Veterans Affairs Canada | Anciens Combattants Canada

Veterans Independence Program Audit

Final: May 2010

Canada

This report was prepared by the Audit and Evaluation Division

ACKNOWLEDGEMENT

Audit and Evaluation Division acknowledges the time and effort given by departmental managers and staff to provide information associated with this audit.

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1.0 EXECUTIVE SUMMARY

The Audit of the Veterans Independence Program (VIP) was approved by the Departmental Audit Committee in 2009. The objectives of the audit were to determine if:

1. up-to-date policies and procedures were in place to support program delivery;
2. program payments were accurately calculated and paid to eligible clients and approved providers;
3. regulatory and policy requirements were complied with; and
4. the quality assurance function provides an ongoing assessment of compliance requirements and identifies opportunities for improvement.

The audit found that while business procedures exist for the most recent additions to the VIP, no comprehensive business procedures are in place for the parts of the program in existence since its inception. Policies are regularly supplemented by directives, e-mails, and interpretations, however, this information is not provided in a uniform manner, not included in the Veterans Programs Policy Manuals, not linked for ease of access, and not effectively communicated. It is the consensus of the audit team that VIP policies are therefore not sufficiently up-to-date to support program delivery.

The calculation of VIP payments differ depending upon the element, rates for service, and duration of service. Payments can be advanced to a client, paid directly to the client or to a registered provider on behalf of the client. There is a lack of information provided in the benefit notes field on the contribution arrangement (CA) form and in VAC documentation regarding the CA amount which is the detailing of the payment plan. This information is not shared with Medavie Blue Cross (the contracted payment processor) regarding the calculation and disbursement of benefit payments.

With only an annual rate limit as a cost control, the Department may want to examine alternative approaches to ensure the calculation of clients VIP payments are based on identified/assessed client need and not unduly determined by the provider costs.

The eligibility criteria for VIP is varied and complex and recent expansions to the program have made determining client eligibility more difficult for staff. The introduction of the Frail Policy has challenged staff to provide VIP programs to clients with a demonstrated need within the umbrella of the existing regulations and eligibility criteria. The introduction and application of the frail policy is not compliant with the existing regulations in the VHCRs.

There is a need for additional monitoring of compliance, quality control, and system

controls at all levels of the VIP. These concerns have been identified and the Department is well underway to reversing this situation through ongoing reviews of policy and organizational changes to the way the program is delivered and managed.

There are several activities that address areas of performance standards, performance measurement, quality control, account verification, and quality assurance. However, there is no comprehensive quality assurance framework that provides ongoing assessment of compliance requirements regarding: regulations, policy, Section 34 of the Financial Administration Act, and standards for completion of the CA.

In the professional judgment of the Chief Audit Executive, sufficient and appropriate audit procedures have been conducted and evidence has been gathered to support the accuracy of the opinion provided in this report. The Audit and Evaluation Division concludes with a high level of assurance that the overall control framework for the administration of the Veterans Independence Program in place and used by the Department from April 01, 2008 to March 31, 2009 presented too many material weaknesses to ensure the accuracy and compliance of the transactions processed with relevant authorities.

In particular, weaknesses were found relating to the distribution and updating of policies, the inability to assure the accuracy of the calculation of VIP payments, the ongoing challenges to get the CA signed by clients, insufficient controls to prevent unauthorized changes to the CA by clients and providers, and insufficient monitoring, reporting and oversight regarding compliancy and expenditures.

This opinion is based on the conditions as they existed at the time of the audit. The opinion is only applicable to the entity examined and for the scope and time period covered by the audit.

The recommendations contained in this report are intended to improve the management of the Veterans Independence Program. It is acknowledged that program managers have already initiated actions to address many of the findings of the audit.

Recommendations

Recommendation 1 (*Essential*)[1]

It is recommended that the Senior Assistant Deputy Minister, Policy, Programs & Partnerships in consultation with the Assistant Deputy Minister, Service Delivery

[1] See Annex D for explanations of the significance of recommendations

& Commemoration: (i) review and update the existing policies and procedures for the Veterans Independence Program; (ii) ensure effective and timely communication of updates to the appropriate staff and; (iii) ensure better communication of changes and/or integration of any expansions to the program.

Recommendation 2 (*Important*)

It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration, in conjunction with the Director General, Finance Division, develop and implement improved controls to ensure that VIP payments are accurately documented and calculated, and changes resulting from increased costs or frequency of service that result in changes to the CA amount are pre-authorized.

Recommendation 3 (*Critical*)

It is recommended that the Senior Assistant Deputy Minister, Policy, Programs & Partnerships: (i) implement a process to review and resolve current challenges to the compliancy of the Frail Policy with the VHCRs; and, (ii) ensure that ineligible clients are not receiving benefits under the VIP.

Recommendation 4 (*Essential*)

It is recommended that the Director General, Service Delivery Management, review the VIP payment process so that controls are placed on each transaction rather than on the annual total, with a view to ensuring that the Department can intervene in a timely manner in case of client health issues, service issues, or provider pricing issues.

Recommendation 5 *(Essential)*

It is recommended that the Director General, Service Delivery Management: (i) develop a training protocol for staff regarding the standardized completion of the VAC 1305 form; and (ii) ensure that in addition to the letter to staff regarding signing of CAs, better quality controls are implemented to ensure compliance and reduce the error rate for unsigned CAs.

Recommendation 6 (*Important*)

It is recommended that the Director General, Service Delivery Management establish a quality control and quality assurance team at all levels to develop a robust quality control and monitoring system to ensure that compliance

monitoring and reporting is done on a regular basis.

Recommendation 7 ***(Important)***

It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration: (i) ensure that the number of clients declared eligible for VIP as a result of the 'Frail Policy' are tracked and reported in a manner consistent with the way other client groups are tracked; and (ii) track the program and administrative cost of VIP files pended for 'insufficient funds'.

Original signed by

Orlanda Drebit
Chief Audit Executive

June 3, 2010

Date

2.0 PROGRAM BACKGROUND

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

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

The Veterans Independence Program (VIP) is authorized by Part II (Sections 15-20) of the Veterans Health Care Regulations (VHCRs), made pursuant to Section V of the Department of Veterans Affairs Act. The VIP does not replace other federal, provincial or municipal programs. The VIP is only available in Canada and cannot be offered to clients who live outside of the country.

The following table depicts VIP client volumes and program expenditures from fiscal year 2006-07 to 2008-09:

Veterans Independence Program Clients and Expenditures						
	2006-07		2007-08		2008-09	
Region	Clients	Expenditures	Clients	Expenditures	Clients	Expenditures
Atlantic	17,535	$85,721,863	17,566	$86,015,736	18,529	$85,616,894
Quebec	10,711	$30,471,111	10,521	$29,036,549	10,224	$27,649,230
Ontario	35,233	$96,689,993	37,211	$107,481,596	39,338	$117,607,159
Western	37,788	$73,784,427	37,821	$80,485,804	37,985	$88,571,421
Total	101,267	$286,667,394	103,119	$303,019,685	106,076	$319,444,704

The overall objective of the VIP is to prevent or delay the need for institutional care through the provision of at-home services to eligible clients[2]. The program objectives of the VIP are:

- To offer supportive service and intervene only to the extent that health needs cannot be met through personal and family support, or through provincial and community programs;
- To recognize the right and responsibility of the individual to remain at home for as long as it is reasonable, safe and practical to receive VIP services;
- To promote personal independence as well as personal and family responsibility in planning and providing care appropriate to the recipient's health needs;
- To encourage an independent lifestyle to whatever degree possible; and
- To meet the health needs of recipients in a cost-effective manner[3].

3.0 AUDIT OBJECTIVES

The objectives for the Veterans Independence Program audit were to determine if:

1. up-to-date policies and procedures were in place to support program delivery;
2. program payments were accurately calculated and paid to eligible clients and approved providers;
3. regulatory and policy requirements were complied with; and,
4. the quality assurance function provides an ongoing assessment of compliance requirements and identifies opportunities for improvement.

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[2] Appendix C - VIP Renewed Terms and Conditions for "Contributions to Veterans under the Veterans Independence Program (VIP) to assist in defraying costs of extended health care not covered by provincial or municipal health care programs".

[3] Integrated Results-based Management Accountability Framework and Risk-based Audit Framework - September 30, 2008.

4.0 SCOPE

The audit examined activities that occurred between April 1, 2008 and March 31, 2009.

This audit examined whether the Department effectively discharges responsibilities for management of the VIP as required under:

- Part II (sections 15-20) of the Veterans Health Care Regulations (VHCRs), made pursuant to section 5 of the Department of Veterans Affairs Act.;
- Section 34 (exceeding rates)[4] of the VHCRs;
- Sections 32, 33, and 34 of the Financial Administration Act; and
- Treasury Board Transfer Payment Policy and Directive.

The audit also reviewed whether the program is in compliance with departmental policies and procedures such as delegated authorities, program payment methods, program governance/administration, and quality assurance responsibilities.

The team conducted a comprehensive review of the legislation, regulations, terms and conditions, policy and directives to assess the adequacy of controls and to determine whether policies, procedures, and guidelines were being followed.

The Auditable Financial Statements (AFS) Project was concurrently conducting a review of systems controls and business processes and it was agreed that the resulting information would be shared with the audit team to avoid respondent's burden and over-lap of objectives. As a result, system controls and business processes were not comprehensively reviewed by the audit team where reliance could be placed on the AFS work.

5.0 METHODOLOGY

The audit engagement was conducted in accordance with the Institute of Internal Auditors' (IIA) Standards for the Professional Practice of Internal Auditing, as required under the Treasury Board Policy on Internal Audit, with the exception that the external assessment prescribed by Standard 1312 for the purpose of the quality assurance and improvement program has not been completed. This external assessment of the internal audit function at VAC has been scheduled for 2010-2011. The standards require that the audit be planned and performed to obtain reasonable assurance that the Veterans Independence Program is delivered in accordance with governing authorities.

[4] Section 34. (1) VHCR authorizes the minister to pay cost at a rate that is higher that the rates set out in section 20 or 23 if certain conditions are met.

Audit procedures consisted of a preliminary survey, reviews of a judgementally selected sample of files to examine high cost contribution arrangements, and interviews with senior departmental officials to gather corporate information regarding their interpretation of eligibility for and administration of the VIP. Additionally, the audit team conducted an extensive literature review of reports and working papers of previous internal and external audits conducted and post-payment verification on the Veterans Independence Program. These efforts were undertaken to identify areas of high risk for detailed analysis. The team worked closely with the ongoing AFS project to avoid scope overlap, duplication, and 'respondent's burden' on staff.

During the audit, the audit team reviewed the management control framework and conducted interviews with staff who are responsible for the management and delivery of the Veterans Independence Program. Interviews were conducted with Finance staff in Head Office and Regional Offices to obtain an understanding of internal controls relating to the post payment verification process. Interviews were also conducted with staff from the Policy, Programs and Partnership Branch responsible for overall program management, the development of policy, and performance measurement and service standards. Staff from the Contract Administration Directorate were interviewed to understand Medavie Blue Cross' responsibility and the role of the Federal Health Claims Processing System (FHCPS) in processing VIP payments. Finally, the auditors conducted interviews with staff from Service Delivery Management (SDM) in Head Office, Atlantic Canada, Ontario, and the Vancouver DO and Regional Management Centre (RMC) of the Western Region.

A sample of client files, with corresponding Client Service Delivery Network (CSDN) and FHCPS documentation, were randomly selected from a total population of approximately 106,000 distinct VIP clients with approximately 5,230,000 transactions. The time period covered was April 1, 2008 to March 31, 2009. This timeline was chosen as it was the most recent complete fiscal year available. In order to ensure sufficient coverage, the sample size was determined by using a 90% confidence level, with an assumed +/- 5% margin of error. This confidence level resulted in a random sample size of 270 files for the four regions; namely Atlantic, Quebec, Ontario, and Western. Results of this sample are presented throughout the report.

All of the clients in the sample had elements from the overall Veterans Independence Program suite of programs (housekeeping, groundskeeping, access to nutrition, etc.). All of the selected files were Veterans Affairs Canada clients (Veterans, survivors, or primary caregivers) and had their primary residence within Canada. Various processes were examined for compliance (signing of CAs, advance payment vs. reimbursement, correct amount of payment and payee, etc.)

6.0 STATEMENT OF ASSURANCE

The audit evidence gathered is sufficient to conclude with a high level of assurance that the overall control framework for the administration of the Veterans Independence Program in place and used by the Department from April 01, 2008 to March 31, 2009 presented too many material weaknesses to ensure the accuracy and compliance of the transactions processed with relevant authorities.

In particular, weaknesses were found relating to the distribution and updating of policies, the inability to assure the accuracy of the calculation of VIP payments, the ongoing challenges to get the CA signed by clients, insufficient controls to prevent unauthorized changes to the CA by clients and providers, and insufficient monitoring, reporting and oversight regarding compliancy and expenditures.

This opinion is based on the conditions as they existed at the time of the audit. The opinion is only applicable to the entity examined and for the scope and time period covered by the audit.

Please refer to the body of this report for further details regarding the audit findings.

7.0 OBJECTIVE 1: To determine if up-to-date policies and procedures were in place to support program delivery.

The VIP is authorized by Part II of the Veterans Health Care Regulations, made pursuant to section 5 of the Department of Veterans Affairs Act. The program policies are documented in Volume Two (Health Care Programs) of the Veterans Programs Policy Manuals (VPPM). The Veterans Services (VS) Tool Box on the VAC intranet provides various toolkits, procedure manuals, business processes, and guidelines (some specific to the VIP) for VAC staff to reference.

7.1 Key Findings and Observations

Policy

VIP Policy has been, and continues to be, an on-going area of discussion among Head Office, Regional Office and District Office (DO) staff. DO staff report that policy is complex, often out-dated due to the number of supplementary directives, emails, and interpretations associated with a policy that may be in circulation. These factors make reliance on the policy as written in the VPPM difficult. The majority of interviewees stated that although policy supports the delivery of VIP benefits and services, a comprehensive updated plan providing general goals and procedures to help guide decision making and actions is not presently represented in the policy.

The majority of VAC staff interviewed stated that the VPPM has too many grey areas and is often vague, leading to VIP policy being too complex and too open to interpretation. Some reasons for this complexity are that the program is national in scope and is delivered through, and in conjunction with, various provincial and regional health care programs and providers. The audit team acknowledges that in order to accommodate the stated variances, and the unique needs of individual clients, it is necessary for the policy to be broad, however, the consensus is that it is much too broad to be as effective as it should be to support effective, efficient and consistent program delivery. This is evidenced by the way the same policy is applied by different staff to effectively the same set of circumstances in different parts of the country.

Another reason for VIP policy complexity is that updates and new policy directives are sometimes not formally communicated to staff and changes are not made to the existing policy in the VPPM. For example, the policy for Housekeeping and/or Grounds Maintenance Services for Wartime Survivors (VPPM Vol. 2, 3.1.10) still has the draft watermark but is part of the online version of the VPPM. There is a lack of confidence in the comprehensive status of the policies in the VPPM and due to this, some staff still use hard copy policy manuals that they are personally responsible for updating instead of the VPPM on the intranet.

Policy Interpretation

The VPPM and Veterans Services Support Network [5] (VSSN) have provided some policy interpretations as well as, best practices. This information is not linked or validated to allow the user to apply it with confidence that the policy/interpretation is the most updated and correct version.

During the fieldwork interviews, a frequent observation was that staff find the VPPM very cumbersome and difficult to search. There are often draft policies, directives, and/or memos sent out to staff via email that are not incorporated into policy or housed in one searchable and related location. With several information management options available, staff stated that there should be a better way to link regulations, policies, policy interpretation and procedures in one easy-to-find location so that specific topic areas can easily be accessed. One definitive source of information would help reduce inconsistencies in program delivery and application of eligibility criteria.

Regional Variances

The majority of staff interviewed stated that VIP policy should better incorporate regional variances, perhaps through directives which are region specific, linked to the related policies, and housed in one repository. These work-arounds already exist, albeit informally for the most part, and are generally communicated through e-mails to affected staff/regions.

The audit team acknowledges that there are differences in costs for the provision of services within the same province and between rural and urban providers. One marker of regional variances is the number of exceeding rates (Section 34 of the VHCRs) put in place because of a practice or characteristic of an area/region. Some notable examples are the number of Section 34s for personal care in British Columbia because the provincial government uses a means test to determine their contribution to the client. In parts of Ontario, the number of Section 34s used for groundskeeping, specifically snow removal, are high. In Nova Scotia, there is a large number and associated high cost of Section 34s used for intermediate care.

In the Atlantic Region there is an unusually high number of intermediate care cases which exceed rates compared to the rest of the country. For example, in Nova Scotia, the provincial legislation does not support the type of programs covered by VIP for Veteran clients and the province expects VAC to intervene as first payer for the

[5] VSSN is a network on the VAC intranet site that provided current and archived advice to field staff on specific inquiries answered by Head Office Program and Service Policy Division and National Operations Division. There is currently a moratorium on the VSSN. It is no longer being updated however it is still accessible.

Veteran. This situation results in VAC approving higher numbers of intermediate care services at an exceeded rate in order to put the necessary services in place for the clients. There is also a significant shortage of nursing home beds. The shortage of beds combined with a lack of provincial support and the high cost of intermediate care fees, means that the Department is often left to pay the majority of the facility per diem rate for clients.

The impact of these regional variances is that policy wording either has to be vague enough to incorporate all provincial situations or informal ad-hoc regional e-mail directives are used. The risk of using ad-hoc or regional e-mails is that unless these are effectively communicated, clients moving from one area of the country to another will find themselves receiving more or less benefits and services than they were used to, and staff not in a position to explain the difference.

Procedures and Processes

As stated in section 4.0, outlining the scope of this audit, the AFS project was conducting a review of the VIP business processes as part of their work. It was agreed to remove this area from the scope of this audit to avoid duplication of effort. During the field work, staff were asked if in addition to policy there were sufficient procedures and processes in place to support VIP delivery.

Staff reported that documented business processes and procedures exist for the recent expansions to the VIP for Primary Caregivers and Survivors, however, the older components of the program do not have documented business processes. The audit team was informed that senior staff train new staff using their individual training processes. While at first this transfer of corporate knowledge may seem commendable, the risk is that training will not be consistent from office to office and it also facilitates the transfer of incorrect processes to new staff.

VAC also has the Veterans Services Tool Box that can be accessed on the Department's intranet. Through this portal there are various screening and assessment tools and guidelines available. These tools are useful, however they can be difficult to search as they are not all sequenced by program and processes are not always up-to-date. An example of out-dated materials are the business processes for the VIP spousal expansion project and pre-2005 primary caregivers have not been updated online to reflect the transfer of the work from Head Office to the Region/Districts.

7.1.1 Specific Policy Issue Areas

Contribution Arrangements

As defined by Treasury Board (TB), a contribution arrangement (CA) is effectively a contract between the Department and the client, as such, these documents should be signed by both parties to the arrangement.

Over the years VAC has had a consistently high error rate (33% in 2008)[6] in the post-payment verification process that was caused mainly by the lack of signatures on the CA. To address this problem, a directive was sent out to field staff in December 2008 to clarify when a contribution arrangement is required to be signed by VAC and by the client. Almost a year later, this information is not yet updated in the VPPM online.

Other issues relating to the VAC contribution arrangement will be further elaborated on throughout this report.

7.2 Conclusions

- VIP policies are documented in Volume Two (Health Care Programs) of the Veterans Programs Policy Manuals (VPPM).
- Changes to VIP policies are not always appropriately communicated to staff, and to the extent that they are, are not stored in an easily accessible format (i.e. intranet);
- Documented business processes only exist for the most recent VIP expansions. No comprehensive, documented procedures/business processes exists for the pre-expansion parts of the program to facilitate consistent VIP delivery by staff;
- There is a need to better communicate regionally specific adaptations to policy in order to provide staff with complete information;
- Policy and directives regarding the completion of the CA need to be revised in the VPPM and monitored for compliance.

7.3 Recommendation

Recommendation 1 (*Essential*)

It is recommended that the Senior Assistant Deputy Minister, Policy, Programs & Partnerships in consultation with the Assistant Deputy Minister, Service Delivery & Commemoration: (i) review and update the existing policies and procedures for the Veterans Independence Program; (ii) ensure effective and timely communication of updates to the

[6] VIP Quality Assurance Report, VAC Corporate Internal Control, January 1, 2008 to December 31, 2008

appropriate staff and; (iii) ensure better communication of changes and/or integration of any expansions to the program.

Management Response (I):

Management agrees with this recommendation.

Management agrees that existing VIP policies and procedures for the Veterans Independence Program require review and updating. In the fall 2008 an extensive review of the Long Term Care Program - VIP continuum of support was undertaken. This led to a comprehensive review of all VIP policies as efforts were made to modernize policy through a continuum of care model.

Following extensive research and consultation with program staff in 2009, VIP policies were reviewed and priorities identified for the revision and modernizing of policies within this program area. Currently, many VIP policies have been revised and are in draft form. Efforts are being made to continue revising or developing policies to meet program goals and address gaps.

This review of existing policies is an ongoing activity that will continue to happen as a matter of routine policy development and maintenance.

Management Response (ii and iii):

Management agrees with this recommendation.

As VIP policies are drafted, consultation is ongoing with program and front-line staff. In addition, program/operational directives and business processes are being developed parallel to policy to support implementation of the policies. Management agrees that staff must have effective and timely updates of changes to promote national consistency but are equally concerned of the importance of having the above supporting documents ready and available for use at the time of policy release. To this end, Policy, Programs & Partnerships is working collaboratively with Service Delivery & Commemoration to meet the policy, program and operational goals of the VIP.

When changes occur within the VIP, such as the recent Allied Veterans Initiative, the Program Policy Directorate engages and works in collaboration with the Health Care Programs Directorate and Service Delivery & Commemoration, to ensure changes are communicated to appropriate staff. Efforts are also underway to simplify and manage electronic information so it is more useful and accessible to staff.

Management Action Plan:

Corrective Action(s) to be taken		OPI (Office of Primary Interest)	Target Date
1.1	Review VIP policies and prioritize policy revisions and development based on client needs and program gaps.	PPD/HCPD	December 2010
1.2	Modernize approaches to electronic sharing and integration of policies.	PPD/Comms	Progress Update Feb 2011; December 2011
1.3	Develop associated program directives and business processes as required to support the policy priorities.	HCPD/SDM	As required
1.4	Consult and communicate to staff as required.	PPD/HCPD/ SDM	As required

8.0 OBJECTIVE 2: To determine if program payments are accurately calculated and paid to eligible clients and approved providers.

Clients are considered eligible for VIP benefits when they meet one or more criteria as set out in the Veterans Health Care Regulations (Sections 15-18). A contribution arrangement is initiated for all eligible clients and is required to be signed by the client and the Department. The CA defines the type(s) and frequency of intervention that is authorized and facilitates payment. Clients can be reimbursed for the cost of service in advance in exceptional circumstances or after the service is provided. Payment can be made to the provider if they are registered with Medavie Blue Cross. When using a registered VIP provider, the client is not required to spend their own money for approved expenses. However, if the client uses a non-registered VIP provider to receive a pre-authorized service, the client must submit original receipts within 18 months of the date they received the service, with a claim form, to VAC for reimbursement.

8.1 To determine if program payments are accurately calculated

Key Findings

According to the VPPM, a contribution arrangement is the instrument through which the terms and conditions of the contribution and the obligations of both the Department and the client are recorded and explained to the client. Prior to the contribution arrangement being established, the Area Counsellor (AC) or Client Service Agent (CSA) completes an assessment/evaluation of client needs. Based on the identified and eligible need, local provider costs and availability, the AC or CSA determines an annual contribution amount.

The contribution amount is an estimate of the intervention(s) costs, however it is the amount that is signed off by the client and the Department. While the amount may change as a result of a change in the circumstances of the client or increased provider cost, those changes should be authorized by the Department and the CA should be amended to reflect the change. The audit team found that in a number of situations when changes were made by the client or provider to the rate or frequency of service stated on the CA, the changes were not communicated to the Department or pre-authorized.

The determination of the calculation of payment for VIP elements varies. For example, in terms of housekeeping and groundskeeping, VAC's share of the contribution is determined by the frequency and the duration of the service multiplied by the provider's hourly rate. For home adaptations, the client must provide the Department with a

minimum of two contractor bids which are to be reviewed by the Department. For the intermediate care element, the Department has a maximum meals and accommodation fee which the eligible client is required to pay before the Department supplements the monthly facility fee.

Calculating the accuracy of payments was difficult to do during the file review due to the lack of standardization of the information provided in the benefits notes field on the contribution arrangement form (VAC1305). Information was not always provided on the contribution arrangements in regards to the number of hours of service provided and the rates of service for benefits such as, housekeeping, groundskeeping and personal care. This information was sometimes found on the CSDN in the client notes or on the CA, however a significant number of the contribution arrangements had little or no supporting documentation on the hard copy file.

Staff reported difficulty determining rates for clients living in assisted care facilities due to varying definitions of what qualifies as assisted living, inconsistent pricing across provinces, and varied services included in the monthly rate (e.g. housekeeping, personal care, meals, etc.). VAC is currently examining this issue as a priority in the policy review process.

8.1.1 Conclusions

- Staff reported that the amount included on the CA is an estimate of the cost of the approved intervention given that the client is responsible for selecting the provider and that availability and rates for service vary.
- The Department is not always informed when there is a change made by the client or provider to the calculated amount on the CA.
- Calculating the accuracy of payments was difficult to determine due to the lack of standardization of information provided in any of the key VAC records, including the benefit notes field on the CA form.

8.1.2 Recommendation

Recommendation 2 (*Important*)

It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration, in conjunction with the Director General, Finance Division, develop and implement improved controls to ensure that VIP payments are accurately documented and calculated, and changes resulting from increased costs or frequency of service that result in changes to the CA amount are pre-authorized.

Management Response:

Management agrees with this observation. It is assumed to mean the method in which Contribution Arrangements are calculated and the documentation to support the calculation (not the resulting payment from FHCPS).

Significant work is currently underway as a result of Audited Financial Statement observations. Consultations are occurring with Stakeholders to explore an efficient and effective method to calculate, authorize and document 1305 activities.

Management Action Plan:

Corrective Action(s) to be taken		OPI (Office of Primary Interest)	Target Date
2.1	Consultation with various stakeholders (Policy, Program Management, Finance) and establish working group to explore options to address this finding.	SDM	March 2010
2.2	Analyze options, make recommendation & obtain approval on recommendation. Develop associated work tools, processes etc.		April 2010
2.3	Communicate to staff & implement controls to ensure the Contribution Arrangement calculations are documented.		September 2010
* Assumption no system impacts			

8.2 To determine if program payments are paid to eligible clients

Key Findings

According to the VPPM, the following clients may be eligible for VIP services:

- Disability benefit recipients who require VIP for their pensioned conditions;
- Wartime pensioners who are seriously disabled (with disability entitlement at 78% or higher) or are medium disabled (48-77%) and who require VIP services for any health condition;
- Disability benefit recipients, who have multiple health conditions which, when combined with their VAC entitled condition places them at risk, may be provided VIP services;
- War Veterans who qualify because of low income as established under the War Veterans Allowance Act;

- Totally disabled Veterans in receipt of Prisoner of War Compensation or Detention Benefits;
- Overseas Service Veterans (OSV) who are at home awaiting admission to a priority access bed;
- Canada Service Veterans who are over age 65 and income qualified; and
- Qualified survivors or primary caregivers of certain Veterans or Civilians.

Program payments are paid to eligible clients when clients qualify for the benefit or service received by meeting the program eligibility criteria as stated in the appropriate regulations and policy.

District office staff reported that eligibility criteria as defined in the VHCRs and the related policy interpretation and directives for VIP are too complex and need to be streamlined. Field staff report trying to work around the complexities of applying the current 'patchwork' of policy to the client needs particularly where new eligibilities are added every few years. In addition, due to recent reorganizations at head office, staff consistently reported difficulty getting 'expert' advice and direction from program specialists regarding policy interpretation.

Staff interviewed reported that determining eligibility by district and regional staff is made more difficult when Head Office overturns a decision of the District Office that was upheld at the Regional Office. Staff realize that it is the prerogative of senior management to make difficult decisions regarding policy interpretation; however, the issue here is that once the original decision to overturn is made, often no explanation is provided regarding the reason for reversal of the original decision. In addition, clients may be informed of the decision before field staff.

Overturned eligibility decisions are also confusing for some clients as they often compare each others application results. Staff reported clients generally do not understand why one client is eligible for a service but another, in an apparently similar situation, is not. Staff report that the impact of these situations result in the loss of confidence in front line staff by clients regarding their ability to correctly determine client's eligibility, as well as loss of time having to explain complex eligibility criteria to clients.

The 'frail' criteria for VIP eligibility was first introduced as a pilot project and used for Veterans pensioned for hearing loss who were not eligible to receive VIP benefits because the need for services (groundskeeping and housekeeping) were not related to their pensioned condition. The file review conducted during this audit supported this as 67% of the frail clients sampled who were receiving VIP due to frailty had a pensioned condition involving hearing loss or tinnitus only. Staff interviewed generally reported support for this application of the policy as they stated it was based on the demonstrated need of the client, however, the way the policy is currently applied has

been challenged and is under review for not being consistent with the regulations and may therefore be non-compliant.

Section 15(1) of the VHCRs states that for a pensioner to be eligible this situation must exist; “their war-related pensioned condition impairs their ability to remain self-sufficient at their principal residence without those services.” There is a significant body of opinion that purports there is no legislative authority to provide VIP to clients defined as “frail”. The VHCRs require that there be a correlation between the pensioned condition and the ability of the client to remain in their home. It is also the finding of the audit team that the current frail policy overlooks this requirement. This unresolved issue may present a problem for clients now considered eligible whose eligibility may have to be protected or grand-fathered. VAC has committed to review the frail issue with central agencies.

8.2.1 Conclusions

- Eligibility criteria is often too complex and is sometimes supported by unclear policy;
- When a determination of client eligibility is overturned by Head Office, if the decision is not properly communicated, it creates confusion for clients and causes credibility issues for DO and RO staff;
- Recent changes/expansions to VIP eligibility and the patchwork approach to the program policy and eligibility makes it more difficult to determine client eligibility;
- The Frail Policy granting eligibility to clients described as “frail” has been challenged, is under review, and requires clarification regarding its compliancy with the VHCRs.

8.2.2 Recommendations

Recommendation 3 ***(Critical)***

It is recommended that the Senior Assistant Deputy Minister, Policy, Programs & Partnerships:

(i) implement a process to review and resolve current challenges to the compliancy of the Frail Policy with the VHCRs; and,

(ii) ensure that ineligible clients are not receiving benefits under the VIP.

Management Response (i):

Management agrees. Options are under review to determine the most effective and accountable way to meet the health needs of frail Veterans within the program's governing framework. These options may involve adjustments to the instruments governing the benefits provided to frail Veterans, such as policies and regulations. Management has also committed to central agencies to develop a management intervention plan to review the relevant governing instruments, and ensure the internal control framework is consistent with auditable financial statements.

The Department will ensure that authority requirements are being met regarding the correlation between the Veterans' pensioned condition and the impairment of their ability to remain self-sufficient at their residence. In using this authority, it is incumbent on VAC to connect, as a contributing factor, their pensioned condition to their impairment. Although for many clients the connection is rather simple and obvious, for those who are frail it is more complex and therefore not so obvious. That is not to say, however, that it does not exist. Research on frail affirms that a series of health conditions can result in complex symptomatology which does not always result in easily visible correlations between each health condition and the impact it can have on self-sufficiency. Research further substantiates that while a correlation may not always be easily discerned, there is a relationship such that even minor conditions within a complex mix of multiple health conditions impacts to some measure on the health needs of the individual, and by extension, their ability to remain self-sufficient.

Management Response (ii):

Management agrees with the recommendation. Clients must meet eligibility requirements as set out in the VHCR's before they are able to receive benefits and services through the VIP. At the same time, the eligibility criteria for the VIP is complex and is not neatly provided in one single provision, given the incremental add-ons to client groups over the last number of years.

Work is underway in Policy at simplifying or clarifying eligibility by creating policy based on client type rather than by program area. In addition to policy, program directives are being developed to assist staff in making decisions in particularly complex and difficult cases. In addition to policy, Program Management will prepare and maintain Program Directives that lay out the requirements that must be satisfied to support program intent. Focus will be on protocols for decision making and the importance of documentation of decisions taken.

One of the conclusions cited in the audit report concerns VIP appeals that are overturned at HO. A Final Level Appeals Unit has been established at HO to address

this issue. The included Management Action Plan also references action being taken by this new unit to support the learning of regional staff through communication of changes to decisions and/or correction of mistakes in policy interpretation.

Management Action Plan:

Corrective Action to be taken		OPI (Office of Primary Interest)	Target Date
(i) Implement a process to review and resolve current challenges to the compliancy of the Frail Policy with the VHCRs			
3.1	Research and analysis of options, impacts, costs and benefits.	Policy and Research Division	April 2010
3.2	Develop and finalize a recommendation regarding the most effective and accountable way to meet the needs of frail Veterans within the program's governing framework.	Policy and Research Division	June 2010
3.3	Management intervention plan committed to central agencies, including milestones for closure and monitoring plan.	Policy and Research Division	June 2010
(ii) Ensure that ineligible clients are not receiving benefits under the VIP			
3.4	VIP policies are currently being reviewed and revised, where appropriate. Eligibility policies, in particular, are being revised to help direct and simplify the programs, services and benefits available to clients within each eligibility group.	Policy and Research Division (in consultation with Program Management Division)	April 2010
3.5	All VIP overturns at HO are actioned by the Final Level Appeals Unit and are followed up with a phone call and written message to the RDCS explaining why the decision was overturned.	Final Level Appeals Unit	November 2009

8.3 To determine if program payments are paid to approved providers

Key Findings

Provider Types

Under the VIP, clients are able to acquire services from a provider in their community who may be registered or non-registered with Medavie Blue Cross. A registered provider is one registered with Medavie Blue Cross that can submit bills directly for payment. Registered providers must meet certain criteria and standards (eg. GST number and proof of being bonded) while non-registered or private providers do not. A non-registered or private provider is eligible to receive program payments as well but is paid through the client. In addition, according to VPPM Chapter 3.1.9 Client Relatives, Section 3.3, client family members residing outside the client's home are also permitted as service providers under VIP.

VAC is not responsible for hiring VIP service providers. The Department simply reimburses the service provider directly or reimburses the client for services rendered and it is the responsibility of the client to pay non-registered providers. Providers are rarely identified on the contribution arrangement, however they may be identified in the AC's assessment. In some situations a benefit may be put in place based on the client's need before a provider is identified to the Department. Often VAC does not have any information on the non-registered VIP provider and the review of sampled files indicated that over 85% of VIP providers are non-registered.

The VIP allows for a supplier of choice and therefore the audit team cannot confirm that program payments are paid to 'approved providers'; however, payments are made to registered providers and when the client uses a non-registered provider, payment is made to the client.

Payment Methods

Under the Veterans Independence Program, there are two principle methods of payment:

- Client Reimbursement and;
- Advance Client Payment.

Client reimbursement allows payments to be made directly to the client or to a registered provider on behalf of the client. The Department promotes the use of registered providers as the preferred method as it provides for better accountability of funds. Client reimbursement allows for the payment of VAC's contribution of the cost incurred to provide the service after the provision of the service.

With advance payment, clients are advanced payment monthly, bi-annually, or annually based on the estimated cost of the intervention(s). Clients are not required to submit receipts, however they are asked to retain copies of receipts. Given these circumstances, it would be difficult for VAC to ensure that payments were paid to 'approved providers' and/or that services were delivered. VAC is required to conduct follow-ups with clients to ensure that assessed needs are being met through the approved interventions. The file review of sampled files confirmed that 88% of the files reviewed indicated follow-up activity.

The new conditions under which advance payment is approved are more restrictive to allow for better control. According to the Enterprise Reporting Database (RDB)[7], clients on advance payment are declining. In April 2008, 11.3% of VIP clients were receiving advance payment. The numbers have been steadily decreasing and in October 2009, only 8.4% of VIP clients were on advance payment. The numbers are consistent with the audit team's review of sampled files which also indicated a downward trend for VIP clients on advance payment. In total, only 8% of the sampled files from the review were on advance pay.

Some weaknesses were identified in the authorization of advance payments in the District Offices. The authorization process requires the Client Service Team Managers to authorize all advance payment arrangements; however, during field work, the audit team learned of situations when the CSTM was not consulted and had not authorised clients' placement on advance payment. A regional ad-hoc file review also identified a lack of documentation on hard-copy files to support the approval of advance payment to clients.

Pended Claims

A related problem identified by the auditors is the issue of pended claims. A pended claim occurs when Medavie Blue Cross processes a claim that does not satisfy the system's rules. The pend prohibits the system from paying the claim. The criteria for non-payment are:

- lack of funds in the contribution account;
- client is not eligible for service billed;
- claim is dated after date of death of client;
- there is a suspension of benefit; and
- services provided are not covered.

[7] RDB is a database of VAC client and program information that contains information extracted from the main CSDN database, and from other sources/systems.

Medavie Blue Cross produces a report called 'VIP PVAC and Pends' on the Output Management System (OMS) every month which shows the number of pended claims by District and Region. The report indicates the number of pends being worked on and the number of pends outstanding. A review of claims pended for one district showed that of 143 claims outstanding, 78% were pended for 'lack of funds in the contribution account'. DO staff reported the most frequent reason given for this situation is that the amount stated in the CA was expended before the agreed upon time frame.

The problem as reported occurs when the client or provider changes the rate or frequency of service and submits a bill in excess of what was agreed upon. For example, after billing $100 per month for the first 3 months as agreed, the next claim is submitted for $900. FHCPS will pay the $900 claim and issue a notice to the District Office through the OMS reports on FHCPS. The next claim received will be pended based on the depletion of the $1,200 contribution arrangement and will not be paid until cleared by VAC field staff.

While increases to the CA in some cases may be warranted by a change in the client's circumstances (eg. increase in care needs), the Department should be informed in a timely fashion and should reassess the situation to authorize the increase, if justified. The impact of these billing changes can lead to overpayments, not from the perspective of paying more than the amount stipulated on the CA, but by exhausting the account in a much shorter time frame, pending the claim, and creating the need for new money to be allotted to the CA.

A situation involving non-authorization of additional services resulting in pended claims occurred when it was discovered that a second registered provider began the same service for a Veteran without authorization or knowledge of the Department. This provider serviced the client on the alternate week to the first provider. When the second registered provider was informed that they could not bill unless authorized by VAC, the provider stated they did not normally call for authorization. A request was made to stop payment to the second provider but the payment continued because the system pays as long as there is money in the CA. As a result, the contribution arrangement was depleted in half the approved time frame for the intervention and a pend was created.

During the file review another situation was discovered with a pended claim where a client moved to a retirement home. The benefit notes on the CA indicated that because of the adjustment for board and lodging, the client rate of reimbursement should have been $410.63 a month. Medavie Blue Cross paid the complete bill as submitted by the institution for $1082.90 per month. While this claim was paid to a registered/approved provider, the amount paid was an incorrect (an overpayment) and caused the next claim to be pended for insufficient funds.

During the fieldwork staff consistently reported that the greatest contributing factor to pended claims, and the work associated with resolving pends, is that the FHCPS pays every claim received unless the aforementioned criteria for non-payment are present, regardless of the amount of the claim.

The examples cited here call into question a) the benefit of evidence regarding how the payment amount is calculated on the CA, b) the sufficiency of information provided to the payment processor, and c) are there controls in place to ensure that payments are authorized and paid in the correct amounts to 'approved' providers?

8.3.1 Conclusions

- Non-registered providers represent over 85% of VIP providers. Payment is made directly to registered providers and to the client when a non-registered provider is used;
- To improve accountability, VAC has limited the use of Advance Pay to exceptional situations, however some additional monitoring may be required to support this initiative.
- VAC staff does not consistently include contribution rates and frequencies or monthly disbursement amounts in the contribution arrangement, benefit notes, or in the Client Master File (notification amount box) because staff say the notes are not read.
- Inconsistent completion of the contribution arrangements leads to a breakdown in controls and to payments made that are incorrect, not properly authorized, or on occasion, payments to non-approved providers.

8.3.2 Recommendation

Recommendation 4 (*Essential*)

It is recommended that the Director General, Service Delivery Management, review the VIP payment process so that controls are placed on each transaction rather than on the annual total, with a view to ensuring that the Department can intervene in a timely manner in case of client health issues, service issues, or provider pricing issues.

Management Response :

Management agrees with this recommendation.

Work is already underway on the development of a business process "Medavie Benefit Notes" to address this observation. Consultation underway with various stakeholders on this item. Potential concerns being raised regarding impact upon external contractor's ability to maintain current level of service with increased level of processing

steps per transaction. The impact of proposed changes to Medavie & the client would need to be reviewed.

Management Action Plan:

Corrective Action(s) to be taken	OPI (Office of Primary Interest)	Target Date
4.1 Review impact of proposed changes with Medavie and the client	SDM	March 2010
4.2 Consultation with various stakeholders (Contract Administration, Program Management, Finance) to further develop business process.		March 2010
4.3 Distribute & implement Business Process to monitor VIP claims **Decision reached may significantly impact upon external Contractor		June 2010

9.0 OBJECTIVE 3: To determine if regulatory and policy requirements are complied with.

In the VIP Terms and Conditions the following areas assist with the compliance monitoring of legislation, policies, and procedures:

- Audit and Evaluation Division provides some compliance monitoring through mandated periodic reviews;
- AC assessments and Annual Follow-ups are considered to be a method to measure appropriateness of service delivery and meeting of clients needs;
- Client Service Team Managers are to review monthly reports for sample compliance testing;
- The Program Performance Unit (PPU) produces periodic quality reviews; and
- The Corporate Internal Control unit with VAC Finance monitors compliance through the Post Payment Verification review. The unit reviews compliance involving contribution arrangements regarding the delegation of authorities, and sections 32, 33, and 34 of the FAA.

9.1 Key Findings and Observations

Literature Review

During the literature review the audit team discovered that in order to improve policy direction and compliance, the following activities have been completed or are under way in the Department:

1) Policy/Functional Network Consultation of VIP-related issues occurred during the summer of 2008 with each region indicating that policies need to be updated in order to be more relevant to the current needs of clients and the current provincial health care frameworks. It was noted that consistency in VIP decision making is a challenge and that updated VIP policy along with further clarification through program directives will go a long way to resolving many VIP related issues. The comments and concerns generated from these consultations provide valuable insight into some of the challenges facing VIP as well as potential solutions for improved program integrity.

2) VAC is currently undergoing a reassessment of the Department's policies, including those associated with the Veterans Independence Program. The main drivers for this are: (a) the changing landscape of programs and service delivery in the provinces and (b) the need to update the policy to reflect the change in client demographics (Traditional clients versus the New Veterans Charter clients).

The primary VIP policy areas under review are:

- contribution arrangements;
- principal residence;
- pensioner eligibility;
- client relatives; and
- exceeding rates.

These policies will be the first priority and once completed the Policy Directorate will systematically be reviewing the remainder of the VIP policies.

In accordance with the preceding policy review areas, the VIP Program Management area is also actively working on the associated program directives. Though not yet developed the five directives currently in development are:

- exceeding VIP rates for Veteran clients;
- exceeding VIP rates for Survivors;
- exceeding VIP rates for Primary Caregivers;
- procedure for determining VIP contribution arrangement allotments for clients in assisted living arrangements; and
- procedure for determining when to use advance payment.

3) The Auditable Financial Statements (AFS) project is responsible for preparing the Department for an audit of its financial statements by the Office of the Auditor General. For each of the key financial statement components the following activities will be undertaken by the project team:

- understand and document the core underlying business processes and supporting systems;
- identify the key controls with these processes and systems;
- assess the adequacy of these controls through observation, review and testing; and
- identify requirements to add, modify or delete controls within these core underlying business processes to address identified control deficiencies[8].

The AFS team has recently produced a Financial Reporting Risk Assessment that includes the VIP. The assessment addressed process risk issues such as the Frail policy, updating policy terminology, system controls regarding data

[8] VAC Audited Financial Statements & Statement of Internal Control Readiness Project Framework & Initiation Document. September 30, 2008.

input, verification of signatures on contribution arrangements, pended claims, and program overpayments.

4) An independent consultant completed a Process and Controls Gap Analysis of the Information Technology General Controls at VAC in March 2009 which included a readiness assessment of the IT general controls for the Department. The assessment encompassed access to programs and data, program changes, computer operations and program development for financially relevant systems in the scope of the analysis. Since both CSDN and FHCPS were included in the scope of the review, the VIP audit team did not reexamine these system controls. Results from the analysis indicated that there is limited formal approval of access rights and privileges for CSDN and there is a lack of monitoring. There are also no system controls to stop a staff member from entering information in regards to clients outside of their jurisdiction.

File Review

As mentioned in the Methodology section of the report, the audit team conducted a file review based on a statistically-based sample which tested specific compliance areas, reviewing contribution arrangements, exceeding rates, delegated authorities, benefit limits, and supporting documentation.

The results of the file review showed that the majority (95%) of the hard-copy files had contribution arrangements attached; however, only 64% of these contribution arrangements were signed by the client. In the sample, 88% of clients had a current follow-up completed on hard-copy file or on the CSDN. Of the files reviewed from the sample that indicated a signing authority level on the contribution arrangement form (VAC 1305), 90% of the CAs were signed within their delegated authority limits.

The file review revealed that a number of clients receiving the maximum amount for some elements of the program under-billed every year. There were also clients who received access to an element year after year without ever using the element.

Only 27% of the sample cases had supporting documentation indicating the frail assessment criteria on file. Due to this, it was difficult to determine why many clients were deemed eligible as frail clients.

In one file, a client received VIP in error (the application was denied, however it was entered into the system). Although the case was later brought to the District Director's attention, no remedial action was taken and the client continues to receive the benefit.

In addition, the team conducted random file sampling for compliance of the following:

- that VIP benefits were provided only in Canada;
- whether any survivors were inappropriately receiving access to nutrition;
- whether services were being inappropriately provided at more than one residence; and
- whether home adaptations were appropriately authorized.

The audit team found no occurrences of: VIP provided outside of Canada; survivors receiving access to nutrition; or, clients receiving services at more than one residence.

In the one instance of current home adaptations found in the sample file review, the appropriate assessments and supporting documentation were on file.

Interview Findings

When interviewing field staff there was a general consensus that policy was too complex and there was a need for better procedures, the majority reported that the current VIP annual limits were inadequate as a result of: increasing provider costs; reduction in the number of and contribution for services previously covered by the provinces; and, in most cases VAC paid 100% of the costs incurred due in part to long provincial wait-lists.

It was reported in every site visited that occasionally, DO staff awarded benefits at the maximum limit to avoid having the claim pended for insufficient funds as a result of future increases in the rate or frequency of service, and to avoid having to get the client to sign a new CA.

Depending on the region and district office, staff could be more or less strict regarding the application of policy. As mentioned in Objective #1, comments on whether policy was to be strictly adhered to, or used solely as a guideline, were also frequently raised and may contribute to regional differences noticed in how policy is applied.

Regarding issues of policy and compliance with regulations, DO staff reported that, after their peers, the resources most called on were the STEOs.

The STEOs interviewed reported that their quality control function was not being done as much as it should be due to workload demands.

As part of their role, CSTMs are to review monthly samples of CAs for policy compliance; however, at each site visited the team was told that because of significant workloads pressures, the CSTMs did not have time to conduct the necessary reviews.

The Program Performance Unit (PPU) is a part of the Program Management Division that was created as a result of a recent re-organization within the Department. At the time of data collection for this audit, there were no clear roles and responsibilities identified between PPU and Service Delivery Management (SDM) regarding monitoring compliance and performance management. The plan was that PPU will be responsible for measuring the performance of the program in regards to policies, regulations, business processes, etc.[9] and SDM will focus on monitoring the consistency of service delivery.

Compliance with regulatory requirements

The Department provides a number of benefits and services through the VIP as mandated under the VHCRs. The program is well received by clients as reported in client surveys conducted by the Department and is recognized as a trend setter regarding the care and management of health-related issues for clients as they prepare to transition from home to residential or long-term care facilities.

The VIP is administered in a manner that is mostly compliant with the enabling regulations. There are however some areas where challenges exist to the Department being entirely compliant. The AFS Project has identified an issue of non-compliance regarding the OSV client and their eligibility for intermediate care, this issue is already being reviewed and will not be addressed further here.

One issue discussed here and under discussion with central agencies is the eligibility for VIP granted to clients identified as “frail”. In addition, several internal audits, OCG audits and post payment verification reviews have continued to report high error rates regarding the requirement for the client’s and the departments representative’s signature on the CA.

Frailty

The majority of interviewees were of the opinion that the current Frail Policy is not in line with the VHCRs under Section 15 (1) Eligibility of pensioners, as it states that a Veteran pensioner is eligible for VIP if, it is assessed that “their war-related pensioned condition impairs their ability to remain self-sufficient at their principal residence without those services”. As discussed more extensively under Section 8.2.1, under the Frail Policy there is no direct correlation between the client’s need for services and their pensioned condition. This is a position supported in discussions with central agencies.

[9] The RMAF/RBAF lists QMP responsible for this area, however this section no longer exists.

Contribution Arrangements

The most recent Post Payment Verification review confirmed that there continues to be a significant problem acquiring client signatures on the CA as well as, the signatures of VAC's representative. From the interviews conducted during the fieldwork, there now appears to be a better understanding of when a signed contribution arrangement is required and there is a commitment from management and staff to ensuring that VAC is compliant in this aspect.

Of the files sampled during the file review, 36% did not contain a signed CA by the client or power of attorney, while 10% did not contain the signature of a VAC representative. These figures show VAC is still above the allowable error rate and the figures are in line with the recent Post Payment Verification review.

9.1.1 Conclusions

- There is ongoing monitoring of compliance with regulatory and policy requirements through: audits and evaluations; post payment verification reviews; regional ad hoc reviews; the reassessments of policies and directives.
- Updated VIP policies and directives will improve program delivery.
- The Department is currently reviewing a number of VIP policies and directives to better accommodate a changing client demographic and service delivery in the provinces.
- The AFS project reported that there is insufficient system controls and monitoring regarding the CSDN and FHCPS.
- Key positions responsible for monitoring and quality control at the DO and RO levels report while some monitoring is done, due to high workload demands, they are unable to do the required amount of monitoring.
- Recent reorganizations within VAC have delayed some monitoring activities but will position the Department to better fulfil their responsibilities to regularly monitor issues of compliance.
- VAC has been challenged by the central agencies to ensure that the use of the 'Frail' policy is compliant with the VHCRs.
- VAC continues to have an unacceptably high error rate caused by unsigned CAs.

9.1.2 Recommendation

Recommendation 5 *(Essential)*
It is recommended that the Director General, Service Delivery Management: (i) develop a training protocol for staff regarding the standardized completion of the VAC 1305 form; and (ii) ensure that in addition to the letter to staff regarding

signing of CAs, better quality controls are implemented to ensure compliance and reduce the error rate for unsigned CAs.

Management Response:

Management agrees with this recommendation.

Work is currently underway as a result of Audited Financial Statement observations. Significant discussion is occurring with Stakeholders to explore items as noted in Recommendation # 2. This consultation includes exploring best mechanism to support this process (possibly replace 1305 with other viable option).

Management Action Plan:

Corrective Action(s) to be taken	OPI (Office of Primary Interest)	Target Date
**will be completed in conjunction with Rec, # 2		
5.1 Consultation with various stakeholders (Policy, Program Management, Finance) and establish working group to explore options to address this finding.	SDM	March 2010
5.2 Analyze options, make recommendation & obtain approval on recommendation. Develop associated work tools, guidelines etc, for use in training.		April 2010
5.3 Communicate to staff & implement compliance monitoring		September 2010

10.0 OBJECTIVE 4: To determine if the quality assurance function provides an ongoing assessment of compliance requirements and identifies opportunities for improvement.

Quality assurance provides confidence that deliverables meet the requirements of the client, relevant quality standards exist, and activities are properly performed. The quality assurance function entails a series of planned steps necessary to ensure a program provides quality services. It is an ongoing assessment involving testing of compliance that will continue for the duration of the program.

10.1 Key Findings and Observations

Quality Assurance Objectives

Appendix C of the Terms and Conditions of the Veterans Independence Program explains the expected results and outcomes of the program. The goal of the VIP is assisting clients to remain healthy and independent in their homes. Through the services and supports provided, the expected results and outcomes of the VIP, from a recipient perspective, are:

- Increased independence and self-sufficiency;
- Improved long-term health;
- Improved quality of life for recipients and families; and
- Reduced health care costs (compared to institutionalization).

Quality Assurance Controls

There are three main methods of monitoring the Veterans Independence Program for quality assurance. Finance Division completes post payment verification on VIP payments, VIP Program Management determines whether the program is achieving its' client-centred outcomes, and Service Delivery determines if the program delivery is effective and consistent. As mentioned above, the Program Performance Unit (PPU) does not at this time have clear roles and responsibilities defined. Due to a reorganization of the Divisions and responsibilities within Head Office, there is currently no quality assurance team responsible for the VIP, however PPU has conducted some quality reviews of the program.

The PPU has conducted and is in the process of conducting the following quality reviews:

- a Quality Review on Advance Payment in December 2008 which determined that compliance with Advance Payment policies was inadequate particularly with regards to the signing of CA forms; and

- a Quality Review is presently underway regarding the decision level of the Client Service Agent. The issue being examined is the feasibility of increasing the delegated authority level for the CSA.

During the fieldwork, the audit team were made aware of informal attempts at cost control and, by default, some level of quality assurance. One District Office set local maximums for non-registered providers of certain elements (e.g. housekeeping). Though not set in policy, this practice enables the district to ensure, to some degree, that service is provided at an acceptable and affordable cost.

The audit team learned that provider cost and delegated authority levels can play a significant role in determining the level of intervention clients received. Staff reported in some cases reducing the level of the intervention to what was possible to authorize at their level of authority. As a result, high provider cost may cause a reduction in the frequency or duration of the intervention as some staff put programs in place up to their limit to avoid the paperwork and delays required to request a Section 34 VHCR (exceeding rates).

Performance Measures

Performance measurement is the process whereby an organization establishes the parameters within which programs should operate to reach the desired results. The Terms and Conditions of the Veterans Independence Program stated the need for a Results-Based Management and Accountability Framework (RMAF) and a Risk-based Audit Framework (RBAF). These were prepared and submitted to TBS on September 30, 2008. This document contains a performance measurement plan with outcomes and a logic model; however, it is already somewhat outdated as certain units referenced in the document with roles in performance measurement (e.g. QMP, NOD) no longer exist in the organization.[10]

The planned results and performance measures within the RMAF/RBAF are realistic and measurable, however, they are more focused on service delivery than on program management. There is minimal goal-setting in terms of turn-around times, client volumes, or expenditures for the program.

As mentioned in Objective 3, roles and responsibilities are being redefined due to re-organization of the Quality Management function and the Service Delivery function. During fieldwork, the audit team learned that both units are in discussions regarding their respective roles and responsibilities for performance measurement. The distinction needs to be made between measuring the satisfaction associated with the

[10] An updated Logic Model and Performance Measurement Plan was submitted to TBS in June 2009. The RMAF/RBAF reviewed in this audit has been superseded.

administrative delivery of the program versus measuring the program in regards to its compliance with regulations, policies, objectives, business processes and procedures.

Monitoring

Financial and non-financial data are used to monitor and support decision-making for effective performance measurement, and reporting results. The methods used to monitor the VIP are formal and informal, some direct and others indirect. These methods include: quality controls, transaction sampling, national client surveys, research, literature reviews of comparable programs, and audits and evaluations.

Recent work regarding the VIP completed by the Audit and Evaluation Division include:

- VIP Baseline Study (May 2004) to establish baseline measures to facilitate a future evaluation of the VIP payment process before and after FHCPS implementation.
- VIP Baseline Study II (March 2006) to take a snapshot of VIP payment processing following the changeover to FHCPS and to compare to the VIP Baseline Study from 2004.
- Evaluation of the Veterans Independence Program (December 2006) to assess the program results and accountability for the purposes of renewing the Terms and Conditions with Treasury Board.

The Transfer Payment Policy also requires that an evaluation of the VIP be completed prior to the renewal of the VIP Terms and Conditions before November 30, 2011. This evaluation is scheduled in the departments five year evaluation plan.

The PPU plans to establish a schedule for periodic reviews of various programs. This process is ongoing.

The Terms and Conditions of the VIP states that “home visits or other follow-up activities are conducted annually by District Office staff to ensure continuing entitlement to the VIP services and compliance with the terms of the contribution agreement.” The file review found 88% of the client files sampled had a current VIP annual follow-up documented on file or on the CSDN.

The Veterans Programs Policy Manuals (VPPM) section 3.1.7 states that in respect of Contribution Arrangements, (subsection 3.32) “VIP accounts should be reviewed periodically to ensure that projected costs will not exceed the approved contribution arrangement limits. If it seems likely that the approved amount will be exceeded, the case should be reassessed and consideration given to options such as:

a) Selecting alternate service providers at lower cost;

b) Counselling the client on needs and expenditures; or
c) Increasing the contribution and, if necessary, seeking authority to exceed the maximum financial limits under section 34, VHCR. “

As previously stated, 85% of VIP clients use non-registered providers and are therefore responsible for selecting the provider. Some District Offices have responded to the lack of controls by setting informal benefit limits for non-registered providers based on the going rates set in the community.

The identified and assessed need is a control, however, with only annual limits as the primary financial control, coupled with the fact that payments are only controlled when the annual limit is reached, and given an increasing workload, there are not sufficient controls in place to satisfy this policy.

There is a significant amount of work and documentation required to have a Sec. 34, VHCR (exceeding rates), approved. Even when it is possible, staff reported benefits may only be awarded up to their maximum delegated authority to expedite the process and to avoid the additional work.

Reporting

There are a number of reports available regarding the Veterans Independence Program:

- The Enterprise Reporting Database (RDB), a database of client and program information, produces a series of exception reports to capture clients with expiring follow-ups and contribution arrangements.
- The Corporate Information System (CIS) produces a series of summary reports on VIP program expenditures and client counts. These reports are used to project program utilization and cost.
- The Output Management System (OMS) functionality within the FHCPS creates VIP reports pertaining to expiring contribution arrangements and Advance Pay comparisons, the Advance Pay comparison reports have not been updated in approximately 18 months.
- There is a report which identifies current pended claims within the FHCPS, once the pends are cleared. There is no reporting on the resolution or monitoring.

Most managers interviewed reported they were receiving too many reports and they did not have the time to review all of the information.

There is no comprehensive way to track and report the number of frail clients awarded VIP. Some regions have implemented informal reporting on the number of clients per

month but the information is not consistently collected or reported. The CSDN has no frail indicator box and the information may only be found in hard-copy files or in the client notes area of CSDN which cannot be queried. Often, there is little or no supporting evidence on the client file as to why the client was classified as frail.

Another unreported area is the program and administration costs of pended claims as discussed in Objective 2.

10.2 Conclusions

- There are three primary methods used to monitor QA for the VIP program.
- During the conduct of the audit, roles and responsibilities regarding monitoring of the VIP were in transition as new roles and functions were being redefined.
- There is no QA Team at HO responsible for VIP.
- The newly formed PPU has conducted some quality reviews. One review addressed the issue of advance pay and found that compliance to the advance pay policy was inadequate, the second review is in progress.
- Some staff limited VIP interventions up to their maximum delegated authority levels to avoid requesting Section 34 VHCR exceeding rates approval, to expedite the process for the client and to reduce the level of effort required to put the intervention in place.
- Section 3.1.7 of the VPPM, regarding monitoring of contribution arrangements is not being followed due to fact that the client selects the provider in most situations and workload pressures restrict the effectiveness of the other measures.
- Managers would like to have fewer more comprehensive reports to review.
- There is no uniform monitoring or reporting of the numbers of clients who become eligible for VIP as a result of the 'frail' policy.
- There is no monitoring or reporting of program or administrative costs of claims pended for insufficient funds.

10.3 Recommendation

Recommendation 6 (*Important*)

It is recommended that the Director General, Service Delivery Management establish a quality control and quality assurance team at all levels to develop a robust quality control and monitoring system to ensure that compliance monitoring and reporting is done on a regular basis.

Management Response:

Management agrees with this recommendation.

Work is currently underway as a result of an Audited Financial Statement observation. Consultations are occurring with vested Stakeholders to explore items as noted in Recommendation # 2 & 5. This consultation includes exploring options to implement a quality review process.

Management Action Plan: (will be completed in conjunction with Rec, # 2 & Rec # 5)

Corrective Action(s) to be taken		OPI (Office of Primary Interest)	Target Date
6.1	Consultation with various stakeholders (Policy, Program Management, Finance) and establish working group to explore options to address this finding.	SDM	March 2010
6.2	Analyze options, make recommendation & obtain approval on recommendation. Develop associated work tools, reporting mechanism.	SDM	April 2010
6.3	Communicate to staff & implement QC process.	SDM	September 2010

Recommendation 7 ***(Important)***

It is recommended that the Assistant Deputy Minister, Service Delivery and Commemoration (i) ensure that the number of clients declared eligible for VIP as a result of the 'Frail Policy' are tracked and reported in a manner consistent with the way other client groups are tracked; and (ii) track the program and administrative cost of VIP files pended for 'insufficient funds'.

Management Response:

Management agrees with this recommendation.

Steps will be taken immediately to track new VIP clients being added as a result of the Frail Policy. Analysis will be done to determine the scope of identifying clients already in receipt of VIP under Frail. In addition, consultation will be completed to determine if program and administrative costs can be tracked for claims pended for "insufficient funds".

Management Action Plan:

Corrective Action(s) to be taken		OPI (Office of Primary Interest)	Target Date
Go-Forward Basis:			
7.1	Consultation with various stakeholders (IT, Policy, Program Management, Finance) to detail system requirements to add Frail indicator to CSDN or FHCPS.	SDM	March 2010
7.2	Develop Business Process / Operational Directive for staff.	SDM	June 2010
7.3	Distribute direction to staff.	SDM	July 2010

11.0 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, Service Delivery Management
Director General, Program Management
Director General, Policy and Research
Director General, Communications Division
Director General, Finance Division
Director General, Departmental Secretariat and Policy Coordination
General Counsel, Justice Canada
Deputy Coordinator, Access to Information and Privacy
Office of the Comptroller General
Office of the Auditor General

ANNEX A VIP AUDIT TERMS OF REFERENCE

Veterans Independence Program

Description: The Veterans Independence Program (VIP) provides benefits to eligible clients to allow them to remain healthy and independent in their own homes and communities. The program benefits include home care services such as housekeeping and grounds maintenance, ambulatory health care, social transportation and home adaptations. When care in the home is no longer reasonably practical, the program assists clients to remain in their communities by providing access to intermediate care in community facilities. In March 2008, there were 100,000 clients accessing this program with annual program expenditures of $300 million.

Rationale: The VIP is one of the largest departmental programs and has experienced a number of operational and program changes over the past few years, including the expansion of the program to survivors. It has been several years since the program has been examined by Internal Audit and current post-payment verification results indicate that there is a need to improve controls in the program. This audit will also support the work required to prepare for the audit of the Department's financial statements.

Preliminary Audit Objectives: To determine whether:

1. Up-to-date policies and procedures are in place to support program delivery;
2. Program payments are accurately calculated and paid to eligible clients and approved providers;
3. Regulatory and policy requirements are complied with;
4. The quality assurance function provides an ongoing assessment of compliance requirements and identifies opportunities for improvement.

Related Authorities:
Veterans Health Care Regulations

Related Core Controls:
ST-7 – Compliance with financial and program management laws, policies, and authorities is monitored regularly.
ST-10 – Transactions are coded and recorded accurately and in a timely manner to support accurate and timely information processing.
ST-11 – Appropriate system application controls exist.
ST-12 – Records and information are maintained in accordance with laws and regulations.
ST-13 – There is appropriate segregation of duties.

Overall Audit Priority: Moderate (6/9) risk x significance

Risk Exposure	Significance of Auditable Unit
VIP annual expenditures exceed $300 m. for home and level II care, and other services. There have been recent changes to program eligibility. Past audits and post-payment verification have identified error rates that exceed established limits. The overall risk exposure is moderate (2/3).	VIP home care has a significance rating of high and the non-departmental institutions and other services auditable units are rated moderate. These programs have a profound impact on the quality of life for 100,000 clients (3/3).

Year: 2009-10 **Target Completion Date:** January 2010

Resources: 2,025 hours and $10,000 travel

ANNEX B AUDIT CRITERIA

Objective #1: Up-to-date policies and procedures are in place to support program delivery.

- Up-to-date policy exists to allow program staff to deliver the program.
- Up-to-date procedures/business processes exist to allow program staff to deliver the program.

RELATED CORE MANAGEMENT CONTROLS

PP-2. The organization has a formal and rigorous approach to policy and program design.

ST-5. Financial and program management policies and authorities are established and communicated.

ST-6. Financial management policies and authorities are reviewed regularly and revised, as required.

Objective #2: Program payments are accurately calculated and paid to eligible clients and approved providers.

- Program payments are accurately calculated.
- Program payments are paid to eligible clients and approved providers.

RELATED CORE MANAGEMENT CONTROLS

G-6. The oversight body/bodies request and receive sufficient, complete, timely and accurate information.

ST-10. Transactions are coded and recorded accurately and in a timely manner to support accurate and timely information processing.

ST-15. Reviews are conducted to analyze, compare and explain financial variances between actual and plan and to ensure that payments are accurately calculated and paid to eligible clients and approved providers.

Objective #3: Regulatory and policy requirements are complied with.

- Program delivery is compliant with VAC program and central agency, criteria and policy.

RELATED CORE MANAGEMENT CONTROLS

ST-7. Compliance with financial and program management laws, policies and authorities is monitored regularly.

ST-11. Appropriate system application controls exist.

ST-12. Records and information are maintained in accordance with laws and regulations.

ST-13. There is appropriate segregation of duties.

Objective #4: The quality assurance function provides an ongoing assessment of compliance requirements and identifies opportunities for improvement.

- A sufficient number of controls and reporting systems are in place to ensure quality assurance, compliance and opportunities for program improvement.

RELATED CORE MANAGEMENT CONTROLS

RP-2. Management has identified appropriate performance measures linked to planned results

RP-3. Management monitors actual performance against planned results and adjusts course as needed

ANNEX C MAXIMUM VIP BENEFIT LIMITS

Service	Maximum Rate Payable
a) Home Care Service	$9,107.28 per client per calendar year, including up to the maximum amounts for grounds maintenance services and personal care services noted below:
1. Grounds maintenance services	$1,270.78 per client per calendar year
2. Personal care services for Veteran pensioners and civilian pensioners also in receipt of attendance allowance	An amount not to exceed the cost of service for up to 59 days per calendar year
b) Ambulatory Health Care Service	$1,058.99 per client per calendar year
c) Transportation Service	$1,270.78 per client per calendar year
d) Home Adaptations Service	$5,294.92 per principal residence
e) Intermediate Care Service	$ 127.59 per client per day
Survivors	$2,460.00 per client per calendar year
1. Grounds Maintenance Services	not exceed $1,270.78 per client per calendar year.
2. Housekeeping	not to exceed the combined total of $2,460.00.

* Taken from VPPM Volume Two, Appendix G, Veterans Independence Program Maximum Rates Payable (effective January 1, 2009 to December 31, 2009)

ANNEX D 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.