

22 Eligibility for Medical Cards

- 22.1** Holders of medical cards issued by the Health Service Executive (HSE) are entitled to receive primary care services without having to make payments to the service providers. The majority of costs related to the service provision are paid directly to the service providers by the HSE. In relation to prescription medicines, a charge per item payable by the cardholder was introduced in October 2010.¹
- 22.2** In most cases, eligibility to receive a medical card depends on an assessment of the cardholder's means. Cardholders are legally obliged to inform the HSE if relevant circumstances change e.g. increased income, change in medical condition. It is an offence to provide false information on a medical card application or not to inform the HSE of a change in circumstances which may affect eligibility.
- 22.3** Two types of cards are issued, with different service coverage.
- A full medical card entitles the cardholder to a range of services free of charge, including all visits to a general practitioner (GP), in-patient and out-patient hospital services, required prescription medicines (subject to the appropriate prescription charge) and certain dental and ophthalmic services.
 - A GP visit card entitles the holder to attend his/her GP free of charge.
- 22.4** The HSE also operates a long term illness scheme. Under this scheme, where an individual suffers from one of 15 listed illnesses, prescription medicines directly related to the treatment of the illness are supplied free of charge. Eligibility to this scheme is not related to income and it operates separately to the medical card/GP visit card scheme. In 2012, 69,500 individuals made claims under this scheme at a total cost of €117 million. The operation of the long term illness scheme is not included in the scope of this report.
- 22.5** Up to June 2011, the issuance of medical cards was administered in approximately 100 local health offices, reflecting the former health board structure. Since 1 July 2011, card issuance has been managed centrally within the HSE, by the Primary Care Reimbursement Service (PCRS). The objective of the centralisation process was to
- provide for a single uniform system for medical card applications and renewals replacing the different systems previously operated in the local health offices
 - streamline work processes and implement process improvements resulting in more efficient processing
 - reduce the number of staff required to process applications and renewals
 - improve customer services
 - over time, to ensure a more accountable and better managed medical card processing service.

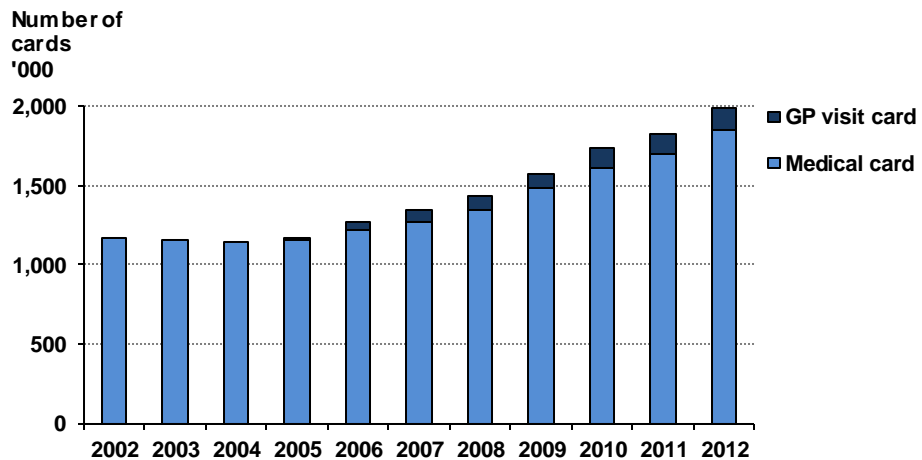
¹ The charge was initially set at 50 cent per item (capped at €10 per month for each individual. It was increased to €1.50 per item from January 2013, capped at €19.50 per month per person or family.

Focus of the Examination

- 22.6** A key risk in a decentralised administration system is inconsistency between regions in the application of eligibility rules. The HSE stated that while the medical card scheme had been the basis for the delivery of the majority of primary care services in Ireland for 40 years, all stakeholders were aware of the issues relating to the administration of the assessment of eligibility and the integrity of the medical cards register.
- 22.7** The HSE recognised that assessment for eligibility for medical cards was not consistent between the 100 offices conducting the reviews and some cardholders were granted medical cards for long periods, in some cases up to 20 years.
- 22.8** In consultation with the Department of Health, HSE management decided that a fundamental change in the administration of the scheme was required. The centralisation of administration of medical card assessment allowed the HSE to introduce a uniform system for assessment of eligibility. However, the HSE recognised that reviews of eligibility in the early stages of the centralisation process were likely to identify a material level of non-renewal. It does not produce an estimate of the number of medical cards in issue where the cardholder is not eligible.
- 22.9** This examination was carried out to examine
- trends in the costs associated with the provision of medical cards in the last ten years
 - the adequacy of the controls over the initial award of cards and over the renewal process
 - the process of review of eligibility for cards in issue
 - the level of card-holding in excess of entitlement, and the value of the related excess payments.

Number of Cardholders

- 22.10** The number of medical cards in issue has increased over the past decade as shown in Figure 22.1. The GP visit card was introduced in 2005. The number of GP visit cards issued in 2005 and 2006 was relatively low. However, since 2007, between 5% and 7% of all cards issued are GP visit cards. At the end of 2012, just under two million individuals, representing 43% of the total population, had medical cards.

Figure 22.1 Number of medical and GP visit cards in issue, 2002 to 2012

Source: Primary Care Reimbursement Service statistical reports

Backlog in Processing Applications

- 22.11** A considerable backlog developed in processing applications in the first six months following centralisation. The backlog stood at 58,000 at January 2012. The HSE undertook to clear this backlog by April 2012 and to process all fully completed applications within 15 working days.
- 22.12** The HSE implemented a number of initiatives in order to address the backlog and some of the issues arising as a result of delays in processing applications and renewal. These included
- extending renewal of medical cards by way of cardholder self-assessment to cardholders aged under 70 years of age
 - allowing GPs to extend the period of eligibility in certain cases (e.g. vulnerable persons) or to add new-born babies to the medical card database.
- 22.13** The HSE stated that the backlog was cleared by the end of April 2012. In April 2013, the HSE stated that 96% of fully completed applications are processed within the target turnaround time.¹

Cost of Medical Cards

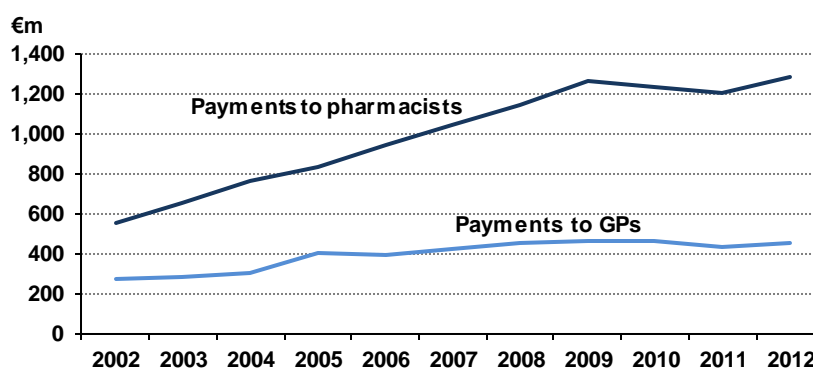
- 22.14** The main components of medical cards costs are payments to GPs and payments to pharmacists
- Payments to GPs are categorised as fees and/or allowances. Fees are payable in relation to individual medical card patients registered on a per capita basis. GPs are also entitled to claim out of hours payments (where patients are seen outside normal practice hours) or where special services (excisions, suturing, vaccinations, catheterization, family planning, etc.) are delivered. Allowances are also paid to GPs in relation to annual and study leave, locum, nursing and other practice support.

¹ The HSE stated that about 78% of the applications received during 2012 had been fully completed by the applicant. The remainder would have required some follow up by HSE staff.

- Drugs, medicines and appliances approved under the General Medical Service (GMS) Scheme are provided through retail pharmacies. The pharmacist claims the cost of the medicine provided together with a dispensing fee. The costs of the medicine provided comprises about three quarters of the total amount paid to pharmacists.

22.15 The cost of providing GP services and medicines under the medical card scheme has increased significantly in the last decade as shown in Figure 22.2. In 2002, the HSE paid a total of €823 million to GPs and pharmacists in respect of services provided to medical card users. By 2012, this had increased to just over €1.7 billion. There was a significant increase in payments to GPs in 2005. Since then, total payments have ranged from €400 million to €450 million. In contrast, payments to pharmacists increased from €551 million in 2002 to €1.3 billion in 2012.

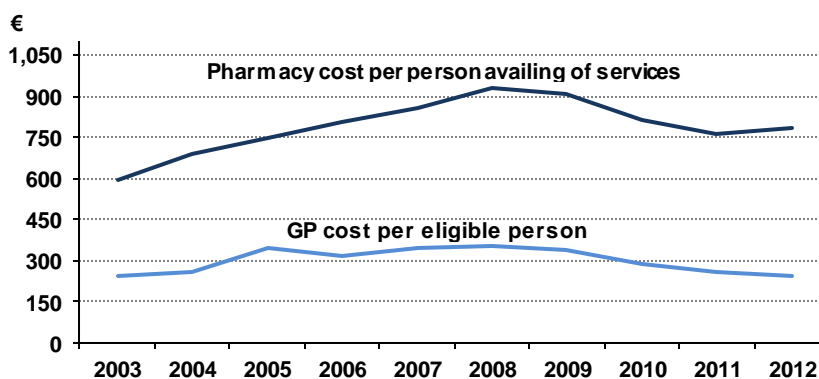
Figure 22.2 HSE expenditure in relation to medical cards, 2002 to 2012



Source: Primary Care Reimbursement Service statistical reports

22.16 The average cost peaked in 2008 when the HSE paid service providers an average of €1,285 in respect of individuals in possession of a medical card. This had fallen to just over €1,000 per person in 2012. The average payment to GPs decreased by 31% between 2008 and 2012 and the average payment to pharmacists in relation to people who availed of the service decreased by 16% over the same period (see Figure 22.3).

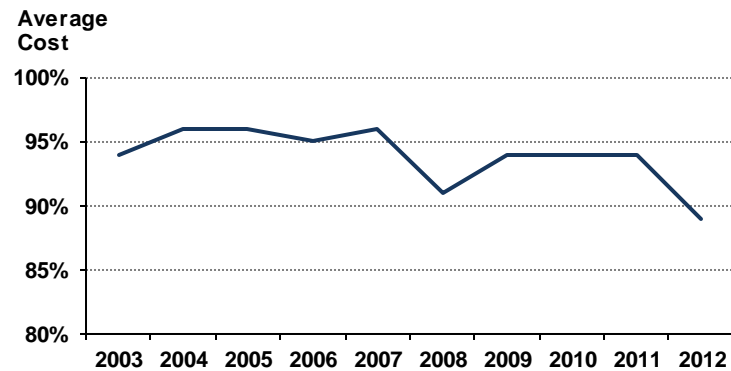
Figure 22.3 Average medical card cost per person, 2003 to 2012



Source: Primary Care Reimbursement Service statistical reports

- 22.17** The average pharmacy cost per person is calculated on the basis of the number of cardholders who availed of services in the year. Between 2003 and 2011, in general, 94% to 96% of eligible persons availed of pharmacy services during the year. This decreased to 89% in 2012 (see Figure 22.4).

Figure 22.4 Proportion of eligible persons availing of pharmacy services



Source: Health Service Executive

- 22.18** A review conducted by the HSE in October 2012 examined medical card costs arising in the first four months of 2012, as compared with the same period in 2011. This found that
- Over half of the additional pharmaceutical costs were due to more people availing of services while the remainder was, in the main, explained by changes in prescribing practices. Both the average number of prescriptions per claimant and the average drugs per prescription increased over the period.
 - Almost a quarter of doctors prescribed more for their patients in the first four months of 2012 as compared to 2011.
- 22.19** The HSE stated that it has introduced a number of initiatives to achieve cost savings in relation to prescribed medicines
- The introduction of reference pricing and generic substitution, commencing in November 2013, means that the HSE will set the price it will pay for a group of interchangeable medicines. The list of interchangeable medicines will be developed by the Irish Medicines Board. Irrespective of the drug prescribed, the HSE will only pay the agreed reference price for that group of products. If the patient chooses a more expensive product, the patient will pay the difference.
 - It has recently established a Medicines Management Programme which aims to encourage cost effective prescribing by GPs. Under this programme, doctors are asked to prescribe particular drugs for stated illnesses. Drugs prescribed for high cholesterol and peptic ulcer disease/reflux account for about 15% of the HSE's expenditure on medicines. The programme has commenced by identifying particular drugs that doctors should prescribe for these illnesses. It is planned to extend the programme to other illnesses over time.

- It has also established a prescribing feedback module which gives GPs information needed to achieve cost savings by prescribing better value products. At present, the module provides information to GPs indicating the patients and products to focus on in order to achieve maximum savings. The HSE plans to further develop this module, as reference pricing and generic substitution are implemented later in 2013. It also plans to upgrade the feedback so that it provides benchmarks for individual GPs which shows how their prescribing practice compares with that of other GPs.

22.20 The HSE stated that the medical card scheme is demand led and the proportion of people who avail of services can fluctuate. For example, in 2008 and 2012, the number of eligible persons availing of pharmacy services dropped significantly. There was no change to the medical card scheme which could account for the fluctuations (as shown in Figure 22.4). The HSE has not reached any conclusions on the reasons for such fluctuations and stated that further research may be beneficial. The HSE noted that the Medicines Management Programme will allow it to monitor and analyse changes in prescribing behaviour.

Award of Medical Cards

22.21 Medical cards are usually awarded on the basis that applicants' means are less than specified limits. In addition, the HSE has discretion to issue cards in cases where medical needs would result in hardship.

Means Tested Applications

22.22 Different means thresholds apply for certain groups and card classes, depending on weekly income, marital status and age (see Figure 22.5).

Figure 22.5 Income thresholds for medical cards/GP visit cards, June 2013

Applicant's status	Weekly income limits for:	
	Medical card	GP visit card
Under 70		
Single	€164 — €201	€246 — €302
Married/ cohabiting couple/ single parent families with dependent children	€266 — €298	€400 — €447
Over 70		
Single	€600	€700
Married/ cohabiting couple	€1,200	€1,400

Source: Health Service Executive

22.23 The assessment of income also takes account of the number of children who are financially dependent on the applicant, rent and mortgage payments, childcare costs and the cost of travelling to work.

22.24 In addition, persons who had been in receipt of payments due to unemployment or illness benefit from the Department of Social Protection for a year or more are entitled to retain their medical card for three years after taking up employment, without the application of means test. Adult and child dependents of the individual covered by the retention will also be granted a medical card.

Assessment of Applications

- 22.25** Applicants must provide evidence in relation to income and any outgoings being claimed in the means test.
- Where applicants are in receipt of payments from the Department of Social Protection, this evidence can take the form of a letter from the Department or an individual payment slip.
 - Where applicants are not in receipt of payments from the Department of Social Protection, income can be evidenced by payslip, P60, notice of assessment from the Revenue Commissioners or a letter from the employer confirming the applicant's salary.
- 22.26** The HSE has access to the Department of Social Protection's Infosys database which provides information on payments made by the Department to individuals. It also shows summary income information in relation to individuals not claiming payments from the Department. The income data is the latest recorded income data the Revenue Commissioners received. This may be the P35 filed by the employer in relation to the previous tax year or the tax return submitted by the individual, so it may not accurately reflect the applicant's current salary.
- 22.27** The HSE has stated that, irrespective of the evidence supplied by the applicant, all income noted in the application is checked to Infosys.
- 22.28** Control over the approval process for means tested cards was examined as part of this examination. A sample of 50 approvals for medical cards awarded in 2012 in instances where the applicant satisfied the means criteria was examined. Over 90% of the cases examined had appropriate evidence of means, and had been correctly awarded the cards in line with scheme provisions. However, the examination identified weaknesses in relation to four of the cases examined (8% of the sample).
- In two cases, the evidence on file suggests that the card had been approved in error.
 - In one case, a payslip provided by the applicant had not been taken into account in assessing income.
 - In one case, the monthly earnings were calculated incorrectly prior to input.
 - In two further cases, the documentary evidence was not on file or was inadequate. In these cases, the costs claimed could have impacted on the award of the medical card.
 - In one case, no documentary evidence was provided in relation to rental outgoings allowed as deductions in calculating net income.
 - In the other case, an outgoing for home improvement loan repayments was allowed without clear evidence to support the purpose of the loan.
- 22.29** The HSE has indicated that eligibility will be reviewed in relation to the four cases where the audit identified weaknesses in relation to the controls over the assessment of eligibility.

- 22.30** In addition, three out of the 50 cases examined had discretionary costs taken into consideration in their assessment. These are medical costs for on-going prescription costs and GP or hospital visits. PCRS primarily accepts GP (or hospital) reports outlining the applicant's illness and medication requirements. It was found that GP reports were accepted as the main form of evidence but they did not always specify the number of visits by the applicant or the cost of the medication to be taken and the frequency of purchase.
- 22.31** In 2013, the HSE introduced a template report for completion by GPs which requires the GP to provide information on the frequency of patient attendance and the type of medication required.

Changes in controls

- 22.32** In order to deal with the backlog that had emerged at the beginning of 2012, the HSE and the Department of Health agreed that
- Where essential information to allow assessment of eligibility was available, a medical card /GP visit card was issued for a period of one year, with any follow up required being conducted during that period.
 - Where sufficient information had not been provided to enable an assessment of eligibility, the applicant was contacted to capture the additional information required.
 - Where the HSE had misfiled applications, the applicant was contacted by phone so that sufficient details could be captured to assess eligibility. This comprised about 700 cases.
 - Cases requiring a decision from a supervisor would be escalated.
 - Letters would issue to all applicants deemed ineligible.
- 22.33** In order to prevent further backlogs from developing, the HSE also
- introduced renewal by self-assessment in relation to cardholders aged under 70 years of age, based on risk criteria
 - automatically extended eligibility for a further year where individuals whose card was due for renewal in the second half of 2012 had accessed medical services in the previous twelve months, in order to reduce the number of cases due for renewal in 2012.

Cards awarded on Discretionary Grounds

- 22.34** Where an applicant's means exceed the limits set, the HSE has discretion to award a medical card if not doing so would result in undue hardship, or to award a GP visit card where not doing so would result in it being unduly burdensome to that person to provide GP services to him/herself and his/her family. Medical cards awarded using this discretion take account of the individual's circumstances and the level of illness and related costs.
- 22.35** About 5.5% of cards were awarded on this discretionary basis in 2012. In exercising this discretion, the HSE has stated that it considers whether meeting medical costs would compromise the applicant's ability to continue in employment or provide reasonable housing and care for dependents or exceptional costs arising as a result of medical or social circumstances.

- 22.36** In making the decision, the HSE seeks to take account of medical costs, poor money management skills and the impacts of addictions such as alcohol, drugs and gambling. In this regard, HSE staff will, in general, liaise with the applicant's doctor, HSE medical officers, public health nurse or social workers, Community Welfare Officers or the Money Advice and Budgeting Service.
- 22.37** A sample of 25 medical cards approved on discretionary grounds was examined as part of the audit. In the majority of cases, the cards were awarded on the basis of significant expenditure in relation to medical costs.¹
- 22.38** The HSE stated that where an applicant's income levels exceed relevant thresholds, and there is evidence of circumstances (medical or social) which may result in undue hardship to the applicant in arranging medical services, a medical card or GP visit card may be awarded. It does not record separately cards awarded on the basis of medical or social circumstances.
- 22.39** In general, the audit found that while letters from the GP provided details of the illness of the individual, there was no attempt to quantify the medical costs involved and therefore provide evidence that these costs would cause financial hardship to the individual. As outlined above, in 2013, the HSE introduced a new form for completion by GPs which requires the GP to specify the normal number of GP visits and the type of medication required.

Medical Card Amendments by GPs

- 22.40** In February 2012, the HSE entered an agreement with the Irish Medical Organisation (IMO) whereby GPs, in certain circumstances, can make amendments to the medical card database by temporarily extending card eligibility for four months, or restoring eligibility where a patient presents who has had their eligibility removed due to not responding to renewal notices from the HSE. They can also add new-born babies to their GMS list where the parents of the babies hold a medical card and amend the database in relation to patients who are deceased. This procedure became effective on 1 September 2012. In most cases where a GP amends the medical card database, third party verification is sought from the family or a nursing home, or the HSE initiates a review of eligibility.
- 22.41** In 2012, GPs made a total of 14,000 amendments to the database. Over 90% of the amendments related to births and deaths. In 800 cases, GPs re-instated eligibility where they were of the opinion that eligibility had been removed in circumstances where the applicant had not responded to renewal notices and eligibility should be restored. The database was amended in 200 cases where GPs were of the opinion that it was a sensitive case.²
- 22.42** When new-born babies are added to the system by GPs, both the date of birth and also the date of addition are recorded. The baby is deemed to have a medical card from the date of birth and capitation is payable to the GP from the first day of the month following birth. Arrears payments issue to GPs in respect of these cases.

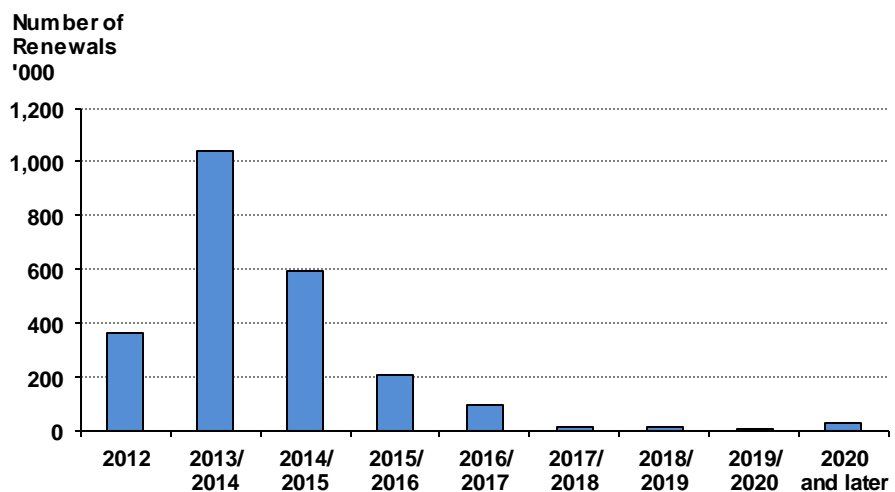
¹ In one case, no evidence had been provided in relation to significant expenditure by the individual on medical costs. However, the applicant's income levels only marginally exceeded the relevant thresholds.

² In such cases, eligibility is extended for a year. No third party verification is completed routinely since by definition the purpose of this action is to prevent correspondence being issued to individuals not in a position to deal with such administration.

Renewal of Cards

- 22.43** Under revised rules issued in 2011, standard medical cards are normally valid for three years in the case of people aged under 66, and for four years for persons aged 66 or over. Dependents of medical cardholders on reaching the age of 16 are automatically issued with a card in their own right.
- 22.44** The medical card database contains a card renewal date in respect of each cardholder. Three months in advance of that date, a notification is sent to the cardholder advising that a completed card renewal application is required to maintain entitlement to services. This is a relatively straightforward exercise in most cases as it involves the applicant confirming that relevant circumstances have not changed. About 70% of renewals operate on this self-assessment basis.
- 22.45** Where a cardholder does not respond to a renewal notice and a subsequent reminder, the medical card lapses when the expiry date on the medical card is reached.
- 22.46** The medical card database at May 2013 was reviewed to identify the number of cards due for renewal in each succeeding period of 12 months. The results are shown in Figure 22.6. The numbers of cards renewed in 2012 is included for comparative purposes.

Figure 22.6 Medical card renewal dates, at May 2013



Source: Analysis of medical card database by the Office of the Comptroller and Auditor General

Note: The renewal period in each year is from May to the following 30 April

- 22.47** Analysis of the renewal dates on the medical card database shows that over one million cards are due for renewal between May 2013 and 30 April 2014. Given that a standard eligibility period of between three and four years is applied, the number of cards due for review would be expected to be reasonably constant when compared year on year.
- 22.48** The large increase in renewals in 2013 is affected by
- the extension of eligibility for one year in relation to medical cards due for renewal in the second half of 2012 where cardholders had been actively using their cards - these cards fall to be renewed in 2013
 - the HSE's plan to standardise eligibility periods and conduct reviews in relation to cardholders who had eligibility periods in excess of the standard three or four years.

- 22.49** In relation to cardholders with expiry dates more than four years from the current date, the HSE noted that when administration of medical card processing was centralised, some cardholders had long eligibility periods, some in excess of 20 years. As part of the centralisation project the HSE initiated a programme of work to standardise the periods of eligibility commencing with cards with the longest eligibility periods. The HSE is currently working on those cardholders with eligibility of five years.
- 22.50** The HSE also stated that it is working towards implementing a system whereby risk assessment rather than expiry of the term of the card will be the primary driver of review activity.
- 22.51** The HSE uses two methods to review eligibility. These are set out in Figure 22.7.

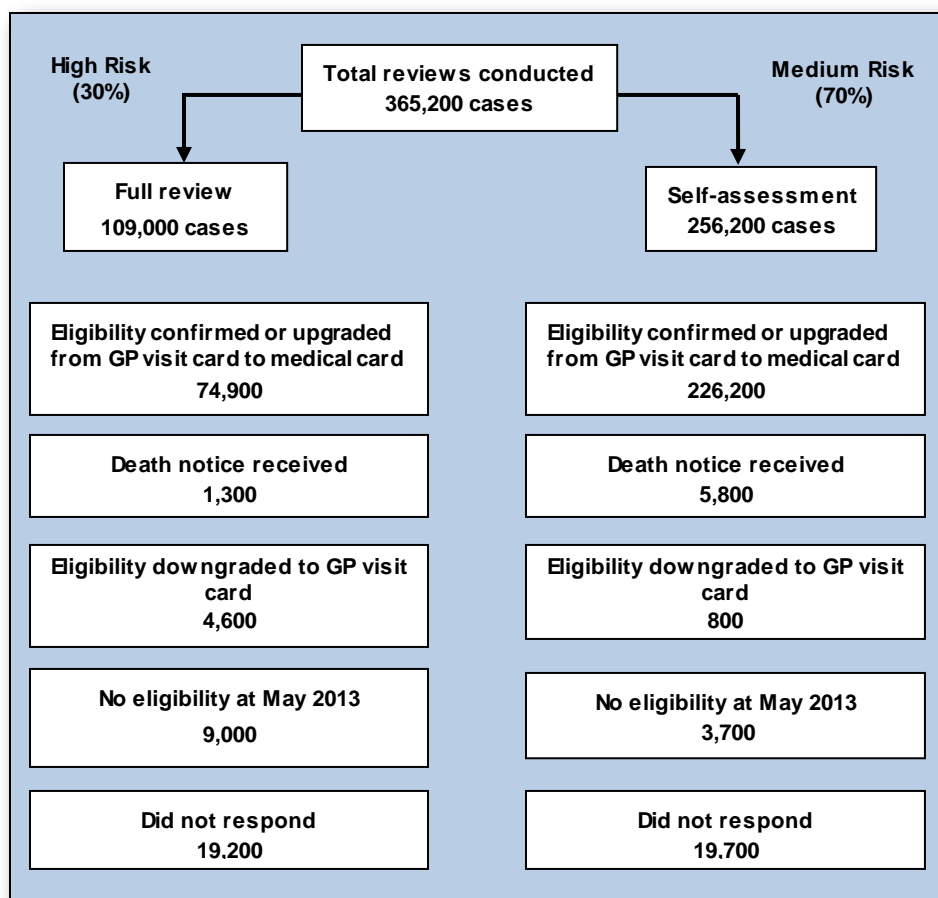
Figure 22.7 Types of review on expiry of medical cards

Category	Assessed risk level	Format of review
Full review	High	Full review of eligibility comparable with initial application
Self-assessment	Medium	The cardholder ticks a box on the renewal form confirming that his/her circumstances have not changed since the original application and signs the form

Source: Health Service Executive

- 22.52** Senior management in PCRS decide which renewals will be subject to full review or cardholder self-assessment based on the capacity of the organisation to process renewals and how many cardholders fall into particular risk categories. In general, the process seeks to select cardholders for full review who may have a higher risk of being ineligible and include
- medical cards originally awarded on a discretionary basis
 - family income declared at the time of the original approval was close to the thresholds allowed
 - cardholders aged over 70, where the income declared on the original application would not meet eligibility criteria under the revised thresholds introduced in April 2013.
- 22.53** In 2012, the HSE issued renewal notices to 365,200 cardholders. In May 2013, the HSE reviewed the current status of cardholders reviewed during 2012 in circumstances where the medical card was expiring. This was done in order to get a more accurate reflection of eligibility for these cardholders since it takes account of late responses, new applications and/or appeal procedures. The results are outlined in Figure 22.8.

Figure 22.8 Results of 2012 card renewal process, as at May 2013



Source: Health Service Executive

- 22.54** The results of the review of eligibility on expiry of medical cards varies considerably in line with the type of review conducted.
- 22.55** Overall, there is a high non-response rate. 10.7% of cardholders had not responded to renewal and the medical card had lapsed as a result.¹ The non-response rate was higher when the HSE signals that it intends conducting a full review (17.7%) as compared to where the assessment of eligibility is conducted by cardholder self-assessment (7.7%).
- 22.56** When cardholders who had not responded to the renewal process by May 2013 or where death notices have been received are excluded
- 94.3% of cardholders had their eligibility confirmed or upgraded from a GP visit card to a medical card. Where eligibility was confirmed by cardholder self-assessment, 98% were renewed, compared to 85% of renewals where the HSE conducted a full review.
 - 1.7% of cardholders renewed had previously had a medical card but were eligible only for a GP visit card when eligibility was reviewed – 5.2% were downgraded in the case of full reviews, and 0.4% in self-assessed cases.
 - Overall, 4% of cardholders who received renewal notices were found not to have eligibility to a medical card in May 2013. The ineligibility rate was 10.2% where the HSE conducted a full review, compared to 1.6% where the review was conducted by way of cardholder self-assessment.

¹ Status as at May 2013.

- 22.57** The HSE stated that it is aware that certain categories of cardholders do not engage with the renewal process but subsequently reapply when medical services are required. The HSE also noted that it expects a higher response rate where the review is conducted by way of self-assessment as opposed to where a full review is conducted, as the process is much easier to complete.

Targeted Reviews

- 22.58** During 2012, for the first time, the HSE reviewed eligibility in relation to individuals who had not accessed medical services for periods of twelve months or more. Just under 40,000 medical cardholders were contacted to confirm their residence. 61% of cardholders confirmed residence. The remainder (15,515 individuals) did not reply and had eligibility removed. The majority of these individuals had not reapplied or been granted a medical card as at May 2013.¹
- 22.59** In relation to the results of the assessment of eligibility, the HSE stated that since the type of review conducted – self-assessment or full review – is decided on the basis of risk criteria, it would expect those cases assessed as higher risk, where a full review is conducted, to have a higher proportion of cases deemed ineligible. The HSE indicated that its risk assessment process is being refined and will be significantly enhanced as data obtained from the Revenue Commissioners is used to identify high risk cases.

Review of Cards in Issue

- 22.60** Heretofore, PCRS was unable to validate client information through routine access to other government sources. While PCRS staff have access to Infosys (the Department of Social Protection database), it does not have the capacity to electronically match its own data on medical cards with data held by other government departments such as the Revenue Commissioners and the Department of Social Protection.
- 22.61** Legislation enacted in March 2013 provides for the furnishing of data by the Department of Social Protection and the Revenue Commissioners to the HSE.² Enhanced analytical capability is also required to allow for data matching, to check eligibility both at the time of the application and on an on-going basis to detect changes in circumstances.

Data Sharing with the Revenue Commissioners

- 22.62** The data sharing legislation allows the HSE to forward a file of current medical cardholders to the Revenue Commissioners. In relation to each record, the file includes the PPSN number of the cardholder and of the cardholder's spouse, where relevant. The Revenue Commissioners will then supply data in relation to each PPSN listed showing details of employment and the latest reported income figures (PAYE and Income Tax).
- 22.63** Considerable progress has been made in integrating data provided by the Revenue Commissioners with HSE systems. Some sample data has been matched and the HSE expects that data matching will be fully operational in September 2013.

¹ These reviews are outside of the normal reviews of eligibility at the end of the term of the card and are not included in the reviews outlined in Figure 22.8.

² Section 8 Health (Alteration of criteria for eligibility) Act 2013.

22.64 The examination of sample data has identified a particular data protection issue. A review of eligibility for medical card requires information in relation to a family's income. The Revenue Commissioners are of the view that it cannot, under the current legislative arrangements supply Revenue information to the HSE in relation to spouses. Therefore it can only provide Revenue data in relation to those PPSN numbers provided by the HSE. It cannot provide additional information to inform the HSE of spouses income where the HSE is unable to provide the relevant PPSN number. This issue reduces the usefulness of Revenue data in detecting ineligibility. The data protection issues are currently being considered by the HSE and the Revenue Commissioners.

Data Sharing with the Department of Social Protection

22.65 The HSE currently has access to the Department of Social Protection's systems on an individual case basis. Under the new legislative provisions, the HSE plans to obtain electronic downloads of data from the Department of Social Protection in relation to welfare payments made by that Department. This will allow the HSE to identify cardholders who are no longer in receipt of welfare payments and may no longer be eligible for a medical card.

22.66 Progress has not yet been made in relation to the actual data transfer process.

Deceased Cardholders

22.67 In 2012, the HSE introduced data sharing with the Death Events Publication Service (DEPS) operated by the General Register Office. The HSE obtains a file of deaths each week. This is uploaded to the medical card database. While there may be a delay in recording a death with the General Register Office, any amounts paid to GPs after the date of death are recouped from the GP. In 2012, some 10,000 records were updated as a result of information from DEPS. In addition, GPs can update the database to reflect the death of patients on their GP list. In 2012, GPs made 4,400 such amendments.

Penalties for False Disclosure

22.68 The legal basis for the system of eligibility originates in the Health Act 1970 and it is the responsibility of the HSE to determine eligibility. The Act also provided that the HSE may require a person to make a declaration in such form as it thinks appropriate in relation to his/her means. Where an individual makes a false declaration, the penalty on summary conviction is a fine and/or imprisonment for a term not exceeding three months. Furthermore, the Act provides that a person with entitlement to services shall notify the HSE of any change in those circumstances which disentitles him/her to the service and shall be liable to a fine on summary conviction for knowingly contravening this requirement.

22.69 The HSE stated that, in the last five years, it has not initiated legal proceedings in relation to false declarations or failure to notify a change in circumstances in relation to medical cards.

22.70 Where a cardholder is found to be ineligible, the HSE removes eligibility from the date of discovery. There is currently no legislative basis for recovering irregular payments made by the HSE on behalf of the cardholder.

Excess Expenditure

- 22.71** The HSE has stated that it was aware prior to centralisation of the service, that eligibility criteria were not being applied in a uniform way in the numerous locations where medical cards were awarded and reviewed. It stated that the centralisation of processing and the application of standard assessment guidelines identified significant numbers of medical cards where the cardholder did not satisfy the eligibility criteria.
- 22.72** The results of the 2012 card renewal process would suggest a significant level of excess payment in the medical card system as a result of changes in the cardholder's circumstances since the medical card was initially granted or eligibility was reviewed.
- 22.73** The HSE stated that it may not be feasible to establish when a cardholder became ineligible. Until recently, it did not have a legal basis for reviewing client income data in order to establish when the cardholder exceeded the income threshold. It stated that since medical cardholders can claim a range of allowable expenses, it would be almost impossible to establish when the client became ineligible.
- 22.74** The HSE commissioned a review conducted in 2012 by PWC to assess the level of excess expenditure under the medical card scheme. The assessment estimated the potential exposure arising from ineligible beneficiaries at between €65 million and €210 million. However, the assessment was limited in scope as it was conducted on the basis of a review of reports rather than a detailed analysis of the database and expenditure. The report concluded that a more reliable estimate would involve a detailed review of the PCRS database.
- 22.75** The HSE subsequently employed Accenture to conduct a review of PCRS expenditure. The agreed terms of reference of the review of excess medical card expenditure was to identify cost drivers, risk areas and associated controls. The review did not develop a baseline estimate of the level of excess expenditure under the medical card scheme.
- 22.76** An estimate of the overall level of excess payments in relation to medical cards could be derived from analysis of current eligibility in relation to a random sample of cardholders. By repeating the exercise on an annual basis, the HSE could track the effectiveness of its control and management of the medical card system.
- 22.77** In order to calculate a reliable estimate of the level of ineligible cardholding and the relevant costs, it is important that
- all cases for inclusion in the process are selected randomly from the population of medical cardholders at a specific time
 - the sample size is sufficiently large to yield reasonably reliable estimates
 - the reviews are carried out promptly following sample selection
 - a full review of eligibility is conducted
 - assessment of the cost associated with ineligibility
 - the results are capable of being audited.

Conclusion and Recommendations

- 22.78** The centralisation of medical card administration and processing will assist the HSE in ensuring that a uniform assessment process is applied. It will also facilitate data sharing with other State agencies which will allow the HSE to target reviews of cardholder eligibility in a more informed way.
- 22.79** The centralisation project resulted in significant backlogs in processing application and renewal notices at the end of 2011 and early in 2012. The HSE introduced a number of initiatives to deal with the backlog and to prevent further backlogs from developing. This included extending the self-assessment basis for renewal of medical cards, allowing GPs to amend the medical card database in certain circumstances and extending eligibility in relation to some categories of medical cardholders due for renewal in 2012.
- 22.80** As part of this examination, the application of controls for the approval of medical cards was examined in relation to a sample of 50 medical cards approved during 2012. The review identified shortcomings in relation to 8% of the sample examined. Some of the shortcomings resulted in the approval of medical card applications in circumstances where the evidence would suggest that the applicant had not satisfied the eligibility criteria. In other cases, where outgoings had been assessed, no documentation or inadequate documentation was supplied by the applicant.

Recommendation 22.1: The HSE should

- review the controls in place in relation to approval of medical cards and provide more specific guidelines to staff involved in the approval process
- clarify how the information on payslips is used in order to ensure an applicant's salary is accurately calculated — in particular, the use of information on a single week's pay should not, in general, be used to calculate an individual's annual salary
- conduct more internal reviews of medical card approvals to ensure prescribed controls are being applied.

Accounting Officer's Response: Agreed. Procedures for processing medical card applications and renewals have been enhanced during the course of 2013. Specifically, the enhanced procedures and associated training ensures that a consistent process is used for the purpose of capturing an applicant's salary. The HSE also plans to conduct additional internal reviews to ensure that prescribed controls are being applied.

- 22.81** In 2012, the HSE reviewed eligibility in relation to 365,000 cards which were due to expire. 30% of the reviews involved a full review with the eligibility in the remaining cases confirmed by the applicants through a self-assessment process.
- 22.82** Between May 2013 and April 2014, over one million cards fall to be reviewed. This, together with a planned review of 61,000 medical cards with eligibility periods in excess of the standard three/four years will present a challenge to the HSE.

Recommendation 22.2: The HSE should examine the resources required to conduct the required reviews while taking account of the risk criteria attaching to individual cardholders.

Accounting Officer's Response: Agreed. Additional processing review capacity is being provided in 2013 to perform the required number of reviews. Data received from the Revenue Commissioners will be incorporated into its risk assessment model.

Recommendation 22.3: In light of the large proportion of medical cards that are renewed on the basis of self-assessment by the medical cardholder, the HSE should institute processes which serve as a check on the accuracy of declarations made. This could include a review of eligibility in relation to a random sample of renewals where the cardholder has declared that there has been no change in circumstances.

Accounting Officer's Response: Agreed. The HSE plans to conduct a full review of a sample of cases who have confirmed eligibility by way of cardholder self-assessment. This will serve as a control on the self-assessment process.

- 22.83** The available evidence suggests there is a significant level of excess payment in the medical card system. In the main, this arises as a result of changes in the cardholder's circumstances over the validity period of the card.
- 22.84** Cardholders are legally obliged to inform the HSE of a change in circumstances which may affect eligibility. The HSE does not routinely monitor the number of cards surrendered voluntarily but identified just 22 such instances in 2012.
- 22.85** A significant proportion of medical cards lapsed as a result of non-response to renewal notices issued during 2012. Some non-responses may be attributed to medical cardholders failing to understand what they are required to do. They may subsequently be issued with new cards. However, some of those receiving the request may not respond because they are aware they do not satisfy the eligibility criteria.

Recommendation 22.4: The HSE should investigate further the reasons for the high level of non-response to renewal notices. Such a review might involve closer examination of a sample of cases to look at information held by the Revenue Commissioners (such as employment and income data), details of payments from the Department of Social Protection, and follow up after six months to establish the proportion of individuals who had reapplied and established eligibility. Evaluation of these results would allow the HSE to estimate the proportion of non-responders who were ineligible.

Accounting Officer's Response: Agreed. The HSE intends to use data records from the Department of Social Protection (when data matching is operational) and the Revenue Commissioners to ascertain when cardholders' circumstances change. It expects the rate of non-response to reduce as a result of targeted review of cases where the cardholder has not received medical services for a significant period of time and cases where the HSE has evidence that the cardholder's circumstances have changed (using data from the Revenue Commissioners and the Department of Social Protection).

22.86 Historically the HSE has not developed an estimate of the level of excess payment in the medical card system. Such an estimate would allow it to measure the effectiveness of its control systems.

Recommendation 22.5: The HSE should analyse the reasons for cardholders becoming ineligible in order to identify the key drivers of excess payments. Such an exercise would inform its overall control strategy and point towards areas where additional controls may be required at the initial application stage and would allow for an identification of the main risk criteria which should be used to select cases for review during the eligibility period.

Accounting Officer's Response: Agreed. The HSE agrees that enhanced intelligence in relation to the reasons for loss of eligibility could be used to inform additional controls which may be of benefit.

Recommendation 22.6: The HSE should conduct reviews of random samples of cardholders on an annual basis. This would allow the HSE to develop an estimate of the level of excess payment in the system as a whole. Tracking changes in this estimate of excess payment would allow the HSE to evaluate the effectiveness of its overall control strategy.

Accounting Officer's Response: Agreed. The HSE has conducted a random review in 2013 and intends completing random reviews on an annual basis.