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- Policies and procedures relating to the home support programs for adults were incomplete and outdated.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

- Controls over the Medical Care Plan registration process require improvement in that the Department currently accepts photocopies of original documents which can be easily altered or falsified. In addition, information on applications processed relating to annual newborns is not validated with provincial vital statistics registries to ensure applicants are eligible to receive coverage under the Plan. For example, in 2002-03, 5,500 applications relating to newborns were processed without validation with provincial vital statistics registries.

- The beneficiary card requires improvements in that it only contains the beneficiary name and number, and does not provide adequate safeguards to identify the user in order to ensure that only eligible beneficiaries receive medical services. As well, the Province has never re-registered beneficiaries and the cards that were issued in 1969 when the Plan was introduced are still valid today. As a result, the Department cannot ensure that only eligible beneficiaries receive medical services.

- At December 2002, there were 81,350 more beneficiary numbers issued than there were residents in the Province. Although some of the difference may be accounted for by various factors including deceased card holders whose deaths have not been reported to the Department, and former residents who have left the Province, the Department does not have the information necessary to determine this. The Department cannot determine how much, if any, has been paid on behalf of ineligible beneficiaries.

- In 2003, $320,000 and in 2002, $318,000 was paid for out-of-province medical care services relating to terminated or invalid beneficiary numbers because the Department is required under reciprocal billing arrangements to pay for these medical services.

- At December 2002, there were 371,144 cards that had been designated as terminated in the Registration System and

which could be used in any other province or territory of Canada. This highlights the need for the Department to institute stronger controls over its cards by the use of expiry dates, unique identifiers and requiring periodic re-registration.

- The Department is not adequately investigating why payments are made for out-of-province medical services for individuals who are not eligible for coverage under the Province's Medical Care Plan. Although monthly reports are produced which are designed to determine beneficiary eligibility relating to out-of-province payments, at the time of our review in March 2003 the Department had only contacted beneficiaries listed in its May 2002 report and no work has been started on the monthly reports generated since that time.

2.22 Monitoring Health and Community Services Boards

There are four health and community services boards in the Province comprised of St. John's, Eastern, Central and Western Regions. Each of these boards has local offices throughout the Province. Health and Community Services in Northern Newfoundland and Labrador are administered as separate components of the Grenfell Regional Health Services Board and the Health Labrador Corporation, respectively.

As a part of our audit work, we continue to monitor the financial position and annual operating results of the four community services boards.

The combined financial position of the four health and community service boards at 31 March 2003 shows total unfunded liabilities of $23.7 million, a 158% increase from the $9.2 million reported in 1999-00. These net unfunded liabilities will eventually have to be funded by Government.

The St. John's Regional Health and Community Services Board had total unfunded liabilities of $10.2 million and accounts for 43% of the $23.7 million total reported for 2002-03. The St. John's Regional Health and Community Services Board's unfunded liabilities have