Veterans Affairs Canada | Anciens Combattants Canada

PROGRAMS OF CHOICE ANALYSIS AUDIT

Final: June 2009

Canada

This report was prepared by the Audit and Evaluation Division

ACKNOWLEDGEMENT

The Audit and Evaluation Division would like to acknowledge the efforts of those who provided input to the audit, with particular thanks to staff engaged in the delivery of the program and functional units responsible for program management.

The Audit Team consisted of the following:
Basil Andrew, Audit and Evaluation Manager
Tim Brown, Audit and Evaluation Officer
Adrianne Van Lunen, Audit and Evaluation Officer

Table of Contents

Executive Summary

In May 2008, Veterans Affairs Canada (VAC) Audit and Evaluation Committee approved an audit of the Federal Health Claims Processing System (FHCPS) Programs of Choice. The focus of the audit was on VAC's overall administration of the Treatment Benefits Program which provides treatment benefits and services to eligible Veterans. The audit was conducted from October 2008 to February 2009.

The FHCPS is one of the largest health claims processing systems in the country. The system, operated by Medavie Blue Cross on behalf of VAC, the Department of National Defence (DND) and the Royal Canadian Mounted Police (RCMP), provides health claims adjudication and processing services for the three partner Departments. VAC uses the FHCPS to process benefits and services associated with the Treatment Benefits Program and the Veterans Independence Program. The scope of the audit related only to the Treatment Benefits Program. As well the audit did not include an analysis of DND or RCMP programs.

The Treatment Benefits Program provides benefits and services to eligible clients through fourteen Programs of Choice which are processed through the FHCPS. The following table provides an overview of the key information associated with VAC's Treatment Benefits Programs for 2007-08. Additional information associated with each of the Programs of Choice is presented in Section 1.1.

VAC's Treatment Benefits Program (2007-08)			
Program of Choice	**Clients**	**Transactions**	**Expenditures**
1. Aids for Daily Living	15,312	62,309	$3,065,420
2. Ambulance Service/Health Related Travel	30,400	498,385	18,959,103
3. Audio Program	48,435	403,111	39,462,892
4. Dental Services	31,560	226,958	17,654,442
5. Hospital Services	1,926	16,162	2,241,501
6. Medical Services	1,490	3,736	468,942
7. Medical Supplies	18,994	142,101	6,763,399
8. Nursing Services	23,426	173,219	8,413,653
9. Oxygen Therapy	2,289	34,840	3,560,174
10. Prescription Drugs	80,348	5,939,103	124,223,815
11. Prosthetics & Orthotics	5,430	11,466	2,848,280
12. Related Health Services	36,016	370,632	21,400,735
13. Special Equipment	28,197	225,337	29,309,321
14. Vision Care	19,137	119,097	5,233,635
Total	111,653	8,226,456	$283,605,312

Treatment benefits are delivered to eligible clients by registered health care providers. Clients are provided with a Health Care Identification Card which indicates the Programs of Choice for which they have eligibility. Each Program of Choice has a unique Benefit Grid which defines the treatment benefits approved for that particular program. Clients present their health card along with required prescriptions to the health care provider of their choice. Providers verify eligibility, and when necessary, obtain authorization from one of several authorization units which have been established to administer the programs. Based on the most recent National Client Satisfaction Survey, 79% of clients who received treatment benefits considered the program met their needs. Additional information associated with processes used to deliver the Treatment Benefits Program is presented in Section 1.2.

To address the audit objectives, fieldwork was conducted in the operational areas involved with the delivery of the Treatment Benefits Program. As well, audit work was conducted in units which have functional management responsibility for the program.

Audit assurance is being provided associated with the following audit objectives: adequacy of system edits, adequacy of reporting and opportunities to reduce the number of transactions used to deliver the program. Appropriate audit procedures have been conducted and sufficient evidence obtained to provide this assurance and support the findings contained in this report.

Conclusions by Audit Objective:

To assess the adequacy of the Department's management control framework regarding the benefits provided through the Programs of Choice

The audit identified a number of opportunities to improve the administration of the program, including: fully implementing the recently adopted management framework for the Treatment Benefits Program, completing the Benefit Grid Review and initiating reviews of the Dental Services and Prescription Drug Programs, making greater use of the Benefit Review and Formulary Review Committees; conducting quality reviews of the program to ensure compliance with legislative and policy requirements; and reviewing operational units engaged in the delivery of the program.

To assess the adequacy of the system edits and controls associated with dollar limits, frequency limits and prescriber recommendations for benefits available through the Programs of Choice

The process to maintain the edits in the benefit grids is complicated by the fact that specific edits must be established for benefits on a province/territory basis. Historically, VAC has not dedicated sufficient resources to this activity and for some of the Programs

of Choice the edits had not been updated for a number of years. Dollar limit edits had not been established for all benefits covered by the program. This results in providers being reimbursed for amounts claimed, without verifying if rates charged are reflective of market rates.

Controls contained in the Benefit Grids to ensure that provincial programs are accessed had not always been activated. As well, a clear strategy is needed to define where agreements with health care provider associations are required for each of the Programs of Choice.

To determine the degree of compliance with applicable policies

The audit originally planned to sample transactions and conduct compliance testing against VAC legislative and policy requirements for the Treatment Benefits Program. After conducting preliminary planning to address this audit objective a number of factors were identified which resulted in the decision to exclude transaction testing during the audit. Some of these factors included; policies for the program require significant updating and consolidation, a major review of the Benefit Grids was underway and improvements are required to management processes used to monitor program delivery's compliance with policy. The audit contains recommendations to update and consolidate policies and procedures for the program.

To assess the adequacy of information used for decision making and reporting

Improvements are required to the provision of information and regular reporting to operational, functional and senior managers associated with the Treatment Benefits Program. Much of the information being used to manage the program was being extracted from the FHCPS using ad hoc queries or with manually prepared reports.

To identify opportunities to reduce the number of benefit codes used to process treatment claims

Based on the analysis of claims data, the greatest opportunity to reduce the number of Benefit Codes (transactions) being used to deliver the Treatment Benefits Program without negatively impacting client benefits, appears to be in the Health Related Travel, Audio Services, Prescription Drugs and Vision Care Programs of Choice.

The recommendations contained in this report are intended to improve the management and delivery of the program. It is acknowledged that new program management structures which were being put in place at the time of the audit should address many of the findings contained in this audit report. Completion of the review of the Benefit Grids, currently in progress, which will define the benefits and services to be covered by the Treatment Benefit Program and the associated program rules, is seen as an important

first step to improving overall administration of the program.

The audit report contains 12 recommendations of which 6 are deemed essential and 6 important, see Annex C for a definition of the significance of the observation. Detailed recommendations contained in this report are listed below.

Recommendation 1 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch in consultation with the Assistant Deputy Minister, Service Delivery and Commemoration Branch ensure the recently adopted program management structure for the Treatment Benefits Program is fully implemented, including clearly defining and communicating the roles and responsibilities of units and staff engaged in the management and delivery of the program.

Recommendation 2 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch:

- **ensure the goods and services provided through the Treatment Benefits Program are reviewed on a regular basis;**
- **establish delegated authorities to approve changes to the Benefit Grids;**
- **complete the Benefit Grid Review currently underway and implement necessary changes to the program;**
- **initiate a review of the Benefit Grids for the Dental Services and Prescription Drug Programs; and**
- **track client and provider concerns associated with the Treatment Benefits Program.**

Recommendation 3 (Important)
It is recommended that the Director, Disability Benefits and Treatment Benefits Program:

- **finalize the Terms of Reference for the Benefit Review and the Formulary Review Committees; and**
- **ensure the Formulary Review Committee conducts reviews of claim trend data associated with the Prescription Drug Program.**

Recommendation 4 (Essential)
It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch in consultation with the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch implement a process to conduct quality reviews for the Treatment Benefits Program to ensure compliance with regulatory and policy requirements, to assess the consistency of service delivery and to identify areas where changes are required to programs,

policies and processes.

Recommendation 5 (Important)
It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch:

- **develop a strategy to implement the relevant outstanding recommendations in the Treatment Authorization Centre Review;**
- **establish a process to conduct regular reviews of the activities and work performed in the Treatment Authorization Centres**;
- **conduct an analysis of the client reimbursements and provider payments to identify claims which could be forwarded to the third party contractor for processing; and**
- **improve operational reporting for activities performed in the Treatment Authorization Centres, including the establishment of reports to monitor client and provider payments.**

Recommendation 6 (Important)
It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch in consultation with the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch:

- **establish line management responsibility for the Special Authorization Unit;**
- **review the Special Authorization Formulary to confirm if all prescription drugs should continue to require preauthorization; and**
- **monitor the cost and number of calls used to process individual authorizations completed by the unit.**

Recommendation 7 (Important)
It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch determine how changes to business processes could be implemented to reduce the requirement to have cases adjudicated by the Exceptional Benefits and Head Office Appeals Units.

Recommendation 8 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch:

- **ensure that appropriate edits are entered in the Benefit Grids for treatment benefits covered by the program and assess options to restructure the program to simplify regular maintenance requirements;**
- **ensure that adequate resources are assigned to conduct regular reviews of the edits in the Benefit Grids for the fourteen Programs of Choice; and**
- **establish a system of records to document changes which have been made to the Benefit Grids and associated edits.**

Recommendation 9 (Important)
It is recommended that the Director, Disability Benefits and Treatment Benefits Program determine where agreements with provider associations are required and assign responsibility for their negotiation and maintenance.

Recommendation 10 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch in consultation with the Assistant Deputy Minister, Service Delivery and Commemoration Branch review and update existing policies and procedures for the Treatment Benefits Program, create new policies and procedures where required and consolidate this information in one location.

Recommendation 11 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch determine the regular reporting needs of operational, program and senior management associated with the Treatment Benefits Program and place these reports in production.

Recommendation 12 (Important)
It is recommended that the Director, Disability Benefits and Treatment Benefits Program:

- **establish a process to monitor the number of transactions used per claim to deliver the Treatment Benefits Program; and**
- **initiate a process to review the Health Related Travel, Audio Services, Prescription Drugs and Vision Care Programs of Choice to identify opportunities to reduce the number of transactions being used to deliver these programs.**

1.0 Introduction

1.1 Treatment Benefits Program Overview

The Veterans Affairs Canada (VAC) Treatment Benefits Program provides benefits and services to eligible clients through fourteen Programs of Choice. These programs are administered for VAC through the Federal Health Claims Processing System (FHCPS), an automated system operated by Medavie Blue Cross (Medavie), a third-party contractor. The contract also provides services for health claims processing for the Department of National Defence and the Royal Canadian Mounted Police.

Treatment services and benefits are provided to eligible clients for the treatment of pensioned conditions and disabilities or as supplementary coverage when the required treatment benefits are not provided under provincial health programs or through a client's private insurance.

The following provides a brief overview of the benefits and services provided through each of the Programs of Choice:

Aids for Daily Living - devices and accessories, including necessary repairs, designed to assist the activities of a Veteran's daily living. Examples of eligible benefits include walking aids, self-help aids, bedroom aids, and bathroom aids.

Ambulance/Health Related Travel (HRT)
Ambulance - ambulance services to or from a medical facility when required due to medical condition.

Health Related Travel - client travel costs incurred in order to receive a treatment benefit or service.

Audio (Hearing) Services - benefits to help with hearing impairment. Examples of eligible benefits include hearing aids, telephone amplifiers, infrared devices, hearing aid accessories and dispensing/fitting fees.

Dental Services - basic dental care and some pre-authorized comprehensive dental services.

Hospital Services - treatment services provided in an acute care, chronic care, or rehabilitative care hospital. Benefits include both inpatient and outpatient services provided in an accredited provincial hospital or health facility.

Medical Services - medical services provided by a licensed physician. Services include medical examinations, treatment or reports specifically requested by VAC.

Medical Supplies - medical and surgical equipment and supplies used in a non-hospital setting. Examples of eligible benefits include medical and surgical, bandages and incontinence supplies.

Nursing Services - nursing assessments and provision of services by a registered nurse or a qualified nursing assistant. Examples of eligible services include foot care, the administration of medications, application of dressings and counselling Veterans or caregivers in the use of medical supplies.

Oxygen Therapy (Respiratory Equipment) - oxygen equipment and accessories, as well as the rental or purchase of other respiratory supplies and equipment. Examples of eligible benefits include oxygen concentrators, compressors, and oxygen gas.

Prescription Drugs - standard benefits include prescription drugs, over-the-counter medications and some medical supplies. Special Authorization Benefits provide eligible clients with less common or higher cost therapies approved by VAC.

Prosthetics and Orthotics - necessary prosthetics or orthotics in addition to accessories and repairs for these benefits. Examples of eligible benefits are artificial limbs, braces and custom-built footwear.

Related Health Services - benefits from health professionals such as chiropractors, massage therapists, acupuncturists, physiotherapists, chiropodists and psychologists.

Special Equipment - equipment required for the care and treatment of VAC clients which have been prescribed by an approved health professional and supported by other documentation as required. Examples of eligible benefits are hospital beds, walkers, lifts, home adaptations, wheelchairs, and driving aids.

Vision (Eye) Care - benefits to correct and manage sight impairments. Examples of eligible benefits include eye examinations, basic single lenses and bifocal lenses. This program also provides low-vision aids which are available to clients from the Canadian National Institute for the Blind.

The following tables provide data regarding the number of clients, transactions and expenditures by Programs of Choice for the period April 1, 2002 to March 31, 2008.

Clients by Program of Choice						
Program of Choice	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
1. Aids for Daily Living	17,948	19,215	19,032	18,668	16,282	15,312
2. Ambulance Service/HRT	16,835	32,494	33,049	33,902	33,156	30,400
3. Audio Program	40,836	43,849	45,901	49,580	48,911	48,435
4. Dental Services	33,508	33,766	34,221	33,892	32,727	31,560
5. Hospital Services	7,376	7,922	7,228	5,939	2,558	1,926
6. Medical Services	3,970	3,229	2,347	2,251	1,850	1,490
7. Medical Supplies	22,304	22,284	21,764	21,134	20,047	18,994
8. Nursing Services	16,789	16,245	20,355	21,999	22,707	23,426
9. Oxygen Therapy	2,918	2,938	2,819	2,636	2,411	2,289
10. Prescription Drugs	83,797	83,535	84,470	84,250	82,888	80,348
11. Prosthetics & Orthotics	7,664	7,728	7,003	6,771	5,871	5,430
12. Related Health Services	29,733	32,215	33,385	35,721	36,314	36,016
13. Special Equipment	18,416	20,250	22,523	26,092	27,580	28,197
14. Vision Care	24,699	24,356	23,799	23,221	20,636	19,137
Unique Clients	111,386	114,661	116,246	117,091	114,973	111,653

Treatment Transactions by Program of Choice						
Program of Choice	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
1. Aids for Daily Living	57,914	70,287	70,315	71,284	62,604	62,309
2. Ambulance Service/HRT	58,026	383,895	454,336	521,202	525,288	498,385
3. Audio Program	345,339	393,063	397,395	421,405	405,555	403,111
4. Dental Services	232,330	242,340	250,397	247,586	229,598	226,958
5. Hospital Services	39,628	47,821	49,379	46,424	16,608	16,162
6. Medical Services	9,111	7,152	6,030	6,584	4,690	3,736
7. Medical Supplies	138,193	150,104	148,986	151,639	145,040	142,101
8. Nursing Services	143,161	142,785	157,884	177,489	169,692	173,219
9. Oxygen Therapy	58,674	54,948	47,483	43,842	34,790	34,840
10. Prescription Drugs	4,079,450	4,247,147	4,695,127	5,152,201	5,557,321	5,939,103
11. Prosthetics & Orthotics	15,931	15,441	13,968	13,512	11,863	11,466
12. Related Health Services	336,883	354,115	364,597	371,128	357,829	370,632
13. Special Equipment	123,714	136,372	161,840	189,244	209,031	225,337
14. Vision Care	157,002	148,161	148,129	145,126	126,971	119,097
Total	5,795,356	6,393,631	6,965,866	7,558,666	7,856,880	8,226,456

Treatment Expenditures by Program of Choice						
Program of Choice	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
1. Aids for Daily Living	$3,917,283	$4,350,828	$4,053,678	$3,717,601	$3,122,746	$3,065,420
2. Ambulance Service/HRT	3,746,470	17,325,649	19,287,605	20,726,938	20,422,437	18,959,103
3. Audio Program	35,443,566	37,291,720	37,638,920	41,418,791	39,141,589	39,462,892
4. Dental Services	17,497,775	18,120,241	19,356,662	19,628,516	18,490,078	17,654,442
5. Hospital Services	17,651,240	26,817,206	28,263,504	28,176,655	3,355,357	2,241,501
6. Medical Services	453,109	581,637	556,121	585,780	516,862	468,942
7. Medical Supplies	6,908,430	7,174,048	7,019,982	7,316,543	6,930,970	6,763,399
8. Nursing Services	5,115,187	5,840,764	6,579,152	7,563,439	7,993,893	8,413,653
9. Oxygen Therapy	5,596,072	5,622,208	4,988,003	4,700,778	3,773,340	3,560,174
10. Prescription Drugs	106,698,698	112,058,121	119,307,697	124,319,888	126,588,301	124,223,815
11. Prosthetics & Orthotics	4,237,451	4,466,830	3,474,127	3,229,978	2,847,892	2,848,280
12. Related Health Services	13,534,479	15,330,432	16,317,569	18,626,138	19,718,044	21,400,735
13. Special Equipment	22,837,073	25,065,024	27,093,932	30,569,336	30,848,276	29,309,321
14. Vision Care	6,017,700	6,106,938	6,151,403	6,239,108	5,542,170	5,233,635
Total	249,654,533	286,151,646	300,088,355	316,819,489	289,291,957	283,605,312

1.2 Overview of the Processes used to Deliver the Treatment Benefits Program

Treatment benefits are delivered by registered health care providers approved by VAC. Medavie registers providers and processes provider claims based on VAC's registration criteria and benefit policies. Clients are provided with a Health Care Identification Card which indicates the Programs of Choice for which they have eligibility, based on VAC's Health Care Legislation. Clients present this identification card and required prescriptions to the provider of their choice. Providers verify client's eligibility and, when necessary, obtain authorization to provide the service or benefit. Provider claims for treatment benefits and services are processed by Medavie either using an on-line Point of Sale system for the Prescription Drug Program or by submission of hard copy claims for the other Programs of Choice.

Each Program of Choice has a unique Benefit Grid which defines the benefits and services which are approved by VAC, associated with that particular program. For example the Audio Program defines the types of hearing aids which are approved benefits, with each type having a unique benefit code. Providers are given a copy of the Benefit Grid when they register for the program. The Benefit Grid defines for each specific benefit the prescription the client must obtain, the dollar limit VAC will

reimburse, the frequency limits and the requirements for preauthorization which must be obtained before the registered provider can deliver the treatment benefit to the client.

The requests for benefits which require a preauthorization are administered through a number of organizational units, including:

- VAC district offices which authorize benefits for the Nursing Services, Oxygen Therapy and Special Equipment Programs of Choice;
- a Treatment Authorization Centre, operated by Medavie, which authorizes benefits for the Audio Services, Medical Supplies and Prosthetics and Orthotics Programs of Choice;
- a Treatment Authorization Centre, located in VAC's Head Office, which authorizes benefits for the Dental and Prescription Drug Programs; and
- a Special Authorization Unit, operated by Medavie, which authorizes prescription drugs on the Special Authorization Formulary;
- Foreign Countries Operations, located in VAC's Ottawa Office, authorize benefits for Canadian Veterans residing outside Canada and Allied Veterans residing in Canada; and
- Treatment Authorization Centres located within VAC offices in St. John's, Montreal and Vancouver which authorize benefits associated with the balance of the Programs of Choice.

VAC has also established an Exceptional Benefits Unit located at Head Office. This unit reviews and adjudicates requests for treatment benefits which are not on the approved list of benefits or when the request does not meet the criteria contained in the Benefit Grids. District, Regional and Head Office Health Care Teams are also involved with the administration of the Treatment Benefits Program.

In addition to the units involved in delivery of the Treatment Benefits Program, functional support is provided by directorates in both the Policy Programs and Partnerships Branch and Service Delivery and Commemoration Branch. These functional units include:

- the Disability Benefits and Treatment Benefits Directorate (referred to as the program management unit) of the Policy and Programs Division which is responsible for management of the Treatment Benefits Program including maintenance of the Benefit Grids. This Directorate is also considered to be the owner of the program;

- the Program Policy Directorate of the Policy and Programs Division which is responsible for policy development and interpretation;

- the National Service Centres Directorate of the Centralized Operations Division

which is responsible for the Centres of Expertise including the Treatment Authorization Centres; and

- the Case Management and Program Performance Directorate of the Policy and Programs Division which is responsible for development and ongoing operation of the National Quality Management Programs as well as the Veterans Service Support Network (VSSN), the Adverse Drug Utilization Evaluation Committee, and the Head Office Health Care Team.

1.3 Audit Objectives and Approach

The audit contained the following five objectives:

- to assess the adequacy of the Department's management control framework regarding the benefits provided through the Programs of Choice;
- to assess the adequacy of the system edits and controls associated with dollar limits, frequency limits and prescriber recommendations for benefits available through the Programs of Choice;
- to determine the degree of compliance with applicable policies;
- to assess the adequacy of information used for decision making and reporting; and
- to identify opportunities to reduce the number of benefit codes used to process treatment claims.

The FHCPS processes benefits and services associated with the Treatment Benefits Program and the Veterans Independence Program. The scope of the audit only included VAC's Treatment Benefits Program.

Methodology:
The audit was conducted in accordance with the Standards for Professional Practice of Internal Auditing adopted by the Government of Canada. To address the audit objectives, fieldwork was conducted in each of the operational areas which are involved with the delivery of the Treatment Benefits Program, including; district offices, Treatment Authorization Centres, Special Authorization Unit, Exceptional Benefits Unit and Head Office Appeals Unit. Audit fieldwork was also conducted in VAC Head Office functional management areas responsible for the treatment Benefits Program, including; Program Policy, Disability Benefits and Treatment Benefits, the National Service Centres and Case Management and Program Performance. The administrative processes associated with the operation of the Benefit Review Committee and Formulary Review Committee were also reviewed during the audit.

Audit fieldwork included an extensive review of documentation associated with the

Treatment Benefits Program, interviews with program delivery management and staff, interviews with medical professionals, physical observation of delivery processes and a significant analysis of program data.

The audit reviewed the Benefit Grids for each of the fourteen Programs of Choice and conducted data analysis of transactions used to process claims for treatment benefits.

The audit did not conduct detailed testing of treatment transactions to determine the degree of compliance with applicable program policies. This decision was taken after it was determined policies and procedures for the program need to be updated and consolidated, a major review of the Benefit Grids was underway and management processes to conduct quality reviews of program delivery require improvements.

Assurance:
Audit assurance is being provided associated with the following audit objectives: adequacy of system edits, adequacy of reporting and opportunities to reduce the number of transactions used to deliver the program.

The terms of reference for the audit are contained in Annex A and audit criteria for each audit objective is contained in Annex B.

Observations presented in this report are classified as critical, essential or important, see Annex C for definitions of the significance of each category.

2.0 Audit Findings by Objective

2.1 Management Control Framework

Objective 1: To assess the adequacy of the Department's management control framework regarding the benefits provided through the Programs of Choice.

The audit work to address this objective included a review of the:

- implementation of the new Program Management structure for the Treatment Benefits Program;
- control framework to determine benefits and services which are included in the Treatment Benefits Program and regular reviews of the eligible benefits;
- operation of the Benefit Review and Formulary Review Committees;
- processes in place to monitor delivery of the Treatment Benefits Program including compliance with legislative and policy requirements; and
- operational units engaged in the delivery of the Treatment Benefits Program.

Observation 1

Review of the implementation of the new program management structure for the Treatment Benefits Program

To address this objective, fieldwork was conducted in a broad cross section of Head Office program and policy areas who have responsibility for the administration of the Treatment Benefits Program. Input was obtained from operational units who use the Benefit Grids to delivery the program and are involved with front line service including district offices, Treatment Authorization Centres, the Special Authorization Unit, the Exceptional Benefits Unit and the Head Office Appeals Unit.

As a result of the Departmental realignment, implemented in March 2008, a new program management structure was put in place for all of the major departmental programs, including the Treatment Benefits Program. With this new program management structure the Policy, Programs and Partnerships Branch is responsible for policy development and overall management of Departmental programs. The Service Delivery and Commemoration Branch is responsible for day-to-day delivery of the programs. It is generally acknowledged that implementation of this new program management structure will take time; however, in the long run should improve VAC's overall management of the Treatment Benefits Program.

Audit Findings:

- New organizational structures have recently been put in place with the realignment of the Veterans Services Branch into two new Branches (Programs, Policy and Partnerships and Service Delivery and Commemoration). The realignment has resulted in significant changes to both operational structures and the roles and responsibilities of managers and staff responsible for the management and delivery of the Treatment Benefits Program. Many of the managers and staff in the Disability Benefits and Treatment Benefits Directorate, who have responsibility for the overall administration of the Treatment Benefits Program, are in new positions. Work is progressing in both Branches to define this new program management structure at a broad level. However, work is required to fully implement the intent of this initiative, particularly in terms of defining program management, developing clear roles and responsibilities for functional management directorates and defining tasks for each area at a more detailed level. Management has committed to addressing these issues by the Fall of 2009.

- Work descriptions for staff in the Disability Benefits and Treatment Benefits Program Directorate have not been updated to reflect the duties of the positions resulting from the recent reorganization.
- Staff engaged in the front-line delivery of the Treatment Benefits Program expressed concerns that they did not clearly understand the responsibilities of

the various Head Office organizations which support program delivery. There are many organizations involved with the delivery of the Treatment Benefits Program and they need to work together with the Head Office organizations responsible for program management and direction to ensure that client needs are met in a timely manner and to ensure the program is properly managed. It is recognized that significant improvements in the area of program responsibility have been made with the establishment of designated directorates which have overall responsibilities for management of the larger Departmental programs. To ensure the objectives of creating these program specific directorates are achieved, there is a need for Head Office program managers to further define the roles of their units and communicate these new responsibilities across the organization, particularly to staff responsible for direct program delivery.

- VAC 411, an on-line tool on VAC's Intranet, which is to be used as a phone directory for staff and provide organizational reporting relationship information has not been updated for many organizations and positions involved with the administration of the Treatment Benefits Program. This makes it very difficult to identify specific staff who are responsible for program management and delivery. This issue was raised on many occasions to the audit staff as fieldwork was being conducted and it was indicated that improvements to the accuracy of information in this system would assist staff to determine who is responsible for various aspects of program delivery and management. Senior management are aware of this issue and steps are being taken to address the accuracy of information in the system.

Recommendation 1 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch in consultation with the Assistant Deputy Minister, Service Delivery and Commemoration Branch ensure the recently adopted program management structure for the Treatment Benefits Program is fully implemented, including clearly defining and communicating the roles and responsibilities of units and staff engaged in the management and delivery of the program.

Management Response:
While roles and responsibilities as well as communications material on the recently adopted program management structure have been developed and provided on a general basis, management agrees that more detailed information on the Treatment Benefits Program is needed.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
1.1	Develop clear definition of roles and responsibilities of units and staff engaged in the management and delivery of the Treatment Benefit Program.	Associate Director General, Policy and Programs, in collaboration with Director General, Centralized Operations	September 2009
1.2	Communication of roles and responsibilities to staff in Head Office as well as Regional and District Offices, in the Treatment Authorization Centres and other areas as required.	Associate Director General, Policy and Programs, in collaboration with Director General, Centralized Operations	September 2009

Observation 2
Review of the control framework to determine benefits and services which are included in the Treatment Benefits Program and regular reviews of the eligible benefits

The audit examined the process used to determine the actual benefits and services which are included as part of the Treatment Benefits Program. This included a review of the processes used to add and remove program benefits and activity associated with performing regular maintenance of the Benefit Grids. Audit findings associated with the management of the edits for benefits are presented in Observation 8, page 25.

The Disability Benefits and Treatment Benefits Directorate has responsibility for managing the processes to determine the benefits and services which will be included in VAC's Treatment Benefits Program.

Audit Findings:

- There have been reviews conducted for some of the benefits and Programs of Choice over the past few years; however, VAC does not have a process to review the Benefit Grids on a regular basis.

- Previous work has been conducted to review the eligible benefits of the program, including a major review in 2005. As well, other reports prepared by Medavie

have identified changes needed to the program benefits. However, not all of the recommended changes were implemented.

- The Veterans Programs Policy Manuals (VPPM) indicates the Director General, Health Care approves the addition of items to the Benefit Grids for the Treatment Benefits Program; however, this position no longer exists. Program management is developing a new process to authorize changes to the program benefits.

- Program management recognizes the Benefit Grids have not been updated for several years and there are significant changes required to both the benefits themselves and the program rules which apply to the benefits. The risk associated with not updating the eligible benefits on a regular basis is that clients do not have easy access to new products and services. Program management is in the process of conducting a major review of the Benefit Grids, with the exception of the Dental Services and Prescription Drug Programs. The scope of the review is to update the rates and frequencies in the Benefit Grids, de-list unused benefits, update policies and address issues relating to case management.

- VAC did not have an established process to track client and provider concerns associated with the program to identify changes required to the Benefit Grids. In addition, information from other sources should be used on a regular basis to determine where changes may be required to the program. Some examples include requests for the approval of exceptional benefits, client appeals, client complaints, requests for non-formulary products, etc.

- The health care environment is continuously changing. Program management needs to establish a process, with adequate resources, to review the Benefit Grids on a regular basis. It is recognized this will be a time consuming function as the range of goods and services provided through the programs is quite broad and the programs are provided to clients in all provinces/territories, where the costs of goods and services can vary substantially.

Recommendation 2 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch:

- **ensure the goods and services provided through the Treatment Benefits Program are reviewed on a regular basis;**
- **establish delegated authorities to approve changes to the Benefit Grids;**
- **complete the Benefit Grid Review currently underway and implement necessary changes to the program;**
- **initiate a review of the Benefit Grids for the Dental Services and Prescription Drug Programs; and**

- **track client and provider concerns associated with the Treatment Benefits Program.**

Management Response:

Management recognizes the need to regularly review the goods and services provided through the Treatment Benefits Program to ensure that the necessary guidance is available to facilitate decision making with respect to benefits covered by the program. A significant proportion of the goods and services provided are currently being reviewed in the context of the Benefit Grid Review project, which is examining all Programs of Choice with the exception of Dental Services and Prescription Drugs. Management agrees to initiate a review of the Dental Services and Prescription Drug Programs once the changes resulting from the Benefit Grid Review project have been implemented, although it should be recognized that considerable work is required to keep these up to date on a regular basis. This will help ensure the currency of the Benefit Grids. Management will also be exploring options that will facilitate the ongoing maintenance of the Benefit Grids in support of decision making.

Management agrees to establish delegated authorities to approve changes to the Benefit Grid and work is already well underway.

Finally Management recognizes the importance of tracking client and provider concerns with the Treatment Benefits Program, which will help identify required changes to the goods and services provided. This will be addressed as part of the knowledge management strategy that has recently been initiated.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
2.1	Establish delegated authorities to approve changes to the Benefit Grids	Associate Director General, Policy and Programs	June 2009
2.2	Complete the Benefit Grid Review currently underway and implement necessary changes to the program	Director, Disability Benefits and Treatment Benefits Program	March 2010
2.3	Initiate a review of the Benefit Grids for the Dental Services and Prescription Drug Programs	Director, Disability Benefits and Treatment Benefits Program	April 2010
2.4	Establish a process to track client and provider concerns associated with the Treatment Benefits Program	Director, Disability Benefits and Treatment Benefits Program	January 2010
2.5	Develop options for the maintenance of the Benefit Grids to ensure the goods and services provided through the Treatment Benefits Program are reviewed on a regular basis	Director, Disability Benefits and Treatment Benefits Program	January 2010
2.6	Implement approved approach for maintenance of Benefit Grids	Director, Disability Benefits and Treatment Benefits Program	Late 2010

Observation 3
Review of the Benefit Review and Formulary Review Committees

The Benefit Review Committee mandate is to provide expert advice on health care benefits to program management for all Programs of Choice except the Dental Services and Prescription Drug Programs. This includes responding to requests for changes to existing benefits and the addition/removal of benefits from the Benefit Grids. The effectiveness of this committee is seen to be critical to ensure the benefits provided through the Treatment Benefits Program are relevant.

The Benefit Review Committee membership includes:
- Manager, Treatment Benefits Program (Chair);
- National Medical Officer;
- National Nursing Officer;
- National Treatment Authorization Centre Manager;

- Policy Analyst; and
- National Manager of Client Services.

The purpose of the Formulary Review Committee is to review, maintain and revise the Prescription Drug Program. Some of the specific accountabilities contained in the committee's Terms of Reference include the provision of recommendations and advice to management of the Treatment Benefits Program regarding the inclusion/removal of prescription drugs, reviewing existing products and reviewing claim trend data.

The Formulary Review Committee membership includes:
- Director, Disability and Treatment Benefits (Chair);
- Director, National Service Centres;
- National Medical Officer;
- National Coordinator Treatment Authorization Centres;
- Manager, Head Office Treatment Authorization Centre;
- Team Leader, Head Office Treatment Authorization Centre Pharmacy;
- Medical Consultant, Head Office Treatment Authorization Centre Pharmacy;
- National Substance Abuse Consultant;
- Senior Analyst, Treatment Benefits; and
- representatives from Medavie, Federal Health Care Partnership and the Department of National Defence.

The audit examined the extent to which the Benefit Review Committee and the Formulary Review Committee are meeting their established mandates.

Audit Findings:

Benefit Review Committee:

- The Benefit Review Committee had not been meeting on a regular basis. During the past year the committee has only met on two occasions. Without an actively functioning committee, there is a risk their mandate may not be fulfilled.

- Benefit Review Committee members indicated the committee could play an enhanced role in the provision of recommendations to improve management of the program. At the time of the audit, new Terms of Reference for the Benefit Review Committee had been drafted.

- Opportunities exist to make greater use of the Benefit Review Committee to conduct periodic reviews of the Benefit Grids for each of the Programs of Choice to determine if there are required changes to the benefits and services provided through the programs. This would allow VAC to ensure the grids are maintained on a regular basis and eliminate the need to conduct major projects to update the

Benefit Grids.

Formulary Review Committee:

- The Formulary Review Committee has been playing an important role in assisting VAC manage the Prescription Drug Program by reviewing new prescription drugs being considered for addition to the formulary and making recommendations to VAC program managers. The committee also plays an active role in assisting with policy development.

- The draft Terms of Reference for the Formulary Review Committee indicates the committee is responsible for conducting reviews of claim trend data to identify potential financial risk to VAC due to inflationary trends or changes in practice. The effectiveness of the committee in assisting VAC manage the Prescription Drug Program would be enhanced if this function were performed more regularly which would also reduce the risk of negative budgetary implications associated with changes in provider billing practices.

- It has been a number of years since a comprehensive review of the existing formulary has been performed to identify required changes.

Recommendation 3 (Important)
It is recommended that the Director, Disability Benefits and Treatment Benefits Program:

- **finalize the Terms of Reference for the Benefit Review and the Formulary Review Committees; and**
- **ensure the Formulary Review Committee conducts reviews of claim trend data associated with the Prescription Drug Program.**

Management Response:

Until the completion of the changes to the benefit grids identified in the context of the Benefit Grid Review Project, the project's Steering Committee will review proposed changes and make recommendations to Senior Management for implementation of the changes. Management agrees to finalize Terms of Reference for the Benefit Review Committee once the Steering Committee has addressed all the changes proposed in the context of the Benefit Grid Review Project.

Revised Terms of Reference for the Formulary Review Committee (FRC) were adopted by the Committee at its February 2009 meeting. Management agrees to ensure that the FRC conduct reviews of claim trend data associated with the Prescription Drug Program.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
3.1	Finalize Terms of Reference for the Benefit Review Committee.	Director, Disability Benefits and Treatment Benefits Program	January 2010
3.2	Establish FRC process for review of claim trend data associated with the Prescription Drug Program.	Director, Disability Benefits and Treatment Benefits Program	April 2010

Observation 4
Review of the processes in place to monitor delivery of the Treatment Benefits Program and compliance with legislative and policy requirements

As referenced in Section 1.2, the Treatment Benefits Program is administered through a number of organizational units with each playing an important role in the delivery of the Program.

The audit reviewed the management processes being used to monitor the delivery of the Treatment Benefits Program, including processes to assess compliance with legislative and policy requirements.

Audit findings:

- The VPPM outlines a departmental policy to conduct quality control and program review associated with health care programs; however, the focus is on case management and the Veterans Independence Program. The policy does not contain specific direction associated with the delivery of the Treatment Benefits Program.

- Functional managers do not have adequate processes in place to quality control and monitor the delivery of the Treatment Benefits Program in the various operational units which are delivering the program. There are many aspects presenting risks that could be examined when monitoring program delivery. Some examples include compliance with regulatory and policy requirements, consistency of service delivery, supporting documentation obtained to support the decision taken, appropriateness of medical consultation, connection of benefits to pensioned condition, completeness of information entered in the Client Service Delivery Network, etc.

- Most organizational units engaged in the delivery of the Treatment Benefits

Program are focused on addressing individual client cases and striving to provide high quality client service. Operational managers indicated the focus on client cases provides little time to perform monitoring of program delivery and policy compliance.

- The Program Policy Directorate, responsible for the development of policies for the Treatment Benefits Program, did not have a function dedicated to monitoring program delivery's compliance with existing policy.

- The Case Management and Program Performance Directorate is currently in the process of designing tools to begin to assess the performance of Departmental programs; however, it was indicated that it will be some time before a process would be put in place for the Treatment Benefits Program.

- VAC has contracted out the services associated with the operation of a Treatment Authorization Centre for three of the fourteen Programs of Choice, as well as the operation of a Special Authorization Unit to approve prescription drugs on the Special Authorization Formulary. Improvements are required to processes used to monitor these functions performed by the contractor.

- The Standards Training and Evaluation Officers, located in VAC Regional Offices, have not been actively engaged in the monitoring of the delivery of the Treatment Benefits Program by the field offices.

- With the recent organizational realignment and the new structure for management of Departmental programs, a need was identified to develop and implement a process to monitor service delivery. While there was evidence to indicate that some monitoring of program delivery was occurring, responsibility for this activity had not been clearly assigned to either Policy and Programs Division or to Centralized Operations Division.

Recommendation 4 (Essential)
It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch in consultation with the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch implement a process to conduct quality reviews for the Treatment Benefits Program to ensure compliance with regulatory and policy requirements, to assess the consistency of service delivery and to identify areas where changes are required to programs, policies and processes.

Management Response:

Management agrees with this recommendation**.**

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
4.1	Develop a quality review process for the Treatment Benefits Program to ensure compliance with regulatory and policy requirements, assess consistency of service delivery and identify opportunities for improvement.	Director General, Service Delivery Management	September 2009

Review of the operational units engaged in the delivery of the Treatment Benefits Program.

The following three audit observations relate to specific operational areas which were reviewed during the audit, they include the:

- Treatment Authorization Centres operated by VAC;
- Special Authorization Unit operated by Medavie; and
- VAC's Exceptional Benefits Unit and Head Office Appeals Unit.

The audit reviewed operational processes in each of these units to gain an understanding of the roles and responsibilities each unit had associated with the delivery of the Treatment Benefits Program.

Observation 5
Treatment Authorization Centres Operated by VAC

VAC operates three generic Treatment Authorization Centres located in St. John's, Montreal and Vancouver which respond to inquiries from suppliers of treatment benefits and makes decisions associated with treatment authorizations and claims for the following Programs of Choice: Aids for Daily Living, Ambulance Services, Hospital Services, Medical Services, Nursing Services, Related Health Services, and Vision Care. In addition, VAC operates a Treatment Authorization Centre, located in Head Office, which provides authorizations associated with the Dental Services and Prescription Drug Programs of Choice.

Audit Findings:

- Many key recommendations in the Treatment Authorization Centre Review conducted by the Veterans Services Branch in 2005 have not been implemented. Some of the more significant recommendations include the need to: establish performance and productivity standards for TAC Analysts, analyze claims redirected (pended) from the contractor, analyze client and provider payments for redirection to the contractor for processing, implement a quality assurance process, update VPPM to align with the Benefit Grids and ensure the grids reflect association rate changes in each province. National Service Centres Directorate

recently reviewed the outstanding recommendations and have prioritized specific areas requiring action. Implementation of the recommendations in the Treatment Authorization Centre Review would improve overall administration of these units.

- Functional program managers do not have a process in place, at a national level, to conduct regular reviews of the activities and work performed in the Treatment Authorization Centres. Such reviews would provide useful information regarding the quality of the work performed in these units, consistency of decision making among units and should identify opportunities to address program and operational issues.

- Treatment Authorization Centres continue to process significant volumes of client reimbursements and provider payments (49,000 payments during 2008) which results in additional administrative processing costs for VAC. The intent of contracting a third party was that the majority of these payments where possible would be entered in the system by Medavie and this would allow the Treatment Authorization Centres to focus on their core business.

- In reviewing the operation of the Treatment Authorization Centre, the audit observed that analysts have the ability to enter payments in the FHCPS and complete all the necessary steps to have a cheque issued to the client or provider. Normally, most payment systems only allow an operator to enter the data and another position, usually a supervisor, would approve the entries for payment. This weakness in internal financial controls is compounded by the fact there was no compensating control such as detailed reporting to Treatment Authorization Centre management regarding client reimbursements and provider payments by analyst. This risk has also been raised in the Auditor General Management Letter (Public Accounts 2007-08). In the response to the Auditor General's observation, VAC indicated that it was considered to be too costly to modify the front end system controls. Program managers are establishing a working group to explore alternative options to address this issue. As an interim measure, reporting could be put in place to allow for supervisory review of payments.

- There is a need to improve the reporting being provided to the Treatment Authorization Centre managers. Much of the reporting being provided to managers related to the unit's production statistics. Managers were not being provided with sufficient information to monitor the activities associated with the authorizations completed in the unit.

Recommendation 5 (Important)
It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch:

- **develop a strategy to implement the relevant outstanding recommendations in the Treatment Authorization Centre Review;**
- **establish a process to conduct regular reviews of the activities and work performed in the Treatment Authorization Centres**;
- **conduct an analysis of the client reimbursements and provider payments to identify claims which could be forwarded to the third party contractor for processing; and**
- **improve operational reporting for activities performed in the Treatment Authorization Centres, including the establishment of reports to monitor client and provider payments.**

Management Response:

Management agrees with the above-noted recommendations and has initiated work to enhance service delivery and management practices. Management actions in response to the audit will take into account the impact on program expenditures, the impact on TAC staffing, and the support required from Head Office and Regional colleagues.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
5.1	Develop a strategy to implement the relevant outstanding recommendations in the Treatment Authorization Centre Review;	Director General, Service Delivery Management	September 2009
5.2	Establish a process to conduct regular reviews of the activities and work performed in the Treatment Authorization Centres;	Director General, Service Delivery Management	September 2009
5.3	Conduct an analysis of the client reimbursements and provider payments to identify claims which could be forwarded to the third party contractor for processing; and	Director General, Service Delivery Management	December 2009
5.4	Improve operational reporting for activities performed in the Treatment Authorization Centres, including the establishment of reports to monitor client and provider payments.	Director General, Service Delivery Management in consultation with the Director General, Policy and Programs	December 2009

Observation 6
Review of the Special Authorization Unit operated by Medavie

The majority of prescription drugs provided to eligible clients through the Prescription

Drug Program are adjudicated automatically through an electronic link between the pharmacies and the FHCPS. Pharmacies request on-line authorization to provide benefits to clients and receive a response from the system.

In the interests of containing costs and protecting clients' health, VAC has designated specific prescription drugs which are not processed using this automated service. These prescription drug products are contained in the Special Authorization Formulary. When pharmacies are requesting authorization of these products using the online system, they are informed to call the Special Authorization Unit. This unit is operated by Medavie and is located in Moncton, New Brunswick.
The Special Authorization Unit, which is staffed with medical professionals, adjudicates request for benefits based on specific criteria approved by VAC for each product. Quite often the work required to determine if an authorization will be granted requires the input of the client's physician or other medical information to determine the diagnosis and assess the treatment plan.

Audit Findings:

- It is not clear which Head Office program area has responsibility for the Special Authorization Unit.

- As of January 2009, there were approximately 2,300 products with unique Drug Identification Numbers on the Special Authorization Formulary. During 2008, only 862 of these products were provided to eligible clients.

- VAC is incurring significant administrative costs associated with the approval of low dollar value prescription drug products contained on the Special Authorization Formulary. It was observed that 37% of the products provided during 2008 had an average cost of less than $40.00. It is acknowledged that, without proper controls in place, shifting products to the regular formulary has the potential risk of increasing overall program costs as more clients would have access to these benefits without requiring preauthorization. However, the Special Authorization Formulary has not been reviewed for some time to determine if the products should remain on this formulary.

- VAC reimburses Medavie for authorizations performed by the Special Authorization Unit based on the number of calls required to complete the authorization. While some benefits can be authorized when the pharmacy is on the phone requesting the approval, quite often there was a requirement to contact the clients physician or other health care professionals to obtain additional information. It was observed that for some cases it took several calls to complete the authorization. Information was not being reported to indicate the number of calls associated with individual authorizations. This information would

be useful to allow VAC to monitor the administrative costs associated with the authorization of specific benefits on the Special Authorization Formulary.

Recommendation 6 (Important)
It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch in consultation with the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch:

- **establish line management responsibility for the Special Authorization Unit;**
- **review the Special Authorization Formulary to confirm if all prescription drugs should continue to require preauthorization; and**
- **monitor the cost and number of calls used to process individual authorizations completed by the unit.**

Management Response:

Contract Administration is responsible and does monitor the cost of the Special Authorization Unit calls at a macro level. Action will be taken to confirm line management for the Special Authorization Unit. The Special Authorization Formulary will be reviewed to confirm if all prescription drugs should continue to require preauthorization.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
6.1	Confirm line and functional management responsibility for the Special Authorization Unit	Director General, Service Delivery Management	September 2009
6.2	Review the Special Authorization Formulary to confirm if all prescription drugs should continue to require preauthorization	Director General, Service Delivery Management and Director General, Policy and Programs	December 2009
6.3	Monitor the cost and number of calls used to process individual authorizations completed by the unit.	Director General, Service Delivery Management	September 2009

Observation 7
Exceptional Benefits and Head Office Appeal Units operated by VAC

The Exceptional Benefits Unit, located at VAC Head Office, reviews requests for

treatment benefits which are not specifically identified as approved benefits in VAC's Benefit Grids. The unit also handles requests for benefits or services which exceed the dollar limit or frequency limit contained in the Benefit Grids.

The Head Office Appeals Unit is the final level of appeal, for most of the Programs of Choice, for clients who are not satisfied with the Department's decision relating to the approval of specific treatment benefits.

Audit Findings:

- A significant volume of the cases presented to the Exceptional Benefits Unit and Head Office Appeals Unit relate to audio benefits, medical supplies and prosthetics and orthotics (Programs of Choice 3, 7, and 11). Authorizations for these three programs are adjudicated by the Treatment Authorization Centre operated by Medavie. The contractor must adjudicate requests for benefits based on a very specific set of criteria which have been provided by VAC. Cases which cannot be processed are either forwarded to the Exceptional Benefits Unit or are declined, in which case the client is able to exercise their appeal rights.

- The dollar value of the goods and services being presented to the Exceptional Benefits and Appeals Unit were not always being tracked. This information should be used to determine if low dollar value benefits could be adjudicated at the local service delivery level.

- There were approximately 745 decisions relating to the Treatment Benefits Program rendered by the Exceptional Benefits Unit from May to December 2008, of these 96% were approved.

- There were approximately 850 health appeals relating to the Treatment Benefits Program which were received by the Head Office Appeals Unit during 2008, of these approximately 690 related to Programs of Choice 3, 7, and 11.

- Management did not have systematic processes in place to analyze cases or assess risks to determine if changes in policy or business processes could be made to reduce the volume of cases being dealt with by these two units.

- Development of new policy guidelines for dealing with requests for benefits and services which are not contained on the Benefit Grids, particularly for low dollar value benefits, would allow for greater empowerment of front line staff and would improve client service. A new business process is being developed to address this issue.

Recommendation 7 (Important)

It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration Branch determine how changes to business processes could be implemented to reduce the requirement to have cases adjudicated by the Exceptional Benefits and Head Office Appeals Units.

Management Response:

Management agrees with this recommendation. Work is underway with the Delegated Decision Making Project to ensure that, as decision making is delegated to the field, business processes are updated to support the new approach.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
7.1	In context of the Delegated Decision Making Project, review and update business processes for referral of cases/decisions to the Exceptional Benefits and Head Office Appeals Units.	Director General, Service Delivery Management	December 2009

2.2 System Edits and Controls

Objective 2: To assess the adequacy of the system edits and controls associated with dollar limits, frequency limits and prescriber recommendations for benefits available through the Programs of Choice.

The audit originally intended to perform a detailed analysis of edits in the Benefit Grids for the fourteen Programs of Choice. Given that program management initiated a major review of the Benefit Grids to update the edits in the system, it was not deemed practical for internal audit to conduct a detailed assessment of the grid edits at this time. Therefore, only a cursory review of the system edits was performed and the audit primarily focused on the management processes used to establish and update the edits contained in the Benefit Grids for each of the eligible program benefits.

The number of benefits associated with each Program of Choice range from a few unique benefits in some (Nursing Services) to several thousand unique benefits in others (Prescription Drugs). Each program has an associated grid which is entered in the FHCPS and contains specific edits for each benefit. These edits are the rules which govern the delivery of the program and allow for system-based adjudication of benefits.

Some of the key edits contained in the Benefit Grids include: prescriber, recommender, preauthorization requirements, frequency, maximum amount/VAC fee, provincial coverage, etc. For additional information associated with the system edits see Annex D.

The Benefit Grids and associated edits for each of the Programs of Choice are province/territory specific and are influenced by a number of factors including; provincial fee schedules, market prices for treatment benefits, existence of agreements with provider associations, provincially recognized health professionals, existence of provincial programs, etc.

Assurance is being provided associated with this audit objective. Appropriate audit procedures have been conducted and sufficient evidence obtained to provide this assurance and support the findings.

Observation 8
Processes in place to manage the edits in the system for the fourteen Programs of Choice

Audit activity associated with this objective focused on the processes in place to manage the edits in the system for the fourteen Programs of Choice and the management of agreements with health care provider associations. Audit findings associated with the management of the actual benefits were presented in Observation 2, page 10.

Audit Findings:

- The process to maintain edits to the Benefit Grids is complicated by the fact that specific edits must be determined on a province/territory basis. This is particularly the case when establishing the edit for the Maximum Amount/VAC Fee to be used. There are often significant variations between provinces/territories for market prices for treatment benefit goods and services. In essence, VAC must maintain more than 150 different Benefit Grids to deliver the Treatment Benefits Program. Several of the Programs of Choice contain many specific benefit codes which makes VAC's program unique when compared to other health benefit plans. To ensure the edits in the grids remain current requires a significant investment of resources.

- Program management does not have a process in place to ensure the edits in the Benefit Grids are reviewed on a regular basis so they are reflective of industry practices which increases the risk that VAC rates paid for goods and services are not reasonable. Over the past few years VAC has not assigned adequate resources to maintain the edits in the Benefit Grids. This has resulted in the need to conduct the comprehensive Benefit Grid Review.

- Previous work has been conducted to review the edits (prescriber, dollar limits

and frequency limits) in the Benefit Grids, including a major review in 2005. As well, other reports prepared by Medavie have identified changes needed to the edits in the system. However, not all of the recommended changes to the edits were implemented.

- VAC has not established maximum dollar limit edits in the Benefit Grids for some of the program benefits. Program staff indicated when a benefit does not have a maximum dollar limit VAC uses what is referred to as "Usual and Customary", where existing market rates are used to reimburse providers for services rendered. It was observed that what results in practice is that VAC reimburses the provider for the amount claimed without verifying actual market rates.

- VAC relies on a very large network of providers to ensure clients are able to access required treatment benefits through the program. To ensure that providers will continue to use the existing delivery system, VAC must provide reasonable compensation to providers for their services. This requires VAC to ensure that edits entered in the system are fair, while protecting the interests of the taxpayer. However, the Maximum Amount/VAC Fee for some of the program benefits have not been adjusted for some time.

- Input obtained from National Operations Network members resoundingly indicated the edits contained in the Benefit Grids are currently out of date and a process needs to be put in place to maintain the Benefit Grids after the current review is completed.

- VAC plans to implement the "Next Available Agent" call distribution process for the Treatment Authorization Centres, whereby calls from any province could be redirected to any one of the Treatment Authorization Centres. To minimize operational risks and allow for this process to work, program managers in service delivery units have indicated it will be imperative that the Benefit Grids be updated and maintained on an ongoing basis.

- The Veterans Health Care Regulations state that clients who do not require treatment benefits as a result of a pension condition must access provincial programs. While the Benefit Grids have the capability for VAC to establish an edit to identify treatment benefits which are covered by a provincial program, this edit was not always being used.

- Program management did not have an established system to record changes made to the Benefit Grids and corresponding edits for each of the program benefits. This information would provide the historical record of changes made, including authorizing official.

- The Benefit Grid Review is currently examining the edits which have been entered in the system for the treatment programs. It is anticipated that recommendations will be made to make significant changes to the benefits

covered by the programs and the associated edits.

Recommendation 8 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch:

- **ensure that appropriate edits are entered in the Benefit Grids for treatment benefits covered by the program and assess options to restructure the program to simplify regular maintenance requirements;**
- **ensure that adequate resources are assigned to conduct regular reviews of the edits in the Benefit Grids for the fourteen Programs of Choice; and**
- **establish a system of records to document changes which have been made to the Benefit Grids and associated edits.**

Management Response:

Management recognizes the importance of ensuring that the Benefit Grids provide the necessary guidance to facilitate decision making with respect to benefits covered by the program. Management will explore options for the maintenance of the Benefit Grids such as outsourcing such maintenance.

Management agrees that adequate resources need to be assigned to maintain the Benefit Grids, in accordance with the approach that will be developed for the maintenance of the Benefit Grids. Management recognizes that it is important to ensure cost-effective strategies are used to keep the Benefit Grids up-to-date.

Management agrees to establish a system of records to document changes which have been made to the Benefit Grids and associated edits. A system of records has been initiated in the context of the current review process.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
8.1	Implement a system of records to document changes which have been made to the Benefit Grids and associated edits.	Director, Disability Benefits and Treatment Benefits Program	May 2009
8.2	Develop options for the maintenance of the Benefit Grids	Director, Disability Benefits and Treatment Benefits Program	January 2010
8.3	Implement approved approach for maintenance of Benefit Grids	Director, Disability Benefits and Treatment Benefits Program	Late 2010

Observation 9
Management of agreements with health care provider associations

VAC has entered into agreements in some provinces with health care associations who represent providers such as optometrists, pharmacists, and audiologists. These agreements indicate the rates VAC will reimburse providers for goods and services provided to Veteran clients. Some of the more recent agreements have been established with the assistance of the Federal Healthcare Partnership.

The audit reviewed the process to establish and maintain agreements with health care provider associations.

Audit Findings:

- VAC does not have a clear strategy defining where agreements with provider associations should exist. In some cases, agreements exist in one province but not in another, for example VAC has an agreement with the optometerist associations in Atlantic Canada which specifies rates VAC will reimburse providers for specific goods and services. However, a similar agreement for the same program benefits with the optometerist associations in Ontario did not exist and VAC reimburses providers the amount submitted.

- There are resource and program cost implications associated with negotiating and

maintaining agreements with health care provider associations.

- Responsibility and resources within Disability Benefits and Treatment Benefits Program Directorate have not been clearly assigned for the negotiation and maintenance of agreements with associations representing providers.

- Some agreements with health care provider associations have expired; however, they continue to be used to administer the delivery of the program without a full assessment of any associated legal risks.

- VAC uses Medavie negotiated rates for the prescription drug program in some provinces while in other provinces the program is delivered without current agreements in place. Edits entered in the system for pricing of prescription drugs and associated dispensing fees vary among provinces/territories.

Recommendation 9 (Important)
It is recommended that the Director, Disability Benefits and Treatment Benefits Program determine where agreements with provider associations are required and assign responsibility for their negotiation and maintenance.

Management Response:

The negotiation and maintenance of agreements with provider associations is an important aspect of the management of the Treatment Benefits Program. Management agrees to develop and implement a strategy with respect to provider associations. The strategy will include agreements negotiated in collaboration with other Federal Partners through the Federal Healthcare Partnerships and agreements negotiated directly with provider associations.

Management Action Plan:

Corrective Actions to be taken	Office of Primary Interest	Target Date
9.1 Pursue Development of a strategy for the negotiation of agreements with provider associations.	Director, Disability Benefits and Treatment Benefits Program in collaboration with Federal Healthcare Partnerships	April 2010

2.3 Compliance with Policies

Objective 3: To determine the degree of compliance with applicable policies.

This audit objective examined the adequacy of policies and procedures to support the delivery of the Treatment Benefits Program and the management processes in place to monitor program delivery against legislative and policy expectations.

The audit originally planned to sample transactions and conduct compliance testing against VAC legislative and policy requirements for the Treatment Benefits Program. After conducting preliminary planning to address this audit objective, a number of factors were identified which resulted in the decision to exclude transaction testing during the audit. Some of these factors included:

- policies for the program require significant updating and consolidation;
- a major review of the Benefit Grids is underway, which presumably will make significant recommendations to change program policies; and
- management processes to monitor program delivery's compliance with legislation and policy require improvements.

Observation 10
Adequacy of Program Policy and Procedures

Policies are intended to provide a guide to decision makers to allow for the achievement of desired program outcomes. Procedures provide a series of actions which when executed will allow policy to be implemented. To ensure legislative requirements of the program are met, it is essential that sound policies and procedures exist. The audit reviewed the adequacy of policies and procedures to support the delivery the Treatment Benefits Program.

Audit Findings:

- Policies for the Treatment Benefits Program contained in the VPPM, the primary source of policy direction, had not been updated on a regular basis and some date back to the early 1990's. Policies referenced organizational structures, units and positions that no longer exist. Additionally, the VPPM did not contain policy for many of the benefits provided through the program.

- Policy and procedures used to support the delivery of the program had not been consolidated in one policy and procedures manual. Policy and procedures used by delivery staff were located in a variety of sources on-line including the VPPM, online work tools and business processes, Benefit Grids and the VSSN.

- Program delivery staff indicated that in addition to on-line sources, policy and procedures are often communicated in Groupwise messages, minutes of staff meetings and informally from line and functional managers. Staff indicated this policy direction was not being incorporated into official policy and business processes. Having policy and procedures located in multiple locations makes it difficult for staff to easily access the information required to deliver the program.

- The VSSN is an on-line tool which allows program delivery staff to bring forward issues associated with program delivery to Head Office for clarification. The audit observed that VSSN was being used as an additional source of policy and procedural guidance in a more general context. Program policies and procedures were not always being updated as a result of issues raised and responded to in the VSSN.

- Units engaged in the delivery of the program had developed their own work tools to assist with their day-to-day activities associated with the delivery of the program. For example, Treatment Authorization Centre staff maintained a set of files by Program of Choice on their desk with reference material and policy for common benefits provided through the programs. When staff use in-house developed policies and procedures there is a risk of inconsistent program delivery and associated decisions.
- National Operations Network members expressed concerns with informal policy and procedural pronouncements reaching all staff who need the information to deliver the program. Members indicated many requests have been made in the past to update policies and procedures for the Treatment Benefits Program. Members indicated policy/procedural information should be located in a single accessible location. As an alternative, a quick link to access benefit specific information in the VPPM, applicable business processes and the Benefit Grids would facilitate easy retrieval of information.

- It is anticipated the current Benefit Grid Review will recommend many changes to the benefits and edits contained in the grids. This will result in required changes to VAC's policies and procedures associated with the Treatment Benefits Program.

Recommendation 10 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch in consultation with the Assistant Deputy Minister, Service Delivery and Commemoration Branch review and update existing policies and procedures for the Treatment Benefits Program, create new policies and procedures where required and consolidate this information in one location.

Management Response:

Management agrees that the ease of reference to existing policies and procedures by staff at all levels would be assisted if policies and procedures were made available in a revitalized Intranet location and provided in a user-oriented manner.

Program of Choice policies and procedures have been developed over numerous years, and updating is an ongoing process balancing priorities, emerging issues, and available resources.

Currently, the Program Policy Directorate is working to prioritize policy revisions which will enable the Department to shift program delivery from an entitlement-based to a needs based approach. SDC will be consulted and will be part of the policy priority setting exercise, to ensure operational needs are addressed, programs and services are delivered consistently and appropriately, and that business processes are revised and distributed at the same time as new and revised policy.

The corrective actions identified will require significant inter-branch and cross-directorate shared leadership and cooperation. The Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch and the Assistant Deputy Minister, Service Delivery and Commemoration Branch to develop a proposal and budget for funding a team to deal with this recommendation.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
10.1	Review/renew established procedures for informing all levels of the Department of changes to policies and procedures	Director General, Policy and Programs	July 2009
10.2	Modify, in partnership with program management, operations and communications, the Intranet presence for policies and procedures consolidating these in an interactive user-friendly manner	Director General, Policy and Programs and the Director General, Service Delivery Management	Fall 2010
10.3	Establish a cycle to revise policies, procedures and processes considering program management and operational priorities, Departmental initiatives and emerging issues	Director General, Policy and Programs and the Director General, Service Delivery Management	Early 2011

2.4 Information used for Decision Making and Reporting

Objective 4: To assess the adequacy of information used for decision making and reporting.

This objective examined the adequacy of reporting associated with the Treatment Benefits Program and the extent to which data in the FHCPS was being used on a regular basis to manage the program.

The FHCPS contains a wealth of information associated with treatment benefits which have been provided to VAC's clients. This data provides a significant source of information to allow for the management of the Treatment Benefits Program.

Observation 11
Adequacy of reporting associated with the Treatment Benefits Program and the extent to which data in the FHCPS was being used to manage the program.

The audit reviewed the provision of information and reporting associated with the Treatment Benefits Program to managers responsible for operational delivery of the program, functional managers responsible for the overall administration of the program and senior departmental managers.

Assurance is being provided associated with this audit objective. Appropriate audit procedures have been conducted and sufficient evidence obtained to provide this assurance and support the findings.

Audit Findings

- Regular reporting from the FHCPS for operational managers, functional program managers and senior managers requires improvement. While some reports existed to manage specific aspects of the program, the audit found there were very few regular reports in production which were designed to allow for overall management of the Treatment Benefits Program.

- The Head Office unit which has overall responsibility for the management of the Benefit Grids was not receiving information on a regular basis to monitor program activity. Much of the information being used to manage the program was being extracted from the system using ad hoc queries. Establishment of regular reports would provide the necessary information to allow VAC to improve the management of the Treatment Benefits Program, make necessary adjustments to the policies and procedures and identify required changes to the Benefit Grids.

- VAC does not have systematic processes in place to analyze and report on

benefit usage and the associated costs being paid for treatment benefits provided through the program. Regular reporting was not being provided to program management regarding benefit utilization patterns, average costs being charged for goods and services, provider billing practices, program transaction processing costs, etc.

- Reporting by units which deliver the Treatment Benefits Program was primarily related to production statistics. Reporting generally related to the number of authorizations, number of payments made and number of calls handled. Much of the data used to prepare the reports was being manually maintained. Operational units were provided with few reports associated with the actual benefits processed.

- Reporting to units engaged in the delivery of the Treatment Benefits Program associated with operator activity within the FHCPS was not being provided to unit managers. Some examples of information which should be regularly reported include; authorizations entered, use of the waive function to override dollar and frequency limits, use of the "Other" code and payments entered in the system.

- Very little reporting from FHCPS is being provided to the district offices associated with treatment benefits being used by clients. Provision of information from FHCPS to front line delivery staff would improve client case management.

- Reporting needs to be established to allow for a more systematic approach to monitor compliance with departmental policies relating to the program. Improved reporting would provide assurance the program is being delivered as intended.

- Previous Internal Audits and reports by the Auditor General of Canada have identified a need for VAC to invest additional resources to make greater use of data in the FHCPS to improve overall program management.

Recommendation 11 (Essential)
It is recommended that the Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch determine the regular reporting needs of operational, program and senior management associated with the Treatment Benefits Program and place these reports in production.

Management Response:

Management agrees to develop a Performance Measurement Framework that will include identification of regular reporting needs and to place the reports into production.

Management Action Plan:

Corrective Actions to be taken		Office of Primary Interest	Target Date
11.1	Develop a Performance Management Framework for the Disability and Treatment Benefits Programs	Director, Disability Benefits and Treatment Benefits Program in collaboration with Director, Case Management and Program Performance	December 2009
11.2	Place reports identified in the context of the development of the Performance Management Framework into production	Director, Disability Benefits and Treatment Benefits Program	April 2010

2.5 Opportunities to Reduce Treatment Benefit Transactions

Objective 5: To identify opportunities to reduce the number of benefit codes used to process treatment claims

VAC's administrative costs for claims processing, which are paid to the third party contractor, are based on fees for each transaction which is entered in the FHCPS. The contract defines a transaction as the entry of a single benefit code in the system. The contract contains provisions for two types of transactions, "Electronic" and "Non-electronic". Electronic transactions are mainly associated with the Prescription Drug Program of Choice and are processed electronically through the Point-of-Sale system which connects pharmacies to the FHCPS. Non-electronic transactions are associated with the remaining thirteen programs of choice and are manually entered in the FHCPS from paper claims submitted by clients and registered providers. The transactions rates have not been included in this report as this information is proprietary to the contractor and cannot be released publicly.

The following table provides a breakdown of the number of transactions processed for the past five fiscal years.

Transactions - Treatment Benefits Program	
2003-04	6393631
2004-05	6965866
2005-06	7558666
2006-07	7856880
2007-08	8226456

The following table provides a breakdown of the number of transactions by Program of Choice for 2007-08, sorted by program with the highest volume of transactions.

Transactions (2007-08) by Program of Choice			
Prescription Drugs	5939103	Medical Supplies	142101
Ambulance/Health Rel. Travel	498385	Vision Care	119097
Audio Program	403111	Aids for Daily Living	62309
Related Health Services	370632	Oxygen Therapy	34840
Dental Services	226958	Hospital Services	16162
Special Equipment	225337	Prosthetics and Orthotics	11466
Nursing Services	173219	Medical Services	3736

Assurance is being provided associated with this audit objective. Appropriate audit procedures have been conducted and sufficient evidence obtained to provide this assurance and support the findings.

Observation 12
Assessment of opportunities to reduce the number of transactions used to process treatment claims.

This audit objective examined:

- the management processes in place to monitor the usage of transactions (Electronic and Non-electronic) to process treatment claims; and

- the Benefit Grids and claims data to identify Programs of Choice where opportunities exist to reduce the volume of transactions required to deliver the program, without negatively impacting client benefits.

Audit Findings:

- Program management did not have a systematic process in place to conduct regular detailed analysis of transactions being used to deliver the Treatment Benefits Program.

- There is a limited amount of regular reporting to program management associated with the number of benefit codes used to process treatment claims. Information on a per claim basis relating to transactions and expenditures was not being made available to program management to allow for the identification of opportunities to reduce the number of transactions being used to deliver the program.

- Based on a preliminary analysis of data and physical observation it appears the greatest opportunity to reduce the number of transactions being used to delivery the Treatment Benefits Program are in the following Programs of Choice: Health Related Travel, Audio, Prescription Drugs and Vision Care.

- The processing of a Health Related Travel claim requires a significant number of transactions to be entered in FHCPS. There are twenty six individual benefit codes for the Health Related Travel program, some of which include breakfast, lunch, dinner, mileage, taxi, accommodations, parking and escort fee. In reviewing the Health Related Travel claims, 52% of the claims processed for the period September to November 2008 used three or more benefit codes (transactions). It was also observed that in at least one Treatment Authorization Centre, detail associated with health related travel claims was also being entered in the Client Service Delivery Network.

- VAC has structured the Audio Program in a way which requires providers to include detailed information regarding the goods and services provided to Veteran clients. In 2007-08 there were approximately 403,000 transactions used to process claims for the Audio Services program. The Benefit Grids for the Audio Program contain more than 250 unique benefit codes. A typical audio claim includes benefit codes (transactions) for: hearing aid - left, hearing aid - right, dispensing fee - left, dispensing fee - right, batteries, post fitting hearing aid fee - left, and post fitting hearing aid fee - right. The requirement to submit claims broken down at this level of detail has a direct impact on the number of transactions required to deliver the program.

- VAC is incurring transactions and processing fees to have clients access provincial drug programs. Pharmacies submit claims first to the provincial programs for benefits provided to Veteran clients. To access some provincial programs clients are required to pay a co-payment. Pharmacies then submit this

co-payment to VAC through the FHCPS. This results in a significant volume of small dollar claims in VAC's Prescription Drug Program.

- In reviewing the Prescription Drug claims for the period April to August 2008, approximately 3,500 clients had more that 150 transactions (30 or more per month). It was observed that many of these clients are residents of long term care facilities. While it is recognized that a process exists to review individual client drug history to identify adverse health issues, the focus of the process was not on the associated transaction processing costs of delivering the benefits.

- The Vision Care Program has been structured in a fashion which is similar to the Audio Program as providers are required to include detailed information regarding the goods and services provided to clients. A typical vision care claim includes benefit codes (transactions) for: optometric exam, frames, lenses, various coatings and a dispensing fee. The requirement to submit claims broken down at this level of detail has a direct impact on the number of transactions required to process Vision Care claims. This process is different than the practices of many other similar health plans which use fewer benefit codes and have a maximum financial limit for vision care benefits.

- VAC incurs significant costs to process transactions through the FHCPS. It is recognized that entry of detailed information in the system provides a data source which could be used to actively manage the program. Program management did not have systematic processes in place to use this data to identify opportunities to reduce the number of benefit codes used to process treatment claims.

Recommendation 12 (Important)
It is recommended that the Director, Disability Benefits and Treatment Benefits Program:

- **establish a process to monitor the number of transactions used per claim to deliver the Treatment Benefits Program; and**
- **initiate a process to review the Health Related Travel, Audio Services, Prescription Drugs and Vision Care Programs of Choice to identify opportunities to reduce the number of transactions being used to deliver these programs.**

Management Response:

Management recognizes that it is a worthwhile process to examine Health Related Travel, Audio Services, Prescription Drugs and Vision Care Programs in order to identify opportunities to reduce the number of transactions per claim being used to deliver; however, it also recognizes that it is not critical to the effective provision of services to clients.

Management Action Plan:

Corrective Actions to be taken	Office of Primary Interest	Target Date
12.1 Establish a process to monitor the transactions used per claim	Director, Disability Benefits and Treatment Benefits Program	June 2010
12.2 Examine each of the targeted programs to identify opportunities to reduce the number of transactions per claim.	Director, Disability Benefits and Treatment Benefits Program	
• Vision Care • Audio Services • Health Related Travel • Prescription Drugs		• December 2010 • May 2011 • December 2011 • May 2012

3.0 Distribution

Deputy Minister
Departmental Audit Committee Members
Chief of Staff to the Minister
Senior Assistant Deputy Minister, Policy, Programs and Partnerships Branch
Assistant Deputy Minister, Services Delivery and Commemoration Branch
Assistant Deputy Minister, Corporate Services Branch
Director General, Policy and Programs Division
Director General, Centralized Operations Division
Director General, Service Delivery Management Division
Director General, Communications Division
Director General, Finance Division
Director General, Human Resources
Director general, Departmental Secretariat and Policy Coordination
General Counsel, Justice Canada
Associate Director General, Program Management
Director, Disability Benefits and Treatment Benefits Program
Director, Case Management and Program Performance
Director, Program Policy
Deputy Coordinator, Access to Information and Privacy
Office of the Comptroller General
Office of the Auditor General
Program Analyst, Treasury Board of Canada, Secretariat

Annex A Terms of Reference

Background:
FHCPS is a large and complex health claims processing system that provides automated health claims adjudication for federal departments and payments to health care providers or reimbursement to clients for eligible services. Contractors and providers under contract for outsourcing health claims administration are paid a transaction fee for each benefit code processed. There is a need for VAC to ensure that the benefit code utilization is monitored regularly and is consistent with the intent of the program. A cursory review of benefit code utilization for health related travel claims indicated opportunities to decrease the number of benefit codes used, thus reducing processing costs.

Rationale:
AED's Audit of the Outsourcing of Health Claims Administration, January 2006, identified potential audit work on a POC by POC basis.

Proposed Statement of Work:
To provide a review of each Program of Choice. A risk assessment will be conducted to determine the order in which the POC's will be reviewed.

Objectives:
1. To assess the adequacy of the Department's management control framework regarding the benefits provided through POCs.
2. To assess the adequacy of the system edits and controls associated with dollar limits, frequency limits and prescriber recommendations for benefits available through the POCs.
3. To determine the degree of compliance with applicable policies.
4. To assess the adequacy of information used for decision making and reporting.
5. To identify opportunities to reduce the number of benefit codes used to process treatment claims.

Annex B Audit Criteria

Objective 1: To assess the adequacy of the Department's management control framework regarding the benefits provided through the Programs of Choice.

- The new Program Management framework for the Treatment Benefits Program resulting from organizational realignment should be operational.

- Roles and responsibilities for program delivery relating to administration of the Programs of Choice should be clearly defined and understood.

- The Benefit Grid Review Committee should respond to requests for changes to the grids in a timely fashion, provide expert advice on health care benefit and services and make recommendations to management regarding goods and services to be provided by the program.

- The Formulary Review Committee should respond to requests for changes to the prescription drug formulary in a timely fashion and provide expert advice and recommendations to VAC program management.

- The benefits and services provided through the Treatment Benefits Program should be reviewed by Program Management on a regular basis.

- Adequate policy and procedures associated with treatment benefits should be made available to staff who are responsible for the delivery of the program.

- Functional managers should have a process in place to monitor the operational units engaged in the delivery of the treatment program including; District Offices, Treatment Authorization Centres, Special Authorization Unit, Exceptional Benefits and Appeals Unit. Monitoring should ensure the program is being delivered as intended and delivery is consistent among offices.

Objective 2: To assess the adequacy of the system edits and controls associated with dollar limits, frequency limits and prescriber recommendations for benefits available through the Programs of Choice.

- The Benefit Grids for each Program of Choice should contain appropriate edits to allow for proper administration of the program.

- A process should exist to ensure that edits in the Benefit Grids are maintained on a regular basis. Edits should be reflective of industry practices and provide assurance that VAC rates paid for goods and services provided by the program are reasonable.

- Responsibility for negotiation with health care provider associations should be clearly assigned and agreements should be current.

Objective 3: To determine the degree of compliance with applicable policies.

- Adequate policies and procedures should exist to support program delivery.

- Management should have process in place to ensure the delivery of the Treatment Benefits Program complies with applicable legislative and policy requirements.

Objective 4: To assess the adequacy of information used for decision making and reporting.

- Management processes should exist to monitor utilization and costs of treatment benefits administer through the FHCPS. This includes systematic analysis of claims data at the organizational, client and provider levels to identify issues requiring changes to the Benefit Grids and program.
- Reporting from FHCPS should be sufficient to allow for overall management of the Treatment Benefit program.

- Staff responsible for client case management should be provided with sufficient information and reporting associated with treatment benefits being used by clients.

- Reporting should be provided indicating when the system edits are overridden. This information should be used to identify necessary changes associated with the administration of the program.

- Sufficient reporting should be provided to senior managers associated with the Treatment Benefits Program.

Objective 5: To identify opportunities to reduce the number of benefit codes used to process treatment claims.

- The Benefit Grids should be structured in a manner which balances the need for program information with the need to minimize the usage of benefit codes (transactions) to process claims for treatment benefits.

- Management process should exist to monitor the usage of benefit codes to deliver the treatment program and make necessary adjustment to minimize program administration costs.

Annex C Significance of Observations

To assist management in determining the impact of the observations, the following definitions are used to classify observations presented in this report.

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.

Important - relates to one or more significant weaknesses for which some compensating controls exist. The weakness results in a low level of risk.

Annex D Edits Contained in the Benefit Grids

The following are the standard edits which are contained in the Benefit Grids for each of the Programs of Choice:

- Prescriber - this edit defines the type of health professional who must prescribe the benefit or service before VAC will agree to pay for the benefit. The requirements vary with the treatment benefit in question. Commonly required prescribers include medical doctor, registered nurse, respirologist, etc.

- Recommender - this edit defines the type of health professional who must recommend the benefit or service, for example a respiratory specialist must recommend some oxygen program benefits.

- Pre-authorization - this edit defines benefits for which the provider must obtain pre-authorization prior to providing the good or service to the client, for example nursing services must be pre-authorized by VAC's District Offices.

- Frequency - this edit defines the number of treatments a client is entitled to or the period of time which must elapse before a product previously provided can be replaced, for example the number of physiotherapy visits covered per year or the time required before a request to replace a wheelchair would be considered.

- Negotiated Fee - this edit defines the dollar value VAC is willing to pay for a specific good or service which has been established based on a negotiated agreement with health care providers, for example, Optometric Dispensing Fees - New Frames.

- Maximum Amount\VAC fee - this edit defines the maximum amount VAC is willing to pay for a specific good or service where there are no negotiated fees with health care providers in place. These limits are to be based on market rates, for example, a maximum fee has been established for Bedroom Lifting Devices.

- Provincial Coverage - this edit defines where provincial coverage for the particular good or service exists.

- Comment - This provides additional information associated with the benefit code to system users to assist with adjudication of benefit requests.