8 REVENUES AND RECOVERIES

BACKGROUND

8.1 Health care costs in Nova Scotia are the Provincial government's largest program expenditure. Medically necessary services provided to residents of Nova Scotia are insured under the Health Services and Insurance Act. Uninsured services are billed to the patient or third parties and, as such, generate revenue for the District Health Authorities (DHAs). Insured outpatient services to non-Nova Scotia residents are billed to the respective jurisdictions and provide revenue for the DHAs. Insured inpatient services provided to non-residents of Nova Scotia are billed to the respective Canadian jurisdictions and generate revenue for the Department of Health (DOH).

8.2 Revenues related to services that are uninsured or provided to non-residents should be sufficient to cover the costs. When fees are insufficient, these services are, in effect, subsidized at the expense of insured services.

8.3 The Revenue/Recovery Section within the Corporate Services Branch of DOH is responsible for the following recoveries and payments which are summarized in Exhibit 8.1:

- recovering the cost of hospital services provided to residents of other provinces from the province of residence according to Section 17 of the Health Services and Insurance Act (approximately $30.8 million for fiscal 2003-04);

- recovering hospital and medical costs when such costs are the result of a wrongful act or omission of another (third party liability claims) according to Section 18 of the Health Services and Insurance Act (motor vehicle levy of approximately $14 million and non motor vehicle claims of approximately $0.1 million for fiscal 2003-04); and

- payments to other jurisdictions when residents of Nova Scotia receive medical services within those jurisdictions (approximately $21 million for fiscal 2003-04).

8.4 The fees to be charged for hospital services provided to Canadian residents of other provinces are governed by interprovincial agreements.

8.5 The accounting for revenues varies depending on whether an inpatient or outpatient service was provided and whether the person is a resident of another Canadian province. Recoveries for inpatient hospital services provided to residents of other Canadian jurisdictions are recorded as recoveries of the DOH. All outpatient revenues are recorded by the District Health Authorities (DHAs) along with inpatient revenues from residents of other countries.

8.6 Each of the District Health Authorities (DHAs) records revenues from sources including:

- non-Canadian residents;
- uninsured (not medically necessary) services;
- services provided to individuals who are not insured through MSI (groups such as RCMP, Veterans, Armed Forces);
- preferred accommodation (semi-private/private rooms);
- long-term care per diem billings;
- Federal Government and Workers' Compensation Board for patients insured under those programs; and
- laboratory (e.g., water testing) and other support services.

8.7 Our audit excluded recoveries from services sold by one DHA to other DHAs (e.g. lab services). Exhibit 8.5 reflects revenue received by DHA by source as reported on the respective 2003-04 audited financial statements. It does not include revenues from the Provincial government. The total non-provincial government revenues recorded by the DHAs for 2003-04 amounted to $132.8 million.

8.8 We last conducted a broad scope audit of Health Revenue and Recoveries in 1995 (see chapter 12 of 1995 Report of the Auditor General). In 2000, we performed a government-wide audit of user fees which included a section relating to revenues/ recoveries at DOH (see chapter 3 of 2000 Report of the Auditor General).

RESULTS IN BRIEF

8.9 The following are the principal observations from this audit.

- Neither the Department nor the DHAs have *case costing* information to assess whether revenues and recoveries are adequate to cover the cost of services delivered.

- Due to delays in receipt of information from the DHAs and IWK, the Department has not been able to issue invoices to other provinces on a timely basis. The Department receives payments within a reasonable timeframe once billing to the other jurisdictions is completed. The Department also needs to ensure that it has proper documentation in the form of non-resident declaration forms to support all out-of-province billings in the event that the patient's eligibility for coverage is challenged by the paying province.

- Currently not all costs are included in the motor vehicle levy calculation. The Department of Health needs to develop a process to recover costs of the Insured Prescription Drug Program and inter-hospital ambulance transfers from third parties either through the levy or in some other way.

- The DHAs show accounts receivable of $42 million as at March 31, 2004. Of this amount, 37% had been outstanding for more than 90 days. This indicates a need for more focus on collection of accounts receivable.

- Our audit revealed significant variations in DHA billing rates. The Department should review DHA revenues and recovery rates for consistency across the system.

- There is inconsistency in recording and reporting of revenues and recoveries across the system. Revenues are sometimes netted against expenses rather than being specifically identified as revenues. The Department of Health is aware of the problem and has recently begun discussions with the DHAs with the objective of increasing consistency.

AUDIT SCOPE

8.10 The objectives of our audit at the Department of Health were to:

- determine whether the DOH has adequate systems and controls to provide for timely collection of revenues and recoveries relating to provision of insured services to non-residents and claims related to third party liability;

- determine whether the DOH is receiving sufficient information to assess whether revenues and recoveries are adequate to cover the cost of the services delivered;

- determine whether the DOH has adequate systems and controls to ensure that payments to other jurisdictions for insured medical services provided to Nova Scotia residents comply with legislation and policies; and

- follow up on findings from previous audits (1995 Revenue and Recoveries audit and 2000 User Fees audit)

8.11 In addition, we had several objectives related to District Health Authorities. The objectives of that section of the audit were to:

- determine whether the DOH has adequate policies and systems to monitor the fees charged by District Health Authorities for uninsured services and services provided to residents of other countries;

- determine whether the fees charged by DHAs for uninsured services and services provided to residents of other countries are reasonably consistent and compare the total amounts recorded by each DHA;

- determine the DHAs' policies for collection of accounts receivable relating to revenues and recoveries; and

- determine the policies which govern DHAs' accounting for revenue and recoveries and whether these amounts are recorded consistently on the DHAs' audited financial statements.

8.12 Our audit criteria were obtained from recognized sources including the Canadian Institute of Chartered Accountants' *Professional Engagement Manual*, various sections of the Health Services and Insurance Act, the Canada Health Act and the 2003 Nova Scotia Financial Measures Act.

8.13 Detailed on-site fieldwork was conducted through the summer of 2004. Fieldwork included detailed transaction testing, examination of policies and procedures, detailed review of systems descriptions, review of reports and other documents deemed to be relevant, and discussions with management and staff.

8.14 We also sent a written survey to each of the DHAs and the IWK to obtain information on a Province-wide basis related to accounts receivable and credit management policies, billing rates and policies, and any studies which compared costs of service delivery with the billing rates charged. In addition, we completed detailed audit work at the Capital District Health Authority as part of an audit reported on in chapter 6 of this Report. Testing of billing and credit management practices at the CDHA was performed to gain a more informed understanding of the processes in these areas.

PRINCIPAL FINDINGS

Recoveries from Other Provinces - Department of Health

8.15 Background and overall conclusion - Documentation and information supporting non-resident inpatient billings is forwarded from the various Provincial hospitals to the Revenue/Recovery Section at DOH. Staff review these billings for appropriate documentation and use of correct billing rates according to interprovincial agreements prior to delivering the billings to provincial counterparts across Canada. For calendar year 2003, approximately 5,200 non-resident inpatient billing transactions totaling $31.5 million were processed by the Section. Provincial practice is to bill the other jurisdiction within 30 days from receipt of information from the hospital. According to the interprovincial agreement the recipient jurisdictions have 30 days to approve and reimburse the billing jurisdiction.

8.16 Our audit of recoveries at the DOH consisted of a review of the key internal controls in the billing and collections systems and compliance with legislation, agreements and policies for Non-Resident In-Patient (NRIP) services. Sixty billing transactions were selected from 2003 calendar year data for testing of compliance, accuracy, validity, completeness, timeliness and authorization.

8.17 We concluded that the timeliness of billing to other jurisdictions needs to be improved. The target times for issues of billings is being exceeded. The Department receives payment on a timely basis once billing to the other jurisdictions is completed. The Department also needs to ensure that it has proper documentation in the form of non-resident declaration forms to support all out-of-province billings in case the patient's eligibility for coverage is challenged by the paying province.

8.18 Timeliness - Our testing identified problems with the timeliness of billing other jurisdictions for services provided to non-residents of Nova Scotia. The Provincial practice is to invoice other jurisdictions within 30 days following receipt of information from the hospital. For the sample transactions tested, the average time between discharge and billing was 133 days. The delay occurred as a result of the DHAs not submitting the billings to DOH on a timely basis. Once DOH receives the information, billings are forwarded to the other provinces in a timely fashion. Payments are required to be made within 30 days of billing. Our testing revealed that other provinces pay promptly, averaging 39 days from invoice date to receipt of payment.

8.19 We were informed by management that billing delays at the DHAs were complicated by problems in obtaining computer software updates during 2003. A decision was made at the national level to include expiry dates on health cards, as well as diagnostic and procedure codes on invoices. This required changes to the hospital and Department software which added complications. Initial deadlines for completion of software changes had to be extended by management and have recently been achieved. The backlog of incomplete billings at the hospital level is being reduced and billing is becoming more current, but not yet within the 30 days of discharge date policy.

8.20 The current billing cycle impacts negatively on the Province's cash flow. The policies have been designed to minimize the negative effects on cash flow and we encourage the Department to require the DHAs to comply with its policy of submitting billing information to DOH within 30 days of discharge.

Recommendation 8.1

We recommend that the DOH Revenue/Recovery Section require billings from the DHAs and IWK to be submitted to DOH within 30 days of discharge.

8.21 Documentation - The Inter-Provincial Agreement indicates that non-resident declaration forms are necessary so that Nova Scotia is not responsible for payment of the service if the home province refuses to accept responsibility. These forms indicate whether the non-resident patient is eligible for medical coverage in the respective province of residence. Our testing identified weaknesses in the hospitals' submission of non-resident patient declarations to the Department of Health. If challenged by other provinces, the Department of Health will request documentation from the hospital if it is not already on file. Without this form, there is a risk that revenue might be uncollectible. Our testing revealed that non-resident patient declarations were not received from the hospitals in 7 of the 60 sample items examined.

Recommendation 8.2

We recommend that the DOH Revenue/Recovery Section ensure that all non-resident patient declaration forms are obtained from hospitals at the time billing data is submitted to the Department.

8.22 Adjustments to interprovincial billings - Our testing of recoveries also included examination of a sample of adjustment transactions to determine whether adjustments were properly approved, granted in a timely manner, and granted for valid reasons based on adjustment reason codes. Our conclusion was positive; adjustments were undergoing a verification and authorization process in a timely manner.

Payments to Other Provinces - Department of Health

8.23 Background and overall conclusion - Documentation and information supporting hospital services provided to Nova Scotia residents in other Canadian jurisdictions is forwarded from other jurisdictions to the Revenue/Recovery Section at DOH. Staff review these billings for correct billing rates based on interprovincial agreements and verify Nova Scotia medical insurance coverage prior to payment. For calendar year 2003, there were approximately 2,700 out-of-province claims for inpatients ($18.5 million) and 30,300 claims ($3.9 million) for outpatients. According to interprovincial agreements, recipient jurisdictions have 30 days to approve the claims and reimburse the billing jurisdiction.

8.24 We concluded that the payments to other jurisdictions are occurring on a timely basis. Most other jurisdictions have encountered problems similar to Nova Scotia with respect to being able to provide invoices on a timely basis.

8.25 Computer system - Out-of-province outpatient claims are entered manually by staff into the mainframe computer system. Currently management is developing, in cooperation with New Brunswick, a process for exchange of electronic files to eliminate the time-consuming task of rekeying the data. We support this initiative and encourage extension of the initiative to all jurisdictions.

Recommendation 8.3

We recommend the Department of Health implement necessary changes to enable electronic exchange of reciprocal billing information with all jurisdictions.

8.26 Results of testing - Our examination of payments made to other jurisdictions for Nova Scotia residents receiving health services outside the Province focused on compliance with legislation, policies and key internal controls. A sample of 60 inpatient transactions and 60 outpatient transactions was selected to test for compliance, accuracy, validity, completeness, timeliness and authorization.

8.27 Results from our examination indicated that payment transactions comply with relevant legislation and policies and that key internal controls are functioning. Testing revealed that 25 of the 60 out-of-province inpatient items tested exceeded 100 days from discharge to invoice date. Payments are occurring on a timely basis. Of the 60 items examined, only 11 exceeded 10 days between the statement and payment date and no items exceeded 30 days.

8.28 Adjustments to interprovincial billings received - A review of two separate adjustments to out-of-province inpatient and outpatient transactions was also conducted to determine whether the Revenue/Recovery Section adhered to the standard request for adjustment process. Our testing revealed that standard processes were being followed, denied adjustments were followed up, and reasons provided for approval or denial of adjustments were adequate.

Are Fees Adequate to Cover Costs of Services?

8.29 Background and overall conclusion - The objective of this phase of the audit was to determine whether DOH is receiving sufficient information to assess whether revenues and recoveries are adequate to cover the cost of services delivered. Our examination involved discussions with management to determine whether:

- the rationale for the recovery rates selected was documented;
- a cost analysis was being completed periodically; and
- the full cost of each service provided could be determined.

8.30 Our examination revealed that the interprovincial billing rates for outpatient and high cost procedures are set nationally and that there is no documented rationale for the recovery rates selected. The Nova Scotia Department of Health has not determined the full cost of each service provided, and no cost analysis has been completed to ensure that recoveries are sufficient to cover the costs of providing these services. Nova Scotia does not have *case costing* systems to facilitate provision of cost information for services provided.

8.31 Inpatient rates - Inpatient services for most procedures are billed using the hospital's average per diem rate. As part of our examination of costs we reviewed the per diem rate schedule for Nova Scotia hospitals to insure that rates being used were approved rates for the service period. For fiscal 2003-04, these rates at the regional hospital level varied across the Province from a low of $650 to a high of $1,000, and $1,465 at the IWK. The per diem rates for Nova Scotia hospitals approved for 2003-04 were supplied by the Canadian Institute for Health Information (CIHI) and reviewed by the Inter-Provincial Working Group

Committee operating under the reciprocal billing agreement. These rates are adjusted annually for hospitals which submit cost data to CIHI.

8.32 High cost procedures - Rates for certain, specified high cost procedures are set nationally by an Inter-Provincial Working Group Committee. All provinces are expected to participate in reviewing these rates. Examples of high cost procedure rates are as follows:

- Heart transplant - $75,220
- Kidney transplant - $19,500

8.33 Prior to the most recent update on April 1, 2004, rates had remained constant since September 1, 1998. The recent update resulted in no change to the charge rate for high cost procedures.

8.34 Outpatient rates - Similarly, outpatient rates are also set nationally through the Inter-Provincial Working Group Committee. These rates were updated in April 2004. Prior rates had been established in September 1998. In these cases, generally the charge rate has increased. Management informed us that many jurisdictions, including Nova Scotia, were not capable of providing the costing data on outpatient services. As a result, the Working Group had to rely solely on information provided by Alberta, Ontario and British Columbia. Management indicated that Nova Scotia has no plans to start collecting this data in the future.

8.35 Management noted that the Inter-Provincial Working Committee is currently reviewing the various rates used for billing inpatients and outpatients. CIHI cost information, as supplied by the various jurisdictions, is being used to review the adequacy of recoveries versus costs. The process is in its initial stages and more work remains to be done before completion.

Recommendation 8.4

We recommend that the Department of Health work towards accumulating the necessary cost information to assess whether fees are adequate to cover the cost of services delivered.

Third Party Liability - Health Costs Related to Motor Vehicle Accidents

8.36 Background and overall conclusion - In 1992, amendments were made to the Health Services and Insurance Act to allow the Department of Health to recover an equitable amount of health care costs related to motor vehicle accidents through an annual levy on the insured vehicles in the Province. Financial and statistical models were developed by an independent actuarial firm engaged to calculate the levy amount. Actuarial reports were prepared in 1994 and 2001. Currently, the Superintendent of Insurance, through the Department of Environment and Labour, is responsible for the actual administration and collection of the $14 million from insurance companies based on the number of vehicles insured. The current levy

amounts to $25.89 per insured vehicle. The Superintendent's Office provides levy information reports and payments to DOH.

8.37 Our overall conclusion is that improvements can be made in the areas of verification of revenue to be collected and collection of levy receivables from the insurance companies. Additionally, the Department is not recovering all health care costs related to motor vehicle accidents.

8.38 Costs excluded from the levy - The Actuarial Report identified certain services which are not included in the calculation of the levy (e.g., Insured Prescription Drug Program and inter-hospital ambulance transfers) and data that may not reflect the true service cost (e.g., long-term care and other future costs). There is no requirement in the legislation for periodic review of the components of the levy.

Recommendation 8.5

We recommend that the Department of Health develop a process to recover costs currently excluded from the motor vehicle levy from third parties.

8.39 Billing of the motor vehicle levy - Our examination of the billing process revealed that the Superintendent of Insurance invoices the insurance companies on a quarterly basis and payment is expected within 60 days of the billing date. Furthermore, in a sample of 8 transactions tested, all but one of the items tested exceeded the allowable 60 day payment terms.

Recommendation 8.6

We recommend more stringent credit monitoring to ensure collection of the motor vehicle levy from the insurance companies within the 60 day policy, including consideration of charging interest on overdue amounts.

8.40 Verifying the number of vehicles - Our examination of the levy also revealed that the Superintendent of Insurance places full reliance on the Insurance Bureau of Canada (IBC) to calculate the number of vehicles used in levy calculations. There is no attempt to reconcile the number of vehicles registered with the Nova Scotia Registry of Motor Vehicles to the numbers reported by the IBC. Reconciling these independent data sources would provide assurance of the completeness and accuracy of the data provided by the insurance industry through the IBC. Because this information is used for invoicing, it is important that it be accurate.

Recommendation 8.7

We recommend that the Superintendent of Insurance develop a process for reconciling the number of vehicles reported by the IBC to the number of vehicles registered with the Nova Scotia Registry of Motor Vehicles to ensure motor vehicle levy invoices are based on accurate information.

Third Party Liability - Health Costs Related to Non-Motor Vehicle Accidents

8.41 In addition to third party liability recoveries through the motor vehicle levy, recent changes have also been made to the non-motor vehicle third party liability claims process. The recent change requires the injured party or their solicitor to file documentation with the Department. The purpose is to inform the Department of the nature and amount of the claim being filed against a third party, to include the Department's costs in the claim and to provide an affidavit outlining the settlement of the claim. This change was introduced through legislation to ensure that the Province was made aware of injury claims filed and would receive its appropriate share of all personal injury claims settlements. We did not complete any testing in this area due to the very small dollar amount over the past two fiscal years ($162,00 for 2002-03 and $91,000 for 2003-04).

Are DHAs' Fees Adequate to Cover Costs of Services?

8.42 Background and overall conclusion - The DHAs and IWK earn revenues from hospital services provided to out-of-country residents, uninsured (not medically necessary) services, and services provided to individuals not insured through MSI such as RCMP, Veterans, and Armed Forces. Revenue is also provided from the following items which are billed to users: preferred accommodation (semi-private/private rooms); long-term care per diem billings; laboratory and support services and other items. Exhibit 8.5, taken from the 2003-04 audited financial statements of the various DHAs and IWK, provides the dollar amounts involved.

8.43 We concluded that the rates charged by the DHAs are not consistent across the Province. Further, there has been minimal analysis of whether the fees charged are adequate to cover the costs.

8.44 Monitoring by DOH - In recent years, DOH has undergone structural changes as a result of changes to legislation. Each DHA is a separate entity with its own board and is responsible to operate at a break-even. DOH management indicated that the Department does not view its role as setting or monitoring rates charged by DHAs for uninsured services, rather the Department believes that DHAs should ensure the rates in use are sufficient to cover costs.

8.45 As a result of DOH's policy of allowing DHAs to set rates, there is a wide variation in the rates charged. We requested billing policies and rates for uninsured

services and the results are included in Exhibit 8.3. The fees charged for the items selected are not consistent among the DHAs. The following are examples of these inconsistencies.

- outpatient day surgery for non-insured Nova Scotia residents or residents of other provinces - $252 to $505 (depending on the location)
- outpatient day surgery for non-Canadian residents - $505 to $1,010
- inpatient rates for non-insured Nova Scotia residents - $412 to $1,173
- inpatient rates for residents of other provinces - $412 to $1,700
- inpatient rates for non-Canadian residents - $1,500 to $3,200

8.46 We believe that there should be consistency in the rates charged by the various DHAs for these services.

8.47 DHA policies - All DHAs have formal policies related to fees charged for uninsured services, services provided to uninsured residents of Nova Scotia and services provided to residents of other countries.

8.48 Adequacy of fees - We surveyed the various DHAs and IWK to ascertain whether any cost studies had been completed to determine if the fees charged were adequate in relation to cost of services provided. The responses were basically that none had been completed. South West Nova (DHA 2) had completed an assessment in 2002 because this topic had been raised at a regular monthly meeting of the Chief Executive Officers (CEOs) of the DHAs and IWK. The review was applicable to a limited number of services and did not include full costing. The result was shared among the CEOs, however, no further work has been completed. CDHA management indicated that it had completed reviews of fees charged by similar-size health organizations across Canada and noted CDHA fees are in the high end of the range of fees charged by those organizations.

8.49 It is important to note that the systems which accumulate cost information at the DHAs do not collect sufficient, appropriate information on the cost of individual services provided to permit DOH and the DHAs to assess adequacy of fees. The financial systems do not incorporate *case costing* and cannot accumulate costs on a case-by-case or procedure-by-procedure basis.

Recommendation 8.8

We recommend that the Department of Health review the rates charged by DHAs for the most common uninsured services and establish common rates which recover the costs of services provided.

Credit Management at DHAs

8.50 Background and overall conclusion - We surveyed the various DHAs and the IWK to obtain aged accounts receivable summaries at March 31, 2004 along with the credit management policies for the applicable organization.

8.51 According to the data provided, total accounts receivable as at March 31, 2004 amounted to $42 million. Approximately $15 million (37%) of these accounts receivable have been outstanding more than 90 days, $11 million or 73% of the $15 million is over 120 days. Exhibit 8.2 provides a more detailed analysis of the accounts receivable as reported. The large amount of overdue receivables indicates a need for more attention to the area of collections.

8.52 CDHA indicated that the majority of the overdue accounts are low risk and will eventually be collected from entities such as the Federal Government, reciprocal billings to other provinces and the Workers' Compensation Board. High risk overdue accounts include amounts due from non-Canadians and preferred accommodation and, in CDHA's case, 70% of those amounts are due from insurance companies. Slow collection is a problem for the DHAs and the ability to decrease the amount of overdue accounts will depend upon cooperation from the paying organizations.

8.53 Policies - All organizations have formal policies related to credit management with the exception of the IWK and the Cape Breton District Health Authority (DHA 8). The policies assign responsibility and define procedures for regular monitoring, including completion of monthly aged accounts receivable listings, criteria for past due account and payment demand correspondence, and criteria for follow-up by phone and placement with collection agencies. Bad debt write-off criteria and required approvals are also defined.

8.54 There is no requirement in the DHAs' or IWK policies for charging interest on overdue accounts. Delays in collection of accounts causes a slow down in cash flow and reduces cash balances which results in loss of earned interest on bank balances. Maximizing collections could contribute funds available for patient care.

Recommendation 8.9

We recommend that all DHAs have formal credit management policies and that the policies be complied with.

We also recommend that the DHAs make significant efforts to increase the timeliness of accounts receivable collection.

Accounting and Financial Statement Presentation

8.55 Overall conclusion - We concluded that there is inconsistency in recording and reporting of revenues and recoveries across the system. Certain DHAs follow the MIS Guidelines of the Canadian Institute for Health Information (CIHI) in this area while others do not. Revenues are sometimes netted against expenses rather than being specifically identified as revenues. The Department of Health is aware of the problem and has recently begun discussions with the DHAs with the objective of increasing consistency.

8.56 CIHI MIS Guidelines - DOH has instructed the DHAs to apply the CIHI MIS Guidelines for recording revenues and financial statement disclosure.

8.57 These guidelines require specific coding and grouping of accounts in the completion of the DHA financial statements. This facilitates comparison of data by CIHI in production of various hospital reports. When DOH implemented the national MIS Guidelines and the MIS information project, each DHA was required to re-map the coding of revenues and recoveries in the financial systems to conform.

8.58 Inconsistencies identified - DOH staff reconciles the MIS information with the audited financial statements on an annual basis. This process has identified inconsistencies in recording of revenues across the system. Certain DHAs follow the MIS Guidelines while others have netted or offset revenues and recoveries against expenses.

8.59 As shown in Exhibit 8.5, which is composed of data from the audited financial statements of the DHAs and IWK, there is inconsistency in the reporting of revenues in the financial statements of those entities. DOH and the DHAs/IWK have recently started discussions on how to resolve these inconsistencies and the need for standardized reporting.

Recommendation 8.10

We recommend that the Department continue with its efforts to achieve conformity with the MIS Guidelines in recording and standardized reporting of revenues and recoveries across the DHAs.

8.60 Follow up from prior audits - We followed up on the recommendations from our 1995 Report on Revenue and Recoveries and from our 2000 government-wide audit of User Fees for uninsured services. We discussed the status of the recommendations with management and reviewed relevant documentation. Exhibit 8.4 provides the detail on recommendations and the status of implementation.

CONCLUDING REMARKS

8.61 Overall, the Revenue/Recovery Section appears to have appropriate systems and controls in place and is in compliance with legislation and policies relative to billing and payment of hospital services. DOH, the DHAs and the IWK Health Centre need to work together to increase the efficiency of the billing process to ensure that the bills to other jurisdictions and third parties are issued on a timely basis.

8.62 Currently, it is impossible to determine whether the revenues related to most uninsured services or services delivered to uninsured residents are sufficient to cover associated costs. The systems which accumulate cost information at DOH and the DHAs do not collect sufficient, appropriate information on the cost of individual services provided to permit DOH and the DHAs to assess adequacy of fees. DOH and the DHAs should work towards collecting cost information to be used in assessing the adequacy of fees charged and develop more consistent rates for services across the health system.

8.63 The level of overdue accounts receivable requires much more attention by the DHAs. More stringent collection policies and development of target guidelines should be considered by the DHAs and IWK.

Exhibit 8.1

Reciprocal Billings and Third Party Recoveries - 2003-04

Program Recoveries	Amount ($ thousands)
Out-of-Province Recoveries	$ 30,802
Third Party Liability Recovery	$ 13,979
Out-of-Province Hospital Payments	$ (21,303)
Total	**$ 23,478**

Exhibit 8.2

District Health Authorites - Aged Accounts Receivable as at March 31, 2004

	Total	Current	Over 30 days	Over 60 days	Over 90 days
			($ thousands)		
Capital	$ 22,047 100.0%	$ 13,067 59.3%	$ 2,406 10.9%	$ 944 4.3%	$ 5,630 25.5%
Cape Breton	$ 10,028 100.0%	$ 2,226 22.2%	$ 283 2.8%	$ 1,345 13.4%	$ 6,174 61.6%
IWK	$ 3,125 100.0%	$ 2,385 76.3%	$ 231 7.4%	$ 80 2.6%	$ 429 13.7%
Other	$ 7,098 100.0%	$ 2,909 41.0%	$ 776 10.9%	$ 203 2.9%	$ 3,210 45.2%
Total	**$ 42,298** **100.0%**	**$ 20,587** **48.7%**	**$ 3,696** **8.7%**	**$ 2,572** **6.1%**	**$ 15,443** **36.5%**

District Health Authorites - Summary of Fees Charged for Selected Medical Services

Exhibit 8.3

	Nova Scotia Resident - Not Insured		Other Province Resident - Not Insured		Non-Canadian	
	High $	Low $	High $	Low $	High $	Low $
Emergency/outpatient visit	140	50	140	50	363	110
In-patient - one night stay at a regional hospital	1,173	412	1,700	412	3,200	1,500
Out-patient - Day Surgery - basic	505	252	715	252	1,010	505
Cosmetic Surgery ("In-patient")	700	412	1,700	412	1,815	1,700
Cosmetic Surgery ("Out-patient")	400	252	715	252	715	505
Diagnostic - Radiology Procedure						
Chest, single view	140	18	140	18	280	48
CT Head, combined	1,188	252	1,386	252	1,452	504
Laboratory procedure						
Water test (routine)	20	13	20	13	20	20

Exhibit 8.4

Status of Recommendations from 1995 Audit - Health Revenue and Recoveries

Ref	Recommendation	Status
12.16	Timeliness of payment from other jurisdictions needs improvement. Timeliness of billings to other jurisdictions needs improvement.	Payments from other jurisdictions are generally within the 30 day terms of the Inter-Provincial Agreements. Billings from the Department are with the 30 day policy once the information is received from the DHAs and the IWK.
12.23	The Department may open a file then close it soon after because the amount to be recovered is minimal or the injured party is not filing a claim. We recommend these claims be pursued if the potential benefit exceeds the estimated cost to the Province of pursuing the claims.	Changes have been made, legislation now requires the injured party or their solicitor to file documentation with the Department informing them of the nature and amount of the claim, to include the Department's costs in the claim and provide an affidavit outlining the settlement of the claim.
12.24	For opened claims, the Department determines the in-patient hospital and professional service costs incurred in treating the injured party and submits this on a Statement of Claim to the liable party's insurer. The Department does not recover the costs of amounts under the Insured Prescription Drug Plan or ambulance services although these are allowable under the Act. These costs are not pursued because there is no adequate reporting system. We recommended that all allowable costs under the Act be pursued. We also recommended improvements in internal control procedures relating to the calculation of claimed amounts.	Ambulance costs are now included in the levy calculation.
12.29	The Department is planning to develop a system to track actual costs incurred as a result of motor vehicle accidents which will eliminate reliance on estimating and projecting cost data. We urge the Department to proceed with development of this system because information on actual costs is necessary to evaluate the adequacy of the levy.	Recommendation not acted upon

Status of Recommendations from 2000 Audit - Health User Fees

Ref	Recommendation	Response
3.47	The Department does not monitor the practices which organizations use to establish, levy and collect user fees. During the annual budget review process, the Department monitors the reasonableness of anticipated user fee revenues, using 1995 revenues as a benchmark. We have recommended the Department take a more active role in ensuring that user fee policies and practices of health care facilities are reasonable, efficient and economic.	Recommendation not acted upon.

Exhibit 8.5

Summary of Revenue by DHA and IWK – Excluding Revenue from the Province of Nova Scotia ($ Millions)

As at March 31, 2004	District Health Authority (DHA)										
	Total	1	2	3	4	5	6	7	8	9	IWK
	$	$	$	$	$	$	$	$	$	$	$
Federal Government/Veterans Affairs Canada	17.0	2.1	1.4	2.0	0.5		1.7			9.3	
Patient (inpatient, outpatient and clinics)	25.2	1.6	1.2	2.1	1.2	1.1	1.1	1.9	13.6		1.4
Physician funding	4.5	2.5	2.0								
Program Recoveries	11.4	3.0	4.1	4.3							
Other/Miscellaneous	13.7	0.6	0.8	0.3		0.1	0.2	0.1	1.2	10.4	
Charges to MSI	16.2				3.3	1.6	2.7	2.8	5.8		
Rental income, recoveries and sales	6.6				0.3		0.3	0.1			5.9
Foundations and auxiliaries/Canadian Breast Cancer Foundation	0.3				0.1						0.2
Investment income	0.3				0.1	0.1	0.1				
Food services/Cafeteria income/Dietary recoveries	7.6				0.1	0.2		0.5	1.4	5.4	
Laboratory and support services	5.6				0.1		0.1			5.4	
Long-term care	1.2					1.2					
Laundry recoveries	0.2							0.2			
Preferred accommodations/Net differential	10.9								1.8	7.1	2.0
Non-resident billings	8.5									8.5	
Workers' Compensation Board	3.6									3.6	
	132.8	9.8	9.5	8.7	5.7	4.3	6.2	5.6	23.8	49.7	9.5

Legend – District Health Authority (DHA):

1 – South Shore
2 – South West Nova
3 – Annapolis Valley
4 – Colchester East Hants
5 – Cumberland
6 – Pictou County
7 – Guysborough Antigonish Strait
8 – Cape Breton
9 – Capital
IWK – IWK Health Centre