demonstrate that the client actually received the services or goods being billed and also whether the client was entitled to receive the services or goods.

2.20 Western Regional Health and Community Services Board

The Western Regional Health and Community Services Board (the Board) was established 1 January 1996 and operates under the authority of the *Health and Community Services Act.*

Financial Operations

Since the Board commenced operations in 1996 its financial position has deteriorated to the point where it had an accumulated deficit of $4.0 million at 31 March 2003. The Board has had operating deficits in each of the last five years ranging in amounts from $0.3 million in 2003 to $1.1 million in 2002 and 2001.

The Board's financial operations are monitored throughout the year through monthly variance reports of actual and budgeted expenditures; however, there are issues relating to the Board's budget as follows:

- The Board's budget is not being approved by the Department of Health and Community Services until well into the fiscal year; therefore, the flexibility to take action to stay within the budget is reduced.

- Each year the Board submits a budget based on the expected costs and normally results in a deficit since Provincial funding is insufficient to cover the projected costs. The Board, however, operates under the premise that additional funding will be provided by the Province. Although in most instances this funding is eventually provided, usually in March, this results in a budget system where deficits will occur if the additional funding is not provided and steps are not taken to reduce costs to the available funding level.

Home Support Programs

A major contributor to the increasing deficit has been the increase in direct client costs for the home support for seniors program and the home support programs for mentally and physically challenged adults. Costs for these programs were $10.9 million or 29% of total Board expenses in 2002-03.

The Board's ability to manage home support program costs is made more difficult as a result of the limitations of its management information systems to provide all of the financial information necessary to monitor and control program costs.

The $8.9 million of direct home support costs in 2003 represent an increase of 98% over the direct home support costs of $4.5 million in 1997-98. Our review of these programs identified the following:

- Home support program expenditures were not adequately monitored and controlled. Expenditures were made through three different payment systems and, as a result, individual client costs were not readily available.

- The required annual client assessment relating to the type of care and level of support for clients of the programs for adults is not always completed. The assessments relating to the program for seniors were not always fully completed or approved. As a result there are instances of inadequate support for the type and level of service being assessed and provided.

- One client was funded $275,000 under the programs for adults even though the client did not meet the eligibility criteria as set out in Board policy for the type of care being provided i.e co-operative apartment arrangement.

The required annual financial assessments to determine the clients' contribution were not always completed accurately and were not always accompanied by the required documentation. As a result the Board cannot be certain that all clients are making the proper financial contribution towards the service being provided.

- We found that there was not always adequate documentation to support expenditures. For example, time sheets to support the level of care being assessed and paid for were not on file, in addition, monthly allowances for items such as community access and personal expenses were not always adequately supported. Furthermore, once the monthly allowances were approved they continued to be paid each year without a review to determine whether the allowance continued to be required. As a result, there are instances where payments are being made by the Board without adequate support to demonstrate that the client actually received the services or goods being billed and also whether the client was entitled to receive the services or goods.

- Reconciliations between allowances paid and the actual costs incurred by clients to identify over and under payments were not always completed as required. There were instances where reconciliations were inaccurate, not submitted on a timely basis, lacked the required detail and, furthermore, over and under payments identified during the process were not always settled on a timely basis.

- Policies and procedures relating to the home support programs for adults were incomplete and outdated.

2.21 Medical Care Plan Beneficiary Registration System

The Newfoundland Medical Care Plan was introduced in Newfoundland and Labrador on 1 April 1969. For the year ended 31 March 2003, payments under this system totalled $206.5 million. Upon approval by the Department of Health and Community Services of an application for coverage under the Medical Care Plan, the person is issued a beneficiary card. This card contains a unique and usually lifetime identification number and provides access to coverage under the Medical Care Plan.

Due to weaknesses in controls over beneficiary registration, the lack of security features contained in beneficiary cards, and weaknesses over monitoring claims paid, there could be a significant cost to the Province associated with the payment of ineligible claims. Specifically: