Chapter 5
Departments of Health and Wellness and Family and Community Services Prescription Drug Program

Contents

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Background

5.1 The Prescription Drug Program (PDP) is one of many healthcare services provided in the Province of New Brunswick. PDP was established in 1976 to improve and maintain the well being of the people of the Province by making specified drugs available to selected groups of people.

5.2 These people are referred to as "beneficiaries" and include people who can least afford the high cost of prescription drugs and those who have specified medical conditions. Beneficiaries of the program are senior citizens with limited income, people in need of financial assistance, nursing home residents, children in care, and people with cystic fibrosis, AIDS, MS, or organ transplants. The program consists of several "plans" each designed to meet the needs of the beneficiary groups. Each plan has different eligibility requirements and provides different drug benefits. Approximately 15% of the population are beneficiaries of the program; the two largest plans are the plan for seniors and the plan for people in need of financial assistance.

5.3 Atlantic Blue Cross Care (Blue Cross) administers the program for the Department of Health and Wellness. They are responsible for program delivery. In addition, there are ten central office staff at the Department of Health and Wellness who work on the program (director, pharmacists, physicians and program support). They are responsible for program management, which includes deciding what drugs to include, day-to-day monitoring, legislation, etc. Within the program, there are approximately 1,400 prescribing doctors and 165 pharmacies dispensing drugs.

5.4 Our Office has an interest in the healthcare services provided by the Province. In the past few years, we have done audit projects on

ambulance services, the Extra-mural hospital, and hospital corporation governance. We believe that the Prescription Drug Program is significant because it can help individuals obtain drugs that are needed to prevent discomfort, sickness or even death. Also, the program is significant because it has the potential to have great value for money; by providing drugs and controlling a medical condition, it may be possible to prevent more serious health problems with higher treatment costs.

Scope

5.5 Although the Prescription Drug Program has several plans, this audit covered only Plan F – Family and Community Services Beneficiary Group. Plan F provides drug benefits to people who receive income assistance and those who have drug expenses for which they do not have the resources to pay. While the Prescription Drug Program is the responsibility of the Department of Health and Wellness (H&W), eligibility for financial help with drug costs for Plan F is the responsibility of the Department of Family and Community Services (FCS). In the fiscal year ended 31 March 2001, Plan F accounted for approximately $23 million of the total program expenditures of $77 million. During the year, there were over 58,000 individuals who had Plan F health cards with drug benefits.

5.6 The objective for this audit was to determine if the Department of Health and Wellness and the Department of Family and Community Services have appropriate systems and practices in place within the Prescription Drug Program to ensure:

- each person who is eligible for benefits within Plan F is offered the program; and
- Plan F provides services only to those people who qualify.

5.7 As indicated by the objective, the audit covers the availability of the plan and eligibility for its benefits. Usage of health cards issued to individuals was not part of the scope of this audit.

Results in brief

5.8 The Department of Health and Wellness and the Department of Family and Community Services have some systems and practices that are helpful in providing the Prescription Drug Program to people who are eligible for benefits under Plan F. However, the current systems and practices are insufficient in ensuring that each person who is eligible for benefits within Plan F is offered the program, and that Plan F provides services only to those people who qualify. There are situations where there are services available, but no one is using them. And, there are cases where services are being provided to individuals who are not eligible.

5.9 We believe that many of the problems we identified result from inadequate co-ordination and communication between the Department of Health and Wellness and the Department of Family and Community Services. Both departments have direct involvement in delivering Plan F, yet there is very little formal contact between the

two departments; there is no written agreement stating their roles and responsibilities, and there is no working committee or regular meetings to ensure that problems are identified and addressed.

5.10 We believe the Department of Health and Wellness and the Department of Family and Community Services should work together and make improvements in the delivery of Plan F.

The registration process for Plan F

5.11 Eligibility for financial help with drug costs for Plan F of the PDP is the responsibility of the Department of Family and Community Services. FCS has several ways of helping people in need with their drug costs. The Department can issue "health cards" with prescription drug benefits to individuals who are determined to be eligible. FCS can provide financial assistance to eligible individuals who have private medical plans but cannot afford the participation fees (the amount paid when a prescription is obtained). And, the Department can also provide financial assistance to eligible individuals who have access to private medical plans but cannot afford the monthly insurance premiums (the cost of purchasing insurance).

5.12 Both FCS and the PDP operate under the principle that the Province is the payer of last resort. People qualify for a health card, only if they have no other health insurance coverage. There are four groups of health card recipients under Plan F.

1. "Basic assistance" clients who qualify for a health card because they receive income assistance monthly.
2. "Health card only" clients who qualify because of their drug costs and financial situation.
3. "Extended health card" clients who qualify during a transitional period as they move from income assistance to employment.
4. Clients who qualify for a health card under section 4(2)(b) of the regulation under the *Family Income Security Act* because they receive financial assistance monthly, for specific expenses they have.

5.13 Applicants contact their local FCS office to find out if they are eligible for financial assistance or a health card. Screeners and Needs Assessment Specialists are FCS workers who talk with the applicants to obtain information that is used to determine if the applicants are eligible. NBCase is the automated case management system, developed by Andersen Consulting and FCS in the mid 1990s, which FCS now uses to determine eligibility. If applicants are determined to be eligible, then a health card is mailed to them the following day and the PDP Division registers them as a beneficiary.

5.14 When a prescription is required, the individual presents their health card to the pharmacist. Using the computer system, the pharmacist

verifies the individual's drug coverage with Blue Cross and electronically submits a drug claim for payment. The individual pays a $4 participation fee for adult prescriptions and a $2 participation fee for a child's prescription.

5.15 Our first three audit criteria relate to the registration process for eligible clients of Plan F. They address the eligibility requirements for the plan, whether the registration process ensures compliance with the eligibility requirements, and the promptness of registering eligible clients and removing individuals who no longer qualify.

Eligibility requirements

5.16 Our first criterion states:

There should be clearly stated eligibility requirements for the plan.

5.17 To determine whether this criterion was met, we examined the eligibility requirements for each of the four groups of health card recipients.

"Basic assistance" clients

5.18 "Basic assistance" clients qualify for a health card because they receive income assistance monthly. Each "basic assistance" client is eligible for a health card if they do not have coverage under another plan. The policy lists the exceptions: Natives, post secondary students and any other individuals having coverage under another plan. The eligibility requirements for "basic assistance" are set out in the *Family Income Security* legislation. Eligibility is determined by a financial assessment.

5.19 The eligibility requirements for this group of health card recipients are clear.

"***Health card only" clients***

5.20 Health cards are issued to people who apply for a health card and are determined eligible because of their drug costs and financial situation. These health cards are issued under section 4(4) of the regulation under the *Family Income Security Act*. The intent of section 4(4) is to provide assistance in emergency situations, and it allows eligibility to be determined without imposing the standard financial formula.

5.21 Eligibility is determined by a financial assessment. There is discretion in deciding what expenses and what amounts are considered in performing the assessment. Policies and procedures in NBCase provide guidelines to help decide which expenses and, in a few cases, what amounts to consider.

5.22 The eligibility requirements for "health card only" clients are not clear. The legislation clearly gives the Minister the authority to issue the health cards and the authority to use discretion in determining eligibility. Although policies and procedures do provide some guidance for determining eligibility, they are not extensive enough to make the eligibility requirements clear.

"Extended health card" clients

5.23 The "extended health card" is issued to help people, during the transition period, as they leave the financial assistance program for training or employment. Like the "health card only", these health cards are issued under section 4(4) of the regulation under the *Family Income Security Act* which allows eligibility to be determined without imposing the standard financial formula.

5.24 Eligibility requirements for the "extended health card" are stated in a policy, "if the loss of the health card is a significant barrier to clients wishing to move from assistance to training and/or employment, a health card may be issued to assist them during this transitional period."

5.25 The eligibility requirements for the "extended health card" are clear.

"***Section 4(2)(b)" clients***

5.26 "Section 4(2)(b)" clients qualify for direct financial assistance under Section 4(2)(b) of the legislation because of their financial situation and because they have specific expenses, e.g. training, childcare, medical supplies, transportation. Once an applicant qualifies for financial assistance as a "section 4(2)(b)" client, they also become eligible for a health card. The policy states, "4(2)(b) clients are eligible for the same level of health card coverage as basic assistance clients." This means that everyone receiving financial assistance under section 4(2)(b) is entitled to a health card, provided they do not have access to other health coverage.

5.27 The intent of section 4(2)(b) is to provide financial assistance for specific expenses. Like section 4(4), it allows eligibility to be determined without imposing the standard financial formula and discretion is introduced. The financial formula used in determining eligibility is complicated; NBCase facilitates performing the financial assessment.

5.28 The eligibility requirements for this group of health card recipients are clear, but somewhat complicated.

The financial eligibility requirement is different for each group of health card recipients.

5.29 In three of the four situations where health cards are issued, eligibility requirements include a financial assessment. Eligibility requirements for the "extended health card" do not include a financial assessment.

5.30 In each of the three situations where eligibility requirements for a health card include a financial assessment, the financial assessment is different.

- For "basic assistance" applicants, the financial assessment includes only income and assets; expenses are not considered. Some types of income are exempt; for example, wages to a maximum of $200/month, the refundable child tax credit and the refundable federal sales tax credit. And, some assets are exempt; for example, liquid assets to a maximum of $2,000.

- For "health card only" applicants, the financial assessment includes income, assets and expenses. Expenses are closely examined, and only those relating to necessities are considered. All types of income are considered, including those exempted when applying for "basic assistance". And, assets considered include the $2,000 that is exempted when applying for "basic assistance". Without the same exemptions as "basic assistance", this financial assessment is more restrictive.
- For "section 4(2)(b)" applicants, the financial assessment includes income, assets and expenses. However, only specified expenses are considered. The assessment includes all types of income; then a comparison is made between total income and the "basic assistance rate".

5.31 While we acknowledge that the unique needs of different client groups result in the need to tailor the eligibility requirements, using different financial assessments for the same health card might result in the unfair delivery of the program. For example, because the financial assessments are different, it is possible that a health card be refused to someone who is employed that has the same, or even a lower, income than someone who is receiving "basic assistance". The individual receiving "basic assistance" will automatically receive a health card. This has the potential to be unfair to the low-income worker.

Some employees are unaware that "section 4(2)(b)" clients are eligible for a health card.

5.32 We saw several client files where the case notes clearly indicated that the employee was unaware that "section 4(2)(b)" clients are eligible for a health card. And, we saw one case where the notes made by several different employees indicated that they did not clearly understand the "health card only" and section 4(2)(b) policies.

Some employees are confused with the eligibility requirements between two groups of health card recipients.

5.33 Some employees are confused as to when to perform a "health card only" assessment and when to perform a section 4(2)(b) assessment. Since the assessments are different, confusion poses a risk that individuals who are eligible for assistance may be determined ineligible.

5.34 Our testing in NBCase, on health card recipients, revealed several cases where the wrong assessment had been performed; a "health card only" assessment was performed when a section 4(2)(b) assessment should have been performed. This is significant because the financial assessments are different and the benefits/services are different. This problem commonly occurs with applicants having high medical expenses because of diabetic supplies. We saw several cases where a "health card only" assessment was performed and a health card was issued. This is the wrong service for this group of clients. Diabetic supplies are not included as benefits within the Prescription Drug Program; the health card will provide the client with their insulin, but it will not provide their diabetic supplies. The proper service for these individuals is to perform a section 4(2)(b) assessment. If eligibility is determined, the individual will obtain

financial assistance for their diabetic supplies in addition to the health card for their insulin.

Conclusion

5.35 This criterion is partially met.

5.36 Eligibility requirements for the plan are stated in legislation, policies and procedures. Within the plan, health cards are issued to four groups of clients. We found that the eligibility requirements for three of the four groups are clearly stated. However, the lack of clearly stated eligibility requirements for one group, coupled with complicated eligibility requirements for another group, causes some employees to be confused with the eligibility requirements between two groups of health card recipients.

5.37 We are concerned by the differences in the financial eligibility requirements for the four groups of health card recipients within the plan and the potential for unfairness.

Recommendations

5.38 To ensure that health cards are issued in a fair manner, we recommended that the financial eligibility requirement for each of the four groups of health card recipients within the plan be reviewed and amended, as necessary. The eligibility requirements for the "health card only" should be enhanced so that they are clear to employees and applicants.

5.39 Since some staff are confused with the services provided to "health card only" and "section 4(2)(b)" clients, we recommended that training needs be identified and assessed. A training plan should be established to reflect these needs, and it should be incorporated into the financial budget.

FCS response

5.40 *Our Operational Support branch will revisit the Health Card Only eligibility requirements, with the focus of ensuring comparable levels of assistance throughout the province. It is important that we respect the discretionary aspects of Health Card Only cases, as set out in Section 4(4) of the regulation under the Family Income Security Act, so absolute uniformity is not our expectation.*

5.41 *Our Operational Support branch will identify the specific training needs with respect to Section 4(2)(b) and Section 4(4) cases, and will incorporate this into its user training plan for front line staff.*

Compliance with eligibility requirements

5.42 Our second criterion states:

The registration process should ensure compliance with the eligibility requirements.

5.43 The registration process should ensure that each eligible person who applies is given benefits, and that the plan provides services only to those people who qualify. To determine whether this criterion was met, we

examined a few specific eligibility requirements and then tested active clients to determine if the requirements were met. We also performed an analysis and testing to determine if health cards are issued consistently throughout the Province.

5.44 Applicants contact their local FCS office to find out if they are eligible for assistance. Screeners and Needs Assessment Specialists talk with the applicants to obtain information that is entered into NBCase to determine if they are eligible. FCS believes that their registration process does ensure compliance with the eligibility requirements. They told us that since NBCase was introduced in 1996, the Department is doing very well processing applications consistently throughout the Province. They said that NBCase has standardized the decision-making process and the programmed eligibility rules are strictly adhered to. They feel it is a very objective system.

The registration process does not always ensure that the Province is the payer of last resort.

5.45 Paragraph 2.01(1) of the Prescription Drug Payment Act states, "Notwithstanding the definition 'beneficiary', no person is eligible to receive benefits under the programme if the person has, or is covered by, a contract or plan of insurance that, in the opinion of the Minister, provides benefits similar to the benefits provided under the programme." Paragraph 4(1) of the General Regulation – Family Income Security Act states, "As a condition of initial eligibility…all persons in the unit shall satisfy the Minister that they have, to the best of their ability, explored every possibility of support available to them." The legislation is clear. The Province is the payer of last resort; individuals who have access to other health coverage are not eligible for benefits.

5.46 Our testing revealed that FCS is not in full compliance with the payer of last resort legislation. During our testing we found several cases where Natives had been issued a health card and some system control weaknesses in NBCase. The following is a brief discussion of these situations.

5.47 The federal government is responsible for the drug program for all Natives, regardless of whether or not they live on a reserve. Natives are not eligible for the PDP and FCS's policies and procedures clearly state this.

5.48 Since all "basic assistance" clients are eligible for a health card, NBCase is programmed such that if the client is entered as a Native during the registration process, then the system automatically denies a health card. When a Native is not identified in NBCase, a problem occurs; they are issued a health card even though they are not eligible.

5.49 We tested the active cases as of 14 May 2001, to determine if there were any Natives who had health cards. Our testing did not permit us to identify all Natives. However, we did determine that there were 65 Natives with health cards. We chose a random sample of six to confirm that they

had federal coverage for drugs, and to determine whether or not they were using their New Brunswick PDP health card. The federal program confirmed that all six had coverage with them. Two of the six had obtained benefits under the New Brunswick PDP. The results of this test indicated that the registration process does not always ensure compliance with the eligibility requirements, and that the plan does provide services to some people who do not qualify.

5.50 Since the legislation clearly states that the Province is the payer of last resort, controls are needed to identify applicants that have other health coverage available to them. There are "features" within NBCase that we consider are control weaknesses for the Prescription Drug Program. The following examples concern the risk that the applicant may have other health coverage.

- During the application process, NBCase contains many prompts to aid the workers in obtaining information and determining eligibility. However, there are no prompts in the system to encourage the Screener or the Needs Assessment Specialist to ask about other health coverage. We see this as a control weakness.
- Another control weakness within NBCase that we identified is a "bug" within the system. Once the health card has been "turned off" for a "basic assistance" client, whenever NBCase re-evaluates eligibility, the health card is "turned back on". A change in income, assets, address, marital status, etc. will trigger the system to re-evaluate eligibility. This bug affects the largest group of health card recipients within Plan F; there are over 50,000 "basic assistance" clients. Although it is likely that most of these clients do not have other health coverage, we know that there are some that do and are, therefore, not eligible for the PDP. And, since Plan F has participation fees that are lower than most health plans, it is very likely that an individual with two health cards would choose to use the Plan F card because they would have to pay less.

The registration process does not always ensure that health cards are issued consistently.

5.51 The second largest group within Plan F are the "health card only" clients. As of May 2001, there were over 2,300 "health card only" clients. These are people who apply for a health card and are determined eligible, because of their drug costs and financial situation, using a financial assessment. When performing the financial assessment, the worker in the region uses discretion in deciding what expenses and what amounts are to be used in the assessment. Preliminary information indicated that these health cards might not always be issued on a consistent basis.

5.52 FCS recognizes that when discretion is introduced, it comes with a risk of inconsistency. They are attempting to control this risk by 1) providing guidelines to help workers in making decisions and 2) requiring the approval of each "health card only" client within a region by the Supervisor. Supervisors meet regularly and communicate frequently by email in an attempt to provide consistency between regions.

The Department thought there should be virtually no variance between "health card only" cases within a region, and there should be very little variance between regions. They told us that in cases where the guidelines are not followed, the case notes should clearly document reasons why they were not. They reported that the workers in the regions are very thorough when performing the financial assessments.

5.53 We performed an analysis on all active cases in NBCase as of 14 May 2001. The analysis showed great inconsistency in the ratios of "health card only" clients to "basic assistance" clients. This means that one of the two factors in the ratio must be inconsistent. Since the approval process for "basic assistance" applicants involves a standard financial assessment performed by NBCase with very little, if any, discretion by the worker, we believe that the inconsistency is in the approval of "health card only" applicants. The analysis showed that in one regional office, there was one "health card only" client for every seven "basic assistance" clients; however, in another regional office, there was one "health card only" client for every sixty-two "basic assistance" clients.

5.54 We found more evidence that "health card only" applicants are not always treated consistently in our testing of specific cases in NBCase. Testing on a sample of financial assessments, performed on people applying for a health card, indicated the following inconsistencies. (The sample covered thirty health cards issued in four of the seven regions.)

- There is inconsistency in the use of the expense guidelines for food; clothing; routine transportation; and household and personal. The expense guideline for food is 30% of the "basic unit rate". One case, with one adult and one dependant, was allowed $400 as a monthly food expense; the guideline was not used and the case was approved for a health card. A different case, with two adults and three children, was allowed only $259 as a food expense; the guideline was used and the case was not approved for a health card.
- There is inconsistency in the documentation supporting the use of the allowable "medical transportation - gas" expense category. The policy says that a medical transportation expense of $0.11 per kilometre is permitted for the use of a private vehicle. We saw some cases where the amount stated in the policy was used to determine the expense figure. However, there were several cases where an amount was entered, but there were no notes or calculations to support the figure. We saw two cases where there was an unexplained medical transportation expense of $100/month and one case where it was $150/month.
- There is inconsistency in the documentation supporting the use of the allowable "other" expense category. We saw two cases where the amount of $100/month was allowed, without explanation. In another case, an amount of $150 was allowed for "other" expenses but it was accompanied only by a general explanation.

Conclusion

5.55 This criterion is not met.

5.56 The registration process does not always ensure compliance with the eligibility requirements. We found several cases where a health card had been issued to an individual having other health coverage. We found evidence indicating that health cards are not being issued consistently and cases where we could not find evidence of financial eligibility.

Recommendation

5.57 We recommended that the registration process be reviewed and amended, where necessary, to ensure that controls are in place to identify applicants having other drug coverage and to prevent these individuals from obtaining a health card. The review should ensure that the NBCase features that we identified as control weaknesses are addressed.

FCS response

5.58 *As a first step to address this recommendation, our Operational Support branch will convey the message to all Screeners, Needs Assessment Specialists and Case Managers that applicants and clients are to be asked if they have health coverage for prescription drugs, under any other plans.*

5.59 *To incorporate this question into our computerized intake process, as well as the case review process, we will explore the feasibility of amending the NBCase system to have this as a dropbox that must be completed as part of the application/case review form.*

Recommendation

5.60 Since issuing health cards to Natives is a recurring error, we recommended that workers in the regions be informed of the importance of identifying Natives in NBCase. Cases in doubt should be identified and followed-up with the federal group responsible for Native drug coverage. We also recommended that someone be assigned the responsibility of monitoring to ensure Natives are not issued health cards.

FCS response

5.61 *Our Operational Support branch will extract all cases from the NBCase system with series 7 & 8 Medicare numbers, will confirm if they have native status with the federal government, and accordingly will delete the provincial health coverage. A similar report will be run and actioned on a quarterly basis.*

5.62 *Screeners, Needs Assessment Specialists and Case Managers will be reminded to properly select the NBCase citizenship description "Registered Indian Act-Canadian" for those clients with native status. The existing NBCase edit will not permit health coverage if registered Indian Act citizenship is recorded.*

Recommendation

5.63 To bring more consistency to the issuance of health cards, we recommended the following:

- **Explanations for the existing inconsistencies in the office ratios of "health card only" clients to "basis assistance" clients should be obtained. Inappropriate procedures should be identified and corrected.**
- **Explanations for the existing inconsistencies in the financial assessments performed on "health card only" applicants should be obtained. Inappropriate procedures should be identified and corrected.**
- **The guidelines for expenses for "health card only" applicants should be reviewed, and amended if necessary. All regional workers involved with the registration process should be informed of the proper usage of the guidelines.**
- **Controls should be established in the registration process to ensure that health cards are issued consistently to all eligible applicants and that health cards are issued only to those applicants that meet the eligibility requirements.**

FCS response

5.64 *Although we expected inconsistencies to be found during your review, as we are aware of the diversity in demographics and availability of health coverage that exist between regions, the extent of the differences has prompted us to have our Internal Audit Unit schedule a review of health card only cases in the near future.*

5.65 *This review will focus on identifying unique and best practices, as well as supporting document requirements in all regions, and will assist the Operational Support branch in its examination of eligibility criteria for this client group.*

Prompt registration and removal

5.66 Our third criterion states:

Procedures should be in place to ensure the prompt registration of a person who qualifies for the program and the prompt removal of a person who no longer qualifies for the program.

There are procedures in place to ensure the prompt registration of a person who qualifies for the program.

5.67 Registering an individual in the program is a two step process. The first step is determining eligibility and the second step is issuing the health card benefit.

5.68 FCS is solely responsible for the first step, determining eligibility. Applicants contact their local FCS office to find out if they are eligible for financial assistance or a health card. Screeners and Needs Assessment Specialists are FCS workers who talk with the applicant to obtain information that is entered into NBCase, which FCS uses to determine eligibility.

5.69 FCS stated that they feel that NBCase helps with prompt processing and our observations support their statement. We observed the Screeners in one region while they were working and NBCase appeared

helpful in many ways, such as prompting questions to ask, quickly performing calculations, and scheduling interviews. FCS also said that prompt registration is not really a concern because their legislation states that if a person is determined eligible, then assistance will be given retroactively to the date of the application and that NBCase is programmed to make this happen.

5.70 Once the regional offices of FCS determine eligibility and a health card is approved, the information must be forwarded to Blue Cross. The Blue Cross data file is prepared daily and transferred nightly. Blue Cross does a daily update to the Prescription Drug Program's adjudication system, which registers the eligible individuals as beneficiaries, giving them access to the program's benefits. On the day following the approval, a health card is mailed to the individual through NBCase. Although this normal process gives an individual access to drug benefits on the day following the approval of the health card, there is also a process in place for emergency situations that provides same-day access to the program's benefits.

5.71 The data file transfer from FCS to Blue Cross appears to work well. There is a formal process in place, with controls, to ensure that the file is sent properly, that the file is received properly and that the Blue Cross system is updated properly. Should a problem occur, there is a formal process for addressing it promptly. Both FCS and the PDP Division reported that problems are rare and that the existing system is working well.

5.72 We tested a random sample of 25 cases in Plan F, where drug benefits had been received, to determine if the client was registered as eligible for prescription drug benefits in NBCase at the time the benefit was received. In each of the 25 cases, the client was registered as eligible for drug benefits in NBCase at the time the benefit was received. The results of this test indicated that eligibility information is being transferred properly from FCS to Blue Cross.

There are procedures in place to ensure the prompt removal of a person who no longer qualifies for the program.

5.73 The procedures for removing a person, who no longer qualifies for the program, are very similar. NBCase is programmed such that when eligibility ceases, the health card benefit is automatically terminated. Eligibility ceases when either a FCS worker enters information into NBCase that terminates eligibility or when the eligibility period lapses. This information is also sent to Blue Cross in the data file that is transferred nightly.

5.74 We tested a random sample of 99 cases, where the prescription drug benefits had been terminated in NBCase, to determine if the individual had received drug benefits after their case had been terminated. We found no cases where drug benefits had been received after the termination date. The results of this test indicated that the eligibility

information is being transferred properly and the Blue Cross system is being updated promptly.

There is no process allowing the PDP Division to terminate the benefits of someone in the Plan.

5.75 On occasion, the PDP Division becomes aware that a beneficiary of Plan F has other drug coverage, and is therefore not eligible for the program. Since the PDP Division is responsible for the program's expenditures, it is important that they have a means of initiating the removal of people who are not eligible for the program. There is no formal process in place that allows the PDP Division to terminate the benefits of someone in Plan F.

There is no formal process for the PDP Division to help people secure a health card.

5.76 The PDP Division reported that they have been involved with cases where determining eligibility was not done promptly. The cases involved individuals who were told by the FCS Screener that they were not eligible for a health card, but later it was determined that they did qualify. They reported that it is very difficult for mental health patients specifically to get past the telephone screening for eligibility. They reported, on average, having to respond to one case per week dealing with eligibility issues. The number of cases and the time required to address each issue might indicate problems with the registration process and/or the eligibility requirements.

5.77 FCS reported that they saw no evidence of delays in screening. Given the differences between departments with respect to the promptness of determining eligibility, we feel it would be appropriate for them to work together to resolve the matter.

Conclusion

5.78 This criterion is substantially met.

5.79 For normal cases, procedures are in place to ensure the prompt registration of a person who qualifies for the program and the prompt removal of a person who no longer qualifies for the program. However, like most systems, there are situations which do not fit the normal profile; and formal procedures are not in place for dealing with these cases.

Recommendation

5.80 We recommended that a formal process be established that facilitates the prompt removal of individuals from the program when it has been identified by the PDP Division that they have other health coverage.

FCS response

5.81 *Our Operational Support branch will outline an information sharing process for PDP's consideration.*

5.82 *It is intended that upon receipt of other health coverage information, this branch will take prompt action to delete the client's eligibility for health benefits in the NBCase system.*

H&W response

5.83 *PDP will support establishing a formal process for removing those individuals who have been identified, though supportive documentation, as having other prescription drug coverage.*

Recommendation

5.84 We recommended that the two departments develop a formal process for how the PDP Division is to help people secure a health card through FCS. The process should ensure the applicant is eligible before approving the health card and that proper documentation is maintained.

FCS response

5.85 *Since the determination of eligibility for financial assistance with health related costs, including PDP, rests solely with the Minister of Family and Community Services, the established process of making application at one of our service sites will not be altered, except by order of the Executive Council.*

5.86 *However, should PDP have concerns about a specific applicant situation, our Operational Support branch, once advised of the particulars, will promptly examine the intake information on file and will provide feedback to PDP.*

H&W response

5.87 *PDP will support development of a formal process designed to address situations that do not fit the normal profile for applying for prescription drug services under the FCS health card.*

Establishing policies and procedures

5.88 Policies and procedures establish rules to ensure that a program is provided in accordance with legislation and that the program is delivered consistently throughout the Province.

5.89 The next two audit criteria relate to policies and procedures regarding eligibility for the plan. They address whether policies and procedures are documented, accessible by staff and kept current; and whether they are monitored for compliance.

5.90 Our fourth criterion states:

> *Policies and procedures regarding eligibility should be documented and easily accessible by staff. They should be reviewed annually and updated as needed.*

There are documented policies and procedures regarding eligibility.

5.91 All policies and procedures regarding eligibility for the plan are on NBCase. The on-line system ensures that staff have access to the current policies and procedures.

5.92 The PDP Division does not have a copy of FCS's policies and procedures regarding eligibility for the plan. Since the policies and procedures are on NBCase and the Division does not have access to NBCase, the policies and procedures are not easily accessible by the Division. The PDP Division finds it difficult to respond to the public's

questions and complaints without having easy access to the plan's policies and procedures.

Some of the policies and procedures in NBCase, relating to health cards, are not correct.

5.93 We reviewed the policies and procedures relating to health cards and noted that some of the information appeared incorrect. We requested that these policies and procedures be reviewed. It was confirmed that some of the information was not correct.

Policies and procedures are reviewed and updated.

5.94 Changes are initiated in several ways, including the use of issues identified by the regions. Changes made to policies and procedures are dated, and easily seen in NBCase. However, there is no scheduled review of all policies and procedures, and at the time of our review, there was some outdated information. In order to reduce the risk of confusion and maintain a manageable amount of information, "house cleaning" of policies and procedures is needed periodically.

Information needs have not been determined and formal communication channels, between the two departments, have not been established.

5.95 The PDP Division told us that resolving problems relating to Plan F can be a very inefficient process for them. Problems they encounter include: discovering beneficiaries of the plan who have other health coverage, handling complaints and resolving eligibility issues when serving their public advocacy role. Obtaining the required information is not always easy; formal communication channels have not been established and the rules for sharing information are unknown.

5.96 The PDP Division does not have access to NBCase. NBCase is the automated case management system used by FCS to determine eligibility. Amongst other information, NBCase includes information on applicants, information on clients (both active and terminated), and policies and procedures. The PDP Division wants access to NBCase. They believe that access to this information will allow them to improve the administration of the program, be more accountable for the money spent, provide better service to clients, and resolve problems.

Conclusion

5.97 This criterion is partially met.

5.98 We were pleased to find that policies and procedures regarding eligibility are documented and maintained in NBCase. They are updated when FCS sees the need. However, policies and procedures are readily accessible to FCS staff only, and there are places where some of the information is not correct. Without correct, clear policies and procedures, FCS workers could deliver the service improperly or give the public wrong information about the Prescription Drug Program.

5.99 The PDP Division is not consulted when FCS develops or changes their policies and procedures relating to the plan. Information needs have not been determined and formal communication channels, between the two departments, have not been established.

Recommendation

5.100 We recommended that FCS provide the PDP Division with a copy of all the current policies and procedures relating to the plan.

FCS response

5.101 *Our Operational Support branch will ensure that the NBCase procedures relating to Plan F will be made available to PDP. Presently, the NBCase policies are accessible via the Internet. It is our intention to explore the viability of providing PDP with an electronic copy of the information, including procedures, that appears on the NBCase On Line Help screens.*

H&W response

5.102 *PDP agrees that FCS should provide the division with a copy of all current policies and procedures relating to the Plan.*

Recommendation

5.103 We recommended that the PDP Division carefully review all current policies and procedures relating to the plan from their perspective. Suggested changes should be given to FCS for consideration. Corrections, that are considered necessary, should be made in NBCase as soon as possible.

FCS response

5.104 *Suggested policy and procedure amendments from PDP will be welcomed by the Operational Support branch. It will consider the change requests, discuss any concerns with PDP, and will incorporate the agreed upon changes into the NBCase On Line Help screens.*

H&W response

5.105 *PDP will assign responsibility of FCS prescription drug policy review to a DHW staff person when a formal process has been established.*

Recommendation

5.106 We recommended that the two departments work as a team and both be directly involved in preparing and amending policies and procedures relating to the plan. We also recommended that someone at FCS be assigned the responsibility of providing the PDP Division with a copy of all changes, made to policies and procedures relating to the plan, as they occur.

FCS response

5.107 *Our Operational Support branch has the responsibility to maintain NBCase policies and procedures, including those related to Plan F coverage. This branch will liaise with PDP, and will ensure that amendments are shared with PDP.*

H&W response

5.108 *PDP will co-operate in amending policy/procedure updates relating to the Plan.*

Recommendation

5.109 We recommended that FCS assign someone the responsibility of collecting all required updates to policies and procedures and annually making the changes to keep the information relevant and correct.

FCS response

5.110 *Assignment of this responsibility rests with our Director of the Operational Support branch, as it is a function of this branch to update NBCase policies and procedures on a continuous basis.*

Recommendation

5.111 We recommended that the two departments work together and determine their information needs, including whether or not the PDP Division should have access to NBCase. Formal communication channels between the two departments should be established.

FCS response

5.112 *Access to the NBCase system by PDP is not an option at this time due to current legislation that prevents such sharing of personal information with other departments.*

H&W response

5.113 *However, we are willing to discuss with PDP their information needs and will endeavour to put in place a communication mechanism that will satisfy these needs, including the resolution of case-specific situations.*

H&W response

5.114 *PDP will assign a staff person to work with FCS staff in determining information needs and establishing a formal communication process.*

Monitoring compliance with policies and procedures

5.115 Our fifth criterion states:

Policies and procedures should be monitored for compliance.

5.116 Monitoring compliance with policies and procedures determines if a program is operating in accordance with legislation and if the program is delivered consistently throughout the Province. Monitoring is an important function.

A proper monitoring system has not been established.

5.117 A proper monitoring system has not been established for the plan. Regular monitoring procedures are not being performed and have not been developed.

5.118 FCS does perform activities to determine if their policies and procedures are being followed. Monitoring of “basic assistance” and “section 4(2)(b)" clients is performed within the region by management and investigators, and is performed overall by regional directors and by the audit services group. Although monitoring of “basic assistance” clients and “section 4(2)(b)” clients indirectly monitors health cards issued to these clients to some extent, FCS does not perform any specific activities for monitoring the issuance of health cards. FCS investigators do not monitor “health card only” clients. This is a group of over 2,300 clients.

An accountability framework is not in place for Plan F.

5.119 We found the legislation for the plan cumbersome and confusing. Six pieces of legislation (Acts and Regulations) and two different departments are involved. The *Family Income Security Regulation* is the authority for the Department of Family and Community Services to issue

health cards and it states the eligibility requirements. The *Health Services Regulation* is the authority for drug benefits provided to Plan F beneficiaries to be paid under the Prescription Drug Program. The *Prescription Drug Payment Regulation* is the authority for the Department of Health and Wellness to pay for drugs on behalf of beneficiaries of the program. Although the beneficiaries of the other plans within the PDP are defined in the *Prescription Drug Payment* legislation, there is no description of Plan F or reference to these beneficiaries.

5.120 The PDP Division has no control over eligibility for plan F clients; they have no involvement in the registration process; yet, they are responsible for the program's costs and its administration.

5.121 When the responsibility for determining eligibility and issuing health cards is not assigned to those responsible for the program's budget, it is difficult to manage and control expenditures; and, accountability is challenged.

5.122 Who is, or should be, responsible for monitoring the plan is not clear. There is no written agreement between the departments stating monitoring roles and responsibilities. However, management of both departments agree that Plan F beneficiaries are clients of FCS and that H&W is simply a service provider. This being the case, we question the adequacy of the accountability structure for the plan.

Conclusion

5.123 This criterion is not met.

5.124 Policies and procedures are not monitored for compliance. A proper monitoring system has not been established for the plan and our observations indicated that monitoring is lacking.

5.125 An accountability framework is not in place for Plan F. It is not clear who is responsible for monitoring the plan; there is no written agreement between the departments stating monitoring roles and responsibilities.

Recommendation

5.126 We recommended that the two departments work together and develop a proper monitoring system for the plan that satisfies both departments' needs.

FCS response

5.127 *We endorse the need for monitoring of all programs, including those related to Plan F and are willing to discuss this issue with PDP, although we recognize that monitoring of a jointly administered program presents challenges, especially with limited resources.*

5.128 *The costs associated with monitoring vs the benefits to be realized will have to be identified before any FCS resources are committed.*

H&W response

5.129 *PDP currently monitors prescription drug usage of FCS clients for its own purposes. The program has shared or created documents when requested by FCS. PDP would be willing to co-operate in a more formal process that would enable both departments to share available data for use in program management.*

Recommendation

5.130 In order to enhance accountability for the plan, we recommended that the two departments formalize their relationship in a written agreement that states their roles and responsibilities. We recommended that the two departments establish goals for the plan. We also recommended that the two departments establish a formal working committee that meets regularly to ensure that interdepartmental issues are identified and addressed promptly.

FCS response

5.131 *With the enhancements expected in working relations between PDP and FCS resulting from this review, it is appropriate for the two departments to jointly ratify their respective roles and responsibilities with respect to Plan F.*

H&W response

5.132 *PDP will assign a DHW staff person to develop an agreement that formalizes the relationship and states roles and responsibilities with FCS in the following areas:*

- *establish goals for health card prescription drug issues that meet the needs of both departments;*
- *maintain a seat(s) on a working committee, comprised of management staff from both departments to discuss on-going and urgent issues;*
- *discuss the feasibility/necessity of changing existing legislation of both departments to establish a joint responsibility center for budget and access issues.*

Public awareness and serving the target group

5.133 Each program or service provided by government has a purpose. When government provides social programs, something is being done for a group of people. In order for a program to be effective, the target group must be identified and served. The last audit criterion deals with serving the target group.

5.134 Our sixth criterion states:

> *Information on the program, including eligibility requirements and the application and termination processes, should be made available to all potential applicants.*

There is information on Plan F on the Internet.

5.135 Plan F is described briefly, along with each of the other plans within the Prescription Drug Program, on the Department of Health and Wellness' website. The Department of Family and Community Services' website provides their policies, and information on health cards is available there.

5.136 We found that it is not easy to locate the policies relating to health cards on the Internet. All the information on the program, including eligibility requirements and the application and termination processes, is not conveniently located together. We reviewed the policies on the Internet relating to health cards and noted that some of the information was incorrect.

There is no information on Plan F that is prepared in hard copy for the public.

5.137 There is no information prepared in hard copy for public consumption that specifically describes the plan, including eligibility requirements and the application and termination processes. The PDP Division does not have pamphlets to distribute to the public that discusses Plan F, and general pamphlets used in the past have not made reference to Plan F. FCS has pamphlets on some of their services that are for public distribution; however, health cards are not discussed in the pamphlets.

5.138 We asked FCS how people become aware of the help that is available for unmanageable drug costs. FCS told us that they do not advertise; the demand for services already exceeds the supply of financial resources. They said, “Clients find us”. They told us that community service resources (emergency shelters, food banks, and transition houses) and health professionals (physicians and pharmacists) refer potential clients to their department for help.

There are two available services that are not being used.

5.139 Individuals who have private health coverage but cannot afford the participation fees (the amount paid when a prescription is obtained) may be eligible for financial help. This is one of the benefits available under section 4(2)(b). Examples of individuals who may need this financial assistance are people who have cancer or mental illnesses because the drugs used to treat these illnesses are extremely expensive. This assistance is briefly described in the information on FCS’s website.

5.140 Another one of the benefits available under section 4(2)(b) is financial assistance for the “monthly cost to receive coverage for prescription drugs from a private plan” (monthly premium). We could not find information on this type of assistance on FCS’s website, but we did see it described in the policies and procedures in NBCase.

5.141 We reviewed the usage of these two services by first determining the number of “section 4(2)(b)” clients. We then determined the number of people within this group that were receiving financial assistance to help pay for participation fees and the number of people that were receiving financial assistance to help pay for monthly premiums for private health coverage. On 14 May 2001, there were ninety “section 4(2)(b)” clients in the Province. There were no clients within this group that were receiving financial assistance to help pay for participation fees. There were no clients within this group that were receiving financial assistance to help pay for monthly premiums for private health coverage.

5.142 It is important to provide financial assistance to those with private coverage, who need help paying participation fees, in order to prevent these individuals from cancelling their private coverage and then coming to the department for a health card. This would result in the Province paying for the full cost of the drugs. Likewise, it is important to provide financial assistance to those who need prescription drugs and have access to private coverage, but need help paying the monthly premiums. Helping individuals obtain private drug coverage will make it unnecessary for them to come to the department for a health card, whereby the Province pays for the drugs.

Conclusion

5.143 This criterion is not met.

5.144 Information on the program, including eligibility requirements and the application and termination processes, is not available to all potential applicants. Not everyone has access to the Internet and without computer access, information provided on the Internet is not useful.

5.145 There are two available services that are not being used. Individuals who have private health coverage but cannot afford the participation fees are not receiving the proper service. And, individuals who need prescription drugs and have access to private coverage, but need help paying the monthly premiums, are not receiving the service that is available. This may be partly due to the lack of public disclosure of these services.

Recommendation

5.146 We recommended that the two departments work together in creating a pamphlet for the public that provides general information on the Prescription Drug Program and more detailed information on Plan F, including the benefits available, the eligibility requirements, the application and appeal processes, and phone numbers where more information can be obtained.

FCS response

5.147 *With PDP spearheading and funding this initiative, we will actively assist in the provision of information on the eligibility, application and appeal processes.*

H&W response

5.148 *PDP has a public information sheet that gives a brief description of the FCS plan. The program is currently considering updating the existing PDP pamphlet. With co-operation from FCS, a revised pamphlet would incorporate suggested information and be distributed to both departments as well as to relevant stakeholders.*

Recommendation

5.149 We recommended that information on the plan be available through both departments, at the regional offices of both departments, at the offices of health professionals (such as cancer specialists and psychiatrists), and at pharmacies, hospitals, and other community support centres. We also recommended that the phone numbers, where more information can be obtained, be provided on the reverse side of the health card that is issued to clients.

FCS response

5.150 *Our service sites throughout the province will prominently display and make available the Plan F information pamphlets to the public.*

5.151 *The provision of these pamphlets to all clients with health card drug coverage should address the need for any additional information, and therefore makes the suggestion of printing a phone number on the health card redundant.*

H&W response

5.152 *PDP will provide assistance with the circulation of drug plan information to all relevant stakeholders.*

Recommendation

5.153 Since providing financial assistance to individuals to cover expenses relating to participation fees and monthly premiums for private health coverage could reduce costs to government, we recommended that FCS determine why these services are not being used and make corrections as necessary.

FCS response

5.154 *Our upcoming internal audit and Operational Support branch reviews of health card only cases may provide some insight as to why there is no apparent activity in the payment of participation fees or monthly premiums for other health coverage.*

5.155 *This issue will also be addressed in the Section 4(2)(b) and 4(4) case training of front line staff.*