audits completed may suffer. This can result in missed opportunities to identify overpayments made to providers and to prevent errors before they occur. Furthermore, while audits take years to complete, overpayments may remain outstanding.

It is important that balances owing from the audit process are collected efficiently, ensuring that health care funding is used as intended, and stale balances do not become uncollectible. When receivables remain outstanding for extended periods of time, while tools such as the Physician Claims Intervention Program and ministerial orders are not leveraged, the effectiveness and value of the audit process are called into question.

Conclusions

The findings in this audit indicate that the Department of Health and Community Services is unable to ensure that public health care funds are distributed appropriately to health care providers for services provided to beneficiaries of the Medical Care and Dental Health Plans.

Many of the same findings relating to audit and collections were noted in our last MCP report from 2014 - over 10 years ago.

MCP has been slow to develop strong control processes, including the prevention of double payments with WorkplaceNL. Controls around manual adult dental reimbursement are still not entirely sufficient to prevent potential fraud, similar to the occurrence between 2015 and 2019. IT system controls are not entirely reliable either; a third of the claims processing rules we looked at either served no purpose or did not work properly. Finally, the age and complexity of MCP's systems contribute to inefficiencies. These issues have a direct impact on service providers, creating administrative burden and making it difficult to submit accurate claims in the first place. Systems are old, built on outdated technology, with known issues and would benefit from significant upgrades. There are no plans to replace them any time in the near future.

We found that the design of the claims audit processes is generally adequate. However, audits took a long time, with the reason for delays being difficult to understand. Moreover, not many audits are being completed by the audit division; at times only one or two a year. Once they are completed, there is very little success in recovering money. Throughout our audit period of April 1, 2021 to March 31, 2024, annual recoveries never exceeded five per cent of balances owing in a year, and no money at all was recovered from April 2022 to March 2023.

There are tools available that could improve the process that are seldom used, reducing overall effectiveness. Specifically, the Physician Claims Intervention Program is rarely used to prevent inappropriate payment of claims; ministerial orders are not used to enforce recoveries; and the Audit Review Board, intended to help in dispute resolution, last met in 1997. With low productivity and insignificant recoveries, we question the effectiveness of the current audit function as an oversight measure for the MCP program.

Recommendations

Recommendation 1

The Department of Health and Community Services should ensure the various information technology issues identified throughout this audit are addressed, such as the state of their aging systems, general control deficiencies, and the lack of data entry controls.

Response:
The Department of Health and Community Services accepts this recommendation

Recommendation 2

The Department of Health and Community Services should work with WorkplaceNL to implement a process that would prevent and detect double billing of services.

Response:
The Department of Health and Community Services accepts this recommendation.

Recommendation 3

The Department of Health and Community Services should mitigate the risk of fraud by ensuring that any adult dental program payments made through the manual reimbursement process are approved by management prior to being issued.

Response:
The Department of Health and Community Services accepts this recommendation.

Recommendation 4

The Department of Health and Community Services should ensure their internal audit processes operate in the spirit and intent of their legislation, regulations, and policy.

Response:
The Department of Health and Community Services accepts this recommendation.

Recommendation 5

The Department of Health and Community Services should strengthen oversight processes, including the use of key performance indicators, to ensure that public funds are distributed appropriately to providers for medical care and dental health plan services.

Response:
The Department of Health and Community Services accepts this recommendation.

Recommendation 6

The Department of Health and Community Services should implement adequate and timely overpayment collection processes, including the use of recovery tools such as payment interceptions and ministerial orders.

Response:
The Department of Health and Community Services accepts this recommendation.

Appendix - About This Audit

Why this Audit is Important

The Newfoundland and Labrador Medical Care Plan and Provincial Dental Health Plan are publicly administered comprehensive plans of public medical and dental insurance, provided to residents of the province. The Audit and Claims Integrity Division, within the Department of Health and Community Services, is accountable for ensuring that public health care funds are distributed appropriately to health care providers for services delivered to beneficiaries of the plans. As such, the division must have well designed and effective systems and controls to process health and dental claims. It must also exercise diligence in its administration of audit processes, including the collection of recoveries, thereby providing the public with assurance of the appropriate use of health care funds.

Objective

The objectives of our audit were to determine:

1. Whether the Department of Health and Community Services' claims system has controls in place to ensure physician and dentist claims are processed accurately; and
2. Whether the Department of Health and Community Services is providing effective oversight of the Medical Care Plan and Dental Health Plan.

Criteria

Audit criteria were developed based on discussions with MCP management, review of relevant documentation, legislation, policies and procedures, and literature reviews, including reports of other legislative auditors. The Office of the Auditor General defined four criteria regarding the objectives, which senior management of the Department of Health and Community Services accepted as suitable.

The Office of the Auditor General assessed whether the Department of Health and Community Services' claim system had controls in place to ensure physician and dentist claims are processed accurately against the following criteria:

1. The department's claims system has appropriately designed system controls, including general information technology controls; and
2. The department's claims system's controls are operating effectively.

The Office of the Auditor General assessed whether the Department of Health and Community Services is providing effective oversight of the Medical Care Plan and Dental Health Plan against the following criteria:

1. The department monitors the operation of the Medical Care Plan and the Dental Health Plan; and
2. The department audits the claims related to the Medical Care Plan and Dental Health Plan.

Scope and Approach

Our audit began in December 2023 and covered the period from April 1, 2021, to March 31, 2024. The focus was on MCP's IT general controls and application controls, as well as monitoring of the plans, and the audit process for physician and dental claims.

The audit focused on the IT general control framework of the MCP claims processing system, including access control, segregation of duties, change management, and backup configurations. It further examined the specific applications for claims entry, processing, and monitoring, with particular attention on the design and operation of claims processing controls. Manual controls for the WorkplaceNL Workers Compensation program and the Adult Dental program were also reviewed.

With respect to oversight, the audit evaluated the effectiveness and efficiency of the claims auditing and collections processes. It also reviewed how the Department of Health and Community Services monitors the operation of the MCP Audit and Claims Integrity Division.

The Newfoundland and Labrador Drug Prescription Plan and the remuneration of salaried physicians were excluded from this audit. The processing of approved payments by the Department of Finance was also excluded.

Audit Standards

This independent assurance report was prepared by the Office of the Auditor General of Newfoundland and Labrador after auditing the Department of Health and Community Services' Medical Care and Dental Health Plans through our audit objective and criteria.

This audit was performed to a reasonable level of assurance with the Canadian Standard on Assurance Engagements 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada and under the authority of the Auditor General Act, 2021.

This Office applies the Canadian Standard on Quality Management. This standard requires our Office to design, implement, and operate a system of quality management, including policies and procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of the Association of Chartered Professional Accountants of Newfoundland and Labrador.

Management Representations

The Deputy Minister of the Department of Health and Community Services confirmed that senior management had provided the Office of the Auditor General with all the information they were aware of that had been requested or that could significantly affect the findings or conclusions of the audit report on behalf of the Department of Health and Community Services.

Use of Expert

During this audit, the Office of the Auditor General used the services of a consultant with expertise in system controls. Specifically, this consultant was engaged to test IT general controls.

Date Conclusion Reached

We obtained sufficient and appropriate audit evidence on which to base our conclusions on March 12, 2025 in St. John's, Newfoundland and Labrador.

DENISE HANRAHAN, CPA, MBA, ICD.D
Auditor General

About Us

Vision
Promoting positive change and accountability in the public sector through impactful audits.

Mission
To promote accountability in government's management and use of public resources and encourage positive change in its delivery of programs and services.

Values
Above all else, the Office of the Auditor General must have independence, credibility and integrity. These are essential to everything we do; and critical to our success. The Office of the Auditor General complies with professional and office standards to produce relevant and reliable audit reports. The Office of the Auditor General's independence of government, in fact, and in appearance, provides objective conclusions, opinions and recommendations on the operations of government and crown agencies. Our staff work in a professional and ethical manner, ensuring respect, objectivity, trust, honesty and fairness.

Audit Team
The Auditor General and the Deputy Auditor General wish to thank the diligent audit team who performed their work with independence, credibility, and integrity:

Lindy Stanley, CPA - Assistant Auditor General
Brad Brown, CPA - Audit Principal
Sarah Reynolds, CPA - Audit Manager
Martin Cook, CPA, CISA - Manager of Audit Support & Innovation
Stephanie Hartley, CPA - Audit Senior
Caitlin Kendell-O'Gorman - Audit Senior
Erica O'Brien, CPA - Audit Senior
Caitlin Lockyer - Auditor
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The Auditor General also would like to thank Chrysta Collins, Manager of Communications and Stakeholder Engagement, for report editing and design, as well as stakeholder management.

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