Veterans Affairs Canada
Anciens Combattants Canada

Veterans Independence Program Reimbursements Process Audit

Final: October 2011

Canada

ACKNOWLEDGEMENT

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Table of Contents

EXECUTIVE SUMMARY i

1.0 BACKGROUND 1

2.0 ABOUT THE AUDIT 3

2.1 Audit Objectives 3

2.2 Scope 3

2.3 Methodology 3

2.4 Statement of assurance 4

3.0 AUDIT RESULTS 5

3.1 Observations, Recommendations and Management Action Plans 5

3.1.1 Policies and Procedures 5

3.1.2 Performance measures and Monitoring 8

3.1.3 Claims referred to VAC for action 8

3.1.4 Opportunities to improve efficiency and effectiveness 11

3.2 Audit Opinion 11

4.0 DISTRIBUTION 12

Appendix A – Risk Ranking of Recommendations and Audit Opinion 13

Appendix B – Audit Criteria 14

EXECUTIVE SUMMARY

Since 1981, Veterans Affairs Canada has administered a community-based, national program to eligible Veterans, their families, and other primary care-givers. These services include home care, home adaptations, ambulatory health care, and intermediate nursing home care. Now known as the Veterans Independence Program, it offers self-managed care in co-operation with provinces and regional health authorities. The program allows eligible Veterans, their families, and other primary care-givers to focus on maintaining their health, independence, and their quality of life. Every effort is being made to integrate the Veterans Independence Program administration with provincial and local resources to ensure a cost-efficient choice of service is available and to avoid duplication of service delivery. As of March 31, 2011, there were 108,000 participants in the Veterans Independence Program and the total Veterans Independence Program expenditure for the fiscal year 2010-2011 was $338 million.

Veterans Affairs Canada is responsible for setting up and amending the contribution arrangements while an external Contractor, Medavie Blue Cross, is responsible for processing the claims. There were 475,060 transactions processed between December 2010 and April 2011. The expected turnaround time to process a claim is ten business days.

In the Spring of 2011, Senior Management requested an audit of the Veterans Independence Program reimbursement process to identify opportunities to further improve the process. This audit builds off the results of a 2010 audit of Veterans Independence Program and is focused on a single objective to assess the efficiency and effectiveness of the reimbursement process. The scope covered the period from November 2010 to April 2011.

Audit Opinion

In the opinion of the audit team, the Veterans Independence Program reimbursement process was determined to be generally acceptable. One issue with compliance was identified as well, there is a need to establish and communicate a service standard for claims referred to Veterans Affairs Canada for action. However, the audit results indicated that the reimbursement process was reasonably efficient and effective with 97% of transactions processed within 10 business days and there was an appropriate monitoring system in place.

Recommendations:

Recommendation 1

It is recommended that the Director General, Service Delivery Management Division, ensure that staff processing Veterans Independence Program reimbursement claims understand what is required with regard to the documentation of decision making; as well as provide training on the functionalities of the Federal Health Claims Processing System. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Complete the development of training materials on the process to document decision making and on the functionalities of the Federal Health Claims Processing System.	Service Delivery Management	December 2011
Deliver training	Service Delivery Management	March 2012

Recommendation 2

It is recommended that the Director General, Policy and Research Division, ensure that Veterans who receive the Veterans Independence Program benefits meet legislative eligibility requirements. (Critical)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Implement the new policy	Program Policy	March 2012

Recommendation 3

It is recommended that the Director General, Service Delivery Management Division, clearly establish, document and communicate the service standards for claims referred to Veterans Affairs Canada for action. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Review and ensure appropriate service standards are in place for the Veterans Independence Program	Service Delivery Management	January 2012
Communicate service standards to staff	Service Delivery Management	March 2012

Statement of Assurance

In the professional judgment of the Chief Audit Executive, sufficient and appropriate audit procedures have been conducted and evidence gathered to support with a high level of assurance the accuracy of the audit opinion provided in this report. This audit opinion is based on a comparison of the situation at the time of the audit and the pre-established audit criteria that were agreed on with management. The audit opinion is only applicable to the entity, process and system examined. The evidence was gathered in compliance with Treasury Board policy, directives, and standards on internal audit and the procedures used meet the professional standards of the Institute of Internal Auditors. The evidence gathered is sufficient to provide senior management with a high level of assurance on the audit opinion.

Original signed by *October 3, 2011*

_____ _____

Don Love
Chief Audit Executive

Date

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1.0 BACKGROUND

Since 1981, Veterans Affairs Canada (VAC) has administered a community-based, national program to eligible Veterans, their families, and other primary care-givers[1]. These services include home care, home adaptations, ambulatory health care, and intermediate nursing home care. Now known as the Veterans Independence Program (VIP), it offers self-managed care in co-operation with provinces and regional health authorities. The program allows eligible Veterans to focus on maintaining their health, independence, and their quality of life. Every effort is made to integrate the VIP administration with provincial and local resources to ensure a cost-efficient choice of service is available and to avoid duplication of service delivery.

The VIP attempts to prevent or delay the need for long term care by supporting eligible recipients to remain self-sufficient in their homes and communities. Recipients use VIP services as a contribution, along with their own resources, to achieve as much independence as possible. The VIP also recognizes that staying at home is often the preferred alternative to institutional care and the benefits provided through the VIP are a cost-effective method of support when compared to the cost of a health care facility. However, when home care is no longer reasonable, VIP assists Veterans to remain in their communities by providing intermediate care service in community facilities rather than care in contract beds.

As of March 31, 2011, there were 108,000 participants in the VIP Program and the total VIP expenditure for the fiscal year 2010-2011 was $338 million. The following table presents VIP reimbursement claims processed during the scope of this audit.[2]

Table 1 - VIP Claims Processed

Period	Veteran	Provider	Total
December 2010	52,208	38,238	90,446
January 2011	59,154	41,474	100,628
February 2011	49,545	29,650	79,195
March 2011	61,400	34,818	96,218
April 2011	64,860	43,713	108,573
Total	287,167	187,893	475,060

Source: Medavie Blue Cross – VAC Operational Reports

[1] For the purposes of this report the term “Veteran” will be used to describe the group of Veterans, their families, and other primary care-givers who are eligible under the VIP.
[2] November is not included in the table because the Operational reports recording this information only started in December 2010.

There are two information systems that are being used to capture information and to deliver the VIP. For program delivery, VAC uses the Client Service Delivery Network (CSDN) to set up contribution arrangements and record information. For processing payments the Federal Health Claims Processing System (FHCPS) is used by a third-party contractor, Medavie Blue Cross (MBC).

VAC is responsible for setting up contribution arrangements and entering into both CSDN and FHCPS. VAC is also responsible for making any reassessments or amendments to a current VIP contribution arrangement. MBC receives the claims directly from Veterans or providers and is responsible for processing the VIP claims. Three types of VIP payments are being processed: Advance Payments, Veteran Reimbursements and Provider Reimbursements.

Whenever MBC is unable to process a claim, an action item is referred to the respective VAC district office via the FHCPS. VAC staff address the action item and refer the action item back to the MBC staff to process the claim. Monitoring of any outstanding claims referred to VAC is the responsibility of the Client Services Team Managers (CSTM) and claims outstanding over 30 days are to be followed up by the CSTM.

2.0 ABOUT THE AUDIT

2.1 Audit Objectives

Currently, VAC is in the process of re-engineering the VIP program. In support of this initiative, in the Spring 2011, Senior Management requested an audit of the VIP reimbursement process to identify opportunities to further improve the process. This audit was recommended for approval by VAC's Departmental Audit Committee (DAC) and subsequently approved by the Deputy Minister on April 13, 2011.

In 2010, an audit of the VIP was completed. The focus of the 2010 VIP audit was to assess compliance with legislation or policies, accuracy of payments and the quality assurance function. This audit of the VIP reimbursement process builds off the results of the 2010 audit with the single objective to assess the efficiency and effectiveness of the VIP reimbursement process.

2.2 Scope

This audit will assess the process for both Veteran and provider VIP reimbursements, excluding Intermediate Care. Intermediate Care was excluded because it is being covered by a separate audit of the Long Term Care Program which is currently in progress.

In November 2010, the delegated authorities relating to VIP were revised along with the associated roles and responsibilities for setting up a contribution arrangement in CSDN and FHCPS. As a result, this date was selected as the starting point for the scope of the audit. The scope consisted of claims processed during the period of November 1, 2010 to April 30, 2011.

2.3 Methodology

The audit was conducted in accordance with the Institute of Internal Auditors' (IIA) Standards for the Professional Practice of Internal Auditing, as required under the Treasury Board Policy on Internal Audit. To achieve the audit's objectives, the following methodologies were used:

- Interviews were held with employees at MBC, Contract Administration staff at VAC's Head Office (HO), and program staff at VAC HO and in four district offices (DO) to gather an understanding of the current VIP reimbursement process as well as to gather necessary data for the audit.

- Two VAC district offices and both of MBC's offices were visited to observe, consult and confirm VIP processes.

- A walkthrough was conducted with MBC staff to obtain an understanding of the VIP claim reimbursement process. This also enabled the audit team to assess efficiency and effectiveness of the process.

- A statistical sample of 260 claims was reviewed. The sample was chosen from a population of 475,060 claims based on a 90% confidence interval and a 5% margin of error. This enabled the audit team to verify the accuracy of reported processing times, determine the percentage of claims that were taking longer than the standard, analyze claims referred to VAC, determine overall efficiency and make any necessary recommendations for changes.

- A non-statistical sample of 50 claims referred to VAC during the month of May was reviewed to determine the processing times by VAC and MBC. It is important to note that historical information regarding claims referred to VAC is not stored meaning once the pending claim has been actioned any record is removed from the system.

- Supportive documentation such as policies, procedures, directives and business processes were reviewed to determine that both MBC and VAC departmental policies and procedures result in VIP payments made in an efficient and effective manner.

2.4 Statement of assurance

In the professional judgment of the Chief Audit Executive, sufficient and appropriate audit procedures have been conducted and evidence gathered to support with a high level of assurance the accuracy of the audit opinion provided in this report. This audit opinion is based on a comparison of the situation at the time of the audit and the pre-established audit criteria that were agreed on with management. The audit opinion is only applicable to the entity, process and system examined. The evidence was gathered in compliance with Treasury Board policy, directives, and standards on internal audit and the procedures used meet the professional standards of the Institute of Internal Auditors. The evidence gathered is sufficient to provide senior management with a high level of assurance on the audit opinion.

3.0 AUDIT RESULTS

3.1 Observations, Recommendations and Management Action Plans

3.1.1 Policies and Procedures

Veterans Programs Policy Manual (VPPM) explains how to set up and amend contribution arrangements for VIP. This manual is published on the department's intranet and it is accessible to all staff. When Client Service Agents (CSAs) were given delegated authorities for Housekeeping, Grounds maintenance and social transportation, new policies were created and posted on the VAC intranet. The additional delegation of authorities given to the CSAs requires them to document justification of decisions which the staff find to be time consuming. The DO staff conveyed a need for additional instructions on the extent of documentation required. This will also help ensure consistencies across the district offices.

MBC has created a FHCPS Manual that contains information on processing claims and referring claims to VAC for action. This manual can also be accessed on VAC's Intranet site. During the walkthrough and interviews with staff, it was noted that VAC staff were knowledgeable about VPPM policies that are on the departmental intranet, however, some staff were not aware of the FHCPS manual.

In the absence of a national process for VAC staff, district offices were following their own protocols for actioning claims referred to VAC and there were also inconsistencies in the documentation of decision making for items such as payment authorizations. Walkthroughs of the process identified that these inconsistencies among VAC offices occasionally created difficulty for MBC staff processing the claims.

From the walkthrough exercise, it was noted that VAC staff were not utilizing the full functionality of the FHCPS. One example noted, was that VAC staff were utilizing CSDN client notes instead of FHCPS member notes to communicate with MBC staff regarding claims referred to VAC. CSDN client notes contain volumes of information on many aspects of the Veteran's benefits most of which does not relate to the reimbursement of a Veteran's claim thus requiring both VAC and MBC staff to search for the information they required. Whereas, FHCPS member notes are specific to payment problems and both VAC and MBC staff agreed that using FHCPS member notes would be more efficient. VAC staff already have access to FHCPS member notes and the reason why they weren't already using it was VAC staff were not trained on the how to use the FHCPS.

During the course of the audit, VAC staff suggested that changes be made to reimburse what is available in the contribution arrangement for low risk items such as housekeeping and ground maintenance rather than requiring the claim to be referred back to VAC. Accompanying the payment would be an explanation of the benefits

encouraging recipients to contact the department if a change in need has occurred. This opportunity to improve the process had already been identified by Program Management prior to the commencement of the audit and this change was implemented after fieldwork was completed in July 2011.

In the 2006 Audit/Evaluation of the Residential Care Program (Ontario Region) it was observed that "*VAC has not obtained Treasury Board approval or legislative authority to provide residential care and treatment benefits to clients using Frailty directly as the basis of eligibility*" with a recommendation to address this issue. Since this time Treasury Board Secretariat has been consulted with direction to revise the policy. At the time of fieldwork, a new policy was in development but had not been implemented and staff were continuing to utilize the frailty policy.

Recommendation 1

It is recommended that the Director General, Service Delivery Management Division, ensure that staff processing Veterans Independence Program reimbursement claims understand what is required with regard to the documentation of decision making; as well as provide training on the functionalities of the Federal Health Claims Processing System. (Essential)

Management Response

Management agrees with this recommendation and has been actively working toward a resolution. Since the time period covered by the audit, up to April 2011, there have been significant changes to the delegation of authority and decision making for VIP which has reduced the complexity, and improved the service delivery of VIP by changing the way decisions are made within the Department. To support this, the "Requirements for Decision Making and Determination of Need Program Directive" and a variety of new tools (Guiding Questions, Criteria/Situation requiring referral for Case Management) have been released to assist decision makers in identifying Veterans' needs, ensure that the appropriate level of VIP services are approved for the Veteran and that decisions are appropriately documented. The new delegations and directive follow the principles of administrative law and are consistent with the Six-Step Decision-Making Model training that staff have now received.

In addition, VIP Program Management in consultation with field staff is developing comprehensive training to support Client Service Agents (CSAs) with the delivery of VIP. A portion of this training will be dedicated to providing staff with further clarity around decision making and the functionality of FHCPS. Delivery of this learning is planned for fall 2011. Once delivered, the success of the training will be evaluated on an ongoing basis based on feedback and recommendations. Adjustments and future learning will be determined by this process.

As well, the Program Performance Unit in consultation with Program Management has developed a performance monitoring tool which will assist with compliance monitoring of VIP decisions. This monitoring will assist in ensuring program level compliance and allow for corrective action such as training to occur if systemic issues are detected. Release of this tool is being coordinated with the pending release of amended VIP policies.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Complete the development of training materials on the process to document decision making and on the functionalities of the Federal Health Claims Processing System.	Service Delivery Management	December 2011
Deliver training	Service Delivery Management	March 2012

Recommendation 2

It is recommended that the Director General, Policy and Research Division, ensure that Veterans who receive the Veterans Independence Program benefits meet legislative eligibility requirements. (Critical)

Management Response

Management agrees with this recommendation. A new policy has been approved which clarifies eligibility for the Veterans Independence Program which clearly outlines how staff are to determine eligibility with direct linkages to the Veteran's pensioned/awarded condition. A comprehensive implementation approach has been developed; including staff training and communications materials to ensure all parts of the Department are clear on regulatory requirements. In addition, Program Performance and Audit and Evaluation are being engaged to monitor and or evaluate implementation of the policy change.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Implement the new policy	Program Policy	March 2012

3.1.2 Performance measures and Monitoring

A definition of the processing turnaround time (TAT) for MBC is contained in the contract, signed in 2005. It states a one business day TAT for Veteran reimbursements and ten business days TAT for provider reimbursements. At the time of signing the contract, a one day TAT appeared reasonable given that the Department forecasted only a small number of Veteran reimbursements. However, as illustrated in Table 1 on Page 1, currently there are more Veteran reimbursements than provider reimbursements. As a result VAC and MBC have accepted ten business days to be the standard for both Veteran and provider reimbursement claims.

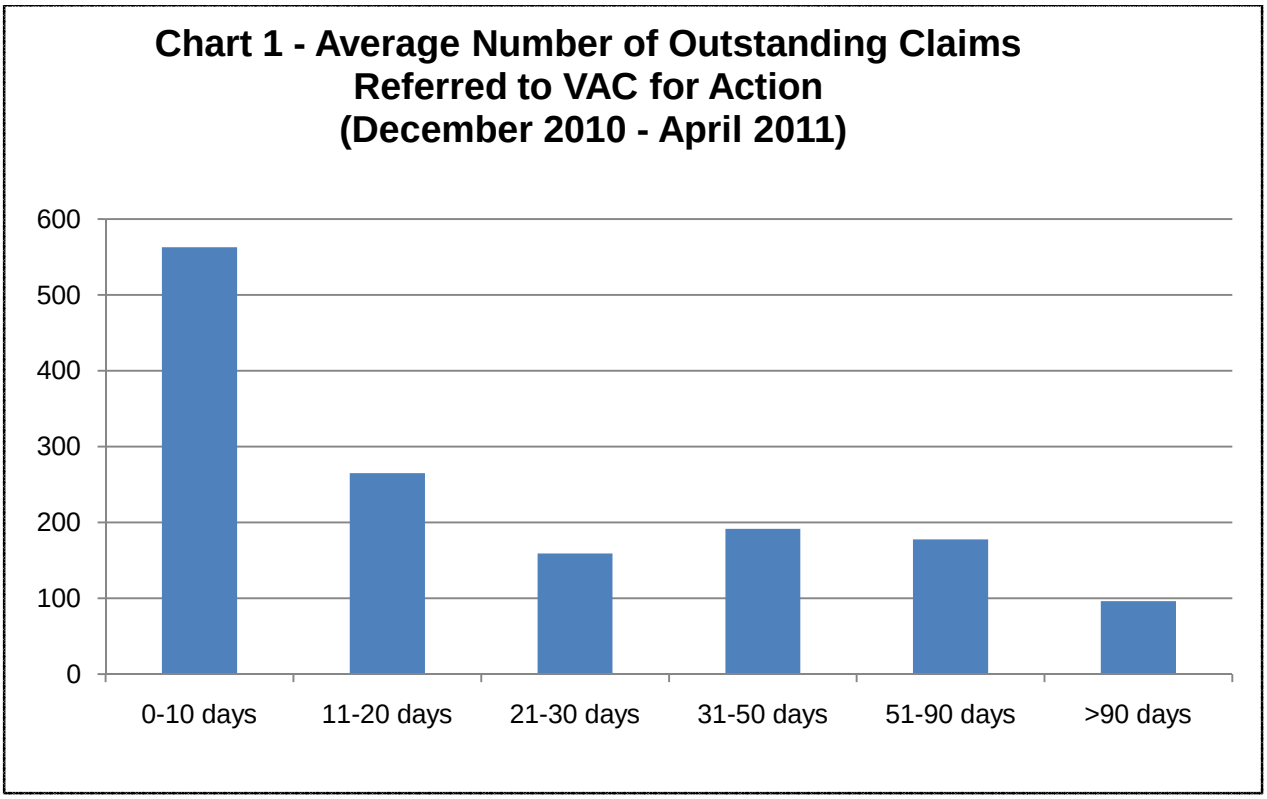
Since December 2010, at VAC's request, MBC has been providing the department with a monthly operational report to monitor TATs. VAC has been using this information to follow-up with district offices to clear backlogs of outstanding claims referred to VAC. The results of these reports identified that over 97% of claims were processed within the 10 business day TAT.

The results of the statistical sample indicate that 97% of the claims were processed within ten business days with the average TAT being seven days. Only six claims in the sample of 260 took longer than ten business days all of which were referred to VAC for action. Four claims had been referred to VAC for action taking between 13 and 34 days to process. One claim was referred to VAC for a provider set up requiring 91 days which was a delay on the providers end. Finally, a provider claim was incorrectly sent to the Medavie office which processes Veteran claims resulting in a 24 day TAT to process. These results from the statistical sample are consistent with Operational Reports produced by MBC which show that only 3% of claims require greater than 10 business days to process.

3.1.3 Claims referred to VAC for action

As part of VAC's transformation initiative, the Department has been working with MBC to improve the reimbursement process for both Veterans and providers. One area of particular focus has been to reduce the volume of claims referred to VAC for action.

Since November 2010, operational reports are now created by MBC identifying outstanding claims referred to VAC for action. Then beginning in March 2011, MBC started monitoring daily claims referred to VAC for action with reason codes, and showing totals of outstanding claims at month's end. However, it should be noted that once an outstanding claim referred to VAC has been actioned it is not tracked so historical data is not available. These monthly reports identified that the month's end average was 1,372 outstanding claims referred to VAC for action. The table below presents an aged chart showing length of time outstanding.



Source: Medavie Blue Cross – VAC Operational Reports

It was identified that the most common issue requiring MBC to refer a claim to VAC for action is the early depletion of the Veteran's contribution arrangement. VAC management was aware of this issue and prior to the commencement of the audit had implemented a change requiring MBC to begin notifying VAC in advance when a Veteran is likely to deplete the contribution arrangement. Even with this change there are still circumstances when Veterans will deplete their contribution arrangement requiring MBC staff to refer the claim to VAC for action; however, it was reported by staff at both VAC and MBC that this change has significantly reduced the number of claims referred to VAC. Unfortunately without historical data regarding the volume or reason for claims referred to VAC for action the audit team was unable to quantify the impact of this change.

To determine the current TAT for claims referred to VAC for action and the reasons, a non-statistical sample of 50 claims was reviewed. The results were as follows:

- One of the fifty claims took MBC longer than ten business days to process.
- Fourteen of the fifty claims took VAC longer than ten business days to complete the necessary action with the longest requiring 76 business days.

- Overall, the average TAT for all three steps was 24 business days to process the claim with the longest requiring 85 business days.

It was noted that over 50% of the claims referred to VAC for action continues to be the depletion of the Veterans contribution arrangement. One anomaly identified related to the recent introduction of the Harmonized Sales Tax (HST) in Ontario and British Columbia. This change resulted in a significant percentage of claims referred to VAC for action. However, this cause of referral to VAC will eventually disappear when the contribution arrangements are updated.

An issue identified was the absence of a service standard for claims referred to VAC. In the absence of any direction, most staff believed the standard to be 30 calendar days because that is the timeframe that the operational reports were measuring. In some cases staff reported that they were focusing on other priorities until these claims approached 30 days. This miscommunication of expectations results in delays to process payments for both Veterans and providers.

Recommendation 3

It is recommended that the Director General, Service Delivery Management Division, clearly establish, document and communicate the service standards for claims referred to VAC for action. (Essential)

Management Response

Management agrees with this recommendation. Program Management is committed to reviewing existing service standards to ensure that appropriate service standards are in place. Once a determination has been made the service standards will be documented and communicated to staff.

In addition VIP related service standards will be incorporated into the comprehensive VIP training being delivered to Client Service Agents.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Review and ensure appropriate service standards are in place for the Veterans Independence Program	Service Delivery Management	January 2012
Communicate service standards to staff	Service Delivery Management	March 2012

3.1.4 Opportunities to improve efficiency and effectiveness

The following are some identified opportunities for management consideration:

- The contribution arrangement information is entered twice in both the CSDN and FHCPS systems. Reducing this to a single entry could result in a significant improvement in efficiency as all 108,000 contribution arrangements are updated at least once a year and can take 10 to 15 minutes to update both systems.

- When a contribution arrangement needs to be amended, the current form requires that all existing information be re-entered in addition to the change in the contribution arrangement. As described above this would also result in a significant reduction in resource time spent entering data.

- Over 50% of the claims referred to VAC requiring action were due to insufficient funds in the contribution arrangement. One opportunity to help further reduce this number would be to automatically update the annual rate increases.

- Whenever a claim reaches the contribution limit, the entire amount is withheld until the contribution limit is increased. If a system edit was introduced to allow claims to be paid up to the limit and only the difference withheld until the contribution limit has been adjusted, this would reduce delays in Veterans and providers receiving the majority of their VIP reimbursement.

- The FHCPS system could provide an indicator to show that the maximum statutory rate had been reached to help prevent MBC staff from referring any additional claims to VAC for the year.

- FHCPS form letters could be reviewed to make necessary changes including deleting unnecessary spaces between paragraphs thus reducing the letter to two pages rather than three.

3.2 Audit Opinion

In the opinion of the audit team, the Veterans Independence Program reimbursement process was determined to be generally acceptable. One issue with compliance was identified as well, there is a need to establish and communicate a service standard for claims referred to Veterans Affairs Canada for action. However, the audit results indicated that the reimbursement process was reasonably efficient and effective with 97% of transactions processed within 10 business days and there was an appropriate monitoring system in place.

4.0 DISTRIBUTION

Deputy Minister
Associate Deputy Minister
Veterans Ombudsman
Departmental Audit Committee Members
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Office of the Auditor General

Medavie Blue Cross
Vice President, Government & Corporate Secretary
Director, Federal Administered Programs and Corporate Audit
Director, Government Financial Services

Appendix A – Risk Ranking of Recommendations and Audit Opinion

The following definitions are used to classify the ranking of recommendations and the audit opinion presented in this report.

Audit Recommendations

Critical	Relates to one or more significant weaknesses for which no adequate compensating controls exist. The weakness results in a high level of risk.
Essential	Relates to one or more significant weaknesses for which no adequate compensating controls exist. The weakness results in a moderate level of risk.

Audit Opinion

Well Controlled	Only insignificant weaknesses relating to the control objectives or sound management of the audited activity are identified.
Generally Acceptable	Identified weaknesses when taken individually or together are not significant or compensating mechanisms are in place. The control objectives or sound management of the audited activity are not compromised.
Requires Improvement	Identified weaknesses, when taken individually or together, are significant and may compromise the control objectives or sound management of the audited activity.
Unsatisfactory	The resources allocated to the audited activity are managed without due regard to most of the criteria for efficiency, effectiveness and economy.

Appendix B – Audit Criteria

Audit Criteria	Result
Policy, Procedures and roles have been clearly defined and communicated.	Partially met
Management has identified appropriate performance measures linked to planned results.	Partially met
Management monitors actual performance against planned results and adjusts course as needed.	Met
Compliance with financial and program management laws, policies and authorities is monitored regularly.	Partially met
Transactions are coded and recorded accurately and in a timely manner to support accurate and timely information processing.	Met
Records and information are maintained in accordance with laws and regulations.	Met
There is appropriate segregation of duties.	Met