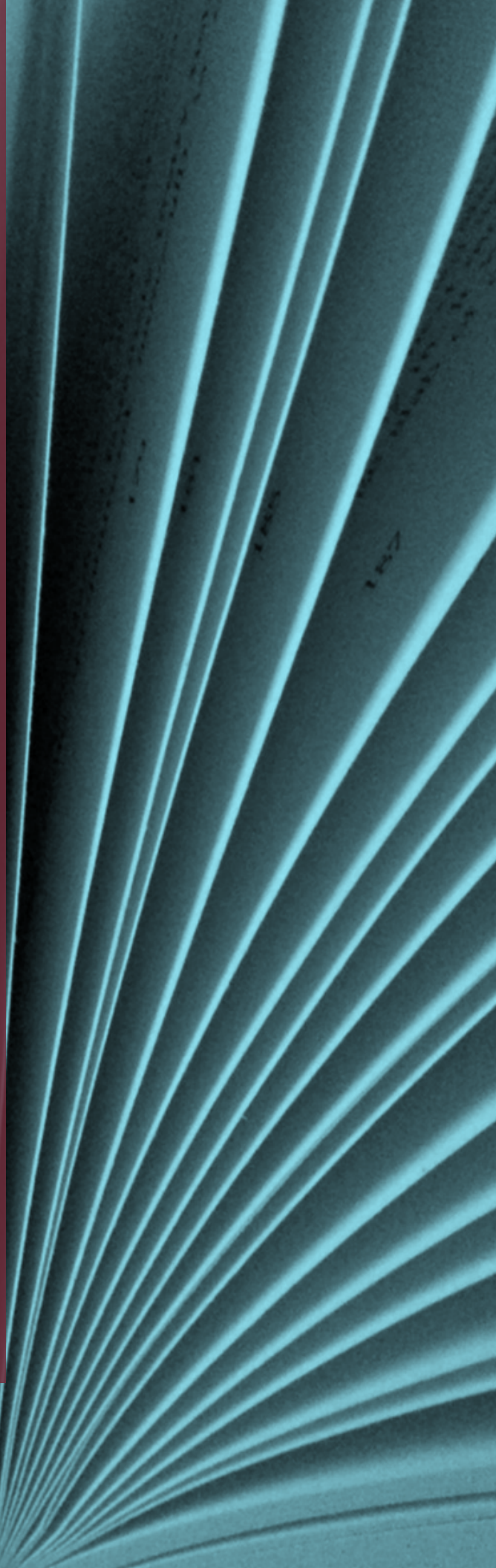
PROGRAMS ADRIFT

Complaints to the Ombudsman Reveal Systemic Issues

Alberta Adult/Child Health Benefit Programs

Own Motion Investigation Full Report



ALBERTA OMBUDSMAN

JULY 17, 2024

Table of Contents

1. Executive Summary

On February 16, 2022, former Ombudsman, Marianne Ryan, opened an investigation into systemic issues at the Alberta Adult Health Benefit program (the **family program**) with two ministries – Alberta Health and Community and Social Services (renamed to Seniors, Community and Social Services in October 2022). The Ombudsman decided to investigate systemic concerns brought to our attention after receiving several complaints about delays in issuing eligibility decisions, staff providing incorrect information and providing poor customer service, and multiple complaints about the family program losing clients' applications and other documentation.

The three questions we sought to answer were:

1. Are the procedures for processing applications for the family program administratively fair?
2. Does the family program communicate with applicants and clients in an administratively fair manner?
3. Does the family program have an administratively fair process for addressing service complaints raised by clients and applicants of the program?

Senior management assigned a team of five investigators and a manager to complete this investigation. The team met with staff on-site at the program offices, conducted multiple interviews with staff from three different ministries, and reviewed hundreds of internal documents and communications from both Alberta Health and Seniors, Community and Social Services (SCSS). On December 22, 2022, we expanded the investigation to include the sister program to the family program, the Alberta Child Health Benefit program (the **child program**). Together, we refer to them as "the **programs**."

From the start, this investigation unfolded in unexpected ways. From our first interaction to almost our final interviews with the programs' staff, we learned of more administrative problems. So, we issued two different reports to the authorities as preliminary findings – one on October 24, 2022, and a second on April 14, 2023.

The investigation concluded that the procedures for processing applications, the way the programs communicate with applicants and clients, and the programs' internal complaints processes are not administratively fair. We also found that the technology used to operate the programs does not function properly and there is a significant lack of accountability for the effective operation of the programs.

In all, we made 28 findings, resulting in 28 recommendations and five observations by the Ombudsman to SCSS and Alberta Health.

2. A Complaint to the Ombudsman

On July 15, 2021, the Alberta Ombudsman's office received a complaint from Ahmed[1] about the adult program. Ahmed had applied for benefits for his family three times (October 2020, April 2021, and May 2021), and had not received a decision for any of his applications. He said, his two children, and both he and his wife, have serious health issues. The household had over $5,500 in ongoing prescription expenses each year. Ahmed said without help, they cannot afford to live.

When he phoned the Health Benefit Contact Centre at the end of June 2021, a supervisor told him they had sent him a letter requesting more information. Ahmed told the supervisor he had not received anything in the mail. The supervisor told him to take the problem up with Canada Post. The supervisor then explained the program was waiting for Ahmed to send in proof of ongoing medical expenses. Ahmed told the supervisor he had submitted the required medical expenses three times, by fax, as requested by the program. The supervisor told him to send them in again. Instead, Ahmed wrote to the Ombudsman.

In his complaint to us, he was afraid the program was discriminating against him because of his name. He also complained that:

- the program unjustly refused to provide him with health benefits.
- Alberta Health had not informed him of the status of his October 2020, April 2021 or May 2021 applications.
- the way the supervisor spoke to him was disrespectful.

The investigator on Ahmed's case contacted Alberta Health to try to get a response and find an early resolution to his complaint. The investigator confirmed the program had not received the necessary medical expenses, but staff promised that if Ahmed sent them in again, they would expedite a review of his file and issue a decision. They gave the investigator an email address for this submission. Ahmed agreed to re-submit the medical expenses, emailing them on July 29, 2021.

Ahmed was approved for benefits on July 29, 2021; however, the program did not tell him. By August 10, 2021, Ahmed contacted us again. He was frantic as he had heard nothing about his eligibility for benefits. The investigator contacted Alberta Health and asked if someone would call Ahmed to notify him of the outcome of his application. They agreed.

The program mailed Ahmed an approval letter and benefit cards which he received August 12, 2021. The fact he received the letter was further proof to Ahmed that the program had never previously mailed him anything.

After finally learning he was approved, Ahmed cried and expressed his gratitude for our help. Over the previous months he had no choice but to borrow money from his family in Egypt to help pay for an eye exam for his son, who has a visual impairment, and to buy

[1] Names have been changed throughout this report to protect the individuals' privacy.

diabetic supplies. He said, he could now die because he knows his wife and children are taken care of.

The investigator identified several concerns over the course of this investigation:

- The program does not keep a record of correspondence sent to clients. So, it cannot be sure it sent a letter.
- There is no clear complaint process to resolve concerns about how program staff communicate with clients.
- The only way to submit information to the program is through fax or regular mail. Faxing is not reliable, as Ahmed had two fax confirmation sheets, yet the program said it did not receive his submissions.
- It was unclear how the program manages files and what records it keeps on client files.

At the end of our involvement with Ahmed, when we explained that two ministries are responsible for the program, Alberta Health and SCSS, he shared an Egyptian saying: "A boat with two captains will sink."

3. The Scope of our Investigation

3.1. Issues for Investigation

The Ombudsman sent opening correspondence to the Deputy Ministers of Alberta Health and Community and Social Services on February 16, 2022. The issues for investigation were:

In December 2022, we expanded the investigation to also include the child program.

The investigation focused on how SCSS's Common Service Delivery branch (**CSD**) processes family program applications, how the programs communicate with applicants and clients, and how the programs resolve service complaints.

3.2. Links to Administrative Fairness

These issues are linked to our eight administrative fairness guidelines as follows:

1. **Chain of Legislative Authority**

   The powers of government ministries come from the law. Where legislation has granted a decision-maker the power to make decisions, those decisions must be made in accordance with the legislation, regulation, and policy. If policy is lacking or unclear, then decisions may be inconsistent with the legislation or made in an arbitrary manner. The Ombudsman expects decision-makers to have clear policies that guide the decision-making processes.

   In this case, the Ombudsman expects to see clear policies for the processing of the programs' applications aligned with the relevant law. He also expects the programs to have policy or guidelines for its internal service complaints process.

2. **Duty of Fairness**

   Decisions made by administrative bodies often have an immediate and profound impact on people's lives. Flowing from these decisions is a duty to act fairly and to make procedurally fair decisions. The Ombudsman expects people to be informed of their right to appeal or ask for further review of a decision.

   In this case, the Ombudsman expects applicants and clients to be notified of their right to appeal decisions on their benefits in writing. He would also expect people to be able to ask for a review of how their service complaints were handled.

3. **Participation Rights**

   People have the right to participate in the decision-making process, presenting their case to the decision-maker and to know the case against them. The Ombudsman expects the decision-maker will ensure a person has sufficient time to respond when requesting information. A decision-maker should also ensure there is a valid process for everyone to submit information.

   In this case, the Ombudsman expects the programs to have an accessible and secure way for all people to submit information to the programs, to give a clear explanation about what information is missing from a submission, and to share what evidence was used when approving or denying benefits.

4. **Adequate Reasons**

   There must be a rational connection between the evidence considered and the conclusions reached by the decision-maker. The Ombudsman expects the decision-maker to explain the evidence and arguments they considered in arriving

at their conclusions. Decision-makers should also be able to explain why they rejected certain evidence.

In this case, the Ombudsman expects the programs to provide adequate reasons in their decision letters to explain why the decision-maker denied a request or benefit.

5. Apprehension of Bias

Decision-makers must show impartiality and independence when making decisions. The Ombudsman expects decision-makers be careful to avoid a perception or appearance of bias by declaring any potential conflict or referring the review of a decision to a party not involved in the original decision.

In this case, the Ombudsman expects all benefit decisions to be made by an impartial and independent decision-maker. He also expects the programs to have a level of review for service complaints to an impartial and independent decision-maker.

6. Legitimate Expectations

There is a legitimate expectation that decision-makers will follow their regular practices and procedures when making a decision. The Ombudsman expects decision-makers to follow their advertised processes, keep promises made to people, issue consistent instructions and information, and fully inform people about all the criteria pertaining to a program or service.

In this case, when a person applies for a benefit, the Ombudsman expects the programs will assess the application and issue a decision promptly, based on the published criteria.

7. Exercising Discretionary Powers

Discretionary decision-making can be established in law or through policies. Decisions must be made honestly and only within the scope of the discretionary power granted to the decision-maker.

In this case, the Ombudsman expects that if law or policy allows for discretion, the programs exercise that discretionary power. Where discretion is applied, the decision-maker must comply with legal requirements.

8. Is the Decision Reasonable?

Decision-makers must reach their conclusion based on the arguments and evidence before them. A reasonable decision shows how the decision-maker considered and assessed the arguments and evidence.

In this case, the Ombudsman expects all program decisions will clearly explain how the decision-maker assessed the evidence and arguments put forward by people.

3.3. Our Process

Our investigative process included the following steps. We:

- Reviewed, analyzed, and summarized all relevant complaints received by our office;
- Conducted a jurisdictional scan of other provincial and territorial health benefit programs throughout the country;
- Gathered information from Alberta Health and SCSS;
- Interviewed staff from Alberta Health, CSD, and Technology and Innovation;
- Collected and analyzed all the template letters the programs use to communicate with applicants and clients;
- Conducted an on-site file review;
- Reviewed the legislation, regulation, and program policy and procedures;
- Assessed all internal Ministry communications related to the programs, including documents on Action Request Tracking System (ARTS); and
- Completed a final site visit with key program staff.

4. Overview of the AAHB and ACHB Program

4.1. The Roles of the Ministries

Alberta Health and SCSS share responsibility for the programs.

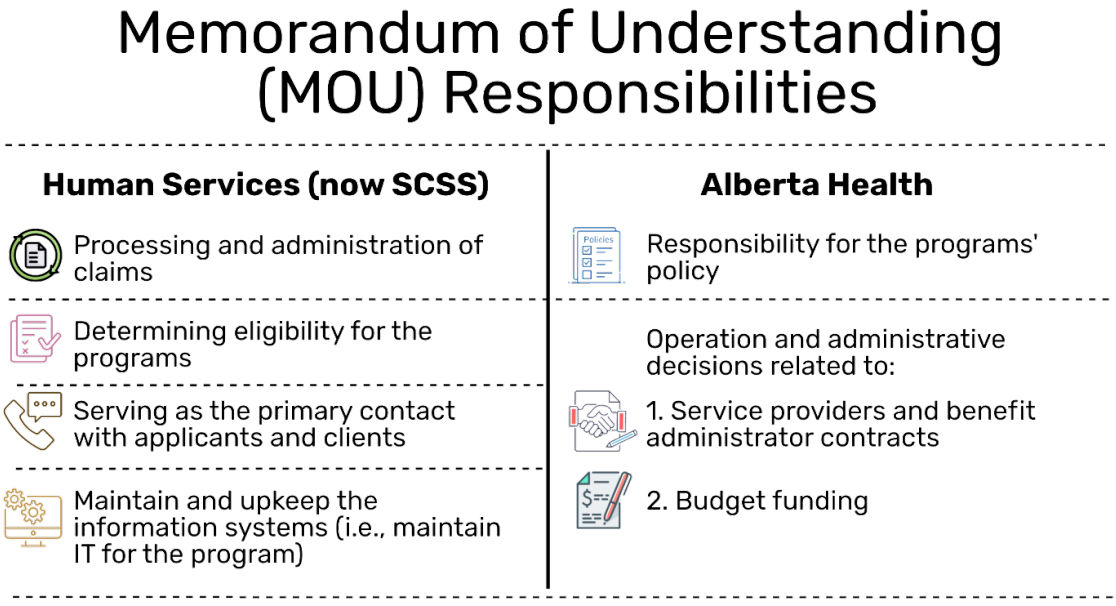
The Memorandum of Understanding (**MOU**) and the Shared Services Agreement (**SSA**), both effective April 1, 2014, explain the roles and responsibilities of each Ministry. When these documents were signed, SCSS was known as Human Services.

4.1.1 Memorandum of Understanding

Responsibilities

According to the MOU, financial accountability, and administrative responsibilities for the health benefits of seven key programs, were transferred from Human Services to Alberta Health on April 1, 2014.

A summary of SCSS and Alberta Health's responsibilities under the MOU can be found on the next page:



Information Technology

Section 4.4 of the MOU says Human Services will continue to provide service support including "case workers, call centers, client support, and other client interaction services, **financial and information technology system supports**, [emphasis added] program administration, and other services as outlined in the Shared Services Agreement."

This implies that Human Services, now SCSS, is responsible for the technology used by the programs and possibly for paying for those systems. However, the MOU also says that Alberta Health is responsible for budget funding. The difficulties caused by this confusion will become more evident when we discuss our findings about needed improvements to the programs' technology.

In our final questions to both ministries, we asked CSD and Alberta Health to tell us who is responsible for funding improvements to the technology. CSD pointed out that Technology and Innovation is responsible for funding improvements and updates to the technology systems used to run the programs. Technology and Innovation said they understood it was Alberta Health's responsibility to fund upgrades to the technology. In contrast, Alberta Health told us that maintaining AHB Production[2] is the responsibility of SCSS, with significant improvements to AHB Production to be determined by both ministries. However, Alberta Health also says their ministry paid for the Distributed Imaging system (DIMG), a new workflow tracking system that Service Alberta also provides funding for ongoing maintenance.

These responses offered no clear alignment on who is responsible to fund technology improvements.

[2] Alberta Health Benefit Production (AHB Production) is an information system used by the programs as a primary database for all client files. It is the main computer system, about 30 years old.

4.1.2 Shared Services Agreement

Purpose of the Agreement

The SSA between the Ministries of Alberta Health and Alberta Human Services sets out how the two ministries will share "common responsibility… for the operations of the drug and supplementary health benefit programs" which were transferred from Human Services to Alberta Health on April 1, 2014.

The purpose of the SSA is to ensure a seamless transfer of responsibility for the health benefits provided to clients in the programs, "with little or no impact on existing clients of these programs." The SSA expired three years ago. Both ministries identify the need to update the SSA. When we asked about this, CSD reported the SSA remains in effect until either party gives notice to discontinue. They say they will work on the SSA after the MOU is updated.

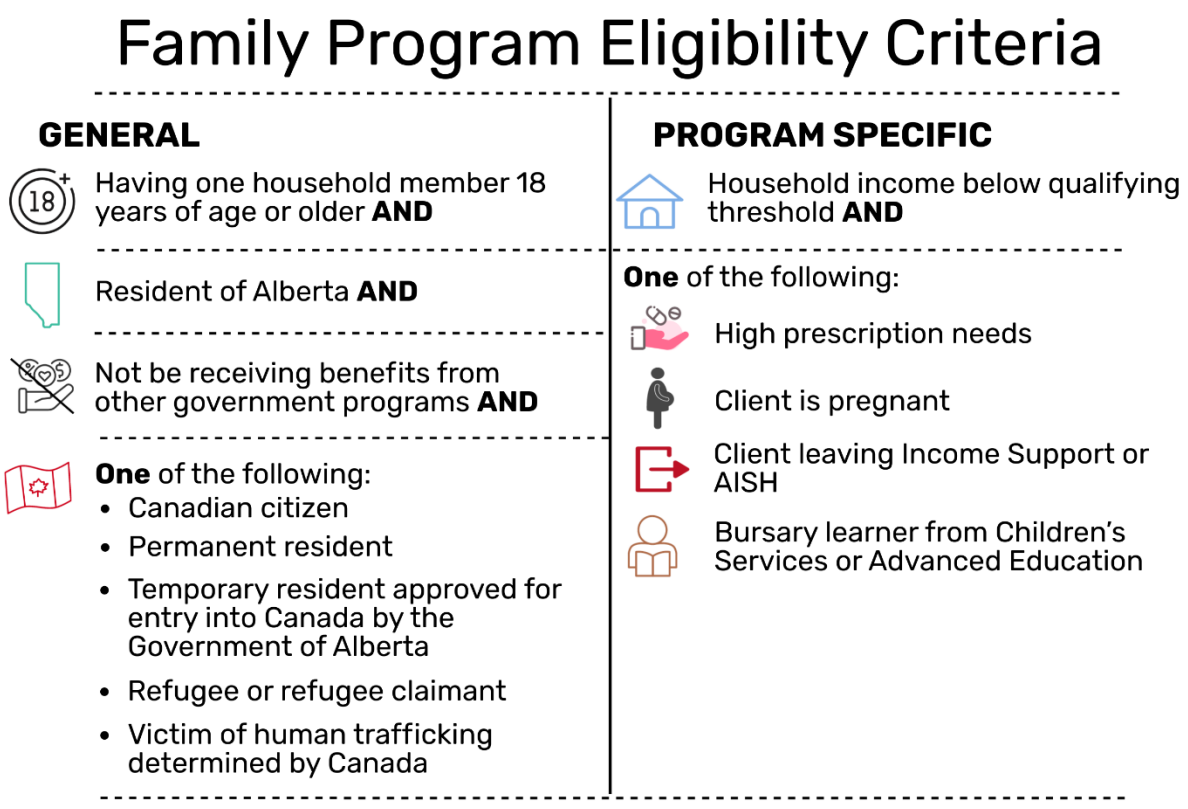
4.2. The Family Program

CSD is responsible for processing applications for the family program and communicating with applicants and clients. The Health Benefit Contact Centre (HBCC), embedded in CSD, is the primary contact centre for members of the public and clients of the program. Staff who work at the CSD and process applications are called **assessors**.

The family program is an extension of health benefits offered through two other government programs, Income Support and Assured Income for the Severely Handicapped (AISH). The government's website has information about the purpose of the program, the eligibility criteria, the benefits, income thresholds, and how to apply. The website also explains what happens if you are approved for benefits, the requirement for clients to keep the program informed of changes in family status, and how dependents who are turning 18 or 19 can remain active on the account. Finally, the website explains what people can do if their application is not approved.

Clients leaving Income Support and AISH due to excess income may qualify for the family program. It is also provided to other households that meet the program criteria explained below. Generally, the family program covers the whole household (adults and their minor dependents). The family program treats children 18 or older who are not in school to be separate from their parents' household, and not eligible for benefits under their parents' coverage. These young people can apply for the family program on their own.

To qualify for the family program, the applicant needs to meet one or more of the following criteria:



An application form for the family program is available on the website. We found applicants had to print and complete the form and then mail it in through regular mail or fax it to the CSD. There was no option to email an application form, to apply online, or to apply by phone.

Benefits of the family program include basic dental care, eye exams and glasses, prescription drugs, ambulance services, essential over-the-counter medications, and diabetic supplies. Payment for benefits is made directly to service providers – pharmacies, dental offices, optical, and ambulance services in Alberta.

4.2.1 Qualifying Income

The family program eligibility is income based. Established in 2015, the Health Benefits: Qualifying Income Levels, Section 87, 88, 89 and 90 ministerial order (MO 1/2015) sets out the maximum qualifying income for the program:

Household/Family Type	Maximum Qualifying Income
Single Individual	$16,580
Single Parent with one Child	$26,023
Single Parent with two Children	$31,0101
Single Parent with three Children	$36,325
Single Parent with four Children*	$41,957
Couple with no Children	$23,212
Couple with one Child	$31,237
Couple with two Children	$36,634
Couple with three Children	$41,594
Couple with four Children*	$46,932

*For each additional Child add $4,973

Applicants' income is verified through the Canada Revenue Agency (**CRA**), so all adults in the household must submit their tax return each year. When the CSD receives an application, it sends a request to CRA for proof of income. The applicant can also submit a copy of their Notice of Assessment (**NOA**) for the most recent tax year.

Families can qualify for the family program if their combined household income, minus the cost of ongoing prescription drugs and diabetic supplies, is equal to or less than the qualifying income for their family type.

4.2.2 Impact on Albertans

As of January 26, 2023, CSD told us that a total of 57,187 eligible Albertans were receiving family program benefits. This included 22,843 heads of households, 26,177 dependants, and 8,167 spouses. In a follow-up correspondence, SCSS reported that by May 31, 2023, 72,907 eligible Albertans were receiving family program benefits. This included 30,981 applicants, 30,482 dependents, and 11,444 spouses. This is an increase of 27.5% in four months.

For the fiscal year 2022-23, SCSS said the family program received 15,581 applications and estimated it declined benefits to 7,277 households at the 2022 renewal period.

4.3. The Child Program

For families with low-income and no ongoing prescription drugs and diabetic supply costs, the children may be eligible for health benefits apart from their parents. For example, if a household of two adults and two children has no ongoing prescription drugs and diabetic supply needs, but the combined household income is under the threshold, the children are eligible for benefits under the child program.

The child program provides the same benefits as the family program—but only for the children up to age 18.

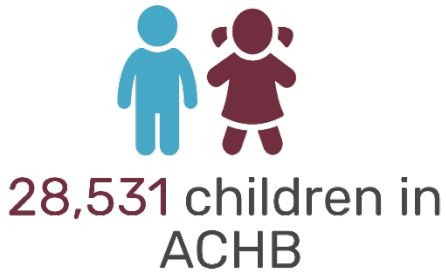
Once children are 18, they are removed from the child program. But they can then apply for the family program.

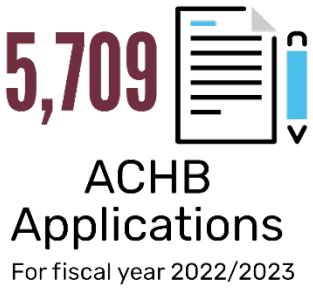
The same income guidelines apply to the child program as the family program.

4.3.1 Impact on Alberta Children

SCSS told us that as of May 31, 2023, there were 28,531 eligible dependents receiving ACHB benefits.

For the fiscal year 2022-23, they said the child program received 5,709 applications.





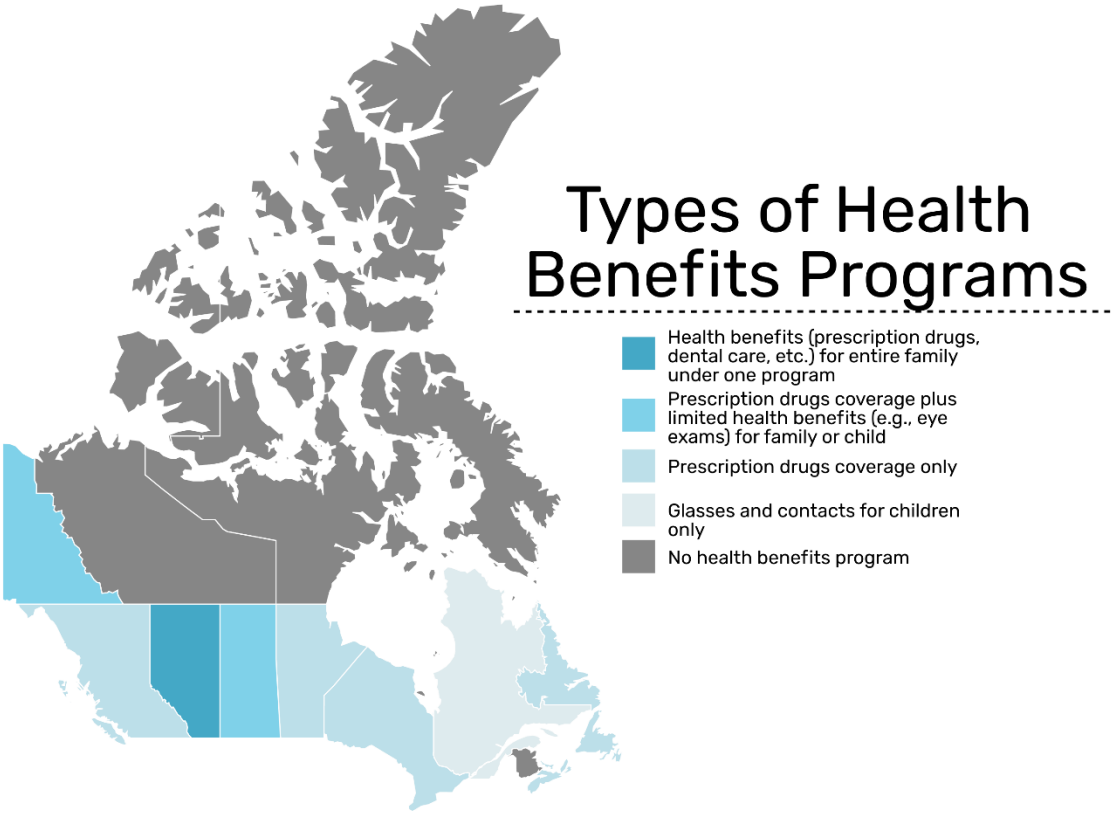
4.4. Jurisdictional Scan

We completed a jurisdictional scan to examine how other provinces and territories provide financial benefits for residents' health needs. We looked at the types of benefits each jurisdiction provides, the eligibility criteria for those benefits, the application process, and the complaints process.

We focused on provincial or territorial programs which:

- Provide a health benefit to people who are not receiving income assistance; and
- At a minimum, provide coverage for prescription drugs.

We learned the programs in Alberta are unique and generous. They provide benefits for the entire family for various supplemental health needs (prescription drugs, dental care, optical care, diabetic supplies, and ambulance) all under one program. This is significant support compared to other programs across Canada.



Aside from Saskatchewan's Family Health Benefits Program and the Yukon's Children's Drug and Optical Program, most other jurisdictions cover only prescription drugs. Saskatchewan's Family Health Benefits Program includes coverage for emergency ambulance services, eye exams and glasses, dental care, and prescriptions drugs. The Yukon's Children's Drug and Optical Program provides coverage for eye exams, glasses, and prescription drugs.

Some provinces and territories have other separate programs which cover other health expenses. For example, Quebec's See Better to Succeed Program provides only glasses and contacts for children.

Alberta's family program provides the same coverage irrespective of age. In contrast, the health items covered under Saskatchewan's Family Health Benefits Program depend on whether a person is an adult or child. For example, adults receive coverage for prescription drugs and eye exams, while children receive coverage for these items plus dental care, glasses, and emergency ambulance services.

There were notable differences in eligibility and the amount of assistance the different programs provided. One of the main differences was whether programs provided financial assistance to families (adults and children), adults only, or children only. Some programs require coverage from other health benefits plans to be used first (as do Alberta's family and child programs). Others provide full coverage without requiring other health benefit plans to be used first; and some programs only cover part of the cost.

The application process in each jurisdiction typically allows submissions online, by fax, email, or phone.

Yearly renewal processes also differed. In some jurisdictions, clients were assessed for eligibility the following program year by the program and were notified by the program as to their eligibility (like the family and child programs). In other jurisdictions, clients had to re-apply each year.

Most of the jurisdictions provided little information about service complaint processes. For most programs, it was unclear how applicants and clients can raise concerns about the programs.

4.5. Review of the Legislation

The programs are offered under the *Income and Employment Supports Act* (the Act) and the *Income Support, Training and Health Benefits Regulation* (the Regulation).

We completed a full legislative review of the Act and Regulation. Our review did not identify any concerns with the Director's legislative authority to provide health benefits for eligible children or adults, or in determining eligibility.

4.5.1 Income Support, Training and Health Benefits Regulation

Appeals

Any decision to deny a person's benefits under the programs can be appealed to the Citizen's Appeal Panel, as set out in section 43(1) of the Act. It reads:

> 43(1) Any decision of the Director
>
> (a) relating to eligibility or continuing eligibility for, or the amount or value of, assistance under Part 2,
>
> (b) relating to an amount repayable under section 35, or
>
> (c) relating to any other matter provided for in the regulations,
>
> other than a decision referred to in section 44, may be appealed to an appeal panel.

We interpret this section to mean that any decision CSD makes denying or terminating benefits under the programs can be appealed, except those matters referred to in section 44.

Section 44 of the Act reads:

> 44 No appeal lies to an appeal panel with respect to the following matters:
>
> (a) a decision with respect to assistance under Part 2, Division 1 that does not affect eligibility for or the amount or value of assistance;
>
> (b) a decision under Part 5;
>
> (c) a variation, refusal or cancellation of assistance under Part 2 caused by an amendment to this Act or the regulations;
>
> (d) any other matter exempted from appeal by the regulations.

We reviewed the legislation and clarified when people should be able to appeal a program decision and when they cannot appeal. Only 44(d) above applies to health benefits. This means we must look to the Regulation to see what matters are exempt from an appeal.

Section 97 of the Regulation identifies only two exemptions to an appeal for health benefits. These are:

1. A decision of the health benefit exception committee; and
2. What service constitutes a "health benefit" under section 73 of the Regulation.

Goods and services provided as health benefits are defined as decisions of the Minister. We interpret this to mean an appeal panel cannot overturn a decision about the type of health benefits provided under the Regulation.

Whenever the programs issue a decision letter denying a benefit, including a request for reimbursement or backdating, or stop issuing the benefit, we conclude they must inform the applicant or client of their right to appeal the decision.

In our interviews with CSD staff (see section 5.1), and through our review of the template letters the programs use with applicants and clients, we learned that most of the decisions issued by the programs do not properly inform people of their right to appeal. CSD staff told investigators the only decision they issue that should mention a right to appeal is a denial of benefits after a reassessment.

Our team provided specific feedback to SCSS about their template letters and, specifically, notifying applicants and clients of their right to appeal, on April 14, 2023. The decision to provide this feedback before issuing this final investigation report was a matter of timing. The programs had planned to update the template letters before the annual renewal period, and we wanted to give them adequate time to make the necessary edits.

More details about our suggestions to improve the template letters are discussed in section 7.1.2.

4.6. Family and Child Programs Policy

The AAHB Policy (the policy) is available online and is part of the Alberta Works Policy Manual.

4.6.1 Family Program Policy

Intent, Benefits and Duration

The intent of the family program is to support low-income Albertans, so they have access to various health benefits.

Initial eligibility

Clients leaving Income Support or AISH programs roll over into the family benefit after they leave their original program. The initial eligibility section of the policy states that other Albertans may be eligible for the family program but can be enrolled only by assessors at the HBCC. These include pregnant women, households with ongoing prescription drugs and diabetic supplies, special learner students, and refugees.

Benefits start the day after the household is approved.

High Drug Costs Definition

To be considered as an ongoing high drug cost, the drugs must be:

- Listed on the Alberta Health and Wellness Drug Benefit List, or Community and Social Services Drug Benefit Supplement, or approved by the Health Benefit Exception Committee.
- Dispensed at least three times in the last year (substantiated by a pharmacy) or confirmed by the prescriber that it is a new prescription and will be ongoing.

4.6.2 Child Program Policy

The ACHB policy or child program policy is also available online and is part of the Alberta Works Policy Manual.

Intent and Coverage

The intent of the child program is to support children of low-income families with access to health benefits that contribute to health and well-being, including improving school performance.

Coverage is effective from the date the application form is signed by the applicant (the parent or guardian of the child). The policy says a program supervisor can approve retroactive coverage before the application date when the lack of coverage would cause financial hardship. However, it is unclear how supervisors assess such a situation and what circumstances constitute financial hardship.

Initial eligibility

Under the child program, the parent or guardian who claims the child as a dependant on their income tax return and receives the Canada Child Tax Benefit for that child, is considered the applicant. The policy states that this rule applies to parents with joint or shared custody, as well as to parents who are 16-17 years old. The children are the clients.

The initial eligibility section states that health benefits are provided to children in the following circumstances:

1. Children in households with low income, if the household income is equal to or less than the qualifying income level for their household type.

2. Children whose parents are no longer eligible for either the Income Support or AISH programs and do not receive benefits through the family program, are eligible for child program benefits. Households are exempt from the qualifying income level until the annual date of renewal if the application is made within 90 days of the Income Support of AISH file closure. In these cases, coverage is retroactive to the day following the closure of the Income Support or AISH file.

3. Children of applicants approved for full-time learner benefits unless the applicant fails to start the training program. These households are also exempt from the qualifying income level until the annual date of renewal.

4. Children of applicants who are low-income refugees or refugee claimants as long as they are legally entitled to stay in Canada.

4.6.3 General Policy

Payment Of Benefits

The General Policy states that both family and child program clients are expected to use their health benefits card to obtain eligible health goods or services. The benefit providers (such as pharmacies and dentists) then deliver goods and services within the rules in the applicable agreements and drug lists.

The programs fund 100% of the eligible expenses at the cost agreed on in the benefit provider user agreements. The exception to this is if a family has coverage through another benefit provider, for example, an employer. In those cases, SCSS charges the employer and then covers the rest of the cost under the General Policy – Coordination of Benefits.

Reimbursements

A reimbursement is a sum paid to a client to compensate them for money they spent on a qualifying benefit, such as a prescription refill or dental check-up. Page 25 of the Health Benefits Training Manual says the program does not offer reimbursements. Program staff also told us the programs do not issue reimbursements under any circumstances.

The General Policy contradicts this position. It says that reimbursements can be made if the programs provide prior approval for the payment or if "the expense was incurred during an emergency situation."

Through our review of SCSS's Action Request Tracking System (ARTS), we saw examples where clients asked for reimbursements but were denied and directed to contact the service provider (their pharmacy) and ask them to issue a refund (see case study). We did not see any case where a client was approved for payment of an expense or reimbursed for expenses incurred in an emergency.

Case Study – Backdating and Reimbursements

In August 2022, Janet, an adult program recipient, wrote to the then Minister of Health asking for reimbursement for medication costs she incurred after being cut off from the program between October 2021 – January 2022. Janet said in September 2021, she received a letter from the program telling her benefit coverage was ending at the end of the month. Janet submitted documents showing she was eligible. The program reviewed the information and reinstated her benefits in January 2022.

Janet complained that during the lapse of coverage, she incurred medication costs. She asked the program to reimburse her for those expenses. The program confirmed she was eligible for benefits, but they could not reimburse her for the costs she incurred. Instead, it suggested she ask her pharmacy to resubmit her prescriptions to Alberta Blue Cross using her benefit card and then have the pharmacy reimburse her directly. Janet noted her pharmacy told her it cannot reimburse her this way.

Outcome: Dawson's concerns were resolved after the program contacted the pharmacy about the issue and the pharmacy agreed to reimburse her.

Backdating

The Health Benefits Training Manual speaks about backdating files, which involves changing the active coverage dates to extend the date of service. Backdating allows the client to ask their service provider to refund them for any benefit expenses they directly paid for. The service provider can then submit a payment request for the expense through Alberta Blue Cross using the client's benefit card. Again, the onus is on the client to coordinate this with their service provider directly. The programs do not issue refunds or provide reimbursements.
An assessor can backdate a client's file to show they should have had benefits from a date before their receiving goods or services from a provider.

Examples that may require a backdate on a file include:

- If an assessor made an error when keying in the start date in a client's file;
- The AHB Production system was not working and required a data fix; or
- A client's file transfer from AISH or Income Support was delayed.

There are specific limitations to backdating files. For example, an assessor cannot backdate a file to before the beginning of the current benefit year. So, if a problem occurs on September 25 but is not reported to the program until October 10, the furthest back the assessor can backdate the file is to September 30. This is because October 1 is the beginning of a new benefit year.

Processing applications

The policy describes how assessors should process family program applications and enrol clients with ongoing prescription drugs and diabetic supplies needs.

While the policy requires staff to notify applicants of their eligibility for the family program by letter, the policy does not require the program to keep a copy of the letter on the applicant's file.

Annual Renewal

Every year at the same time, all the active client files for both programs are reviewed to see if the current clients are still eligible for the next benefit year. This is called Annual Renewal. Annual Renewal applies to all program recipients except those in sub-type 78 Pregnancy.

The policy states the benefit year is July 1 to June 30. However, in 2020, the benefit year was changed to October 1 to September 30 annually.

If the client has not filed taxes for the last year, CSD must send a letter to notify the client their benefits will end at the end of the benefit year (September 30) and tells the client they should file their tax return. To be considered again for either program, the client must file their taxes and then send CSD their NOA to have their financial eligibility assessed. Once CSD receives the CRA documents, assessors review the client's financial eligibility.

Exceptions to Qualifying Income Levels for Renewal

The programs realize that a client's income in September of a given year may be lower than reported on their last year's income tax return, which covers the previous calendar year. When the NOA shows the income is higher than the qualifying income levels, the policy says CSD staff may request documentation to verify:

- The client's anticipated income for the current income tax year; and
- The cost of ongoing prescription drugs and diabetic supplies.

Assessors can then re-calculate eligibility by estimating the client's income for the balance of the year, deducting the household's cost of ongoing prescription drugs and diabetic supplies. This option for income reassessment is available only after October 1 of the calendar year and is not available two benefit years in a row.

Re-adjudication

At any time during the benefit year, if a family's structure changes, CSD may need to check whether a household is still eligible for benefits. For example, when a dependent turns 20 years old, they are removed from the household's file, and the file is sent to be automatically re-adjudicated to determine if the remaining household members continue to be eligible.

4.7. The Technology

To better explain our findings, we provide the following context about the technology the programs use.

The programs use two different systems:

1) **DIMG** is a new workflow tracking system introduced in June 2021 to process the programs' applications and accompanying documents. Everything sent to the programs is first processed through DIMG. Here are some details on how documents are processed in DIMG:

    - Faxed documents are automatically digitalized and added to DIMG in the order in which they are received.
    - Mailed documents are scanned by administrative staff and uploaded to DIMG. The system can also accept documents by email, but we found the programs do not use it.
    - Administrative staff "index" the application package, which involves labelling each key record in the system (i.e., Application Form, NOA, Residency certificate), to help assessors locate the information quickly. Administrative staff also enter essential identifying information such as Social Insurance Number (**SIN**) and Personal Health Number. The application is then placed in the DIMG work queue.
    - Assessors are the CSD staff who review the applications and data, conduct reassessments, and respond to specific questions from Albertans about the programs. Calls of this nature taken by assessors are referred to as Tier 2 calls made to the HBCC while Tier 1 calls are typically general in nature and handled by the call centre staff.
    - Assessors open the work queue in DIMG, and in date order, process the applications. If there are any missing documents or information, DIMG will automatically generate a letter to send to the applicant or client, explaining what is missing and instructing the individual to contact the programs. In July 2022, the letters retained on the system were blank (a glitch).
    - If an application does not include any income information, the programs send an electronic request to the CRA to verify income. A response takes only 15 minutes. The assessor then adds the income to the application.

- Once an application is processed, the assessor exports the file to the main legacy system, AHB Production.

2) **AHB Production** is a system that automatically adjudicates applications and stores all the client files. AHB Production is referred to as a "legacy program" because it is old by technology standards.

    - If the application is complete, AHB Production will automatically adjudicate the file to assess it for eligibility for the program.

        - If the application is approved, AHB Production sends a notification to Alberta Blue Cross, which automatically sends out the approval package and health benefit cards to the client.

        - If the application is denied, AHB Production automatically generates a letter, which staff must print and mail to the applicant informing them of the outcome.

    - If the application is not complete, AHB Production automatically generates a letter for the applicant telling them to mail or fax the missing information. At our site visit June 29, 2023, we learned the system will only generate a letter for one missing information issue at a time; so, if more than one piece of key information is needed, the applicant will not be notified until they respond to the first notification letter.

    - Every year during the annual renewal period (August – September), the programs experience multiple technological glitches with AHB Production. These glitches negatively impact many vulnerable Albertans. These are detailed in section 7.3.

    - Transition Bin: AHB Production has different holding areas, called bins, where files are sent depending on the action required. The Transition Bin is where applications are held if they are missing any information or are incomplete. The Transition Bin automatically generates a letter (or letters) notifying the applicant or client what information is missing. The file is then held in the Transition Bin indefinitely waiting for a response from the applicant or client.

    - Staff do not monitor, or check files sent to the Transition Bin. At the time of our site visit on July 13, 2022, there were approximately 5,300 files in the Transition Bin.

4.7.1 Limitations of the System During Renewal

During the renewal period, assessors' access to the AHB Production database is limited for about two weeks, which can cause problems for applicants and clients. Assessors work within an offline version of the database for about two weeks, until September 1.

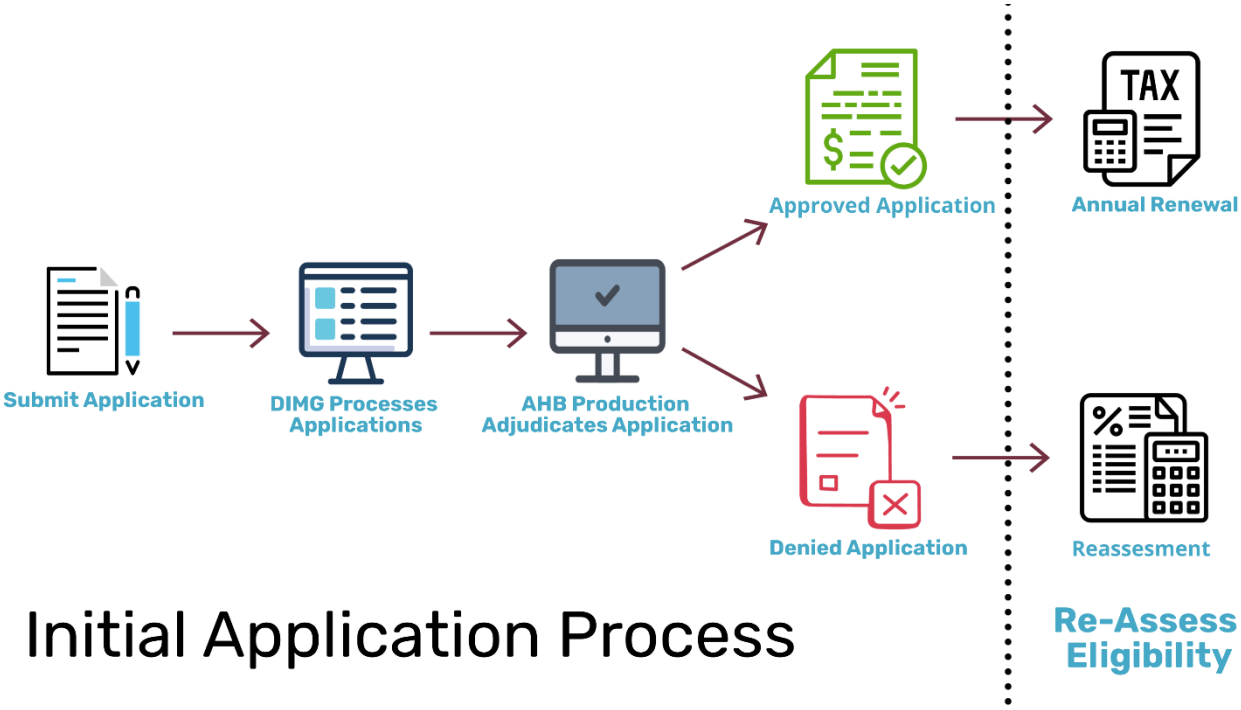
An email from the programs' supervisor explained that in this time, assessors cannot:

- Update addresses or names.
- Update information related to the dependents, spouse, or applicant.
- Add a spouse or dependent.
- Perform any Director Approvals, File Closures, or Resubmits.
- Print any correspondence or benefit cards.
- Create or import files from CRA.

Later, the supervisor explained that during the offline period, assessors individually track applicant and client changes where they might have to add, update, or remove information. After the offline period is over, each assessor then must use their own tracking notes to update the applicant and client files in AHB Production.

4.8. How Applications are Processed

The graphic below illustrates how CSD processes applications.



4.8.1 Initial Applications

The policy currently says the benefit period is from July 1 to June 30; however, the programs have changed the benefit period from October 1 to September 30 to better align with the CRA. Administratively, the renewal period for the programs is from mid-August to the end of September. During the renewal period, and before October 1, the programs request income verification from CRA on all current client files. The goal is to assess if a client is still eligible to receive the benefit. As of October 1 of each year, if the household's income is too high, the clients would lose their benefits.

The programs automatically renew health benefits for the next benefit year if the household or family income provided by the CRA is below qualifying income levels, after deducting the household's annual prescription or medical expenses for the family benefit.

4.8.2 Reassessments

We learned about reassessments from reviewing the programs' website, reassessment policy, our site visit on July 13, 2022, and from numerous interviews. The programs use the common term "reassessment" to describe any review of applicants' or clients' eligibility for benefits. We found this very confusing as there are at least three different types of reassessments:

1. An estimation of a household's income (done only between October 1 to February 28).
2. A re-adjudication of an existing application using the more recent year's NOA (completed between March 1 and September 30).
3. Re-adjudication of a household's income after a life change (for example, separation or divorce).

If a person applies for the programs and is found to be ineligible because their household income is too high, they receive a rejection letter, which says they are not eligible because the family's income exceeds the programs' maximum. The letter also tells the person they "may request a reassessment" of their eligibility.

As of June 21, 2023, the website explained:

> "The current benefit year is October 1, 2022, to September 30, 2023, and program eligibility is based on your 2021 income assessed by the Canada Revenue Agency. Before you can request an income reassessment, your application must have already been denied based on your 2021 income."

The programs divide the year into two parts: October 1 to February 28 and March 1 to September 30. The way the programs re-evaluate a person's eligibility depends on when in the year they apply for benefits. The website refers to reassessments occurring any time of the year, but this is not accurate.

October 1 to February 28

If a person is denied benefits after October 1 of a given year, they can request a reassessment. Essentially, they are asking the program to use an estimate of their income to test for eligibility for the rest of the current year.

This is possible only if the person can provide enough documentation for staff to estimate their income. Instead of using last year's NOA for proof of income, the applicant can give the assessor evidence of income for this year, which the assessor will then use to estimate the client's income for the rest of the year.

For example, if a person was denied benefits at the renewal on October 1, 2022, based on their 2021 NOA, they can provide proof of income such as pay stubs, Employment Insurance documentation, or Workers' Compensation benefits, and the assessor will estimate their household income for 2022. This estimated income, minus the household's cost of ongoing prescription drugs and diabetic supplies, is then used to manually calculate the client's eligibility.

When staff spoke about reassessment, they were referring to this estimate of income. The Government of Alberta's website[3] provided the following directions to people for an income reassessment:

> **To apply for an income reassessment**
>
> You must follow these steps:
>
> 1. Complete the Request for Reassessment of Eligibility for Health Benefits form (PDF, 704 KB).
> 2. Write a cover letter explaining your current income situation and why it differs from your 2021 income.
> 3. Collect appropriate income verification/estimated income documents as stated above.
> 4. Mail or fax all reassessment documents.

To approve a file after reassessment, the assessor uses a Director Approval. A supervisor explained that this is a manual process that tells the system to ignore the income check and process the application as approved. Director Approval is an override that allows an assessor to tell AHB Production to override the automated adjudication and approve the file.

March 1 to September 30

If a person applies for benefits between March 1 to September 30, the programs use their NOA from two years previous, not the immediate past year, to determine their income. For example, if a person applies for benefits on March 30, 2023, the programs use income from the 2021 NOA to assess eligibility. This lets people apply for benefits even though they may not have yet filed their most recent taxes. If the programs deny the application because the income is too high, the rejection letter says they can request a "reassessment."

This excerpt from the website described the steps an applicant should take if denied benefits between March 1 and September 30, 2023.

> **To apply for an income reassessment**
>
> You must follow these steps:
>
> 1. Complete the Alberta Adult Health Benefit application as before.
> 2. Attach a copy of your 2022 CRA Notice of Assessment.
> 3. Mail or fax it.

[3] https://www.alberta.ca/alberta-adult-health-benefit

Case Study - Reassessments

Bob wrote to the Minister of Health, complaining he and his wife's family program coverage was terminated.

As directed in the termination letter Bob received from the program, he submitted a request for reassessment. However, the program told him his request did not have enough information for the program to reassess his application. Bob emailed the Minister's office.

Outcome: The Minister responded to Bob's email, telling him he can:

Reapply for the program using his 2021 income submitted to CRA instead of his 2020 income. Should he choose this option, he needs to complete a new family program application and request for reassessment form. He should also provide a copy of his family's 2021 medication costs.

If he reapplies and is again denied, starting October 1, Bob can request another reassessment which would estimate his family's 2022 income.

Importantly, the Minister provided no information to Bob about his ability to submit a notice of appeal regarding the program's termination of his coverage.

However, this is not correct. Staff explained that applicants do not have their income reassessed during this time, despite what the program website and rejection letter say.

Staff said this is neither a re-application nor a reassessment because the applicant does not need to send in a new application form, and assessors are not manually estimating the applicant's income. In this situation, the programs should ask the applicant to send in their most recent NOA from the last calendar year.

Going back to our example, if the person applies for benefits using their 2021 NOA between March 1 and September 30, 2023, and is denied, once they have filed their income tax return for 2022, they can submit the NOA from 2022 and use that to assess eligibility.

When a person is denied benefits before October 1, they will frequently follow the instructions on the website and submit another application and attach their newest NOA. However, a new application is unnecessary and can cause problems. While the assessors typically check to see if there is a previous application by searching both systems using the client's SIN, they may miss the duplicate (they have to search two systems and six different places.)

Supervisors say that assessors should know that it is a re-application because the latest NOA is attached, but that is not always the case. If assessors do not realize the reassessment request is a duplicate, they may process the package as a new application and the file will go through the normal adjudication process. This often results in different decisions and contradictory correspondence sent to the person, confusing to them and assessors.

If the assessor does find the original application, they do not add any new information or create a new application to the file. They simply review the income from the latest NOA and if all information is provided, leave a note indicating what information the programs received and then use 'Director Approval' to approve the application, overriding the original decision denying it.

The last type of re-assessment occurs when family structure changes. The programs must review the client's eligibility for the program based on the new structure. For example, if a couple divorces, and the family changes from two adults and two children to one adult and two children, the programs must check to see if the new family structure meets the qualifying income for the programs.

4.9. How the Programs Communicate with Applicants and Clients

4.9.1 Written Correspondence

The programs try to communicate with applicants and clients using regular mail. But they can't track if letters were mailed.

Most of the correspondence the programs send out is generated automatically by either the AHB Production or DIMG systems, which send out personalized letters created from templates loaded into the systems. Administrative staff receive digital batches of letters each day that they print and then mail out. DIMG stores a copy of the letters generated for applicants and clients, but AHB Production does not. Neither system can track whether a letter was printed and mailed out.

The letters the programs send tell people what's missing from their file, program decisions about eligibility, answer a specific request, or alert clients to a coming event that may affect their household eligibility.

For example, when a person submits an incomplete application, DIMG will generate a letter telling them there is missing information. The letter explains what information the program needs and tells the person to either provide the information by calling the HBCC or to send the missing information by regular mail or fax.

Eligibility decisions can occur at different times throughout the benefit year.

People approved for benefits receive an ACHB Approval letter or AAHB Approval letter and benefit cards, sent out directly from Alberta Blue Cross. We reviewed the approval packages, and identified several issues, discussed below.

People found not eligible for the programs receive a letter with decision. What they receive depends on the process that found them not eligible (for example, at renewal or through reassessment).

The programs have an email address, but up until recently it was only used as a last resort; it was supposed to be used when people could not use mail or fax. When a person emailed the program, they received an automated response explaining the programs required documents to be sent as PDFs. This occurred even though DIMG converts all file formats for indexing by assessors.

When people mail or fax information to the program, the programs do not confirm they have received the information. The only confirmation a client may have is the fax confirmation sheet from the sending fax machine. If people want to confirm the programs have received their information, they have to phone the programs.

But if they call the HBCC, the person they speak with may not be able to confirm the programs received the documents because they are not tracked or visible until they are uploaded to DIMG by staff.

4.9.2 Verbal Communication

The HBCC receives calls from the public. It handles basic calls seeking general information about the programs. Assessors handle more detailed calls. For example, the status of an application, including what information is missing and what the next steps are. When people call the HBCC, staff will either answer the question or transfer the caller to an assessor.

Assessors only rarely phone people and are actively discouraged from making calls. If an assessor is working on an issue for a person, they will ask the person to call back later while they try to resolve the problem. Once the problem is solved, the assessor records the outcome in the person's file. This allows any assessor who receives a call from a person to explain how the problem was solved and the outcome. It also puts the onus on the person to contact the programs again.

After a call, assessors can record the details in the comments section of the file in AHB Production. The Health Benefits Training Manual does not mention recording the details of the conversation in the comments section or anywhere else. This means the programs do not consistently record all communication between themselves and applicants or clients.

4.10. The Programs' Complaint Process

4.10.1 Complaint Escalations

People can complain about the service they receive from the programs. When a person asks for their concern to be escalated, the assessor completes an escalation request in the programs' SharePoint and assigns it to a team lead or supervisor. Supervisors coach assessors to log comments on the client or applicant's file, indicating the caller requested an escalation. However, this is not a requirement.

After receiving a note about the escalation, the team lead or supervisor will review it and typically call the person, even if the escalation was requested in an email. The team leader or supervisor is supposed to log the outcome of the escalation in SharePoint. As a best practice, the team lead or supervisor should also log a comment on the applicant or client's file, summarizing the outcome.

4.10.2 Quality Assurance

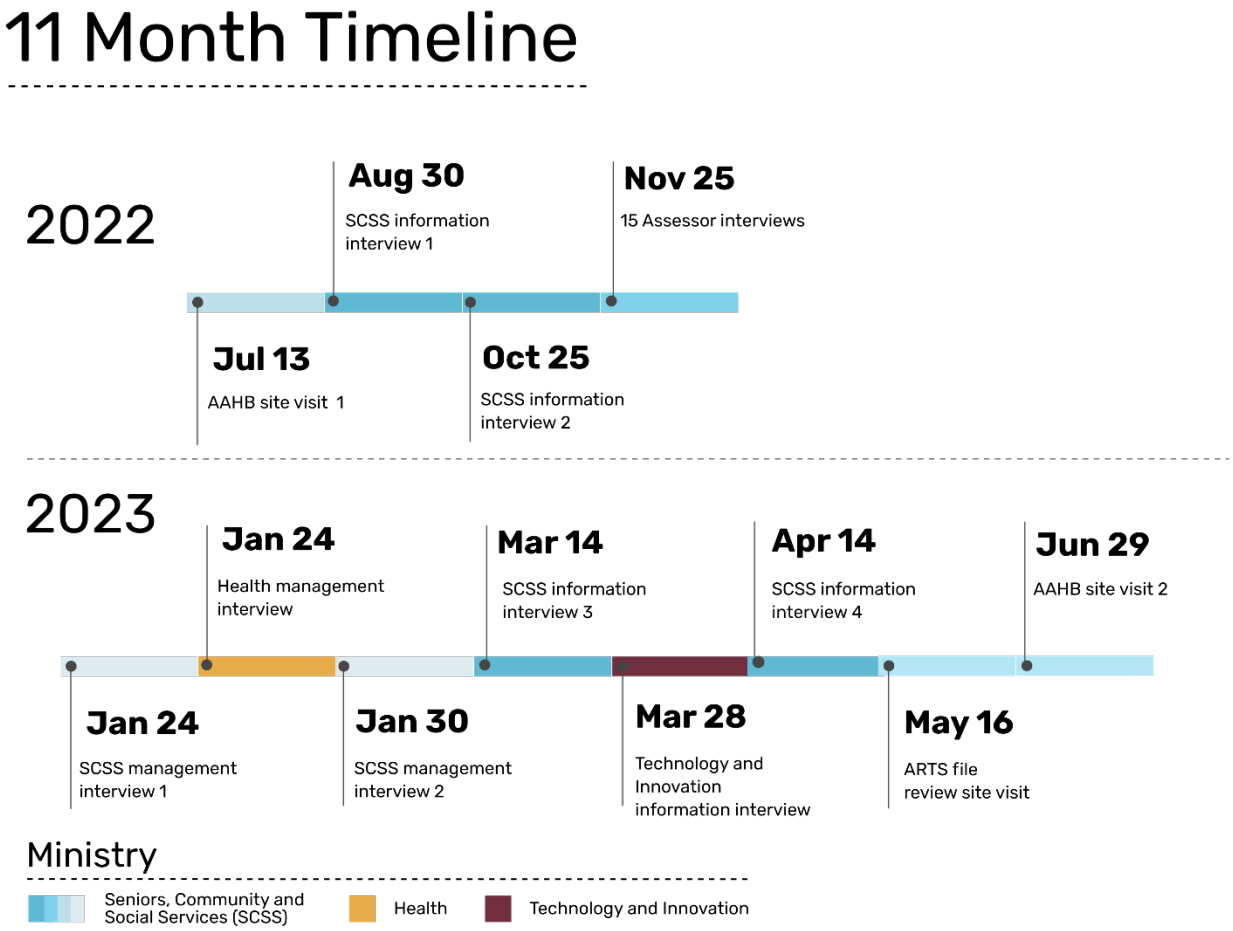
CSD's Contact Centre Quality Management Guide (the Guide) says all calls to the programs are recorded. Supervisors are supposed to listen to at least three call recordings each month and complete a call evaluation form for each assessor. If an assessor falls below the average score (85/100), supervisors are supposed to provide

coaching such as one-on-one mentorship, email feedback, or job shadowing. Supervisors are to provide assessors with call evaluation cards every month.

But we found no evidence that call evaluations are being completed and staff explained that evaluations have not occurred for the last several years. Supervisors will review call logs if they receive a complaint about a specific assessor.

5. Interviews with the Authorities

Over an 11-month period, we interviewed multiple people from CSD, Alberta Health, and Technology and Innovation. Below is the timeline of our interviews, file reviews, and site visits:



5.1. Seniors, Community and Social Services

We conducted numerous interviews with staff from SCSS. We interviewed one subject several times as they were the most knowledgeable about the programs.

5.1.1 Site Visit

July 13, 2022 - The purpose of this meeting was to learn how the family program works, how its database systems work, and to review files we had received complaints about over the past three years. The key insights from these interviews:

- **The programs don't keep documents**. The new DIMG system was supposed to retain a copy of the letters printed out and mailed to applicants and clients. But all the letters we viewed in the system were blank. AHB Production shows the date a letter was printed but does not keep a copy.

- **Staff throw out letters**. Staff said that if a letter is missing information, such as an incomplete address, they will put it in the recycling bin. They do not notify assessors or make notes on the client file.

- **No quality controls are in place**. Supervisors do not have time to evaluate assessors' work.

- **No monitoring of incomplete files**. The Transition Bin stores applications waiting for missing information before being sent to adjudication. It had 5,300 files at the time of our visit. No one goes back to check on those files. They are not sent to adjudication, so people don't get a decision or updates.

- **No policies on internal complaint escalations**.

- **Assessors do not consistently record their discussions** or interactions with applicants and clients in the database systems.

- **The onus is on applicants and clients to** find out what is happening with their file.

5.1.2 Supervisor / Team Lead Interviews

Interview #1 - The purpose of this interview was to follow-up on our questions about how the programs operate and process applications. The key insights from this interview:

- The programs' email address is neither publicized nor used for the regular submission of applications; it was just created during COVID. All submissions to the programs must be sent by fax or regular mail except in special cases.

- Applications to the programs are processed in the order they are received.

- Adjudication of an application is done automatically by AHB Production after all the required documents are entered into DIMG.

- Applicants can submit missing information up to the end of the benefit year (September 30). After that, they would have to submit a new application. This is because once the new benefit year begins, assessors can no longer re-submit a file.

- Most correspondence is automatically generated by AHB Production. There is no way for supervisors to know if letters have printed successfully and been mailed out from AHB Production.

- About 5 – 10% of calls to the programs are related to missing documents.

- Evaluations or monitoring of staff interactions with clients (as the Guide requires) have not been done for at least two years.

Interview #2 - The purpose of this interview was to learn more about the template letters, reassessments, how the family program manages dependents who turn 18 or 19 years old, communication with clients, escalations, and quality control. The key insights from this interview:

- The only time applicants and clients are notified of the right to appeal is when they have completed an income reassessment and been denied.

- When a child turns 18 or 19, their parent must submit a statutory declaration to the family program confirming the child is still in school. This is the only way for the child to stay on the household's benefits. While waiting for the declaration, the family's file is manually classified as an "exception," which allows the rest of the household to keep receiving benefits. Otherwise, the whole household would have benefits withheld.

- Manual tasks, such as exceptions, are a "point of failure" in the system because the assessors do not always complete the task, (for example, because they are away), or the system does not let it go through.

- There is no set time for processing applications; however, the programs try to keep the turnaround under four weeks. At the time of interview, it was two weeks.

- Alberta Health gives the final sign-off on the template letters. It can take considerable time to get new letters uploaded and operational in the system.

Interview #3 – The purpose of these interviews was to clarify technology issues and invite suggestions for improvements to the programs. The key insights from these interviews:

- Six significant technical glitches occurred at the last renewal in August/September 2022. These are all reported in the Technical Problems, section 7.3 of the report.

- The only matters the program tells clients they can appeal are those related to being declined benefits based on income after reassessment.

- The programs are direct bill programs only. They do not offer reimbursements, even when there is an error or technical problem with the programs' IT systems.

- One supervisor creates all the training materials for the programs.

Suggestions for improvements raised to us included:

- Increase the income thresholds—they are too low and have not been updated for years.
- Replace AHB Production with a new content management system. Clarify policy. It is hard to clarify the program's position at appeals.
- Advertise the programs—they are not as well-known as they should be.

Interview #4 - The purpose of this final site visit was to follow up on several issues we learned about in our July 13, 2022, site visit. We confirmed the following key insights in this interview:

- The DIMG system now retains copies of outgoing client letters. But AHB Production does not keep any client letters.

- The programs are not conducting assessor call evaluations as the Guide requires. There are no quality checks except when a client complains about an assessor to the supervisor.

- Staff no longer throw out client letters instead of mailing them. A glitch in the mail merge function has been fixed so the address block is complete and readable on all letters. Staff now review the addresses on all letters to ensure it is close to the Canada Post address and fix any errors and reprint the letter.

- Multiple letters can be "triggered" in DIMG at different stages in processing by different assessors, resulting in duplicates of letters to a client. When staff receive multiple letters for the same client, they will review DIMG to identify which letter makes the most sense to send; usually the most recent letter.

- AHB Production is limited to sending one letter at a time for any missing information.

- The programs get a lot of returned mail. The day we visited, 40+ letters had been returned in the past three days. Staff explained they don't have time to call clients about returned mail. But they will go into the client's file and to see if the comments show a new address. If so, they will resend the mail. If not, they make a note about the incorrect address. They currently do not close the client's file.

- Four of five files where clients had complained about their benefits with CSD did not have comments reflecting how complaints had been dealt with by the assessors or managers.

5.1.3 Assessor Interviews

It was important to get the perspective of the programs' front-line staff who process applications and interact with applicants and clients. We interviewed 13 assessors. A key question we asked them was: "What suggestions do you have to improve the program?"

November 25, 2022 - Key insights from these interviews:

- Program application forms are confusing. While a household can apply for all the adults and children using the family form, many applicants send in both the family and child program forms.

- Duplicate applications are a problem: applicants commonly send in more than one application. DIMG and AHB Production do not alert assessors if there is already an application in the system. So, if an assessor does not check for duplicates already on file, the applicant may get multiple, contradictory letters from the programs.

- The most common missing information in applications is the medication list (75% miss this). The second most common missing information is immigration documents.

- The programs' interaction with each other causes lapses in coverage. One example was a family switching from the child program to the family program. They may have child program coverage for their children, but now they have ongoing prescription drugs and diabetic supplies costs, so they qualify for the family program. The child program cannot just switch the family over to the family program. The assessor must close the child file and wait for a family application to be processed.

- There are still a lot of complaints about clients not receiving the program mail.

- If the programs receive returned mail, indicating a client may have moved without telling the programs, standard practice is to close the client's file, stopping benefits. Assessors may try to call a client first, but if they don't speak to the client, the standard practice is to stop benefits.

- Faxing is difficult and frustrating for clients. It's an earlier technology and an uncommon way for people to submit documents. Most people do not have access to a fax machine.

- Most assessors said the income thresholds for the programs are too low.

- Dental expenses cannot be used as an ongoing medical expense; only prescription drugs and diabetic supplies are accepted.

- There was an increase in denials at renewal time in October 2022 because many households received Canada Emergency Response Benefit (CERB) which increased their income in 2021. CERB income was not exempted.

- There are technical glitches associated with the renewal period.

- On a typical day on the phones, assessors may take 25 – 40 calls each.

- Staff at the HBCC (Tier 1) cannot update client files; they can only add comments to a file. This means changes a client thinks have been made to their file, for example an updated mailing address, may not be changed. An assessor

(Tier 2) can make changes, but unless the assessor sees the comment or note, the address is not changed.

- Assessors believed the training they received was lacking and communication among the assessor team could be better.

Suggestions for improvements raised to us included:

- Have an online fillable application form; a system that does not allow the applicant to submit the form as incomplete.
- Combine the program application forms so families can select which program they are applying for.
- Allow the programs to send and receive information by email.
- Allow DIMG to automatically search for and recognize duplicate applications.
- Produce clearer and more comprehensive letters telling applicants and clients all the steps they need to take and what information is missing, rather than piecemeal letters.
- Provide more specific information in reassessment letters about what the programs need from applicants and clients.
- Audit files to confirm self-employment income and whether 18 and 19-year-olds are still in school.
- Allow other medical costs to be used to assess eligibility, such as yearly dental and psychologist costs.
- Avoid interruptions in benefits by not requiring staff to close one file to process another for the same family.
- Improve the program computer systems and fix problems faster.
- Improve communication between the HBCC and the assessors.
- Improve training for assessors; ensure clearer communication among all assessors.
- Allow assessors to transfer calls to one another or to a team lead.
- Produce clearer information on the program websites.

5.1.4 Management Interviews

We interviewed program management to better understand their perspective on the problems with the programs, how they have communicated their concerns to the Deputy Minister's office, and what improvements they think would help the programs.

Interview #1 – The key insights from this interview:

- Income thresholds should be reviewed as they do not reflect the current economic situation for Alberta families.
- The reassessment process needs improvement: it is administratively burdensome for Albertans and staff.
- AHB Production desperately needs to be replaced as it no longer meets program needs.
- The programs do not get a lot of appeals.

Interview #2 – The key insights from this interview:

- The technology system is old; they need an entirely new system that is user-friendly, and web based.
- The IT provider is slow to react to problems with AHB Production; CSD needs to constantly ask about the status of fixes.
- Managers are not involved in training, reimbursement requests, backdating files, adjudications, transfers, or reassessments. They have little involvement in applicant and client complaints or escalations; supervisors are trained by their peers to respond to escalations.

5.2. Alberta Health

The team had one manager interview with Alberta Health.

January 24, 2023 – The key insights from this interview:

- Since 2014, Alberta Health's responsibility for the programs has been for policy development and management, and expenditures. Alberta Health's policy role is to determine medical services and costs covered by the programs, fee schedules, and income thresholds.

- The main barrier facing the program is a lack of staff, which results in longer application processing times and an outdated IT system.

- Program improvements raised to us included the following areas:

    - The delineation of roles between Alberta Health and SCSS
    - Staff training materials
    - The IT system

5.3. Technology and Innovation (Formerly Service Alberta)

Given the involvement of Technology and Innovation in contracting technological services for the programs, we concluded it was important to understand their view of the problems with the technology. We conducted one interview with a key staff member from Technology and Innovation.

March 28, 2023 – The key insights from this interview:

- Business Technology Operations' Application Management Services (AMS) branch manages the IT application AHB Production. Technology and Innovation considers it an old, limited "legacy application." The programs would benefit from a new IT application.

- Since at least 2014, Technology and Innovation understood that Alberta Health would provide funding to maintain AHB Production; however, this has not happened. Instead, Technology and Innovation has being using its own annual operational budget to maintain AHB Production; this has been very costly. For

example, we were told that for the 2022-23 fiscal year, Technology and Innovation spent $290,000 on AHB Production.

- AMS decided to submit an Authorization to Proceed to raise concerns about using its funds to maintain AHB Production. AMS submitted a draft Authorization to Proceed to Alberta Health in December 2020. To date, Alberta Health has not responded.

- On January 3, 2023, the province announced its desire to develop a new digital strategy. Part of the new strategy is to create and use modern technology to administer programs. Because of this, there is a belief that the province no longer wants to put time or money into legacy applications like AHB Production.

- Many of the IT issues facing AHB Production result from its age and limited capability. The most common reported IT issues are:

    - Missing information for a family program client's spouse;
    - Information disappearing from a family program client's file; and
    - Coverage dates showing incorrectly.

An in-depth tracking list of all the IT tickets related to AHB Production was shared with us.

6. File Review

We sent a request for documents from Alberta Health and SCSS's Action Request Tracking System (ARTS) on March 16, 2023. We asked our ministry contacts for the full record of action requests in the ARTS system related to the programs. This included all briefing notes, recommendations to the Minister, and internal correspondence related to the programs.

The team completed the ARTS file review on May 16, 2023. Our review of the various files is integrated throughout this report.

7. Key Findings

7.1. Preliminary Findings

Our preliminary meeting with CSD staff on July 13, 2022, raised urgent concerns. We met with our contacts in both ministries to allow them to resolve the problems immediately, before we issued our report. That would improve outcomes for thousands of Albertans.

7.1.1 Findings Related to Processing Applications

On October 24, 2022, we met with both Alberta Health and SCSS to share our preliminary findings.

We followed up with a letter to the DMs of Alberta Health and SCSS on October 27, 2022, on six issues:

1. **Unfair application denials** – the family program denies applicants benefits without:
   a) clearly explaining how the applicant failed to meet the eligibility criteria;
   b) explaining the legislative authority for the decision; and
   c) informing applicants of their right to appeal.

2. **Lack of information** – The departments fail to adequately explain to applicants what is needed when applying for the family program. Specifically, the application form does not give all the information required from applicants to assess eligibility for ongoing prescription drugs and diabetic supplies.

3. **Correspondence to applicants may not be sent** – As of July 13, 2022, staff discard letters with missing information or an address that does not make sense. They do not tell the assessors the letter has been discarded or make a note on the file.

4. **Lack of internal controls** – CSD does not review assessors' work, monitor the Transition Bin which houses over 5,000 incomplete applications, or evaluate calls between assessors and applicants or clients calling the HBCC.

5. **The onus to learn the status of files is on clients and applicants** – CSD relies on people to call the HBCC to learn the status of their file. The template letters sent to applicants and clients do not explain what applicants or clients must do next.

6. **The template letters are not administratively fair** – Many of the letters do not cite the legislative authority for the decision, notify applicants and clients of their right to appeal, or explain next steps.

Authority's Response to Preliminary Findings

On February 17, 2023, CSD shared a copy of their response to these preliminary findings, a document called the Health Benefits Contact Centre and Processing Improvement Project workplan. CSD sent an update on July 12, 2023, showing they had taken little action to correct these problems.

7.1.2 Findings Related to the Template Letters

On April 14, 2023, we shared our suggestions to improve the administrative fairness of the template letters with SCSS. We concluded there was some urgency to provide this feedback ahead of the Ombudsman's final report because the Health Benefits Project workplan set a target of updating all the letters by March 2023.

Details about the problems we identified with the template letters are reported in section 7.2, finding 10.

The email response from Executive Director, CSD, acknowledged our suggestions and said they would review the suggestions for adoption and implementation. The updated

workplan set the estimated date of completion for the template letter updates at the fourth quarter of 2023-24, so not until March 2024.

7.2. Findings Related to the Issues

These findings, and the related recommendations, are aimed at improving the programs' processes to ensure Albertans are treated fairly.

Issue #1 Are the procedures for processing applications for the programs administratively fair?

1. Finding: The family program does not give adequate reasons for denying benefits

The family program will deny benefits without explaining why.

For example, if a person does not send at least 90 days of ongoing prescription drugs and diabetic supplies receipts (many people fail to send receipts) and their income is above the eligibility levels, AHB Production denies the application. The rejection letter says it is denied because the household income exceeds the program maximum.

But this is only partly true. It would be more accurate to tell applicants they did not qualify because they did not include evidence of the family's ongoing prescription drugs and diabetic supplies expenses.

Case Study - Inadequate Reasons

In March 2022, Gita contacted her MLA, the then Minister of Health, asking the Minister to help her connect with staff from the family program.

The MLA's office said Gita applied for the program and was denied. Gita contacted the HBCC to ask why she was denied, as the letter she received was unclear. Gita reported she was provided with inconsistent information from the HBCC.

Outcome: The program left a voicemail for Gita explaining the reasons her application was denied and the additional information she should provide to the program so they could assess her eligibility.

If applicants contact the program after they are denied and ask for more information, assessors should tell them to submit a Patient Expense Report showing their annual costs for prescriptions or medication receipts.

The rejection letter then goes on to say, "if your current income is lower than reported the previous year or your family has high ongoing prescription medication costs, you may request a reassessment of your eligibility…". It does not specifically say the family program requires at least 90 days of ongoing prescription drugs and diabetic supplies expenses to deduct from the household income. Or that the application was denied because the applicant failed to provide enough documentation to calculate the yearly costs for prescription expenses.

2. Finding: The programs do not adequately explain reassessments

When people are denied a benefit, they are told they can ask for a reassessment, an internal review process unique to the programs.

But the programs impede people's participation rights when they do not clearly explain the different types of reassessments. People may not understand the status of their application, what information the programs require to assess their eligibility at different times of the year, or the available reviews and appeals.

Staff said the reassessment letters are confusing and result in many more inquiries. They wish the letters could more specifically tell the applicants all the information they are missing.

3. Finding: The programs generate letters but do not ensure they send the letters

When letters are generated by the DIMG system or AHB Production, this simply indicates the letter has been created by the systems, but not that it has been mailed. Once the letter is printed, there is no guarantee that staff mail the letter. If there is anything that does not make sense in the letter, like a sentence missing in the template or something missing in the address line, staff will simply discard it. They do not make a note in the file indicating they did not mail a specific letter. Rather, the programs rely on applicants and clients to call into the HBCC to ask what is going on with their file.

As of July 2022, no safeguards were in place to ensure a letter has successfully been mailed.

After our October 24, 2022 meeting, the program clarified the proper administrative procedures after printing a letter. We learned that any letters "that are not valid are returned to the Team Lead." The Team Lead is then supposed to follow up with the assessors to correct the problem.

At our June 29, 2023, site visit, staff said they are no longer discarding letters. Staff explained that previously there was a problem with the mail merge, and the addresses in some letters were not complete. CSD has since fixed this problem. Staff said they now check address blocks and if there are errors or problems, they return the item to the assessor.

Moving forward, to ensure the mail problem does not recur, it is important to put safeguards in place to monitor outgoing correspondence.

It is administratively unfair for the programs to fail to issue written decisions to applicants or clients, as this impairs their participation rights. It also means the duty of fairness is not met, as the programs fail to notify people of their right to another level of review.

4. Finding: People could apply and submit information only by fax or regular mail

As section 4.2 explains, we discovered that people could submit documents (including applications) to the programs only by fax or regular mail. This has been corrected and people can now submit applications through email.

Staff report that faxing is a problem because most Albertans do not have easy access to a fax machine. Many people become confused about how to provide the programs with the information it needs. More problems resulting from faxing include:

- Faxing is difficult and documents are often unreadable or lost;
- Applicants will often fax duplicate copies of their application because they do not know if the program has received their original; and
- Documents come in too dark or too light, so people must resubmit them.

We have seen evidence of these problems in several complaints to our office.

Further, to mail in their application, most people will print the application form and fill it out using pen or pencil. This leads to increased errors as assessors must decipher applicants' handwriting. Recently, the programs updated their application form to make it editable but it is still missing key information.

Email is one way people could submit their application to DIMG or communicate with the programs. But at the time, we were told the programs don't use email. Staff explained that they could not support the workload if everyone emailed material and most people do not know how to send in PDF files, which is the only file format the system accepts.

This explanation was confusing, as the DIMG manual says the system can accept documents in other formats and automatically updates it to PDF. The DIMG manual explains that all that is required is for staff to forward the email to the DIMG system, and it automatically adds the documents to the Incoming Docs box. We confirmed DIMG can convert other file formats during our site visit on July 13, 2022.

Previously, supervisors discouraged staff from using email with applicants and clients. They used email only as a last resort. This impeded Albertans' participation rights, as it reduced how securely and effectively people could send information to the program.

5. Finding: The programs deny reimbursements, contrary to policy

The General Policy allows clients to request reimbursements if the programs provide prior approval for the payment or if "the expense was incurred during an emergency situation."

But the General Policy does not explain how a client obtains prior approval, nor does it define what an emergency is. Even if a client made such a request, we were told neither SCSS nor Alberta Health can issue funds. Further, the General Policy does not cover situations where clients may incur costs because the program technology is not operating correctly. That occurs frequently around renewal time.

Staff told us about a technical glitch which occurred in August 2022 during the renewal period, estimating almost 5,500 client files were closed in error. Later, we learned the number was in fact 7,394 files closed because of the glitch. The programs learned about the coverage ending early when clients called the HBCC to say their health benefit card did not work. The programs' IT provider, CGI, had to do a large data fix behind the scenes, which took several days. During the lapse in coverage, assessors told clients they could not fix the problem and could not offer coverage. Clients were directed back to the service provider to try their card again when coverage was reinstated. However, the programs would not provide reimbursements.

The same problem happens when the programs backdate benefit start dates. The programs may agree that a client is eligible for benefits from an earlier date, yet they do not reimburse clients for expenses incurred in the backdated period.

Both Alberta Health and SCSS tell clients to request reimbursements from the service provider directly. An email from Alberta Health to a client says the programs do not have the ability to generate a cheque to reimburse a client and "Alberta Blue Cross does not issue cheques for AAHB unless the higher ups get involved and force ABC [Alberta Blue Cross] to do so."

The programs' refusal to issue reimbursements is an unfair fettering of discretion available in the General Policy.

SCSS argues that clients can contact the 24/7 Income Support Contact Centre for immediate assistance. This is limited to a month's worth of prescription medications or emergency dental services.

6. Finding: The child program does not have a procedure for approving retroactive coverage in situations of financial hardship.

Policy for the child program says clients can be approved for retroactive coverage if the household is in financial hardship. However, there is no procedure explaining how an assessor would determine financial hardship. Without a clear policy, the chain of legislative authority is impacted, and clients are not treated fairly and consistently by the program.

7. Finding: Clients temporarily lose coverage when they move between or within programs. Emergency benefits to fill the gap are only partial.

Assessor interviews revealed that clients can lose coverage if a client switches between family and child benefits or between family program sub-types. When this happens, the client's coverage stops until the new benefit is processed.

Clients have a legitimate expectation that if they have been receiving benefits, and continue to be eligible, their benefits will not stop.

A household with child program coverage for their children could become eligible for the family program if one of the household members has a new ongoing prescription drug or diabetic supply cost. In this case, the parents can apply for the adult program for the whole family, essentially adding health benefits for the adults in the home in addition to the children. But CSD cannot just switch the family. Assessors must close the child program file and wait for a family program application to be keyed into the system. This typically results in a break in coverage.

As noted under Finding 5, SCSS argues that clients can contact the 24/7 Income Support Contact Centre for immediate assistance. This is limited to a month's worth of prescription medications or emergency dental services.

8. Finding: The programs do not consistently record all verbal communication with clients

During our investigation staff said that if people want to know what is happening with their file, ask questions, or provide updates, they must phone the HBCC to speak with an assessor. They couldn't email. So most of a person's communication with the programs was verbal.

During our site visit on July 13, 2022, we reviewed the cases familiar to us in the programs' system. We did not see any notes relevant to issues we already knew about. On June 29, 2023, we reviewed a sample of five client files we learned about through the ARTS file review. Two of them had notes relevant to the problems the clients raised with the programs.

The programs do not have a policy requiring assessors to log comments in the applicant and client files in the AHB Production system, including any complaints or escalations. Instead, assessors are told it is best practice to add comments to the files when they interact with people. We find this to be inadequate.

Not requiring assessors to note all their communications with applicants and clients restricts Albertans' participation rights, as their interactions, concerns, and questions are not fully captured by the program and considered for decision-making. Given that most of the contact between the programs and applicants or clients is through telephone calls, the lack of adequate notetaking directly diminishes applicants and clients' participation rights as their arguments and evidence are not part of the record for decision-making.

9. Finding: The programs' auto-response email says the programs accept only PDF files

Initially, the auto-response email from the AHB@gov.ab.ca email address was incomplete and inaccurate. It told recipients they can submit only PDF documents to the program. The email told people to call the contact centre, but it did not provide a phone number or the full name of the centre so people could look it up. We pointed this out to CSD last year (July 2022), and it had not changed.

As of October 6, 2023, the auto-response email has been updated to include contact information including the HBCC's phone number. But it still says only PDF files can be submitted to the program.

Issue #2: Does the family program communicate with applicants and clients in an administratively fair manner?

10. Finding: Template letters do not consistently meet the requirements of administrative fairness

We reviewed all template letters the programs use to communicate with applicants and clients. On April 14, 2023, we provided feedback to CSD on the template letters. Here is a summary of our feedback:

1. **Legislative authority** – The letters issued by the programs should identify the legislation giving the Director the power to make a specific decision and identify the decision-maker, even if that is by title.

2. **Appeal information** – To meet the duty of fairness, whenever the programs issue a decision letter that denies a benefit, including a request for reimbursement or backdating, or stops issuing the benefit, they must inform the affected person of their right to appeal the decision. We cited 19 template letters that should have a notice of appeal but do not.

3. **Reassessments** – The term "reassessment" is used to refer to three different processes. So it was challenging to understand what a reassessment was, and how and when a person could request one. The programs should use distinctive terms to describe the various types of reassessments affording people their right to participate in the process.

4. **Contact information** – Clients may lose their benefits if they do not notify the programs of an address change, usually discovered when CSD receives returned mail. To improve fairness, the programs should emphasize the importance of clients' keeping their address current in three different template letters.

Case Study - Appeals

Myeong contacted her MLA's office to complain that her family program benefits, which she has been receiving for eight years, were stopped. She understood that the program had discontinued benefits as she had not provided a copy of her most recent tax documents. However, Myeong said she had submitted her tax documents to the program multiple times. When she spoke with the HBCC, they told her benefits were stopped because her income was above the threshold. Myeong contacted CRA, who confirmed her income was below the threshold.

Myeong was not advised of her right to request an appeal of the decision to end her benefits.

Outcome: After Myeong contacted her MLA's office, an assessor reviewed her file, including the documents from CRA and confirmed her eligibility. Myeong contacted the HBCC and was told her benefits were reinstated and she would receive updated benefit cards.

5. **Clear and consistent information** – To ensure people have fair and equal access, the programs should use the same term to refer to the cost of ongoing prescription drugs and diabetic supplies. They should also provide applicants and clients clear, accurate instructions for how to contact the program through the appropriate call centre - HBCC.

6. **Deadlines** – The programs do not set deadlines for making decisions on applications or for returning requested material. So applications sit in the Transition Bin with no decision and no access to an appeal. To meet the duty of fairness, the programs should issue decisions within a reasonable timeframe and give applicants information on appeals.

7. **Next steps** – Many template letters do not clearly inform people of the next steps or what happens next. This impedes their participation rights. For example, if a person does not provide a statutory declaration about an 18-year-old child still being in school, their benefits will stop. Typically, the letters just tell people to call the HBCC. Albertans have a legitimate expectation the programs will disclose all the information people need to understand their obligations. The programs should tell people what they must do next.

11. Finding: The programs do not adequately inform applicants and clients of their appeal rights

Any decision about a person's eligibility can be appealed to the Citizen's Appeal Panel. However, the only time the programs inform people of their right to appeal is when they have been denied benefits following a reassessment. This does not align with the statute. And it is contrary to the duty of fairness.

Instead, the family program's primary rejection letter offers people the opportunity to request a reassessment. The supervisor shared the advice the programs give to assessors at renewal time when a client might receive this rejection letter.

> "Please do not use the word 'appeal,' clients must first be reassessed/income estimate for current year's income."

As section 4.5.1 (Appeals) explained, we concluded that the only two situations where people do not have a right to appeal are related to:

1. A decision of the health benefit exception committee
2. What service constitutes a "health benefit" under section 73 of the Regulation

We gave this feedback to the ministries on April 14, 2023, identifying the 19 template letters where people should be notified of their right to appeal, but are not.

12. Finding: The programs do not clearly and consistently explain how they differ from each other

People are often confused by the difference between the two programs. The family program application form does not clarify the differences in the two programs. The program's website says the Alberta Adult Health Benefit program "includes children who are 18 or 19 years old if they are living at home and attending high school." This implies the program is for adults only. There is reference to the "household," but no definition of it and no explanation of the relationship between the two programs.

The child program application form and website do not explain how it relates to the family program. So, people may apply for the family program for the adults in the household, and then also apply for the children of the household.

The program names likely contribute to this confusion. The family program name (Alberta Adult Health Benefit) does not sound like a program for a family or household; the name implies it is for adults only.

Albertans have a legitimate expectation that all information they need to understand and apply for a benefit program will be adequately explained on the programs' website and on their application forms.

13. Finding: The family program does not clearly and consistently explain that eligibility depends on households' having ongoing costs for prescription drugs and diabetic supplies

While the family program application form says people must attach a list of ongoing prescriptions and diabetic supplies including the cost, it is not obvious that to qualify for the program, people must have ongoing, recurring prescriptions throughout the year. This impacts applicants' participation rights.

The family program application form has a statement in the footer of the text box on the first page which says:

> "You must attach a list of ongoing prescriptions and diabetic supplies from your doctor or pharmacist, including the cost."

It also says at the end of the application form:

> "…you may be eligible if your combined household income less the cost of prescription drugs and diabetic supplies is equal to or less than the AAHB qualifying income level for your family type."

However, the directions may not be obvious enough or explicit enough, particularly because people must submit **at least 90 days** of ongoing prescription drugs and diabetic supply expenses for the assessors to estimate annual costs. There is no specific field or section of the form requiring people to report these medical costs. So people may not submit the required documentation to allow a fair assessment of their eligibility.

The family program has a definition for "high drug cost," yet this information is not available on the application form. Nor is it available on the program website. To be an ongoing high drug cost the drug must be:

- Listed on the Alberta Health and Wellness Drug Benefit List or Community and Social Services Drug Benefit Supplement or approved by the Health Benefit Exception Committee; and
- Dispensed at least three times in the last year (substantiated by a pharmacy) or confirmed by the prescriber that it is a new prescription that will be ongoing.

Assessors raised the following concerns about the application process:

- The main problem with family program applications is missing medication lists. One assessor said they believe 75% of applications do not have the medication expenses included.
- A quick checklist on the application could help people to send everything the program needs.
- An online application system would allow people to complete the form and have the application go directly to health benefits. It would help people feel more secure about their private information and ensure the form is fully complete.

The requirement to submit at least 90 days of ongoing prescription drugs and diabetic supplies expenses is also not mentioned in the program's Missing Medication letter, on the family program website, or in the rejection letter. These places are where we would expect to find this detail. The rejection letter does say:

> "If your current income is lower than reported for the previous year, or your family has high ongoing prescription medication costs, you may request a reassessment of your eligibility for health benefits."

However, this implies it is optional to send in "high ongoing prescription medication costs," not a program requirement.

By failing to clearly explain what information the family program needs to assess a person's eligibility for benefits, the program impedes their participation rights. There is also a legitimate expectation that all required information for assessing eligibility will be included on the application form.

14. Finding: The family program does not clearly and consistently explain how eligibility is based on household income minus the annual costs of prescription drugs and diabetic supplies

In relation to finding 13 above, the family program's website does not explain that the program calculates the household's income threshold by deducting the annual costs of ongoing prescription drugs and diabetic supplies from the family's income. Failure to provide this information impacts applicants' participation rights.

This is explained on the family program application form; however, the explanation is incomplete as it does not specify it is the full year's costs of prescription drugs and diabetic supplies.

It would be clearer to explain how income is calculated for the programs in both the application form and on the program website, in the section titled "How to Calculate your Income."

Both the application form and website use the word "high" to describe the costs of a household's annual ongoing prescription drugs and diabetic supplies. But it's not cost alone, it's cost relative to family income. If a household of two parents and two children has combined income of $38,000, annual recurring prescription costs of $1,366 or more make them eligible. Another household with income of $96,632 and prescription costs of $60,000 would also be eligible. The point is not the cost in isolation, it's the cost relative to family income.

Our final concern in this area is the wording in the Medical Expenses section of the Request for Reassessment form. It reads:

> "If you believe your current income is insufficient to pay for your family's ongoing health costs, provide the last 12 months of your household's ongoing prescription drug costs for a deduction from your estimated income."

This sentence is misleading because it sounds optional, like the wording in the rejection letter cited above. It is also confusing because the family program needs only 90 days of expenses to calculate a household's annual costs.

15. Finding: The programs put the burden on people to contact the Health Benefit Contact Centre to find out the status of their file or application.

If a person wants to know what is happening with their file or what the next step is if they have been denied benefits, the burden is on them to call the HBCC. The template letters do not adequately explain the next steps.

Case Study – What is happening?

In October 2021, Cameron, a family program client, wrote to the then Minister of Health complaining that his pharmacist recently told him that he and his wife no longer have program coverage for their medications. Cameron complained the family program did not advise him his coverage was cancelled.

Cameron contacted the HBCC and was told the program sent him a letter in August 2021, advising him his benefits had ended because his income was too high. Cameron argued he never received the letter, and it was sent to the wrong address. He had told the program that he moved but they had not updated his address. Cameron said he was told over the phone he could appeal the cancellation of his coverage, but he understood it will be weeks for an appeal hearing to take place.

Outcome: The then Minister told Cameron that based on the additional information he provided following his conversation with the HBCC, a reassessment was underway. If the reassessment finds Cameron is eligible for the program, his health benefit coverage will be backdated to the date he submitted the Income Reassessment documents.

Our review of the template letters found that people are usually directed to call the HBCC or visit the program websites to find out what they should do next. But when we asked CSD program staff how people would know what the programs require, they answered, "They would have to call us."

The programs do not provide full, complete information about the benefit, the status of their applications, and necessary next steps. As a result, people do not have the information they need to respond appropriately or as they see fit.

16. Finding: Program approval letters lack enough information for clients to understand what they must do

We had the following concerns about the approval package:

- The letters do not identify the start date for benefits.
- The letters do not stress how important it is for clients to keep their contact information current (benefits may be terminated if a letter is returned to the programs).
- The letters say clients cannot ask for reimbursements, contrary to policy.
- There is no information about when clients or their dependents may become ineligible for benefits (if their income increases, when they turn 65, or when dependents turn 18 or 19 and are no longer in school).
- The language in the letters is misleading or unclear. For example, "continued eligibility" and "to avoid an interruption in coverage" both refer to a termination of benefits.

Insufficient information given to clients about their obligations impedes their participation rights.

17. Finding: The programs do not confirm they have received material from people who mail or fax them

As section 4.9.1 explains, when people send information to the programs by mail or fax, the programs do not send them confirmation of receiving the information.

Assessors said that people will send documents to the programs multiple times, because they do not know if the programs received the material. The programs end up processing duplicate applications, making incorrect decisions because documentation may not be attached to the right file, and the whole process is slowed down.

The programs do not acknowledge when they receive documentation which in turn impacts clients and applicants' participation rights.

18. Finding: The family program application form has errors

The family program application form incorrectly references the child program in two places. In the declaration section, applicants are asked (under #5) to confirm:

> "I understand my eligibility for the Alberta Child Health Benefit program will be assessed automatically each year, unless I inform the Health Benefits Contact Centre that I no longer wish to receive this benefit."

Applicants are also asked to consent to the CRA providing the Alberta Government information from their income tax returns and other tax information about them for the administration and enforcement of the child program.

There is no reference to the family program in these two instances, even though this is the family application form. Albertans have a legitimate expectation for information on application forms to be complete and accurate.

19. Finding: Program policies do not accurately reflect current program practices

In 2020, the programs changed the benefit year to run from October 1 to September 30. However, the programs have not updated the policy to reflect this change—it still says the benefit period is from July 1 to June 30.

Staff said that the health benefit policies are not as clear and distinct as they could be. As a result, when staff attend appeal hearings for the programs, it is difficult to clarify what the programs have done because it is not in policy. For example, the benefit year is incorrect, the policy does not say when applicants or clients should be notified of their right to appeal, how clients can obtain prior approval for reimbursements, how retroactive coverage in financial hardship cases can be approved, and how reimbursements work.

To maintain the chain of legislative authority and operate within the policy, the programs should update the policy to reflect current practice.

Issue #3: Does the family program have an administratively fair process for addressing service complaints raised by clients and applicants of the program?

20. Finding: The programs lack policies on responding to and escalating complaints

There are no written policies or procedures for how supervisors manage complaints from the public. Instead, staff are trained to resolve problems and encouraged to de-escalate situations.

Supervisors can choose how often they are notified when an assessor has logged an escalation on the programs' SharePoint, or an assessor can tell their supervisor they logged a complaint. There is no standard for when supervisors should respond to escalations, although assessors said it was within 1-3 business days.

Once supervisors resolve an escalation, they can record their action as a comment in the person's file in AHB Production. This is not policy, and every supervisor and team lead have a different approach and practice.

A review of client case files related to previous Ombudsman and ARTS complaints found many of the files did not speak about escalations and none of them said what the supervisor did to resolve the complaint. The case files for one of our complainants did not have any record of any escalations.

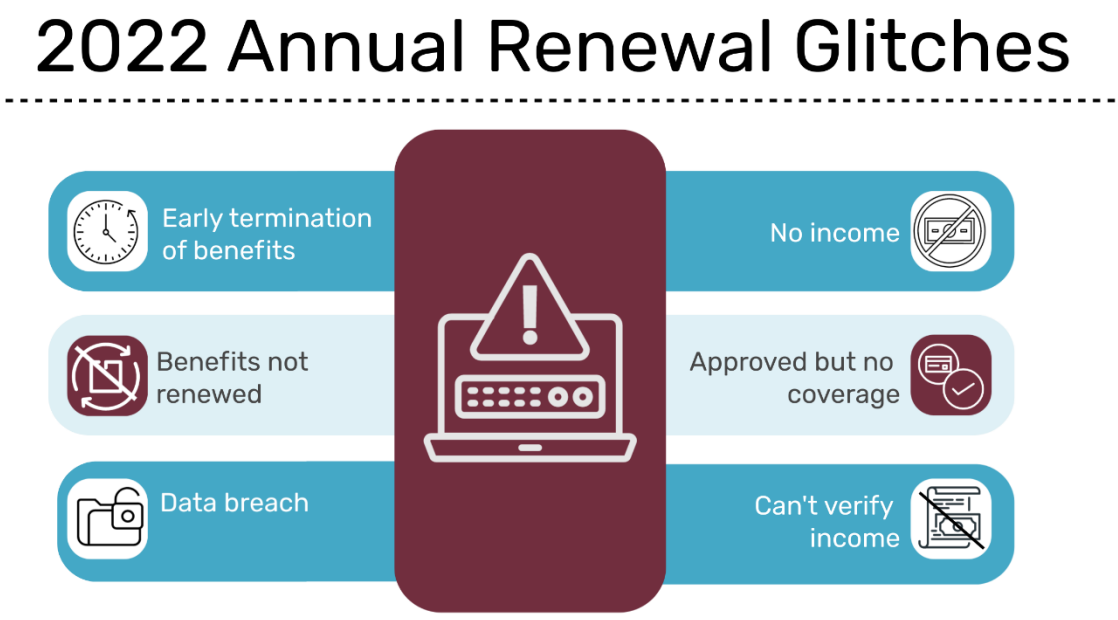
A lack of clear policies is not fair because complaints will be handled inconsistently.

7.3. Technical Problems

21. Finding: Program technology is not effective

Numerous issues came to light during our investigation related to the limitations and technical problems that regularly occur with AHB Production. From our staff interviews we learned about several technical problems or glitches which occur every year at renewal time.

In 2022, six glitches affected thousands of recipients.



1. **Early termination of benefits** – The benefit year for the programs is from October 1 to September 30. If a person is no longer eligible for the program, perhaps because their income has increased, then their benefits would end as of September 30. However, in 2022, the AHB Production system stopped coverage for thousands of people on August 26, 2022. This affected 4,280 family program files and 3,114 child program files. The programs were alerted to the problem when clients began calling because their coverage was declined at the dentist or the pharmacist.

To solve this problem, staff said they:

- Alerted the vendor, CGI, who began working on a fix. CSD reported CGI fixed the system by September 3, 2022.
- Added a recorded message on the HBCC's voicemail telling callers of system problems and plans to resolve them shortly.
- Let people who called HBCC know there was an ongoing technical problem. Assessors then referred clients to emergency benefits. But CSD reported emergency benefits did not receive any requests because of the incorrect expiry date.

2. **Benefits not renewed** – When a file is manually adjudicated by an assessor, they can approve benefits using a Director Approval. The assessor manually adjudicates the file, and the client gets the benefit. A Director Approval does not carry over into the next benefit year. This means the assessor must manually approve the benefit file again each year.

3. **Data breach** – dependents from applications by Ukrainian Evacuees (coded as UKEV in the system), appeared on the files of unrelated family program clients. This glitch was associated with 1,201 UKEV files and 1,002 non-UKEV files. The breach was reported to the provincial Office of the Information and Privacy Commissioner by Alberta Health.

4. **No income glitch** – Files were passed to adjudication and "Approved" without receiving an income verification check from CRA. So files were sent for adjudication with $0 listed as the income for the household in error.

5. **Approved but no coverage glitch** - AHB Production files with subtypes 71 (UKEV), 78 (pregnancy) and 79 (high prescription cost) were showing as approved, but they did not receive coverage. They did not appear to have had any approval letters printed, cards mailed, or coverage dates.

6. **Cannot verify the income glitch** – From our November 25, 2022, interviews with assessors, we learned that since DIMG has come online, there has been a glitch in the system where if a client file is missing any information and sent to the Transition Bin, the system will automatically send a letter to the client saying, "we can't verify your income – missing income information." This is not always correct. The system will also send a second letter telling the client the correct information about what is missing and what the program needs to assess eligibility for the programs.

One-problem-at-a-time letters

At our final site visit, we learned about another problem with AHB Production. The system is limited to generating one letter at a time for any missing information. For example, if an application is missing a list of the ongoing medical expenses and an immigration document, AHB Production will automatically generate a letter for the applicant telling

them about only one problem. This means clients do not learn about any additional problems until they send in material requested from the first letter. Once the program receives the first piece of missing information, AHB Production will generate the next letter asking for the other missing documentation. To minimize delays, staff try to manually check the file to see how many letters should be sent to the applicant or client.

Program staff told us many times that the programs need a new content management system. While we reviewed all the briefing notes related to the programs from both Alberta Health and SCSS, we did not see any concrete plans or evidence that either ministry is tackling these recurrent problems.

Albertans have a legitimate expectation that if they are approved for a specific benefit, they will receive it. Program clients also have a legitimate expectation the programs will work correctly. And if government makes an error, they will not be held responsible to fix it. Finally, clients have a legitimate expectation that program decisions are based on accurate information. These legitimate expectations are not being met while the programs use the current technology.

22. Finding: Staff at the Health Benefit Contact Centre cannot directly update client files when people call to report a change

Staff at the HBCC do not have access to make changes in the AHB Production system. So if a client calls the HBCC to update their address, which the program requires them to do, the staff answering that call (Tier 1 call centre staff) cannot change the client's address. All that Tier 1 staff can do is make a note on the client's file. After, if an assessor does not read the note and make the required change, any correspondence sent from the programs will go to the client's old address. Likely, then, any future correspondence will be either lost or returned to the program as the recipient is no longer at the address.

Administrative staff said that when mail is returned, they will check the file to see if there is a note updating the mailing address. If there is, they will make the necessary changes.

But critical information may be lost or delayed, such as renewal decisions denying a benefit or a request for a statutory declaration for a child about to age out of the program.

Clients have a legitimate expectation that if they call the HBCC as directed to notify the programs of any changes these changes will be updated on their file.

23. Finding: The inability of staff to transfer phone calls impedes prompt complaint resolution

The telephone technology the programs use does not allow all staff to transfer calls from one assessor to another or to a team lead. This limits the public's access to prompt complaint resolution with a team lead or supervisor.

7.4. Findings related to accountability of the programs

24. Finding: The programs do not issue decisions on incomplete applications

The Transition Bin is the holding place for applications with missing information. It has thousands of files where no decision has been issued. At the time of our first site visit on July 13, 2022, over 5,300 files were in the Bin awaiting information, having accumulated over the past year.

No one monitors or checks the files in the Transition Bin. When an application ends up in the Bin, staff assume the system generates a letter and front office administrative staff print and mail it. Applicants end up in limbo with no benefits and no decision.

There are times when mail is not sent, or the correct letter is not generated, or other mail problems arise. So applicants do not know the outcome of their application and are stuck with no benefits. With no decision, there is no right to appeal.

We reported this concern to our contacts with both ministries. On July 12, 2023, CSD confirmed they have started clearing out the Transition Bin.

Albertans have a legitimate expectation that when they apply for the programs, they will receive an eligibility decision within a reasonable time. If the application is incomplete, people have a legitimate expectation the programs will tell them what information is missing and give them adequate time to provide it. Neither of these expectations are met. To meet the duty of fairness, the programs should issue a decision on all applicants' eligibility promptly.

25. Finding: Supervisors are not evaluating calls, contrary to the CSD Contact Centre Quality Management Guide

Supervisors are not evaluating assessors' phone calls with applicants and clients who call the HBCC, contrary to the CSD's Contact Centre Quality Management Guide. However, if a person calls and complains to a supervisor that an assessor was disrespectful to them on a specific day and specific time, the supervisor can listen to those calls. They can then respond to concerns.

As it is required by policy, we expect the programs to evaluate calls.

26. Finding: The programs lack procedures to ensure outgoing mail is actually sent and returned mail is handled fairly

In CSD's July 12, 2023, update on the workplan, they confirm the program is now ensuring letters are printed properly. The update also states that administrative staff will forward any incorrect letters to an assessor for review. We understand the original problem we identified with discarded mail arose when the mail merge function did not operate properly.

Because written correspondence is the only form of communication between the programs or applicants and clients, there should be consistent oversight to confirm staff are following the correct procedures to deal with incorrectly addressed mail and that this process be put into policy. This would meet the guideline for chain-of-legislative-authority and protect peoples' participation rights.

It is not administratively fair to close files when a letter is returned to the programs. Further, we did not find any policy that explains how the programs should manage returned mail.

When we finished our investigation, we understood the programs were not closing files when mail was returned. But it was previously considered a best practice. Until critical updates can be made to the AHB Production system, or a new system is implemented, the programs should not automatically close files when mail is returned.

27. Finding: The programs' training programs for assessors are inadequate

Our interviews with staff and managers identified the need for the development of a more comprehensive training program for assessors.

Supervisors would like the training material to be more standardized, with examples to illustrate how assessors should complete their work. Ultimately, they would like to have the training accessible through the Government of Alberta's business application or a similar online platform.

Having a comprehensive training program for all assessors will ensure they comply with legislation, regulation, and policy.

28. Finding: Managers are not directly involved in delivering the programs

Only one person was responsible for a large portion of program operation. As of spring 2023, one person was responsible for training, supervising assessors, preparing for and attending appeals, re-writing template letters, reviewing reimbursement requests and backdating requests, reviewing reassessments, conducting call evaluations, and responding to service complaint escalations.

Throughout this investigation, that person was working in an acting capacity. Yet she was clearly the knowledge-keeper for the program and key to most of the programs' functioning. This heavy centralization of function and knowledge in one person creates a risk for the future administration of the program.

8. Findings, Recommendations, and Observations

At the conclusion of an investigation, the Ombudsman may make recommendations and/or observations. If an issue of administrative unfairness is identified, the Ombudsman usually makes recommendations to remedy that issue. Sometimes an investigation uncovers the potential for unfairness or identifies areas of concern that do not meet the threshold of unfairness. In these latter cases, the Ombudsman may make observations. The Ombudsman expects recommendations to be followed and monitors an authority's compliance with them since they are meant to remedy a specific issue identified in the investigation. Observations are monitored differently since they are meant to provide assistance to authorities to prevent potential unfairness.

8.1 Findings and Recommendations

Findings	Recommendations
Processing applications	
The family program does not give adequate reasons for denying benefits.	1. I recommend the family program explain why it denies benefits.
The programs do not adequately explain reassessments.	2. I recommend the programs use distinct terms to describe each type of reassessment to clarify the type of decision and the information people need to provide for the programs to assess their eligibility, including: • the estimate of household income • a re-adjudication of an existing application using a more recent Notice of Assessment • a re-adjudication of household eligibility after a life change
	3. I recommend the programs correct the website and rejection letter to clarify that if an application is denied between March 1 and September 30 of any year, people can submit their most recent notice of assessment to have their application re-adjudicated.
	4. I recommend that if an application is missing information, the programs give people a full list of all the information they need to complete the review.

The programs generate letters but do not ensure they send the letters.	5. I recommend the programs: • set up quality control procedures to confirm letters are properly printed and mailed • resolve any technical problems quickly
People could apply and submit information only by fax or regular mail.	6. I recommend the programs examine using an online application system.
The programs deny reimbursements, contrary to their policy.	7. I recommend the programs follow their policy and approve reimbursements for costs caused by program errors or emergencies.
The child program does not have a procedure for approving retroactive coverage in situations of financial hardship.	8. I recommend the child program follow its policies and approve retroactive coverage to avoid financial hardship.
Clients temporarily lose coverage when they move between or within programs. Emergency benefits to fill the gap are only partial.	9. I recommend the programs ensure clients receive all the coverage they are entitled to.
The programs do not consistently record all verbal communication with clients.	10. I recommend the programs' policies require assessors to record all interactions with everyone.
Communicating with clients and applicants	
Template letters do not consistently meet the requirements of administrative fairness.	11. I recommend the programs update all their template letters to meet the requirements of administrative fairness. Letters must: a) identify the Director's legal authority to make a specific decision and identify the decision-maker b) give people notice of their right to appeal a decision to deny or end a benefit c) distinguish the different types of internal review or reassessment at different times of the benefit year d) tell clients their benefits may end if they do not inform the program of an address change

	e) use a consistent phrase to refer to ongoing prescription costs and medical expenses f) use only the number for the programs contact center g) set deadlines for clients to submit documents and then inform people of the decision h) tell people the next steps to resolve specific issues or problems
The programs do not adequately inform applicants and clients of their appeal rights.	12. I recommend the programs give people written notice of their right to appeal if their benefits are denied or ended.
	13. I recommend the programs consider an appeal process like the Assured Income for the Severely Handicapped (AISH) program uses.
The programs do not clearly and consistently explain how they differ from each other.	14. I recommend the programs' application forms and websites explain how the programs differ.
The family program does not clearly and consistently explain that eligibility depends on households' having ongoing costs for prescription drugs and diabetic supplies	15. I recommend the family program update all program information (such as the application form, website, and template letters) to clarify that to be eligible for benefits, people must: • have ongoing costs for prescriptions or diabetic supplies • submit at least 90 days of receipts for these costs
The family program does not clearly and consistently explain how eligibility is based on household income minus the annual costs of prescription drugs and diabetic supplies.	16. I recommend the family program update all program information (such as the application form, website, and template letters) to clarify that to determine eligibility, the program deducts ongoing costs for prescriptions and diabetic supplies from household income.
	17. I recommend the family program remove the word "high" from its description of annual prescription costs.

The programs put the burden on people to contact the Health Benefit Contact Centre to find out the status of their file or application.	18. I recommend the programs provide better written information to people about the status of their files or applications, next steps, and reasons for program decisions.
Program approval letters lack enough information for clients to understand what they must do.	19. I recommend the programs amend the approval packages to include: • the start date for benefits • an explanation of when the client or their dependents may become ineligible • a notice that benefits may end if the client does not notify the program of a change in mailing address
The family program application form has errors.	20. I recommend the programs correct typographical errors in the application form.
Program policies do not accurately reflect current program practices.	21. I recommend the family program update its policies to reflect current practices.
Responding to complaints	
The programs lack policies on responding to and escalating complaints.	22. I recommend the programs establish policies for responding to and escalating complaints. The policy should include: • procedures to notify supervisors of an escalation • a timeframe for supervisors to respond to a complaint • what supervisors should note on the client file • if there is a higher level of review to an impartial decision-maker If complainants are not satisfied with the outcome of escalation, the programs may refer them to the Ombudsman.

Fixing technology problems	
Program technology is not effective.	23. I recommend Alberta Health and Seniors, Community and Social Services immediately resolve recurring problems caused by their ineffective technology.
	24. I recommend the ministries work with other government partners to replace the legacy program, AHB Production.
Staff at the Health Benefit Contact Centre cannot directly update client files when people call to report a change.	25. I recommend the programs ensure they update client files when people call to report a change.
Ensuring accountability	
The programs do not issue decisions on incomplete applications.	26. I recommend the programs monitor incomplete applications in the Transition Bin and set reasonable deadlines for applicants. If the programs don't receive information by the deadline, they should decide the application and notify applicants of the decision.
The programs lack procedures to ensure outgoing mail is actually sent and returned mail is handled fairly.	27. I recommend the programs develop procedures to handle mail. The procedures should: • require staff to ensure outgoing mail is actually sent • explain the steps staff must take before closing files
The programs' training programs for assessors are inadequate.	28. I recommend the programs develop and deliver more comprehensive, standardized training for assessors.

8.2 Findings and Observations

Findings	Observations
The programs' auto-response email says the programs accept only PDF files.	1. The programs' email auto-response should have accurate information about acceptable file formats.
The programs do not confirm they have received material from people who mail or fax them.	2. The programs should confirm that they have received material from people who mail or fax them.
The inability of staff to transfer phone calls impedes prompt complaint resolution.	3. The programs should ensure that staff can transfer phone calls internally.
Supervisors are not evaluating calls, contrary to the CSD Contact Centre Quality Management Guide.	4. The programs should follow the CSD Contact Centre Quality Management Guide and evaluate calls.
Managers are not directly involved in delivering the programs.	5. The programs should ensure that managers have a role in the decision-making processes, provide adequate support and oversight of the programs, and perform quality control and monitoring of the program.

9. Glossary

Acronym	Full Name
AAHB	Alberta Adult Health Benefit (the family program)
ACHB	Alberta Child Health Benefit (the child program)
Act	*Income and Employment Supports Act*
AHB Production	Primary database for all client files
AISH	Assured Income for the Severely Handicapped
ARTS	Action Request Tracking System
AMS	Application Management Services
Assessors	CSD staff who process AAHB and ACHB applications
CRA	Canada Revenue Agency
CSD	Common Service Delivery, in SCSS
DIMG	Distributed Imaging system used to track applications
Guide	CSD Contact Centre Quality Management Guide
HBCC	Health Benefit Contact Centre
MOU	Memorandum of Understanding
NOA	Notice of Assessment from Canada Revenue Agency
Policy	Alberta Adult Health Benefits Policy
Regulation	*Income Support, Training and Health Benefits Regulation*
SCSS	Seniors, Community and Social Services
SIN	Social Insurance Number
SSA	Shared Services Agreement
Transition Bin	A folder in AHB Production where incomplete or deficient applications are held

If you have any questions about the Alberta Ombudsman, or wish to file a complaint with us, please get in touch.

Edmonton Office:

9925 – 109 Street NW, Suite 700
Edmonton, Alberta T5K 2J8
Phone: 780.427.2756

Calgary Office:

801 - 6 Avenue SW, Suite 2560
Calgary, Alberta T2P 3W2
Phone: 403.297.6185

Email: info@ombudsman.ab.ca
Website: www.ombudsman.ab.ca
Toll free: 1.888.455.2756

Social Media: