National Defence / Défense nationale

Chief Review Services / Chef - Service d'examen

CRS / CS Ex

Audit of Canadian Forces Health Services (CFHS)

April 2014

7050-62 (CRS)



Canada

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Acronyms and Abbreviations

ADM(Mat)	Assistant Deputy Minister (Materiel)
CAF	Canadian Armed Forces
CFHS	Canadian Forces Health Services
CMP	Chief Military Personnel
CRS	Chief Review Services
DND	Department of National Defence
FTE	Full Time Equivalent
FY	Fiscal Year
HQ	Headquarters
HR	Human Resources
MOU	Memorandum of Understanding
OPI	Office of Primary Interest
PWGSC	Public Works and Government Services Canada
RCMP	Royal Canadian Mounted Police
VAC	Veterans Affairs Canada

Results in Brief

The Department of National Defence (DND) is responsible for the health care of Canadian Armed Forces (CAF) members. CFHS is the designated health care provider within DND, and it currently operates 126 units and detachments including medical clinics, dental detachments, mobile units, a field hospital, medical and dental schools, a research establishment and a medical equipment depot. CFHS employs approximately 4,800[1] military and civilian full time equivalent (FTE) personnel across Canada, of which roughly 2,500 were working at the 32 medical clinics and 26 dental detachments at the time of the audit. In addition to providing medical services to deployed operations and in garrison, CFHS relies on the civilian health care community for additional health care needs.

Overall Assessment

Although there are some important deficiencies in the execution of invoice approval and post-payment verification, CFHS has developed some good management practices in the areas of governance, risk management and internal controls. Some improvements are required in the risk management, performance management, and management oversight on personnel planning.

From Fiscal Year (FY) 2007/08 to FY 2011/12, the total budget for CFHS has increased from approximately $336 million to $431 million.[2] While the average rate increase over the 5 years is approximately 7 percent annually, the rate increases in FY 2010/11 and FY 2011/12 were reduced to 2.1 percent and 0.3 percent, respectively. During the same five-year period, the number of CAF members has increased, on average, 2 percent annually. In FY 2011/12, roughly 40 percent of the total budget, approximately $178 million,[3] was consumed by two contracts. The Federal Health Claims Processing System Contract, with a contract expenditure of approximately $123 million in FY 2011/12, processes CAF members' health claims from civilian sector providers and DND pharmacies. The Health Services Support Contract, with a contract expenditure of approximately $55 million in the same fiscal year, provides civilian medical contractors to fill in vacancies at CAF clinics.

The objective of this audit was to assess whether the necessary risk management practices, controls and governance structure were in place to ensure the optimal use of these resources.

[1] This represents the total number of FTE positions at all CFHS facilities, not including vacant positions.
[2] Salaries and benefits for regular force members and for reserve force members, information management and technology costs, and infrastructure costs related to CFHS operations are not included in their budget.
[3] This amount includes $120.4 million in payment to civilian sector providers for the health care services they provided to CAF members.

Findings and Recommendations

Contract Management. The financial control framework for overseeing the CAF health claims approval process has not been functioning as intended. The audit found weaknesses in the framework in terms of invoice approval and post-payment verification. At the headquarters (HQ) level, transaction fees were not verified by CFHS staff. At the CAF clinic level, high risk claims from civilian sector providers are not investigated by the CAF clinics to confirm that the services were rendered. As part of the post-payment verification sampling process, certain claims are classified as high risk when the member surveyed does not respond to a request to confirm that the services were rendered, or when the member indicates that the services were not rendered. As well, signed pre-approval forms for referred health services were not prepared for 48 percent of the sampled claims that required them.

It is recommended that CFHS update current guidance on the CF claims approval process for sampling methodology and high risk claims follow-up procedures, enforce consistent adherence to the updated guidance, and improve the financial control framework for claims verification and pre-authorization.

The fees reimbursed by the provinces to hospitals for certain medical services performed on provincial residents were compared to the fees that hospitals charge CAF members for the same services. The audit found that the median mark-up of the fees charged for services to CAF members over the fees charged for residents was double.[4] DND paid approximately $51.6 million in hospital services for CAF members in FY 2011/12. Furthermore, DND has been paying the employer payroll health tax for the CAF members in four provinces. The average amount of health tax paid between calendar year 2010 and 2012 was approximately $86 million annually. DND receives no direct benefit from these health tax payments. The Department pays for the health tax on CAF payrolls, but still pays for all medical services that CAF members receive, services that provincial residents would receive at no charge. As a result of the audit, management is reviewing the issue of the employer health tax, and indicated that they are monitoring the fee markup for hospital services.

CFHS should pursue possible avenues to achieve potential saving opportunities in reference to the provincial health billing.

For the management of the Health Services Support Contract, no guidance was in place for monitoring contractor timesheets and invoices, which resulted in the timesheets not being consistently reviewed at CAF clinics or at CFHS HQ. The current contract does not require the contractor to submit individual signed timesheets to DND, even though DND makes payments based on the hours indicated on the timesheets.

It is recommended that CFHS, in conjunction with Director General Procurement Services, develop a framework to reduce the chances of processing inaccurate invoices and timesheets.

[4] This is based on the median rate comparisons for services analyzed.

Risk Management. CFHS identifies its risks and mitigation strategies in its annual business plan. CFHS has implemented some good mitigating strategies to reduce contractor performance and financial risks. However, mitigating strategies need to be developed to address the risk of its dependency on civilian contractors for key systems related to health care delivery to CAF members.

It is recommended that CFHS update its risk assessment to include the risk associated with its dependencies on contractors, and develop a plan for maintaining care should the contractor unexpectedly not be in a position to provide the services.

Performance Measurement and Management. CFHS has implemented some good performance metrics that are adequately benchmarked with similar healthcare organizations and mapped to organizational objectives. Some minor changes can be made to improve the clarity of data input requirements at the CAF clinics and to formalize the reporting of performance results.

It is recommended that CFHS revise and complete the performance measures, improve guidance for data requirements, and formalize the frequency of reporting.

CFHS Human Resource Management. CFHS's workforce requirements are contained in a document that is referred to as "the clinic model." The clinic model includes an analysis of the optimal number and professional qualifications of medical personnel required on each base, based on the client population. The model is used by CAF clinics as a staffing baseline when planning their staffing needs every year. However, interviews with staff at the sampled CAF clinics indicated that the model no longer accurately reflects all of their current needs, as the environment in which some clinics operate has changed over time. Due to hiring and budget constraints, making changes and additions to positions in the clinic model is difficult and time-consuming, so new personnel needs are mostly filled by contractors. There is a need for the clinic model to be updated and CFHS is in the process of doing this; consequently, no recommendation was included in the report.

Note: For a more detailed list of Chief Review Services (CRS) recommendations and management response, please refer to Annex A—Management Action Plan.

Introduction

As the designated health care provider for Canada's military personnel, the CFHS mandate includes:

- delivering medical, mental, and dental heath care, offered on an individual needs basis;
- providing a deployable health services capability to operational commands; and
- providing health care advice to CAF members.[5]

The military environment carries many unique challenges in providing health services, such as maintaining the deployability of health care professionals, managing a distinct patient demographic (for example: no minors and no seniors), and ensuring continuity of care over a vast geographic location. The *Canada Health Act* excludes military members from provincial insured health programs (meaning that CAF members do not receive free treatment at civilian hospitals), so in addition to serving their primary role of providing support to CAF deployed operations, the CFHS must also provide health services to CAF members at home.

In the current environment with fiscal constraints and staffing pressures, CFHS has identified, in its FY 2013/14 business plan, the pressures "stemming from corporate direction to reduce Class B and public service positions." In order to provide the same level of service, these staffing pressures could potentially force CFHS to increase its reliance on contractors. Based on the business plan, CFHS has continued to achieve success in certain areas. For example, the plan states that "the CF health care system was evaluated by Accreditation Canada and received an outstanding review." The plan also states that the CAF system is the "only pan-Canadian primary care based system that has been accredited and will be used as a model for other health care systems in Canada."[6]

CFHS manages 32 medical clinics across Canada, divided between two groups: *1 Health Services Group* for western Canada, and *4 Health Services Group* for eastern Canada.[7] Dental services are provided by 26 dental detachments embedded within the clinics. As indicated in Table 1, the medical clinics and dental detachments employ a workforce of approximately 2,500 FTEs.

[5] The Surgeon General's Report 2010. http://publications.gc.ca/collections/collection_2011/dn-nd/D3-26-2010-eng.pdf
[6] CFHS Business Plan FY 2013/14.
[7] CFHS also operates field ambulances, mobile medical units, two schools, one research establishment and one medical equipment depot.

Regular Force at Medical Clinics and Dental Detachments	Public Service at Medical Clinics and Dental Detachments	Contractors at Medical Clinics and Dental Detachments	Subtotal	Personnel at Other Locations	Grand Total
1,100	1,000	400	**2,500**	2,300	**4,800**

Table 1. CFHS FTE Workforce Breakdown. This table represents the FTE workforce for CFHS. Other locations include mobile units, ambulances, schools, research establishments, depots and HQ. The information is based on approximated data provided by CFHS.

CFHS expenditures for FY 2011/12 were approximately $431.2 million,[8] of which 40 percent was incurred by two contracts: the Federal Health Claims Processing System Contract, held by Blue Cross, and the Health Services Support Contract, held by Calian. A breakdown of the CFHS expenditures for the last five FYs is presented in Table 2, and it suggests that while the budget increased significantly early in that period, the budget was essentially frozen in FY 2011/12. Professional services expenditures consume close to half of the annual budget. The Health Services Support Contract and the Federal Health Claims Processing System Contract accounted for $178 million, or 82 percent, of the $216 million of the professional services expenditures in FY 2011/12.

Budget Items (amounts in millions)	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
HR excl. Regular Force Pay	$92.8	$108.7	$118.7	$119.6	$126.5
Professional Services	$154.2	$166.0	$199.9	$206.6	$216.1
Medical Supplies	$53.3	$52.9	$54.6	$51.9	$44.1
Purchase of Major Equipment	$5.8	$8.3	$6.4	$9.8	$10.6
Patient Travel	$2.6	$2.5	$3.0	$3.1	$2.8
Others (leases, O&M, etc.)	$27.6	$48.1	$38.8	$39.1	$31.1
Total	$336.3	$386.5	$421.4	$430.1	$431.2
Annual Percentage Increase	N/A	14.9%	9.0%	2.1%	0.3%

Table 2. Summary of CFHS Expenditure Trending Analysis. This table highlights CFHS expenditures from FY 2007/08 to FY 2011/12 for personnel salaries, professional services, medical supplies, purchase of major equipment, patient travel and other. The table excludes salaries and benefits for regular force members and for reserve force members, information management and technology costs, and infrastructure costs related to CFHS operations.

[8] This amount does not represent the total expenditures of the CAF health care program, as it excludes information management and technology costs, infrastructure costs, and pay and benefits to regular force members and reservists in the medical field, because these expenditures are not part of the CFHS annual budget. Based on the salary data for different military trades and ranks within the military pay application (Human Resources Management System, version 7.5), the regular force pay in CFHS was estimated to be $350 million to $450 million, of which approximately $316 million to $420 million was for medical professionals. The information management and technology costs, infrastructure costs, and the reserve force pay and benefits, could not be estimated with an accepted level of confidence.

Federal Health Claims Processing System Contract

When services cannot be provided at various CAF clinics, CFHS refers members to the civilian health care community. Unlike some plans, this is generally not a user pay and reimbursement system, but rather the civilian sector providers submit claims for reimbursement directly to the claims administrator: Blue Cross. To process these claims, the Department has been using an automated processing system maintained by Blue Cross since 1999.[9] Although DND and the Royal Canadian Mounted Police (RCMP) are end-users of the contract with Blue Cross, Veterans Affairs Canada (VAC) is the ultimate project authority responsible for its administration on behalf of the VAC-DND-RCMP partnership. A Memorandum of Understanding (MOU) between DND and VAC outlines the responsibilities of each department, including the responsibility for DND to verify the accuracy of its claims. A new MOU, expected to be signed prior to the expiration of the current contract in 2015, stipulates that DND will start to pay roughly $2.4 million[10] annually to reimburse its proportional share of VAC's contract administration costs.

In FY 2011/12, DND paid roughly $122.5 million to Blue Cross, including approximately $120.4 million as reimbursement for the claims from civilian sector providers and $2.1 million for claims processing fees, which were charged at an average of | | | | | | per transaction.

The Health Service Support Contract

The Health Service Support Contract, held by Calian since 2004, is intended to provide health services contractors to fill temporary vacancies[11] at CAF clinics across Canada. In FY 2011/12, CFHS spent approximately $55 million on these contractors. At the time of the audit, 16 percent[12] of the workforce was made up of contractors who are filling vacancies in the permanent organization establishment. Vacancies exist as a result of maternity leave, military rotation, requirements for deployment and inability to staff certain types of positions. As a large number of contractors are occupying key positions at CAF clinics, there is a high reliance on the contractors to provide core care to CAF members.

There are benefits and disadvantages to using contractors instead of hiring employees. Some of the benefits of having contractors are that they often provide flexibility on employment duration and require shorter staffing time. On the other hand, having

[9] Blue Cross sends monthly invoices to VAC outlining the reimbursement amount to the civilian sector providers, and the administrative charges for processing the claims. VAC then forwards the invoices attributable to CAF members to DND. DND reimburses VAC through monthly interdepartmental settlements based on the amount on the Blue Cross invoice.
[10] DND does not reimburse VAC for the fixed contract administration cost under the current MOU.
[11] Examples of vacant positions include physicians, dentists, psychiatrists, counsellors, dieticians, and social workers.
[12] This is based on the FTE personnel count at the CAF clinics, and it excludes vacant positions that were not occupied at the time of the audit. The contractor FTE counts do not include administrative contractors provided by temp help service providers, as this analysis focuses on medical professional contractors provided by Calian.

permanent employees can provide stability to the workplace, which potentially improves continuity of care.

CAF health care costs were not compared to Canadian health care costs in general, as CAF health care costs are affected by unique factors, such as the requirement of having to be operationally ready for deployed operations. As well, the patient demographics are substantially different, as CAF health care clients do not generally include minors or seniors. Finally, CAF members often perform in high-risk environments.

Rationale for Audit

In light of CFHS's total budget, the challenges that it faces in meeting its mandate and the vital role it plays in ensuring force readiness, the CRS 2013/2014 Risk-based Audit Plan included an audit of CFHS.

Objectives

The objective of the audit was to assess whether CFHS has the necessary risk management practices, controls and governance structure in place to ensure optimal use of resources for the delivery of health services.

For a detailed list of criteria associated with the audit objective and the source of the criteria, please refer to Annex B—Audit Criteria.

Scope

The audit scope included an assessment of current CFHS management practices in the utilization of both personnel and financial resources for delivering health services from FY 2011/12 to FY 2012/13.

The audit scope did not include the following:

- Personnel and financial resources employed outside of Canada.
- An assessment of the quality of medical treatment and care provided by CFHS, including qualifications of personnel.
- The management of assets (buildings, equipment, and information systems).
- The system and management processes of external stakeholders (VAC, Calian and Blue Cross).

Methodology

The following methodology was used in conducting the audit:

- Reviewed relevant Government of Canada and DND policies, directives and initiatives relevant to CFHS operations;
- Reviewed Health Services Support Contract and Federal Health Claims Processing System Contract, and related documents;

- Identified and reviewed current CAF claims management process guidance, instructions and training manuals;
- Reviewed guidance and planning documents for allocation of personnel resources at CAF clinics;
- Interviewed staff from Assistant Deputy Minister (Materiel) (ADM(Mat)), Chief Military Personnel (CMP), CFHS HQ, and three selected CAF clinics;
- Performed trend analysis on the CFHS budget from FY 2007/08 to FY 2011/12 using financial data stored in the Defence Resource Management Information System;
- Reviewed contract expenditures incurred through the Health Services Support Contract and the Federal Health Claims Processing System Contract from FY 2011/12 to FY 2012/13;
- Reviewed audit reports prepared by VAC and Blue Cross; and
- Conducted sampling analysis in the following areas:
  - **Health Services Support Contract.** Selected a judgemental sample of 43 invoices at the three sampled CAF clinics between 1 April 2012 and 28 February 2013, to review the accuracy of the invoices.
  - **Staffing Requests.** Selected a judgemental sample of 11 staffing requests in FY 2012/13, to verify supporting analysis for hiring requests.
  - **Federal Health Claims Processing System Contract.** Selected a judgemental sample of 125 claims in FY 2011/12 and FY 2012/13, to verify compliance with pre-approval requirements and evidence of services invoiced.
  - **Provincial Billing Rates.** Selected a random sample of 68 claims across Canada for hospital services between 1 April 2012 and 31 January 2013, to compare billing rates charged to DND for CAF members to the rates the provinces reimburse hospitals for civilian provincial residents.

Statement of Conformance

The audit findings and conclusions contained in this report are based on sufficient and appropriate audit evidence gathered in accordance with procedures that meet the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing*. The audit thus conforms to the Internal Auditing Standards for the Government of Canada, as supported by the results of the quality assurance and improvement program. The opinions expressed in this report are based on conditions as they existed at the time of the audit, and apply only to the entity examined.

Findings and Recommendations

Contract Management

Additional CFHS oversight is needed to improve the payment verification process for the health services contracts.

The Federal Health Claims Processing System Contract

Financial Control Framework for the CAF Health Claims Approval Process. CFHS established a four-tier financial control framework to provide oversight on CAF claims processing, but not all the necessary controls are functioning as intended. The financial control framework relies on a combination of pre-payment and post-payment verification steps, performed by both external and internal stakeholders. Together, these control activities are expected to function effectively to provide assurance on the accuracy of CAF claims payments.

Good Practice

A policy document exists detailing the roles and responsibilities of all stakeholders in the CAF claims approval process.

Tier 1 controls are performed by Blue Cross and include audits of civilian health care providers. Tier 2 controls are performed by VAC and include audits of Blue Cross. Although both Tier 1 and Tier 2 controls are outside the scope of this CRS audit, the VAC and Blue Cross audit reports were reviewed and no serious or systemic errors were identified. The most recent VAC audit[13] focused on the Blue Cross National Investigative Unit, which is responsible for conducting its own audit activities to ensure that the health care providers are complying with requirements. These activities by the National Investigative Unit include distributing letters to confirm that benefits billed are actually received by plan members, and reviewing supporting documentation on site at the health provider's facility. The VAC audit found that "the planning process (for the audit activities conducted by the National Investigative Unit) was found to be well developed, that Blue Cross was meeting all contract requirements and resources were effectively expended," and that "the activities were determined to be generally acceptable with no significant weaknesses identified."

The Tier 3 controls are designed to ensure the accuracy of DND payments to Blue Cross.[14] This includes the validation of claim amounts and the applicable per-transaction administrative charges included on the monthly Blue Cross invoice. Although CFHS HQ has been conducting a validation of the claim amounts on the monthly invoices, no verification has been performed to

Good Practice

CFHS HQ monitored how the bases were reviewing and approving rejected claims by Blue Cross through site visits to CAF clinics.

[13] Audit of the Federal Health Claims Processing System's National Investigative Unit, October 2012.
[14] VAC, as the project authority for the Federal Health Claims Processing System Contract, officially pays Blue Cross based on the monthly invoices. DND reimburses VAC through an interdepartmental settlement for the CAF claims.

ensure that the total amount for transaction administration charges on those invoices is accurate. In FY 2011/12, DND was charged approximately [redacted] for every transaction processed by Blue Cross. [redacted]

The Tier 4 controls are performed at the various CAF clinics. This includes routine reviews and approval of the claims that are rejected by the automated edit checks at Blue Cross,[15] and also includes a quarterly post-payment verification on a sample of CAF claims. The quarterly post-payment verification sampling on CAF heath claims is a key control activity to ensure services were rendered, as there are currently no pre-payment verifications on the majority of the claims.[16] However, in order to ensure that this control activity is effective, improvements are required on the reporting of verification results, the sampling methodology, and the follow-up procedures for high risk claims.

- Currently, not all the CAF clinics are reporting their findings on a timely basis. For example, the Edmonton clinic had not completed the verification for January and March 2013 at the time of the audit visit in July 2013.
- In addition, the methodology used by the CAF clinics for the post-payment verification only includes the claims that are in the top 10 percent in terms of value. The sampling methodology is documented currently in the CFHS guidance on claims approval process.[17] The claims in the top 10 percent value usually include services by the same type of providers and received by the same group of patients. This further reduces the coverage of the sampling. Without increasing the current number of sampled claims, a new methodology that incorporates both high risk claims and a random sample from the rest of the population would improve coverage. The risk-based sample could consider factors such as high dollar value, high risk vendors, high risk transaction types, etc.
- During quarterly post-payment verification, the CAF clinics send out email verifications to CAF members who have had claims in order to confirm that the service did take place. If the CAF member does not respond to the e-mail or denies having received that service, the claims are deemed “non-certifiable” claims. Current CFHS guidance on the claims approval process does not require that follow-up actions be undertaken on “non-certifiable” claims. Thus, this type of high risk claim is not being investigated to ensure that the services have been rendered. Based on the results at two of the sampled bases,[18] approximately 19 percent of the claims verified every quarter are “non-certifiable” claims.

[15] Blue Cross reviews CAF claims based on pre-determined DND criteria, such as member eligibility and the CAF spectrum of care. For example, if a claim does not fall within the spectrum of care, Blue Cross automatically rejects it and sends it back to the CAF clinic. The appropriate authority at the clinic will evaluate that claim and may decide to “re-approve” and pay the claim.

[16] In addition to DND’s quarterly post-payment verification sampling, Blue Cross conducts periodic verifications on a sample of health care claims, which includes the claims from CAF, RCMP and VAC, to confirm that the services were provided.

[17] Federal Health Claims Processing System Responsibilities, Section 34 of the *Financial Administration Act*, version 3.0 March 2013.

[18] One sampled base provided incomplete Post-Payment Verification results.

> Within the "non-certifiable" claims, approximately 3 percent are claims for which the CAF member has denied receiving the service. Not investigating these high risk claims increases the risk that DND could be paying for claims that are not legitimate.

A CRS sample of CAF health claims at three selected CAF clinics revealed that approximately 48 percent of the claims are missing the required signed pre-approvals. Out of the 99 claims reviewed, 80 required pre-approvals to be sought prior to the service. However, a signed pre-approval was missing for 38 of the 80 claims. CFHS guidance requires a pre-approval form signed by the Base Surgeon or by an authority at CFHS HQ for claims that are outside of the official health coverage for CAF members, which is called the spectrum of care. Of the 38 claims that were missing a pre-approval, 21 were higher risk as they were for services outside the spectrum of care. The clinics and CFHS HQ indicated that they accept a verbal authorization from the base surgeon as a form of pre-authorization, but, without the proper pre-approval documentation, it is difficult to determine whether DND has been paying for unauthorized claims.

Provincial Health Billing. The audit sampling analysis found that the median billing rates for specific hospital services[19] are approximately double for CAF members compared to rates the provinces reimburse hospitals for the same services delivered to provincial residents. For example the rate that DND paid for a regular force member to receive one session of obstetrics and gynaecology consultation in Ontario is $202.50, while the same service for a provincial resident would be funded at a rate of $101.70 by the province. In FY 2011/12, according to the Blue Cross claims database, DND paid a total of $51.6 million for hospital services received at various provincial hospitals and similar facilities. If DND paid the same rates as what the provinces reimburse the hospitals, DND's total payment for FY 2011/12 could potentially have been $26 million less.

DND has also paid approximately $86 million annually[20] for employer payroll health taxes for both the regular force members and reservists. The employer health tax is a source of funding for provincial medical services. The tax is applied to employers based on their payroll to fund part of the costs for the medical services used by its employees. However, as the CAF members are not covered by the provincial insured health care system, as stipulated in the *Canada Health Act*,[21] DND is paying for these medical services in addition to paying the employer payroll health taxes. Furthermore, force members and reservists pay provincial income taxes and, in some provinces, the provincial health premiums that help fund the provincial health care system.

[19] The hospital services include hospital care, surgery, assessments, etc. Most of the services are included in the provincial insured health care program. Since there was no commonality in the coding used for other services, the audit was unable to make comparisons in other areas.
[20] The number is based on an average of three calendar years from 2010 to 2012. The employer health tax is paid in four provinces: Ontario, Quebec, Newfoundland, and Manitoba.
[21] RCMP applied for and was successful in having the *Health Act* amended to include its members, thereby giving them the same access to provincial insured health care services as civilians.

Senior management was aware of the hospital rate markup and of the employer health tax premiums paid by DND. As a result of the audit, the issue of the employer health tax is being reviewed, and CFHS management has indicated that they have started tracking hospital rate markups. The recommendation in this area was limited by the scope of the audit, and focuses on value for money.

DND Control over the Federal Health Claims Processing System Contract. The current arrangement, whereby VAC is the project authority, reduces DND control over the CAF claims payment approval process. Although DND is able to access the audit reports on Blue Cross published by VAC, the department has no control over the frequency and the scope of the audits. In addition, DND did not have a complete copy of the contract, including key sections, such as the basis of payment outlining the most updated transaction fees.[22] A new MOU, expected to be signed prior to the expiration of the current contract in 2015, stipulates that DND will now start to pay roughly $2.4 million[23] annually to reimburse its proportional share of VAC's contract administration costs. CFHS management has indicated that even with the new administrative fees, they feel that the arrangement with VAC is still the preferred option.

The Health Services Support Contract

No specific DND guidance was provided regarding invoice and timesheet verification procedures at the bases, so practices at the CAF clinics are inconsistent. Currently, the approval of contractor timesheets is solely the responsibility of CAF clinics.

- As there is no requirement to keep the timesheets submitted by the contractors, the clinic supervisors who sign off on the timesheets do not always keep copies.
- CAF clinics do not consistently receive monthly invoices. The clinics that receive copies of the invoices do not always compare the signed timesheets against the invoice to ensure the accuracy of the invoice, as they are not required to do so.

Calian currently sends invoices to CFHS HQ to be processed, but the existing contract does not require Calian to submit the health service providers' timesheets to support the invoices. Instead, a labour hour summary report that lists the individual timesheets' hours is provided with the invoice. A Public Works and Government Services Canada (PWGSC) representative conducts random sampling monthly to check for discrepancies between the labour summary report and the individual timesheets that they access at Calian offices, although DND does not conduct any additional verification of the accuracy of the labour summary report before completing Section 34 of the *Financial Administration Act*. A sample of 43 contractor invoices was examined for accuracy, and, while no errors in hours invoiced were identified, there were eight contractors who had

[22] The requested portions of the contract were later provided by VAC, in response to a request by the audit team. However, DND did not have a copy on hand prior to the audit request.
[23] DND does not reimburse VAC for the fixed contract administration cost under the current MOU.

worked and invoiced more hours than the weekly ceiling hours allowed in the task authorization.[24]

Current contract terms do not provide DND with easy access to the contractor timesheets, which is key backup documentation to support payments. The timesheets are held at various bases, while the payments are made at the CFHS HQ. In addition, procedures on timesheets and invoices have not been established to ensure consistent and effective practices. Without the proper procedures, errors in invoices are less likely to be detected.

Recommendations

1. CFHS should update current guidance on CAF claims approval process for sampling methodology and high risk claims' follow-up procedures, enforce consistent adherence to the updated guidance, and improve the financial control framework for claims reconciliation and pre-authorization.
OPI: CMP/CFHS

2. CFHS should pursue possible avenues to achieve potential saving opportunities in reference to the provincial health billing.
OPI: CMP/CFHS

3. CFHS, in conjunction with Director General Procurement Services, should develop a framework to minimize the risk of processing inaccurate invoices and timesheets.
OPI: CMP/CFHS

[24] Task authorization is the pre-authorization document signed prior to having the health service providers work at the clinics. It lists the agreed upon hourly rate and the maximum hours they are allowed to work during a week.

Risk Management

CFHS has identified key risks in its annual plan and manages them effectively, although the risk related to the reliance on outside contractors for delivering core health services and a strategy to manage this risk have not been identified.

CFHS has implemented the following good risk management practices.

- CFHS identifies and assesses some key risks, as well as their associated mitigation strategies, during the annual business planning process.
- CFHS budget allocation documents identify activity prioritization and a funding structure that is based on risk and impact analysis. CFHS organizations prepare reports to highlight the impacts associated with activities being underfunded.
- CFHS has also established risk management practices to mitigate the financial and performance risks in the two major contracts.

One area that requires improvement is the risk management of CFHS's high dependency on civilian contractors to deliver core health care services. DND has relied on Blue Cross to process CAF health claims since 1999, and the contract with Calian that began in 2004. Currently, the CFHS business plan recognizes the dependencies on the civilian community for medical resources as a risk. However, the existing mitigation does not include procedures to maintain the ability to provide health care to CAF members should there be an unexpected loss of contractor services. Currently, key CFHS activities are dependent upon contractors, as the daily processing of CAF members' claims is solely reliant on the Blue Cross system, and approximately 16 percent of core CAF clinic staff are contractors. A more detailed plan outlining risk management strategies would help ensure business continuity.

Recommendation

4. CFHS should update the risk assessment regarding the dependencies on contractors and develop a plan for maintaining care in case of potential loss of contractor support.
OPI: CMP/CFHS

Performance Measurement and Management

The CFHS performance measurement framework requires some improvements for monitoring and reporting.

CFHS Performance Metrics

CFHS has established a performance measurement framework that consists of 33 performance metrics. As well, CFHS prepares reports that include:

- details on what the metric is measuring;
- why the metric is important to CFHS;
- visual charts and graphs that highlight results in relation to targets; and
- actions required to improve or maintain performance levels.

Good Practice

CFHS has established performance metrics that have been mapped to key CFHS objectives and activities, as well as benchmarked with similar healthcare organizations.

One of the key issues for CFHS is the staffing and retention of reservists and public service personnel, but there are no dedicated performance metrics. Additionally, a few metrics were found to be incomplete, duplications, or not significant to CFHS operations.

Performance Measurement Data Accuracy

There is no assurance of the quality of the performance data submitted by CAF clinics due to unclear definitions, limited monitoring, and insufficient guidance on performance data reporting requirements. For example, the sampled bases had a different interpretation of the data that should be submitted for the metric that measures patient "no-shows." One base included cancelled appointments as "no-shows" while another excluded them. Staff at CAF clinic indicated that they would benefit from clearer definitions of the required metrics. As well, not all CAF clinics consistently report their performance data to the CFHS HQ.

Performance Measurement Reporting

The reporting of the performance data to senior management is on an ad hoc basis, as there is no mechanism to ensure formal and regular reporting. Without regular updates on these performance metrics, senior management may not be receiving complete, timely and accurate information for monitoring and decision-making purposes.

Having an effective performance measurement framework with good quality data would allow managers to understand current operational needs and make better decisions.

Recommendation

5. CFHS should revise and complete performance measures, improve guidance for data requirements, and formalize the frequency of reporting.
OPI: CMP/CFHS

CFHS Human Resources Management

The planning and allocation of CAF clinics' personnel resources are based on a staffing allocation model that could be enhanced by recognizing the evolving needs of individual clinics and by considering labour market pressures.

The CAF Medical Clinic Model. In order to document and track CAF clinics' workforce requirements, CFHS developed a tool called the clinic model. The clinic model identifies the optimal amount of medical personnel requirements and their required professional qualifications based on the base population. Thus, CAF clinics use the clinic model as a staffing baseline when planning their staffing needs every year. While the model has improved the continuity of care through the primary care initiative, it does not adequately reflect the current personnel needs at all CAF clinics or consider medical professional labour market pressures. Interviews with staff at the sampled CAF clinics indicated that additional medical personnel are required at the CAF clinics yet are not supported by the clinic model.

Establishment Change Request Process. The Establishment Change Request is a tool that is used by CAF clinics to request changes to their position charters, including creating new positions that are not currently recognized in the clinic model. However, interviews with staff at the sampled CAF clinics indicate that because of Department-wide budget constraints, permanent additions to the existing position charters are uncommon, as an addition of one position requires an offset of another position. As well, these requests require extensive justification and a high level of approval. As a result, CAF clinics rely on contractors and temporary help services, which may increase health care costs.

Continuity of Care. For continuity of care, the clinic model includes a fixed number of public service medical doctors; however, all of the public service medical doctor positions at the sampled bases are vacant and currently staffed with contractors. This may be due to compensation discrepancies between the public service and private sector, as well as the competitive demand for medical doctors in the civilian health care sector. The current practice at the CAF clinics is to rely on contractors.

The needs of CAF clinics change over time, and the CAF clinics refer to the Clinic Model as their staffing baseline. Having an updated clinic model will allow the clinics to perform more effective HR planning, which in turn helps reduce reliance on contractors in some areas where permanent staffing is an option, and, thereby, potentially realize cost efficiencies.

CFHS has indicated that they are currently planning to reassess the clinic model, and the priority will be on primary care. There is a need for the clinic model to be updated and CFHS is in the process of doing this; consequently, no recommendation was included in the report.

General Conclusion

The audit identified some weaknesses in management practices in the area of governance, internal control and risk management, while compensating controls do exist in certain areas. The financial control framework for the CAF health claims approval process did not function as intended, primarily due to important deficiencies in the invoice approval and in the post-payment verification processes that could result in inaccurate or improper amounts being paid. However, it is worth noting that the results from audits conducted by VAC and Blue Cross did not identify serious weaknesses on the part of the claims approval process that exists outside of DND. While CFHS implemented good risk management practices in some areas, the key risk of reliance on contractors to deliver core CAF health services has not been adequately addressed. CFHS has designed a performance measurement framework, but minor improvements on the quality of data and the reporting of the performance results are required. Also, management oversight could be strengthened to provide updated guidance on personnel planning at the clinics for the delivery of health services to CAF members. Lastly, health related payments for services and taxes to other jurisdictions need to be reviewed. The recommendations are provided to enhance the governance and process controls, and to support the delivery of better health services for CAF members.

Annex A—Management Action Plan

CRS uses recommendation significance criteria as follows:

High—Controls are not in place or are inadequate. Important issues are identified that could negatively impact the achievement of program/operational objectives.

Moderate—Controls are in place but are not being sufficiently complied with. Issues are identified that could negatively impact the efficiency and effectiveness of operations.

Low—Controls are in place but the level of compliance varies.

Contract Management

CRS Recommendation (High Significance)

1. CFHS should update current guidance on CAF claims approval process for sampling methodology and high risk claims' follow-up procedures, enforce consistent adherence to the updated guidance, and improve the financial control framework for claims reconciliation and pre-authorization.

Management Action

1.1—CFHS should update current guidance on CAF claims approval process for sampling methodology.

CFHS is in the process of re-validating the current sampling methodology. With the assistance of the CFHS Comptroller, a package is being assembled for the Assistant Deputy Minister (Finance and Corporate Services) staff to review in order to seek formal concurrence with the re-validated sampling methodology. Any new guidance resulting from this process shall be implemented in all clinics across Canada.

OPI: CMP/CFHS
Target Date: September 2014

1.2—CFHS should update current guidance on CAF claims approval process for high risk claims' follow-up procedure.

The National Investigation Unit (NIU) at Blue Cross is mandated by contract to systematically follow up on every high-risk claim identified by the clinics. These claims are carefully examined by the Unit using diverse means, including verification letters, and recoveries are made from health care providers who submit illegitimate claims. Based on the latest data provided by the Unit for the 1st, 2nd and 3rd quarters of the current FY, over 1,500 verification letters have been sent to CAF members, and nearly $1,350 has been recovered from health care providers.

In addition, units will be directed to refer all non-certifiable claims, done through quarterly audits, back to Blue Cross for follow-up and recovery if applicable. CFHS will also implement a monitoring procedure to ensure that Blue Cross is following up on all

non-certifiable claims, and Blue Cross will be engaged to provide sufficient information to allow CFHS to ascertain that every non-certifiable claim has been reviewed. This will ensure both a local audit and response, as well as a third party claims processing audit and response. This two-pronged approach will increase discovery and ensure that appropriate actions are being taken.

OPI: CMP/CFHS
Target Date: April 2014

1.3—CFHS should enforce consistent adherence to the updated guidance, and improve the financial control framework for claims reconciliation and pre-authorization.

The new Federal Health Claims Processing System Contract, which is scheduled for implementation in August 2015, includes a revised version of the guidance which will strengthen the sampling methodology, and thereby improve the financial control framework for claims reconciliation and pre-authorization. In the meantime, approval to resume Federal Health Claims Processing System staff assistance visits to clinics will assist in further enforcing consistent adherence to the guidance.

OPI: CMP/CFHS
Target Date: August 2015

CRS Recommendation (Moderate Significance)

2. CFHS should pursue possible avenues to achieve potential saving opportunities in reference to the provincial health billing.

Management Action

CFHS has initiated a plan to [redacted] will be identified through quarterly financial reporting processes, and will be closely monitored by CFHS.

OPI: CMP/CFHS
Target Date: June 2014

Annex A

CRS Recommendation (Moderate Significance)

3. CFHS, in conjunction with Director General Procurement Services, should develop a framework to minimize the risk of processing inaccurate invoices and timesheets.

Management Action

CFHS is working with its units across the CAF to ensure that timesheet verification is appropriately done and at the right level. Written direction was sent to the units in September 2013, outlining the responsibilities of the Clinic Managers and their delegated staff in reviewing timesheets. Further direction was also given at the CFHS Comptroller workshop in February of 2014.

CFHS and Director General Procurement Services have also established a review system with the Blue Cross whereby this contractor sends a copy of selected timesheets that have been identified as discrepancies by the Procurement Authority during the detailed review of each monthly invoice. Appropriate corrective actions, including financial recovery, are taken by the Contractor each month as required as a result of this detailed review.

OPI: CMP/CFHS
Target Date: Completed February 2014. Will continue to monitor

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Risk Management

CRS Recommendation (Moderate Significance)

4. CFHS should update the risk assessment regarding the dependencies on contractors and develop a plan for maintaining care in case of potential loss of contractor support.

Management Action

Identified as being a strategic risk in the annual L2 Strategic and Business Plan, general mitigation strategies have been identified. These strategies will be further developed and articulated by *1* and *4 Health Services Groups* to include available courses of action in the employment of existing uniformed and Public Service Health Care providers in order to maintain care while identifying related operational risk. These efforts will form part of an endorsed and annually reviewed Business Continuity Plan. Furthermore, CFHS will continue to work closely with other CMP organizations responsible for recruiting and personnel policies, in order to address shortages of Uniformed Health Care providers and the staffing of Public Service vacancies, with the goal of reducing the reliance on contracted services and providers.

OPI: CMP/CFHS
Target Date: June 2015

Annex A

Performance Measurement and Management

CRS Recommendation (Low Significance)

5. CFHS should revise and complete performance measures, improve guidance for data requirements, and formalize the frequency of reporting.

Management Action

The CFHS performance measurement framework is an evolving system that is constantly under review and revision to ensure it remains dynamic and responsive to the health support needs of the CAF and its soldiers. The Performance Measurement Cell will continue to review and revise performance indicators through a logic modeling process. Particular focus will be given to revision and creation of appropriate performance indicators related to the management and performance of the Federal Health Claims Processing System Contract and the Health Service Support contract.

CFHS performance management stakeholders will be consulted deliberately and systematically in order to clarify data requirements and computation methodologies of all strategic performance indicators. Once confirmed and collated, both data collection requirements and indicator methodologies will be distributed to all personnel involved in data collection and reporting. A calendar detailing the schedule of indicator data requirements will also be developed and distributed. The Chain of Command will be engaged at the operational and tactical levels to improve data quality. Further, the CFHS Performance Measurement Cell will engage clinic managers at their annual national forum with the aim of providing formal structured guidance on performance measurement at the tactical level.

OPI: CMP/CFHS
Target Date: March 2016

Annex B—Audit Criteria

Criteria Assessment

The audit criteria were assessed using the following levels:

Assessment Level and Description
Level 1: Satisfactory
Level 2: Needs Minor Improvement
Level 3: Needs Moderate Improvement
Level 4: Needs Significant Improvement
Level 5: Unsatisfactory

Management of Professional Service Contracts

1. Controls are in place to ensure effective and efficient management of professional services contracts and the optimization of value for money.

   Assessment. Level 3—A fairly comprehensive control framework has been developed, but there are some important weaknesses related to invoice approvals that need to be addressed. Although not detailed in the report, the high degree of reliance on contractors may not optimize value for money.

Risk Management

2. Risks in planning and managing resources and in contract management have been identified and managed according to requirements.

   Assessment. Level 2—Risks and mitigation strategies are identified in the annual business planning process. Risk management practices exist to mitigate contract financial and performance risks. However, the mitigation of the key risk regarding reliance on contractors needs improvement.

Performance Measurement and Management

3. Standards and targets are established and communicated. Results and performance are tracked, measured and linked to the objectives of the organization.

   Assessment. Level 2—A fairly effective performance measurement framework has been developed and implemented but requires minor improvements. A series of well-thought-out standards and targets has been established. The results of performance measurement are not formally communicated to senior management.

Annex B

Human Resource Management

4. Sufficient management oversight exists to monitor the use of medical services personnel for the delivery of health services.

   Assessment. Level 2—CFHS has developed a clinic model that includes the allocation of medical services personnel. This is a great planning tool, although the current version does not reflect the up-to-date personnel needs of some CAF clinics, and does not consider recent labour market pressures for medical professionals. There is a need for the clinic model to be updated, and CFHS is in the process of doing this; consequently, no recommendation was included in the report.

Sources of Criteria

Treasury Board Secretariat, Core Management Controls: A Guide for Internal Auditors, November 2007.

Audit Criteria Area	Audit Criteria Description	Reference to Core Management Controls
Management of professional services contracts	Controls are in place to ensure effective and efficient management of professional services contracts and the optimization of value for money.	ST-2, ST-5, ST-7, ST-11, ST-10, ST-13, ST-15, ST-18, ST-22 , AC-1, AC-2, AC-4, PPL4,
Risk management	Risks in planning and managing resources and in contract management have been identified and managed according to requirements.	RM-1, RM-2, RM-3, RM-4, RM-6, RM-7
Performance measurement and management	Standards and targets are established and communicated. Results and performance are tracked, measured and linked to the objectives of the organization.	RP-1, RP-2, RP-3
Human resources management	Sufficient management oversight exists to monitor the use of medical services personnel for the delivery of health services.	G1, G6, PPL1, PPL-2, RP-3, ST18

Table 3. Audit Criteria references to Treasury Board Secretariat Core Controls. This table shows the Treasury Board Secretariat core controls corresponding to each of the four audit criteria used in conducting this audit.