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Final Audit Report

Audit of the Non-Insured Health Benefits Medical Transportation

October 2010

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Executive Summary

To support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians, Health Canada's Non-Insured Health Benefits Program provides coverage for a range of benefits. These benefits are provided to all registered Indians and recognized Inuit, regardless of income or place of residence in Canada when they are not insured by provinces and territories or other private insurance plans. Medical transportation is one of the benefits covered by this program. In fiscal year 2008-2009, medical transportation's total expenditures amounted to $275 million.

Transportation Benefits are managed by two groups within Health Canada. First Nations and Inuit Health Branch, through its Non-Insured Health Benefits Directorate, is responsible for policy development, program design and national coordination while, the Regions and Programs Branch, through its staff located across Canada, is responsible for program delivery.

The objective of this audit was to determine whether the Non-Insured Health Benefits Program has an effective management control framework in place to support the activities related to the delivery of medical transportation benefits. The three following lines of enquiry were assessed:

- the overall management control framework in place for the Program;
- the management of contribution agreements (i.e. delivery of services managed by communities); and
- the management of operationally managed benefits (i.e. delivery of services managed by Health Canada regional staff).

The Ontario and Manitoba Regions have been included in the scope of the audit for the second and third lines of enquiry.

The Audit and Accountability Bureau conducted this audit in accordance with the *Internal Auditing Standards for the Government of Canada*, and has examined sufficient, relevant evidence and obtained sufficient information and explanations to provide a reasonable level of assurance to support the audit conclusion.

The Non-Insured Health Benefits Program has a management control framework in place to support the delivery of benefits in the two following areas: governance and strategic direction; and policy and program design. However, opportunities for improvement were identified in the areas of risk management and information systems.

In terms of the management of contribution agreements in the Regions, while the Manitoba Region has put in place good monitoring controls, in the Ontario Region, it was found that controls, in the area of financial reporting, documentation of site visits and early intervention in case of significant issues, are insufficient.

For operationally-managed benefits, the claim verification process is not clear enough in terms of roles and responsibilities and documentation of verification steps, in the Ontario Region. As for Manitoba, account verification procedures were found to be effective.

The report includes seven recommendations aimed at addressing the above-noted areas for improvement.

Management agrees with the recommendations and its responses indicate its commitment to take action.

Introduction

Background

Provinces and territories are responsible for providing health care services, in accordance with the provisions of the *Canada Health Act*. However, there are a number of health-related goods and services that are not insured by provinces and territories. To support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians, Health Canada's Non-Insured Health Benefits (NIHB) Program provides coverage for a specified range of benefits, including drugs, dental care, vision care, medical transportation, medical supplies, and equipment, short-term crisis intervention mental health counselling, and payment of provincial health premiums in British Columbia for NIHB eligible clients. These benefits are provided to all registered Indians and recognized Inuit, regardless of income or place of residence in Canada unless otherwise covered under another health care plan or a separate intergovernmental agreement (e.g. a self-government agreement).

Medical Transportation Benefits

- Ground travel (vehicle, taxi, bus, train, snowmobile, and ambulance)
- Air travel
- Water travel
- Living expenses
- Transportation costs for health professionals.

Medical transportation benefits include transportation to assist eligible recipients to access medically-required health services that cannot be obtained on reserve or in the community of residence. Medical Transportation Benefits are managed by two groups within Health Canada. First Nations and Inuit Health Branch (FNIHB), through its Non-Insured Health Benefits Directorate, is responsible for policy development, program design and national coordination while, the Regions and Programs Branch (RAPB), through its staff located across Canada, is responsible for program delivery.

Two models have been put in place for the delivery of medical transportation. With the goal of having First Nations and Inuit communities control more of their health services, where possible the Department uses contribution agreements to deliver medical transportation benefits. In these cases, First Nations or Inuit health authorities, organizations or territorial governments deliver the medical transportation benefits. A set of criteria has been developed by Health Canada to determine the eligibility of recipients to receive contribution funding for medical transportation such as the recipients' ability to manage and provide various services, and their history in provision and administration of these services. This model is also used for communities that are located in isolated areas that involve a greater use of air transportation. As of March 31, 2009, there were 473 contribution agreements in place to support the delivery of medical transportation.

The second model is managed by Health Canada program officers and is referred to as "operationally managed benefits". This model is used for off-reserve people, and for communities that have not qualified in meeting the criteria for specific benefits or

contribution agreements or have not expressed an interest entering into a contribution agreement with the Department. Requests for prior approval of transportation benefits are made to regional NIHB transportation units. Claims are then remitted for payment/reimbursement once travel has been completed.

For both delivery models, primary responsibility for verifying individual accounts rests with officers who have the authority to confirm and certify entitlement under Section 34 of the *Financial Administration Act* (FAA), and as such, they are responsible for the legitimacy of the requested payment and for the account verification procedures. As well, financial officers who have delegated payment authority pursuant to FAA Section 33 are responsible for the system of account verification and related financial controls and must be in a position to state that an adequate Section 34 account verification process is in place and is being properly followed. The Chief Financial Officer Branch is responsible for establishing management practices and controls on account verification and ensuring their enforcement across the Department.

In fiscal year 2008-2009, NIHB medical transportation expenditures totalled $275 million. Operationally managed benefits represented $144.7 million or 52.7% of the total benefit and contribution agreements represented $130.3 million (47.3%) **(see Appendices A and B)**.

Objective

The objective of this audit was to determine whether the Non-Insured Health Benefits Program has an effective management control framework in place to support the activities related to the delivery of medical transportation benefits.

Scope and Approach

The Audit and Accountability Bureau conducted the audit in accordance with Health Canada's Risk-Based Audit Plan, which was approved for 2009-2010. The audit was conducted in accordance with the *Internal Auditing Standards for the Government of Canada* and has examined sufficient, relevant evidence and obtained sufficient information and explanations to provide a reasonable level of assurance to support the audit conclusion.

The audit examined NIHB program management, including governance and strategic direction, policy, program design, and risk management; as well as the internal control framework surrounding both the management of contribution agreements and operationally managed benefits in regional offices. Audit criteria have been derived from these controls and have been vetted with management (see **Appendix C**).

The scope of the audit included operations carried out during the fiscal years 2007-2008 and 2008-2009. Two regional offices (Manitoba and Ontario) were selected as well as NIHB Medical Transportation in Ottawa. Fieldwork was conducted from April to October 2009.

Methodology used to assess the effectiveness of the management control framework in place to support the delivery of medical transportation benefits included: interviews of staff in both headquarters and regions; documentation review of relevant policies, processes, and reports; and an analysis of a sample of 20 contribution agreements and 65 transportation claims (submitted for operationally managed benefits) processed through the two regional offices (see **Appendix D**).

Findings, Recommendations and Management Responses

Management Control Framework

Audit Criteria

The NIHB Program has implemented an effective management control framework to support the delivery of medical transportation benefits as it relates to: governance and strategic direction; policy and program design; risk management; and information systems.

Strategic Direction and Governance

The strategic direction and the governance structure of the medical transportation benefits have been found as being effective.

The strategic direction of the medical transportation component of the NIHB Program can be found in the *Medical Transportation 3 Year Business Plan.* The Plan is aimed at providing national consistency of policy implementation, efficient access and cost effective provision of benefits. Key elements of the Plan include the vision, strategic objectives, critical success factors and core strategies. Three key priorities have been identified as follows:

- to create a policy infrastructure which allows for national consistency, efficient access and cost effective provision of medical transportation benefits for First Nations and Inuit people;
- to support the collection and analysis of medical transportation information at regional and national levels, as well as identify and respond to emerging and future program requirements; and
- to create a technical and administrative infrastructure that enhances accountability and management of medical transportation expenditures.

Priorities and underlying operational objectives are effectively communicated via Health Canada intranet, communiqués to staff, NIHB management and First Nations and Inuit communities, and are routinely reviewed for continued relevance.

In terms of governance structure, as previously mentioned, medical transportation benefits are managed in collaboration by the NIHB Directorate and the Regions.

NIHB Directorate's role is to provide overall guidance and coordination from a national program perspective. Its role includes working with regions to: clarify particular aspects of the Program with a view to promoting consistent practices in all regions; determining needs for Program changes; developing frameworks to audit medical transportation benefit administration; and collecting and analysing data to support decision-making.

Regions are responsible for program delivery. They manage the delivery of medical transportation benefits delivered through both contribution agreements and operationally managed benefits. As previously noted, the determination of which approach is utilized depends on a number of factors such as the recipient's history of managing and administering community services, the isolation of the community, and the willingness of a community to enter into a contribution agreement. Decentralized delivery allows the regions, who are most familiar with the recipients, clients, providers and regional professional associations, to negotiate rates, and to develop processes, practices and administrative structures that reflect the specific needs of each region. This governance model is applied in all regions.

The Ontario Region is further decentralized as it is divided into four zones. The regional office, located in Ottawa, is responsible for handling medical transportation for the Southern Ontario Zone and for managing all appeals, communication Program changes and systems across the Region. Medical transportation services for two northern zones are handled through two zone offices located in Thunder Bay and Sioux Lookout. Zone Directors of these offices report to the Regional Director, First Nations and Inuit Health, while program direction is provided by the regional office. In the fourth zone, i.e. the Moose Factory Zone, medical transportation is managed by a First Nation organization, for six communities up the James Bay coast.

Across Health Canada, the NIHB Directorate and regional NIHB managers meet on a regular basis to discuss different aspects of the Program, including recent changes and challenges encountered in its management. There are a variety of vehicles in place to encourage follow-through on decisions and demonstrate where progress is made on specified targets, such as including these targets in performance agreements, daily interactions on issues, and participating in First Nation Inuit Health senior management forums.

One of the key governance bodies is the "*NIHB Management Forum*". The Forum is comprised of NIHB Directors and Managers representing each region as well as management from headquarters. Meetings are held monthly via teleconferences and are in person two times per year. A number of working groups also exist at various staff levels to share lessons learned and best practices (e.g. Medical Transportation Working Group, NIHB Managers Teleconferences). FNIHB and RAPB Senior Management may also be involved if certain issues need to be discussed at a higher level.

Policy and Program Design

The policy and program design of the medical transportation benefits have been found as being effective.

Policies are developed collectively by the NIHB Directorate and Regions. Regional offices may also develop regional guidelines to assist in the implementation of national policy.

The *Medical Transportation Policy Framework* defines the policies and benefits under which the NIHB Program funds eligible clients with access to medically necessary health services, through both contribution agreements and operationally managed benefits.

Regional offices are involved in the integration and coordination of changes to the Policy Framework and underlying policies and operational procedures. These documents have been developed by the NIHB Directorate in consultation with the *NIHB Management Forum.*

From the various working groups mentioned above, the NIHB Directorate, in collaboration with the Regions, documents all decisions deriving from lessons learned and best practices and applies decisions across the Regions. The *Medical Transportation Operations Manual* captures such decisions.

Based on interviews conducted in the reviewed regions, employees have a good understanding of the policy framework. Recipients are also advised of applicable policies and directives (e.g. eligible costs) through various means of communication.

Risk Management

Risks pertaining to medical transportation benefits have not been reassessed recently. Furthermore, mitigation strategies to respond to these risks are not clear.

Some risks pertaining to medical transportation have been identified by FNIHB and are listed in the "*Non-Insured Health Benefits - Risk-Based Audit Framework*", dated April 1, 2005. This document identifies risk areas directly associated with Medical Transportation Benefits such as client access, eligibility of benefits, client satisfaction and costs of medical transportations. It also identifies other risk areas, such as population growth, aging, continuity of leadership within First Nations or Inuit communities; financial sustainability of the NIHB Program; and introduction of new drugs. Furthermore, FNIHB has identified a compliance risk associated with the terms and conditions of the agreements. Risks have been identified for both medical transportation contribution agreements and operationally managed benefits.

Although they are not tailored to address key risks inherent to medical transportation benefits, the FNIHB conducts audits (referred to as "ministerial audits") of recipients that receive contributions from the Branch, including funding for medical transportation. The NIHB Directorate has also developed the *Medical Transportation Audit Framework* that identifies and assesses risks in processes, controls and consistency with policies and practices.

While the NIHB Directorate has documented some of its Program risks, the NIHB Risk-Based Audit Framework dates back to 2005 and does not consider other types of risks such as legal risks, supply source risk (e.g. bankruptcy of a supplier), compliance with various regulations (e.g. *Financial Administration Act*) and policies (e.g. *Transfer Payment Policy*), natural events (e.g. flooding, ice storms, pandemic outbreak), and dependencies and inter-relationships with provincial governments and parties outside of government. Furthermore, the NIHB Directorate has not yet developed a comprehensive approach to manage the risks associated with medical transportation, including the development of mitigation strategies and monitoring activities.

Recommendation No. 1

It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch, in collaboration with the Assistant Deputy Minister, Regions and Programs Branch, ensure that the risk identification and assessment for the NIHB Program is updated, and develop and implement mitigation strategies to respond to the risks identified.

Management Response

Management agrees with the recommendation.

The NIHB Program risk profile will be updated to clearly identify Medical Transportation Benefit risks and related mitigations strategies.

The Program will continue to make use of the range of risk management tools in place as outlined in the audit report aligning with the risk profile. (e.g., *Medical Transportation Audit Framework, NIHB Medical Transportation CA* manual, the NIHB Management Forum and the NIHB Risk Management Committee).

Information Systems

Collection of information for decision-making

Information systems supporting the delivery of medical transportation benefits do not allow for the collection of complete, reliable and timely information for decision-making. Some of the controls of the three systems (two national systems and one in Ontario) that are used need to be strengthened.

One of the key challenges identified by the NIHB Directorate in its three-year business plan is attaining the capacity to collect and analyse nationally consistent utilization (operational) and expenditure information.

Information relating to operationally managed benefits is tracked at the regional level through the Medical Transportation Reporting System for all regions, with the exception of Alberta and Ontario that have kept their own systems that were developed.

As for services provided through contribution agreements, data is collected by recipients. However, most of this data is reported through spreadsheets that have limited built-in controls. As a result, this information is often incomplete or contains discrepancies.

In 2005, a new system, the Medial Transportation Data System, was implemented to collect medical transportation data on a national basis. This system is a repository for selected operational data, as well as the data collected from contribution agreements and ambulance data systems. The consolidated information is used by management for generating reports needed to analyze and monitor medical transportation expenditures. Most of the expenditure data is inputted in the Medial Transportation Data System, using an automated approach. As data loaded into the Medical Transportation Data Store is extracted from the systems used by the Regions, the completeness and accuracy of the data for medical transportation reporting purposes is directly dependant on the quality of the input of Regional data.

Although some progress has been made in the past three years, medical transportation information is still unreliable, which limits the ability of the NIHB Program to conduct accurate and timely monitoring and evaluation of medical transportation benefits. As a result, reporting is mostly limited to cover the number of trips and client/service

eligibility and there is little evidence of measurement of the efficiency of program delivery and recipient outcomes.

Recommendation No. 2

It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch ensure that information systems supporting the delivery of medical transportation benefits allow for the collection of complete, reliable and timely information for decision-making, and that the Assistant Deputy Minister, Regions and Programs Branch ensure quality and timely collection of data for contribution agreements and operationally managed benefits.

Management Response

Management agrees with the recommendation.

The NIHB Program recognizes that quality information assists in making effective policy decisions and assessing cost effectiveness of the various Medical Transportation options Significant progress has been achieved in integrating operational information coming from departmental systems and work will continue to improve MT data capture and analysis.

The operational systems managing MT in the regions are designed to capture and track a common set of indicators and load these into a national database. Some data integrity issues remain to be resolved but work is underway with each region to address outstanding issues. The long term plan is to integrate all MT Systems.

In addition to system limitations issues identified above, the collection and integration of Medical Transportation information, when the service is delivered under a contribution agreement, is faced with capacities issues in terms of human resources and connectivity in First Nation communities. Despite standardized templates, a user guide and training provided to recipients, compliance and quality assurance issues remain.

Through the development of standardized templates, a user guide and training provided to recipients, FNIHB and RAPB have already started to work collaboratively with communities to improve the quality of the information being reported by recipients managing MT under Contribution Agreements.

<u>Controls over access to data</u>

Controls over access to data into the Medical Transportation Reporting System were also reviewed. This system has various controls that limit user access to the different function

modules and medical transportation data. However, no access logs are in place to keep track of users that access the system.

In the case of Ontario, a number of system control deficiencies were identified with the regional system, called the "*Ontario Medical Transportation System*". The most significant deficiency observed allows manual changes to batch files created in the system before the information is sent to the Department's financial system for processing of payments. In reviewing selected transactions, many batches were indicated as having been modified or cancelled. This situation elevates the risk that funds for medical transportation could be used for purposes not intended, or that approval controls may not be effective.

Recommendation No. 3

It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch and the Assistant Deputy Minister, Regions and Programs Branch consider strengthening controls pertaining to access logs in the Medical Transportation Reporting System and batch files in the Ontario Medical Transportation System.

Management Response

Management agrees with the recommendation.

The Assistant Deputy Ministers of the First Nations and Inuit Health Branch and the Regions and Programs Branch will ensure that weaknesses identified by this audit are reviewed and that control measures are assessed.

The results of this audit have been shared with all regional NIHB Managers to ensure that lessons learned and best practices are considered and applied.

A number of measures, such at the enhancement of controls over change management and access to data, have already been implemented in order to address financial and system control issues identified in the Ontario Region. Additional system changes may be implemented following an assessment of the feasibility and the cost effectiveness of the proposed measures against other priorities.

In addition, both branches are committed to following enhanced system change management protocols as promoted by the Corporate Services Branch. Such measures have already been incorporated into the Medical Transportation Reporting System (MTRS).

Regarding privacy protection, it is important to note that the NIHB Program has a privacy code and provides mandatory privacy training to staff before they are granted access to NIHB MT systems.

Management of Contribution Agreements

Establishment of the Funding Level

Audit Criterion
Clear criteria are used to determine the funding level of recipients.

It was found that the funding policies outlined by the NIHB Directorate currently bases the amount of funding on an aggregate amount for medical transportation, as opposed to a breakdown of costs to be covered by the contribution agreement, unless there is a significant change in the medical transportation needs covered by the contribution agreement. As a result, some recipients are required to report only the use of funds as a one-line budget item and root causes for deficits are not easily identifiable and intervention for corrective measures cannot be appropriately undertaken.

In fiscal year 2008-2009, contribution agreements represented $130.3 million (47.4%) of the medical transportation expenditures and of these, $20.3 million were from the Ontario Region and $18.0 million from the Manitoba Region.

The amount of funding awarded to any given recipient each year remains relatively constant unless there is a significant change in coverage for the benefit. When a recipient is accurately funded and not impacted by changes in service delivery availability, small annual increases for inflation are awarded. When there are factors that affect the ability for the First Nations community to deliver eligible benefits within funding levels, “demonstration of need” is required. Likewise, when current funding levels are deemed to be in “excess of need”, they are reduced in the following year. This means that the rationale for the amount of funding awarded is only documented on file when the level of funding is modified.

Recommendation No. 4

It is recommended that the Assistant Deputy Minister of the First Nations and Inuit Health Branch ensure that a new requirement be added to the Medical Transportation Policy Framework to require that the reporting on expenditures of all contribution agreements be itemized by category of costs.

Management Response

Management agrees with the recommendation.

The NIHB Program will review contribution agreement management guidelines contained in the NIHB Medical Transportation CA Manual to ensure that due process is followed in establishing a funding level and the reporting of financial and non-financial information is consistent with the Program requirements including the 21 mandatory medical transportation data elements.

Compliance of Agreements with Program Guidelines

Audit Criterion
Contribution agreements signed with recipients follow the guidelines set for the NIHB Program.

The review of a sample of files has demonstrated that contribution agreements signed with recipients follow the guidelines set for the NIHB Program.

Terms and conditions of contribution agreements for medical transportation, including those related to recipient reporting are established by the NIHB Directorate. Regional offices use a standard contribution agreement template. If significant departures from the template are deemed necessary, approval from the Directorate is required. This ensures that contribution agreements remain aligned with NIHB Program policies.

Monitoring of Agreements

Audit Criterion
Monitoring activities are conducted, namely recipients' reporting are reviewed for accuracy and compliance with the terms and conditions of the agreements, including adequate support of recipients' expenses.

Frequency of reporting required from recipients is not sufficiently linked to their risk profile. While the Manitoba Region has put in place good monitoring controls, in the Ontario Region, it was found that controls, in the area of financial reporting, documentation of site visits and early intervention in case of significant issues, are insufficient.

The NIHB Directorate identifies core reporting requirements for recipients through its mandatory agreement template. Reports from recipients include non-financial (activity/operational) and financial information. Non-financial information includes detailed information on clients and benefits rendered, including information on the volume of transportation carried out. Financial information required is limited to the total amount spent for medical transportation for the period under report. This requirement is

seen as insufficient to ensure that expenses were actually incurred and that they meet the terms and conditions of the contribution agreement.

In fiscal year 2008-2009, recipient reporting requirements have gone from quarterly to three times a year. The first report covers the period of April to September. The next two reports are done every three months. Although Regions may request that the frequency of reporting of a particular recipient is increased according to risks perceived, which is in line with the new Treasury Board of Canada's *Policy on Transfer Payments* that came into effect on October 1, 2008, there are no clear guidelines to help them determine when this should be requested. This is even more important as the first report is only due seven months after the start of any given fiscal year.

Recommendation No. 5

It is recommended that the Assistant Deputy Minister of the First Nations and Inuit Health Branch ensure that the NIHB Program guidelines are clarified in regards to the frequency of reporting required from recipients, based on their risk profiles.

Management Response

Management agrees with the recommendation.

The NIHB Program requires recipients to report a minimum of three times per year for all CAs. However, contribution managers have the authority to increase the level of management, monitoring and reporting requirements, based on the level of risks assessed for recipients, in line with the requirements of the new *Policy on Transfer Payments*. This importance of exercising such authority, when required, will be reiterated to Regional Directors/Managers.

Monitoring practices put in place in each of the two reviewed regions

Further observations are made below with regards to monitoring practices put in place in each of the two reviewed regions.

Ontario Region

The monitoring activities conducted for Ontario mostly involve ensuring that recipient's reports are received on time and that cost totals match other sources of information (e.g. recipient's financial statements or comparable reports). This practice is in line with above-mentioned Program guidelines.

The regional office has adopted a good practice of issuing an annual report for each recipient that provides an overview of the quality of recipient's financial and non-financial reporting, but unfortunately, this practice is not consistently applied among program officers.

FNIHB has developed an intervention policy aimed at providing the mechanisms and procedures required to deal with recipients who are encountering difficulties. However, it was found that staff is not sufficiently aware of this policy. Clear understanding of this policy is critical to ensure that staff identify and address issues in a timely manner.

In one case, a recipient, who operates services for six remote First Nations communities, incurred recurring budget deficits since fiscal year 2001-2002. Apparently, this situation originated from the inability of the Recipient to verify the status of clients in advance of approving services and payments made to ineligible clients. In fiscal year 2005-2006, the Region responded by performing status verification checks on all clients served by the Recipient. However, the Recipient incurred even more sizable annual deficits in following years, with expenses claimed significantly higher than the approved base funding, i.e. $4.5 million. For example, for the fiscal years 2007-2008, 2008-2009 and 2009-2010, claimed expenses have amounted respectively to $8.4 million, $9.8 million and $9.4 million. It should be noted that, all annual deficits incurred by the Recipient have been covered through budget amendments and/or post-approval of expenses.

In fiscal year 2008-2009, with the objective of obtaining better information on the source of increases in expenditures, the Region requested that the Recipient submit complete back-up documentation for every trip claimed. In January 2010, the contribution agreement was amended to include additional reporting requirements and allow greater monitoring of expenditures. The progress achieved by the Recipient in controlling costs and improving its reporting system will be reassessed in September 2010 where a decision will be made as to whether there is a continued risk of recurring annual deficits, whereby, the Region will take over management of the services.

This shortcoming is seen as being ultimately the result of insufficient monitoring by the Ontario Region on activity and expenses incurred by recipients.

The Ontario Region conducts site visits annually, based on operational and budgetary capacity. However, it was found that documentation pertaining to trip objectives, subject topics discussed and outcomes are not always on file.

Recommendation No. 6

It is recommended that the Assistant Deputy Minister of the Regions and Programs Branch request that the Ontario Region strengthen its monitoring activities in the area of

financial reporting, documentation of site visits and early intervention in case of significant issues, such as deficits.

Management Response

Management agrees with the recommendation.

The Regions and Program Branch will ensure that the Ontario Region strengthen its monitoring activities in the area of financial reporting, documentation of visits to recipients communities and continue to follow intervention policies in case where significant issues exist.

To address the recurring deficit problems encountered by a recipient in Northern Ontario, a review process and enhanced controls were put in place in the Spring 2010 based on the FNIHB intervention policy. Health Canada and the recipient are jointly undertaking an operational review to transition the MT service so that Health Canada's Ontario Regional Office will be responsible for the travel prior approval and claims payment and the recipient will focus on coordination of the service such as client liaison. The target date for implementation of the new operational plan is January 1, 2011.

Manitoba Region

The Manitoba Region has implemented a best practice to forecast and monitor recipient expenditures. At the beginning of each fiscal year, budgets itemized by the main cost categories of medical transportation, such as gas, vehicle insurance, driver salary and maintenance, are prepared. An itemized breakdown of how the funding level is determined is communicated to the recipients and there is an understanding that expenditures will be reported against those categories. In the event where a recipient needs more resources, expenditures by category can be closely analysed to determine the appropriateness of the funding and the model in place. Although this information is not mandatory, it is reported by most recipients and has proven to be an effective tool to monitor the use of funds. In some instances, this was instrumental in enabling program officers to identify ineligible costs incurred and implement corrective measures in a timely fashion.

Operationally Managed Benefits

Client Eligibility and Claim Verification

Audit Criteria

There is evidence of a rigorous approach to confirm and approve client and service eligibility, in line with the *Medical Transportation Policy Framework*; transportation expenses claimed are adequately supported and approved prior to payment.

In the Ontario Region, claim verification process is not clear enough in terms of roles and responsibilities and documentation of verification steps. In Manitoba, account verification procedures were found to be effective.

In fiscal year 2008-2009, operationally managed benefits represented $144.7 million or 52.6% of the total benefit and of these, $64.4 million were from Manitoba and $24.8 million were from Ontario. File review and interviews confirmed consistent application of program policy for both approval and payment of benefits and for directing overall program decision-making.

Medical transportation benefits are managed within regional offices. When a request for medical transportation is received, staff assesses each request against client and service eligibility, as well as policy coverage outlined in the *Medical Transportation Policy Framework*. After travel has occurred, clients and/or service providers submit their claims. Staff then reviews each cost element and supporting documentation to ensure consistency with prior approval, and compliance with the Policy Framework.

As part of monitoring practices surrounding claim verification, documentation is to be maintained to substantiate and provide an audit trail for each claim. File review has shown that evidence of client referrals (used to obtain medical intervention outside of the community) and confirmation of attendance at medical appointments are not always on file. It should be noted that payment of medical transportation carriers does not require receipt of evidence of client attendance.

In the Ontario Region, it was found that roles and responsibilities of the employees involved in the claim verification process and Section 34 of the *Financial Administration Act* (FAA), are not clearly defined. A review of supporting documentation did not provide sufficient evidence that claims verification has actually been carried out by staff. Furthermore, in the zone office located in Thunder Bay, auditable evidence, including the date and the identification of the individuals who performed the account verification, was absent.

In Manitoba, account verification procedures for Section 34 were found to be effective. Invoices paid are supported by appropriate approval documents and there is evidence indicating substantiation and review.

Recommendation No. 7

The Assistant Deputy Minister of the Regions and Programs Branch should ensure that, in the Ontario Region, the procedure for conducting the claim verification process is

clarified with regard to roles and responsibilities and documentation of verification steps to be carried out by staff.

Management Response

Management agrees with the recommendation.

The Regions and Program Branch agrees with the auditors' findings and recognizes that there is room for improvement regarding claims reporting relationships and accountabilities between the Ontario Regional Office and its two Zone Offices in Thunder Bay and Sioux Lookout.

The Ontario Region will strengthen and document the existing role of the Ontario NIHB Director (regional policy direction, regional NIHB MVR, OMTS responsibility, reporting, appeals, exceptions, etc.) and incorporate strong functional direction and oversight of operationally managed benefits and contribution agreements in the appropriate work descriptions in the two zones.

Additionally, the Ontario Region will restructure program management of the two NIHB MT zones under one Program Manager. This will assist in ensuring better consistency across the two zones and provide direct operational oversight for the Ontario regional headquarters over the zones.

The Ontario Region will also review roles and responsibilities directly related to the claims verification process to decrease risks of duplication or omission and take corrective actions as required.

Additionally, a review will be undertaken of the absence of auditable evidence for FAA Section 33 highlighted in the Thunder Bay Zone Office.

Conclusion

The Non-Insured Health Benefits Program has a management control framework in place to support the delivery of benefits in the two following areas: governance and strategic direction; and policy and program design. However, opportunities for improvement were identified in the areas of risk management and information systems.

In terms of the management of contribution agreements in the Regions, while the Manitoba Region has put in place good monitoring controls, in the Ontario Region, it was found that controls, in the area of financial reporting, documentation of site visits and early intervention in case of significant issues, are insufficient.

For operationally-managed benefits, the claim verification process is not clear enough in terms of roles and responsibilities and documentation of verification steps, in the Ontario Region. As for Manitoba, account verification procedures were found to be effective.

The report includes seven recommendations aimed at addressing the above-noted areas for improvement.

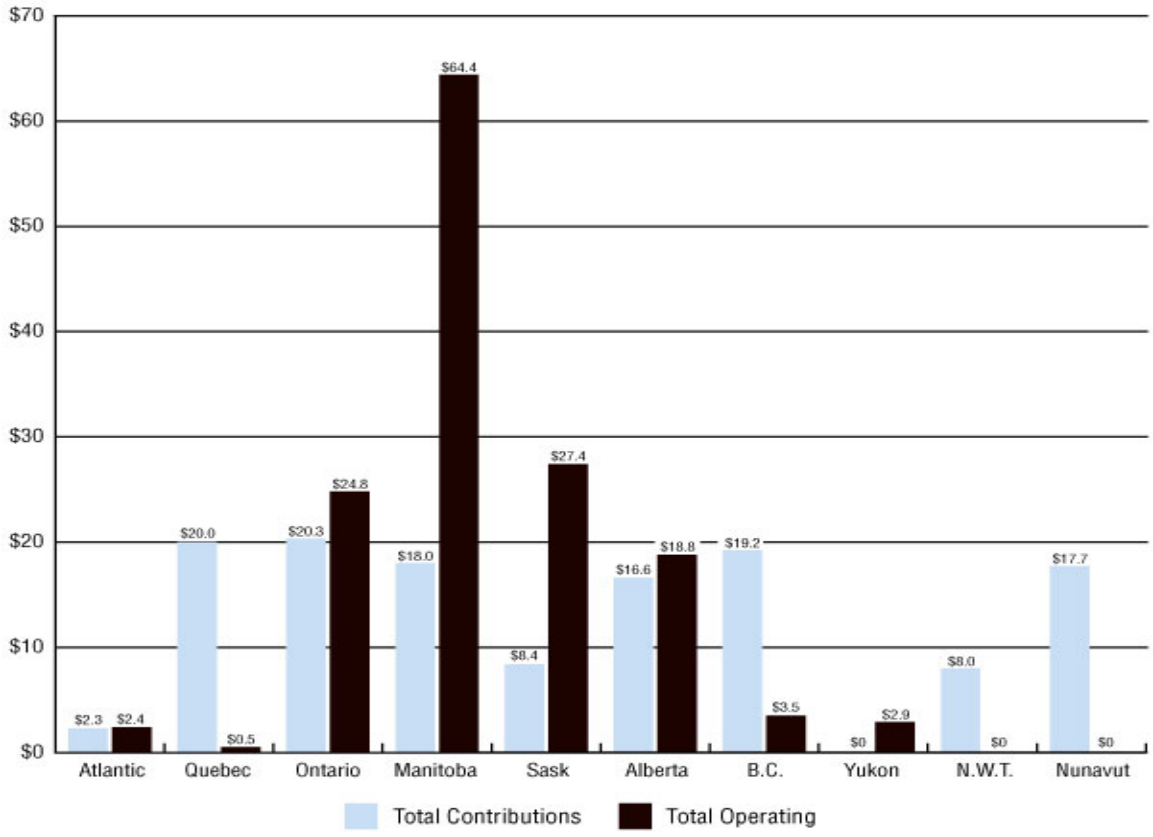
Appendix A -Total Medical Transportation Expenditures by Regional Office - Fiscal Years 2004-2005 to 2008-2009

Regional Office	Medical Transportation						Total NIHB Expenditures 2008-09		Total Eligible Client Population
	2004-05	2005-06	2006-07	2007-08	2008-09				
	$M	$M	$M	$M	$M	%	$M	%	
Manitoba	55.9	63.3	69.0	76.1	82.4	29.9%	183.5	19.6%	131,363
Ontario	35.3	38.6	40.6	45.6	45.1	16.4%	165.2	17.7%	176,401
Alberta	29.7	30.7	32.2	32.1	35.4	12.9%	133.6	14.3%	103,716
Saskatchewan	26.8	28.8	31.8	36.1	35.8	13.0%	131.7	14.1%	129,315
British Columbia	17.3	16.9	20.3	21.6	22.7	8.3%	124.5	13.3%	121,053
Québec	17.3	17.9	18.5	20.1	20.5	7.5%	71.1	7.6%	58,028
Nunavut	14.0	14.8	15.3	16.2	17.7	6.4%	34.5	3.7%	29,140
N.W.T	7.4	6.7	7.1	6.9	8.0	2.9%	23.6	2.5%	24,644
Atlantic	6.1	5.6	4.4	4.6	4.7	1.7%	31.6	3.4%	34,141
Yukon	1.8	2.1	2.4	2.9	2.9	1.1%	9.2	1.0%	7,999
Headquarters (*)							26.2	2.8%	
Total	**211.5**	**225.4**	**241.6**	**262.3**	**275.0**	**100.0%**	**934.6**	**100%**	815,800

* Headquarters does not incur operational expenditures for Benefits. Above costs are for the Medical Transportation Records System (MTRS), i.e. for data conversion and for the development and deployment of new system releases, and, for the Medical Transportation Data Store (MTDS), i.e. for data conversion and upload. These costs vary from year to year depending, on system requirements.

Source: Non-Insured Health Benefits Program Annual Report 2008-2009

Appendix B – Detail of Contribution Agreements and Operationally Managed Expenditures by Regional Office - Fiscal Year 2008-2009
(in millions $)



Note: Yukon, Northwest Territories (N.W.T.) and Nunavut are regrouped together as the Northern Region. Its regional office is located in Ottawa.

Source: Non-Insured Health Benefits Program Annual Report 2008-2009

Appendix C – Lines of Enquiry and Audit Criteria

Line of Enquiry No. 1: Management control framework implemented to support the delivery of medical transportation benefits

Audit Criteria

- Governance and strategic direction;
- Policy and program design;
- Risk management; and
- Information systems.

Line of Enquiry No. 2: Internal control framework in place to support the management of contribution agreements

Audit Criteria

- Clear criteria are used to determine the funding level of recipients
- Contribution agreements signed with recipients follow the guidelines set for the NIHB Program; and
- Monitoring activities are conducted, namely recipients' reporting are reviewed for accuracy and compliance with the terms and conditions of the agreements, including adequate support of recipients' expenses.

Line of Enquiry No. 3: Internal control framework in place to support operationally managed medical transportation benefits

Audit Criteria

- There is evidence of a rigorous approach to confirm and approve client and service eligibility, driven by policies and procedures that are in line with the Medical Transportation Policy Framework; transportation expenses claimed are adequately supported and approved prior to payment.

Appendix D - Sample Selection

This audit covered two selected regional offices: Manitoba and Ontario. Sample selection for each region was based on professional judgement. The goal of this sample was not to provide an audit opinion of the financial data, but rather of the processes and internal controls surrounding that data.

Medical Transportation Managed Through Contribution Agreements

A sample of 10 contribution agreements was selected for each regional office, for a total of twenty. The sample selected equally covered the fiscal years 2007-2008 and 2008-2009. Coverage included both large dollar as well as smaller dollar contribution agreements to ensure consistency in management and controls, regardless of their total value. Coverage was attained for each type of activity description and expense related to the agreements. Other criteria used to select the sample included irregular amounts and zone representation.

Operationally Managed Medical Transportation

A sample of 65 transportation claims was selected (35 for Ontario and 30 for Manitoba). Selection criteria included larger dollar items and significant vendors. 1/3 of the sample was selected from the fiscal year 2007-2008, and 2/3 from the fiscal year 2008-2009.