Ontario Medical Association

OHIP-Eligible Rejected Claims Working Group Recommendations

October 2024

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Executive Summary

Ontario physicians are frustrated by not receiving payment for care they have provided when patients do not have a valid health card. The validity of a health card is an issue between the patient and OHIP, and the claims processing function is controlled by OHIP, but physicians carry the complete financial risk.

Physicians should be paid in good faith for the work they do when a patient is OHIP-eligible and when nondeferrable care is provided to uninsured patients. Issues related to eligibility should be the responsibility of the Ministry.

The OHIP Eligible Rejected Claims Working group was tasked with developing recommendations around commonly occurring situations to facilitate payment for patients that should be insured but there are barriers, and to address payment for uninsured patients who are not OHIP-eligible but receive urgent, non-deferrable care. Specifically, the recommendations target the following areas/groups:

- Newborn Rejections and Neonatal Death
- Missing, Cancelled, and Expired Health Cards
- Uninsured patients receiving non-deferrable care

This report provides a high-level overview of the recommendations for each of these categories, along with their anticipated impact. It outlines actions recommended for the MOH, the OMA and other stakeholders. It includes interim recommendations related to helping members navigate the existing, limited processes, along with recommendations for future advocacy, negotiation/arbitration, and implementation.

Introduction

As part of OMA's governance transformation, a series of changes were introduced to bring members closer to their organization. The General Assembly (GA) was formed with the mandate to set policy priorities and generate recommendations to address the opportunities and challenges facing the profession. The General Assembly is made up of the General Assembly Steering Committee (GASC), the Priority and Leadership Group (PLG), three panels (Advocacy, Compensation, and Issues and Policy), and working groups.

Each year, priorities are identified by the PLG and approved by the Board of Directors based on member-submitted ideas. Panels scope the work and identify if a working group is required to meet the needs of the priority. The panel then defines working group composition by indicating the skills, background, knowledge, and expertise that will be needed to solve issues within their mandate. Recruitment is open to all members and is supported by the OMA's Nominations and Appointments Committee.

On May 14-15, 2022, the GA met in-person for the first time and took the opportunity to conduct three prioritization exercise (one per panel). During prioritization for the Compensation panel, two ideas were amalgamated and the agreed upon priority was defined and presented to the OMA Board of Directors as follows:

Revamp OHIP-eligible rejected claims process to compensate uninsured patients.
An amalgamation of:

1. Revamp the system for registration of newborn health cards to avoid frequent rejections and non-payment of services to OHIP-eligible newborns; and
2. Prioritize negotiations of compensation for physicians who provide emergent/non-deferrable care for uninsured patients.

The priority "Revamp OHIP-eligible rejected claims process to compensate uninsured patients" was approved by the Board of Directors on June 22, 2022.

Upon approval, the panel defined the mandate, objectives and requirements for the working group by considering:

- Historic challenges that resulted from the changes to health card numbers, introduction of version codes and the end of the good faith payments.
- Work the OMA and various committees have undertaken and are undertaking to address challenges with OHIP-eligible rejected claims.
- A scan specific to non-payment situations in other provinces that address similar issues.
- Scope and objective definition for a working group that would allow them to make recommendations that can be implemented by the OMA.

A recruitment ad was posted for all members to access, outlining the groups mandate, time commitment, remuneration and skill set required for all potential applicants.

The ad was posted for 4 weeks, 37 number of applications were received. All applications were reviewed and evaluated using a skills matrix by OMA staff including the General Assembly and Tariff teams as well as panel chairs (Appendix A). Composition was finalized and approved by the Nominations and Applications Committee (NAC) in early 2023**.**

The working group was launched in May 2023 and is known by the name "OHIP-Eligible Rejected Claims Working Group (OERCWG)". Details of the working group composition and approach can be found in Appendix B & D.

Mandate

The mandate for the working group was to develop high-quality recommendations around commonly occurring situations to facilitate payment for patients that should be insured but there are barriers, and to address payment for uninsured patients who are not OHIP-eligible but receive urgent, non-deferrable care.

The working group also received the following scope information:

- In scope for this working group includes:
    - Common circumstances where patients are eligible for OHIP, but do not have a valid health card, or where bills are rejected based on card validity or patient eligibility;
    - Considerations for identifying truly insured patients; and,
    - Uninsured patients that need urgent, non-deferrable care.
- Out of scope issues for this working group include:
    - Truly uninsured services;
    - Truly uninsured patients presenting for elective, non-urgent services; and,
    - Billing rejections not related to matters of OHIP and health card eligibility.

Problem Statement

There are many circumstances where the absence of a valid health card results in physicians not receiving payment for care they have provided. Rejection of claims because of an invalid health card is not controlled by physicians, but physicians carry the complete financial risk. Members have flagged that these chronic issues in receiving fair payment for services rendered are urgent and need solid, sustainable solutions.

Issue Categories:

The OERCWG was established by the Compensation panel to develop recommendations that address the need to find progressive, efficient and effective payment processes that

remunerate physicians for their work. The working group is recommending solutions that can be implemented by the OMA to help achieve:

- A mechanism to ensure all rejected OHIP-eligible newborn claims are reviewed and properly remunerated following an efficient process and within an effective timeline.
- A mechanism to ensure that all specialties receive remuneration for work that is OHIP-eligible but rejected due to the inability of the patient to obtain or renew a health card and use it as defined by OHIP billing policies and processes.
- A mechanism to ensure compensation for physicians who provide emergent/non-deferrable care for uninsured, OHIP-ineligible patients.

Background

As part of the zero tolerance for fraud initiative in 1992, OHIP changed the legal requirements for Health Number assignment. A new individual 10-digit number was introduced to replace the previous 6 number card, which was a single number assigned to all family members. To support the transition, OHIP provided new tools for physicians allowing them to validate health card numbers, such as Interactive Voice Response (IVR) and health card readers. During the transition phase, OHIP would pay for services on a good faith basis where there were issues with version codes or newborn health cards.

The good faith program ended on March 1st, 1998, putting the responsibility for obtaining a valid card on the individual or family. This change has led to physicians carrying the financial and administrative burden for multiple unpaid claims due to complex administrative requirements and system inefficiencies they cannot control or manage. It is considerably challenging for physicians to solve issues in receiving payment when they have provided care for:

- Newborns when registrations are not submitted to OHIP, or version code changes cannot be obtained by the physician.
- Residents who do not have OHIP coverage because they are unable to obtain or renew a health card. Examples include resuscitation from drug overdoses, psychiatric assessment, newborn resuscitation, complicated infectious disease presentations in patients who often leave against medical advice, and medical care provided to patients without stable housing or primary care.
- Emergency care for patients that are not insured but present with urgent non-deferrable conditions.

During the COVID-19 pandemic, a temporary funding stream called the Physician and Hospital Services for Uninsured Persons (PHSUP) became available. This allowed payment for all circumstances where the patient was not insured, including those mentioned above. In many cases before the implementation of pandemic funding, this care was never remunerated as the patients had no capacity to pay. This temporary funding stream allowed claims to be processed without the need to investigate inaccurate version codes, unavailable health cards, or issues

with newborn registration. It resulted in more accurate remuneration for physicians and a decrease in administrative burden. Unfortunately, the PHSUP ended in March 2023.

Currently, when physicians do not have the necessary information to obtain patient OHIP numbers or version codes, they, rather than the Ministry of Health (MOH), continue to bear the financial risk. Therefore, it is appropriate and essential for the MOH and the OMA to resolve issues of non-payment to physicians.

Technical Details to Note:

- Current Health Insurance regulations place the onus on the patient to prove they are eligible for OHIP coverage.
    - OHIP eligibility depends on two main requirements:
        - **Status** - legal status to reside in Ontario such as Canadian citizenship or permanent resident status. Status is primarily determined by the Federal government; and,
        - **Residency** – the patient fulfils the legal definition of being an Ontario resident. Residency is determined by Ontario and is defined in regulation.
- The Personal Health Information Protection Act (PHIPA) stipulates that a patient's health number and version code is their unique identifier, and cannot be altered without their consent. The MOH possesses personal health information and as such cannot provide health information without the patient's consent.

Recommendation Overview

The OERCWG has divided recommendations into the following three areas:

- Newborn Rejections and Neonatal Death
- Missing, Cancelled, and Expired Health Cards
- Uninsured patients receiving non-deferrable care

Using the expertise and experience of the group members, survey data, environmental scans, and stakeholder data (see Appendix C, D, and E), each of the three areas was discussed, current challenges in Ontario were reviewed, and possible solutions proposed and scrutinized.

The section below provides a high-level overview of the recommendations for each category, along with their anticipated impact. It outlines actions recommended for the MOH, the OMA and other stakeholders. It includes interim recommendations related to helping members navigate the existing, limited processes, along with recommendations for future advocacy, negotiation/arbitration, and implementation. Full details for each recommendation are located in the section titled Recommendations in Detail. Especially where regulatory changes are required, estimates of speed and complexity of implementation depend in part on the final implementation plan.

Overarching Principles:

1. The OMA will use all available avenues to advocate for the working group's recommendations, including but not limited to the Physician Services Committee, Advocacy, and future Negotiations/Mediation/Arbitration.

2. Physicians should be paid in good faith for the work they do when a patient is OHIP-eligible, and when nondeferrable care is provided to uninsured patients. It should be the responsibility of the Ministry to resolve issues related to eligibility and payment with the patient.

Recommendations: **Newborn Rejections and Neonatal Death**	
OMA engages with Ministry of Health	**OMA engages physicians and other stakeholders**
1. Pre-assigned Health Number (PAHN) remains valid for a period of 12 months after birth • Rejections go to RA Report not Error Report (prevents stale dating) 2. Failing the above, create a dedicated manual review process with good faith acceptance of claims 3. If payment from OHIP is not possible due to regulatory or other barriers, Ministry should create a separate stream of funding alongside OHIP, billable at OHIP rates, to facilitate this process	1. As an interim measure only, the OMA and OHIP develop joint, web-based education material available to all physicians on newborn health card issues. 2. OMA work with OHA to ensure the MOH form "Interdisciplinary Health Provider (IHP) Health Number Release" 014-4746-84" is completed by the newborn's parents

Impact Summary – Newborn Rejections and Neonatal Death

	Benefit to Administrative Burden and Burnout	Estimated Speed of Implementation	Relative Complexity of Implementation	Benefit to Health Equity
PAHN remains valid for 12 months	↑↑↑	Less than 6 months	Minimal to moderate	↑
Good faith payment, from separate stream of funding if needed	↑	At least 6 months	Moderate	↑
Interdisciplinary health release form		At least 6 months	Moderate-High	
Interim: Joint education material on website		Weeks-Few months	Minimal	

Recommendations: **Missing, Cancelled, and Expired Health Cards**	
OMA engages with Ministry of Health	**OMA engages physicians and other stakeholders**
1. Reinstate reminders about expiring health cards; repeat contact if necessary 2. Update and modernize health card application, renewal, storage, and validation • Virtual/video/digital ID technologies • Linkage to ODSP/OW/ODB • Alternate Proof of Residency and Secure ID Storage • Real-time Online Validation and Release 3. Allow one or more of several alternate billing mechanisms to facilitate good faith payment • Temporary health card number • Allow billing with original health card number with one of several possible alternate designators • 6 month grace period on expired cards • Modified Pandemic model: K codes and hospital billing/flowthrough 4. Maintain database of claims rejected due to eligibility/expiry issues, and exempt resubmissions from stale dating	1. As an interim measure, create a dedicated location on the OMA website where physicians may access information about current resources to validate health cards and obtain up to date version codes. 2. Liaise with the CPSO, involving the Ministry if needed, to clarify the ethical and practical issues involved in providing care in the absence of health coverage or prepayment. Seek CPSO support for the principle that physicians providing care in good faith are entitled to payment from the Ministry for their services.

Impact Summary – Missing, Cancelled, and Expired Health Cards

	Benefit to Administrative Burden and Burnout	Estimated Speed of Implementation	Relative Complexity of Implementation	Benefit to Health Equity
Reinstate reminders about expired cards	↑	Few months	Minimal	
Update & modernize application, renewal, storage and validation processes	↑↑	Varies: 6-12+ months	Varies: Moderate-High	↑↑↑
Allow alternate billing mechanisms to facilitate good faith payment (temporary HCN, alternate designators, 6th month grace period, pandemic-like K-codes)	↑↑↑	At least 6 months	Moderate-High	↑
Maintain a database of claims rejected for reasons of validity/eligibility (exempt from stale-dating)	↑	Months	Moderate-High	
Interim: Dedicated website information		Less than 6 months	Minimal-Moderate	
Liaise with CPSO, involving Ministry if needed, to clarify expectations and reconcile ethical and practical issues	↑↑	Months	Moderate	

Recommendations: **Non-Deferrable Care for Uninsured Patients**	
OMA engages with Ministry of Health	**OMA engages physicians and other stakeholders**
Create a separate stream of funding alongside OHIP, billable at OHIP rates, to cover physician payment for urgent, non-deferrable care for OHIP-ineligible patients • Start with OHIP-ineligible Ontario residents before visitors • Payment in good faith • Mechanisms similar to OHIP-eligible patients in hospitals (e.g., temporary HCN or pandemic-like hospital flow-through)	1. **Work and liaise with stakeholders** to create a single, unified mechanism for funding urgent non-deferrable care provided to OHIP-ineligible patients 2. While working to implement definitive solutions, **improve existing mechanisms and resources for physicians to secure payment at point-of-care**

Impact Summary – Non-Deferrable Care for Uninsured Patients

	Benefit to Admin Burden and Burnout	Estimated Speed of Implementation	Relative Complexity of Implementation	Benefit to Health Equity
Good faith payment from separate stream of funding	↑↑	At least 6 months	Moderate	↑↑
Work with stakeholders to create a single unified mechanism	↑↑↑	Months-Years	Moderate-High	↑↑
Interim: Improve existing mechanisms for physicians to secure payment		6-12 months	Minimal-Moderate	

Recommendations in Detail

Newborn Rejections and Neonatal Death

The issue:

Children born in hospital are given a Pre-Assigned Health Number (PAHN), and physicians providing services to those children use that PAHN to submit OHIP claims. Obtaining a PAHN requires that parents complete a form including the child's name, date of birth, and mailing address, along with attesting that Ontario is their principal residence, and the child will be a resident of Ontario for at least 153 days in the next 12 months. Parents retain the bottom portion of the form, which acts as a temporary health card. The main section of the form must be submitted to the Ministry by either the hospital or at Service Ontario by the parents.

Until March 1, 1998, there existed a good faith process for acceptance of newborn claims. No such processes exist now. As such, bills submitted to OHIP using the PAHN are often rejected. Common reasons for this include:

- The forms were not properly completed, submitted or processed by the hospital, parents, or Ministry
- The parents update the child's registration and obtain a permanent health card and version code (after which the PAHN is considered invalid)
- 90 days after birth (even if no new card issued, and/or even if the patient remains admitted to hospital)

Obtaining updated health card and version code information through existing means (e.g., Interactive Voice Recognition or Health Number Release Form) is often impossible due to multiple factors, including name changes, unavailable contact information, date of birth mismatches, confidentiality concerns (e.g., adoption, CAS involvement), or potential harm and re-traumatization caused by contacting parents in cases of neonatal death. Therefore, bills for care provided in good faith are often rejected, through no fault of the physician, and with no remedy available to the physician.

The cost of these rejections to physicians is enormous. A previous estimate provided by the Ministry showed 1400 PAHN-related rejections for the year 2019. The estimated financial loss to involved physicians from such rejections would range from approximately $100 for basic consultation and care to over $1200 for a single day of advanced resuscitation and care. Thus, the total cost to physicians of this issue is likely measured in the hundreds of thousands of dollars annually.

Overall, physicians bear the complete financial risk and burden of rejected newborn claims, despite having no control over the factors that often underlie such rejections. The administrative burden associated with this process also contributes to physician burnout and demoralization, and takes time away from more important clinical issues.

Improvements to the payment process for newborns are required for physicians to be appropriately compensated for complex care that they provide in good faith. Solutions need to include fair, efficient and timely processes that will help to reduce administrative burden and allow physicians time to deal with more important clinical issues. The OMA's action in this area must also be informed by the history of efforts made to remedy these issues over the past 12+ years, and the barriers faced in those discussions. Future actions must ensure that solutions are escalated to the appropriate parties within the Ministry and Government, or through negotiations and arbitration if needed, in order to finally ensure a satisfactory resolution for members.

Recommendations:

1) Changes to Payment Process Within or Alongside OHIP
    a) That the **PAHN remains valid for a period of 12 months after birth**, after which an updated health card and version code can be issued, so that claims for eligible newborns may be honoured without risk of rejection due to factors beyond the physician's control. This amount of time is specifically chosen over 3 months for two reasons:
    1. Due to the complex nature of these claims, to ensure that physicians have adequate opportunity to submit and resubmit bills without the risk of rejections due to factors beyond their control;
    2. Some newborns have complex care needs such as prematurity or developmental problems requiring complex planned interventions for many months;

    b) That claim rejections during this period be sent to the **Remittance Advice Report** rather than the Error report in order to allow **resubmission** and review without risk of 90-day stale dating.

    c) Failing the above, OHIP should allow a **dedicated manual review process** for the purpose of ensuring that claims for newborns are not rejected for reasons of card validity that are outside the physician's control. Such reasons would include, but not be limited to lack of registration of the PAHN, or lack of availability of an updated version code.
        i) Claims submitted under this process should be reviewed and **accepted in good faith** as long as the physician provides appropriate documentation showing original patient identifiers, combined with evidence of the services provided.
        ii) ii) If legal, procedural, operational, or regulatory barriers exist to payment under OHIP itself, then the MOH create a **separate funding stream** from which payment for otherwise-rejected claims on eligible newborns could be paid.

2) Recommendations on member awareness and education
    a) As an interim measure only, that the OMA and OHIP develop joint, web-based education material available to all physicians on newborn health card issues, including:
        i) A description of the OHIP registration process.
        ii) Common causes of newborn OHIP number rejections.
        iii) Location of OHIP forms obtaining permission to release Health Numbers, and any forms related to Stillbirth and Neonatal Death
        iv) Links to OMA contacts to obtain assistance.
    b) That the OMA work with OHA to ensure the MOH form "Interdisciplinary Health Provider (IHP) Health Number Release" 014-4746-84E or 014-4746-84F is completed by a newborn's parents upon admission

Missing, Cancelled, and Expired Health Cards

The Issue:

For a variety of reasons, otherwise-eligible Ontario residents seeking care in hospital and outpatient settings may have no health card or a cancelled or expired card. The reasons for this include but are not limited to:

- The patient was unaware that the card was expired or cancelled
- The patient is unable to prove status (e.g., lack of birth certificate)
- The patient has no fixed address, or is not able to prove residency
- Lost or stolen identity documents
- Logistic, geographic, and health barriers to in-person Service Ontario visits
- The patient is aware that the card is expired, but has little incentive to renew

Even though none of the above issues are within physicians' control, physicians will not be paid for their services without a valid health card number and version code. As such, physicians carry the complete financial risk for health card issues that are beyond their control.

Providing care for patients who are OHIP-eligible but do not present a valid card also poses ethical and practical dilemmas for physicians. In urgent situations, physicians' professional obligation according to the CPSO is that "care should be provided first and questions about health coverage can be addressed later" (https://www.cpso.on.ca/en/Physicians/Your-Practice/Physician-Advisory-Services/FAQs-for-Physicians; updated November 4, 2024, accessed Aug 9, 2024). However, in doing so, physicians are faced with the strong possibility of neither OHIP nor the patient paying the claim. Physicians also incur significant administrative costs in attempting to obtain payment or health card information. Likewise, in non-urgent situations, options such as turning the patient away until they provide evidence of valid OHIP coverage, or charging the patient directly, can result in risks of conflict and patient complaints, along with risks of liability from delaying care.

In some cases, a paradox exists such that the patient's health card is cancelled/invalid, but the patient continues to be eligible for other benefits such as the Ontario Drug Benefit program, Ontario Works, and ODSP. The government continues to assume Ontario residency for such programs, but requires a special, often in-person, process through Service Ontario to re-prove residency for the sole purpose of re-validating OHIP eligibility.

These issues are also a matter of health equity - the patients most at-risk of facing barriers to health card receipt, renewal, and care are those who are the most vulnerable. Government action is required to minimize barriers to care for these patients.

Other provinces have implemented partial solutions to these challenges. BC, Alberta, Saskatchewan, and Quebec have provisions for good-faith payment in emergencies. BC has a special claim designator code to allow submission after the stale date if a patient's coverage lapses but is later reinstated. Saskatchewan allows retroactive submission of bills up to 6 months after the service, if the patient obtains coverage within that 6 months. For proof of residency, BC allows use of an advocate's mailing address, PEI allows use of any valid mailing address, and Alberta has allowed use of a shelter or other support organization's address.

Ultimately, physicians should not be placed in a position of providing OHIP-eligible patients with medically-necessary, often life-saving, care without a mechanism for reimbursement.
These issues contribute to administrative burden, burnout, and demoralization and must be resolved. Physicians should be paid on a good faith basis when a reasonable opinion is formed that the patient is OHIP eligible.

Recommendations:

General Recommendations

1) **Reinstate patient reminders about expiring health cards (which are presently opt-in only)**
   a) Including a warning that patients who do not renew and are found to be ineligible may be billed for services they receive if their card is expired.
2) **Improve and modernize the process of health card application, security/storage, and renewal**, with particular emphasis on ensuring **equity** for those who are elderly, experiencing homelessness, experiencing mental health and addictions challenges, have limited access to transportation, or face other barriers to the current process.
   i) **Implement virtual/video technologies** and virtual photo capture, in lieu of in-person visits to Service Ontario.
   ii) Implement **real-time and after-hours options** for patient health card renewal.
   iii) Allow new means for individuals to prove or attest for **residency**, including the use of substitute and/or social services addresses for people experiencing homelessness and people who are transiently housed.

iv) Include receipt of **other government services**, such as Ontario Works, Ontario Disability Support Program (ODSP), and the Ontario Drug Benefit Program (ODB) as a proxy for residency and maintain OHIP coverage for patients receiving these supports. Use contacts with these other services to complete any necessary additional validation via virtual connection with Service Ontario.

v) Support and expand existing programs that allow patients to **securely store** their identification with trusted arms-length third parties

vi) Develop **digital health cards**, understanding that for certain populations such as people experiencing homelessness, digital access may require unique security solutions such as voluntary biometrics, and that consultation with patients experiencing homelessness and expert stakeholders would be required.

3) Improve and modernize the systems for secure, real-time **validation of coverage and implement real-time online Health Card Number Release at point of care**
   i) Integrate these processes with hospital and outpatient EMR systems.
4) Maintain a database of claims that are rejected on the basis of eligibility and health card expiry, to act as proof of on-time claim submission. Allow those claims to be resubmitted indefinitely, **exempt from stale dating**, when the MOH or the patient can provide the physician with correct Health Card information.

Changes to the Payment Process Either Within or Alongside OHIP

1) For **hospital settings**: In defined circumstances, implement one of the following:
   a) Allow the hospital/ER to **issue the individual a temporary health number**, similar to temporary newborn health numbers, to be used for billing that hospital visit and any necessary hospital-based follow up services.
   b) **Issue each hospital a unique number**, to be used in lieu of individual health card numbers, for all presumably eligible patients without a health card.
   c) Provide funding to hospitals to **flow through** to physicians, with physician submission of billings to the hospital. This mechanism was used during the Covid public health emergency.
   d) Allow physicians to submit bills using the patient's original health card number but with one of several possible **alternate designators** that enable good-faith payment regardless of card cancellation or expiry. Options might include:
      i) A standardized alternate version code used for all such visits (i.e. the bill is submitted with the patient's original 10 numbers, but with the designated alternate version code, such as QQ or XX);
      ii) An alternate Service Location Indicator; and,
      iii) An add-on billing code.
2) For **non-hospital settings**: For outpatient care, implement one or more of the following:

a) Allow a **grace period** for claims acceptance by continuing to accept bills submitted with expired version codes for a period of up to 6 months after expiry.
b) Allow physicians to submit bills using the patient's original health card number but with one of several possible **alternate designators**, as outlined above.
c) Implement a system similar to **K Codes**, but with values modified to ensure equality with routine OHIP codes

3) Any physician payments in using the mechanisms above should **trigger OHIP to connect with the patient in order to activate or renew permanent coverage**. As the Insurer, OHIP, rather than the physician, should assume responsibility for notifying and pursuing the patient.

Recommendations on member awareness and stakeholder engagement

The working group recognizes that most physicians are already doing everything they can to ensure payment for these claims and are simply met with administrative barriers beyond their control. However, in the interest of supporting as many physicians as possible and considering the above-noted flaws in the current system, we recommend the following supplementary initiatives in order to try to help minimize rejected claims and enable payment wherever possible.

1) That the OMA create a dedicated location on the OMA website where physicians may access the following information:
   a) Existing resources to validate health cards and obtain up to date version codes, when available;
   b) A link to the MOH form "Interdisciplinary Health Provider (IHP) Health Number Release" 014-4746-84E or 014-4746-84F; and,
   c) Links to OMA contacts to obtain assistance with rejected claims related to health card issues.
2) To reduce physician administrative burden, burnout, and demoralization, the OMA should liaise with the CPSO to further clarify and define the circumstances under which physicians are expected to provide care in the absence of health coverage or prepayment. OMA and CPSO should work together, involving the Ministry if needed, to reconcile the ethical and practical dilemmas that physicians face in treating OHIP-eligible patients who lack valid health cards. Specifically, the OMA should seek CPSO support for the principle that physicians providing care in good faith are entitled to payment for their services, including when provided in urgent circumstances. For OHIP-eligible Ontarians, this payment should come from the Ministry.

Uninsured Patients Requiring Non-Deferrable Care

Populations Impacted (OHIP-Ineligible Patients):

- Undocumented residents
- Temporary residents (e.g., work permit, study permit) with gaps or lapses in coverage
- Uninsured travellers to Canada experiencing medical emergencies
- Complications and emergencies related to elective health care tourism and birth tourism

Defining Non-Deferrable Care:

A definition of what constitutes non-deferrable care to uninsured patients is helpful for ensuring clarity and uniformity among government, hospitals, and physicians. Common non-deferrable care could include any of the following:

- Physical or mental health conditions which, if not immediately treated, pose a high probability that the patient will suffer loss of life, limb, or critical organ function
- Conditions which necessitate admission to hospital for stabilization, until such time as acute inpatient care is no longer required
- Conditions which require emergency surgery
- Conditions for which immediate treatment is required to prevent permanent complications (e.g., fractures, burns)
- Labour, delivery, immediate newborn care, and acute complications of pregnancy, including both maternal and fetal/newborn impacts
- Conditions with immediate public health implications (including but not limited to many reportable diseases)
- Presenting symptoms that are clinically suspected to represent any of the above, prior to diagnostic confirmation. This includes the possibility of presentation to outpatient settings. With the exception of public health issues, such conditions would usually require transfer to hospital for diagnosis and treatment.

Recommendations:

1. The Ministry **create a separate stream of funding** alongside OHIP, billable at OHIP rates, to cover physician payment for urgent, non-deferrable care for OHIP-ineligible patients
    a. Start with OHIP-ineligible Ontario residents before moving on to visitors
    b. Remit payment to physicians in good faith when such care is provided
    c. Implement this fund using mechanisms similar to those used for OHIP-eligible patients presenting without a health card (e.g. temporary numbers, hospital flow-through, K-codes)
    d. If, after good-faith care is provided, it is later determined that the patient committed fraud, should not have been eligible for the program, or was otherwise insured, the responsibility for reconciliation and collection should lie with the Ministry, not with physicians.

2. The OMA **work and liaise with stakeholders** to create a single, unified mechanism for funding urgent non-deferrable care provided to OHIP-ineligible patients

3. While working to implement the above funding and payment solutions, **improve existing mechanisms and resources for physicians to secure payment at point-of-care**, when such payment can be obtained (e.g., patient messaging/communications, invoicing, credit card processing, bundled billing with hospitals, bundled billing with other specialists for cases of medical tourism)

Risks and Mitigation

Newborn Rejections and Neonatal Death

Reputational	--
Political	--
Stakeholder	• Hospitals may see the Health Number Release form as additional work without additional government compensation. This could be mitigated by clear processes/checklists/procedures for newborns.
Financial	• There may be a small financial cost for government. However, the involved group of newborns should be OHIP-insured regardless, and the stable medical care for young children should have downstream benefits by reducing chronic health problems. • Small development costs for OMA website updates. • OMA budget implications will depend on implementation plan.
Negotiation	--
Legal/Ethical/COI	--
Membership	--

Missing, Cancelled, and Expired Health Cards

Reputational	--
Political	• Costs to the government; however, given that this is an OHIP-eligible population, these costs should be funded regardless. Technological improvements should ultimately lead to cost savings.
Stakeholder	• Risk that CPSO indicates that physicians must provide care even if they receive zero payment at all. • There may be some concern in MOH and union staff that jobs could be lost. • Some of the options for temporary coverage involve hospitals. These options would require engagement of the OHA.
Financial	• See Political, above. • Small web development costs • OMA budget implications will depend on implementation plan.
Negotiation	• Ministry may attempt to argue that funding is not available, or that funding must come from a fixed physician services budget. However, these are OHIP-eligible patients and should be funded appropriately by the Ministry regardless. Likewise, additional, appropriate funding was in place during the pandemic.

Legal/Ethical/COI	• The Ministry will endeavour to ensure that eligibility regulations are legally sound defensible, and unambiguous. Regulatory changes will need to be able to capture this. Implementation from the OMA side needs to ensure that the final solution adequately addresses key areas of concern.
Membership	--

Uninsured Patients Requiring Non-Deferrable Care

Reputational	• Some members of the public and profession may express concern about the costs associated with extending limited coverage to OHIP-ineligible patients. However, the recommendations are consistent with current OMA position, which is that the government should create a permanent program for uninsured patients. Additional mitigation would include ensuring that the criteria for coverage are well-defined, and that messaging is clear that coverage on the basis of compassion, public health, and possible future cost savings is prudent. Other provinces already have similar programs in place for these reasons. • Caution is warranted with the OMA simultaneously supporting and enabling the current reality of directly billing uninsured patients in some cases (e.g., deferrable care) while also advocating for public funding in some cases. Ensuring public and government support will require a targeted, strategic approach. In order to mitigate this risk, coverage for uninsured patients in non-deferrable situations can be framed on principles of compassion and the protection of public health.
Political	• The Ministry may indicate that this is simply not their problem to manage, and that they should not be responsible for this population. Some members of the public may feel similarly. Clear criteria and narrow application, including coverage on compassionate and equitable grounds, may help mitigate these concerns.
Stakeholder	• The Health Care for All Coalition will be concerned that the recommendations do not go far enough, in that the Coalition has also asked that we lobby for Federal changes to give legal Status to all residents of Ontario. However, Federal Status changes were outside of the mandate of the Working Group. Even without such changes, the recommendations toward funding nondeferrable care for uninsured patients will increase health equity and reduce some barriers to care for the Coalition's target population. • Stakeholders will have varying levels of interest in pursuing a unified program.

Financial	• OMA budget implications will depend on implementation plan. However, an appropriate mechanism will provide value and simplicity for members.
Negotiation	• There is risk that the government will attempt to draw funding for this population from the existing Physician Services Budget, rather than engaging new funding. If this was allowed, it would likely impact relativity by increasing funding to certain specialties but not others. However, this care was funded in the pandemic, and it is widely recognized that earlier treatment can prevent complications (e.g., presentation to ER with a skin infection requiring oral antibiotics, vs. presenting with a later stage involving sepsis and admission)
Legal/Ethical/COI	• Undocumented immigrants are concerned about the risk that their presence will be identified to a government entity, and their residency compromised as a result. Proposed mechanisms for implementing the recommendations must consider this reality and either provide safeguards and assurances, or 'firewall' the personal data to the extent possible. • There are potential medicolegal risks of treating patients from outside of Ontario in emergency circumstances. In order to mitigate this, OMA and CMPA should ensure that members are aware of the CMPA's advice on the matter, currently available at https://www.cmpa-acpm.ca/en/membership/protection-for-members/principles-of-assistance/treating-non-residents-of-canada. Where possible, members should ensure that out-of-country patients sign the CMPA's Governing Law and Jurisdiction Agreement. The CMPA acknowledges in the above document that this is not always possible. The OMA should confer with CMPA as any province-wide program is coming to life, in order to ensure that any additional risks are considered and managed.
Membership	• Some members may express concern about billing at OHIP rates rather than the higher OMA Uninsured rates. However, creating a permanent program for uninsured patients is already OMA policy. Likewise, many cases involving uninsured patients currently go unpaid, so a reliable and consistent payment mechanism, as occurred during the pandemic, is expected to be a net benefit to members.

Appendices

Appendix A: Working Group Recruitment Ad & Recruitment Evaluation Matrix

Working Group applicants were evaluated using a skills matrix with the following guiding criteria:

General skills

- Research and analytical skills.
- Ability to synthesize diverse sources of information.
- Experience in policy development.
- Strong relationship management skills and ability to work effectively with a team.
- Commitment to success.

Issue specific knowledge

- Knowledge of privacy policy as it relates to proposed solutions through OHIP.
- Knowledge and experience of in-hospital billing (e.g., practice/ institution specific solutions).

Experience

- Experience with tariffs.
- Physicians who have experience in treating OHIP eligible patients with no valid health card and those ineligible for OHIP, including, but not limited to:
    - Hospital-based physicians who provide urgent, non-deferrable care.
    - Physicians that practice in urban areas who see many uninsured patients.
    - Physicians who provide pediatric care to newborns and birth tourism care.
    - Physicians who provide mental health and addiction medicine care, preferably in emergent and/or hospital-based settings.

Application Form Questions

- Why are you applying for this role?
- What relevant skills and knowledge can you bring to this group?
- What is your knowledge and experience in treating and billing for OHIP-eligible uninsured patients?
- What is your experience in policy development?

Appendix B: Working Group Membership

Working Group Membership

- Dr. Chris Cavacuiti
- Dr. Elisheva Chernick
- Dr. Achelle Cortel-Leblanc
- Dr. Shawn Kao – Vice Chair
- Dr. Eli Miller
- Dr. Jesse Wheeler - Chair

OMA Staff: Sarina Hum, Katina Kominos, and Jennifer Wilock
Consultant: Dr. Garry Salisbury

Appendix C: Work done to date

Documents Reviewed:

- Error Report Rejection Conditions/Error Codes, MOH, December 2022.
- Critical Condition Good Faith (CCGF) Coverage, The Saskatchewan Medical Association.
- Special Situations, Alberta's Good Faith Policy, 2018 Government of Alberta, Alberta Health, Physicians Resource Guide 2018 pages 43-44.
- Challenges with Infant Registration Program for Newborns in Ontario, Dr. Jane Healey.
- Provincial Scan of nonpayment situations, October 2022, OMA.
- Health Cards & Health Numbers, The Personal Health Information Protection Act, Frequently Asked Questions; Information and Privacy Commissioner of Ontario.
- Summary of Health Card Validation mechanisms, OMA.
- OERCWG- Section Survey and Collated Section Feedback, OMA.
- Supporting the Delivery of Health Care to Ontario's Uninsured Patients, 2024, Ontario Hospital Association

Stakeholder Engagement:

- OMA Section leadership was surveyed regarding existing strategies and possible solutions
- Health Care for All group has provided their policy paper and supporting evidence. Only some of their request is within scope of the working group.
    - A Bridge to Universal Healthcare, May 2023, Health Network for Uninsured Clients
    - Ensuring Access to Health Care for All People Living in Ontario, July 2023, Healthcare for all Coalition
    - Emergency Room Visits by Uninsured Child and Adult Residents in Ontario, Canada: What Diagnoses, Severity and Visit Disposition Reveal About the Impact of Being Uninsured, 2016, Hynie M. et al.
- OMA has engaged in some work with OHA on this matter. Working group received briefing June 2024. This work is currently on hold.

Appendix D: Approach/Methodology

To build recommendations, the working group has relied on their collective knowledge, the subject matter expertise of the OMA staff, and consultant Dr. Garry Salisbury, who has held senior roles within OHIP and the Ministry, and who provided valuable perspective on the feasibility of recommendations and possible paths to success. The OERCWG identified the documents listed in Appendix C to understand the landscape of the issues as presented to them based on:

- How other provinces were tackling similar issues that Ontario physician face;
- Processes/mechanisms already in place with OHIP;
- Physician's opinion/feedback on the mandate;
- Recent previous work with the Ontario Hospital Association, and
- Third party advocacy undertaken by the Health Care for All Coalition.

By reviewing these documents, the group was able to discuss and formulate recommendations that would meet the specific needs of physicians and the public in Ontario.

The OERCWG also developed a survey for chairs of Tariff, Sections, Fora and Medical Interest Groups (MIGs) requesting their review and assistance in creating a comprehensive list of situations where:

- Patients should be insured but encounter barriers registering for OHIP or other government insurances; and,
- Uninsured patients who are not OHIP-eligible and receive urgent, non-deferrable care.

The survey was sent out on Sept 25, 2023, and was closed on Oct 9, 2023. Some of the recurring feedback themes from the chairs included:

- The utility and possible return of the COVID temporary codes;
- Hospital administrators, social work staff, or a designated navigator facilitating renewal of health cards; and
- Education on OHIP processes in place to minimize rejections.

To drive the work forward, the working group chair initiated and formulated a timeline with expected goals for each meeting that were approved and adopted by all working group members. The detailed workplan is outlined in Appendix E.

Shared documents were created where the group collaborated asynchronously and provided guidance, feedback and suggested recommendations by category. The documents were discussed at the planned meetings where additional information was provided to help finalize recommendations.

- **Jurisdictional scan**

3.1 Provincial scan - specific non-paymer

- **Constituency group survey**

OERCWG-Collated%20Section%20Feec

- **Other work completed**

Health%20Card%20Validation%20Mech

Appendix E: Workplan

Meeting Date	Deliverables and Actions between meetings
2023	
May	Orientation, introduction of expression of interest of chair and vice chair
August	Review of mandate, list of issues, review of documents and material. Consideration for stakeholder and additional information needs.
October	Survey to chairs of Sections, MIGs and Fora
December	**Draft and refine recommendations for**: Newborn and neonatal death issues **ID additional resources needed** **Review drafts and comment**
2024	
February	**Finalize recommendations for:** Newborn and neonatal death issues **Draft and refine recommendations for:** Missing, Cancelled, and Expired Health Cards
April	**Edit and refine recommendations for:** Missing, Cancelled, and Expired Health Cards **Draft and refine recommendations for:** Uninsured and non-deferrable care
June	**Offline** – review and comment on Panel draft report**.** **Finalize recommendations for:** Missing, Cancelled, and Expired Health Cards **Refine recommendations for:** Uninsured and non-deferrable care
July	**Offline** – review feedback on Panel draft report**.**
August	**Offline** – review feedback on Panel draft report**.** **Finalize Recommendations** **Draft/Compile Board documents**
October	Finalize Board Documents and presentation
November	Draft to Final recommendation review with panel Submit documents for Board meeting
Dec 4, 2024	Recommendations to the board